

Section Title QUALITY MANAGEMENT	Effective Date:	Page: 1	Date Revised: 11-03 01-07
Subject: DATA COLLECTION FOR RISK MANAGEMENT			

DATA COLLECTION FOR RISK MANAGEMENT

POLICY:

LSC staff will collect pertinent information to enable the Quality Management Committee to monitor the quality of care given to patients during the perioperative period. Risk indicators are incorporated into the Occurrence Report process. Identified cases are documented as soon as possible by staff and reported to Quality Coordinator. Every employee is responsible for completing an Occurrence Form when appropriate. The priority for monitoring risk indicators will focus on the high-volume, high-risk, and problem-prone areas. Our focus is to learn from the situation and work to prevent future occurrences.

PROCEDURE: REPORTING OCCURRENCES

- A. Staff complete the facility occurrence report.
- B. The staff member who observes the occurrence completes the Occurrence Report, describing what happened, explaining how this was discovered, listing causative factors, and summarizing the patient outcome.
- C. Form is then forwarded to the Quality Coordinator. QC investigates causative factors and identifies work practices that contributed to the occurrence and identifies possible corrective action that could prevent future problems. Cumulative data is reviewed to identify existing patterns or trends.
- D. QC is responsible for reporting to the Quality Management Committee. Quality Management Committee will focus on identifying and correcting system deficiencies that contributed to the occurrence. Data is collected for integration into quality management programs, performance improvement projects and for use in managerial decisions and facility operations.

An occurrence report will be completed for any of the indicators listed, as well as any other situation as deemed appropriate by any staff member of LSC. Any case identified by the indicators, or any other occurrence report, will be peer reviewed.

An Occurrence Report is an internal, confidential, legal quality assurance document.

Risk Indicators:

Aspects of care that are potentially high-risk and or problem-prone areas have been identified. These high risk aspects of care are those that may occur frequently; affect a large number of patients; place patients at risk of serious consequences or deprivation of substantial benefit when the care is not provided correctly, not provided when indicated or the care is provided when not indicated; and/ or tend to produce problems for patients or staff.

Aspects of Care/Indicators
Outcomes
1. Death
2. MI/CVA during or within 48 hours of procedure
3. Cardiac/Respiratory Arrest
4. Neurological/Vascular deficit post procedure not present on admission
5. Surgery/Invasive procedure performed on wrong site, extremity, or patient
6. Patient injury
7. Retained foreign body
8. Wrong invasive procedure
9. Unplanned transfer or admission to the hospital within 1 post-procedure day.
10. Unplanned return to surgery
11. Detection of post-surgical infections
12. Pulmonary edema or aspiration causing symptoms requiring treatment or intervention

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13. Laceration, perforation, tear or puncture of an organ or body part during procedure
14. Thrombosis or embolus following invasive procedure
Treatment
1. Post-op stay longer than 4 hours
2. Symptomatic, sustained or treated SBP below 80 or over 200 systolic, if different from pre-op baseline
3. Symptomatic, sustained or treated heart rate below 40 or over 160, if different from pre-op baseline
4. Reintubation in PACU
5. Symptomatic, sustained oxygen saturation below 90%, previously greater than 96%
6. Medication error – incorrect medication, dose or medication omitted
7. Attempted intubation > 3 times
8. Aspiration
9. Skin breakdown/abrasion due to electrocautery pad
10. Hematoma at venipuncture site requiring intervention
11. Venipuncture > 3 times
12. Symptoms suggesting an allergic reaction
13. ER visit after discharge
14. Aborted procedure
15. Surgery delayed
Facility
1. Equipment failure, malfunction or disconnection
2. Equipment not available
3. Medical record information released without authorization
4. Patient fall
5. Visitor even/injury
6. Patient/significant other complaint
7. Specimen insufficient, damaged or lost
8. Defaced, tampered, altered, damaged or lost medical records
9. Scheduled surgery cancelled
10. Incorrect sponge/needle count
11. Consent inconsistent with H & P
12. Incorrect Narcotic count
13. Contamination – sterilizer
14. Bloodborne exposure
15. Confidentiality breach
16. Power Failure
17. Smoke/Fire
18. Spill/leak
Administrative
1. Altercation/Hostility
2. Lost/Damaged Property
3. Threat of Lawsuit
4. Unprofessional/Inappropriate conduct by healthcare professional
5. Patient left AMA
6. Patient left without a driver