Building a Solid Risk Management/Compliance Program

Definition of Risk

Risk is the effect (positive or negative) of an event or series of events.

Event: What Could Happen?
Probability: How Likely is it to Happen?

• Impact: How bad will it be if it happens?
• Mitigation: How can you reduce the Probability (and by how much)?
• Contingency: How can you reduce the Impact (and by how much)?
• Reduction = Mitigation X Contingency

Other Risk Management Considerations

Risk Management and Quality

- Quality Indicators
- Incident Reports
- Patient Grievance
- Adverse Events
- Patient Safety
Risk Management and Infection Control
- Active Surveillance
- Chain of Infection
- Hand Hygiene
- Infection Investigation

Risk Management and Infection Control
- Medical Intervention Factors
- Environmental Factors
- Occupational Exposure
- Visitors and Family Members

Other Risk Reduction Strategies
- Patient Satisfaction
- Trends
- Employee Injuries
- Medical record review
- Sexual misconduct
Risk Assessment

- Complete risk assessment of ASC annually
- Outbreak/Breach/Adverse Event

Factors in Risk Assessment

- Financial
- Clinical
- Operational
- External contracted services
- Internal Staff, Equipment

Sanitary Environment

- During tour of the surgical suites it was observed by surveyor and shown to Staff A (RN Nurse Manager) that the horizontal surfaces of both surgical suites had visible build up of dust in the operating rooms.
Findings include:

- Review of patient medical records revealed the Ambulatory Surgery Center’s patient chart is integrated into the Clinic record and not maintained as a separate entity. The Ambulatory Surgery Center medical record is part of the Clinic record and stored in the medical record department of the Clinic.

- Interview of Staff B (ASC Administrator) confirmed the Ambulatory Surgery Center medical record was not a unique patient record but integrated into the Clinic record. Staff B also confirmed that the Ambulatory Surgery Center does not have a separate storage area for the medical records of patients having procedures in the Ambulatory Surgery Center.

During tour of the facility’s medical office it was observed and shown to Staff B (Medical Director) that the medical records were unable to be locked and secured.

It was also observed and shown to Staff B that the facility lower level basement had all prior patient medical records from 2002 in open boxes and file cabinets that were unable to be locked and secured.

The facility failed to maintain a program to prevent and control infection and communicable diseases involving disinfecting of the YAG eye laser capsulotomy lens.
Administration of Medication

- The patient's record revealed a list of medications used for the procedure, however the record lacked documentation of a signed physician's order for the medications used.

Administration of Drugs

- At the physician's direction, the RN administered two medications through the patient's IV (Intravenous peripheral port), each from a separate syringe.
- Upon inspection of the syringes, the surveyor noted only the names of the medications on each syringe.

Safety

- The facility failed to ensure patient safety by investigating the cause of a fall for one of five sampled patients (Patient #1) and by instituting measures to prevent further falls for all surgical patients.
Safety

- Patient #1 fell from the operating table in the operating room while the patient was being transferred by staff to another operating table in order to complete the surgery.
- Review of the surgeon's notes on that date revealed the patient fell because the "lock gave way and the patient fell to the floor".

Sanitary Environment

- The top of the crash cart and shelf for the suction machine was observed dusty. The top of the suction canister and motor were also dusty.

References

- Association for Professionals in Infection Control and Epidemiology
- Florida Agency for Healthcare Administration
- Accreditation Association for Ambulatory Health Care, Inc.
- The Joint Commission