



➤ **Example for :**

**Negligence**

1. Lack of proper care
2. Basis on malpractice
3. Reasonable care based on a defined standard
4. Mal practice judged by peer review

**Professional liability**

1. Wrong diagnosis ---→ Improper TTT.
2. TTT out side field of competency (privellidge)
3. Abandonment
4. No informed consent
5. No investigation
6. No result of the test



## ➤ Organization wide early warning system:

- An organization wide system to **screen** all patients for real or **potential adverse incidents**, issues, and occurrences that might result in **increased risk to the organization** or corporation and/or less than optimal quality of care.

To identify as early as possible all:

1. Adverse Events
2. Potentially compensable event.



## Adverse Patient Occurrence (APO):

An **unexpected**, **untoward** event with **actual or potential negative impact** on the patient, or person.



## Potentially Compensable Event (PCE):

An **APO** that might **result in a lawsuit** or claim **based on the degree of actual or potential impact on the patient.**

- In most healthcare organizations, the **risk manager** has been given a **list of PCEs** that the facilities **insurance company** wants to be notified about if they should occur.
- The **insurance company** then **examines** the record and makes a **determination if the event truly is a potentially compensable event**. If it is, then the **medical record and any equipment involved in that event should be sequestered** to prevent any alteration to the original record.







## ➤ In case of claim:

- ❖ The **staff** should be aware that if an adverse event occurs and there is equipment involved, it **should be taken out of services and sent to the Risk manager's office**. This would include any equipment, medications, syringes and supplies in use at the time of the event. If this is not accomplished at the time of the event, it is **too late to sequester** these items. If later it is determined that the event was not a PCE, these items can be discarded as appropriate, or placed back into the inventory **for use**.
- ❖ The **Risk Manager** must sign legal papers indicating this when the records are sent to attorneys during a lawsuit. If the medical records are on paper, the record of the visit where the event occurred should be copied.

**The original** must be placed under lock and key, usually in the Risk Management office, and the copy is placed back in medical records in case the patient comes to the facility again for patient care services.





## ➤ In case of claim:

- If someone wants to add a late entry to the record, the individual should be escorted to a private room, and the escort should remain in the room after giving the individual the original record, an appropriate form to write on and a pen.
- The individual must date, time and sign the entry, as well as indicate that it is a late entry.
- The individual is not allowed to remove or cross out anything in the record
- If the medical records are electronic, the Information Management department should make the record read only once the patient is discharged following the event.
- If an individual wants to add a late entry, the Risk Manager should call the Information Management department to unlock the record and then to relock it after the entry is made.



## ➤ In case of claim:

Equipment sequester/Isolation

Medical record kept under locked and key in RM office

Copy place back to MRD

For late entry staff should be escorted in room & sign for late entry

Not allow to remove or cross out in Medical record

EMR will be in read only mode

## IHI Global Trigger Tool:

- ❑ Developed by **IHI** , uses **consistent retrospective random** review of patient records and a list of triggers to track three measures:

- ❖ **Adverse events per 1,000 patient days:**

**Total# adverse events/ Total Length Of Stay (LOS) for all records reviewed X 1,000**

- ❖ **Adverse events per 100 admissions:**

**Total# adverse events/ Total records reviewed X 100**

- ❖ **Percent of admissions with an adverse event:**

**Total# records with at least 1 event/ Total records reviewed X 100**







## Triggers

"clues" or "generic screens" to guide trained reviewers with clinical backgrounds (usually nurses) to review the information in the patient's record that may be confirmed by a physician as an adverse event

Examples: include any code or arrest, patient fall, transfer to higher level of care, change in surgical procedure, readmission within 30 days, and intensive care pneumonia onset.





## Harm

unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment, or hospitalization, or that results in death



### Harm CATEGORIES:

- Category E: **Temporary harm** to the patient and **required intervention**
- Category F: **Temporary harm** to the patient and **required initial/prolonged hospitalization**
- Category G: **Permanent patient harm**
- Category H: Intervention required **to sustain life**
- Category I: Patient **death**



## ➤ Organization wide early warning system:

### ➤ Generic screening:

Concurrently screen every patient hospitalization,  
ambulatory service or home care

An example of 100% review process

### ➤ Incidents reporting:

Notification of adverse patient  
occurrence & PCE

### ➤ Patient safety data screen:

NAHQ survey





## Risk Assessment:

- ❖ Risk analysis
- ❖ Risk Evaluation

## 2-Risk Analysis:

- ❖ Once potential **risks are identified**, they **must be analyzed** in order to determine **their significance**
- ❖ A **tool that is commonly utilized** when an adverse event **occurs** is a **Root Cause Analysis (RCA)**.
- ❖ If **potential** for risk is **identified**, then a Failure Mode Effectiveness Analysis **FMEA** should be **used to identify the risk and attempt to eliminate the risk before an adverse event occurs**.



### 3-Risk evaluation:

- Time of risk ranking
- Process of prioritize the potential risk

$$RPN=S * F$$

1. Who will score the risk?
2. How we will calculate it?

		Severity				
		Negligible	Minor	Moderate	Major	Catastrophic
Likelihood	Almost certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5

*The likelihood that the failure will occur.*

$$RPN = \underbrace{\text{Severity}}_{\text{How severe are the effects of the failure on the system.}} \times \underbrace{\text{Occurrence}}_{\text{The likelihood that the failure will occur.}} \times \underbrace{\text{Detection}}_{\text{The chance that the failure will be detected.}}$$

The RPN ranges from 1 (absolute best) to 1000 (absolute worst) as all 3 inputs are ranked on a scale 1 to 10.



## 4-Risk treat:

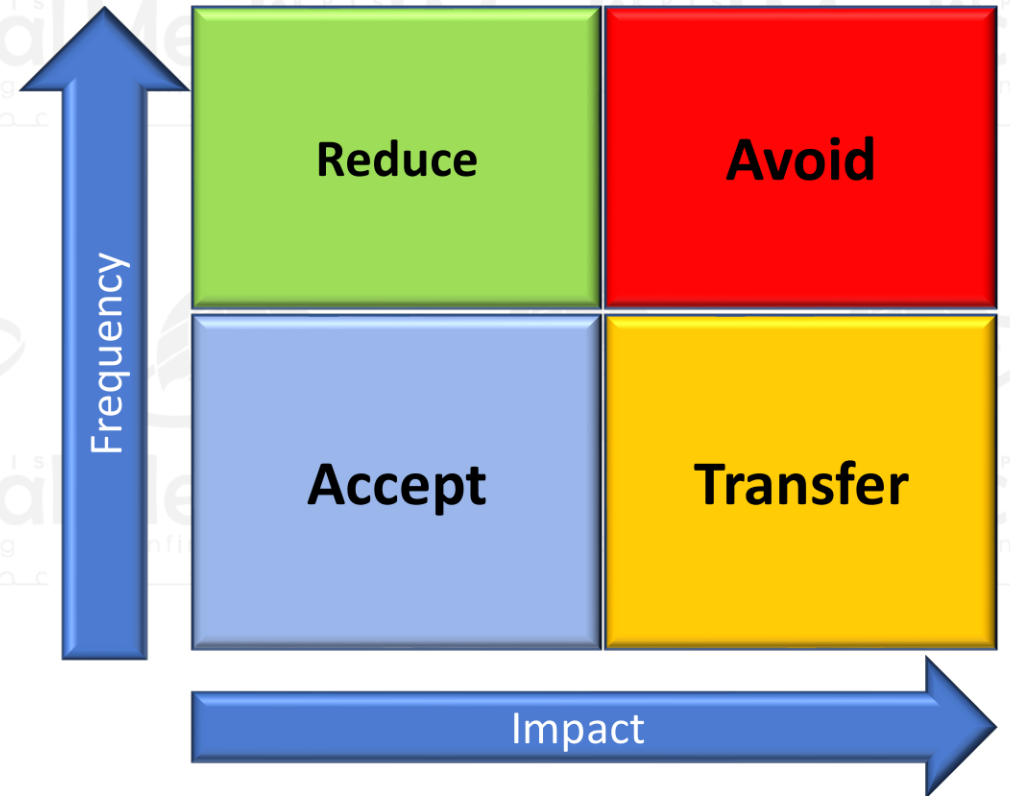
The process of selecting and implementing of measures to modify risk.

➤ There are four main risk management strategies, or risk treatment options:

1. Risk acceptance.
2. Risk transference.
3. Risk avoidance.
4. Risk reduction.

### 1. Risk acceptance:

*A risk is accepted with no action taken to mitigate it*





## 2. Risk transfer (shifting):

A risk is *transferred* via a contract to an external party who will assume the risk on an organisation's behalf.



## 3. Risk avoidance:

A risk is *eliminated* by not taking any action that would mean the risk could occur.



## 4. Risk reduction/prevention:

A risk becomes less severe through actions taken *to prevent or minimise its impact*.





## Risk monitoring:

The process of **tracking and evaluating** the level of residual risk •

- Simply after implementing our action plan (our treatment option) again we will assess the risk score expecting decreasing the score but if it is still high we will analyse the risk again and change our strategy or our action plan to manage it.
- Risk assessment reflects the power of the frontline understanding the processes in their unit will and how it affect on the organization and reflects also system thinking for the leader in the organization.

