CENTRAL STATE HOSPITAL
PLAN

SUBJECT: **RISK MANAGEMENT PLAN**

ANNUAL REVIEW MONTH: March

RESPONSIBLE FOR REVIEW: Risk Management Director

LAST REVISION DATE: February 2008

I. GENERAL

The purpose of the Risk Management Plan (RMP) is to provide guidelines and methods to assure that the broad range of both administrative and clinical activities at the hospital are monitored and coordinated in order to reduce losses associated with client, employee, or visitor injuries, property loss or damage and other sources of potential hospital liability.

The CSH Leadership Team oversees all continuous performance improvement and risk management/root cause analysis process activities of the hospital. This committee assures that performance improvement (PI) and risk management (RM) monitoring and evaluation are conducted, as well as corrective actions taken as appropriate.

The CSH Leadership Team is composed of the Chief Executive Officer, Chief Medical Officer, Support Services Director, Service Chiefs, Chief Nurse Executive, Director of Human Resources Division, Risk Management Director, Information Services and Performance Evaluation (ISPE) Director, Director of Engineering, Director of HIMD, Director of Pharmaceutical Services, Director of Staff Development and Training, Director of Financial Services, and Chief Executive Officer's Executive Assistant.

II RISK MANAGEMENT

The Risk Management Director provides legal advice and counsel to the hospital administration and clinical staff in an attempt to minimize risk and loss and assure that the hospital and its policies, procedures and practices remain in compliance with all applicable state and federal laws, rules and regulations, and policies and procedures. The Risk Management Director is responsible for ensuring all DHR Rules

and Regulations and CSH policies and procedures are enforced.

The Risk Management Office shall be involved in the identification, reporting, analysis and prevention of sentinel events and other serious incidents. (See Division of MHDDAD Policy #2.101.) The Risk Management Office shall be the focal point for reporting (or any related information of any potential sentinel event, or if necessary, provide information which may provide clarity of an event). The Risk Management Office shall initiate any root cause analysis or system review by facilitating the Incident Analysis Team (IAT).

The Facility Risk Manager provides analysis of frequencies, causes, general categories and types of incidents causing injury to clients. The Facility Risk Manager provides specific data to the Risk Management Director in relation to Risk Management activity. The Facility Risk Manager also provides analytical risk management reports to share with the hospital's Leadership Team.

The Risk Management Office will work closely with the CSH Compliance Office to ensure all allegations of client abuse are reviewed and investigated. The Risk Manager is responsible for ensuring these events are reported to the Division's Office of Investigative Services.

Risk Management is the responsibility of every employee at the hospital. Due to the size and complexity of the hospital and its programs, many eyes and ears are necessary for the monitoring of effective management risk. The Risk Manager serves as the focal point of coordination of activities concerning risk management, depending upon the input from each of the areas outlined in this plan. In turn, in association with the Information Services and Performance Evaluation Department, information concerning potential and/or real areas of risk are made available to the Chief Executive Officer, Chief Medical Officer, Chiefs and Clinical Directors as well as other pertinent staff members, through the mechanisms of performance improvement and Administrative Quarterly Reviews.

III. **CLIENT CARE COMMITTEES**

The hospital is a provider of a range of services: acute, intermediate and long term psychiatric care, habilitation, forensic psychiatric services, and skilled nursing care. Because of this spectrum across multiple providers and staff, the hospital has devised means of assuring continuity to inter-connect all clinical areas. It is critical for each discipline to have both the means for communicating with its

peers and for overseeing hospital committees to insure consistency and continuity. Overlapping as well as overseeing these specific disciplines are the Medical Executive Committee and the CSH Leadership Team.

Each Professional Service is responsible for required credentialing and privileging of its members, when appropriate, to insure appropriate licenses and competencies for the protection of the clients of the hospital. Documentation of these credentialing and privileging activities shall be found in the files of the relevant Client Care Discipline Chairperson.

Each client care discipline is responsible for identifying opportunities for improvement as well as resolving problems as a part of the Performance Improvement and Evaluation Process. Monthly reviews are conducted by the Medical Staff and quarterly reviews are conducted for the other Professional Services. All trends or deficiencies which may result in potential loss are reported to the Medical Executive Committee for risk assessment and appropriate referral for corrective action.

Each discipline completes an annual review of its continuous quality improvement/risk management plans and programs. The annual review is reviewed by the Medical Executive Committee as well as the Leadership Team.

There are eight (8) Client Care Disciplines which are responsible for the professional practices and standards at the hospital:

Activity Therapy
Dietetics
Medical Staff
Nursing
Pharmacy
Psychology
Social Work
Rehabilitation Services

IV. **THE MEDICAL STAFF**

The Chief Executive Officer has delegated to the medical staff the responsibility for the direct care of clients. The medical staff is organized and governed by the Central State Hospital Medical Staff By-Laws, Rules and Regulations, with the Chief Medical Officer serving as President of the Medical Staff.

The medical staff is responsible for governing the medical and dental practices at the hospital. The Chief Medical Officer shall consult with the Risk Management Director whenever any medical or dental practice may result in potential liability risk and in every case in which it appears that an incident has occurred which may result in litigation against the state or any of its employees. The medical staff participates in the credentialing and delineation of clinical privileges of its clinicians for certain services/procedures at the hospital.

The medical staff actively participates in the following risk management activities concerning the clinical aspects of client care and safety:

A. Identifying general areas of potential risk in the care and safety of clients and employees.
B. Developing criteria for identifying and evaluating specific cases of potential risk in the care and safety of clients and employees.
C. Participates on the IAT with reviewing any serious events which may warrant a root cause analysis.
D. Corrects identified problems in the care and safety of clients and employees.
E. Designing programs to reduce risk in the care and safety of clients and employees.
F. Referring appropriate matters to the Medical Executive Committee or Leadership Team for evaluation and appropriate corrective action.
G. Conducting a monthly Performance Improvement Executive Committee meeting which reviews and acts upon issues of risk management and continuous quality improvement.
H. The Mortality Review, Infection Control, Pharmacy and Therapeutics, and Medical Record Committees assist the Chief Medical Officer/Medical Staff in identifying risk areas and in providing the training and supervision required to correct or decrease areas of future risk.

V. **ADDITIONAL COMMITTEE ACTIVITIES**

Because of the size and complexity of the hospital, the Chief Executive Officer utilizes eleven (11) standing interdisciplinary committees to monitor, evaluate and coordinate these administrative and clinical activities of the hospital which are not directly under the auspices of the Client Care Committees. These committees submit minutes and reports to the Chief Executive Officer and to the Risk Management Director for their monitoring, assessment and direction/coordination of corrective action when appropriate.

The following are the hospital's standing interdisciplinary committees with active risk management responsibilities:

A. The Infection Control Committee has the responsibility of monitoring an active hospital-wide infection control program and for making recommendations for corrective action.
B. The Research Committee screens requests to engage in research, reviews procedures for use with human subjects, reviews research and consent procedures, monitors progress of research projects, and disseminates research findings.
C. PTFS Service Utilization Review Committees conduct studies of identified areas of concern and continuously attempts to improve the hospital's appropriate utilization of facilities and services to provide a high quality of client care.
D. The Pharmacy and Therapeutics Committee develops and monitors all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard/risk; assists in the formulation of broad policies regarding the evaluation, appraisal, selection, procurement, distribution, use of safety precautions, and all other matters relating to drugs in the hospital.
E. The Provision of Care (POC) reviews and forwards to the Medical Staff Executive Committee signi- ficant reports related to the respective services; ensures that care and treatment are conducted in accordance with the Medical Staff By-Laws, Rules and Regulations.
F. The Environment of Care Team (EOC) reviews accident reports/ statistics, conducts safety inspections, and initiates actions and makes recommendations to enhance safety within the hospital's buildings and grounds. The Risk Management Office will work closely with EOC to ensure the safety and well being of clients, employees and visitors on the CSH campus.
G. The Client Rights and Ethics Committee/CSH Compliance Officer, in its peer/medical review function, reviews all reports of incidents, particularly those which involve possible violations of clients' rights, investigates these incidents, reports on results to the Chief Executive Officer/Service Chief, and makes recommendations for corrective/preventive action. This committee also receives and investigates formal com- plaints which are made pursuant to DHR Rules and Regulations, section 290-4-6.07(1)(b), Remedies for Violations.
H. The Mortality Review Committee reviews circumstances related to client deaths in order to minimize risk and improve care.

I. The Staff Development Advisory Committee reviews training needs, effectiveness of training programs, requests for training travel funds and training sponsorships, and makes recommendations to the Chief Executive Officer.

J. The Medical Records Review Team reviews medical records and relevant policies and procedures to assure that applicable standards of documentation of all phases of client care are met.

VI. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

The Performance Improvement Monitoring and Evaluation Process, through planned and systematic procedures, evaluates the quality of care provided and reports areas of potential risk to the Chief Executive Officer, the Leadership Team, the Medical Executive Committee, and other appropriate staff for corrective action.

VII. QUARTERLY REVIEWS

The Performance Improvement Program monitors topics of interest or concern identified by the Chief Executive Officer, Chief Medical Officer and Chief Nurse Executive, and gathers data and information for presentation to service chiefs, and clinical directors, as well as other appropriate administrative and clinical staff, at meetings called Quarterly Reviews. Data is submitted by the Client Care Services as well as service chiefs, department heads and office directors through special as well as routine reports. At these Quarterly Reviews, monitoring data is presented and discussed and corrective action is planned, with appropriate staff being assigned responsibility for completion within a specific time frame. Concerns falling in the potential risk management area are referred to the appropriate individual/ department/committee for evaluation and/or corrective action, with a copy to the Leadership Team and the Medical Executive Staff.

VIII. REPORTING OF INCIDENTS

The hospital utilizes the Critical Incident Report (CIR), the Medication Error Report, and the Accident/Injury Report to report serious and/or unusual incidents and accidents/injuries. These reports are used by the Performance Improvement Program, Chief Medical Officer, Chief Nurse Executive, IAT, Safety Officer, Risk Management Director and the Facility Risk Manager in taking corrective action and developing preventive measures.

The Risk Management Director is responsible for the review of

each Critical Incident Report, obtaining any additional information required, and keeping the Chief Executive Officer and Leadership Team advised of potential risk or risk involvement. Additionally, the Risk Management Director will participate on the Incident Analysis Team to review events as determine in Division Policy 2.101 and other client to staff injuries. This team will determine if an incident is a sentinel event, potential sentinel event or near miss.

Each Critical Incident Report is reviewed by the Chief Medical Officer, Facility Risk Manager and Safety Officer with appropriate corrective action being requested of the reporting organization, and the Chief Executive Officer, the Risk Management Director, and the Leadership Team being notified of all potential risk or risk involvement.

The Chief Nurse Executive, Department of Pharmaceutical Services Director and appropriate Medical Directors review all Medication Error Reports, take action as required and notify the Chief Executive Officer, Risk Management Director, and Medical Executive Staff of all potential risk or risk involvement.

IX. ROOT CAUSE ANALYSES

A Process for the consistent and effective implementation of mechanisms for the identification, reporting, analysis, and prevention of sentinel events and other serious incidents.

Whenever an actual or potential sentinel event, or other serious incident occurs at CSH, the Risk Management Department will immediately notify the Incident Management and Investigation Section, MHDDAD Office, and Office of Inspector General (OIG).

Any time a potential sentinel event occurs, the hospital's IAT will complete a thorough and credible root cause analysis/peer review, implement improvements to reduce risk, and monitor the effectiveness of the improvements as part of the CSH ongoing performance improvement measures.

X. MEDICAL RECORD REVIEWS

The Director of the Health Information Management Department is responsible for ongoing reviews of the clients' medical records with any deficiencies being reported to appropriate staff for corrective action. Those items identified as risk management issues will be reported to the Leadership Team and the Risk Management Director for monitoring and the Medical Executive Committee for appropriate follow-up.

XI. PEER REVIEW COMMITTEES

Peer Review Committees evaluate incidents involving Client Care Committees which may involve credentials and/or privileges. Recommendations are then made to the Service Chief, Department Head or Office Director for corrective action to be initiated by the hospital. The Human Rights Committee also acts as a peer review committee. Other ad hoc peer review committees may be appointed as necessary.

XII. SAFETY

The Safety Director is responsible for the General Safety Plan. The CSH Environment of Care (EOC) Committee, through the Safety Officer, assures that safety inspections as well as monitoring of identified problems are made and that appropriate corrective action is taken. Service Area EOC Panels are responsible for having Interim Life Safety measures followed in each client care area, as appropriate.

The Baldwin County Fire Department conducts regular fire safety inspections and requests corrective action by the appropriate organizational head. All reports will be copied to the EOC Committee for monitoring and any additional follow-up required.

The Plant Operations Director is responsible for insuring the appropriate scheduled inspection of all medical equipment as well as having all repairs/replacements accomplished when necessary.

Also, the Director of Procurement Services will have a written procedure to follow in the case of equipment recall to assure that all equipment subject to recall is appropriately serviced, repaired, returned or otherwise removed from service when required for the safety of clients, employees and/or others.

XIII. POLICIES, PROCEDURES AND PLANS

The Central State Hospital policies, procedures and plans listed below establish guidelines and methods to assure the flow of information that enables the Facility Risk Manager, the Risk Management Director and the Leadership Team to coordinate risk management activities, minimize risk and

assure improved quality of care for the clients at the hospital.

1.01-Opinions From the State of Georgia Attorney General

In order for an opinion to be obtained from the Attorney General, the service chief, department head or office director must submit a written request to the Risk Management Director. The Risk Management Director is the only individual at the hospital who has been delegated the authority from the Chief Executive Officer to obtain opinions from the Attorney General through the Division of Mental Health, Developmental Disabilities and Addictive Diseases and the Department of Human Resources.

1.03 - Use of Medical/Dental Equipment Not Belonging to the Hospital

In order to protect the safety of the hospital's clients, no equipment may be used except that which belongs to the hospital and is subject to the hospital's preventive maintenance and safety check procedures.

1.04 - Major Hospital Wide Staff Meetings

The Risk Management Director is a member of the Chief Executive Officer's Leadership Team, and attends the CEO's Leadership Forums. This enables the Risk Management Director to have maximum involvement and knowledge of hospital activities, problems, potential risk situations, and areas needing improvement, etc.

1.05/1.05A - Private Duty RN/LPN/Sitter

All private duty staff are required to comply with the hospital's rules and regulations, and may be removed by the appropriate authority if appropriate care is not being received by the client.

DHR Personnel Policy 403 - Pre - Medical and Physical Examination Program

These examinations and screenings are conducted for the safety and protection of the clients as well as for the continued health of the employee.

DHR Personnel Policy 504, and Criminal History Checks

To ensure the continued safety of all clients, anyone with a criminal record applying for employment at the hospital must be cleared by a specially appointed committee (including the Risk Management Director) prior to being allowed employment status.

DHR Personnel Policy 1301 – Drug-Free Workplace

Steps to assure that the hospital is drug free adds a measure of protection to all clients, employees and visitors.

CSH Policy 2.05 Personal Appearance – Dress Code

The security and safety of all clients, employees and visitors, as well as state equipment and property, depends on proper identification of all persons within the hospital at all times.

3.03 – State Property Management

State property must be protected from damage, loss, and theft, and a property management and inventory system is mandatory for such a program.

3.19/3.19A – Life and Fire Safety Inspections

These inspections and the hospital's response to any deficiencies cited are necessary for the continued safety of all clients, employees and visitors.

3.23 – Records in Litigation/Mortality Review

All non-active medical record files identified as involved in litigation or potential litigation are secured in the Medical Record Department. Only the Risk Management Director or the Director of the Health Information Management Department may authorize the release of these records. All active records so identified are closely watched and copies from these records may only be authorized by the Risk Management Director or the Director of the Health Information Management.

4.00 – Client Rights and Organizational Ethics

This policy reflects methods in which particular strategies are utilized at CSH (i.e. Continuous Quality Improvement and Total Quality Management) that allows staff to respond to the needs of clients.

4.01 – Relationships Between CSH Employees and Clients

This policy demonstrates expectations of behavior of each hospital employee when dealing or interacting with clients.

4.03 – Writ of Habeas Corpus/Judicial Supervision

The supervision of issues related to any petition filed by clients is assigned to the Risk Management Director for coordination, handling, and notification of appropriate officials.

3.104 – Use of Seclusion or Restraint for Emergency Safety Situations in DHR Division of MHDDAD Hospitals

To prevent a client from seriously injuring himself/herself or others it is, at times, necessary to utilize restraint or seclusion. This may be used only when no less restrictive methods of controlling behavior has been successful.

4.10 – Visual Reproductions of Clients and Clients' Identification Photographs

Photographs of clients can be very helpful to staff both in documenting physical changes and in providing identification in times of crisis such as a client's leave without consent.

4.14/4.14A – Management And Release Of Clients Acquitted By Reason of Insanity (NGRI)
4.14B – Release of CSH Binion Clients Acquitted Not Guilty By reason of Insanity or Incompetent for Trial

The Risk Management Director assists in monitoring the release procedures applicable to forensic clients. These procedures were designed to protect both the due process rights of the clients and the safety interest of the public.

Provides specific guidelines for forensic services to follow when a forensic client no longer requires maximum security levels.

6811.2.4 – Actions Necessary Upon Death of a Consumer While in DHR Hospital or Following Discharge from DHR Hospital

Careful procedures must be followed uniformly in the case of all deaths of clients. State law requires CSH to report each

death to the Baldwin County Coroner.

4.21/4.21A - Coding and Tracking of Court Orders and Georgia Department of Corrections Admissions (Commitment Types 244, 201, 204, 205, 206, 241, and 243)

The Risk Management Director reviews all court orders for adequacy and appropriateness, and seeks corrective action when necessary from courts, attorneys, district attorneys or other involved agencies. Any such problem which cannot be solved at the hospital level is referred to the Division of Mental Health, Developmental Disabilities, and Addictive Diseases for assistance.

4.28 - Relationship With the Ga. Advocacy Office

This policy provides for the coordination of advocacy systems within hospitals for the treatment of mental illness.

4.32/4.32A - Alleged Sexual Assault on a Client

It is recognized that sexual assaults may be alleged at the hospital. Due to varying situations and degrees of the mental illness of a client, it is necessary to have guidelines in place to ensure prompt medical examination with the consent of the client or legal representative.

4.33 - Client Visits and Visitors' Responsibilities

Monitoring visits with clients is necessary for the physical safety of all clients as well as staff and visitors.

4.36 - Right to Consent/Refuse

The Risk Management Director acts as a consultant to the medical staff when questions arise as to informed consent issues.

4.37 - Allegations of Client Abuse Investigation and Employee Action to be Taken

4.37A - Allegations of Client Verbal and Physical Abuse and/or Neglect

All clients have the right to be free from abuse and neglect, and it is the responsibility of every employee at the hospital to report any such occurrence.

4.42/4.42A - Advance Directives

Clients have the right to make health care decisions, including those decisions concerning life support/sustaining equipment. Living Wills and Durable Powers of Attorney for Health Care are the two advance directives recognized in Georgia.

2.100 - Informed Consent and Involuntary Administration of Psychotropic Medication in DHR Hospitals

Central State Hospital recognizes the personal integrity of all persons, and the protection of client rights. It is also the policy of the hospital to obtain informed consent whenever possible prior to administration of psychotropic medication.

4.46 - Suspected Abuse Prior to Admission; or Upon Return from Trial Visits/Temporary Leaves

The notification and reporting of alleged, confirmed or suspected abuse to clients prior to admission or during temporary leaves/trial visits shall be made to the appropriated authorities.

5.02 - Control of Firearms and Contraband Items

Firearms, other weapons and contraband items must be controlled for the security of all individuals at the hospital.

2.101 - Reporting of Consumer Deaths and Critical Incidents

The Risk Management Director is responsible for reviewing each Critical Incident Report (CIR), obtaining additional information as needed, coordinating corrective actions and related documentation and reporting areas of potential risk/loss to the Chief Executive Officer and to the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD).

5.10 - Notice of Possibility of Claim

All division chiefs, department heads and office directors are responsible for insuring that the Risk Management Director is notified of any incident which may result in litigation against the state. The Risk Management Director then collects any necessary data concerning the incident and reports it to the Legal Services Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases, and the DHR Office of Insurance Programs and Claims.

5.13 - Liability and Bond Coverage

All staff are required to notify the Risk Management Director in all cases of potential liability. The Risk Management Director then coordinates all necessary notifications concerning the potential risk situations, and works with the Division of Mental Health, Developmental Disabilities and Addictive Diseases as well as the Attorney General's Office in any case which results in litigation.

5.21/5.21A - Management of Bio-Medical Maintenance Program

The hospital takes necessary precautions with its clinical and non-clinical equipment to protect clients, employees, visitors and physical facilities from hazards arising from the use of electrical equipment. This is accomplished through the systematic inspecting/testing of the equipment and preventive maintenance and repair of state owned/leased clinical and non-clinical equipment.

5.23/5.23A - Pre-Admission Search

It is necessary and desirable to provide a safe, secure environment for clients, employees and visitors at the hospital. During admission/intake it is essential that dangerous materials and objects (including medications ordered prior to the client's arrival at the hospital) are removed from clients seeking hospitalization.

5.25/5.25A - Storage and Disposal of Drug Samples

Drugs and drug samples must be properly stored and disposed of for the protection of the clients.

6.04 - Release of Information to News Media and Attorneys; and Publication of Articles

To insure accuracy of information presented as well as to protect the confidentiality of the hospital's clients, only specified persons, including the Risk Management Director, may

release any information to the news media.

Because of confidentiality requirements, attorneys contacting any staff member are to be referred to the Risk Management Director.

6.06/6.06A - Utilization of Middle Georgia Correctional Complex Inmates

The usage of inmate labor is of great assistance to the hospital, but proper control and coordination is necessary to insure that contact with clients is avoided.

7.02/7.02A - Research

Research is a valuable tool, but the rights of the clients must be protected by appropriate reviews and procedures.

The following Plans dealing with emergency situations are a vital part of the risk management plan of the hospital:

8.01 - Emergency Preparedness Manual
8.02 - Interim Life Safety Measures
8.03 - Fire Safety
8.04 - Safe Use Handling and Storage of Flammable and Combustible Liquids
8.06 - Motor Vehicle and Traffic Regulations
8.08 - Safe Management Plan, outlines the functions of the Safety Officer, the Safety Committee and other individuals involved in safety activities.
8.10 - Plan for Performance Improvement and Quality Enhancement

The Continuous Quality Improvement and Risk Management Plans are intricately related and, in some aspects, overlapping. The Medical Staff Executive Committee and the PI Committee oversee both areas and assure the accomplishment of objectives in both areas.

8.11 - Plan for Client Care

8.15 - Hazardous Chemicals and Waste Management

Special procedures and training are required in these areas to protect all of the hospital's clients, employees and visitors as outlined in this plan.

XIV. **LITIGATION/POTENTIAL LITIGATION**

The Risk Management Director is responsible for the collection and presentation of appropriate data, information and material as required by the Attorney General and/or courts in matters related to lawsuits involving the state of Georgia and/or its agencies/employees and for advising the Chief Executive Officer (CEO) and Division of Mental Health, Developmental Disabilities and Addictive Diseases of areas which may result in litigation.

XV. **TRAINING**

Appropriate training is a vital element of any risk management program. The Staff Development and Training Department (SDT) is responsible for developing training on those issues found to be important by the hospital Leadership Team, the Medical Executive Staff, the PI Committee, as well as those required by federal or state laws, rules and regulations, and accreditation agencies. A full listing of training courses can be obtained from the Staff Development and Training Department.

Approved:

This plan was approved by the CMO and CEO in April 2008.