Clinical Risk Management Basics:
What Health Centers Need to Know
February 17 & 18, 2010

About KePRO

• Quality improvement and care management organization

• Founded in 1985; headquartered in Harrisburg, PA

• Works with HRSA on Medical Malpractice Claims Reviews and Risk Management Services under a contract initiated in 2004.

• Provides risk management and patient safety technical assistance to section 330 FTCA deemed Health Centers and Free Clinics.

www.kepro.org

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About ECRI Institute

- Independent, not-for-profit applied research institute
- Patient safety, healthcare quality, risk management to healthcare organizations across the continuum
- Dedicated Web site for HRSA grantees. Log in with user id and password at: www.ecri.org/clinical_RM_program
- 40-year history, 320 person staff
  - Physicians, nurses, patient safety, risk management, quality professionals, clinical engineers
  - AHRQ Evidence-Based Practice Center
  - WHO Collaborating Center
  - Federally designated Patient Safety Organization

Objectives

- Recall the definition of clinical risk management
- Recognize three main goals of clinical risk management
- Identify the steps in the risk management process
- Recall three important characteristics of a culture of safety
- Recognize the top five areas of clinical risk for health centers and their providers
What is clinical risk management?

- An approach to improving the quality and safety of healthcare by identifying what places patients at risk of harm and taking action to prevent or control the risks

Clinical Risk Management Goals

- Identification of risks
- Prevention of harm, injury, and loss
- Control of systems and processes
  - Reducing severity
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Risk Management Process

Identify Risks ➔ Analyze Risks ➔ Select/Implement Strategies

- Corporate Level
- Health Center Level
- Provider Level

Systematic Risk Management Process

 Identified Risk ➔ Priorities Set ➔ AVOID ➔ PREVENT ➔ REDUCE ➔ SEGREGATE ➔ SEPARATE ➔ DUPLICATE ➔ CONTRACTUAL TRANSFER ➔ TRANSFER ➔ Feedback
Web Resources

Appropriate Prescribing of An Eight-Step Approach

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A systematic approach advocated by the World Health Organization can quality and erroneous prescribing. This six-step approach to prescribing

Identify Risks

- Findings from assessments
- Claims reports
- Near misses
- Reports and trends of adverse events and unsafe conditions
- Medical records
- Patient complaints and surveys
- Patient safety alerts

Web site Resources:
- Self-Assessment Questionnaires
- Toolkits
- E-news
Sample Policies and Tools

**HANLING PATIENT COMPLAINTS**

**Purpose**
To provide an efficient and effective mechanism for reporting patient complaints.

**Guidelines**
1. A chain of command* to handle patient complaints should be established, with appropriate authority and direction for handling day-to-day practice administrators should be available.
2. Any patient concern may be promptly resolved.

**ANECDOCTAL NOTE FOR PATIENT COMPLAINTS**

*All patient, family, or external customer concerns are part of the Quality Improvement.*

- Date of Report: __________
- Name of Patient (or other involved): __________

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**Comprehensive Internal Reporting**

- **Adverse events**
- **Near misses**
- **Unsafe Conditions**
- **Sentinel events**
Analyze Identified Risks

- Priorities
- Trends
- Potential magnitude

Risk Control Techniques

- Avoids or reduces the frequency or severity of a risk
  - Exposure Avoidance
  - Loss Prevention
  - Loss Reduction
  - Segregation of loss exposure
Risk Control Techniques (cont.)

- Separation of loss exposure
- Duplication of loss exposure
- Contractual transfer for risk control
Web Site Resources

www.ecri.org/Clinical_RM_Program

Web site resources:
- Guidance articles
  - Web Resources
- Sample policies & tools
- Standards & guidelines
- Education & training tools

Monitor the Risk Management Program

Are the selected techniques working?
- Set standards for acceptable performance
- Compare actual results with expected results
- Correct substandard performance
- Alter unrealistic standards

Self-Assessment Questionnaire

Corrective Action Form

ECRI Institute
“Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.”

Culture of Safety

- Culture of safety
  - “Collective product of individual and group values and attitudes, competencies, and patterns of behaviors in safety performance”
  - Strategic goal / Core value of every health center/Service
- Risk management/patient safety as “everyone’s responsibility”
- Proactive ID of unsafe practices
- Mistakes openly discussed
- “Just” culture
- Systems approach to improvement
Guide to Just Decisions about Behavior

**Disciplined**
- Intentionally causes harm or tampers with error reporting process

**GRAY AREA**
- Reckless or intentional disregard for patient safety
- Repeatedly violates organization policies, processes or standards
- Failure to participate in patient safety initiative
- Near Miss or Error occurred due to minor deviation from process or policy
- Carelessness in providing Patient care or adherence to policy or process

**Blame-free**
- Employee made error in judgment when no policy or process in place
- Employee made error by incorrectly interpreting ambiguous policy or process
- Employee made error while following organization policy or process

**Key “Gray Area” Questions**
1) Was the act or omission reckless?
2) Was the act or omission repeated or very similar to others?
3) Did the act or omission undermine patient safety initiatives?

Source: Missouri Baptist Medical Center
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Characteristics of a Strong Safety Culture

- Views “errors as treasures”
- Educates staff to recognize that faulty systems contribute to errors
- Accountability undiminished
- Focus on identifying root causes and systems improvements vs. “name, shame, and blame” culture
- Open support of personnel involved in an error

Source: Missouri Baptist Medical Center
Reprinted with permission
Characteristics of a Strong Safety Culture

- Job descriptions and responsibilities incorporate safety principles
- Materials procurement and technology dissemination with safety as a criterion
- Budget planning and necessary resources for optimal safety
- Openness about errors and problems—including with patients/families
- Incentives and rewards—rewards error reporting, not the absence of errors

Top 5 Areas of Clinical Risk

- Diagnosis related: 25%
- Obstetrics: 24%
- Treatment related: 23%
- Medication related: 12%
- Surgery: 7%

Source: KePRO 2009 Annual Report for HRSA
Case Example #1

“I woke up this morning feeling weak—I wonder if I could see Dr. Diaz today”

Source: TeamSTEPPS

Case Example #1

“You may be right. Let’s bring him in today for an ECG and a blood pressure check.”
Clinical Risk Management in Action

1. Inadequate triage/failure to question the patient
   ✅ Risk management action: provide triage training and guidelines to the front office clerk

Sample Policies and Tools:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding</td>
<td>How much?</td>
</tr>
<tr>
<td></td>
<td>Where is it coming from?</td>
</tr>
<tr>
<td></td>
<td>Are you bleeding or coughing?</td>
</tr>
<tr>
<td></td>
<td>Are you taking any medications?</td>
</tr>
<tr>
<td></td>
<td>Because to ask about any</td>
</tr>
</tbody>
</table>

Clinical Risk Management in Action

2. Communication success!
   ✅ Risk management action: tell the story; reinforce effective communications between health center staff
Case Example #2

► “My dad is confused and he’s been falling asleep.”

Case Example #2

► CT scan “ASAP”
► Blood cultures
► “Go to the coumadin clinic.”
Case Example #2

- Patient died
- $150,000 award

Clinical Risk Management in Action

1. **Failure to order immediate CT scan and INR**

   Risk management actions:
   - Standardized terms for urgent diagnostic tests
     - STAT? Today?
   - Use confirmation feedback
Clinical Risk Management in Action

2. Unsafe handoff; Ineffective communication

✓ Risk management action:
  - Implement standard handoff process
  - Provide written instructions and ask patients to repeat back

OFFICE VISIT SUMMARY

To be sure that we understood and agree about your care today, a summary of today's visit:

Patient name

Visit Summary

Seen by

Symptoms/concerns

Clinical Risk Management Program Website

www.ecri.org/Clinical_RM_Program
“Clinical Risk Management Basics” archived on Web site
www.ecri.org/Clinical_RM_Program

Questions?
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Thank You!