JHS- Risk Management

Jackson Health System
Clinical Orientation Program
Objectives

- Explain the term Just Culture
- Describe the role of the R.M. department
- Recognize events reportable to R.M.
- Discuss who reports events, in what time frame and where (Quantros system).
Just Culture

- Reduce harm to the next patient
- Turn adverse events into opportunities for improvement
- Allows people to acknowledge their mistakes and learn from them
- Sharing of lessons learned without fear of retribution
- Balances the need to learn from mistakes with the need to take disciplinary action
Chain of Command

- Health care professionals must communicate up through the chain of command until there is resolution of the issue
Chain of Command: Physicians

Chief Medical Officer

Chief of Service

Attending Physician

Senior/Chief Resident

Intern/Resident
Chain of Command - Nursing

- CNO
- Assoc. CNO
- Administrator in Charge (AIC)
- Director Pt Care Services
- Associate Director
- Nurse Manager
- Associate Nurse Manager
- Clinical Staff Nurse
- Staff Nurse
Chain of Command: Other Professionals

Administrator

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Department Director

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Manager/Supervisor

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Health Care Professional
Risk Management Defined

• Healthcare Risk Management is the identification, analysis and evaluation of risks.
Risk Management Functions

- Maintain an incident reporting system to track events.
- Correct, reduce or eliminate risks.
- Investigate and analyze all incidents and provide recommendations and/or measures to reduce risks and injury.
Additional Roles

• Works in conjunction with Quality Management
• Helps minimize system exposure to legal and economic loss
• Reports to regulatory agencies
• Supports the disclosure of adverse events.
What is the name of our reporting system?

- We are all a part of the risk team.
- Duty to report adverse events within 3 business days
Reportable Events

What are some of the events that should be reported?

- Sexual Assault Allegations
- Death in restraints – must be reported to CMS.
- Equipment malfunction- must be reported to the manufacturer.
Types of Events

• **Near Miss** – events that could have caused harm to the patient but never reached the patient.

• **Adverse Incidents** – requires medical intervention; results in harm to the patient.
Types of Events cont’d

- **Code 15** – Result from medical intervention rather than patient condition.
  - The RM must report these to the state within **15 calendar days** of the event.
    - Death, brain or spinal injury, permanent disfigurement, fracture/dislocation of bones/joints, removal of surgical foreign objects, surgery- wrong pt, procedure, or site.
Documentation: Key Points

• Report: Who, what, when, where, and how
• Report any identified occurrence or potential occurrence.
• Reported by the person who was directly involved or witnessed the occurrence.
• Do not reference the incident report in the medical record
Documentation: Key Points

• Incident reports are confidential.
• Incident reports are not the place to provide an opinion.
• Access Quantros via the net portal or directly from the medical record.
Post Event Follow Up

- **Investigation** – Questions regarding the facts. Medical record review.
- **Review** – Clinical review; multidisciplinary. Result: Develop a risk reduction strategy.
- **Root Cause Analysis** – Find **real cause** of an event; focus on system instead of individual. Result: Action plan for improvement.
• Must disclose any adverse incident that results in serious harm.
• Disclosure must be done asap by the attending physician.
• Disclosure is not acknowledgement of liability; cannot be used as evidence in a malpractice trial.
Sexual Misconduct

- Allegations reported immediately to RM and Supervisor.
- Police notification; If the person is a vulnerable adult or child, also notify DCF
- Licensed professionals also have results of the accusation and investigation submitted to the Department of Health (DOH).
- While there is an investigation the accused is placed on administrative leave.
Restraint/Seclusion – Reporting Death

• If the patient dies while in restraints or seclusion it must be reported. This excludes the 2-point soft restraints.
• Dies within 24 hours after the pt has been removed from restraints or seclusion.
• If the patient dies within a week of use of restraints or seclusion; restraint contributed directly or indirectly to the death.
Equipment Malfunction

- Report to supervisor and biomed engineering
- Remove equipment from patient care area; quarantine
- Put it in Quantros
- If the patient is harmed put it in Quantros including the harm to the patient and how managed; notify RM
PACU – 2 Person Rule

- There must be more than one person caring for patients in PACU. Except in emergencies.
- Exempt from the 2 person rule if:
  - live observation, electronic observation
A Farewell to Falls

- Staff documents Morse Fall Score per shift
- Patients should be on fall precautions as necessary
- Bed alarms must be set if applicable
- Bed must be in the low position
A Farewell to Falls

• **After a Fall:**
  – stabilize patient & notify primary team
  – Document who was notified
  – Conduct a post fall assessment and document
  – Complete a post fall huddle with staff
  – Carry out and document post fall orders
• Document all in Quantros and notify supervisor and the RM if there is an injury
Contact Security (85-6111):

– If you feel threatened or are unsure of your safety or the safety of the patients
– If someone is being disruptive
– If you ask a visitor to stop taking pictures in the patient care area and they refuse
Potential Claims of Liability

• Claims for liability are managed by claims adjusters.
• Risk Management Claims section manages medical malpractice, general liability claims for the system.
• Examples: Injury, theft, fire, vandalism, property damage, auto accident, etc.
Risk Management

Main – 305.585.2900
JNMC – 305.654.3199
JSMC – 305.256.5162

Risk Manager on call 305.216.5391