Risk Management Quarterly

AUGUST, 2015 Volume 1, Number 2

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KARQM 2015 Conference Held

The 2015 KARQM Conference was held on October 15th at the Via Christi hospital on East Harry. There was great attendance—partially due to the generosity of the KARQM Board providing free attendance for KARQM members. Topics addressed that day included "PR for Risk Managers—How to Demonstrate the Value of RM to Your Organization", "When things Don't Go According to Plan", "Double Trouble: Drug Diversion in Healthcare", "Error Causation" and "Who's Who of Kansas Quality Data Reporting." Deborah Stern gave an AHA update and new officers were elected during the business meeting. If you were not able to attend this year—start planning on next year. It is a great conference and a good chance to network with other Quality and Risk Managers from the state!

Patient Safety Corner

Patients should be able to trust that they can obtain healthcare without harm. But, despite many "calls to action," harm continues to be a significant health care problem. Hospital leaders must take an active role in communicating that patient safety is a top priority in their organization. The Board of Directors in healthcare organizations have a moral and fiduciary responsibility for patient safety. The Board sets the tone for patient safety by doing more than reviewing data in the meeting—they should also define patient safety priorities and objectives, craft strategy, and design systems for organizational control. A study completed in 2003 by Joshi & Hines found that hospital boards were "well attuned" to publicly reported quality data, but there was a significant difference in the CEO's perception of what the board knew about quality and patient safety and their actual knowledge level. The Board of Trustees is not only a valuable leader in the transformation to a culture of safety—but it is they who have the final responsibility and authority for the facility's risk management program. Joshi and Hines suggest the following tactics to increase the Board's engagement in quality and patient safety:

Increase the Board's Literacy in Quality and Patient Safety

- Educate the board on salient quality issues beyond public reporting;
- Initiate discussions with the board on what defines a quality expert and consider adding quality experts or those passionate about safety to the board;
- Use retreats for having in-depth dialogue on quality and patient safety improvement projects within the hospital;
- Have board members attend conferences about quality and patient safety.

Risk Management Reports are due to KDHE each quarter.

Here are the due dates:

--Quarter 1-April 15th

--Quarter 2-July 15th

--Quarter 3-October 15th

--Quarter 4-January 15th

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

Frame an Agenda for Quality

- Initiate discussion between the board chair and CEO on the status of quality and patient safety in the hospital. How is the hospital progressing? What are the barriers? What are the strengths? How can the board support improvement?
- Ensure that discussion of quality and patient safety on the board agenda gets equal billing with other agenda items.

Quality Planning, Focus and Incentives

- Create a vision of quality and patient safety for the hospital with long-term outcome measures and goals;
- Ensure the quality and safety measures the board reviews are assessed annually and are well understood by board members;
- Integrate the quality and patient safety measures into the overall board performance and board strategic milestones.

Patient-Centeredness

- Share patient stories at board meetings to further focus on patient-centeredness;

"Leaders enable safety culture by creating a context that directs greater attention and action toward safety." Hospital leaders that are passionate about quality and patient safety are imperative to building teams focused on safe and reliable care.

Joshi, M.S., Hines, S.C.(2006). Getting the Board on Board: engaging hospital boards in quality and patient safety. Journal on Quality and Patient Safety. 32(4). 179-185.

Vogus, T.J., Sutcliffe, K.M., Weick, K.E. (2010). Doing no harm: enabling, enacting, and elaborating a culture of safety in health care. Academy of Management Perspectives. November. 60-77. doi: 10.2139/ssrn.190462

Survey Management Update

KDHE has identified an increasing number of EMTALA complaints resulting in a larger number of onsite investigations during 2015. To prevent problems in your organization--be sure that those in your organization that need to know about EMTALA have adequate information about EMTALA obligations. There is a NEW educational material about EMTALA located at the KDHE Risk Management website found at http://www.kdheks.gov/bhfr/state_ach_licensure_forms.html

QUESTION CORNER

I know that a non-punitive approach leads to improved event reporting and open dialogues about building safety processes and systems. How do I comply with the Kansas Risk Management statutes and regulations and still foster a non-punitive approach?

The best way to demonstrate your non-punitive approach is to provide more focus on understanding what led to the adverse event and your work to implement meaningful improvements or mitigation strategies to prevent recurrence. Often the focus remains on the determination for the standard of care determinations (SOC), and while important to do in order to meet the Kansas Risk Management regulations, the SOC is merely a taxonomy measure. Taxonomy is important so we have consistency in identifying events and summarizing causal factors-- but the real value of adverse event reporting is the important improvements we make to safety systems!

What considerations should our committee have when we are looking at an event when the situation involves a known complication, such as a pneumothorax developing during the insertion of a central line?

Known complications should be distinguished from patient safety or adverse events resulting from deviations from generally accepted standards of care. An easy method to use when considering an event with a known complication is to ask four questions:

1. Was the procedure, treatment or test appropriate and warranted based on nationally recognized standards of care?
2. Was the complication a known risk, was it anticipated, and did the care team plan ahead to take steps to prevent it?
3. Was the complication identified in a timely manner?
4. Was the complication treatment according to the standard of care and in a timely manner?

If the answer to all four questions is "Yes," the event should not be considered an adverse event. If any of the four questions is answered "No," it probably is an adverse event.

HPI (2012) Cause analysis: a method to find and fix system problems p.19

Quarterly Quote

"The biggest challenge to moving toward a safety health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm." Institute of Medicine