SUBJECT: RISK MANAGEMENT PROGRAM

EFFECTIVE DATE: 08/02/2021

I. PURPOSE:

Risk management is defined as the identification, analysis, and evaluation of health and safety risks and the selection of the most advantageous method(s) of correcting identifiable risks as a way to protect patients and staff from foreseeable harm, promote the quality of healthcare, and promote a safe environment.

The purpose of the health services Risk Management Program is to identify and correct patterns of management and/or healthcare practices that could lead to adverse outcomes. The Risk Management Program seeks to protect the human and financial assets of the Department and ensure the continuous improvement of inmate health and safety by identifying healthcare risk factors and by reducing errors.

NOTE: All health services staff members are part of the Office of Health Services Risk Management Program, except that the Reception and Medical Center Hospital (RMCH) is licensed pursuant to Chapter 395, Florida Statutes, and therefore has a separate Quality and Risk Management Programs. Refer to RMCH's *Patient Safety Plan*, *Quality Management Plan*, and *Risk Management Plan*.

These standards and responsibilities apply to both Department staff and Comprehensive Health Care Contractor (CHCC) staff.

A. OBJECTIVES:

1. Reduce the probability of adverse incidents that may result in injury to inmates in the medical or mental health units and inmates on Self-Harm Observations Status (SHOS) in designated Observation Cells.

2. Identify adverse or suspected adverse incidents and events and correct any underlying contributing factors.

3. Promote early analysis and evaluation of health and safety risks.

4. Review data accumulated from occurrence reports and other sources to identify trends and conditions and plan appropriate preventative measures.

5. Implement planned preventative measures to reduce the probability of future adverse incidents.

B. DEFINITIONS:

1. **Central Office Risk Manager**- the central office employee designated by the Health Services Director to direct the planning and implementation of the Risk Management Program.

2. **Comprehensive Health Care Contractor (CHCC)-** staff contracted by the Department to provide medical, dental, and mental health services at designated institutions within a particular region. Contractor is responsible for coordinating the Risk Management Program at designated institutions. The CHCC shall utilize staff that is comparable to Department staff for the management of the Risk Management Program.

3. **Regional Risk Manager**- the regional health services employee or CHCC staff who has been designated to coordinate the Risk Management Program within a specific region.

4. **Institutional Risk Manager**- the institutional health services employee or CHCC staff who has been designated to coordinate the Risk Management Program within a specific institution.

II. OCCURRENCE REPORTING:

The purpose of an occurrence reporting system is to identify health and safety risks within the health services unit(s) and minimize errors by documenting adverse inmate occurrences. Its effectiveness depends on all members of the healthcare team taking an active role to ensure the reporting of clinically-related adverse inmate occurrences.

A. Occurrence: Is an event that results or may result in injuries to an inmate while under the care or control of health services personnel. The following events or occurrences, the level of intervention, and inmate/patient outcome must be reported using "*Occurrence Report*," DC4-690A and initiated as soon after the occurrence as possible:

1. Falls, with or without injury, which require healthcare personnel intervention;

2. Medication administration errors with or without injury;

3. Certain events associated with high risk for the inmate such as the use of chemical or physical restraints for mental health reasons;

4. Self-injury requiring placement on SHOS;

5. Incidents which require transportation to an outside facility or emergency room as a direct result of the provision of healthcare provided by the Department; and

6. Blood-borne pathogen exposure.

B. Level of care Intervention: all occurrences require a level of intervention and are recorded on the "*Occurrence Report*," DC4-690A and "*Clinical Risk Management Occurrence Trending Report for Inmates under the Direct Supervision of Institutional Health Services*," DC4-690B. The levels are identified as follows:

1. Level 1: Nursing Assessment
2. Level 2: Nursing Treatment
3. Level 3: Medical Clinician Assessment and/or Treatment
4. Level 4: Outside Provider/Emergency Transport/Emergency Consult

NOTE: All suicide attempts require, at a minimum, notification of a medical clinician (Level 3). All other occurrences will require a nursing assessment (Level 1), as a minimum level of intervention. Only the highest level of care is checked on the reports.

C. Sentinel Event: Is an unexpected occurrence involving death or serious physical injury that is associated with the healthcare provided by the Department to an inmate or which occurs while an inmate is receiving medical, mental, or dental care, or while an inmate is housed in the medical or mental health unit. These events or occurrences shall be immediately reported to regional and central office risk managers by telephone and email. A notification list with contact information shall be posted in the infirmary control station.

A system of review will be established for any suspected reportable or non-reportable sentinel event. The system will include a review of the event and completion of Section II and III of DC4-690A, *Occurrence Report,* within 15 days of its occurrence. These sections focus on the process and system failures that may have contributed to the sentinel event.

1. Reportable Sentinel Events include:

(a) Suicide or homicide that occurs while an inmate is in the medical unit receiving medical, mental, or dental care, or while an inmate is housed in the medical or mental health unit, or while an inmate is on SHOS in a designated Observation Cell;

(b) Death of an inmate involving any type of restraints (including chemical restraints) on a medical or mental health unit;

(c) Surgery or invasive procedure on the wrong body part of inmate while in the medical unit;

(d) Any death, paralysis, coma, or other major loss of function associated with a medication error, or other healthcare provided; or,

(e) Unanticipated occurrence involving an inmate under medical supervision that results in death or serious physical injury.

2. Non-Reportable Sentinel Events - The following events are considered **non-reportable** sentinel events:

(a) Any event not related to the provision of inmate medical, mental, or dental care;

(b) Medication errors that **do not** result in death or major loss of function;

(c) Non-invasive procedure resulting in temporary loss of function;

(d) Suicides or self-injuries that occur **other** than in the medical or mental health unit or designated Observation Cell (general population);

(e) A death that is attributed to the natural course of an inmate's illness or underlying condition that has been under treatment.

3. Focus Review- Is a sentinel event that warrants a deeper investigation into systems analysis and/or professional performance evaluation/review by an external panel.

(a) The institution's Clinical Risk Manager will complete the "occurrence review" section V. of the "*Occurrence Report*," DC4-690A within 15 calendar days of the occurrence. Copy of the completed document will be sent to the Regional Medical Director (RMD) and Central Office Risk Manager.

(b) The Regional Medical Director (RMD) will review the occurrence report findings and recommendations to determine if review by an external panel is warranted. If death occurred, the RMD may delay determination until at the time of the mortality review unless obvious system failures or professional performance issues are identified. If warranted, the RMD will notify the Chief Clinical Advisor or designee.

(c) If RMD determines that an external evaluation/review is unwarranted a brief synopsis of her/his review of the occurrence report will be documented and maintained as part of the Clinical Risk Managers files; if death occurred, it will be documented and maintained as part of the Mortality Review. A copy of report will be sent to the Chief Clinical Advisor or designee.

(d) The external panel (FDC/CHCC staff outside of reporting institution) will be chosen by the RMD and will consist of a minimum of two appropriate healthcare peers to perform a systems analysis and/or professional performance evaluation.

(e) The external panel will complete evaluation/review within 15 working days of notification and provide findings to the RMD.

(f) The RMD will provide the external panel's findings and recommendations to the Chief Clinical Advisor or designee and Central Office Risk Manager.

(g) Outcome decision: collaboration between the RMD, Chief Clinical Advisor and appropriate discipline directors will determine the finals actions.

D. Occurrence Review – provides a review of the event/occurrence to help identify risk points and potential contributions to the event; and to determine potential improvements in processes or systems that would tend to decrease the probability of such events in the future. The occurrence review is completed on section V. of the "*Occurrence Report*," DC4-690A within 15 calendar days of the occurrence by the Clinical Risk Manager.

III. RESPONSIBILITIES:

A. Office of Health Services: The Office of Health Services is responsible for the administration of the Risk Management Program, to include:

1. Establishing the activities related to the program through:

(a) Development of strategies to ensure a successful program.

(b) Evaluation and improvement of the quality of healthcare processes and outcomes.

2. Ensuring corrective action is addressed for all findings reported in the risk management occurrence reports.

3. Acting as a resource for all risk management related issues.

4. Maintaining records of the risk management activities including, but not limited to various reports from regional office staff and other correspondence.

C. Regional Risk Manager: The designated regional health services employee or staff will:

1. Ensure a risk management program exists in each institution within their region.

2. Act as the liaison between central office and the institutions on risk management issues.

3. Compile data received from each institution onto to the DC4-690B, "*Clinical Risk Management Occurrence Trending Report for Inmates under the Direct Supervision of the Institutional Health Services",* and identify trending issues through analytical review.

4. Ensure corrective action is addressed for occurrence findings and trending issues.

5. Evaluate occurrence reports, trending reports, training/in-service provided, and system changes to improve the quality of healthcare process and outcomes.

6. Submit compiled data, findings, and corrective actions on trending issues to central office risk manager.

7. Ensure sentinel event occurrence reports are submitted to the central office risk manager within 20 days of occurrence.

D. Institutional Risk Manager: The designated institutional health services employee or staff will:

1. Coordinate the risk management program at the institution through:

(a) Trend analysis of occurrence reports.

(b) Ensuring a corrective action plan is implemented and completed.

(c) Maintaining records of risk management activities including, but not limited to occurrence reports, trending reports, and training/in-service provided, and system changes to improve the quality of healthcare processes and outcomes.

(d) Submit a copy of each occurrence report within ten (10) business days to the regional risk manager which includes an incomplete report of sentinel event.

(e) Ensure review of a sentinel event and completion of DC4-690A within 30 days of its occurrence, and submit to the regional risk manager upon completion.

2. Participate in the monthly Institutional Quality Management (QM) Committee meetings required by HSB 15.09.01 and provide reports to their regional risk managers.

IV. RISK MANAGEMENT PROGRAM GUIDELINES:

A. An event or incident which results in an actual injury to the inmate, while under the care or supervision of health services staff, must be reported on "*Occurrence Report*," DC4-690A.

B. The individual who discovers the incident or event and/or has the best knowledge of the incident is responsible for initiating the DC4-690A.

C. The report must be initiated as soon after the occurrence as possible and shall be forwarded with all supporting documents to the institutional risk manager within seventy-two (72) hours of occurrence.

D. The DC4-690A is a confidential document that shall not be copied or placed in the medical record. The report shall contain only the facts surrounding the incident. It should not include conclusions, subjective information, or finger pointing.

E. The medical record shall contain an entry that only documents the facts surrounding the occurrence. Critical comments or statements which place blame on specific individuals or groups shall not be included. No reference shall be made that an occurrence report was completed.

F. The institutional risk manager is responsible for ensuring completeness of the report and shall forward it to all appropriate persons for necessary action. The reports shall be completed with all necessary documentation within ten (10) days after occurrence of the event. If reporting a sentinel event, all required sections shall be completed within 15 days of its occurrence.

G. The *Occurrence Report* (DC4-690A) shall be retained by the institutional risk manager and provided as stipulated in section III. C. 7 or made available upon request to the central office risk manager or CHCC Risk Management Program manager/director.

H. The institutional risk manager shall perform a trend analysis using data collected from the *Occurrence Report* (DC4-690A). "*Occurrence Trending Report*," DC4-690B, shall be completed on a monthly basis utilizing the collected data. Trend analysis summarizing any trends or patterns that have been identified, any concerns, any opportunities for improvement and any other relevant information should be documented on page two of same report without inmate identifiers.

I. A copy of DC4-690B shall be forwarded to the regional risk manager or Risk Management Program director no later than the fifth (5th) working day of the following month.

J. The institutional risk manager shall present identified risk issues to the Institutional QM Committee.

K. The Institutional QM Committee shall discuss possible corrective actions, make recommendations when necessary, and ensure follow-up. The committee shall also develop a plan to identify risk and minimize error.

L. Any discussion of the DC4-690B by the Institutional QM Committee shall be included in the minutes.

M. The Regional Risk Manager or CHCC Risk Management Program director will receive the monthly institutional risk management trend reports **as well as a copy of each completed *Occurrence Report*** (DC4-690A) and look for trends or patterns that may be indicated in a specific institution, region or statewide.

N. The Regional Risk Manager or Risk Management Program director shall provide a quarterly report on the 20th of the first month following the quarter to the central office risk manager for review. The Central Office Risk

Manager will present this information to the Office of Health Services Quality Management team and follow-up when necessary.

O. Each director responsible for a comprehensive medical program shall participate in the quality management meeting held by Office of Health Services Quality Management Program at least every 2nd and 4th calendar quarter unless otherwise directed by the Department. The information presented shall include graphs showing collected data trends, recommendations for improvements, and implementations of corrective action plans and follow-up when necessary for all institutions under their control. Any trending identified as an issue from another contractor providing services must be documented objectively, clearly and concisely with a possible resolution if appropriate.

V. CONFIDENTIALITY:

A. Occurrence reports are considered quality management documents and as such are protected by Section 945.6032, Florida Statutes, and Section 766.101, Florida Statutes. They are also confidential and exempt from the provisions of Section 119.07(1), Florida Statutes, and Section 24(a) of Art. I of the State Constitution. Any proceedings of a QM committee are exempt from the provisions of Section 286.011, Florida Statutes, and Section 24(b) Art. I of the State Constitution. Refer to Procedure 401.006, *Confidentiality of Health Services Medical Committees Information.*

B. Although considered confidential, these reports may become discoverable during subsequent litigation and therefore should be accurate, objective, complete and factual. Critical comments or statements which place blame on specific individuals or groups shall not be included.

VI. AUTHORITY AND RESPONSIBILITY:

Refer to HSB 15.09.01, *Quality Management Program*, for further descriptions of positions/offices and their specific areas of responsibility.

VII. RELEVANT DC FORMS AND ATTACHMENTS:

DC4-690A *Occurrence Report*
DC4-690B *Clinical Risk Management Occurrence Trending Report for Inmates under the Direct Supervision of the Institutional Health Services*

Health Services Director

Date

This Health Services Bulletin Supersedes: Clinical Risk Management Manual dated 1993
TI 15.09.08 dated 12/29/95
HSB dated 9/28/10, 10/17/11, 01/09/14, 2/5/15, 2/14/17, 11/3/17, 10/19/18,
AND 10/15/2019