Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities

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Annual Risk Management Report for 2003

Brief History of Kansas Risk Management

This report represents the eighteenth in a series written by staff of the KDHE (Kansas Department of Health and Environment). The report outlines the issues, problems, findings, and significant changes which have occurred in the implementation of the Kansas Risk Management law (KSA 65-4921 et. Seq.).

In 1987, House Bill 2661 passed requiring every medical care facility in Kansas to establish an internal risk management program. On 9/1/87, Bill Rein was named as the Director of Quality Assurance and Risk Management to provide oversight for the new legislative mandate. In 1988, risk management surveys began with annual surveys of 160 facilities by two Risk Management Specialists.

In 1996 following passage of House Bill 2867, combination licensure and risk management surveys for all non-accredited hospitals and ASCs (Ambulatory Surgical Centers) were initiated to assure compliance. Two Risk Management Specialists surveyed the 187 facilities at least every three years. The 1997 article, entitled *The Kansas Risk Management Program: What Has Changed and What Remains the Same,* explored the changes and early implementation efforts brought on by passage of House Bill 2867. That article explained the conceptual process of incorporating risk management laws and statutes with existing state licensure regulations into some revised "standards review" which had not been conducted in a number of years. A limitation on similar Medicare surveys was a result of revised federal funding priorities. The article presented the philosophy and development of a new survey instrument, a summary of the types and frequency of deficiencies cited during the initial reviews, as well as statistics historically gathered on risk management reporting to licensing agencies.

New risk management statutes were passed in 1997 that included peer review and designated reports, records, and proceedings as confidential and privileged. On February 27, 1998, new risk

management regulations became effective to enforce the new statutes. The January 1999 article, entitled *Two Years of Experience and Lessons Learned* reviewed the new regulations. The regulations were designed to reflect what had become recognized as the basic standards for risk management programs across the state.

"*Striving for a Better Tomorrow*" submitted in 2000, reviewed the survey process for 1998 and 1999. The role of the medical facility surveyor continued to be primarily that of a regulator but also increased as an educator to hospitals and ambulatory surgical centers concerning the protection of risk management information, the need of the risk managers to become more proactive with observation and record review to ascertain possible risk management problems, and for risk managers to become more involved with minimizing patient adverse events.

"*To Error is Human, BUT can be Deadly*" submitted in 2001, reviewed the risk management program for calendar year 2000. There is an increase in the government and the public's awareness of medical errors with a demand that something must be done to protect patients from medical errors. The emphasis is placed on improving processes in order to minimize occurrences.

"Creating a Safer Health Environment" submitted in 2002, outlined the categories that states are using to develop risk management programs. The following categories were established as criteria to be included in the development of the state programs:

- How does a state identify its goals for mandatory reporting systems?
- What information will a state collect?
- Who will collect the information and administer the system?
- How will reports be submitted?
- How will information be stored?
- How will a state assure data accuracy?
- How will a state act on an incident report?
- What types of disclosure policies will be in place?
- How can a state learn from the information to enhance and/or sustain quality improvement?

While Kansas has accomplished most of these steps, the last step continues to be one that is most difficult to accomplish. One of the recommendations for completing the last step is that states establish a coalition for the prevention of medical errors to determine approaches for alerting and informing facilities about the risk of errors and practices for addressing identified problems. The states that have established this coalition have done so with members from all licensing agencies involved with the prevention of medical errors. Some states have also invited consumers to

participate with the coalition. At this time, Kansas does not have this type of organized coalition and there is not a system in place for the separate entities to share and review aggregated data collected and to assess for system improvement. However, members from the KARQM (Kansas Association of Quality and Risk Managers) and the KHA (Kansas Hospital Association) has been meeting with the KDHE in order to improve communication between these organizations/agencies in regard to the risk management process. Hopefully, this will lead to the organization of a coalition that can learn from the information gathered by all of the stakeholders and improve the quality of care in Kansas medical care facilities.

On 7/28/04, National Academy for State Health Policy released a bulletin entitled, "Higher toll cited from hospital errors," by Scott Allen, Globe Staff. The article identified medical mistakes as the third-leading cause of death in the United States, behind heart disease and cancer. The article quoted Dr Samantha Collier, vice president of medical affairs at HealthGrades which publishes rankings of hospitals and doctors. According to Dr Collier, "There is little evidence that patient safety has improved in the last five years." "The equivalent of 390 jumbo jets full of people are dying each year due to likely preventable, in-hospital medical errors, making this one of the leading killers in the US." The analysis used a broad definition of medical error. The definition change to include cases in which hospital staff failed to respond quickly to signs of infection or other dangerous problems accounted for almost the entire increase in the number of deaths. The group noted that the increase in deaths came almost entirely from adding "failure to rescue" the patient as a medical error.

HealthGrades identified 195,000 deaths annually from 2000 - 2002 and estimated that Americans paid an extra $19 billion in medical costs for the victims of these mistakes. Studies repeatedly showed that medical errors were widespread and harmed up to one in every 25 patients admitted to the hospital.

It must be understood that the definition for an adverse event is not universal. The definition for adverse or a sentinel event from the Joint Commission on Accreditation of Healthcare Organization is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof". 'Serious injury specifically includes loss of limb or function." Colorado's definition is "All deaths arising from unexplained causes or under suspicious circumstances. Brain and spinal cord injuries. Life-threatening complications of anesthesia. Life-threatening transfusion errors or reactions. Burns; missing persons; physical, sexual, and verbal abuse; neglect; misappropriation of property; diverted drugs; malfunction or misuse of equipment." New York 's definition is "An unintended adverse and undesirable development in an individual patient's condition occurring in a hospital." A list of 47 occurrences that must be reported follows the definition.

In Kansas, a reportable adverse event would include all unexpected occurrences in which the standard of care was not met and that injury occurred or there was a probability of injury. This would include minor injuries as well as the more severe. Kansas adverse events also include those incidents that were possible grounds for disciplinary action by the appropriate licensing agency, such as, unprofessional conduct. Many of the adverse events reported in Kansas, would not be reported to these other entities, therefore it is impossible to accurately compare the data with other states.

Ambulatory Surgical Centers

KDHE implemented the new certification, licensure and risk management survey process for ASCs in the spring of 2001 using the new state regulations which were approved in April 2001. The CMS (Centers for Medicare and Medicaid Services) mandates that the states survey at least 17% of the ASCs each year for compliance with federal regulations. Under the provisions of KSA 65-433, KDHE plans to survey ASCs for state licensure and risk management more often. All ASCs should have a complete certification, licensure and risk management survey by the end of 2003. If CMS requirements do not change, starting in 2004, KDHE plans to continue to conduct a licensure/risk management survey with the addition of a federal survey every other time.

As medical care changes and the need to stay overnight after surgery becomes less prevalent, the number of ASCs continues to grow. In 1987, there were eight ASCs licensed in the state of Kansas. Today there are forty-seven licensed and certified ASCs. In 2002, KDHE conducted nine surveys in ASCs. In order to comply with surveying ASCs every three years, KDHE anticipates an increase in the number of surveys to approximately 10 to 15 each year.

Acute Care and Critical Access Hospitals

Implementation of the new combined licensure/survey process for medical care facilities began on December 1, 1996. The goal was to survey each hospital at least every two and a half to three years.

In 2000, federal certification requirements for resurveys in non accredited hospitals were increased from 5% to 33% each year. Since many of the regulations are similar, the federal certification resurvey and Licensure/risk management processes were combined to meet the increased work load.

Along with the increase of federal certification requirements, Kansas has had an increase in the number of hospitals converting to CAH (Critical Access Hospitals). There were 19 initial

surveys completed in 2001 with 13 of those 19 changing from an acute care hospital to a CAH. At the end of 2002 there are 51 Critical Access Hospitals, 8 of which converted from acute care hospitals in 2002. Each time an acute care hospital converts to a CAH, it requires an initial survey of that facility using the federal CAH regulations. Along with this CAH survey, KDHE inspects the facility to assure that they are complying with the Risk Management regulations. Approximately one year after the initial CAH survey is completed, KDHE returns to the facility for a certification and risk management resurvey. Thereafter, the CAH is placed on the rotation to be surveyed approximately every three years. Converting to a CAH has not demonstrated any changes in the risk management outcomes. It is hopeful that the supporting hospitals will be able to assist the CAHs with improving their risk management and quality improvement programs which may lead to improvement in patient safety. The Risk Management Specialist continues to conduct surveys each year, assists the generalist surveyors and is a consultant for hospital staff, Regional Managers and generalist surveyors.

Risk Management Issues

Confidentiality of Risk Management information continues to be at the forefront of discussions between risk managers and associated organizations. Confidentiality concerns are associated with the *Adams vs. St. Francis Regional Medical Center's* decision of releasing the relevant facts and the *Unzueta vs. Schalansky* decision when the plaintiff's attorney was given access to all of the risk management investigational interviews of witnesses, both staff and patients. Although the mental impressions, decision-making processes, and conclusions of hospital personnel involved in the risk management or peer review processes continue to be protected, there is concern from risk managers that this may change in the future.

The Risk Management Specialist and the Director of Medical Facility/Survey Support met with members of the Kansas Association of Risk and Quality Managers (KARQM) and members from the Kansas Hospital Association (KHA) in 2001 to discuss risk management concerns. This group continues to meet on an ongoing basis to work on developing meaningful interpretations of these definitions so that Kansas has a more universal reporting system and to work on developing better communication between associations and organizations that play a part in the risk management process.

The generalist surveyors continue to answer risk management questions during the risk management survey process. The Risk Management Specialist is available to provide education for the medical care facilities. Two of the statutes that continue to be problem areas are the confidentiality of information and minimizing occurrences. Many Kansas facilities have a changeover of risk managers during the three years between surveys and do not understand the necessity of protecting the reporter's name, assuring that risk management information is secured at all times, the need to take immediate action when an error occurs, and further minimizing

occurrences by tracking "near misses" and finding ways to improve processes. The risk management surveyors can assist the facilities in assuring that they meet the Kansas Risk Management statutes and regulations and with improving their risk management process.

Risk management regulation KAR 28-52-4 mandates that facilities assign a separate standard of care for each involved provider and the individual case. Finding the individual providers involved with the error and determining a standard of care for those providers has been the focus of risk management for many years. Beginning in 2000, we have seen a trend by facilities to place an emphasis on looking at the process of care not just the individuals involved. Although this does not mean that the risk management committees can discontinue reviewing individuals involved in the adverse event and assigning the individuals a standard of care, the trend of looking at the process as well as the individual is encouraged by KDHE. Assessing the process and making improvements on those processes demonstrates a positive approach to minimizing future occurrences. As the Institute of Medicine, Committee on Quality of Health Care in America reports in the book *"To Error is Human: Building a Safer Health System*," ***people in all lines of work make errors*** . Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing. We need to build safer systems by designing processes of care that will ensure that patients are safe from accidental injury.

The Risk Management Specialist

In addition to conducting on-site surveys and revisits, the KDHE's Risk Management Specialist has been involved in other risk management activities. Those activities included but were not limited to:

1) review and approval of new and amended risk management plans;
2) responding to inquiries about state and federal regulations or the risk management process;
3) reviewing adverse events and their corrective action as reported by facilities;
4) reviewing facilities' quarterly reports;
5) advising new facility applicants of risk management requirements;

6) providing consultation and presenting workshops and in-service training to risk managers and hospital personnel throughout the state and;
7) providing consultation and training to KDHE surveyors.

The turnover of risk managers throughout the state continues and many are placed in their positions without training or orientation. In 2003, the Risk Management Specialist provided educational programs for medical care facilities throughout the state, both in a group setting and on an individual basis. The group educational sessions presented by the Risk Management Specialist included:

Risk Management 101
Infection Control
Risk Management - What It Means to You

Medical Facility Survey Process

Each hospital should anticipate that the survey process will take approximately one week to complete. The ASCs, depending on size, will take approximately one to three days. When deficiencies are cited, the facility should receive a revisit within six months. The date of a revisit will depend on the anticipated date of correction that the facility has placed on their State of Deficiencies and Plan of Correction (2567) but no later than six months after the original standard survey. The survey revisit is accomplished in four to eight hours. Table 1 compares the number of surveys completed each year.

Table 1
Comparison of the Number of Surveys Completed each year
December 1996 through December 31, 2001.

Year	Number of Surveys Completed
December 1996	3 surveys
1997	29 surveys
1998	26 surveys
1999	43 surveys
2000	39 hospitals & 2 ASCs
2001	22 hospital (resurveys) 3 hospitals (initial) 17 CAH (resurveys) 13 CAH (initial) 7 ASCS (resurveys) & 3 (initial)
2002	70 Surveys & Resurveys (39 CAHs) (9 ASCs) (30 Hospitals)

2003	
December 1, 1996 through December 31, 2003	TOTAL 207 surveys completed

Citing a Deficiency

During the survey process, surveyors observe care provided to patients, review medical records for appropriate documentation, review facility policies for the required elements, conduct patient, family and/or staff interview, and observe the physical environment of the facility. During the survey if the surveyor identifies that the facility's practice is not consistent with the regulatory requirement, a deficiency is written at the appropriate code/tag. Each regulation is divided into several codes/tags.

In order to assure that facilities are not cited twice for the same deficiency, surveyors will cite only the federal regulation if the deficient practice violates both state and federal requirements. Since there are no regulations for risk management in the federal regulations, and all risk management deficiencies are cited on a separate state deficiency statement due to confidentiality.

CAHs were surveyed for compliance with certification and risk management regulations. Hospitals with swing beds were required to complete a Swing Bed MDS (Minimum Data Set) beginning in July, 2002, for Medicare recipients . CAHs with swing beds were not required to complete Swing Bed MDS. A class was conducted during the last half of 2002 on the Swing Bed MDS process and the differences between hospitals with swing beds and CAHs. The SB MDS is completed for reimbursement purposes only and does not constitute a full assessment of the patient. A full assessment must be completed on all patients in swing beds in addition to the SB MDS. Both hospitals with swing beds and CAHs have experienced the following problems found during the survey process

1) failure to fully assess patients,
2) failure to protect patient records from unauthorized use, and
3) failure to implement a quality assurance program.

Risk Management Goals for 2003

The Bureau of Health Facilities Risk Management continuous goals, are to:

- Assist facilities in improving the risk management process through educational programs and consultation;
- share positive accomplishments or best practices from other Kansas facilities;
- share information accumulated from literature, the direct involvement with other states and the direct involvement with federal coalitions/organizations;
- monitor facility risk management programs through the survey process;
- improve communication between state licensing agencies concerning specific cases and best practices.

KDHE believes that it is important to maintain and improve communication between licensing agencies, medical care facilities, and professional organizations in order to reach these goals. Questions related to the medical care facilities' licensure and/or risk management may be directed to:

Lynn Searles RN, Risk Management Specialist or
Charles Moore, Director Medical Facilities/Survey Support
Licensure and Certification Program
Bureau of Child Care and Health Facilities
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, Kansas 66612-1365

Statistical Information on the Risk Management/Licensure and Certification Survey Process

Tables, Appendixes, and Chart

Tables Introduction

Historically data has been presented to medical care facilities related to the number of incidents confirmed to meet standard of care determination levels 3 or 4, the agency to which the incident was reported, and the number of reports generated by facility size. These figures are updated through the end of 2002 and are presented in the following tables. In addition, two new columns have been added to separate the number of reportable incidents into the two categories of Standard of Care (SOC) III which is standard of care not met, with injury occurring or reasonably probable and SOC IV which is possible grounds for disciplinary action by the appropriate licensing agency.

Table 3
Comparison of Reportable Incidents
By Year and By Licensing Agency

1991 - 2003

Year	Total # of Reported Incidents	SOC III	SOC IV	KSBHA	KSBN	KDHE	KSPB	Other
1992	664			101 (15%)	260 (39%)	132 (20%)	N/A	171(26%
1993	571			80 (14%)	304 (53%)	123 (22%)	N/A	64 (11%)
1994	569			64 (11%)	273 (48%)	134 (24%)	N/A	89 (16%)
1995	530			103 (19%)	230 (43%)	130 (25%)	N/A	67 (13%)
1996	512			69 (13%)	268 (52%)	143 (28%)	N/A	32 (7%)
1997	488			66 (14%)	257 (52%)	140 (29%)	N/A	25 (5%)
1998	361			46 (13%)	198 (55%)	84 (23%)	7 (2%)	27 (7%
1999	441			65 (15%)	186 (42%)	151 (34%)	12 (3%)	27 (6%)
2000	571			72 (13%)	285 (50%)	191 (34%)	3 (.05%)	20 (4%)
2001	436	320	116	48 (11%)	208(48%)	149(34%)	14(3%)	17 (4%)
2002	501*	395	106	57 (12%)	222 (47%)	149 (34%)	14 (3%)	16 (3%)
2003								

*__**Table 3**__ above depicts the number of incidents reported to licensing agencies for the years 1992-2003. The 1998 figure is the lowest number in the ten reporting years and represents a significant decrease from all of the other years. There was a decrease in the number of issues reported to risk management and a decrease in the number of reportable incidents to all licensing agencies in 2nd quarter 1998. It did slowly increase in 3rd and 4th quarter, 1998. There was a decrease in 1999 followed by a sharp increase in 2000. Another decrease in 2001 followed by an increase in 2002.

*The total number of incidents reviewed and investigated by all providers during 2002 was 93, 627. Five hundred and one (501) SOC III and SOC IV determinations represent 5.35% of the total.

Table 4
Comparison of Average Number of Incidents
Reviewed and Total Number of Reportable Incidents Filed
By Facility Size
2000 - 2003

Facilities by by Size Category	Number of Facilities in Size Category	Avg # of Incidents/Total # of Reportable Incidents Reviewed 2000	Avg # of Incidents/Total # of Reportable Incidents Reviewed 2001	Avg # of Incidents/Total # of Reportable Incidents Reviewed 2002	Avg # of Incidents/Total # Reportable Incidents Reviewed 2003
1 - 25 beds	57 facilities	218/97	213/97		
26 - 50 beds	39 facilities	373/102	362/71		
51 - 100 beds	21 facilities	591/86	485/38		
101 - 200 beds	14 facilities	906/7	780/55		
200 + beds	15 facilities	2093/242	2057/191		
ASCS's	45 facilities	24/5	28.5/0		
Totals		/571	/436		

***Table 4** above compares the average number of incidents reviewed and the total number of incidents reported, by facility size, during 2000 and 2001. The average number would equate to item number 4 on the *Kansas Department of Health and Environment Confidential Quarterly Report* form, while the total figure would represent item number 5 (c) and 5 (d) on the same form. The bed size is based on the acute bed count as determined by a facility's license. For example, a facility licensed for 20 acute beds and 60 long term care beds would be included in the 1-25 bed grouping. Mental health, mental retardation, and psychiatric hospitals are listed by total bed count.

Table 5
Comparison of Total Number of Reportable Incidents Generated
By Facility Size and Licensing Agency
1996-2001

Hospitals

Facility Size	Year	KSBHA	KSBN	KDHE	Pharmacy	Other
1-25 beds	**2003**					
	2002	6 or 7%	29 or 32%	53 or 38%	1 of 1%	3 or 3 %
	2001	4 or 5%	36 or 45%	34 or 42%	1 or 1%	6 or 7%
	2000	16 or 18%	47 or 54%	17 or 20%	1 or 1%	6 or 7%
	1999	4 or 6%	32 or 46%	24 or 34%	3 or 4%	7 or 10%
	1998	5 or 11%	30 or 67%	7 or 15%	0	3 or 7%
	1997	4 or 8 %	29 or 56%	17 or 33%	0	2 or 3%
	1996	4 or 9%	24 or 56%	13 or 30%	2 or 5%	0
26-50 beds	**2003**					
	2002	9 or 13%	38 or 53%	22 or 31%	3 or 4%	0
	2001	17 or 24%	36 or 50%	20 or 28%	3 or 4%	3 or 4%
	2000	11 or 12%	39 ir 42%	35 ir 38%	0	7 ir 8%
	1999	14 or 17%	45 or 55%	19 or 23%	1 or 1%	3 or 4%
	1998	13 or 15%	41 or 48%	27 or 31%	0	5 or 6%
	1997	24 or 24%	42 or 42%	24 or 24%	3 or 3%	6 or 6%
	1996	16 or 17%	43 or 46%	27 or 29%	0	7 or 8%
51-100 beds	**2003**					
	2002	6 or 9%	25 or 36%	34 or 49%	2 or 3%	2 or 3%

	2001	4 or 11%	21 or 54%	9 or 24%	0	4 or 11%
	2000	22 or 26%	39 or 45%	25 or 29%	0	1 or 1%
	1999	15 or 23%	22 or 34%	21 or 33%	0	6 or 10%
	1998	12 or 20%	34 or 57%	7 or 12%	2 or 3%	5 or 8%
	1997	7 or 8%	54 or 61%	22 or 25%	1 or 1%	5 or 5%
	1996	13 or 16%	34 or 43%	29 or 36%	3 or 4%	1 or 15
101-200 beds	**2003**					
	2002	9 or 17%	36 or 67%	8 or 15%	1 or 2%	0
	2001	6 or 11%	38 or 69%	10 or 18%	0	1 or 2%
	2000	5 or 9%	38 or 67%	13 or 23%	0	0
	1999	10 or 15%	34 or 51%	7 or 10%	7 or 10%	9 or 13%
	1998	6 or 9%	51 or 74%	5 or 7%	5 or 7%	2 or 3%
	1997	16 or 20%	50 or 61%	11 or 13%	2 or 2%	2 or 4%
	1996	10 or 11%	57 or 60%	15 or 16%	1 or 1%	12 or 12%

Facility Size	Year	KSBHA	KSBN	KDHE	Pharmacy	Other
201+ beds	**2003**					
	2002	13 or 8%	87 or 50%	59 or 34%	8 or 5%	6 or 3 %
	2001	17 or 9%	85 or 45%	76 or 40%	10 or 5%	3 or 1%
	2000	16 or 7%	122 or 50%	101 or 41%	2 or .08%	3 or 1%
	1999	22 or 14%	53 or 34%	79 or 50%	1 or 1%	2 or 1%
	1998	10 or 10%	42 or 41%	38 or 37%	0	12 or 12%
	1997	15 or 9%	80 or 49%	66 or 40%	2 or 1%	3 or 1%
	1996	23 or 12%	110 or 57%	57 or 29%	1 or 1%	3 or 1

Ambulatory Surgical Centers	**2003**					
	2002 2001	1 or 8% 0	0 0	3 or 23% 0	0 0	9 or 69% 0
	2000	2 or 40%	0	0	0	3 or 60%
	1999	0	0	1 or 100%	0	0
	1998	0	0	0	0	0
	1997	0	2 or 100%	0	0	0
	1996	3 or 42%	0	2 or 29%	0	2 or 29%

*__Table 3__, compares the total number of incidents reported by facility size and licensing agency, including percentages of reports to agencies by facility size and year.

KDHE RISK MANAGEMENT ARTICLES

1. **"Risk Management Defined"** discusses the history of risk management enabling legislation (House Bill 2661). This article attempts to explain the purposes for requiring risk management programs, the elements necessary to meet statutory requirements, and plans for KDHE's first survey cycle. The article was written in 1988.

2. **"Health Care Risk Management in Kansas: 1990 Issues"** attempts to answer the eight most frequently asked questions about risk management laws during KDHE's first survey cycle. Those questions include: What is the essence of the risk management law? Why are hospital committees required to determine standards of care in individual cases? What is necessary to assure that standards of care are met?

How must an investigation be accomplished to meet the requirements of state risk management laws? The article was written in 1989.

3. **"The Failures of Risk Management"** addresses the early problems faced by risk management programs. Those problems included administrative turnover, failure to document provider- and issue-specific standard of care determinations, lack of incident reporting logs sufficient to assure that each case received a standard of care determination, and lack of executive committee oversight. The article also discusses KDHE objectives for its third risk management survey cycle. This article was written in 1990.

4. **"A Statutory Approach to Hospital Risk Management: Five Years in Kansas"** reviews the history of risk management programs from 1987 to 1991. In addition, the article discusses the results of over 200 interviews with direct care staff concerning risk management program in 64 facilities. This article was written in 1991.

5. **"Five Years of Risk Management in Kansas: An Overview"** was published in The Kansas Nurse and provides an overview of the risk management program from a nursing perspective. The article was written in 1992.

6. **"Kansas Risk Management Laws: Report and Observations on the First Three Survey Cycles"** describes the survey cycles implemented by KDHE. Comparisons of incident reporting activities by aggregate facility size to types of licensing agencies are made. The article was written in 1993.

(continued)

"Resident Abuse, Neglect, and Exploitation and the Kansas Risk Management Law" describes the role of the risk management law in relation to other federal and state statutes related to allegation of resident abuse in facilities. The article was written in 1994.

8. **"Compliance of Facilities with Kansas Risk Management Surveys: An Update"** provides statistics related to risk management activities from 1988 through 1993. The article was written in 1994.

9. **"Rationale: The Basis for Standard of Care Decisions"** explores the importance of developing clear and reasonable documentation in risk management investigations. The article was written in 1995.

10. **"The Kansas Risk Management Law: Does it need to be Redesigned for the Future?"** discusses the history of risk management in Kansas and its relationship to other quality assurance and quality improvement efforts. The article was written in 1995.

11. **"Final Risk Management Site Review Statistics through Survey Year VI"** provides an overview of compliance history and incident reporting during six risk management survey cycles. The article was written in 1996.

12.` **"The Kansas Risk Management Program: What Has Changed and What Remains the Same"** describes the changes occurring in medical care facility licensure laws following passage of 1996 House Bill 2867. The implementation of a state licensure/risk management survey process is discussed and statistics from early surveys are presented. The article was written in 1997.

13.**"Two Years of Experience and Lessons Learned"** describes the experience of combining the licensure/risk management survey. Provides information on the Adams vs St Francis court case which opened up some of the facts of risk management. Introduced the new regulations which were intended to provide further guidance to medical care facilities in implementing the provisions of KSA 65-4922. This article was written in 1999.

13.**"Striving for a Better Tomorrow"** describes the new role of the Risk Management Specialist, adding an educational component, the start of a new quarterly report which would give corrective action for trending issues as well as the individual. This article was written 2001.

15. **"On-site Licensure/Risk Management Surveys:"To Error is Human" - BUT Can Be Deadly"** Describes the change of focus from looking at only individuals involved with incidents to an emphasis of looking at the process of care. This does not mean that the risk management committees can discontinue reviewing the individuals involved in the adverse event, but the facility should also review the process involved. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing. We need to build safer systems by designing processes of care to ensure that patients are safe from accidental injury. Patients need assurance that the process of care will proceed correctly and safely so they have the best chance possible of achieving desired outcomes. Written 2001.

APPENDIX A

Total of Survey Codes Cited During

Acute Care Hospital Licensure/Certification Surveys Between

January 1, 2001 and December 31, 2001

SURVEY CODES	NUMBER OF FACILITIES CITED	SURVEY CODES	NUMBER OF FACILITIES CITED	SURVEY CODES	NUMBER OF FACILITIES CITED	SURVEY CODES	NUMBER OF FACILITIES CITED
R0007	**1**	A0019	**2**	A0110	**1**	A0351	**1**
R0008	**2**	A0022	**7**	A0111	**2**	A0520	**3**
R0009	**6**	A0031	**1**	A0113	**3**	A0522	**3**
R0022	**1**	A0032	**1**	A0115	**2**	A0523	**2**
R0038	**2**	A0034	**4**	A0120	**2**	A0525	**2**
R0039	**2**	A0042	**1**	A0122	**7**	A0526	**3**
R0042	**1**	A0044	**1**	A0123	**6**	A0527	**2**
R0043	**1**	A0045	**2**	A0124	**1**	A0532	**4**
R0044	**1**	A0046	**1**	A0126	**1**	A0533	**2**
R0052	**1**	A0050	**2**	A0129	1	A0540	**1**
R0063	**1**	A0051	**2**	A0132	**1**	A0546	**1**
R0064	**2**	A0052	**7**	A0139	**1**	A0550	**1**
R0068	**3**	A0053	**1**	A0141	**1**	A0554	**1**
R0101	**1**	A0054	**2**	A0185	**1**	A0571	**2**
R0110	**1**	A0058	**1**	A0188	**3**	A0573	**1**
R0114	**4**	A0061	**1**	A0229	**3**	A0583	**1**
R0125	**2**	A0062	**1**	A0240	**7**	A0753	**1**
R0131	**1**	A0063	**2**	A0242	**1**	A0754	**1**
		A0067	**3**	A0243	**1**	A0755	**1**
		A0074	**1**	A0245	**2**	A0758	**1**
		A0078	**1**	A0255	**2**	A0762	**1**
		A0083	**1**	A0256	**1**	A0765	**3**
		A0084	**3**	A0257	**2**	A0766	**1**
		A0087	**3**	A0270	**2**	A0771	**1**

		A0091	**1**	A0271	**1**	A0772	**1**
		A0094	**1**	A0274	**1**	A0786	**1**
		A0097	**2**	A0291	**1**	A0787	**1**
		A0100	**7**	A0307	**1**		
		A0102	**1**	A0330	**1**		
		A0103	**1**	A0340	**1**		
		A0106	**2**	A0341	**1**		

Total of Survey Codes Cited During
Critical Access Hospital Certification Surveys Between
January 1, 2001 and December 31, 2001

SURVEY CODES	**NUMBER OF FACILITIES CITED**	**SURVEY CODES**	**NUMBER OF FACILITIES CITED**		
C0152	**1**	C0333	**2**		
C0154	**1**	C0334	**2**		
C0200	**1**	C0335	**1**		
C0201	**1**	C0336	**2**		
C0202	**1**	C0337	**4**		
C0203	**2**	C0338	**1**		
C0204	**2**	C0340	**1**		
C0205	**3**	C0342	**2**		
C0211	**1**	C0343	**1**		
C0222	**2**	C0360	**2**		
C0224	**5**	C0363	**2**		
C0225	**2**	C0364	**1**		
C0227	**1**	C0369	**1**		
C0229	**1**	C0383	**1**		
C0241	**3**	C0385	**2**		
C0272	**1**	C0388	**7**		
C0275	**3**	C0389	**2**		
C0276	**4**	C0391	**2**		

C0278	**2**				
C0280	**3**				
C0282	**1**				
C0283	**1**				
C0295	**1**				
C0298	**1**				
C0301	**1**				
C0302	**1**				
C0307	**2**				
C0308	**4**				
C0330	**1**				
C0331	**1**				

Total of Survey Codes Cited During
Ambulatory Surgical Center Licensure and Certification Surveys
Between January 1, 2001 and December 31, 2001

SURVEY CODES	**NUMBER OF FACILITIES CITED**	**SURVEY CODES**	**NUMBER OF FACILITIES CITED**		
Q0003	**1**	S0110	**1**		
Q0004	**1**	S0125	**2**		
Q0005	**1**	S0130	**2**		
Q0007	**1**	S0140	**2**		
Q0009	**1**	S0145	**1**		
Q0011	**1**	S0150	**2**		
Q0012	**1**	S0175	**2**		
Q0018	**1**	S0580	**1**		
Q0020	**2**	S0275	**1**		
Q0021	**1**	S0495	**1**		
Q0022	**1**	S0655	**1**		
Q0026	**1**	S0720	**1**		

Q0027	**1**	S0845	**2**		
Q0028	**1**				
Q0034	**2**				

Total of Survey Codes Cited During
Hospital, CAH and ASCS Risk Management Surveys Between
January 1, 2001 and December 31, 2001

SURVEY CODES	NUMBER OF FACILITIES CITED	SURVEY CODES	NUMBER OF FACILITIES CITED	SURVEY CODES	NUMBER OF FACILITIES CITED
R0800	**4**				
R0801	**9**				
R0802	**15**				
R0805	**6**				
R0810	**1**				
R0815	**1**				
R0819	**16**				

R0820	**2**				
R0822	**2**				
R0825	**2**				
R0826	**1**				
R0827	**2**				
R0828	**2**				
R0829	**1**				
R0831	**1**				
R0832	**8**				
R0833	**14**				
R0835	**1**				
R0836	**1**				

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Table 2
Comparison of Deficiencies cited in the past five years.

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1997 through 2001

Year	Total # of Surveys conducted	Total # of Deficiencies	Federal Deficiencies	Licensure Deficiencies	RM Deficiencies	Average # Deficiencies Cited
1997	29	484	N/A	390	94	16.7
1998	26	192	N/A	143	49	6.7
1999	43	195	N/A	141	54	4.5
2000	41	260	143	69	48	6.3
2001	Hospitals 25 CAH - 30 ASCS - 10	289 121 50	213 93 17	25 0 19	51 24 14	11.5 4 5

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APPENDIX D

Most Frequently Cited Survey Codes and Percentage of
Facilities Cited Compared by Hospital/Risk Management Surveys
Each Year - 1999, 2000 and 2001

Survey Code Most Frequently Cited in 1999	**Number of Times Survey Code Cited**			**Percentage of Facilities Cited**		
	1999	2000	2001	1999	2000	2001
R819 - Risk Management	25	10	15	58%	24%	27%
R802 - Risk Management	19	11	12	44%	27%	22%
R062 - Licensure	13	1	7* (A122)	30%	2%	11%
R822 - Risk Management	10	3	1	23%	7%	1%

R063 - Licensure	9	5	1	21%	15%	1%

Survey Code Most Frequently Cited in 2000	**Number of Times Survey Code Cited**			**Percentage of Facilities Cited**		
		2000	2001		2000	2001
R802-Risk Management		11	12		27%	22%
R819-Risk Management		10	15		24%	27%
R033-Licensure		6	3* (A84)		15%	5%
R138-Licensure		6	0		15%	0
R801-Risk Management		6	7		15%	11%

*__**Appendix D**__ demonstrates areas of improvement or lack of improvement in the most frequently cited deficiencies in 1999 and 2000. Tag 62 is a licensure regulation concerning safeguarding drugs and biologicals. In 2001 this same deficiency was cited under the federal certification tag A122. Tag 33 is a licensure regulation concerning nursing procedure, including nursing care plans. This is now being cited under tag number A84. Tag 138 deals with lack of a Peri natal committee. This has shown improvement with no citations for this deficiency in 2001. See appendix B for the most frequently cited deficiencies in 2001.

APPENDIX B

Most Frequently Cited Survey Codes and Percentage of
Facilities Cited During 25 Hospital Certification & Licensure
Between January 1, 2001 and December 31, 2001

Survey Code	Number of Times Survey Code Cited	Percentage of Facilities Cited
A0022 - Certification	7	28%
A0052 - Certification	7	28%
A0100 - Certification	7	28%

A0122 - Certification	7	28%
A0240 - Certification	7	28%
A0701 - Certification	7	28%
A0751 - Certification	7	28%

Most Frequently Cited Survey Codes and Percentage of
Facilities Cited During 30 CAH Hospital Certification Surveys
Between January 1, 2001 and December 31, 2001

Survey Code	Number of Times Survey Code Cited	Percentage of Facilities Cited
C0388 - CAH Certification	7	23%
C0224 - CAH Certification	5	17%
C0276 - CAH Certification	4	13%
C0308 - CAH Certification	4	13%
C0337 - CAH Certification	4	13%

*__Appendix C__ contains the descriptions for those deficiencies listed on Appendix B

APPENDIX B (con't)

Most Frequently Cited Survey Codes and Percentage of
Facilities Cited During 55 Hospital & CAH Risk Management Surveys
Between January 1, 2001 and December 31, 2001

Survey Code	Number of Times Survey Code Cited	Percentage of Facilities Cited
R0819 - Risk Management	15	27%
R0833 - Risk Management	13	24%
R0802 - Risk Management	12	22%
R0801 - Risk Management	7	13%
R0832 - Risk Management	7	13%
R0805 - Risk Management	6	11%

Most Frequently Cited Survey Codes and Percentage of
Facilities Cited During 10 ASCS Certification & Licensure/Risk Management Surveys
Between January 1, 2001 and December 31, 2001

Survey Code	Number of Times Survey Code Cited	Percentage of Facilities Cited
R0802 - Risk Management	3	30%

R0801 - Risk Management	2	20%
S0125 - Licensure	2	20%
S0130 - Licensure	2	20%
S0140 - Licensure	2	20%
S0150 - Licensure	2	20%
S0575 - Licensure	2	20%
S0845 - Licensure	2	20%
Q0020 - Certification	2	20%
Q0034 - Certification	2	20%

*__Appendix C__ contains the descriptions for those deficiencies listed on Appendix B

APPENDIX C

Most Frequently Cited Survey Codes on Appendix B
With Summary Descriptions of
Issues Identified
December 1, 2000 - December 31, 2001

Survey Code

Federal Certification Acute Care Hospital

A0022 **482.12 Condition of Participation: Governing Body (5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patient;**

Summary description of issues identified during the survey process: This deficiency is usually written when care issues are identified and the governing body has not been involved with the issues.

A0052 **482.21 Condition of Participation: Quality Assurance (a)(1) All organized services related to patient care, including services furnished by a contractor, must be evaluated.**

This is cited when a facility fails to have a quality assurance program that includes the evaluation of all patient care services.

A0100 **482.24 Condition of Participation: Medical record services. (B)(3) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records.**

This is normally cited when facilities fail to secure medical records when staff are not present especially in areas such as Radiology and adjacent storage.

A0122 **482.25 Condition of Participation: Pharmaceutical services. (B) Standard: Delivery of services. (2) Drugs and biologicals must be kept in a locked storage area.**

This is an ongoing problem in medical care facilities and previously was cited under the licensure regulations. Drugs found in unlocked areas is a frequent occurrence. There is also a problem noted with dangerous chemicals, such as cleaning supplies, being stored in open areas.

A0240 **482.41 Condition of Participation: Physical environment. (c) Standard: Facilities. (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.**

This is cited for lack of maintenance, such as broken tiles, exposed wood, chipped paint, etc. It is also cited when the facility fails to check and ensure that equipment is working properly

A0701 **482.27 Condition of Participation: Laboratory services. (c) Standard: Potentially infectious blood and blood products (3) Quarantine of blood and blood products pending completion of testing.**

If facilities have blood available for patient care, they must have policies in place that will determine the disposition of blood or blood products when notified that there have been repeated reactive HIV screening tests.

A0751 **482.13 (a)Standard: Notice of rights.**

Most hospitals have informed patients of their rights according to state licensure regulations. They have failed to include the federal certification rights, especially concerning patient grievances, participation in care, and restraints.

Federal Certification Critical Access Hospitals

C0388 **483.20 Resident Assessment**.

The facilities have failed to conduct an initial and periodic comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

C0224 **485.623 Condition of Participation: Physical Plant and environment. (3) Drugs and biologicals are appropriately stored.**

There continues to be a problem with facilities not securing drugs and cleaning supplies. The cleaning supplies are labeled as dangerous if swallowed and is a risk especially for children and confused adults.

C0276 **485.635 Condition of Participation: Provision of services. (3)(iv) Rules for the storage, handling dispensation, and administration of drugs and biologicals.**

This regulation has been cited for not keeping outdated drugs separate from those that are being administered to patients, not keeping accurate records for scheduled drugs and allowing unauthorized personnel access to pharmacy.

C0308 **485.638 Condition of participation: Clinical records. (b) Standard: Protection of record information.**

This regulation has been cited for not safeguarding the confidentiality of patient information. At times, this is in the medical records department when staff leave the department and do not secure the records, but usually it is cited when records containing patient names, diagnosis etc. are found accessible to others in Radiology, Lab, Business office, and other storage areas.

C0337 **485.641 Condition of participation: Periodic evaluation and quality assurance review. (1) All patient care services and other services affecting patient health and safety are evaluated.**

Facilities fail to demonstrate an evaluation of patient care, both for services in the facility and those contracted from outside the facility.

State Risk Management for Acute Care and Critical Access Hospitals

R0819 **KSA 65-4923 Reporting requirements (a) If a health care provider or a medical care facility agent or employee who is directly involved in the delivery of health care services, has knowledge that a health care provider has committed a reportable incident, such health care provider, agent or employee shall report such knowledge as follows**

(2) If the reportable incident occurred within a medical facility, the report shall be made to the chief of the medical staff, chief administrative officer or risk manager of the facility.

The committee shall investigate all such reports and take appropriate action, including recommendations of a restriction of privileges at the appropriate medical care facility

Summary Description of Issues Identified: Incidents reported to one of three statutorily defined persons not investigated by duly constituted risk management committee. Findings from closed record review that a possible reportable incident was not reported to one of three identified individuals. Lack of documentation that identified reportable incidents related to corrective actions taken by committee and/or facility.

R0833 **KAR 28-52-4 Standard of care determinations. (b) Separate standard of care determinations shall be made for each provider and each clinical issue reasonably presented by the facts.**

Each provider involved in an incident must receive a separate standard of care. Many times the facilities document a standard of care for the incident but do not look at each providers involvement and determine if their involvement had an impact on the outcome. This is, also, cited when the findings demonstrate more than one issue and the facility determines only one standard of care.

R0802 **KAR 28-52-1 (c) Findings, conclusions, recommendations, actions taken, and results of actions taken shall be documented and reported through procedures established within the risk management plan.**

Facility fails to complete a thorough investigation as to the cause of an incident. Conclusions/rationale for standard of care are not documented. Corrective action taken and results of actions taken not documented.

R0801 **KAR 28-52-1 General Requirements. (b) The plan shall be approved and reviewed annually by the facility's governing body.**

There is no documentation that the facility's governing body reviewed or approved their risk management plan.

R0832 **KAR 28-52-4 Standard of Care determinations. (b) Each reported incident shall be assigned an appropriate standard of care determination under the jurisdiction of a designated risk management committee.**

This regulation is cited when someone reports an incident to administration or risk management and that incident is not given a standard of care by the committee. It may, also, be cited when a facility gives a standard of care which is obviously not appropriate for the incident.

R0805 **KAR 28-52-1. (e) (2) Section II - a description of the measures used by the facility to minimize the occurrence of reportable incidents and the resulting injuries within the facility.**

Summary Description of Issues Identified: The facility fails to utilize the trending of incidents to minimize occurrences and improve facility processes. Providers with multiple occurrences are not identified for trending to minimize occurrences by individuals.

State/Risk Management and Federal Certification for Ambulatory Surgical Centers

R0802 **KAR 28-52-1 (c) Findings, conclusions, recommendations, actions taken, and results of actions taken shall be documented and reported through procedures established within the risk management plan.**

Facility fails to complete a thorough investigation as to the cause of an incident. Conclusions/rationale for standard of care are not documented. Corrective action taken and results of actions taken not documented.

R0801 **KAR 28-52-1 General Requirements. (b) The plan shall be approved and reviewed annually by the facility's governing body.**

There is no documentation that the facility's governing body reviewed or approved their risk management plan.

S0125 **KAR 28-34-52a(a) Patient Rights (4) right to access information contained in the patient's medical record, within the limits of state law, by each patient or patient's designated representative.**

Facilities fail to inform patients of this right.

S0130 **KAR 28-34-52a(a) Patient Rights (5) right to maintain privacy and security of self and belongings during the delivery of patient care services;**

Facilities fail to inform patients of this right.

S0140 **KAR 28-34-52a(a) Patient Rights (7) right to be informed of the facility's policies regarding patient rights.**

Facilities fail to inform patients of all their rights.

S0150 **KAR 28-34-52(c) Patient Rights - Each person having a grievance or complaint pertaining to the provision of any patient services in an ambulatory surgical center may direct the grievance or complaint to the licensing department.**

Facilities fail to inform patients of this right and fail to assure that the patients have information needed to make this grievance or complaint, such as the phone number and/or address of the Kansas Department of Health and Environment.

S0575 **KAR 28-34-58a(b) Infection Control - Upon employment each individual shall have a medical examination consisting of examinations appropriate to the duties of the employee, including a tuberculin skin test. Subsequent medical examinations or health assessments shall be given periodically in accordance with the facilities policies.**

Facilities usually complete a tuberculin skin test both at time of employment and annually thereafter but fail to complete any other type of examination to assure that the employee does not have a communicable disease that would endanger patients.

S0845 **KAR 28-34-61a(d) Physical Environment. Fire and disaster drills. (2) Develop a written plan for addressing the safety of patients, staff, and visitors during disasters. Periodic drills shall be held and a record of each drill shall be kept on file.**

Most facilities have a written fire and disaster plan but fail to provide drills to assure that all staff are knowledgeable concerning their responsibility during a fire or disaster.

Q0020 **CFR 416.45(a) Membership and Clinical Privileges. Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges in accordance with recommendations from the medical staff.**

Facilities fail to assure that medical staff are credentialed and that privileges have been granted by the medical staff and governing body. The facilities fail to assure that all medical staff have a current license to practice, a current DEA certification and current malpractice insurance.

Q0034 **CFR 416.49 Laboratory and Radiologic Services. If the ASCS does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory. The ASCS must have procedures for obtaining radiologic services from Medicare approved facilities, to meet the need of the patients.**

Facilities fail to have documented procedures for obtaining laboratory and radiologic services when they are not available at their facility.