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Lesson: Risk Management Overview

Introduction

Lesson Objectives

Would you know what to do if a customer (Patient, resident or client) had an event which caused harm or had the potential to cause harm?

After you complete this lesson, you should be able to:
• Recognize the role of Risk Management
• Recognize and categorize reportable events
• Identify the team member’s responsibilities and actions if an event occurs

Goals of Risk Management

The goals of the Risk Management Program are to:
• Improve customer safety: patients, team members, visitors and physicians
• Prevent or minimize the risk of events
• Protect the resources of BayCare Health System

The best way to promote safety and minimize risk is through the Risk Management process.

The steps in the Risk Management process are:
• Identify
• Investigate
• Analyze
• Evaluate

This process results in the redesign and improvement of BayCare processes and identifies educational opportunities for the quality and safety of our customers.

Reportable Events

What is an Event?

An event is any unusual occurrence inconsistent with routine care, which causes harm, or has the potential to cause harm, to our customers or property. These events should be reported using the event reporting system.

Categories of reportable events are:
• Adverse drug reaction
• Blood Product
• Equipment/Device/Catheter
• Fall
• Healthcare IT
• IV/Vascular Access Device
• Lab/Specimen
• Maternal/Childbirth
• Medication/Fluid
• Provision of Care (Miscellaneous)
• Safety/Security
• Skin/Tissue
• Surgery/Procedure

Note: Non-hospital programs and services may require additional events to be reported. Contact your manager for details.

Steps to Respond to an Event

When an event occurs, the team member who discovers the situation should identify and address the immediate needs of the patient, visitor or team member first.

After the needs of the patient, visitor or team member have been met, the following reporting steps need to be completed.

• If the event involves a patient, the team member may complete an Event Report
• If the event involves a visitor, the team member should contact Security
• If the event involves a team member, the team member who is involved in the event should contact Employee Health

Serious Events and Sentinel Events

What are Serious Events and Sentinel Events?

Serious events* are any events, as defined by state law, over which health care personnel could exercise control and which are associated in whole or part with medical intervention, rather than the condition for which such intervention occurred.

Sentinel events** are any unexpected occurrence involving death or serious physical or psychological injury, not related to the natural course of the patient’s illness or underlying condition, as identified by The Joint Commission (even if the outcome was not death or major permanent loss of function).

The events are classified as serious or sentinel because they signal the need for immediate investigation and response.

Serious and/or sentinel events may require reporting responsibilities to external regulatory agencies.

* Serious events as defined by the Florida statute

** Sentinel events as defined by The Joint Commission
Examples of Serious Events

The following are examples of serious events (as defined by the Florida statute):

• Death
• Brain or spinal damage
• Permanent disfigurement
• Fracture or dislocation of bones or joints
• Resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility
• Condition requiring specialized medical intervention, to which the patient has not given his or her informed consent
• Condition requiring the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient’s condition prior to the incident

Examples of Sentinel Events

The following are examples of sentinel events (as defined by The Joint Commission):

• Unexpected incident/event resulting in unanticipated death or major permanent loss of function
• Suicide of patient in setting where the patient is housed around-the-clock, including suicides within 72 hours of discharge from such a setting
• Unanticipated death of a full term infant
• Abduction of any patient/infant receiving medical care in the facility
• Infant discharged home to wrong family
• Rape of patient
• Hemolytic transfusion reaction with major blood group incompatibilities
• Surgery/procedure on wrong patient, wrong side of body or wrong body part
• Any patient death, paralysis, coma or other major permanent loss of function associated with a medical error
• Any elopement or unauthorized departure of a patient from an around-the-clock care setting, resulting in a temporally related death (suicide or homicide) or major permanent loss of function
• Any intrapartum (related to the birth process) maternal death
• Any perinatal death, unrelated to a congenital condition, in infant with birth weight greater than 2500 grams
• Assault, homicide, or other crime resulting in patient death or major permanent loss of function
• Patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in fall
• Removal of unintended retained foreign body
• Severe neonatal hyperbilirubinemia (bilirubin more than 30 milligrams/deciliter)
• Radiation overdose involving prolonged fluoroscopy with cumulative dose more than 1500 rads to a single field, or any delivery of radiotherapy to wrong body region or more than 25 percent above planned radiotherapy dose
**Steps to Respond to Serious or Sentinel Events Involving Patients**

When a serious or sentinel event occurs, the team member who discovers the situation should:

- Identify and address immediate patient needs
- Notify the physician
- Notify Risk Management, the manager/supervisor or administrator on duty (AOD) or administrator on call (AOC) in accordance with hospital or facility specific policy
- Document only the facts of the event on the Event Report
- Document event, care provided and personnel notified in the patient medical record

**Risk Management’s Role after a Serious or Sentinel Event**

With any serious or sentinel event, Risk Management will respond and conduct interviews and debriefings.

After investigation and completion of the review process, Risk Management will fulfill any external regulatory reporting requirements.

**Process for Reporting Events**

**Event Report: Online**

All team members have a legal duty to report and document all witnessed or unwitnessed events and near misses involving patients and visitors.

After addressing the immediate needs of the patient or visitor, complete an Event Report.

The Event Report provides information used for process improvement.

The Event Report System can be found on the BayCare Intranet. Team members sign on using their user ID and password to enter an Event Report.

**Event Reporting: Paper Version**

When there is no intranet access, use the paper version of the Event Report.

Complete and submit the report to your manager or supervisor.

**Timeframe for Reporting Events**

Complete the online Event Report by the end of your shift. The system will automatically forward the report to Risk Management.

If you use the paper version of the Event Report, complete and submit it to your manager or supervisor by the end of your shift. Risk Management should receive this Event Report within 24 hours of the event.
Guidelines for Event Reporting: DO’s

When reporting an event:
• Complete all mandatory sections of the Event Report, indicated by a green asterisks (*)
• Document only the facts
• Complete the event report by the end of your shift

Note: Remember to document the event, patient assessment, physician notification, follow-up care and outcome factually in the medical record.

Guidelines for Event Reporting: DON'TS

When reporting an event:
• Do NOT make copies of the Event Report
• Do NOT give a copy to, or discuss, the Event Report with the patient, family, visitors or physicians
• Do NOT document in the medical record that the Event Report was completed
• Do NOT place the Event Report in the medical record
• Do NOT document assumptions, opinions or assign blame
Lesson: Preservation Notice

Introduction

Lesson Objectives

If you received a preservation notice, would you know how to respond?

After you complete this lesson, you should be able to:
• Identify your role should you receive a preservation notice

Preservation Notice

What is a preservation notice?
BayCare has implemented a new process in the organization to notify team members who may have information that is important to a lawsuit. This notification is called a Preservation Notice. A preservation notice is a communication regarding litigation in one of our organizations. The notice requests you, the recipient, take specific steps to help protect information that might be important in defending a lawsuit.

Preserve Information?
When our organization is in litigation, we have to make sure we do not destroy documents and records that may contain information important to the lawsuit. This process is called preserving information or evidence. The preservation notice will give clear instructions about the type of information you need to maintain. Emails, staffing logs, spreadsheets and other electronic and paper documents can be very important in helping us to defend a lawsuit or federal inquiry. Destroying documents after we become aware that we may receive a lawsuit can have serious consequences to our organization. The preservation notice request will stop our organization’s document retention policy regarding any information that may be important to the lawsuit.

Frequently Asked Questions

How will I receive a preservation notice?
• You will receive an email from PreservationNotice@BayCare.org

Why would I receive a preservation notice?
• You would receive a preservation notice if you have been identified as a team member who may have some knowledge about activities that led up to the lawsuit being filed

What should I do if I receive an email?
• Read it carefully and call the contact given in the notice if you have any questions
• Identify any paper or electronic documents that you may have in your possession (department files, Outlook folders, department share drives) which may be important to the lawsuit as explained in the preservation notice
• Do NOT delete or destroy any of the identified items until you have received notice from PreservationNotice@BayCare.org that the lawsuit has ended
Lesson: Sexual Misconduct

Introduction

Lesson Objectives

BayCare is committed to creating and maintaining a safe environment free from conduct or communications considered to be sexual misconduct.

After you complete this lesson, you should be able to:
• Identify what constitutes a Sexual Misconduct
• Identify whom to inform in the event of an act of Sexual Misconduct

Constitutes: To amount to; equal

Sexual Misconduct

Definition of Sexual Misconduct

Sexual misconduct includes any acts of a sexual nature performed on patients by a team member or a member of the medical staff. These acts include but are not limited to:
• Fondling
• Exposure of sexual organs and/or
• Solicitation for prostitution or sexual performance

Sexual misconduct does not include any act intended for a valid medical purpose or any act which may be reasonably seen as a normal care giving action.

Reporting Allegations of Sexual Misconduct

All team members must immediately report any allegations of sexual misconduct to Risk Management.

Anyone who witnesses or possesses actual knowledge of the misconduct that is the basis of the allegation should immediately notify local law enforcement in conjunction with Risk Management.

Risk Management will treat all complaints of sexual misconduct with extreme sensitivity and confidentiality.

Risk Management will begin an investigation with the appropriate parties immediately and expects team members to offer full cooperation concerning the investigation.
Lesson: Reporting Events Involving Medical Devices and Equipment

Introduction

Lesson Objectives
Would you know what to do if a patient sustained an injury from a medical device?
After you complete this lesson, you should be able to:

• Identify steps to take if a patient sustains an injury from a medical device

Events Involving Medical Devices and Equipment

Safe Medical Device Act (SMDA)
The Safe Medical Device Act (SMDA) requires you to report any event in which you suspect a medical device caused or could have caused a death, serious illness, or injury to a patient.

A medical device is any equipment used in monitoring, diagnosing or treating a patient. Examples of medical devices include, but are not limited to:

• Infusion pumps
• Catheters
• Patient protective devices (restraints)
• Artificial implants

Medical Equipment Reporting
If a patient is injured or could have been injured by a medical device or piece of equipment, follow these steps:

1. Care for the patient's immediate needs first
2. Notify the patient's physician and your manager/supervisor
3. Take the involved device/equipment out of service and attach any device/equipment instructions to the involved device/equipment
4. Secure or lock up the device/equipment. Do not allow anyone to change the settings or clean the device/equipment
5. Do not throw away any packaging material
6. Complete the Event Report