

Develop an effective risk-management program

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Everyone in a medical group practice benefits from an effective risk-management program. A strong program helps identify problem areas and enables clinicians to reduce patient errors and poor outcomes. To accomplish this, leaders — including the practice administrator — must constantly gather pertinent information. This allows you to develop policies and procedures that promote quality health care and a safe environment.

The basic components of a risk management program are a source document to report incidents, staff education and a quality-improvement team.

The source document, known as the incident report, is the most important communication link. It supports the entire risk-management program by recording the facts related to the incident. The document should contain:

- The name of the party involved in the incident;
- The date and time of the occurrence;
- The description of the event;
- Any equipment involved;
- The name of those involved in the incident; and
- The names of any witnesses.

Examples of when to use an incident report include:

- Falls;
- Medication-related occurrences (including near-misses);
- Allergic reactions (e.g., to food, drugs, dyes);
- Equipment failures or improper use of equipment resulting in injury;
- Improper consent;
- Lost or broken valuables;
- Patient leaving or signing out against medical advice;
- Unanticipated patient outcome;
- Misdiagnosis; and
- Wrong patient treated or wrong procedure performed.

Staff education is a key element of a successful program. Risk management is not an isolated event, but rather a continuous part of patient care and safety. Each employee contributes to the program's success. Staff education must include what, when and how to report.

Certain incidents may require additional reporting to the state:

- Death;

- Brain or spinal damage;
- Permanent disfigurement;
- Fractures or dislocations;
- Neurological deficits; and
- Procedures performed without informed consent.

Train staff to report an incident promptly, while memories of events surrounding the incident are clear. Emphasize that staff report life-threatening incidents immediately.

A quality-improvement team is the third major component of a practice's risk-management program. The team should be multidisciplinary – the quality improvement process benefits from information from all areas. The team is responsible for analyzing the data and spotting trends. The data should be examined in a variety of ways to evaluate all aspects of the incident and to identify trends. For example, examine the type of incident, the process involved and the caretakers involved.

The technique used to evaluate an incident is called a root-cause analysis. An organization continually looks at why something occurred so it can prevent a recurrence. It is clear that reporting incidents and using the data to effect change can result in high-quality care.

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