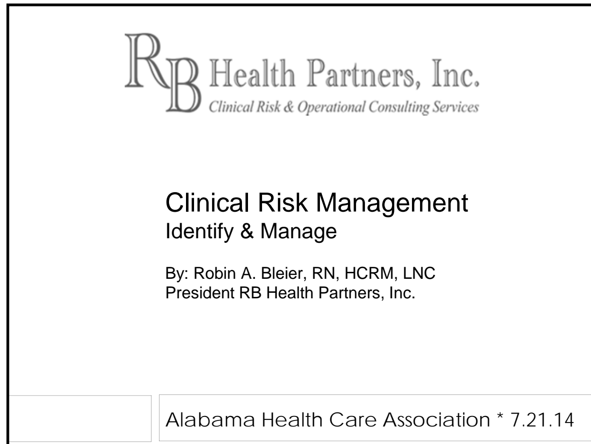

Program Purpose

The purpose of this program is to support participants to:

1. Identify Risk
2. Evaluate Rules & Regulations

Continued Purpose

3. Discuss resident Choice v. Safety
4. Take a systematic approach to management
5. Take a systematic approach to documentation

Objectives

Objectives

Upon completion of this program participants will be able to:

A. Describe the purpose of risk management.
B. Apply the purpose to the long term care environment.

Continued Objectives

C. Detail Federal reporting requirements.
D. Discuss F 441 requirements.
E. Define infection control management process.

Additional Objectives

F. Denote four high clinical risk care area's:
   i. Pain Management
   ii. Diabetic Management
   iii. Anticoagulant Management
   iv. Dialysis Management

Final Objectives

G. Review Rules & Regulations related to selected clinical risk area's in F.

Purpose of Risk Management

The purpose of risk management is to protect the organizations assets.

What are Assets?

Assets Are?

Assets include but are not limited to:

- Residents
- Staff
- Facility
- Reputation
- and and and

Risk Identification

Risk identification is a process where the facility is able to identify reasonable and foreseeable risk factors.

In clinical risk we ask 'is it under the facility control' and 'should the facility have anticipated the circumstance'?

Choice v. Safety

There is a balance that CMS encourages all of us to evaluate between the resident choice and the resident safety.

What examples can you think of?

Federal Abuse Prohibition Review

Interview/Review	Notes
Policies and Procedures Review	
☐ Obtain and review the facility's written policies to determine that they include the following key components: • Screening of potential new hires; • Training of employees (both new employees and ongoing training for all employees); • Prevention policies and procedures; • Identification of possible incidents or allegations which need investigation; • Investigation of incidents and allegations; • Protection of residents during investigations; and • Reporting of incidents, investigations, and facility response to the results of their investigations. ☐ Evaluate how each component of the policies and procedures is operationalized. If the answers to the following questions are not obvious from the policies, interview the individual responsible for coordinating the policies and procedures. If this person is interviewed, ask how do they: • Monitor staff providing and/or supervising the delivery of resident care and services to ensure that care/service is provided as needed to make certain that neglect of care does not occur. • Determine which injuries of unknown origin should be investigated as alleged occurrences of abuse. • Ensure that residents, families, and staff feel free to communicate concerns without fear of reprisal.	

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Federal Abuse Prohibition Review

Interview/Review	Notes
Facility Handling of Alleged Violations	
☐ Review written evidence of the facility's handling of a minimum of three alleged violations (if any exist) since the previous standard survey or the previous time this review was done by the State. Include all residents who triggered the Abuse Care Area in the review of the facility's handling of alleged violations. (If less than three (3) residents triggered and the facility has additional allegation, select additional residents to fulfill the minimum of three residents.) ☐ Determine whether the facility implemented adequate procedures for: • Reporting: – Reports any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. – Ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). – Ensures that results of all investigations are reported to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident. • Investigating: has evidence that all alleged violations are thoroughly investigated. • Protection of the resident during the investigation: prevent further potential abuse while an investigation is in progress, and; • Provision of corrective action: takes appropriate corrective action for verified violations. ☐ Determine whether the facility re-evaluated and revised applicable procedures as necessary.	

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Federal Abuse Prohibition Review

- Resident/Family Interviews
  - Interview several residents and families regarding their awareness of to whom and how to report.
- Direct Care Staff Interviews
  - Interview 5 direct care staff, representing all three shifts, including activity staff and nursing assistants.
- Front Line Supervisors
  - Interview 3 front line supervisors
- Pre-screening of new employees
  - Obtain a list of all employees hired within the previous four months and select five employees.
  - Ask to see written evidence that the facility conducted pre-screening of the employees

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Federal Abuse Prohibition Review

- Determination of compliance:
  - Did the facility meet the requirements for;
    - Employment of individuals
    - Reporting, and
    - Investigating
  - Did the facility develop and implement policies and procedures in the areas of screening, training, prevention, identification, investigation, protection and reporting?

Risk Management Processes

- Root Cause Analysis
- Investigation
- Implementation and Monitoring of Performance Improvement Strategies

What is RCA?

Root cause analysis (RCA) is a method of **problem solving** that tries to identify the **root causes** of faults or problems. A root cause is a cause that once removed from the problem fault sequence, prevents the final undesirable event from recurring. A causal factor is a factor that affects an event's outcome, but is not a root cause. Though removing a causal factor can benefit an outcome, it does not prevent its recurrence for certain.

More on RCA

RCA practice solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. Focusing correction on root causes has the goal of preventing problem recurrence. RCFA (Root Cause Failure Analysis) recognizes that complete prevention of recurrence by one corrective action is not always possible.

RCA Processes

Root cause analysis is not a single, sharply defined methodology; there are many different tools, processes, and philosophies for performing RCA. However, several very-broadly defined approaches or "schools" can be identified by their basic approach or field of origin: safety-based, production-based, process-based, failure-based, and systems-based.

RCA Aim

The primary aim of root cause analysis is to identify the factors that resulted in the nature, the magnitude, the location, and the timing of the harmful outcomes (consequences) of one or more past events in order to identify what behaviors, actions, inactions, or conditions need to be changed to prevent recurrence of similar harmful outcomes and to identify the lessons to be learned to promote the achievement of better consequences. ("Success" is defined as the near-certain prevention of recurrence.)

RCA is Systematic

To be effective, root cause analysis must be performed systematically, usually as part of an investigation, with conclusions and root causes that are identified backed up by documented evidence.

~A team effort is beneficial~

RCA Considerations

There may be more than one root cause for an event or a problem, the difficult part is demonstrating the persistence and sustaining the effort required to determine them.

The purpose of identifying all solutions to a problem is to prevent recurrence at lowest cost in the simplest way. If there are alternatives that are equally effective, then the simplest or lowest cost approach is preferred.

More on Considerations

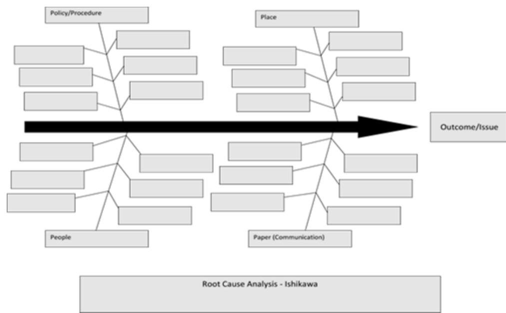
Root causes identified depend on the way in which the problem or event is defined. Effective problem statements and event descriptions (as failures, for example) are helpful, or even required.

To be effective, the analysis should establish a **sequence of events** or **timeline** to understand the relationships between contributory (causal) factors, root cause(s) and the defined problem or event to prevent in the future.

Considerations at a Glance

- Define the problem or describe the event factually.
- "Why" means "What were the factors that directly resulted.
- Identify harmful factors as possible "RCs."
- Identify corrective action(s) to prevent…
- Implement the recommended RC corrections.
- Gather data and classifying it along a timeline of events.
- Classify causes into factors that relate.
- If multiple root causes, reveal those clearly for later optimum selection.
- Identify solutions that to prevent recurrence.
- Identify other methods for problem solving and avoidance.

Root Cause Analysis - Ishikawa



What are the 4 P's

The 4 P's include:

1. Policy and Procedure
2. Place
3. People
4. Paper (communication)

What are the 5 W's

Understanding the 5 W's:

- who,
  - what,
    - where,
      - when, and
        - why (or why not)

Severity Levels

Level 4: Immediate Jeopardy to Resident Health or Safety

Level 3: Actual Harm that is not Immediate Jeopardy

Level 2: No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy

Level 1: No Actual Harm with Potential for Minimal Harm.

RB Health Partners, Inc.
Clinical Risk & Operational Consulting Services
Summary

THANK YOU
RB Health Partners, Inc.
Clinical Risk & Operational Consulting Services
CLINICAL RISK MANAGEMENT
We thank you for your time today.
To learn more about this or to discuss services please contact Robin A. Bleier at robin@rbhealthpartners.com or visit our web at www.rbhealthpartners.com