

RISK MANAGEMENT POLICIES AND PROCEDURES

RISK MANAGEMENT PROGRAM

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Risk Management Program

PURPOSE

Risk management is a systematic process of identifying, evaluating and reducing losses associated with patient, employee or visitor injuries, property loss or damages and other sources of potential legal liability.

RESPONSIBILITY

The Board of Directors is entrusted with the responsibility for the oversight of the Risk Management Program at _____ and its satellite facilities. This responsibility is delegated to the Chief Executive Officer and the _____ staff.

SCOPE

The Risk Management Program encompasses review of the areas of actual or potential sources of risk and/or liability involving patients, visitors, staff and property. This incident reporting system is utilized to collect and trend undesirable or adverse occurrences in all areas throughout the facilities. The Quality Improvement Committee may assist with the data collection in the Risk Management areas through Medical Staff and Clinical Staff monitoring and evaluating specific data information. To accomplish this function, the Risk Manager or the CEO's designee is responsible for developing and maintaining a Risk Management Program that meets the basic operational needs of _____. Among the programs required to meet that end is an insurance program for both commercial and medical malpractice coverage and the development of new programs designed to train staff in minimizing or eliminating risks or safety concerns on a corporate-wide basis.

The Risk Manager or the CEO appoints a designee to handle this function and make regular reports to the CEO or his/her designee on a monthly basis, or more frequently, if necessary. The Risk Manager will review risk exposure on a regular basis and make specific recommendations to the CEO when changes in the Risk Management Program are needed. An example of this would be the increase of coverage for buildings and automobiles, malpractice and general liability policies or the need for new safety or staff training programs in specific areas.

The following is an outline of insurance needs and training programs that would address areas of risk exposure. While the list is not all inclusive, it will assist in the development of a successful Risk Management Program:

COMMERCIAL INSURANCE

1. Property & Casualty
2. Auto
3. Business Interruption

4. General Liability
5. Directors and Officers Coverage
6. Errors and Omissions
7. Inland Marine (i.e., accounts receivable, valuable papers, electronic data processing)
8. Crime (i.e., employee dishonesty, Welfare and Pension Plan, ERISA Compliance)
9. Worker's Compensation
10. Benefits (i.e., health insurance, disability, group life, employment practices)

TRAINING PROGRAMS

1. Safety Programs (Safety Committee: fire drills, disaster planning, workforce safety, building safety inspections, workplace violence)
2. OSHA Training Compliance (exposure to blood borne pathogens, needle sticks, hazardous waste disposal, employee injuries, ergonomic design)
3. Security Programs (employee patient safety issues)
4. Confidentiality Programs (patient and staff confidential information)
5. Provider-Patient Care Issues (i.e., patient complaints of improper medical treatment or dealing with difficult patients).

RISK MANAGEMENT STRATEGIES

In order to approach the process of Risk Management systematically, _____ utilizes the following four-step model for Risk Management:

- The identification of risks
- The analysis of the risk identified
- The treatment of risks
- The evaluation of risk treatment strategies

This model assists in setting priorities for Risk Management activities and ensures a comprehensive Risk Management effort.

Risk Identification:

Risk Identification is the process through which the Clinic Staff becomes aware of risks in the health care environment that constitute potential loss exposures for the _____.

The staff will utilize the following information services to identify potential risks:

- Identification of trends through the incident reporting system
- Patient, visitor, staff and physician complaint reports
- Performance improvement functions
- Peer review activities
- Informal discussions with management and staff members

Risk Analysis:

Risk Analysis is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. These factors establish the seriousness of a risk and will guide management in the selection of an appropriate risk treatment strategy.

Risk Treatment:

Risk Treatment refers to the range of choices available to management in handling a given risk. Risk Treatment strategies include the following:

- A. Risk acceptance involves assuming the potential loss associated with a given risk and making plans to cover any financial consequence of such losses.
- B. Risk avoidance is a strategy utilized when a given risk poses a particularly serious threat that cannot be effectively reduced, and the conduct or service giving rise to the risk may perhaps be avoided.
- C. Risk reduction or minimization involves various loss control strategies aimed at limiting the potential consequences or frequency of a given risk without totally accepting or avoiding the risk. Strategies may include staff education, policy and procedure revision and other interventions aimed at controlling adverse occurrences without completely eliminating risk activities.

Any single strategy or combination of the above Risk Management strategies may be employed to best manage a given situation.

Risk Management Evaluation

The final step in the Risk Management process is risk management evaluation, whereby the effectiveness of the techniques employed to identify, analyze and treat risks are assessed and further action taken when warranted. If improvement and/or resolution of the risk is evident, additional follow-up will be done at predetermined intervals to evaluate continued improvement.

RISK MANAGEMENT PLAN ELEMENTS

The _____ Risk Management Program is concerned with a variety of issues and situations that hold the potential for liability or losses for the clinic. It addresses the following categories of risk:

Patient-Related Risks

- Confidentiality and appropriate release of patient medical information
- The securing of appropriate informed patient consent for medical treatment
- Nondiscriminatory treatment of patients, regardless of race, religion, national origin or payment status
- Protections of patient valuables from loss or damage

Medical Staff-Related Risks

- Medical Staff peer review and quality/performance improvement activities
- Confidentiality and protection of the data obtained
- Medical Staff credentialing, appointment and privileging processes

Employee - Related Risks

- Maintaining a safe work environment
- Reduction of the risk of occupational illnesses and injury
- Provision for the treatment and compensation of workers who suffer on-the-job injuries and work-related illnesses
- Ensuring nondiscrimination in recruitment, hiring and promotion of employees

Other Risks

- Ensuring mechanisms to prevent and reduce the risk of losses associated with fire, flood, severe weather and utilities malfunction
- Ensuring the development and implementation of emergency preparedness plans
- Ensuring that appropriate protocols are in place for hazardous materials/waste management
- Maintaining a safe environment for patients and visitors
- Assisting Quality/Performances Improvement efforts to identify those areas which represent an opportunity to improve patient care and reduce risk

ANNUAL APPRAISAL

As part of the Risk Management Program, the scope, organization and effectiveness of Risk Management activities will be reviewed annually. Program revisions will be recommended, approved and implemented as necessary.

CORPORATE RISK MANAGEMENT PROGRAM

I. AUTHORITY

1. The Board of Directors and CEO of _____ strive to provide a safe environment for customers, visitors and employees by requiring and supporting the establishment of an effective Risk Management Program.

II. DUTIES AND RESPONSIBILITIES

1. A Risk Manager appointed by the Chief Executive Officer and qualified by experience and/or education shall be responsible for the development, implementation and monitoring of a Corporate Risk Management Program including the creation and maintenance of any committees deemed necessary.
2. The Risk Manager shall be responsible for coordinating the investigation of significant incidents including, but not limited to, review of the medical record, interviews of any knowledgeable personnel, review of pertinent policies and/or procedures, and referral of the occurrence as necessary to the appropriate department head or committee(s).
3. The Corporate Risk Management Program shall be based on the monitoring and evaluation of the following:
 - a. customer care occurrences and other center events
 - b. center experience
 - c. applicable laws as indicated
 - d. applicable regulations as indicated
 - e. acceptable medical practice as indicated
4. Through the monitoring of the above, Risk Management shall attempt to identify, evaluate and reduce the risk of injury or loss to customers, visitors and employees of the _____.
5. Risk Management Reports shall be presented to the Continuous Quality Improvement (CQI) Committee and the CQI Committee shall present the reports to the Board of Directors.
6. The Risk Manager shall consult with the Chief Health Officer's office as needed.
7. The Risk Manager shall maintain a formal operational relationship with Continuous Quality Improvement and Human Resource Management through staff meetings to exchange information to support the efforts of the Risk Management Program.
8. Risk Management shall be represented on the Center-Wide Continuous Improvement Committee, Safety Committee, Medical Staff Committee and any committees established to ensure continuity of patient care.
9. Risk Management and/or any committee(s) formed under this policy may recommend policy, procedure and protocol changes designed to reduce

risks. The recommendation shall become effective as policy, procedure or protocol unless the Department Director, Chief Health Officer/Chief Executive Officer overrules the recommendation in writing.

10. The Risk Manager may present and/or participate in ongoing educational programs.
11. The Risk Manager may through the Legal Administrator “on call” system, provide advice and consultation on emergent issues.
12. All Center departments shall comply with the incident reporting policies established by the Risk Management Program and shall cooperate fully in the investigation of incidents.

RISK MANAGEMENT COMMITTEE

I. AUTHORITY

1. The Risk Management Committee is a Corporate committee approved by the Board of Directors through the CEO.

II. PURPOSE

1. To provide: a timely review of significant incident reports, a means of following significant incident trends, and a means of determining and recommending the most appropriate correction for problems with no obvious solution.

III. ORGANIZATION

1. The Risk Management Committee is chaired by the Risk Manager or designee(s) appointed by the Chief Health Officer and Chief Executive Officer.
2. The Risk Management Committee shall be comprised of representatives from the following groups:
 - a. Board of Directors
 - b. Corporate Legal Department
 - c. Executive Staff
 - d. Medical Staff
 - e. Continuous Quality Improvement Committee
 - f. Utilization Review
 - g. Safety
 - h. Risk Management
 - i. Nursing
3. If an appointed member is unable to attend, a proxy may represent the member at any and all meetings.

IV. FUNCTIONS

1. The Committee shall meet on a scheduled monthly basis and maintain minutes. It is most important to reflect in the minutes the action taken to correct or prevent future occurrence of a particular type of incident or problem. The Committee will monitor the recommendations or actions taken until final resolution occurs. All confirmed nosocomial infections are to be included in the reporting of the Risk Management Committee. The minutes are to be maintained on file in the Risk Manager Director's office only.
2. The Risk Management Committee shall at least semi-annually review the Policies and Procedures Manual as well as appropriate federal and state regulations to insure continued compliance.

3. Functions of the Risk Management Committee also include:
 - a. Establishing and implementing the risk identification, evaluation, treatment and monitoring subsystems
 - b. Identifying data resources
 - c. Developing lines of communication
 - d. Evaluating problems to determine corrective action
 - e. Implementing corrective actions
 - f. Monitoring effectiveness of actions implemented
 - g. Advising CEO on matters of policies and procedures
 - h. Reviewing claim activity
 - i. Recommending to the CEO the advisability of waiving patient bills
 - j. Developing educational programs aimed at the reduction of liability claims
 - k. Participating in the investigation of potentially compensable events
 - l. Conducting periodic audits of departments and services for risk exposure
4. It is the Risk Management Committee's responsibility to review and investigate patient incident reports and recommend new or additional programs and procedures to prevent future occurrence of the same or related types of patient incidents.
5. The Risk Management Committee may call upon employees and other personnel who have specific knowledge of incidents under review.
6. The Risk Management Committee may request medical records and other documents specific to incidents under review.
7. The Risk Management Committee may make recommendations to the pertinent clinical departments and/or the Center administration to improve customer care, organization, procedure or policy.
8. The Risk Management Committee shall take all steps necessary to maintain the confidentiality of its review, investigations and other activities.

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

I. AUTHORITY

The Continuous Quality Improvement Committee is designed to objectively and systematically monitor and evaluate the quality and appropriateness of customer care. This includes oversight of professional practice, staff credentialing, safety, quality improvement, infection control and risk management. The Chief Executive Officer (CEO) delegates this responsibility to the Chief Health Officer of _____.

II. PURPOSE

The Continuous Quality Improvement Plan is designed to fulfill the Center's responsibility to its customers, community and staff in accordance with the Joint Commission Accreditation of Health Care Organization (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC) standards, the State Department of Health Code and the policies and procedures of other regulatory agencies.

The CQI Plan will coordinate and integrate all CQI and risk management activities throughout the Corporation, thereby providing an effective and efficient mechanism for identifying opportunities to improve quality of care through assessment, evaluation, conclusion, recommendation, action and follow-up.

III. GOALS

1. To develop appropriate standards for the provision of health services
2. To develop appropriate standards of performance for professional and support staff
3. To systematically monitor and evaluate the quality of care, customer compliance, assess the outcome and continuity of care
4. To identify trends and patterns of care through the use of health maintenance, chart deficiency and other screens
5. To ensure appropriate ongoing staff development and credentialing for all disciplines as identified through monitoring and evaluation
6. To reduce actual or potential risk to the population
7. To reduce financial liability to the corporation

IV. OBJECTIVES OF THE CQI PROGRAM

1. To ensure the provision of quality customer care through objective care evaluation

2. To ensure coordination and integration of all CQI activities by establishing a CQI Committee as the focal point through which CQI information will be exchanged and monitored
3. To identify and correct customer problems by assessing their cause, scope and implementing actions to resolve them
4. To prioritize identified problems so that those directly affecting customer care can be resolved in a timely manner.
5. To ensure communication and reporting among staff, CQI Committee, administrative department directors, supervisors, medical staff and Board of Directors
6. To ensure that all JCAHO and AAAHC requirements are met; all departments will participate in the CQI process

V. ORGANIZATION

The focal point of the CQI Program is the CQI Committee, whose primary responsibility is to monitor the quality of care provided within the Center and its satellite facilities. This committee is authorized as a standing committee and reports to the CQI Committee of the Board through the Chief Health Officer to the Chief Executive Officer to the Board of Directors.

The CQI Committee is composed of representatives from the following areas:

1. Administration
2. Dental
3. Fiscal
4. Health Education
5. Homeless Project
6. Housekeeping/Maintenance
7. Laboratory
8. Medical Records
9. Nursing
10. Patient Services
11. Personnel/Human Resources
12. Pharmacy
13. Quality Assurance
14. Radiology
15. Social Work and
16. WIC

Center Organization:

1. The development and implementation of the CQI Plan is the responsibility of the Chief Health Officer.
2. The CHO and staff will provide support services for all CQI activities through:

- a. Preparation, collection of data from Ancillary Departments and analysis of monthly statistics
- b. Research on development of review criteria
- c. Development of review methods
- d. Staff support to medical staff and ancillary services
- e. Maintenance of CQI records

I. PROGRAM DESCRIPTION

The multidisciplinary CQI Committee will identify problems based on analysis of monthly trends, statistics collected from center incident reports, indicators, generic screens, PHS requirements, quarterly review of patient surveys and input from other committees, staff and CQI structure. Problems to be addressed, but not limited to, are as follows:

1. Continuity of care
2. Support staff performance
3. Provider staff performance
4. Customer compliance
5. Access to care
6. Appropriateness of care
7. Cost of services
8. Safety and preventive maintenance
9. Medical Record System
10. Medication ordering practices
11. Confidentiality issues

The CQI Committee will prioritize problems that directly affect customer care. Additionally, the CQI Committee will refer identified problems to the appropriate supervisor or medical staff member. One individual representing a department or committee will be selected as the liaison of the CQI Committee.

The CQI Committee of the Center will:

- Monitor the progress of the various committees to which problems have been referred for resolution
- Recommend additional corrective action when needed
- Report monthly to the Board CQI Committee, Chief Executive Officer and the Board of Directors when appropriate
- Obtain documentation to substantiate the effectiveness of the overall program

II. EVALUATION OF THE CQI PROGRAMS

1. An outside committee or consultant will evaluate the program to determine its effectiveness on an annual basis.
2. Measures used to determine program effectiveness include:
 - a. JCAHO standards and guidelines
 - b. AAAHC standards and guidelines

- c. Score on PHS Clinical Evaluation Tool
- d. Adherence to BPHV/HRSA guidelines
- e. Reduction of number of incidents
- f. Reduction of customer complaints
- g. Review of major problem resolution

RISK CONTROL

A. GENERAL

In an effort to minimize losses, _____ has established this manual to provide a systematic program designed to reduce or eliminate preventable injuries and accidents to employees, patients and visitors. The ultimate goal of these control measures is to minimize the financial severity of claims arising out of such injuries.

The specific objectives of _____ Risk Management Program are to:

1. Identify the causes of injuries or losses to patients, visitors and employees.
 - a. Seek out situations that could produce occurrence resulting in financial loss.
 - b. Use the Incident Report as a source of data to be reviewed by the Chief Executive Officer and the Chief Health Officer.
 - c. Contact the person involved in the incident as soon as possible. If the person involved is a patient or visitor, contact should be made prior to the person leaving the premises. If the person has a grievance, attempts should be made to deal with the complaint immediately with notification to the CHO and/or CEO.
2. Eliminate dangerous procedures that provide an element of risk in the practice of medicine.
3. Produce a mechanism, other than the courts, to handle claims, i.e.,
 - a. Transfer of liability. The clinic is liable only for that which is its own doing.
 - b. Promote good visitor and patient relations.
4. Each department manager or his/her designee has the overall responsibility to do the following:
 - a. Provide training programs for all members of the health care team to preclude people failures, errors and other deviations from normal operating procedures that lead to financial loss.
 - b. Identify, evaluate and eliminate high risk variances and supportive data.
 - c. Recognize high risk areas and make recommendations to eliminate or at least minimize them.
 - d. Establish a communication system between doctors, nurses and other health personnel to ensure quality patient care through careful scrutiny of all areas for potential legal liability.
 - e. Improve claims coordination by consultation with the Risk Management, Attorney and _____ outside insurance carriers to improve future conditions and correct errors.

B. WORKER'S COMPENSATION: EMPLOYEE INJURIES

_____ has established procedures to review injuries to employees while they are on the job. If an employee is injured while in the course of employment, the clinic may be responsible for the employee's medical expenses, and must, through the state worker's compensation system, provide weekly compensation until the employee returns to work. Benefits are paid in accordance with the compensation laws specific to each state.

1. REQUIRED ACTION

- a. If an injury to an employee occurs, it is _____'s responsibility to take charge of the situation. Employees should be instructed on their responsibilities in handling situations that arise.
- b. Provide immediate medical assistance to the injured staff member as soon as possible. Visit the injured employee to determine the circumstances and cause of the accident. If the employee is unable to provide this information at the time of the accident, obtain it as soon as practical thereafter, but continue to obtain statements from eyewitness to the accident.

2. HOW TO REPORT

- a. The "First Report of Injury" must be completed immediately after the accident. All Worker's Compensation losses require completion of this form. The original and one copy should be forwarded to the local claims office.
- b. If the injury is severe or assistance is needed in the completion of the form, contact the Corporate Risk Manager at _____.
- c. The accurate completion of the form is vital as most states require all compensation claims to be filed within 72 hours. By sending the form to the insurance company as outlined in paragraph "a" above, the insurance company will handle filing of the injury report with the State.
- d. It is vital that the report be filed, as no benefits can be paid to the injured employee until the insurance carrier is in receipt of this report. Failure to properly complete the form can cause needless delay in the filing and payment of benefits to an injured staff member.

There will be times when the injury to an employee is not immediately known. However, when you have first been made aware of the situation, follow the appropriate procedures for the filing of Worker's Compensation Claim. Telephone notification of a loss is not adequate for the reporting of a Worker's Compensation Claim since State laws require the completion of the "First Report Injury" Form on all Worker's Compensation Claims.

FILING INSTRUCTIONS

A file copy of the “First Report Injury” is to be placed in the employee’s personnel file for permanent record. As part of _____ Risk Management Program, a “Report” is also to be completed on all employee injuries. The purpose of this report is to serve as an in-house prevention mechanism in order to minimize and eliminate future similar occurrences. This may best be reviewed through the Center’s Risk Management Committee. In conjunction with the evaluation of injuries, each Center needs to establish an active educational, safety and security program designed to reduce the risk of financial loss due to injury and accidents.

REPORTING OF INCIDENTS

I. AUTHORITY

1. Employees, medical staff and specified professional staff of the _____ will complete an Incident Report when any incident, variance or occurrence transpires with any patient, visitor and/or other non-employee. A report must be completed even if there is no injury.

II. DEFINITION OF INCIDENT, VARIANCE OR OCCURRENCE

1. An incident, variance or occurrence (hereinafter “incident”) is any event which is not consistent with the desired operation of the facility or care of the patient or any event causing patient, visitor and other non-employee dissatisfaction.
2. Examples of incidents include, but are not limited to:
 - a. Physical harm to patient, staff or third parties (visitors, students, etc.)
 - b. Unauthorized leaves by patients
 - c. Accidents in which patients, staff or third parties are injured or die
 - d. Drug or alcohol use or traffic of these substances from the outside
 - e. Damage to or loss of property
 - f. Medication errors
 - g. Poor results from treatment of procedures
 - h. Injuries
 - i. Patient dissatisfaction
 - j. Retained foreign bodies
 - k. Accidental burns
 - l. Neurological deficits
 - m. Mistaken identity
 - n. Patient and visitor falls
 - o. Unexpected transfers to any hospital
 - p. Complaints or serious threats of lawsuits by the patient or the family
 - q. Patient leaving the center against medical advice
 - r. Severe drug reactions
 - s. Unexpected deaths
 - t. Incidents from the use of equipment and medical devices.

III. PROCEDURE

1. Provide immediate appropriate care and follow-up for the patient, visitor or other non-employee if he/she is injured.
2. When there is a serious injury or the subject of an incident (or the family) is angry or upset about the incident, Risk Management should be notified immediately, along with taking other requisite actions, to resolve the issue/matter.
3. Complete an Incident Report Form to:
 - a. Provide a record of the event, document the facts of the incident, identify witnesses and preserve any other evidence at the scene
 - b. Provide a base from which the corporation can further determine, investigate, and evaluate deviations from the standard of care, policies, procedures, protocol, etc.
 - c. Provide a means of refreshing the memory of those having direct knowledge of the event.
 - d. Alert Risk Management of the possibility of a claim or lawsuit to allow for complete investigation and documentation and
 - e. Comply with state and federal regulatory requirements.
4. The Incident Report Form should be completed by the person having the best knowledge of the incident occurs or is discovered. The need for immediate reporting cannot be overemphasized.
5. The following information must be included:
 - a. the name of the patients, visitor or other non-employee (stamping with the correct addressograph plate is sufficient)
 - b. the address of the person (stamping with the correct addressograph plate is sufficient)
 - c. a patient's medical record number (stamping with the correct addressograph plate is sufficient)
 - d. the facts surrounding the incident or occurrence
 - e. any follow-up action taken
 - f. any injury (physical, emotional or otherwise) to the person
 - g. the reaction of the person the family to the incident
 - h. the identity and location of any medical device or equipment that caused and/or contributed to the incident.
6. The person completing the Incident Report Form shall sign it, print his or her name underneath the signature and indicate the extension where he or she can be reached for additional information.
7. The examining physician should not sign the Incident Report Form. However, his or her name should be printed on the form.
8. Should additional space be necessary, attachments to the form are appropriate but should be marked with the addressograph plate and indicated to be a continuation of the Incident Report Form. The attachment must be stapled securely to the IRF.
9. The manager or supervisor of the area should review the IRF and take any appropriate follow-up action necessary (counsel employee, documentation, report to superiors, etc.).

10. All copies of the IRF must be forwarded to the Human Resources Department or placed in the CQI box within 48 hours following the occurrence or discovery of the incident.
11. The Nurse Management Coordinator or Supervisor of the area should complete the Risk Management follow-up and forward it to Risk Management when follow-up has been completed. If follow-up is completed immediately after review of the Incident Report Form, staple it to the Incident Report Form.

IV. MEDICAL RECORDS

1. The facts of the events should be documented in the medical record when the incident involves a patient. However, no reference should be made to the Incident Report Form in the medical record or the fact that an Incident Report was completed.
2. The Incident Report Form is never placed in the medical record.
3. The following guidelines should be used in the medical record documentation of the event:
 - a. be objective and accurate
 - b. write a brief narrative of the events surrounding the incident/occurrence, the follow-up action taken, and the status of the patient
 - c. do not use any of the following terms:
 1. "incident report" or "accident"
 2. "negligent" or "negligently"
 3. "inadvertent" or "inadvertently"
 4. "in error"
 5. "by mistake" or "mistakenly"

V. EQUIPMENT RELATED INCIDENTS

1. If a piece of medical equipment (examples are an x-ray machine) or a medical device (examples are a syringe, a catheter, a tube) is involved in an incident, the name of the equipment or device, the manufacturer, the manufacturer's "lot" number, if available, and other related identification should be documented on the incident report. If there is a malfunction, the incident report should relate the facts that indicated malfunction.
2. It is of primary importance in cases of suspected malfunctions that the equipment be removed from service for later testing. The suspected malfunctioning equipment should be labeled as such and sent to the Chief Health Officer and duly noted on the Incident Report Form.
3. Under no circumstance should the medical device or equipment be discarded. It must be preserved for further investigation. If the device or equipment is contaminated, contact the Chief Health Officer for instructions regarding its proper preservation.

VI. MULTI-DEPARTMENT INCIDENTS

1. When two or more departments or areas are involved in an incident, one of the following should be done:
 - a. Each department or area should complete separate forms.
 - b. The supervisors of the involved departments should collaborate to complete one set of forms.
2. However, each department/area will be responsible for following through on all steps of reporting, regardless of the method of reporting chosen

VII. RISK MANAGEMENT INVESTIGATION

1. Risk Management will review the Incident Report Form.
2. Risk Management may investigate any and all incidents and perform any or all of the following during that investigation:
 - a. review the medical record
 - b. interview knowledgeable personnel identified in the report
 - c. review any pertinent policies and/or procedures which may be applicable to the incident
 - d. request the assistance of other in-house personnel in the review of the incident
 - e. refer to the incident to the appropriate department head for action
 - f. take or request any additional follow-up action that is indicated
 - g. take any other action deemed necessary by the Risk Manager to respond to the incident

VIII. AVAILABILITY OR RISK MANAGEMENT DATA

1. Risk Management logs document certain information into an information system and some statistical analysis is performed on this data. Non-specific information from this database and non-specific information from investigations is available to nursing and other staff who can justify a need for this information (quarterly and annual reports, etc.) However, specific information will not be released unless authorized by the CEO.

Medication Dispensing Errors

POLICY

Dispensing error is defined as:

1. Failure to dispense a medication on receipt of a valid physician order or omission of a medication from the medication order.
2. Dispensing an incorrect quantity or sending an incorrect quantity of medication for use by the provider.
3. Dispensing an incorrect medication, strength, or dosage form.
4. Incorrectly compounding medication.
5. Omission of supplementary labels.
6. Incorrect, incomplete or inaccurate labeling of medications.
7. Dispensing a medication to which the patient has an allergy as listed on the pharmacy medication profile.

PROCEDURE

1. Presumed pharmacy errors detected by nursing services are to be reported on the Medication Error Data Collection Form.
2. Medication Variances are reviewed by the Pharmacy & Therapeutics Committee for use in trending and as performance improvement issues.

DOCUMENTATION

Dispensing errors are documented on the Medication Error Data Collection Form.

Medication Errors Data Collection Form

Date: _____ Provider: _____

Medication Error	Directions: Please indicate implicated medication and <i>briefly</i> describe error. Access to the patient's medical record (MR) may be necessary. PLEASE remember to note the total number of medications the patient is receiving.					
Medication Name(s)	MR#					
Total number of medications	Severity Level:		Severity Level:		Severity Level:	
	Prescribe	Dispense	Prescribe	Dispense	Prescribe	Dispense
Prescribing errors	Dispensing errors					
Incorrect indication/contraindication for the med.						
Incorrect dose based on weight, renal/hepatic function prescribed or dispensed						
Incorrect number of doses dispensed (DISPENSING ERROR ONLY)						
Expired medication dispensed (DISPENSING ERROR ONLY)						
Medications prescribed/dispensed with incorrect or missing Route of administration Frequency Strength Duration Dosage form Miscellaneous (_____)						
Inappropriate abbreviation or poorly written order (PRESCRIBING ERROR ONLY)						
Therapeutic duplication for prescribed or dispensed drug						
No rational indication for prescribed or dispensed drug						
Drug allergy to prescribed drug not noted in medical record/ Drug allergy to dispensed drug OR no allergy noted in medical record						
Significant drug interaction to prescribed/dispensed drug not noted in medical record When necessary, prescribed/dispensed medications are not appropriately monitored or are NOT monitored						
Miscellaneous Drugs to avoid during pregnancy , i.e. Accupril						

Exceptions to the above: _____

Follow-up:

Disclaimer about this document <http://bphc.hrsa.gov/technicalassistance/resourcecenter/disclaimers.html>

Performance Improvement:

Person Completing Form: _____ Date: _____

Date: _____

Medication Error Definition

Severity Levels

Level 0:

Circumstances or events occurred that have the capacity to cause errors, but checks and balances in the system identified it before reaching the patient.

Level 1:

An error occurred, but it resulted in no harm to the patient.

Level 2:

An error occurred that resulted in the need for increased patient monitoring, but caused no harm to the patient.

Level 3:

An error occur that resulted in the need for increased patient monitoring and a change in vital signs, but caused no harm to the patient, or an error occurred that required blood draws for additional laboratory monitoring.

Level 4:

An error occurred that resulted in temporary harm and required intervention treatment with another drug, increased length of stay, or affected the patient's ability to participate in an investigational protocol.

Level 5:

An error occurred that resulted in permanent harm, or a near death event (e.g., anaphylaxis, cardiac arrest) to the patient.

Level 6:

An error occurred that contributed to the death of the patient.

ADVERSE DRUG REACTION (ADR)

POLICY

Definition: An adverse Drug Reaction is any response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function. This excludes therapeutic failures and those reactions, which may normally be anticipated side effects.

Reporting: Adverse drug reactions are to be reported immediately according to procedure.

Documentation: Adverse Drug Reactions are to be documented in the Medical Record, and Adverse Drug Reaction (ADR) Assessment Form.

Review: The Pharmacy and Therapeutics Committee is to review adverse drug reactions. Significant reactions are those reactions that are unexpected and will be reported to the FDA as determined by the Pharmacy and Therapeutics Committee.

PERSONNEL QUALIFIED TO PERFORM PROCEDURE

Registered Nurse, Licensed Practical Nurse, Pharmacist, Physicians and other personnel authorized to administer medications.

EQUIPMENT NEEDED

Medical Record, Adverse Drug Reaction Assessment Form

PROCEDURE

1. The assigned Nurse is to notify the attending physician of known or suspected Adverse Drug Reaction.
2. Prescribed treatment is to be carried out promptly.
3. All known or suspected Adverse Drug Reactions are to be reported to the pharmacy by phoning any pharmacy extension. Report name and suspected drug reaction.
4. Document reactions in the patient medical record.
5. Initiate Adverse Drug Reaction (ADR) Assessment Report.
6. Completed reports are to be forwarded to the Unit Director, the Pharmacy and Risk Management/CQI.

7. The Pharmacy is to evaluate and trend Adverse Drug Reactions identified through spontaneous reporting and retrospective review. The pharmacy is to review all reported adverse reactions.
8. Adverse Drug Reactions and summary reports are represented to the Pharmacy and Therapeutics Committee for review.
9. Adverse Drug Reactions are to be reported to the FDA as determined by the Pharmacy and Therapeutics Committee.

DOCUMENTATION

1. The Assigned Nurse is to document Adverse Drug Reactions in the patient's medical record to include the suspected medication and the reaction observed.
2. An Adverse Drug Reaction (ADR) Assessment Report is to be prepared by the assigned nurse and routed to the above, as listed in #6.

ADVERSE DRUG REACTION RECOGNITION

Recognition of adverse reactions is essential to appropriate intervention to improve patient outcome. Adverse Drug Reactions include anticipated side effects as well as allergic reactions, extension of the therapeutic effect, and toxicities. Examples of indicators of adverse reactions include the following:

1. Physical systems, such as a rash.
2. Changes in mental status, such as lethargy in patients on sleeping aids.
3. Hypokalemia in patients on diuretic therapy.
4. Changes in serum creatinine in patients on aminoglycosides.
5. Toxic serum drug concentration levels, such as serum digoxin levels above 2.0.

Classification

- _____ Definite-reaction appears after rechallenge
- _____ Probable-reaction disappears after drug DC'd, but without rechallenge
- _____ Possible-reaction fits known response pattern, but may also be caused by other elements of the patient's disease.
- _____ Unrelated-reaction is unrelated to drug therapy (does not meet ADR definition)
- _____ Unclear

Follow-Up

Person Completing Follow-up _____ **Date** _____

EARLY INTERVENTION SERVICES/HIV

CONTINUOUS QUALITY IMPROVEMENT PROGRAM

POLICY

Continuous Quality Improvement is vital for development and advancement of optimal clinical care. This CQI program will identify, monitor, and evaluate challenges throughout all components of the EIS program. Through this program conflicts and problems are identified and resolved.

COMMITTEE MEMBERS

Team Physician(s)
Nurse Practitioner
Chief Health Officer (CH0)
Clinic Nurse
Program Coordinator
Case Manager
Program Coordinator
Case Manager
Him (Medical Records) Director
CQI Manager

SCOPE OF COMMITTEE

CQI will address the following issues:

- Quality of HIV care
- Peer Review of Nurse Practitioner/Physician
- Patient Education Program
- Nutritional Educational Program
- Support Services for Clients
- Patient/satisfaction/complaints with services
- Patient utilization/no show rates
- Compliance with HIV risk assessment
- Counseling and Testing procedures
- Partner Notification
- Other issues as necessary

PROCEDURE

- (1) At least quarterly, CQI meetings will be held to discuss issues, share information, and resolve problems.
- (2) The committee will formally review and analyze quality improvement studies directly related to clinical indicators of the EIS Program's current work plan, and subsequently share outcomes and recommendations with appropriate personnel, departments.
- (3) The following will be documented for each problem addressed:
 - a. issue reviewed
 - b. Description of the problem
 - c. action taken to resolve the issue
 - d. outcome of these actions
 - e. any additional necessary follow-up
- (4) On an annual basis, the committee will formally reassess the year's issues to assure the problems remain resolved.
- (5) Agendas and/or minutes will be taken from each meeting and filed in the CQI notebook along with outcome measures and research.
- (6) Administration and CHC staff CQI committee will receive and review quarterly CQI reports.
- (7) The CQI committee will address all mandated and optional services aspects of the EIS/HIV program.
- (8) CQI reviews of the primary care services will emphasize provider adherence to the PHS/DHHS National Standards of care protocols for patient care management.
- (9) Medical record accuracy and completeness, use of clinical flow sheet, and outcomes of clinical care fall within the scope of this committee.
- (10) Peer review of medical charts will occur monthly between physician, nurse practitioner and team nurse. A formal peer review will be conducted quarterly during provider staff meeting.
- (11) The EIS Program will collaborate with the MEDS HIV Center of excellence to do additional peer review on a bi-yearly basis.

EIS/HIV INFECTION CONTROL

POLICY

Safety of _____ employees is a top priority of the agency. A written infection control plan is in place and followed for the safety of employees and clients. (See Infection Control Policy and Procedures Manual)

PROCEDURE

1. Comprehensive infection control measures are defined in the Infection Control Manual and will be strictly followed.
2. These measures include, but are not limited to, requirements for:
 - Personal protective equipment
 - Housekeeping
 - Engineering controls
 - Work practice controls
 - Exposure reporting procedures
3. Additional information is available in the nursing supervisor's office.
4. These policies are distributed and available to staff and new staff members and reviewed yearly as part of the organization's comprehensive safety program.

EXPOSURE CONTROL PLAN

POLICY

_____ is committed to providing a safe and healthful work environment for the entire staff. In pursuit of this endeavor, the following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to blood borne pathogens in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Blood borne Pathogens."

The ECP is a key document to assist our firm in implementing and ensuring compliance with the standard, thereby protecting our employees. This ECP includes:

- Determination of employee exposure
- Implementation of various methods of exposure control, including:
 - Universal precautions
 - Engineering and work practice controls
 - Personal protective equipment
 - Housekeeping
- Hepatitis B vaccination
- Post-exposure evaluation and follow-up
- Communication of hazards to employees and training
- Record keeping
- Procedures for evaluating circumstances surrounding an exposure incident

PROCEDURE

The clinical staff is responsible for the implementation of the ECP. They will maintain, review, and update the ECP at least annually and whenever necessary to include new or modified tasks and procedures.

- Those employees who are determined as having occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in the ECP.
- _____ clerical staff will maintain and provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), labels, and red bag as required. The nursing staff will ensure that adequate supplies of the aforementioned equipment are available in the appropriate areas. The care team physician will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained.
- The nursing supervisor will be responsible for the training, documentation of training, and making the written ECP available to the employees.

METHODS OF IMPLEMENTATION AND CONTROL

Universal Precautions

All employees will *utilize universal precautions*.

Exposure Control Plan

Employees covered by the blood borne pathogens standard receive an explanation of this ECP during their initial training session. It will also be reviewed in their annual refresher training. All employees have an opportunity to review this plan at any time during their work shifts by contacting the nursing supervisor. The nursing supervisor is responsible for reviewing and updating the ECP annually or more frequently if necessary to reflect any new or modified tasks and procedures, which affect occupational exposure.

Engineering Controls and Work Practices

Engineering controls and work practice controls will be used to prevent or minimize exposure to blood borne pathogens. The specific engineering controls and work practice controls used are listed below:

- Self-sheathing needles
- Sharps disposal containers
- Good hand washing practices
- Safe handling of sharps
- Do not eat, drink, smoke, apply cosmetics or handle contact lenses in work area where exposure may occur.
- Do not keep food or beverages in refrigerators, freezers or cabinets where they might be exposed to potentially infectious materials.

Sharp disposal containers are inspected, maintained or replaced by the nursing supervisor whenever necessary to prevent overfilling.

_____ identifies the need for changes in engineering control and work practices through review of incident reports, OSHA records, employee interviews, and committee activities.

Personal Protective Equipment (PPE)

PPE is provided to all employees as required. Training is provided by the nursing supervisor in the use of the appropriate PPE for the tasks or procedures to be performed.

The types of PPE available to employees are as follows:

- Gloves, eye protectors, sharps containers, bio-hazard red plastic bags
PPE is located in supply cabinet and may be obtained by retrieving at will. All employees using PPE must observe the following precautions:
 - Wash hands immediately or as soon as feasible after removal of gloves or other PPE.
 - Remove PPE after it becomes contaminated and before leaving the

work area.

- Used PPE may be disposed of in red biohazard plastic bags.
- Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or Other Potentially Infectious Materials (OPIM) and when handling or touching contaminated items or surfaces or if their ability to function as a barrier is compromised.
- Never wash or decontaminate disposable gloves for reuse.
- Wear appropriate face and eye protection when splashes, sprays, spatter, or droplet of blood or OPIM poses a hazard to the eye, nose, or mouth.
- Remove immediately or as soon as feasible any garment contaminated by blood or OPIM in such a way as to avoid contact with the outer surface.

The procedure for handling used PPE is as follows: *dispose in red biohazard plastic bags, which are placed in larger red biohazard plastic bag. When full, this bag is picked up by contracted biohazard waste agency.*

HOUSEKEEPING

Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded (See Labels), and closed prior to removal to prevent spillage or protrusion of contents during handling.

The procedure for handling **sharps disposal containers** is: call contracted biohazard waste disposal agency for pick up.

The **procedure for handling** other regulated waste is: call contracted biohazard waste disposal agency for pick up.

Contaminated sharps **are discarded immediately or as soon as possible in containers that are closable, puncture-resistant, leak proof on sides and bottoms, and labeled or color-coded appropriately. Sharps disposal containers are available in** each clinic exam room and supply closet.

Bins and pails (e.g., wash or emesis basins) **are cleaned and decontaminated as soon as feasible after visible contamination.**

Broken glassware, which may be contaminated, is picked up using mechanical means, such as a brush and dust pan.

EIS/HIV EMPLOYEE EXPOSURE DETERMINATION

The following is a list of job classifications in which **all** employees have occupational exposure: Providers, Nurses, Lab and X-ray and Custodians. Tasks and procedures in which occupational exposure may occur for these individuals include, but are not limited to: cleaning blood and body fluids, cleaning work surfaces and receptacles, disposing of medical wastes.

EARLY INTERVENTION SERVICES/HIV POST EXPOSURE EVALUATION

Policy:

Should an employee be exposed to any biohazards, appropriate measures will be taken to provide the necessary post exposure care.

Procedure:

1. Should an exposure incident occur, contact the nursing supervisor at extension, #_____.
2. Further information can be found by calling the **HRSA/CDC PEP hotline at 1.888.448-4911.**
3. Additional information can be found in the CDC 5/15/98 Morbidity and Mortality report (i.e., Public Health Service Guidelines for the Management of Health Care Workers Exposure to HIV and Recommendations for Post Exposure Prophylaxis).
4. An immediately available confidential medical evaluation and follow-up will be conducted by an _____ physician, private physician, or local emergency room. Following the initial first aid (clean the wound, flush eyes or other mucous membrane, etc.) the following activities will be performed:
 - a. Document the routes of exposure and how the exposure occurred. As soon as possible, complete a _____ incident report form.
 - b. Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).
 - c. Obtain consent and make arrangements to have the source individual test as soon as possible to determine HIV, HCV, and HBV infectivity; document that the source individual's

test result were conveyed to the employee's health care provider.

- d. If the source individual is already known to be HIV, HCV, HBV positive, new testing need not be performed.
 - e. Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).
 - f. After obtaining consent, collect exposed employee's blood as soon as feasible after exposure incident and test blood for HBV and HIV serological status.
 - g. If the employee does not give consent for HIV serological testing during collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days; if the exposed employee elects to have the baseline sample tested during this waiting period, perform testing as soon as possible.
5. The nursing supervisor ensures that health care professional(s) responsible for employee's hepatitis B vaccination and post-exposure evaluation and follow-up are given a copy of OSHA's blood borne pathogens standards.
 6. The nursing supervisor ensures that the health care professional evaluating an employee after an exposure incident receives the following:
 - A description of the employee's job duties relevant to the exposure incident
 - Route(s) of exposure
 - Circumstances of exposure
 - If possible, results of the source individual's blood test
 - Relevant employee medical records, including vaccination status
 7. The nursing supervisor provides the employee with a copy of the evaluating health professional's written opinion within 15 days after completion of the evaluation.

HANDLING HAZARDOUS WASTE

POLICY

Hazardous waste will be packaged, transferred, and disposed of properly to protect both the persons handling the waste and the environment.

PROCEDURE

1. Comprehensive safety measures defined in the Environment of Care Policy and Procedures Manual is strictly followed.
2. Portable OSHA approved sharps containers for disposal of used lancets and OSHA approved plastic bags for disposal of cotton balls, alcohol swabs and any other contaminated supplies are provided as applicable.
3. Clinic exam rooms have wall mounted OSHA approved sharps containers for Disposal of used needles and any other sharp object. Exam rooms have trash containers with OSHA approved plastic bags for disposal of any contaminated materials. (See also the Environment of Care Policy and Procedures Manual)

ACCIDENT, INJURY OR ILLNESS REPORT

POLICY

Employee accidents, injuries, illnesses or other events or incidents which would cause an accident injury or illness will be reported to ensure proper treatment and/or implementation of measures to avoid future injury, accident or illness.

Procedure

1. Serious injury or illness posing a life-threatening situation will be reported immediately to local emergency response medical services (Call 911).
2. Injuries and illnesses will be reported by the injured employee to his or her supervisor in person or by phone as soon as possible after any life-threatening situation has been addressed. If the injured employee is unable to report immediately, then the incident should be reported as soon as possible.
3. Non-emergency injury or illness will be triaged by the nursing supervisor.
4. A decision may be made to direct employee to their personal physician or a _____ designated physician.
5. Upon notification of an occupational injury or illness, the supervisor will notify the security guard, who will then prepare the necessary record keeping forms (Incident Report Form).
6. Employee will confer with the Human Resources Manager regarding Workman's Compensation rules and regulations as required.

PATIENT'S RIGHTS

POLICY

Patients of _____ will be treated with respect and fairness.

PROCEDURE

1. Patient's rights as defined by the Patient's Bill of Rights will be observed by all staff members.
2. Client assessment forms will be signed by client at first initial case management meeting and filed in case management file.
3. Patient's Bill of Rights is posted in a visible place in the clinic area.

CUSTOMER GRIEVANCE

A customer grievance procedure evolves from expressed customer dissatisfaction with one or more aspects of the program or its attendant services. Dissatisfaction may stem from an administrative decision or procedure, provided (or unprovided) medical care, or with the customer's ability to access medical cares.

All customers have an opportunity to file a complaint or grievance and to receive a reasonable and workable resolution to the complaint. Grievances may be initiated as a result of either a notice of adverse action directed toward a customer or as a result of a customer's dissatisfaction with the _____ program itself.

All customers are informed of the grievance procedure at the time of registration. The procedure is presented in writing in the Patient's Rights. In addition, written information will be available at each primary care site.

The Grievance Process

Grievances may be initiated orally (by telephone or in person) or in writing. Most grievances will originate with an oral complaint.

Oral Grievance Procedure

The Patient Flow Coordinator or Social Worker will strive to ascertain the true nature of the complaint and resolve it as directly and as quickly as possible. If the situation presented evolved from a misunderstanding or lack of information, the representative will act to insure that the customer is advised of the correct information. If the information provided alleviates the customer's concerns, the grievance process is fully documented and ended. However, if after a discussion has taken place, the customer still has one or more unresolved complaints, the process must proceed to the more formal, written grievance procedure.

Written Grievance Procedure

Written grievances may be initiated either as a result of an unresolved oral complaint or without any prior contact. A customer may request a grievance form by contacting the Social Worker or the Patient Flow Coordinator. The Social Worker or Patient Flow Coordinator shall indicate on the grievance form the facts resulting in the customer's complaints as well as any attempts made previously to resolve the situation (e.g., a verbal conference).

All grievance forms should go to _____
Director of Corporate and Community Support Programs.

