SAMPLE

RISK MANAGEMENT PLAN (RMP)

Version updated 08/03/2017

FACILITY X (Name and Logo)

800 MAIN STREET

HOMETOWN, KANSAS  65432

****Update**** indicates areas that are typically needing updating every year.

Please note that the RMP in its entirety is to be submitted to KDHE for initial element approval and annually for subsequent element approval maintenance.
This Risk Management Plan (RMP) has been deemed to be releasable as a public record and is subject to the Kansas Open Records Act known as KORA.
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**Revision History****Update****

This Risk Management Plan (RMP) is reviewed, updated and approved as necessary and no less than annually. The approved RMP in its entirety is then submitted to the KDHE Risk Manager to be maintained on file.

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I PURPOSE

The risk management program of FACILITY X is designed to assure that the standard of care by the staff is maintained at the acceptable level, to reduce the risk of patient injury as a consequence of that care, and to minimize financial loss to the facility.

II Objectives and Statutes/Regulations

The risk management program is designed to:

1) Identify areas of risk in the clinical aspects of patient care and safety
2) Identify criteria for screening assessment with risk potential regarding clinical aspects of patient care and safety
3) Establish the investigative and evaluative process applied to cases with risk potential
4) Assure timely intervention in events below standard of practice
5) Develop policies and programs to reduce risk in clinical aspects of patient care and safety
6) Establish communication between risk management and quality assurance/improvement functions in the facility
7) Report risk management activities to the Kansas Department of Health and Environment and other appropriate licensing agencies, as mandated by law

III GOVERNING BODY AUTHORITY

The governing board duly authorizes the Risk Management Committee and the Medical Staff Executive Committee* as the committees which are responsible for investigating and determining applicable standards of care as required by state risk management laws, KSA 65-4921 et seq. These committees are established for the purposes of compliance with the risk management statutes; to evaluate and improve the quality of health care services and peer review act found at KSA 65-4915(a)(3). The governing board has the final responsibility and authority for the risk management program of FACILITY X.

This plan was developed in accordance with provisions of the aforementioned Kansas statutes. Responsibility for implementation of this plan is delegated to the Risk Manager. Please note that this Risk Management Plan (RMP) has been deemed to be releasable as a public record and is subject to the Kansas Open Records Act known as KORA.

* Larger facilities may find it appropriate to establish more than two committees while the smaller facilities may need only one committee. Those facilities that have one committee should ensure that the committee is multi-disciplinary, such as: two physicians, two registered nurses, a representative from ancillary services etc. Appropriate consulting physicians may also be appointed to this committee.

IV REPORTING OCCURRENCES/INCIDENTS

In accordance with KSA 65-4921 et seq, all employees, health care providers, and medical care facility agents are required to report any “reportable incident” to the risk manager, the chief administrative officer, and/or the chief of medical staff. KSA 65-4921(f) defines the term “reportable incident” as:

An act by a health care provider which: (1) is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient; or (2) may be grounds for disciplinary action by the appropriate licensing agency.

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Health care providers who are subject to statutory risk management include: medical care facilities, doctors of medicine/osteopathy, chiropractors, optometrist, podiatrist, pharmacists, dentists, licensed dental hygienists, physical therapist, physical therapy assistants, occupational therapist, occupational therapy assistants, respiratory therapists, radiology technologists, athletic trainers, naturopathic doctors, registered nurses, licensed practical nurses, mental health technicians, psychologists, social workers, and professional counselors.

Per KSA 65-4927(c), the willful failure of a healthcare providers and/or medical care facility employee to report, as required by law, is punishable as a Class C misdemeanor.

When a reportable incident is identified, the person with knowledge of the incident completes the reporting form for the risk management program (Appendix B). These forms are available to staff in each department of the facility. All reportable incidents are to be reported to the risk manager within 24 hours of discovery. Upon receipt of an incident report, the risk manager will enter the case in the risk management log (Appendix C) for tracking through its completion.

Identification of reportable incidents may be generated by, but not limited to the following method:

1) Personal Observations
2) Occurrence Screens
3) Infection Control Reports
4) Complication Reports
5) Death Reviews
6) Blood Usage Reviews
7) Tissue Reviews
8) Patient Satisfaction Surveys
9) Patient/Family Complaints
10) Medical Record Reviews

The risk manager shall have the authority to review all facility and medical policies, procedures, records, committee minutes and actions, to make recommendations to administration and the medical staff, and to initiate independent investigations to bring cases to satisfactory closure.

Category Types on the Reporting Form includes:

- Fall
- Abuse, Neglect or Exploitation
- Assessment/treatment
- Professional licensure event
- Delay
- Facility process or system-related
- Scope of Practice
- Impairment due to drug, alcohol or cognition
- Falsification
- Documentation of Narcotics
- Medication Error
- Improper Procedure
- EMTALA-Related
- IV line mix-up
- Drug Diversion
- Unprofessional conduct
- IV infiltration
- Other: ________________________________

Per KSA 65-4924: Impaired providers; if a report to a state licensing agency pursuant to subsection (a)(1) of (2) of KSA 1986 Supp. 65-4923 or any other report or complaint filed with such agency relates to a health care provider’s ability to practice the provider’s profession with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor

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V INVESTIGATION OF OCCURRENCES

All clinical variance/incident reports will be investigated by the risk manager or the appropriate department director/designee and will result in a specific standard of care determination. Separate standard of care determinations shall be made for each involved provider and each clinical issue reasonably presented by the facts. Resulting conclusions for standard of care determinations will be documented on the investigational tool (Appendix D). The primary reviewer must sign and date the investigational tool. Preliminary standard of care determinations are recorded on the risk management log.

VI DULLY AUTHORIZED RISK MANAGEMENT COMMITTEES

Results of the investigation are presented to the appropriate committee for final standard of care determination. All reviewers and committees shall be considered peer review committees pursuant to the provisions of KSA 65-4915.

The RMC (Risk Management Committee) functions as the nursing/ancillary staff peer review/risk management committee. Members include department heads from ancillary services, outpatient and nursing; quality improvement director; the risk manager; and the administrator. The risk manager is the chairperson.

The MSEC (Medical Staff Executive Committee) functions as the physician/credentialed practitioner peer review/risk management committee. It is composed of directors for surgery, anesthesiology, obstetrics and emergency departments. The Chief of Medical Staff is the chairperson. Non-voting members include the health information director and the risk manager. Names and titles of all medical staff involved with risk management peer review are included on the signature page.

With respect to each reported incident. The committees must determine: (1) whether individual health care providers met applicable standards of care expected in the facility; (2) if not, whether failure to meet those standards caused injury or had a reasonable probability of causing injury to a patient; and (3) whether any action by a health care provider might be grounds for disciplinary proceedings by the appropriate licensing agency. A list of the acts (Appendix E) which are grounds for disciplinary action by a health care provider licensing board is available to the risk management committees and all health care providers, facility employees and facility agents through the office of Risk Management.

The activities of each risk management committee shall be documented in its minutes. Meetings are held at least quarterly. The meeting minutes demonstrate that the committee is exercising overall responsibility for finalization of all standard of care determinations. All standard of care 1 and 2 determinations, made by individual clinicians or subordinate committees shall be approved by the designated risk management committee on at least a statistical basis. This approval will be documented in the risk management committee minutes.

The minutes of the foregoing committees shall, also, document a specific standard of care determination along with conclusions/rationale for all incidents with standard of care determinations of 3 and 4. Additionally, the minutes will document all incidents for which the standard of care has been changed by the duly constituted committee and rationale for the change. Standard of care determinations are recorded in the log.

The risk management committees may call upon the expertise of any facility personnel or medical staff member in fulfilling their functions. All facility personnel, administration, and medical staff members shall be obligated to cooperate with the risk management committees in acknowledgement of the joint responsibility of the medical staff, facility personnel, and administration for risk management pursuant to Kansas law.

Quality review-contractors/consults; all patient services including those services provided by outside contractors or consultants shall be periodically reviewed and evaluated in accordance with the plan.

The risk manager shall have the responsibility for filing quarterly reports (Appendix F) with the Kansas Department of Health and Environment and reportable finding reports with the appropriate state...
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Remediation and reporting includes determining the corrective action taken such as:

- □ Policy / Procedure Change
- □ Suspension of Privileges
- □ Termination
- □ Counseling / Education
- □ Restriction of Privileges
- □ Revocation of Privileges
- □ Pending
- □ Other: _______

VII STANDARD OF CARE DETERMINATIONS

Each facility shall assure that analysis of patient care incidents complies with the definition of a “reportable incident” per KSA 65-4921(f). This facility shall use the following categories:

1. Standards of care met
2. Standards of care not met, but with no reasonable probability of causing injury
3. Standards of care not met, with injury occurring or reasonably probable
4. Possible grounds for disciplinary action by the appropriate licensing agency

*Categories 3 and 4 are reportable findings and by law must be reported to the appropriate licensing agency. All must be reported to KDHE and in addition, any applicable licensing agency involved such as Kansas Board of Nursing, Board of Healing Arts, et al.

VIII QAPI and Minimizing Occurrences

Facility X has established the following mechanisms to minimize occurrences:

A  **Education:** All new employees will receive information mandating their obligation to report reportable incidents to the risk manager. The purposes of risk management and how to report in this facility will also be explained. The Risk Management plan will be reviewed at this time. Each employee will receive risk management in service on an annual basis, thereafter. A copy of the Risk Management plan and a printed handout explaining the risk management law will be provided to each medical staff member and each board member at the time of appointment and annually, thereafter. Any time the plan is amended, medical staff members, employees, and governing board members will be informed of the changes.

B  **Credentialing and Performance Evaluation:** All Standard of Care determinations will be applied to medical staff credentialing and employee performance evaluation. In addition, reportable findings will be reported to the appropriate licensing agency.

C  **Monitoring Frequency:** Data relevant to reported variances/incidents will be compiled by the risk manager in a statistical summary and will be presented quarterly to the Quality Assurance Performance Improvement Director to be used for identifying trends in practice and patient care. The Quality Assurance Performance Improvement Committee will analyze the frequency and causes of incidents and pursue measures to minimize recurrence through the active cooperation of facility staff, medical staff and administration. Statistical data and summaries will also be reported to the governing board at least quarterly.

D  **Facility Actions:** Internal facility actions may be taken as a result of investigation and data compilation and will be in accordance with facility policies and procedures and bylaws of the medical staff bylaws and governing board.

IX PLAN

A copy of the current risk management plan will be included in the employee policy manual and the bylaws of the governing board and medical staff. The plan will be reviewed and approved by the
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