Risk Management Quarterly

In This Issue

New State Health Facilities Risk Manager

I would like to introduce myself as the new Risk Manager for the Kansas Department of Health & Environment, Bureau of Community Health Systems. My name is Julie Sengstacken and I have been with KDHE since June. I have most recently been working in south Texas—however, my permanent address is in Arkansas City and Kansas has been my home for about half my life. I am a registered nurse by background and hold a Master's degree from the University of Illinois at Chicago in Patient Safety Leadership. I am certified in both quality and accreditation and have held risk management positions in both hospital and regional environments. I am thrilled to be a part of KDHE's Bureau of Community Health Systems, Health Facilities and look forward to working with you!

Patient Safety Corner

"Safety does not depend just on measurement, practices and rules, nor does it depend on any specific improvement methods; it depends on achieving a culture of trust, reporting, transparency and discipline. For healthcare organizations in every country, this requires major culture change." (Leape et al.)

What is culture?

Culture is the invisible force behind the tangibles and observables in any organization, a social energy that moves people to act. Culture is to an organization what personality is to the individual-a hidden, yet unifying theme that provides meaning, direction, and mobilization.

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Risk Management Reports are due to KDHE each quarter.

Here are the due dates:

--Quarter 1-April 30th

--Quarter 2-July 31st

--Quarter 3-October 31st

--Quarter 4-January 31st

You may fax your report to 785-291-3419 or email it to Llee@kdheks.gov.

What is a culture of safety?

A review of the literature identified a broad range of safety culture properties that we organized into seven subcultures and defined as:

1. Leadership: Leaders acknowledge the healthcare environment is a high-risk environment and seek to align vision/mission, staff competency, and fiscal and human resources from the boardroom to the frontline.

2. Teamwork: A spirit of collegiality, collaboration, and cooperation exists among executives, staff, and independent practitioners. Relationships are open, safe, respectful, and flexible.

3. Evidence-based: Patient care practices are based on evidence. Standardization to reduce variation occurs at every opportunity. Processes are designed to achieve high reliability.

4. Communication: An environment exists where an individual staff member, no matter what his or her job description, has the right and the responsibility to speak up on behalf of a patient.

5. Learning: The hospital learns from its mistakes and seeks new opportunities for performance improvement. Learning is valued among all staff, including the medical staff.

6. Just: A culture that recognizes errors as system failures rather than individual failures and, at the same time, does not shrink from holding individuals accountable for their actions.

7. Patient-centered: Patient care is centered around the patient and family. The patient is not only an active participant in his own care, but also acts as a liaison between the hospital and the community.

(Sammer et al., 2010)

Leape, L., Berwick, D., Clancy, C., et al., (2009). Transforming healthcare: a safety imperative. *Qual Saf Health Care*. 18. 424-428.
Sammer, C.E., Lykens, K., Singh, K., Mains, D., Lackan, N.A. (2010). What is patient safety culture? A review of the literature. *Journal of Nursing Scholarship* 42(2). 156-164.

QUESTION CORNER

Do you have a question about a Risk Management issue? If so, feel free to email your questions to jsengstacken@kdheks.gov.

What do I (as the Risk Manager) do if I do not agree with the SOC determined by the Risk Management Committee or the Board? What if they assign a SOC 1 when I believe it should be a SOC 3?

The difference between a SOC 1 and 3 boils down to whether the standard of care was met or not. Ultimately that decision is made by the RM Committee and the Board of Trustees empowers that committee—so, if the RM Committee is unable to make a determination it would default up to the Board. Ideally, whether the standard of care was met or not should be based on the opinion of someone in the same profession with expertise around the subject matter in question.

The question of patient harm only comes in as a secondary matter when determining between these two SOC's (even though it is in reality the most important matter…). Harm can come to a patient even if the standard of care is met. This happens most frequently with known complications or risk factors. A patient could get a pneumothorax from a central line insertion and die—even if the insertion was done expertly.

Is there evidence in the literature that supports your continued concern? If so, make it available to your committee. It is difficult to argue with evidence based literature or best practices published by professional organizations. Was there factors missed in the investigation that might bring a better light to the full story? If so, provide those details. You still have the capability to mitigate risk for any occurrence—and that is much more important than the score assignment as the event is retired.

In the past, I have disagreed with the opinion of others on my committee when it came to scoring. It has helped me to keep in mind the real mission I have as a risk manager and that is to protect patients from harm. Trend the data should future cases come up that are similar or involve the same practitioner. The score itself does nothing to protect patient's or the facility—it is really just a taxonomy measure, so we can all speak the same language about the kind of issues we are tackling in our facilities.

In the Risk Management statute, what is meant by "appropriate licensing agency?" KSA 1987 Supp. 65-4930 and its amendments define "appropriate licensing agency" as "the agency that issued the license to the individual or health care provider who is subject of a report under this act." Although KDHE is also a licensing agent to the facility—the statute utilizes the term "department" when they mean to refer to KDHE. *This definition leads to a correction of the newsletter distributed on August 26, 2015 which stated only SOC 4's should be reported to the "appropriate licensing agency."*

Therefore, according to the statute, <u>all SOC 3's and 4's should be reported to the "appropriate licensing agency."</u> At KDHE we are aware that while reporting certain SOC 3's seems logical--there are other situations in which reporting a SOC 3 seems punitive and counterproductive to a culture of safety. In fact, one of the most important characteristics of a culture of safety and a higher reliability organization is one that has eliminated fear and openly talks about error so that systems and processes can be improved and future occurrences avoided. The Risk Management statutes were introduced over 25-years ago and have not been updated since their introduction. At KDHE we are interested in working with other stakeholders over the next year to review the statutes to affirm that we are guided by laws that meet stakeholders' needs and are aligned with current risk management and patient safety evidence- based practices.