

## 1: Risk Management in Nursing Homes | Hip Protectors

*Risk Management. Although health care providers are well trained and highly skilled, they're still human and can make mistakes. When they do, patient outcomes can be affected and "in a worst-case.*

Existing and future policy Legislation impacting the field of healthcare The hazards of not preparing for potential issues can have significant, long-term effects. Neglecting to have comprehensive risk management plans in place can compromise patient care, increase liability risks, and result in financial losses. Thus, potential risks have to be evaluated and measured in terms of their potential negative effects. Based on the risk assessment, an organization-specific management plan should be developed, implemented, and monitored.

Effective Patient Care Practices The development and implementation of healthcare risk management programs are based on extensive ongoing research. Risk managers must stay up-to-date on relevant information in their organization because research results could prove contradictory to presumptions that would otherwise shape risk management practices. For example, one study published by JAMA Internal Medicine revealed that increasing the hours of sleep residents in teaching hospitals received actually compromised patient safety.

Developing Risk Management Plans Reviewing other studies is one way to develop risk management programs. Based on information provided from other resources, managers should conduct organization-specific risk analyses to determine potential risks. The analysis should identify: What could possibly happen? How likely is something to happen measuring risk? How severe will the outcome be if something did happen? How can the likelihood something will happen be mitigated on the forefront and to what degree? What can be done to reduce the impact and to what degree? What is the potential for exposure or what cannot be proactively avoided? Using analysis results, risk managers can compare the likelihood of different adverse events along with their impacts and rank potential risks in terms of severity. Plans for mitigating risks and handling them appropriately can then be developed. Risk management plans also undergo quality assessments so the interventions and actions proposed are addressed as real potential issues. Once a strategy is in place, it is monitored and modified as needed.

Implementing Strategies for Patient Care As noted, risk management plans are specific to different healthcare facilities. While avoiding potential financial consequences is one concern, patient needs are generally the priority. In clinical studies, for example, Institutional Review Boards IRBs monitor proposed research plans before they are implemented to ensure minimal risk to human subjects. Plans for risk management must cover patient-specific risks and be well documented; they must also be accessible to those working with patients. Many patient risks can be reduced by adequately training physicians and staff, encouraging strong communication among staff-members, providing counseling services for those working with patients, and conducting competency assessments. Other risks posed to patient safety can be mitigated using patient-specific risk management strategies such as:

- Not filling expired prescriptions - Sending patients adequate notification of prescription expiration will support communication between patients and physicians thus reducing potential prescription medication abuse.
- Following up on missing test results - Patients who need to take additional medical tests following appointments may fail to do so, or the test results might get lost. Developing a plan to monitor receipt of test results guarantees the results are reviewed, so patients can then be consulted.
- Tracking missed appointments - Implementing a system to follow-up with patients who miss appointments but fail to reschedule is another proactive step in managing patient risks.
- Communicating with patients - Patients may have limited understanding of information received from physicians.
- Prevent falls and immobility - Making minor modifications to things like bed rails, bathtubs and toilets lacking grab bars, institutional lighting, and the conditions of the ground can significantly reduce the risks of such hazards.
- Sufficient record retention - Keeping patient records on file for an extended period of time or indefinitely is useful for monitoring patient health, even when patients are not actively seeking care.

Risk management protocol should also have plans in place for disposing of records in accordance with federal mandates. Comprehensive risk management plans in patient care can not only facilitate patient safety initiatives but also reduce readmissions. This is ultimately beneficial to overall patient satisfaction and other bottom-line priorities within healthcare organizations. The

## **RISK MANAGEMENT IN NURSING pdf**

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## 2: The Purpose of Risk Management in Healthcare

*Avoiding Liability Bulletin - June 15, The June 1 st bulletin discussed certification in the area of your nursing specialty as one example of risk management. You may be most familiar with risk management whenever you file an incident report pursuant to your facility's reporting policy.*

Delegation Restructuring nursing units has affected nursing and nurse managers in a huge way. A major effect of restructuring of nursing units is a reduction in the ratio of the registered nurse RN to the non-registered nurse non-RN staff. Although the number of RNs on units has decreased, the acuity levels of the patients and the responsibilities of the RN staff have increased. To meet the care needs of the more acutely ill patient and the increased responsibilities, RNs must delegate aspects of patient care to non-RN team members. RNs educated in the last 15 years have been educated in an environment where total patient care, primary nursing, and all-RN staff comprises the care delivery systems and staffing patterns. These delivery systems and staffing patterns are no longer the usual, and the use of Unlicensed Assistive Personnel UAPs and delegation to such personnel become a necessity if quality care is going to be delivered while using fewer resources and managing risk. Many nurses are not skilled in delegation. Principles of delegation are only recently being included in academic programs preparing professional nurses. Thus, many RNs must develop this management skill. Probably the most important issue relevant to appropriate delegation is effective communication skills for all members of the healthcare team. Effective communication skills include the ability to listen, to understand, to question when unclear, and to convey information in an accurate and timely manner. The lack of knowledge about appropriate delegation and the legal burdens added by delegation diminish the RNs willingness to delegate. Thus, many RNs continue to do tasks that should or must be delegated to non-RN team members if quality care is going to be delivered in a more economical fashion. The inability to delegate results in RNs spending time carrying out tasks such as patient hygiene, therefore preventing RNs from completing assignments and tasks that cannot be delegated. An RNs time is better spent developing a plan of care, consulting with other healthcare providers, patient teaching, and performing tasks that require higher level skills and knowledge. The appropriate use of delegation requires nurse managers to develop role descriptions that describe the scope of practice of every patient care team member. The RN staff must know what functions and activities can be delegated and what functions and activities cannot be delegated. Another responsibility for nurse managers, in relation to delegation, is to ensure that RNs know how to: At times, nursing leadership may need to seek legal opinions regarding delegation of activities, including what can and cannot be delegated. The nurse manager is also responsible for ensuring that the non-RN staff are competent in taking on the delegated tasks. That is, the nurse manager must ensure that staff are educated about the tasks to be delegated and have the opportunity to practice the skills with supervision. Practice with appropriate feedback is essential for learning and proficiency to occur. Then, the person to whom a task was delegated must periodically report back on tasks delegated and receive adequate supervision and oversight. Staffing Staffing and maintaining appropriate staffing levels on nursing units remain the greatest challenge facing nurse managers and one of the most important challenges in risk management. Staffing must provide the appropriate mix and numbers of RN and non-RN staff for every shift every day. There are multiple proposed models to use as a framework to establish the staffing requirements on a particular unit. Regardless of the model used, there are several facts that can negatively affect any plan and create risks for the nurse manager. Steinwachs reported that, the most significant factor affecting RN staff productivity is the turnover rate. An increased turnover rate adds significant unplanned expenses for a unit and decreases productivity of the remaining RN and non-RN staff. A couple of significant effects of these solutions are that temporary and agency RNs spend more time performing tasks that should be delegated, and the regular RNs spend more time supervising the increasing number of non-RN staff members. RNs from outside the unit are also not as productive as the regular unit RNs, and RNs assigned permanently to the unit may spend significant time supervising temporary and agency RNs. When a facility implements restructuring and redesign, nurse managers must be involved, especially if any changes directly involve the nursing unit.

Restructuring and redesign usually mean more is going to be expected from everyone. During the actual restructuring and redesign process, nurse managers must be especially diligent to recognizing potential risk issues. As job descriptions expand to include new responsibilities for each member of the nursing care team, nurse managers must ensure that there are no violations of the Nurse Practice Act which guides the practice of professional nursing in that institution and that the RN and non-RN staff members receive the appropriate education to achieve competency in implementing the new responsibilities. Ongoing documentation of the specific competencies of each staff member must be maintained by the nurse manager. Units having nursing care hours exceeding patient acuity may be a source of nursing staff for units with higher census and acuity than usual. Such personnel must know the policies of the institution, applicable procedures and guidelines unique to the facility including risk management practices. Temporary staff must have a thorough orientation to the work setting and ongoing oversight by the nurse manager. These practices are critical to managing risk, providing quality care, and meeting requirements of accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations JCAHO. Staff Competencies Ensuring clinical competency of staff is an ongoing activity and another key component of risk management. Nursing leaders must identify the universal staff competencies for all nursing personnel in an organization as well as unit-specific staff competencies. Staff must have knowledge of the competencies required for their jobs and successfully pass any clinical competency tests before being assigned responsibility for clinical activities on a unit. Time periods between competency checks must be determined, and appropriate documentation of the competencies must be maintained. As discussed in the preceding section, the use of UAPs, the implementation of appropriate delegation, the reassignment of staff across several units and the use of agency staff all require that nurse managers focus energy on implementing mechanisms for validating staff competency and implementing staff development activities that allow for reviewing, maintaining, and updating skills. New technologies being introduced into healthcare and on nursing units and the increasing complexity of patients also give impetus to the need for on-going mechanisms for development and documentation of clinical competencies. Nursing staff must have access to resources 24 hours a day to supplement any skill sets that they do not use on a routine basis. Nurse managers must ensure that staff have time to attend review classes and to demonstrate proficiency in newly-acquired or updated skills. If outside nursing agency personnel are used within a facility, the healthcare institution and the agency must have an agreement about what competencies the nursing personnel must bring to the assignment, who is responsible for evaluating the competencies, and who will make sure that personnel have the time and the opportunity to attend necessary review classes. However, maintenance of and documentation for such a system while controlling costs is a challenge. A system of documentation that communicates care provided and patient status is essential for the following:

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*Healthcare risk managers are in high demand, and employers seek healthcare risk management nurses to minimize liabilities and ensure quality patient care.*

The risk management plan evaluates identified risks and outlines mitigation actions. A risk management plan should be periodically updated and expanded throughout the life cycle of the project, as the project increases in complexity and risks become more defined. Risk management ideally takes a project throughout the phases of risk identification, risk assessment and risk resolution. With the advancement in project management studies and techniques, risk management has taken a main place in the project life cycle ; in most cases at the outset of the project itself. The risk management plan should be a part of your overall project plan. The risk plan for smaller projects can be as simple as a risk management matrix. Complex projects require more thorough risk analysis and planning. For each risk outlined in the risk matrix you will want to create a thorough analysis for each. The main goal of creating the risk matrix is to prioritize your risks. You will never be able to eliminate all risk, but you can prioritize and document risks to attempt to mitigate or eliminate them. The risk management matrix will document the following items: What risks can be associated with this project? Will the risks affect the schedule, resourcing or budget? Probability - the table should contain a probability of the risk occurring. This can be a percentage or a number. Impact - what is the impact to the project if the risk should occur? Build a scale appropriate for the project - smaller projects can use a simple impact of minimal to major whereas larger projects may want a more formal scale. Higher priority items should be mitigated and planned for before lower priority items. Mitigation Response - a brief overview of mitigation steps to eliminate or reduce the risk. The columns will be named after each of the five items in the previous section. The first column can simply be an ID column.

### 4: Risk Management Nurse Jobs, Employment | [www.enganchecubano.com](http://www.enganchecubano.com)

*The Role of the Nurse Manager in Maintaining Quality and Managing Risk Helen A. Schaag, MSN, MA, RN. Maintaining quality while eliminating risk is a major challenge facing everyone in the healthcare delivery system today.*

Processes that are inefficient and variable, changing case mix of patients, health insurance, differences in provider education and experience, and numerous other factors contribute to the complexity of health care. The goals of measuring health care quality are to determine the effects of health care on desired outcomes and to assess the degree to which health care adheres to processes based on scientific evidence or agreed to by professional consensus and is consistent with patient preferences. Because errors are caused by system or process failures, it is important to adopt various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. Each of these techniques involves assessing performance and using findings to inform change. This chapter will discuss strategies and tools for quality improvement—including failure modes and effects analysis, Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis—that have been used to improve the quality and safety of health care. The rationale for measuring quality improvement is the belief that good performance reflects good-quality practice, and that comparing performance among providers and organizations will encourage better performance. In the past few years, there has been a surge in measuring and reporting the performance of health care systems and processes. One of the challenges in using measures in health care is the attribution variability associated with high-level cognitive reasoning, discretionary decisionmaking, problem-solving, and experiential knowledge. These measures are generally developed through a process including an assessment of the scientific strength of the evidence found in peer-reviewed literature, evaluating the validity and reliability of the measures and sources of data, determining how best to use the measure. Benchmarking in health care is defined as the continual and collaborative discipline of measuring and comparing the results of key work processes with those of the best performers in evaluating organizational performance. There are two types of benchmarking that can be used to evaluate patient safety and quality performance. Internal benchmarking is used to identify best practices within an organization, to compare best practices within the organization, and to compare current practice over time. The information and data can be plotted on a control chart with statistically derived upper and lower control limits. However, using only internal benchmarking does not necessarily represent the best practices elsewhere. Competitive or external benchmarking involves using comparative data between organizations to judge performance and identify improvements that have proven to be successful in other organizations. Quality Improvement Strategies More than 40 years ago, Donabedian<sup>27</sup> proposed measuring the quality of health care by observing its structure, processes, and outcomes. Structure measures assess the accessibility, availability, and quality of resources, such as health insurance, bed capacity of a hospital, and number of nurses with advanced training. Process measures assess the delivery of health care services by clinicians and providers, such as using guidelines for care of diabetic patients. Outcome measures indicate the final result of health care and can be influenced by environmental and behavioral factors. Examples include mortality, patient satisfaction, and improved health status. Twenty years later, health care leaders borrowed techniques from the work of Deming<sup>28</sup> in rebuilding the manufacturing businesses of post-World War II Japan. The TQM model is an organizational approach involving organizational management, teamwork, defined processes, systems thinking, and change to create an environment for improvement. This approach incorporated the view that the entire organization must be committed to quality and improvement to achieve the best results. CQI has been used as a means to develop clinical practice<sup>30</sup> and is based on the principle that there is an opportunity for improvement in every process and on every occasion. CPI, an approach led by clinicians that attempts a comprehensive understanding of the complexity of health care delivery, uses a team, determines a purpose, collects data, assesses findings, and then translates those findings into practice changes. From these models, management and clinician commitment and involvement have been found to be essential for the successful implementation of change. Shojania and colleagues<sup>38</sup> developed a taxonomy of quality improvement strategies see Table 1, which

infers that the choice of the quality improvement strategy and methodology is dependent upon the nature of the quality improvement project. The lack of scientific health services literature has inhibited the acceptance of quality improvement methods in health care, 43 , 44 but new rigorous studies are emerging. It has been asserted that a quality improvement project can be considered more like research when it involves a change in practice, affects patients and assesses their outcomes, employs randomization or blinding, and exposes patients to additional risks or burdensâ€”all in an effort towards generalizability. This is a method that has been widely used by the Institute for Healthcare Improvement for rapid cycle improvement. Langley and colleagues 51 proposed three questions before using the PDSA cycles: The PDSA cycle starts with determining the nature and scope of the problem, what changes can and should be made, a plan for a specific change, who should be involved, what should be measured to understand the impact of change, and where the strategy will be targeted. Change is then implemented and data and information are collected. Results from the implementation study are assessed and interpreted by reviewing several key measurements that indicate success or failure. Lastly, action is taken on the results by implementing the change or beginning the process again. This method is applicable to preanalytic and postanalytic processes a. This method is suitable for analytic processes in which the precision and accuracy can be determined by experimental procedures. One component of Six Sigma uses a five-phased process that is structured, disciplined, and rigorous, known as the define, measure, analyze, improve, and control DMAIC approach. Next, continuous total quality performance standards are selected, performance objectives are defined, and sources of variability are defined. As the new project is implemented, data are collected to assess how well changes improved the process. To support this analysis, validated measures are developed to determine the capability of the new process. This methodology overlaps with the Six Sigma methodology, but differs in that Lean is driven by the identification of customer needs and aims to improve processes by removing activities that are non-value-added a. Steps in the Lean methodology involve maximizing value-added activities in the best possible sequence to enable continuous operations. Physicians, nurses, technicians, and managers are increasing the effectiveness of patient care and decreasing costs in pathology laboratories, pharmacies, 59â€”61 and blood banks 61 by applying the same principles used in the Toyota Production System. Two reviews of projects using Toyota Production System methods reported that health care organizations improved patient safety and the quality of health care by systematically defining the problem; using root-cause analysis; then setting goals, removing ambiguity and workarounds, and clarifying responsibilities. When it came to processes, team members in these projects developed action plans that improved, simplified, and redesigned work processes. Root Cause Analysis Root cause analysis RCA , used extensively in engineering 62 and similar to critical incident technique, 63 is a formalized investigation and problem-solving approach focused on identifying and understanding the underlying causes of an event as well as potential events that were intercepted. The Joint Commission requires RCA to be performed in response to all sentinel events and expects, based on the results of the RCA, the organization to develop and implement an action plan consisting of improvements designed to reduce future risk of events and to monitor the effectiveness of those improvements. Those involved in the investigation ask a series of key questions, including what happened, why it happened, what were the most proximate factors causing it to happen, why those factors occurred, and what systems and processes underlie those proximate factors. Answers to these questions help identify ineffective safety barriers and causes of problems so similar problems can be prevented in the future. Often, it is important to also consider events that occurred immediately prior to the event in question because other remote factors may have contributed. The notion has been put forth that it is a truly rare event for errors to be associated with irresponsibility, personal neglect, or intention, 71 a notion supported by the IOM. Even the majority of individual factors can be addressed through education, training, and installing forcing functions that make errors difficult to commit. Failure Modes and Effects Analysis Errors will inevitably occur, and the times when errors occur cannot be predicted. In health care, FMEA focuses on the system of care and uses a multidisciplinary team to evaluate a process from a quality improvement perspective. This method can be used to evaluate alternative processes or procedures as well as to monitor change over time. To monitor change over time, well-defined measures are needed that can provide objective information of the effectiveness of a process. In , the Joint Commission mandated that accredited health care

providers conduct proactive risk management activities that identify and predict system weaknesses and adopt changes to minimize patient harm on one or two high-priority topics a year. In conducting a hazard analysis, it is important to list all possible and potential failure modes for each of the processes, to determine whether the failure modes warrant further action, and to list all causes for each failure mode when the decision is to proceed further. After the hazard analysis, it is important to consider the actions needed to be taken and outcome measures to assess, including describing what will be eliminated or controlled and who will have responsibility for each new action. Several common themes emerged: Substantial and strong leadership support, 80% involvement, 81, 84 consistent commitment to continuous quality improvement, 85, 86 and visibility, 87 both in writing and physically, 86 were important in making significant changes. Substantial commitment from hospital boards was also found to be necessary. Yet adopting a nonpunitive culture of change took time, 61, 90 even to the extent that the legal department in one hospital was engaged in the process to turn the focus to systems, not individual-specific issues. There were many advantages to basing the work of the quality improvement strategies on the teamwork of multidisciplinary teams that would review data and lead change. Team leaders that emphasized efforts offline to help build and improve relationships were found to be necessary for team success. The multidisciplinary structure of teams allowed members to identify each step from their own professional practice perspective, anticipate and overcome potential barriers, allowed the generation of diverse ideas, and allowed for good discussion and deliberations, which together ultimately promoted team building. Teams were seen as being able to increase the scope of knowledge, improve communication across disciplines, and facilitate learning about the problem. Group work was seen as difficult for some and time consuming, and problems arose when everyone wanted their way, 97 which delayed convergence toward a consensus on actions. Team members needed to learn how to work with a group and deal with group dynamics, confronting peers, conflict resolution, and addressing behaviors that are detrimental. As suggested by Berwick, the leaders of the quality improvement initiatives in this review found that successful initiatives needed to simplify; 96, standardize; stratify to determine effects; improve auditory communication patterns; support communication against the authority gradient; 96 use defaults properly; automate cautiously; 96 use affordance and natural mapping e. Several initiatives standardized medication ordering and administration protocols, 78, 87, , , , , realizing improvements in patient outcomes, nurse efficiency, and effectiveness. Related to simplification and standardization is the potential benefit of using information technology to implement checks, defaults, and automation to improve quality and reduce errors, in large part to embedding forcing functions to remove the possibility of errors. Often workflow and procedures needed to be revised to keep pace with technology. Using and analyzing data was viewed as critical, yet some team members and staff may have benefited from education on how to effectively analyze and display findings. Repeated measurements were found to be useful for monitoring progress, but only when there was a clear metric for measuring the degree of success. It was also purported that the costs associated with change will be recouped either in return on investment or in reduced patient risk and thus reduced liability costs. There were several examples of this. Two initiatives that targeted pain management found that educating staff on pain management guidelines and protocols for improving chronic pain assessment and management improved staff understanding, assessment and documentation, patient and family satisfaction, and pain management. Lack of time and resources made it difficult to implement the initiative well. Influential factors attributed to the success of the initiatives were effecting practice changes that could be easily used at the bedside; 82 using simple communication strategies; 88 maximizing project visibility, which could sustain the momentum for change; establishing a culture of safety; and strengthening the organizational and technological infrastructure. Collaboratives could also be a vehicle for encouraging the use of and learning from evidence-based practice and rapid-cycle improvement as well as identifying and gaining consensus on potentially better practices. Quality tools used to define and assess problems with health care were seen as being helpful in prioritizing quality and safety problems 99 and focusing on systems, 98 not individuals. The various tools were used to address errors and growing costs 88 and to change provider practices. These are discussed as follows: The rapid-cycle aspect of PDSA began with piloting a single new process, followed by examining results and responding to what was learned by problem-solving and making adjustments, after

which the next PDSA cycle would be initiated. The majority of quality improvement efforts using PDSA found greater success using a series of small and rapid cycles to achieve the goals for the intervention, because implementing the initiative gradually allowed the team to make changes early in the process and not get distracted or sidetracked by every detail and too many unknowns. HFEMA was viewed as a valid tool for proactive analysis in hospitals, facilitating a very thorough analysis of vulnerabilities. The strength of the following practice implications is associated with the methodological rigor and generalizability of these strategies and projects: The importance of having strong leadership commitment and support cannot be overstated. Leadership needs to empower staff, be actively involved, and continuously drive quality improvement. Without the commitment and support of senior-level leadership, even the best intended projects are at great risk of not being successful. Champions of the quality initiative and quality improvement need to be throughout the organization, but especially in leadership positions and on the team. A culture of safety and improvement that rewards improvement and is driven to improve quality is important. The culture is needed to support a quality infrastructure that has the resources and human capital required for successfully improving quality. Quality improvement teams need to have the right stakeholders involved. Due to the complexity of health care, multidisciplinary teams and strategies are essential. Quality improvement teams and stakeholders need to understand the problem and root causes. There must be a consensus on the definition of the problem.

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In this chapter the authors will discuss the ethics of managing risk from two perspectives: Organization-wide View Risk management is broad in scope. According to Guido , pp. The objective of risk management is to identify and eliminate potential hazards before anyone is harmed or disabled, and to develop and evaluate policies and procedures that provide guidelines for the institution and direct practice. These activities are, of course, helpful in protecting an institution from legal liability and potential financial disaster but more importantly, they serve to protect the public as well as healthcare personnel See American Society for Healthcare Risk Management Code of Professional Responsibility, Appendix II. The relationship of risk management to financial and legal liability is significant. Historically, the focus of risk management has been on financial liability awareness. According to Monagle , p. They further described risk management as a planned program of loss prevention and liability control, but emphasized the importance of detection, education, and intervention. It is the "self-protective" business focus of risk management that may provoke questions as to whether or not risk management is ethical. However, the issue is far broader than "simple" protection of institutions. The maintenance of viable, accountable healthcare service institutions is crucial to the health of the populace - a "greater good," in ethics terms, than not having such resources available. The moral integrity of the risk management process and the individuals involved are critical. Integrity is broadly defined as a state of being whole. Moral integrity encompasses a coherence and consistency within a set of ethical principles and commitments so that these principles and commitments are upheld for the right reasons, even when challenged McFall, ; Rushton, Ethical principles and virtues that ought to be part of a risk management process include respect for autonomy self-determination , non-maleficence do no harm , beneficence act in the best interest of , justice fairness , veracity truthfulness, honesty , confidentiality, and fidelity promise keeping, loyalty. The principle of veracity requires particular discussion in relation to risk management because of its association with the "duty to disclose. Beauchamp and Childress provide an in-depth discussion of veracity and the duty to disclose. In brief, veracity, or truthfulness, is based on the principle of respect for others, and it is clear that adherence to the rules of veracity is essential in fostering trust. Lying and inadequate disclosure clearly violate respect for others and impede a trusting relationship. However, veracity, like informed consent, is a concept that is not absolute because of its inherent nature: Valid questions are frequently asked about the appropriate quantity and quality of information to be disclosed to individuals or the public-at-large in any given situation. While the intention is not to be deceptive, but rather to avoid alarming others, any withholding of information may be perceived as violating a duty to disclose. Legal advice is recommended when such questions arise, especially when risks are recognized. Medical Errors Medical errors are a common source of recognized risks, and concern about them is evident in current literature. According to Leape, research has shown that while "errors are almost always made by individuals, error results from defects in the systems in which we work" , p. Unfortunately, as a result of underreporting, institutions have no reliable indicator of the severity of error problems. Thus, underreporting hinders the process of system improvement for system failures and is an issue of importance for nurses as they take control of risk in their practice. For example, a nurse in an emergency situation gives the patient ten times the ordered dose of lidocaine IV push bolus to treat an arrhythmia. If this had not been reported, the facility would have lost the opportunity to discover that the lidocaine for IV bolus administration and the lidocaine for dilution in an IV drip were stored next to each other in a drawer both in similar syringe-type containers. The individual nurse made the error, but the storage "system" made the effort more likely to occur. Issues of veracity and disclosure in the case include many unanswered questions. Who should tell them? How much information should they be given? It is generally agreed that when errors require treatment modifications to reverse or prevent adverse outcomes, the patient must be told. Patients have a right to be involved in treatment decisions autonomy and to know that they will not incur charges associated with treatment caused by error

justice. Usually the professional who can discuss treatment options with the patient should be involved in disclosing the error. Risk management staff or legal counsel should be consulted for assistance with the disclosure. A more difficult situation arises when no harm comes from the error. Friedson addressed whether patients should always be informed, or if there are situations where nondisclosure may be therapeutically beneficial and, therefore, morally justified. One must consider whose needs are being served by non-disclosure—the needs of the professional or the patient? Making a decision between worrying families needlessly and enriching caregiver and patient relationships by using full disclosure requires professional judgment. Thus, when one chooses to limit or avoid disclosure, one must make that decision based on the benefit or harm to the individual, as well as on the issue of maintaining societal trust which is important in minimizing liability. Clearly, the issue is far from settled. While it may be that the only way to ensure accurate reporting of errors is to provide protection from disclosure such as through peer-review activities, instead of by embracing the "train and blame" paradigm, this approach invokes questions about full-disclosure. But in the interest of improving organizational integrity and subsequently patient care, risk management must strive to address an error as a system failure versus a personal failure and support efforts to track, establish trends, and reduce error. Regulations, Standards, Policies, and Procedures Regulations Standards, policies, and procedures that influence the individual practice of nursing, as well as institutions, are often designed to uphold ethics-based precepts. However, it is essential that nurses distinguish between regulations and standards that are legally binding and policies and procedures that are recognized as being guidelines that allow for professional interpretation in individual situations. As managed care expands and the potential for computer-based statistical tracking is realized, standards of practice are rapidly evolving. Some are based on sound research, while others evolve from less credible sources, but they are increasingly used as benchmarks to measure provider failure Furrow, To control their own risk, nurses must remain alert and aware of the legitimacy of practice guidelines and standards that are being thrust upon them. Professional judgment is essential to protect the best interests of individual patients as well as the general public. One source of widening and increasingly explicit formal expectations for ethical conduct within a healthcare service environment is the Joint Commission on Accreditation of Healthcare Organizations JCAHO. JCAHO has recently incorporated standards for ethical considerations associated with managerial and business aspects of organizations, in addition to existing specific standards related to ethical issues in direct patient care Spencer, Nurses across the country are currently involved in interpreting how these new regulations influence their practice, especially in light of the burgeoning number of managed care organizations. Institutions are beginning to hire compliance officers to ensure that regulations and standards are being followed. Compliance officers are well known to the defense industry and evolved amid stories of the federal government paying hundreds of dollars for a hammer. They became a necessity for the healthcare industry when the Department of Justice announced that stopping fraud and abuse would be one of its main goals. The federal government committed billions of dollars to the effort. Compliance officers, however, will not only be occupied with Medicare billing requirements. They will undoubtedly be responsible for assuring compliance with the myriad of regulations and standards affecting health care. Compliance officers will not be able to work in a vacuum. Compliance committees with institution-wide representation will often be one method used to ensure that the compliance plan is followed. Staff will need to be educated regarding the plan and encouraged to report suspected violations. Institutions would be better served having no plan than a plan that is not followed. Lockheed Martin Corporation adopted a code of ethics that included the following questions that may provide guidance for nurses: What would I tell my child to do? How will it look in the newspaper? Will I sleep soundly tonight? Specialty organizations are also potential information sources, as are institutional ethics committees. Selected Areas of Focus Managed Care With the increase in managed care organizations, nurses are finding themselves exposed to goals and regulations that appear to be business-focused rather than patient-focused. Concern has been expressed that the quality of nursing care is being jeopardized to save costs. The ethical principle of justice and how we can best allocate our scarce resources is the underlying ethical issue of concern as managed care grows. There are opportunities as well as challenges and concerns as we as a society restructure the healthcare delivery system, ideally in a manner that will promote a "greater good.

Quality of nursing care is related to the ethical principles of beneficence and nonmaleficence: Reduction in professional nurse staffing, substituting unlicensed assistive personnel UAP for professional nurses, and requiring nurses to provide patient care in specialty areas with which they are not familiar are some of the concerns expressed by nurses across the country. Balancing the benefits and burdens of such demands can be difficult for individual nurses and institutions alike; good communication, effective reasoning skills, and professional judgment are needed to reach solutions that uphold the ethical responsibilities of all involved. Various professional organizations provide information and guidelines for dealing with issues of quality of care. Issues of veracity have arisen related to managed care organizations limiting of information e. Additionally, a conflict of interest can occur if healthcare professionals have a financial stake in the profit a company might make limiting treatment options might save money and increase company profit. Legislation and policies are being developed and implemented to prevent "gag" orders and protect against conflict of interest, and managed care organizations and consortiums are developing their own codes of ethics. An understanding of professional integrity and moral compromise is of value when a nurse encounters ethical dilemmas related to managed care or other practice issues and wishes to take control of his or her own risk. Winslow and Winslow suggested that compromise is compatible with moral integrity if a number of conditions are met and that nurses are in a position uniquely suited to leadership in fostering an environment that makes compromise with integrity possible. The conditions delineated by Winslow and Winslow include sharing a moral language, mutual respect on the part of those who differ, acknowledgment of factual and moral complexities, and recognition of limits to compromise. Rushton expanded upon these conditions and applied them to a clinical situation. There are ethical and legal concerns related to the protection of this information. Accrediting organizations such as the JCAHO hold nurses and others in leadership positions accountable for the integrity of stored information, and healthcare organizations are required to demonstrate a balance between security levels and ease of access to electronic information Styffe, Styffe differentiated between the functions of privacy, confidentiality, and security in protecting electronic information. Privacy refers to the right of individuals to determine when, how, and to what extent information is transmitted the patient is the primary stakeholder. Confidentiality refers to trust that the information shared will be respected and used only for the purpose disclosed all healthcare providers and organizations are responsible for confidentiality. Security refers to the protection of information from accidental or intentional access by unauthorized people, including change or destruction of the information, and is a part of the system itself. Gostin and colleagues reviewed and commented on the law of health information privacy. State and federal legislation is being developed and revised as information technology evolves and needs for protection are recognized. Nurses need to maintain an awareness of potential changes and rely on the workplace and other professional resources to keep abreast of specific evolving guidelines. Woodward , Bates , and others Symposium: According to Bates p. Nurses are likely to be involved and should be at all levels, but their input is especially needed at the individual institutional level as integrated delivery systems are initiated. Their sensitivity to privacy and confidentiality as it directly affects individual patients is a vital perspective. The ANA has developed three position statements related to electronic information:

### 6: Patient Safety, Risk, and Quality

*Most employers prefer nurse risk managers to have earned a bachelor's degree in nursing, though some may require a master's degree. Typically, a prior managerial position, legal and management.*

Health care risk management is a diverse profession in a dynamic and evolving health care industry. Health care risk managers hold a wide variety of titles and work in a cross-section of organizations. The truth is that we do operate in wide range of settings and organizations. But, we have many common professional attributes. We are nearly 6, members strong. So, who are health care risk managers? Health care risk managers come from a variety of professional and educational backgrounds. We have an interest in the broad-based discipline of health care risk management because we enjoy working to positively influence the health care industry, and contribute to the delivery of safe and trusted health care. We are men and women across the country in every state, and we serve large and small communities and organizations. What do health care risk managers do? By nature, we are flexible professionals and we are an integral part of delivering safe and trusted health care. Specifically, some examples of what we do include risk financing; event and incident management; clinical, financial, legal and general business aspects; the psychological and human factors of health care; statistical analysis; insurance; and claims management. However, our job descriptions are unique to the organizations in which we are employed. How can I become a health care risk manager? There is not a direct, singular route to becoming a health care risk manager. However, there are other backgrounds that health care risk managers come from as well. These include areas such as pharmaceuticals, biometrics, health law and others. One can be trained to be a health care risk manager through education, practical experience or both. Where are the jobs? Healthcare risk managers find employment in a wide variety of organizations such as hospitals, insurance carriers and brokers, health care organizations, consulting firms, long term care, ambulatory care, hospice, office surgeries, physician practices, pharmaceuticals, governmental agencies, independent urgent care centers, and other organizations that support the health care continuum. Why might I choose health care risk management as a career? You might consider the health care risk management field if you enjoy challenging work, a diverse set of responsibilities, continual learning, are open to ongoing change, and can demonstrate an interest in and understanding of health care risk management job attributes.

### 7: Risk Management for Nursing Homes and Independent Living Facilities

*Risk Management For Nursing Homes: Part 1. The senior living industry represents unique risks and liabilities unlike any other industry. Residents in nursing homes require around the clock care.*

Writing in about how rural hospitals are "doing more with less," a hospital risk manager and quality improvement professional described how risk management and quality assurance, as the functions was previously called, were using a collaborative approach to share data to enhance patient care. ASHRM "Different" In the past, a typical organizational chart might have had risk management reporting to a chief operating officer or a legal department and the quality and patient safety activities reporting to a chief medical officer. The organization hierarchy did not allow for any coordination of risk and quality functions, nor did it allow for sharing of data. The following hypothetical scenario illustrates how separate reporting structures and segregated activities for risk and quality can limit their success. Risk management could be examining a particular issue—“an increase in emergency department ED claims, for example”—without knowing that quality has begun a process to improve the discharge process. Some physicians may even be writing their own instructions, increasing the variability in discharge instructions provided to patients. The problems cannot be fully solved without input from everyone involved in the discharge process. Risk management did not emerge as a distinct profession in healthcare, primarily in the hospital environment, until the mids, when the number of malpractice claims against physicians and hospitals increased dramatically and settlements and judgments skyrocketed. The result was a lack of affordable malpractice and hospital liability insurance. In response, healthcare organizations created risk-pooling programs, such as hospital-owned captive insurance companies. Many of the new risk financing programs offered reduced premiums to hospitals that had a risk management program because the practice was expected to reduce claims. In , the American Hospital Association also encouraged hospitals to implement risk management programs as a solution to malpractice problems, calling risk management the "science for the identification, evaluation, and treatment of the risk of financial loss" Dankmyer and Groves; Holloway and Sax. Rather than focusing on the underlying system design faults that contributed to the error, the risk manager would focus on defense of the claim or the lawsuit that might follow. The risk manager accomplished this by documenting the event, meeting with staff involved to learn about the event, and counseling those involved in the incident to refrain from discussing the information with others. Discussions with patients involved in an adverse event were often "too brief and vague" Kuhn and Youngberg. Building a Safer Health System "changed the conversation" about medical errors by saying that bad systems, not bad people, lead to the majority of errors and injuries in healthcare Leape and Berwick. The report called for better analysis of errors and near misses in order to design changes into healthcare delivery to prevent errors. The patient safety movement encouraged risk management professionals to expand their focus to include a proactive, preventive approach and to use a systems approach to understanding errors. Rather than limiting their focus to managing the aftermath of an event, "risk management must be integrated into the system and processes of healthcare work" Youngberg "Meeting". The standards helped to bring attention to the need for creating a culture of safety that promotes transparency and a willingness to learn from mistakes in order to enhance patient safety and prevent similar mistakes from recurring. Starting in edition, the Joint Commission devotes a chapter of its accreditation manual to patient safety systems. While the chapter does not establish new requirements for patient safety, it describes how facilities can use existing accreditation standards to improve patient safety Joint Commission "Patient". Risk manager of today. An earlier survey conducted in did not even list patient safety as a possible risk management function. Now, healthcare risk managers seeking designation from the American Hospital Association AHA as a certified professional in healthcare risk management must demonstrate an understanding of the combined topics of patient safety and clinical risk management in addition to four other areas. Top Activities for Risk Managers for a list of the principal activities identified by survey respondents as either their primary responsibility or one in which they have significant involvement. In addition to the traditional areas of risk familiar to healthcare risk managers i. For example, the organization must consider the risks of new business ventures, ranging from the acquisition

of a physician practice to the decision to provide an emerging technology. For many risk managers, their involvement in patient safety and quality is a portion of their workload in an enterprise-wide approach to risk. Better coordination of their safety and quality activities with their colleagues who are also involved in these areas can help both achieve better results, as well as enable the risk manager to devote time to address other priorities. Hospital committees comprising medical staff leaders and nursing supervisory personnel dealt with quality-of-care, physician, or nursing problems on an individual, ad hoc basis. To meet legal requirements for due process, hospitals began to impose structural requirements on both medical and nursing staff review committees. By 1980, the Joint Commission established quality assurance standards as a formal, systematic program to measure the care rendered to patients against established criteria Martin and Federico. Since then, the Joint Commission has incrementally revised the standards on quality, leading hospitals in the direction of integrated and coordinated hospitalwide efforts to continuously improve performance. In the late 1980s, NCQA worked with corporate purchasers of healthcare services to develop standards to measure quality across health plans. The Joint Commission and the Centers for Medicare and Medicaid Services followed with requirements for healthcare facilities to collect and report performance data. NAHQ "Certified" Several of the activities, such as identifying opportunities for improvement, promoting proactive approaches, and identifying root causes of problems, overlap with those of the risk manager. Just as coordinating these overlapping activities helps the risk manager, so too does the quality manager benefit in achieving better results by bringing the two disciplines together and also in freeing time to complete their many other responsibilities. Many of the principles and frameworks for quality improvement used in healthcare today were originally laid out by quality experts in manufacturing. Edwards Deming to establish quality control measures for manufacturing Dlugacz et al. Other models for continuous quality improvement are similar to the one used by risk managers to guide decision making, further underscoring the shared aspects of the two disciplines refer to the discussion Streamline Activities for a description of those models. Concepts currently popular in healthcare quality initiatives, such as Lean management i. Quality professional of today. The study describes the role of the quality professional of today as very involved with nationally prominent quality activities, including several that promote public reporting of hospital-specific quality measures. These initiatives include the following: Patient Safety Healthcare organizations struggle with where in the organizational structure patient safety activities should fall. Are they the responsibility of risk or quality? Or should they be housed in their own department devoted to patient safety? ECRI Institute views patient safety as one of several intersecting activities of the risk and quality functions. Patient safety enables risk and quality programs to proactively examine care processes and risks and apply patient safety principles e. While the risk and quality functions may vary in organizations, a suggested delineation of their activities is depicted in Figure. Note that many of their overlapping activities promote patient safety. Both quality and risk are involved in the response. While each program may separately address matters related to the event, they also share responsibilities and a common goal for the organization to provide safe, high-quality care. Both may need to review the medical record, although for different purposes. The risk manager looks at the record to determine whether the organization may be responsible or liable for an injury; the quality professional reviews the record to get more information about the event and how it occurred. The risk manager assists with the disclosure of the event to the patient and family and, if appropriate, alerts the insurance carrier to a potentially compensable event.

### 8: An Example of a Risk Management Plan for Use on Any Project

*Hospital-based nursing faces difficult challenges from the vantage point of risk management. Encouragingly, the continuous and passionate wo.*

### 9: Welcome to ASHRM website

*Overview of the Healthcare Risk Management Profession. If you are interested in learning more about health care risk management as a career, this page defines who risk managers are, what they do, how to become a risk manager,*

*where the jobs are, and why you should choose this career.*

*Song on a blue guitar Jesu, Joy of Mans Desiring Cell surface engineering of mesenchymal stem cells Debanjan Sarkar . [et al]. The thankless muse Discrimination and segregation A General History of Earthquake Studies in China Epilogue : coming full circle with one world, one heart. Stay interview essential ingredients Simple get-togethers Robin cook ebooks MCQ tutor for primary FRCS Practice makes Mr. Perfect The Oxford Guide to the History of Physics and Astronomy Hsc test paper 2014 Between doctors and patients Understanding change Michael Fullan 2004 cbr600rr owners manual People Almanac 1999 The New Yorker twenty-fifth anniversary album, 1925-1950. Book of witchcraft and demonology Minds, ethics, and conditionals My Estate Planner Educators survival guide to TV production equipment and setup Gesture drawing a story-based approach What is the Cause of Taking Back our Master Jesus (PTH by Sleep? Aim/Far 1995: Airmans Information Manual/Federal Aviation Regulations (AIM/FAR: Airmans Information Manua Children of the Amulet The quest for new biodynamic substances Ernst Boris Chain Export apple notes to Moore on the right, the good, and uncertainty Michael Smith White Lace Promise (Silhouette Special Edition) Georgie Giraffe Paper Doll 2. Liddell, A. 1938-1975. Pipe cleaners gone crazy The Black Baronet; Or, the Chronicles of Ballytrain On the edges of development Womens Size Medium White Tee Global Competition Integration Silva master mind seminar, the book PT2 Investigators*