SECURITY CLASSIFI

AD-A237 951

ON PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECUR N/A	1b. RESTRICTIVE MARKINGS N/A
2a. SECURITY CLASSIFICATION AUTHORITY N/A	3. DISTRIBUTION / AVAILABILITY OF REPORT UNCLASSIFIED/UNLIMITED
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE N/A	
4. PERFORMING ORGANIZATION REPORT NUMBER(S) 1-87	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION DEWITT ARMY COMMUNITY HOSPITAL 6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION US ARMY-BAYLOR UNIVERSITY GRADUATE PROGRAM IN HEALTHCARE ADMINISTRATION
6c. ADDRESS (City, State, and ZIP Code) FORT BELVOIR, VA 22060	7b. ADDRESS (City, State, and ZIP Code) AHA SAN ANTONIO, TX 78234-6100
8a. NAME OF FUNDING / SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A STUDY TO DEVELOP CRITICAL INDICATORS FOR MONITORING AND EVALUATING POTENTIALLY COMPENSABLE EVENTS FOR THE NURSING RISK MANAGEMENT PROGRAM AT DEWITT ARYM COMMUNITY HOSP.

12. PERSONAL AUTHOR(S)
BAKER, REBECCA D.

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
FINAL	FROM 7-88 TO 7-89	19 MAY 1989	62

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	RISK MANAGEMENT, NURSING, QUALITY ASSURANCE CRITICAL INDICATORS

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

The study presents a literature review of the development of risk management programs to include the Army Medical Department and particularly nursing risk management. A study was performed to identify the most critical indicators of potentially compensable events concerned with nursing practice to be incorporated into a risk management/ quality assurrance screen. Data was gathered from reports of unusual occurrence at DeWitt Army Community Hospital, Fort Belvior, Virginia, and experts in the risk management field. The critical indicators are presented in terms of patient outcome indicators and nursing process indicators. An extensive set of risk management and quality assurrance definitions are included in the appendix.

20. DISTRIBUTION / AVAILABILITY OF ABSTRACT ☐ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	21. ABSTRACT SECURITY CLASSIFICATION
22a. NAME OF RESPONSIBLE INDIVIDUAL REBECCA D. BAKER	22b TELEPHONE (Include Area Code) (703) 664-3884 22c. OFFICE SYMBOL

DD Form 1473, JUN 86 *Previous editions are obsolete.* SECURITY CLASSIFICATION OF THIS PAGE

A STUDY TO DEVELOP CRITICAL INDICATORS FOR MONITORING AND EVALUATING POTENTIALLY COMPENSABLE EVENTS FOR THE NURSING RISK MANAGEMENT PROGRAM AT DEWITT ARMY COMMUNITY HOSPITAL, FORT BELVOIR, VIRGINIA

A Graduate Management Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Captain Rebecca D. Baker, AN

5 July 1989

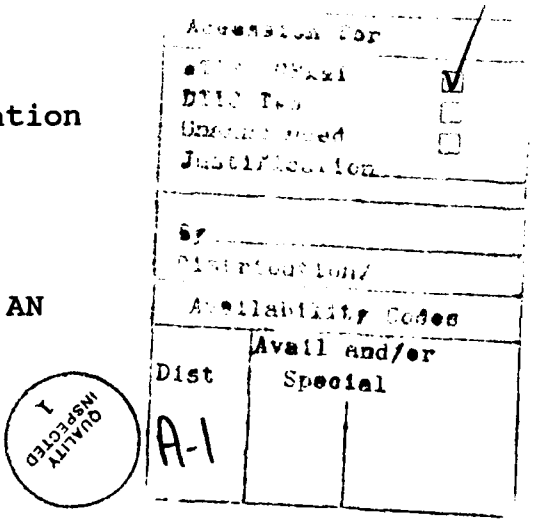

TABLE OF CONTENTS

CHAPTER

I. INTRODUCTION....2

Conditions Which Prompted the Study....2
Problem Statement....6
Objectives....6
Criteria....7
Assumptions....8
Limitations....9
Review of Literature....9
Early Risk Management Programs....10
Current Conceptual Models for Risk Management.13
Integration of Quality Assurance and Risk Management....18
Risk Management Activities Within the Army Medical Department....20
Nursing and Risk Management....26
Methodology....31

II. DISCUSSION....34

Current Procedures....34
Nursing Standards....35
Results of Reports of Unusual Occurrence Analysis..36
Outcome Indicators....36
Process Indicators....37
Results of Interviews with Field Experts....38
Outcome Indicators....38
Process Indicators....39
Implementation....39

III. CONCLUSIONS AND RECOMMENDATIONS....43

Conclusions....43
Recommendations....45

APPENDIX

A. DEFINITIONS....48

B. REPORT OF UNUSUAL OCCURRENCE-DA FORM 4106....54

C. ANALYSIS OF REPORT OF UNUSUAL OCCURRENCE....55

REFERENCE BIBLIOGRAPHY....59

CHAPTER I

INTRODUCTION

Conditions Which Prompted the Study

Since the early 1970's, members of the health care industry have witnessed a "malpractice crisis". This crisis, believed to be a reflection of the litigious nature of our society, has affected all aspects of health care delivery (Kessler and Joseph 1981, 1). As a result, health care managers have been forced to operate within an environment of increasing medical malpractice suits, insurance costs and production costs. Many approaches have been taken by managers within the health care industry in response to the "malpractice crisis". In general, these approaches have been to: (1) increase insurance coverage and shift the risk to the insurance industry; (2) lobby for tort reform to minimize the impact of liability; and (3) establish risk management programs to control the occurrence of compensable events (Orlikoff and Vanagunas 1988, 3).

A study of the types of health care professionals involved in malpractice suits reveals that physicians are most frequently named as a defendant (Northrop 1987, 343). Therefore, most hospital risk management programs have been designed to monitor and respond to physician malpractice. Recent statistics, however, show a significant trend of relatively more lawsuits involving nurses (Trandel-Korenchuk 1983, 75-6; Northrop 1987, 343). The

increase in nurses named in malpractice suits can be attributed to several factors. The first factor is related to the litigation process. Normally, the plaintiff's attorney encourages the plaintiff to name as many defendants as possible in the suit. This action by the plaintiff broadens the base for proof of liability and increases his potential for compensation. As a result, risk is placed not only on the physician but also on the hospital and other professional health care employees, including nurses. The second factor involves an increase in consumer awareness and unrealistic expectations which contribute to consumer dissatisfaction and subsequent claims of liability (Fiscina 1985, 512).

Nurses practicing in military treatment facilities are further affected by the third factor, the Federal Tort Claims Act. In civilian medical institutions, most claimants are interested in recovering damages from whoever has the "deepest pockets", usually meaning either the physician or the hospital. In military medical institutions within the United States, the claimant is able to recover primarily through the guidance set forth in the Federal Tort Claims Act. The health care providers within the military system are protected under the Gonzales Act for actions taken within their scope of employment. As a result of these "Acts" the claimant can recover from the

"deep pockets" of the government by naming any health care provider who is involved in negligence, to include nurses (Zucker 1988).

The increasing potential for nurses to be named in malpractice suits makes the development of an active clinical risk management program for nursing particularly important. Siebelt (1988), a nurse who is a risk management consultant, enumerated that there are four essential elements that need to be included in an active clinical risk management program. These elements include: (1) identification and tracking of potential liability circumstances, (2) prevention, using the information collected in identification and tracking, (3) control of events and circumstances after a potentially compensable event has occurred, and (4) evaluation of the risk management case to further provide information to prevent potentially compensable events.

The risk management program, within the nursing quality assurance program at DeWitt Army Community Hospital, utilizes a report of unusual occurrence to report concurrent variances in nursing practice. Traditionally, occurrence reporting systems have monitored only custodial risk management problems such as falls with minimal focus on clinical practice variations, such as medication errors. As in many other hospitals the reports of unusual occurrences or incident reports are the only data gathering tool for nursing risk management (Orlikoff and Vanagunas

1988, 55). The traditional method of utilizing the incident reporting system to identify adverse patient outcomes has resulted in an ineffective reporting and data gathering system. Quality assurance and risk management professionals within the Army Medical Department stress that many potential adverse patient outcomes, resulting from a variance in nursing practice, are not reported through the documentation on a report of unusual occurrence (Brazil 1988; Guida 1989; Janke 1989; Lynch 1989). In order for the nursing risk management program at DeWitt Army Community Hospital to be successful, a system must be in place to identify, prevent, control and evaluate potential liability circumstances. The risk management system should also identify what occurrences need to be reported, who will evaluate the occurrences, and how the occurrences should be evaluated. Identifying occurrences to be tracked and a method for evaluating the occurrences against nursing standards of practice and standards of care is necessary in order to begin an active clinical risk management program for nursing. An additional benefit of this system is to foster identification of potentially compensable events, increase nursing staff awareness of the nature of events that can incur potential liability, prevent future occurrences and ultimately provide a system for better quality patient care.

Statement of the Problem

To develop critical indicators for monitoring and evaluating potentially compensable events (PCEs) for the nursing risk management program at DeWitt Army Community Hospital (DACH).

Objectives

The objectives of this management project were to:

1. Review documentation relating to the health care risk management programs in both the civilian and military health care systems to include:

a. Evolution of hospital risk management programs, specifically program objectives and components to identify and report potential risk management problems.

b. Summary of the weaknesses of traditional risk management problems.

c. Current conceptual models of risk management.

d. Integration of quality assurance and risk management.

e. Risk management activities within the Army Medical Department.

f. The evolution of risk management components into nursing quality assurance programs.

2. Review the existing quality assurance and risk management programs at DACH. The review will include the Medical Services Quality Assurance and Risk Management

programs (MEDDAC Regulations 40-91 and 40-108) and the DACH Department of Nursing (DON) QA Plan (DON Administrative Policy No. G-14).

3. Review and identify the standards of nursing practice, for which nurses can be held liable, as outlined by DA Pamphlet 40-5--Army Medical Department Standards of Nursing Practice.

4. Analyze the nursing reports of unusual occurrences submitted to the nursing quality assurance coordinator to determine the patient outcome indicators and the nursing process indicators to be used for monitoring and evaluating potentially compensable events.

5. Determine additional critical indicators to be monitored and evaluated by using information provided by quality assurance and risk managements professionals at The Virginia Insurance Reciprocal(TVIR), the U.S. Army Claims Service, and the Office of The Surgeon General(OTSG), Quality Assurance Division.

6. Develop an implementation plan for monitoring and evaluating the critical indicators within the nursing risk management program.

Criteria

The following criteria were applied in collecting the data for analysis:

1. The adverse patient outcome was regarded as the outcome indicator of the potentially compensable event.

2. For the adverse patient outcome to be considered as a critical indicator of a potentially compensable event, the following criteria were met:

a. The adverse patient outcome occurred within the physical structure of the hospital.

b. The adverse patient outcome was recorded as a potential variance from a nursing standard which resulted in a change in either medical and/or nursing intervention.

3. The nursing standard variance associated with the adverse patient outcome was determined to be the process indicator of the potentially compensable event.

Assumptions

1. During the development of this management project, the author discovered a lack of specific data correlating nursing practice variances, associated with care in military treatment facilities, to a specific compensable event. The quality assurance and legal professionals contacted within The Office of The Surgeon General, Quality Assurance Division and the U.S. Army Claims Service, contributed information in support of the following assumptions:

a. The variances in nursing practice standards recorded for the civilian sector are similar to the variances in the military sector.

b. The data gathered from the reports of unusual occurrences, claims filed, and claims settled, maintained by The Virginia Insurance Reciprocal(TVIR), OTSG, Quality

Assurance Division, and the U.S. Army Claims Service, represent adverse patient outcomes that could occur at DACH.

2. The information documented on the Reports of Unusual Occurrence and the Analysis of the Report of Unusual Occurrence, maintained by the nursing quality assurance coordinator at DACH, is correct.

Limitations

1. The analysis of adverse patient outcomes was limited to those recorded and reported on either reports of unusual occurrences, claims filed, or claims settled.

2. The process of submitting claims under the Federal Tort Claims Act does not require that all defendants involved in the negligent act be named, to include nurses.

3. The Feres Doctrine limits the number of claims filed by active duty service members.

Review of Literature

The dramatic increase in medical malpractice claims over the past two decades has necessitated the development of hospital risk management programs. A description of where hospital risk management programs should be in their development today, is offered in the Accreditation Manual for Hospitals (1989):

> ...risk management functions [relate] to clinical and administrative activities designed to identify, evaluate, and reduce the risk of patient injury associated with care. The full

> scope of hospital risk management functions encompasses activities in health care organizations that are intended to conserve financial resources from loss (307).

Financial losses from patient injury associated with provision of health care have been staggering. The Government Accounting Office(GAO) reports that, in 1985, malpractice insurance costs amounted to $5.16 billion or 1.22% of total health care costs (United 1987, 175). During 1984 most of the $2.6 billion paid out in malpractice claims were a result of injuries that occurred in hospitals (Liability 1988, 7). Unfortunately, creating risk management programs to effectively manage and reduce the risk and subsequent cost of patient injury and malpractice claims filed against hospitals and health care providers, has been a difficult and challenging task.

Early Risk Management Programs

"Risk management" was originally conceived in the early 1960's as an insurance industry program to control and finance business activities. During the medical malpractice crisis in the early 1970's, professional liability insurance carriers reacted to the sharp increases in jury awards and settlements by either raising premiums significantly, or pulling out of medical liability insurance altogether. As a result, hospital administrators realized that controlling losses from medical malpractice would have to be the responsibility of hospital management,

thus, the evolution of hospital risk management began (Patient 1985, 102).

The first attempts to organize hospital risk management programs were not successful in reducing financial losses. Consultants from insurance carriers and brokers were among the first risk management professionals to attempt to organize hospital programs. Unfortunately, their previous experience was with business and industry, which resulted in advice inappropriate to the health care setting. Other hospitals resorted to hiring risk managers with experience in safety engineering who lacked the clinical and legal skills necessary for the medical aspects of risk management. One outcome of these early efforts to initiate hospital risk management programs was the establishment of an "incident reporting" system as the primary mode of identifying medically related maloccurrences (Joint[Ch. 1] 1989, 4).

Many reasons exist for the failure of risk management programs throughout the first years of development. Primarily, early programs failed because they did not incorporate the information available from established quality assurance programs. Kessler and Joseph (1981) emphasize that quality assurance activities can greatly "enhance the effectiveness" of risk management programs (3). Additionally, quality assurance activities offer a data base which could serve as a management tool to prevent harm to patients. Although the integration with quality

assurance activities is important, the following is a list of other outstanding factors which influenced the poor implementation of early risk management programs:

-Personnel associated with the programs were not always the most appropriate or qualified;

-No channels of communication were established between RM [risk management] personnel and other health professionals involved in review;

-Risk managers were unable to get the "right" information;

-RM activities were isolated from day-to-day problems in clinical care; and

-Programs lacked clinical staff support and participation (3).

Many of these factors are evident in the "Safety Model", one of the earliest models of risk management. The safety model was a response to the insurance industry's requirement for hospitals to have formal, internal risk management programs, in order to qualify for liability insurance in the mid-1970's. A second model, the "Patient Injury Model", got its impetus from the California Medical Insurance Feasibility Study, funded by the California Medical Association in 1977. Although different in functional methods and techniques, both models outline the necessity of the hospital risk management activity to minimize loss (Orlikoff and Vanagunas 1988, 34-5).

The safety model reflects the traditional approach of custodial risk management, whereas, the patient injury model reflects the contemporary idea of clinical risk management. Table 1 shows a comparison of the safety and patient injury models.

In actuality, the patient injury model falls short in its recommendation for active physician involvement, as active physician involvement is difficult to obtain and maintain. Staff participation is necessary for any risk management program to be effective. Each hospital has faced different legal, insurance, administrative, financial, and human resource constraints in an attempt to produce risk management models and techniques that will best fit their individual needs (Orlikoff and Vanagunas 1988, 36).

Current Conceptual Models for Risk Management

Recent issues regarding the quality of patient care and management of adverse patient outcomes have spurred a great deal of public attention. There are several outstanding reasons why all this attention is being paid to quality. First of all, the expectations of a better educated and more informed public are increasing. Secondly, as technology increases, the number of procedures increase, and the likelihood for adverse reactions increase (Christensen 1988, 6). Additionally, some health care professionals advocate that the nursing shortage will have a significant impact on the quality of patient care and

future malpractice liability (Orlikoff and Vanagunas 1988, 141; Will 1987, 64).

Table 1

Comparison of the Safety and Patient Injury Models of Risk Management

Elements	Safety Model	Patient Injury Model
Basic concept	Reduce patient injury	Improve the quality of patient care
Functional methods and techniques	Limited involvement of medical staff	Requires physician leadership and medical staff involvement
	Integrated with safety programs	Integrated with quality assurance, safety, patient relations, incident reporting, and claims management programs
Program Characteristics	Hospital risk-management (safety) committee	Integrates results of quality of care, patient feedback, and safety surveillance
	Risk manager (safety director)	Hospital administrative support
	Incident reporting procedure (custodial)	Incident reporting emphasizes medical incidents
	Hospitalwide and departmental safety and security program, including inspections	Requires active physician involvement

Source: Orlikoff and Vanagunas 1988, 34-5

This public attention has affected the forces which impact on the administration and delivery of health care.

These external forces, providing the impetus for more stringent standards for regulating and ensuring quality health care, include the Federal Government, state governments, the Health Care Financing Administration (HCFA), the Joint Commission on Accreditation of Healthcare Organizations(JCAHO), and the insurance industry (Christensen 1988, 7; Meyers 1989). According to Christensen (1988), health care organizations must take action to keep pace with new laws, more stringent regulations, and individual patient demands. Furthermore, Christensen predicts that the hospital programs and departments which will become the central focus for reacting to the change are quality assurance, risk management and utilization review (7).

Many models for risk management programs have been developed to respond to the external demands and requirements. Several recently developed models are based on common components and philosophies. The current philosophy, shared by many of the creators and advocates of contemporary models, is that risk management programs must be based on harm prevention, directed toward providing the highest possible standard of care, designed to identify and correct problems before harm occurs, and integrated into quality assurance programs (Kessler and Joseph 1981, 4; Orlikoff and Vanagunas 1988, 36-7; Meyers 1989; Seibelt 1988; Johnson 1988).

A study of the current models of hospital risk management programs reveals a continuity in program functions and components. Meyers (1989), speaking on the JCAHO requirements for quality improvement, summarizes the functions of risk management in health care:

> The risk management program should function to preserve financial resources and protect human resources and other intangibles by: (1) providing insurance against liability and risk of loss; (2) controlling and reducing losses due to patient, staff, and visitor injury or untoward events; and (3) preventing patient injuries.

These functions reflect active, or preventive risk management. In contrast, the actual function of most risk management programs has been reflexive, or reactive, responding only after a potential compensable event has been brought to the attention of hospital management. According to Trandel-Koranchuk (1983):

> An effective risk management program embraces activities that allow the institution and provider to anticipate and prevent actions or situations that may result in harm to the organization, its staff or most important, the public (79).

There are four basic components that exist in current health care risk management models. The first component essential to any risk management program is risk

identification and tracking. Mechanisms must exist to identify potential and actual risk circumstances in order to eliminate, reduce, or prevent patient harm (Dzingleski 1987, 20-1; Orlikoff and Vanagunas 1988, 55). Actual mechanisms include occurrence reporting, claims history analysis, quality assurance/utilization review activities, safety reports, and reports from patient representative activities (Joint[Ch. 1] 1988, 10). The second component, risk analysis, is achieved by applying clinical and managerial expertise to derive pertinent information from the collected data. The third component, risk control/risk treatment, includes activities such as staff education, liability insurance programs, identification and avoidance of high risk services, claims management, and loss prevention. Risk evaluation is the fourth component which is simply the ongoing evaluation of the risk management system (Seibelt 1988; Meyers 1989).

The American Society of Healthcare Risk Management (ASHRM) is a professional organization dedicated to risk management under the sponsorship of the American Hospital Association. The ASHRM, by means of its membership, greatly impacts on current risk management programs. In 1987, a legislative task force from ASHRM published guidelines for the components of a risk management program. The task force documented that there should be a system to identify:

> ...unexpected or unanticipated outcomes which have caused injury or have the potential to cause injury, and identification of risks which have or could potentially have caused a preventable injury or the impairment of patient safety (Dodero 1988, 1).

A system for identifying risks and potential risks should at least include criteria based outcome studies and monitoring systems based on objective criteria (1). Dodero (1988), a member of ASHRM ascertains that one way of identifying risk exposure is by utilizing outcome screens and incident/occurrence reporting systems. Additionally, utilizing outcome screens on a concurrent basis will lower the severity of loss (11).

Integration of Quality Assurance and Risk Management

The Joint Commission on Accreditation of Healthcare Organizations(JCAHO) has included standards pertaining to risk management in the Accreditation Manual for Hospitals (1989). The risk management characteristics support standards within the following areas: (1) Governing Body; (2) Management and Administrative Services; (3) Medical Staff; (4) Quality Assurance; and (5) Plant, Technology and Safety Management. These JCAHO standards support the integration of quality assurance and risk management activities long advocated by risk management professionals and professional organizations.

In 1981, the American Hospital Association(AHA) organized the "Interdisciplinary Task Force on Quality Assurance and Risk Management" to propose recommendations for hospital quality assurance and risk management programs. The task force recommended that hospitals set up a formal integration between quality assurance and risk management activities based on the following reasons:

(1) Integration allows maximum benefit of limited resources.

(2) Both risk management and quality assurance activities require the same sources of data and integration would decrease duplication of effort in collecting and analyzing data.

(3) A communication link between risk management and quality assurance would help to provide optimal solutions to problems.

(4) an integrated approach would result in better in-house education programs (Orlikoff and Lanham 1981, 54). Lanham and Orlikoff emphasize that in theory quality assurance and risk management overlap because, "if high-quality care is not rendered, the hospital may be exposing itself to financial loss" (165).

Dzingleski (1987) also advocates the concept of integrating quality assurance and risk management in her basic principles of managing risk. She supports this by stating, "risk identification is the first element of the risk management process and involves the cooperation of all

services areas" (20). Identification relies on data from the incident reporting system, quality assurance program, utilization review, and patient representative (20). Both risk management and quality assurance activities identify high volume/high risk circumstances, analyze patterns against standards, implement corrective actions, and monitor results (21).

Risk Management Activities Within the Army Medical Department

The Army Medical Department(AMEDD) was one of the first medical care systems to require the integration of risk management and quality assurance activities. This requirement is documented in Army Regulation(AR) 40-66, Medical Record and Quality Assurance Administration. The components for risk management required by this regulation include: (1) identification of problems or potential risk circumstances; (2) incorporating data from the identification process to eliminate, reduce, or prevent accidents and injury; (3) investigation of adverse patient outcomes; (4) coordinate claims follow-up; (5) conduct trend analysis; and (6) report risk management activities to appropriate administrative sources. The data collection tools used by the AMEDD to support risk management activities include incident reports, medical records, generic screens, patient care assessments, and patient complaints (AR 40-66 1987, 41).

Although the AMEDD has had a risk management system in place since the late 1970's, medical malpractice claims settled through the Army Claims Service have been astronomical. In 1985, Fiscina reported that the number of claims against the military health care system have amounted to $110 million (511). There are several factors, based on the personal experience of the medicolegal consultants at the Armed Forces Institute of Pathology (AFIP), that have contributed to the risk management crisis:

(1) There is a discrepancy between access and services promised during recruitment and access and services actually available.

(2) Patients expect perfect results free of any complications.

(3) Attorneys prefer the ease of the Federal Tort Claims System to the complexity of the civilian legal system.

(4) Insensitive care by clerical personnel has contributed to patient dissatisfaction.

(5) Poorly trained and inexperienced personnel staff the emergency department.

(6) Inappropriate telephone consultation is given by non-nursing and non-medical personnel.

(7) Referrals are made to inappropriate facilities.

(8) Ineffective communication exists among providers.

(9) Antagonistic feelings are prevalent among providers.

(10) Inadequate credentialing processes exist.

(11) There is overutilization and inadequate monitoring of physician extenders.

(12) Emergency services are overutilized by nonemergency patients.

(13) Judge Advocate Generals(JAG) are inexperienced in health law and malpractice defense.

(14) Poor documentation exists in medical records.

(15) The incident reporting system is more concerned with reporting environmental safety problems, falls, and medication errors, rather than clinical incidents.

(16) Risk management programs are narrow and deal primarily with the management of claims (reactive risk management), rather than providing a surveillance mechanism which would detect and correct potential problems early (proactive risk management) (Fiscina 1985, 511-17).

Fiscina (1985) offers recommendations for developing proactive, or preventive risk management functions for medical treatment facilities:

(1) Anticipate and identify medicolegal problems.

(2) Develop a formula for recognition of potentially compensable events.

(3) Educate providers on medicolegal matters.

(4) Establish a risk management system to prevent fundamental errors.

(5) Advise management concerning malpractice claims prevention (517).

Unfortunately, the perspective of risk management within the military health care system has been reactive risk management, primarily through claims reporting, claims management, and incident reporting. Several reporting systems within the Department of Defense(DOD) and AMEDD have been instituted in an attempt to manage and respond to malpractice issues. In 1982, the Assistant Secretary of Defense for Health Affairs(ASDHA) initiated an internal reporting system for malpractice claims data. This action followed the establishment of a DOD level quality assurance program. The centralized data collection included number of claims filed, disposition of claims, dollar amount, type of health care provider and speciality. This program was also a result of media attention and pressure on the DOD to manage the problem of malpractice (Vira 1985, 524).

The reporting requirement, as a risk management function, gained even greater impetus with the signing of the Federal Health Care Quality Improvement Act of 1986. The initial purpose of the Act was to establish a national data bank of physician discipline and malpractice actions, in order to restrict the ability of incompetent physicians to move from state to state. Currently, implementation of the Act requires that no group of healthcare professionals, including nurses is exempt from the peer review and reporting requirements. The peer review process requires a

need for the healthcare providers to establish meritorious responsibility for potentially compensable events (Brazil 1988).

The DOD response to the Federal Health Care Quality Improvement Act has been to issue a requirement to report all malpractice claims. In November 1988, the DOD issued DOD Directive 6025.13 which required all uniformed services to report medical malpractice claims and lawsuits closed since 1 January 1988. This was the first attempt by the DOD to require uniform reporting using a standard form. The requirement calls for completion of Department of Defense(DD) Form 2526, Case Abstract for Malpractice Claims, in the event there are: (1) closed cases where the incident occurred after 1 January 1985 and payment was made and (2) closed cases where payment was denied, based on either the Feres Doctrine or the Statute of Limitations, but where peer review noted substandard care (Janke 1989).

The Office of The Surgeon General(OTSG) has been gathering information from Army Medical Treatment Facilities(MTFs) regarding known malpractice claims filed over the past three years. Several reporting problems have been cited by Major Janke (1989), who is responsible for maintaining the data base:

(1) There was no standard form for reporting the information.

(2) Many cases and providers were not reported for fear of being reported to the National Data Bank.

(3) Not all providers involved in the incident, nor all forms of malpractice were reported. The Federal claims system is based on the Federal Tort Claims Act, the Feres Doctrine and the Statute of Limitations. As a result, the active duty plaintiff cannot receive compensation through the claims process, and other plaintiffs are required to file suit against the government and not against specific providers.

(4) Nurses were not usually associated with specific claims unless they were singularly responsible for an incident. Although, a few nurses have been implicated during the peer review process.

Only nine claims involving nurses have been reported to OTSG within the last three years. Major Janke (1989) feels that more nurses would be implicated if the claims process were different. The current data base required by the DOD is configured to track providers who may have rendered substandard care. Unfortunately, the claims process will remain the same, so probably very few nurses involved in incidences will be named in the Case Abstract for Malpractice Claims (DD Form 2526). It will be the responsibility of individual Army MTFs to establish a mechanism to track individual nurses who deliver substandard care that may result in a potentially compensable event. Nursing administrators must develop mechanisms to ensure the timely identification of deviations from acceptable standards of nursing practice

and become responsible for the clinical risk management of nursing practice (Brazil 1988).

Nursing and Risk Management

According to Northrop (1987), a registered nurse and legal professional, "nursing is not immune to professional liability lawsuits", based on the fact that nurses are legally responsible to provide reasonable and prudent nursing care within their standard of practice (343-44). Even as early as 1983, Trandel-Korenchuk documented that the incidences of nurses named as defendants in malpractice suits were increasing (76).

The American Nurses' Association(ANA) has been forced to react to society's interest in nursing malpractice. A National Nurses Claims Data Base was established in 1988 by the ANA in an effort to monitor professional liability claims. The national data base is voluntary and receives input from nurses who experience a liability claim or incident. As of 26 October 1988, information had been collected on more than 30 liability claims and incidents. The objectives for the data base were to: (1) assure reasonable cost of liability insurance; (2) provide a resource for defending nurses against liability; and (3) provide information to be used in developing risk management programs (ANA Newsletter, 1988).

The AMEDD also recognizes that professional nurses are not immune to malpractice claims. Major Phil Lynch, Chief of Medical Malpractice Branch, Army Claims Service,

estimates that 10 to 50 of the 1000 medical malpractice claims per year involve nurses. He also estimates that in 1988 claims paid involving nursing malpractice amounted to $5 million. Recent cuts in DOD spending compounded by the national nursing shortage, have decreased the number of nurses available for direct patient care. Lynch (1989) warns that the courts expect AMEDD staffing standards to be comparable to the staffing standards in civilian hospitals.

Several nurses, contacted by the author, felt that some unusual occurrences may be due to staff shortages. This reasoning is addressed in a study by Wan and Shukla (1987) on the contextual and organizational correlates of the quality of hospital nursing care. The conclusion of the study was that the correlation between incident rates and patient acuity and number of registered nurses on staff was low, but that the incident rates were closely correlated with competence of registered nurses. The researchers suggested that "quality assurance and risk management programs would benefit from developing the capability to account for the competence of individual employees" (64).

The Army Nurse Corps has initiated new quality assurance guidelines in an attempt to establish a broader spectrum of nursing responsibility for clinical risk management. The guidelines are documented in Department of

Nursing Quality Assurance Program AR 40-XX (Final Draft), completed 19 January 1988. The objective of the nursing quality assurance program is to:

> ...provide for a planned, systematic, ongoing process to monitor, evaluate, and document the quality and appropriateness of nursing care and clinical nursing practice; and to identify and pursue opportunities to improve patient care and effect problem resolution (AR 40-XX, Draft).

Risk management is specifically cited as one of the four components of the Department of Nursing Quality Assurance Program. Elements to be addressed in the nursing risk management program include: (1) elopement or leaving the hospital against medical advise (AMA); (2) environmental safety; (3) high-risk circumstance identification; (4) medical materiel problems; (5) patient satisfaction; (6) practice and procedure variances; and (7) unusual occurrence report analysis. Monitoring competence is another component of the nursing quality assurance program. One of the essential elements that is documented as part of the competence component is the reporting of incompetent nursing practice (AR 40-XX, Draft). A comprehensive risk management program should include tools to identify nurses who demonstrate incompetent practice. Within the seven elements of the risk management component,

two elements, practice and procedure variances and unusual occurrence report analysis, should contribute essential information necessary to monitor nursing competence.

Incident or unusual occurrence reports have been the only tool used for years by nurses to report potential risk events. Most of the reported events were concerned with custodial rather than clinical risk management (Brazil 1988). The incident or occurrence reporting system has failed to identify and trend many of the nursing practice variances that have resulted in the occurrences of legal consequence.

The literature documents nursing malpractice cases involving: (1) failure to administer proper or timely treatment; (2) failure to communicate with either the nursing staff, patient, or physician; (3) failure to supervise subordinates; (4) failure to monitor or observe a patient's clinical status; and (5) failure to give medications according to written standards. The impact of these variations in nursing practice standards have resulted in various adverse patient outcomes as serious as death, burns, and brain damage. Nurses need to be aware of their standards of practice and standards of care in order to avoid and prevent risk management problems (Northrop 1987, 344). Nurses, for the most part, have not been acutely aware of the potential risk events concerned with clinical risk management.

The incident/occurrence reporting system is fundamental to nursing risk management and can be augmented by a concurrent screen in order to identify the nursing practice and procedure variances that account for the majority of potentially compensable events. According to Blake (1984), in any given group or array, a relatively small number of items will tend to give rise to the largest proportion of results. In other words, there are critical incidents and critical factors contributing to incidents which should be controlled that lead to the largest proportion of results. This is the principle that is the basis for developing critical indicators of potentially compensable events (38).

Once the critical indicators are identified, the nurses will need to be educated about both the basis for the critical indicators and the responsibility for monitoring their clinical practice. The key to effective risk management programs is staff education and staff accountability (Blake 1984, 38; Fiscina 1985, 517).

In summary, Colonel Robert A. Guida (1989), Nursing Consultant for Quality Assurance, OTSG, offers several substantial suggestions for nursing risk management programs. Nurses need to become more involved in clinical risk management. The nursing staff spends twenty-four hours a day delivering direct patient care and has the perfect opportunity to detect critical indicators of potentially compensable events. A concurrent occurrence

screen based on outcomes is one tool that nurses could use to screen for critical indicators of variances in nursing standards. Data obtained from the screen could be used as a basis for educating nurses concerning risk management, a mechanism to track systemic problems, and a tool for early detection of potentially compensable events. Once the process is refined, the data can be used to monitor nurses who may be practicing substandard nursing care.

Project Methodology

The following methodology was used to determine the critical outcome and process indicators for monitoring and evaluating potentially compensable events (PCEs) associated with the practice of nursing at DACH.

1. The current method of monitoring, evaluating, and reporting of actual and potential adverse patient outcomes, resulting from a possible variation in nursing standards, was examined by utilizing the following resources at DACH:

a. Department of Nursing Administrative Policies concerning nursing standards, patient safety, reports of unusual occurrences, and quality assurance were reviewed.

b. An interview was conducted with the Department of Nursing Quality Assurance Coordinator .

2. An understanding of the acceptable nursing practice standards at DACH was established by reviewing the Army Medical Department Standards of Nursing Practice

(Department of the Army Pamphlet 40-5) and discussing the current nursing standards of care with the Department of Nursing Quality Assurance Coordinator.

3. An analysis was performed of all Reports of Unusual Occurrences, DA Form 4106 (Appendix B) and corresponding Analysis of Unusual Occurrences (Appendix C) submitted to the nursing quality assurance coordinator from 1 January 1988 to 31 December 1988. The following data was derived for each occurrence:

a. Date-Time-Day of Occurrence

b. Hospital Unit

c. Type of Nursing Care Provider

d. Patient Diagnosis and Activity

e. Adverse Patient Outcome (Outcome Indicator)

f. Patient Outcome Category:

-No Injury/Inconsequential

-Patient Inconvenience/Discontent

-Consequential/Temporary Injury or Effect

-Serious Injury or Effect

-Severe Injury or Effect

-Death

-Not Applicable/AMA

g. Nursing Standard of Care/Practice Met/Not Met

h. Nursing Process Variance (Process Indicator) Contributing to the Occurrence

4. Data concerning additional outcome and process indicators to be monitored and evaluated at DACH, was

gathered through interviews with the following risk management and quality assurance professionals:

a. Nurse Quality Assurance Officer, OTSG, Quality Assurance Division.

b. Risk Management Consultants, The Virginia Insurance Reciprocal.

c. Chief, Medical Malpractice Division, U.S. Army Claims Service.

5. An implementation plan utilizing a composite of the process and outcome indicators was developed to use in the nursing risk management program at DACH.

CHAPTER II

DISCUSSION

Current Procedures

Monitoring and evaluating actual and potential adverse patient outcomes, associated with nursing practice at DACH, is outlined by the Department of Nursing Administrative Policy regarding reports of unusual occurrences. Unusual occurrences are described as events which include, but are not limited to, accidents, injuries, and therapeutic misadventures involving patients. The purpose of the Report of Unusual Occurrence, DA Form 4106, is to record unusual incidents or events which occur in the hospital and to serve as a medium to inform the hospital commander, hospital risk manager, physician personnel and nursing supervisory chain of the occurrences.

The report of unusual occurrence is initiated by the professional healthcare provider who first notices the adverse patient outcome or a potential for an adverse patient outcome. The DA Form 4106 is completed as soon as possible in order to obtain the pertinent facts associated with the incident or event. The pertinent facts are then reviewed and evaluated by the nursing chain of command to include the Clinical Head Nurse, Nursing Section Supervisor, Assistant Chief Nurse, Chief Nurse, and Nursing Quality Assurance Coordinator. The form is then forwarded to the Hospital Risk Manager within 48 hours. An Analysis of Unusual Occurrence is to be initiated, completed and

evaluated by the same persons involved with review of the DA Form 4106. The Analysis of Unusual Occurrence is to be completed within 7 days of the occurrence.

The occurrence is evaluated for causal factors such as negligence, unit or individual practitioner trends, events or system problems beyond the control of the nurse, and staffing patterns. The El Dorado Medication Error Tool (EDMET) is used to evaluate the severity of medication errors and the disciplinary measure to be rendered. Reports of all unusual occurrences concerning nursing personnel are discussed monthly at the Department of Nursing Quality Assurance Committee.

Nursing Standards

The professional nursing staff employed by or assigned to DACH are expected to follow the Army Medical Department Standards of Nursing Practice, DA Pamphlet 40-5 (November 1981 with changes added May 1986). A summary of the standards include:

1. Systematic and continuous collection of data concerning the patient's health status.
2. Identification of nursing care problems.
3. Identification of nursing care goals.
4. Formulation of a current and realistic nursing care plan.
5. Written nursing actions/orders to implement the plan of care.

6. Implementation of a care plan with appropriate attention to the patient's safety, psychosocial, physiological and educational needs.
7. Continuous monitoring of the patient's progress.
8. Support of the patient's individual rights.

The nursing staff is also responsible for following the standards of care outlined by the specific nursing units and the standard operating procedures documented by the hospital (MEDDAC), Department of Nursing, and individual nursing units.

Results of Reports of Unusual Occurrence Analysis

The data resulting from the analysis of the Reports of Unusual Occurrence is considered privileged information, therefore, only the information essential for the purpose of this project will be presented. A total of 84 Report of Unusual Occurrences and Analysis of Reports of Unusual Occurrences were submitted to the Department of Nursing Quality Assurance Coordinator during the 1988 calendar year. All of the reports were either potential or actual adverse patient outcomes concerned with nursing practice.

Outcome Indicators

The adverse patient outcome(APO) or potential adverse patient outcome was considered to be the critical outcome indicator of a potentially compensable event. The outcome indicators resulting from the Reports of Unusual Occurrence analysis are as follows:

1. Patient Fall/Patient Found on Floor

2. Actual/Potential APO Resulting From a Nursing Practice Variance
3. Actual/Potential APO Resulting From a Nursing Procedure Variance
4. Actual/Potential APO Resulting From a Medication Error
5. Adverse Drug Reaction
6. Nosocomial Infection
7. Actual/Potential APO Resulting From Intraveneous Fluid Administration
8. Patient Left Hospital Against Medical Advise (AMA)
9. Actual/Potential APO Resulting From Equipment Failure
10. Complaint Concerning Nursing Care

Process Indicators

The critical process indicator is the nursing standard variance which was assessed as the factor contributing to the potential or adverse patient outcome. The resulting process indicators are as follows:

1. Physician Order Not Followed
2. Nursing Order Not Followed
3. Communication Breakdown-Staff
4. Communication Breakdown-Patient/Patient's Family
5. Failure to Supervise Staff
6. Failure to Monitor Patient per Standard of Care
7. Delay in Reporting Abnormal Diagnostic Tests
8. Nursing Assessment Incomplete

9. Medication Administration Standard Not Followed
10. Equipment Use Not Consistent with Standard Procedure
11. Lab Specimen Not Handled According to Standard Procedure
12. Plan of Care Inconsistent With Nursing Assessment
13. Failure to Transcribe/Discontinue Orders According to Standard
14. Failure to Document Nursing Care

Results of Interviews With Field Experts

The results of the information obtained from the interviews with the risk management and quality assurance experts at the Office of The Surgeon General, The Virginia Insurance Reciprocal, and the U.S. Army Claims Service will be presented in a composite form to protect the origin of the adverse patient outcomes, claims settled, or claims filed.

Outcome Indicators

The adverse patient outcomes that were termed as critical outcome indicators of potentially compensable events by the field experts are as follows:

1. Fall
2. Medication/Transfusion/IV Related Injury
3. Injury During Patient Transport
4. Equipment Use Related Injury
5. Injury Resulting from Procedure/Practice Variance

6. Serious Patient Complaint (Determined by nursing staff)
7. AMA/Walkout

Process Indicators

The following process indicators were voiced as the factors most likely contributing to the adverse patient outcomes:

1. Communication Breakdown Between Staff
2. Failure to Follow Hospital Policy
3. Incomplete Discharge Instructions
4. Inaccurate/Untimely Reporting of Patient Status
5. Inaccurate/Untimely Reporting of Diagnostic Results
6. Failure to Monitor/Supervise Subordinates
7. Failure to Carry Out Physician Order
8. Improper Procedure
9. Failure to Monitor Patient

Implementation

Traditionally, the Report of Unusual Occurrence has been utilized as the form for reporting potential and adverse patient outcomes concerning nursing practice. The nurse's decision as to whether a particular incident or occurrence may warrant completion of a Report of Unusual Occurrence is primarily dependent upon the nature of the potential or adverse patient outcome. An abbreviated version of the most common adverse patient outcomes, indicated in the study results, can be utilized as a

outcome indicator screen to be incorporated into the occurrence report.

The Department of Nursing Administrative Policy regarding Reports of Unusual Occurrence should instruct the nursing staff to refer to the outcome screen to monitor and record potentially compensable events until such time that the screen can be incorporated into the actual incident/occurrence report. The ongoing outcome monitors should be screened for actual or potential outcomes related to:

1. Patient Fall/Patient Found on Floor
2. Nursing Practice Variance
3. Nursing Procedure Variance
4. Medication Error
5. Adverse Drug Reaction
6. Nosocomial Infection
7. Intraveneous Fluid Administration
8. AMA/Walkout
9. Equipment Failure
10. Serious Complaint Concerning Nursing Care
11. Blood Product Administration
12. Patient Transport (Intrahospital)
13. Other_____

Once the outcome monitor has been noted, it is necessary to evaluate which, if any, nursing process contributed to the outcome. The process monitors should be incorporated into the nurse's first report of the incident.

An early assessment of the situation will lend more validity to the analysis of process indicators and will assist the nursing chain of command and the risk manager in determining the litigious nature of the event. The process indicators to be evaluated are as follows:

1. Physician Order Not Followed
2. Nursing Order Not Followed
3. Physician Order Improperly Transcribed/Discontinued
4. Communication Breakdown-Staff
5. Communication Breakdown-Patient/Patient's Family
6. Failure to Supervise/Monitor Subordinates
7. Failure to Monitor Patient per Standard of Care
8. Nursing Assessment Incomplete
9. Plan of Care Inconsistent With Nursing Assessment
10. Failure to Document Nursing Care
11. Incomplete Discharge Instructions
12. Medication Administration Standard Not Followed
13. Equipment Use Inconsistent with Standard Procedure
14. Failure to Follow Hospital/Unit Policy
15. Inaccurate/Untimely Reporting of Patient Status
16. Inaccurate/Untimely Reporting of Diagnostic Results
17. Lab Specimen Not Handled According to Standard
18. None 19.

Other_____

More than one process may contribute to any outcome and should be indicated when checking off the screen.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Several conclusions have been derived from the results of this study:

1. The results of the analysis of unusual occurrences at DACH indicate that the nursing staff identifies medication related occurrences in 42% of the occurrence reports. Fall related occurrences are identified in 39% of the reports, and other occurrences make up 19% of the reports. Assuming that the majority of adverse patient outcomes are directly related to the quality of care provided, one might quickly conclude that a prevention program to eliminate falls and medication errors would greatly enhance the overall quality of nursing care provided. A closer examination of the processes that contribute to the fall and medication occurrences gives a more realistic picture for preventing future occurrences and ultimately improving the overall quality of care. In the past, falls, medication errors, and other unusual occurrences have been "treated" categorically. The results of this study indicate that the processes contributing to the outcomes are similar across all three categories. Examples of the most common processes contributing to all three outcome categories are: (1) failure to supervise/monitor subordinates; (2) failure to communicate to staff; (3) care plan inconsistent with nursing

assessment; and (4) failure to follow standard hospital/unit procedures. Treatment of the process rather than the outcome would provide a more effective means of risk prevention activities and ultimately enhance the quality of nursing care provided.

2. The results of the patient outcome/severity fell into one of four categories: (1) no injury/ inconsequential-59%; (2) patient inconvenience/ discontent-32%; (3) consequential (temporary)-5%; and not applicable/AMA-4%. The category patient inconvenience/ discontent was not an outcome/severity category included on any other occurrence reports screened by the author. Yet, the review of literature indicates that persons are most likely to sue someone if they are discontented with their care. Analyzing for patient inconvenience or discontent allows the nursing staff and risk manager another important component with which to analyze the potential for a compensable event. In the event of inconsequential injury, a discontented patient is more likely to file a claim, which, even though the claim may not be substantiated by evidence, still reflects as a processing cost for the government.

3. The evaluation of the standard of care/practice associated with each potential or adverse patient outcome indicated that the standard of care/practice was followed

for 25% of the outcomes. Following the standard of care/practice could have prevented 75% of the potential or adverse patient outcomes.

Recommendations

The recommendations are based on both the review of literature and the results of the management study.

1. The objective of any risk management program should include 100% identification of adverse patient outcomes. In order to complete and facilitate this objective, a screen for critical indicators to be monitored, as indicated in the study, should be included as part of the Report of Unusual Occurrence. Intensive education of the nursing staff will be required to ensure compliance with the program objective.

2. Other objectives of the risk management program should be to:

(1) Provide an efficient and effective reporting mechanism for early reporting and analysis of pertinent data concerning unintended or unexpected patient care outcomes.

(2) Incorporate the results of the process indicator screen into risk prevention activities.

(3) Focus the risk management program on education and prevention.

(4) Integrate the risk management process indicators into the quality assurance program.

(5) Yield meaningful data to facilitate quality of care improvement.

3. OTSG is drafting a new DA Form 4106 to replace the current Report of Unusual Occurrence. It is suggested that the new form require information regarding: (1) the staff most closely involved in the variance, not just witnesses; (2) the outcome/severity category reflecting patient inconvenience/ discontent; and (3) a section to report the possible process variance(s) according to the process screen resulting from this study. This additional information enhances the analysis and provides the relevant data necessary for tracking, trending, and prevention.

4. In order for the risk management system to be effective, the timeliness and accuracy of information regarding all pertinent events is essential. The exact events are easily forgotten and misinterpreted as time passes from the initial time of the occurrence. Several factors are recommended for improving the current reporting and data gathering system:

(1) Increase reporting by educating nurses on the types of occurrences to be monitored. This can be accomplished by conducting inservice training on the indicators used to monitor occurrences (refer to outcome indicators).

(2) Reinforce to the staff that all information is confidential.

(3) Do not require nursing care providers to duplicate information. The initial report form should be streamlined but include all information necessary to provide the data elements required to trend and analyze the occurrence. Requiring the nursing care providers to fill out a "sketchy" initial report and then follow up with an extensive analysis requires duplication of effort and information and prolongs the gathering and analysis of pertinent information.

(4) Many potential and adverse patient outcome are a result of a system problem rather than a single provider. The information gathered from the occurrence report must provide feedback to the system, including education, in order to reduce and prevent future occurrences. Constructive system feedback helps to eliminate the fear of punitive action associated with occurrence reporting.

5. Ultimately, a computer program with information queries and built-in decision and analysis trees will assist greatly in meeting the objectives of risk prevention, risk reduction, and quality patient care.

APPENDIX A

DEFINITIONS

Definitions

Unless otherwise indicated, the definitions are a result of the combined input of the author and Ann Brazil.

Adverse patient outcomes (APO)-An APO is a problem, incident, or occurrence that has caused harm to the patient.

Claim-A claim is a written formal demand for compensation, alleging negligence (unintentional tort) and liability.

Clinical Risk Management-This area of RM centers on deviation from professional clinical standards such as inadequate clinical assessment or judgement that poses a risk to the health, life, or well-being of a patient. The majority of malpractice cases are within the purview of clinical RM.

Concurrent Review-This is an indicator-based, on going review of the process, structure, and outcome at the time of rendering care or treatment to the patient.

Custodial Risk Management-This area of RM centers on structure and environmental problems which pose risk to the patient, family or staff. Custodial refers to the structural concerns of administration--incident reporting procedures, accident reporting, safety programs, and equipment maintenance. Traditionally, incident reports have been used to report custodial risk management circumstances such as patient slips and falls, medication errors, and lost valuables.

Indicator-This is a measurable objective dimension of the quality or appropriateness of patient care or service.

Incident (Occurrence)-An occurrence is any event that happens in the hospital or on the hospital premises that is not consistent with routine patient care or with the routine operation of the facility and that adversely affects or threatens to affect the health, life, or comfort of patients, visitors, or staff.

Negligence-Negligence is an unintentional tort, a wrongful act that does not involve breach of contract for which a civil suit can be brought. In order to recover for malpractice, the plaintiff must demonstrate all of the following elements: (1) the existence of a standard of care or duty owed, (2) the standard of care or duty was violated or not met, (3) the patient-plaintiff sustained an injury, and (4) the breach of the standard of care or duty was the proximate cause for the injury (Orlikoff and Vanagunas 1988, 13).

Nurse-related PCE-This is an PCE that occurs because of a deviation from the nursing standard of care.

Nursing Care Standards-Professional nurses are responsible for developing the standards of nursing practice in order to describe the minimal expectation of performance and to establish criteria for evaluation of performance and to establish criteria for evaluation of the effectiveness of the performance (1981, DA Pam 40-5, 1-1).

Nursing Practice-Nursing practice is defined as a service which gives the individuals, families and groups direct assistance to supplement, restore and maintain health, self-care abilities or adjust to their self-care limitations (AR 40-1, para 2-19a).

Potentially Compensable Event (PCE)-When an APO occurs because of a deviation from a established standard of practice where negligence is probable which may possibly require the facility to pay damages, then the APO becomes a potentially compensable event.

Preventive Risk Management-A preventive RM program centers on the philosophy of risk avoidance and risk prevention. Risk prevention occurs through early detection of potential adverse patient outcomes and active intervention to avoid potentially compensable events.

Quality Assurance-The JCAHO defines QA as a planned and systematic process for monitoring and evaluating the quality and appropriateness of patient care (Joint 1989).

Quality Control-Quality control is a numerical and quantifiable measurement of process and is not concerned with improvement of quality but rather a maintenance of quality. The resulting numerical evaluation either meets an established standard or

fails to meet the standard. Examples of quality checks are equipment calibrations and food temperature checks.

Report of unusual occurrence-This report is most often completed by the nursing staff and is a written report of an incident of harm or potential harm to patients, visitors, or staff.

Reactive Risk Management-This philosophy of RM is built on the premise that potentially compensable events are unavoidable and when they occur the RM process is set into motion. The PCE is evaluated and the facility prepares for a possible litigation or claim.

Risk Management-JCAHO defines standards which pertain to RM in the manual as those which address only those RM functions relating to clinical and administrative activities designed to identify, evaluate and reduce the risk of patient injury associated with care. The full scope of RM functions encompasses activities in health care organizations that are intended to conserve financial resources from loss. These functions include a broad range of administrative activities intended to reduce losses associated with patient, employee, or visitor injuries; property loss or damages; and other sources of potential organizational liability, Many of these activities are beyond the scope of JCAHO standards (Joint 1989).

Standard-A standard is established when an agreed upon and expected level of accomplishment is set forth as a measurement against which actual performance is compared. Deviation from an established standard where harm to a person has resulted may be cause for liability.

Standard of Practice-A standard of practice expresses a set of values about that practice. More specifically, the standard defines the practice and is used as a means to evaluate the practice.

APPENDIX B

REPORT OF UNUSUAL OCCURRENCE-DA FORM 4106

REPORT OF UNUSUAL OCCURRENCE

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

THRU: Commander MEDDAC
Chief, Department of Nursing

TO: Risk Manager

FROM: Ward, Unit, or Clinic_____
DeWitt Army Community Hospital
Fort Belvoir, Va 22060

REPORT IS HEREBY MADE OF THE UNUSUAL OCCURRENCE IN WHICH THIS PATIENT WAS CONCERNED: DATE_____HOUR_____

Date of Admission:_____Diagnosis:_____
HD:_____POD/PPD:_____Activity Level:_____
Physician notified:_____Time notified:_____Time responded:_____

DATE	HOUR	SIGNATURE AND TITLE OF REPORTING OFFICER

RECOMMENDED ACTION

DATE	HOUR	SIGNATURE AND TITLE OF OFFICER

ACTION TAKEN

DATE	HOUR	SIGNATURE AND TITLE OF OFFICER

PATIENT'S IDENTIFICATION

INSTRUCTIONS

Space at left is for mechanical imprinting. If typed or handwritten enter the following:

a. Patient's Name *(last, first, middle)*
b. Register number and ward number.
c. Name of hospital or other medical facility.

"REPRODUCED AT GOVERNMENT EXPENSE"

APPENDIX C

ANALYSIS OF REPORT OF UNUSUAL OCCURRENCE

DEPARTMENT OF NURSING
DEWITT ARMY COMMUNITY HOSPITAL
FORT BELVOIR, VA 22060

ANALYSIS OF UNUSUAL OCCURRENCE

DIRECTIONS: This form will be initiated at the same time the Report of Unusual Occurrence is completed. This will be done by the individual completing the DA Form 4106. The analysis should be stamped with the patient addressograph plate.

Parts I, V, VI and VII in all cases. Parts II, III, or IV whichever applies to the specific unusual occurrence being reported must also be completed.

PART-I

UNIT_____
PATIENT ACUITY CLASSIFICATION_____
UNIT ACUITY LEVEL_____ACUITY CAP_____
NUMBER OF STAFF ON DUTY AT THE TIME OF THE INCIDENT:
RN____LPN____91C___91B___91A___NA___OTHER_____
DATE AND TIME SUPERVISOR NOTIFIED OF THE INCIDENT_____
NAME_____CAME TO UNIT_____PHONED___ _____

IS THERE A PROCEDURE, PROTOCOL OR POLICY OUTLINING ACTION TO BE TAKEN IN A SITUATION LIKE THE ONE PROCEEDING THIS INCIDENT?

_____NO
SHOULD A PROCEDURE, PROTOCOL OR POLICY BE WRITTEN?
_____YES____NO

_____YES
DID YOU FOLLOW THE PROCEDURE, PROTOCOL OR POLICY?
_____YES

WHAT FACTORS MAY HAVE CONTRIBUTED TO THIS INCIDENT DESPITE YOUR COMPLIANCE WITH STANDARDS?
1._____
2._____
3._____

_____NO

WHAT FACTORS LED YOU TO DEVIATE FROM ESTABLISHED PRACTICE?
1._____
2._____
3._____

DID THE PATIENT SUSTAIN AN INJURY OR DID THE PATIENT'S CONDITION CHANGE AS A RESULT OF THE INCIDENT?

____YES
DESCRIBE:

HOW WOULD YOU CLASSIFY THIS INCIDENT?
____FAILED PRACTICE CRITERIA: CORRECTIVE ACTION IS REQUIRED. WHAT SHOULD BE DONE:

____FAILED CRITERIA WITHIN PRACTICE PARAMETERS: NO ACTION IS REQUIRED.

____UNPREDICTABLE EVENT: NO ACTION REQUIRED.

____NOT A NURSING EVENT: REFER TO APPROPRIATE AREA

PART II-FALLS

PATIENT ACTIVITY: BEDREST___BR WITH BRP___UP WITH ASSIST____UP AD LIB____
HOSPITAL PRIVILEGES_____
SAFETY LEVEL: LEVEL I____LEVEL II_____LEVEL III_____

APPROPRIATE NURSING PRECAUTIONS WRITTEN (NURSING ORDERS)?
YES____NO____

APPROPRIATE NURSING PRECAUTIONS TAKEN? YES___ NO___

RESTRAINING DEVICES? YES____NO___
____RESTRAINTS INDICATED_____ORDERED____NOT ORDERED
____ORDERED BUT NOT USED

WITNESSED FALL?
YES____NAME_____
DESCRIBE:

NO____
WHAT DID PATIENT IDENTIFY AS CAUSE OF THE FALL?

PART III-MEDICATION ERRORS

DRUG INVOLVED:
DATE OF ORIGINAL ORDER:
MEDICATION ORDER WAS: VERBAL___PHONE___WRITTEN___
CO-SIGNED: YES____ NO____N/A_____
ROUTE OF ADMINISTRATION: IV___IM___SQ___PO___OTHER_____
DOSE ADMINISTERED:
DOSE ORDERED:
NUMBER OF DOSES INVOLVED IN THE ERROR:
NUMBER OF HOURS IV INFUSED IN ERROR:

INDIVIDUAL(S) INVOLVED IN THE ERROR:

TRANSCRIPTION: VERIFICATION:

WAS A MEDICATION NURSE ASSIGNED? YES___NO___

ERROR INVOLVED THE WRONG: DRUG___DOSE___TIME___ROUTE___
PATIENT___

ERROR LABELED AS: TRANSCRIPTION___VERIFICATION___
ADMINISTRATION____

PART IV-OTHER UNUSUAL OCCURRENCES

TYPE OF OCCURRENCE:

PART V-ACTION TAKEN TO PREVENT FUTURE OCCURRENCES:

_____
SIGNATURE OF PERSON COMPLETING FORM

CONCUR____NONCONCUR____

_____
SIGNATURE OF HEAD NURSE DATE/TIME

PART VI-SUPERVISOR'S EVALUATION

CONCUR____NONCONCUR____
WAS INCIDENT RELATED TO STAFFING POSTURE? YES___NO___
COMMENT:

_____
SIGNATURE OF SECTION CHIEF DATE/TIME

Reference Bibliography

Accreditation Manual for Hospitals 1989. Chicago: Joint Commission on Accreditation of Healthcare Organizations.

American Nurses' Association, Inc. 26 October 1988. Newsletter. Kansas City: American Nurses' Association.

American Society of Healthcare Risk Management Legislative Task Force. 1987. "Model Language for a Healthcare Risk Management Program." February.

Baxter, C. E. 1980. "What Every Nurse Manager Should Know About Risk Management." Health Services Manager 13: 166-167.

"Background Statement: Proposed Standards For Risk Management-JCAHO Accreditation Manual for Hospitals." 1987. Chicago: Joint Commission on Accreditation of Healthcare Organizations.

Beck, B. et al. 1980. "Improving the Effectiveness of Generic Outcome Screening Criteria." Quality Review Bulletin January: 5.

Blake, Patricia. 1984. "Incident Investigation: A Complete Guide." Nursing Management 15: 36-41.

Brazil, Ann. 7 November 1988. Letter to the author.

Christensen, Lynne. 1988. "Quantifying Quality". Milestones. November: 6-7,15.

Department of Nursing Administrative Procedure B-6-Risk Management Plan. February 1988.

Department of Nursing Quality Assurance Program AR 40-XX (Final Draft). 19 January 1988.

Deruvo, Sharon, Major, U. S. Army Nurse Corps. May 1988. Personal interview.

Dodero, Frank C. 1988. "The Risk Management Decision-Making Process in a Health Care Setting." Perspectives in Healthcare Risk Management 8: 10-13.

Dzingleski, Lee. 1987. "The Basic Principles of Managing Risk." Journal of Quality Assurance Fall: 20-22.

Evans, Grace Aileen. 1988. "Nursing Liability Issues: Donaho." Perspectives in Healthcare Risk Management 8: 18.

Fiscina, Sal. 1985. "Malpractice Claims in the Military Health Care System: Survey of Contributing Factors, with Recommendations." Military Medicine 150: 511-523.

Fetzer, Brian C. 1988. "Early Investigation of Incidents Important in Malpractice Defense." Perspectives in Healthcare Risk Management 8: 5-9.

Guida, Robert A. 6 January 1989. Personal interview.

Innes, Else M. and William G. Turman. 1983. "Evaluation of Patient Falls." Quality Review Bulletin February: 30-35.

Janke, Mary. December 1988. Information Paper.

---. 6 January 1989. Personal interview.

---. 24 January 1989. Telephone interview.

Johnson, Josephine Goode. 27 September 1988. "Essential Elements of a Risk Management Program." 13th Annual Education Conference, National Association of Quality Assurance Professionals. Baltimore.

Joint Commission Risk Management Requirements for Quality Improvement. 1989. Chicago: Joint Commission on Accreditation of Health care Organizations.

Jones, M., and D. Dodge. 1980. "Training Model Helps Staff Eliminate Risks." Hospitals 16 Jan.: 167-168.

Kennedy, James Ron. 1984. "Risk Management For Allied Health Departments." Quality Review Bulletin June: 175-180.

Kessler, Paul R. and Eric D. Joseph. 1981. The Risk Management Primer Chicago: Care Communications, Inc.

Kraus, Gary P. 1986. Health Care Risk Management. Owings Mills, Maryland: Rynd Communications.

Lanham, Gary B. and James E. Orlikoff. 1981. "Full Coverage of Issues Reflects Importance of Risk Management." Hospitals 1 April: 165-168.

Liability Insurance & You. 1988. Kansas City: American Nurses Association.

Lynch, Philip. 24 January 1989. Telephone interview.

MEDDAC Regulation 40-108-Medical Services Risk Management Program. 30 April 1988.

Meyers, David. 26 January 1989. Lecture. JCAHO Risk Management Standards Conference. Alexandria, Virginia.

Northrop, Cynthia E. 1987. "Nursing Actions in Litigation." Quality Review Bulletin October: 343-348.

Orlikoff, M. A., and Gary B. Lanham. 1980. "Integrated Approach Improves Quality Assurance, Risk Management Activities." Hospitals September: 59-61.

Orlikoff, James E. and Audrone M. Vanagunas. 1988. Malpractice Prevention and Liability Control for Hospitals. 2nd ed. United States: American Hospital Publishing, Inc.

Orlikoff, James E. and Gary B. Lanham. 1981. "Why Risk Management and Quality Assurance Should Be Integrated." Hospitals 1 June: 54-55.

Patient Safety Manual. 1985. 2nd. ed. Chicago: American College of Surgeons.

Przykucki, Jean. 3 January 1989. Personal interview.

Risk Management Letter. 1986. Missouri Professional Liability Insurance Company and Providers Insurance Company: March/April.

Risk Management Plan, Department of Nursing Administrative Procedure-B-6. Brooke Army Medical Center, Fort Sam Houston, Texas, 1988.

Schroeder, Patricia S. and Regina M. Maibusch, eds. 1984. Nursing Quality Assurance. Rockville, Maryland: Aspen Systems Corporation.

Siebelt, Barbara. 26 September 1988. Lecture. "Managing Risk in the Emergency Department." 13th Annual

Education Conference, National Association of Quality Assurance Professionals. Baltimore.

Swartzbeck, Edna M. and W. Lloyd Milligan. 1982. "A Comparative Study of Hospital Incidents." Nursing Management 13: 39-43.

Trandel-Korenchuk, Darlene M. and Keith M. Trandel-Korenchuk. 1983. "Legal Forum." Nursing Administration Quarterly Spring: 75-80.

United States. 1987. Department of Health & Human Services. Report of the Task Force on Medical Liability and Malpractice. Washington, D.C.: August.

Vira, Carol Mancini. 1985. "Perspectives on Malpractice in the Military Health Care System." Military Medicine 150: 524-528.

Wan, Thomas T. H. and Ramesh K. Shukla. 1987. "Risk Management: Contextual and Organizational Correlates of The Quality of Hospital Nursing Care." Quality Review Bulletin 13: 61-64.

"Will the Nursing Shortage Lead to Liability Suits?". 1987. Hospitals 20 November: 64.

Williams, Timothy, Major(P), U. S. Army Nurse Corps. May 1988. Personal interview.

Zucker, Karen W. May 1988. Lecture. U.S. Army-Baylor Program in Health Administration. San Antonio.