Risk Management Activities Program Guide

December 2019

(Technical Update, August 2021)

I. FOREWORD

This *IHSC Risk Management Guide* supplements the following IHSC Directives:

- 11-02, *Quality Improvement*
- 11-06, *Risk Management*

This Guide explains concepts, assigns responsibilities, and details procedures for the Risk Management Program incident reporting and reviewing. In addition, it outlines the root cause analysis process.

The intended audience is all IHSC personnel, including but not limited to, Public Health Service (PHS) officers and civil service employees supporting health care operations in ICE-owned or contracted detention facilities, and to IHSC Headquarters (HQ) staff. This Guide applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of its employees supporting IHSC.

STEWART D SMITH Digitally signed by STEWART D SMITH
Date: 2019.12.03 13:03:56 -05'00'

Stewart D. Smith, DHSc, FACHE
ERO Assistant Director
ICE Health Service Corps

Date

REL0000034179

Table of Contents

I. FOREWORD 2
II. RISK MANAGEMENT PROGRAM (RMP) 4
III. RISK MANAGEMENT'S COMMUNICATION PROCESS 4
IV. RISK MANAGEMENT INCIDENT REPORTING SYSTEM 5
V. RISK MANAGEMENT EVENT FLOW PROCESS 5
VI. ROOT CAUSE ANALYSIS (RCA) 8
VII. MORTALITY REVIEW PROCESS 12
VIII. REFERENCES 13
IX. APPENDICES 14

REL0000034179

I. RISK MANAGEMENT PROGRAM (RMP)

The purpose of the Medical Quality Management Unit's (MQMU) RMP is to promote patient safety and the utilization of evidence-based risk analysis within the IHSC health care system. RMP promotes a culture of safety that is characterized by non-punitive interactions that emphasize veracity, accountability, and mutual respect.

II. RISK MANAGEMENT'S COMMUNICATION PROCESS

RMP will have open communication with stakeholders when reviewing incident reports to determine and address process related vulnerabilities. RMP facilitates communication with stakeholders to improve health care quality and harm reduction within IHSC detainee and resident populations. This includes communication regarding the following: a specific incident report, incident reporting trends, root cause analysis (RCA) process and action plan. Stakeholders are listed below, but are not limited to this list:

A. Field Stakeholders

Facility Health Program Manager (FHPM) and facility regional leadership – RMP will collaborate with the IHSC facility's FHPM to facilitate safety culture education, review and analyze specific incident reports, contribute with the root cause analysis process and risk management tasks, as needed.

B. Clinical Services (i.e., Chief Nurse, Chief Advance Practitioner Provider (APP), Chief Pharmacist, Chief Behavioral Health, Chief Dentist)

RMP will collaborate with the IHSC Clinical Services Division as the subject matter experts to review specific incident reports and contribute with the root cause analysis process and risk management tasks as needed.

C. Senior Leadership (i.e., Deputy Assistant Directors, Chief of Staff, Deputy Chief of Staff, Assistant Director)

RMP will provide incident reporting statistics, RCA reports, notification of sentinel events, and other correspondence as appropriate. Senior leadership will collaborate with RMP and MQMU Unit Chief on extreme risk score events to determine interim actions, if needed.

REL0000034179

D. Medical Quality Management (Unit Chief, Quality Improvement, Regional Compliance Specialists, and Patient Safety Coordinator)

RMP will collaborate with other MQMU members to review specific incident reports, contribute with the root cause analysis process and risk management tasks, incident reporting statistics, RCA reports, notification of sentinel events, and other correspondence as appropriate.

III. RISK MANAGEMENT INCIDENT REPORTING SYSTEM

A. Purpose of an Incident Reporting System

The purpose of an incident reporting system is to document unusual occurrences, in the IHSC Incident Reporting System on the MQMU SharePoint site, that deviate from established routine or procedure that either resulted, or could have resulted, in an adverse event affecting the health of a detainee.

B. Incident Reporting System Exclusions

The Risk Management Incident Reporting System excludes employee injuries, illnesses and deaths. Staff should report all workforce injuries using the Workforce Injury Reporting Tool on the Public Health Safety and Preparedness (PHSP) Unit SharePoint.

C. Incident Report Event Types

Incident Report Event Types and examples can be found in Appendix A: Incident Report Event Types. Upon review, some events can be noted to have non- medical process failures. If this occurs, the event review process as defined in this guide will not apply.

IV. RISK MANAGEMENT EVENT FLOW PROCESS

The event flow process outlines the way RMP manages unexpected events (See Appendix B: Incident Report Workflow). When a health care staff member identifies an unexpected event, an incident report is generated utilizing the designated IHSC-approved incident reporting system. The Facility Health Program Manager (FHPM) and the assigned Risk Manager (RM) review and analyze the incident to determine the severity and likelihood of reoccurrence, resulting in an associated risk score.

REL0000034179

A. Incident Reporting

When health care staff identify an unexpected event, an incident report is generated utilizing the incident reporting system on IHSC's SharePoint. The employee identifying the unusual occurrence enters an incident report as soon as possible. If the staff member is unclear that an incident requires reporting, it is better to err on the side of caution and submit the incident report. All documentation regarding an incident report, including submission of report, should be only contained within the incident reporting system on SharePoint and not within the medical record.

The FHPM must review all incident reports for the facility on the IHSC SharePoint within three business days of reporting. The assigned RM and FHPM review the description of the incident. After reviewing the incident report, the FHPM and the assigned RM then review the medical records and any associated policies. The FHPM confers with staff involved in the incident, as needed, to obtain any pertinent information regarding the event.

B. Action Determined: Calculating the Risk Score

The FHPM determines the risk score using the steps below:

1. The FHPM determines the severity score of the incident from the severity score chart and assesses the probability of recurrence utilizing the probability score chart. (Refer to Appendix C:Severity Score Chart and Appendix D: Probability Score Chart.)

2. The risk score is calculated by multiplying the severity score by the probability score. The risk score determines the applicable intervention to the incident. (Refer to Appendix E: Risk Matrix.)

3. The FHPM can consult with the assigned RM to determine the risk score, as needed.

4. The FHPM inputs the findings from the medical record and any deviation from guidelines, policies, or correctional standards in the "Event Review Comment Section" of the incident reporting system. The FHPM documents any identified process vulnerabilities. If an action plan is implemented in response to the incident, this is also documented in the incident reporting system.

5. The risk score indicates the appropriate response to the incident. The facility's follow up is based on the risk score.

Refer to Appendix F: Examples of Calculating the Risk Score.

REL0000034179

C. Determining an Action Plan based on the Risk Score

(b)(7)(E)

(b)(7)(E)

(b)(7)(E)

(b)(7)(E)

(b)(7)(E)

(b)(7)(E)

(b)(7)(E)

VII. REFERENCES

Carroll, R. L. (2011). *Early Warning Systems for the Identification of Organizational Risks. Risk Management Handbook for Healthcare Organization Handbook: Vol. 1. The Essentials* (pp.169- 205). San Francisco, CA: John Wiley & Sons, Inc.

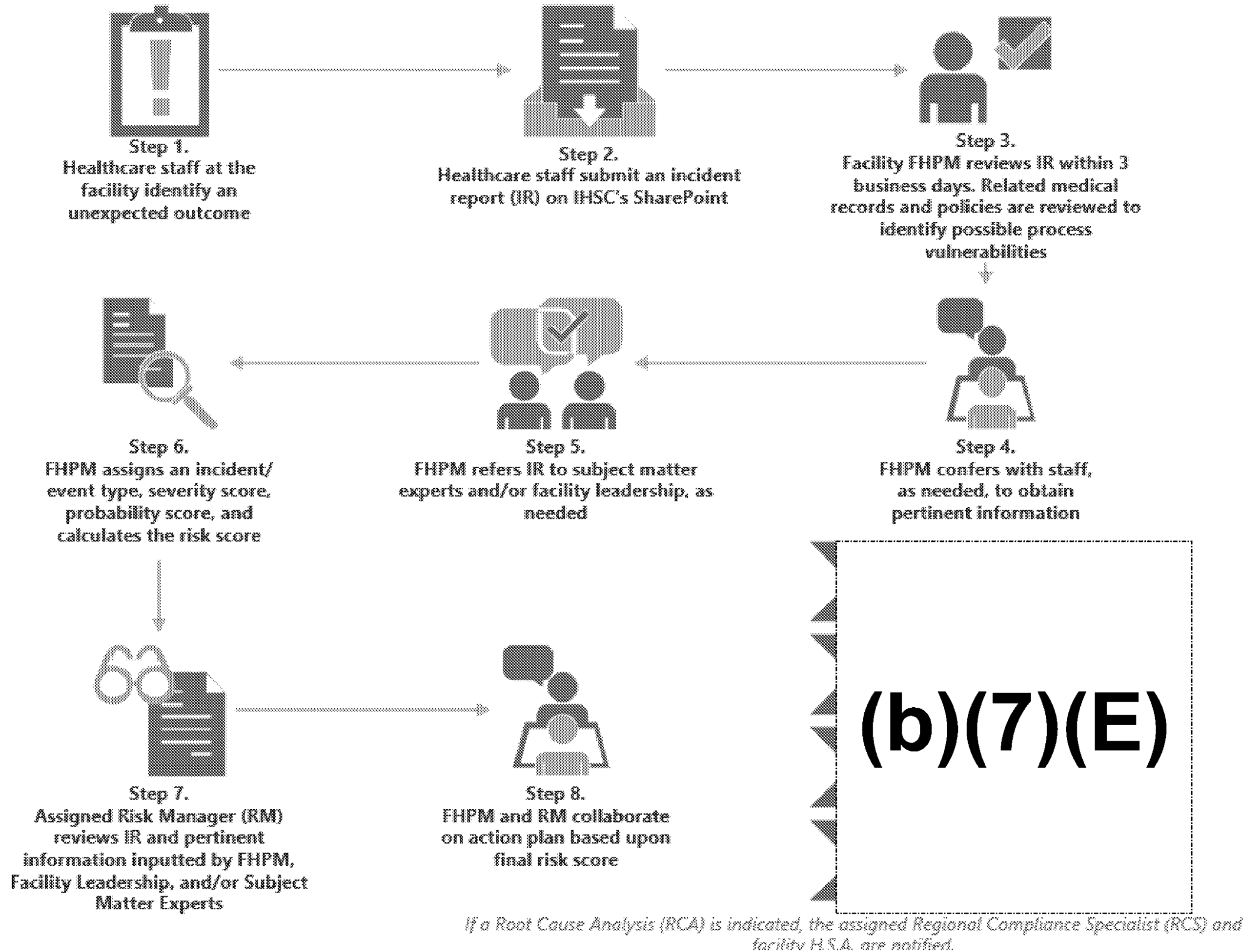
National Patient Safety Agency. (2008). *A Risk Matrix for Risk Manager*. London, England: Author.

National Patient Safety Foundation. (2016). *RCA2: Improving Root Cause Analysis and Actions to Prevent Harm (Ver.2)*. Boston, MA: Author.

REL0000034179

VIII. APPENDICES

Appendix A: Incident Report Workflow



REL0000034179

Appendix B: Incident Report Event Types

Type of Incident/Occurrence	Definitions/Examples
Adverse Drug Reaction	• Any unexpected or dangerous reaction to a medication.
Altercation	• Incident involving a detainee physical in nature (fighting, hitting, striking, etc.)
Altercation with Injury	• Incident involving a detainee physical in nature, which caused injury to the detainee(s) (i.e. fighting, hitting, striking, etc.)
Child to Child Contact (Dilley Only)	• Any child to child physical contact such as pushing, hitting, biting or etc.
Clinic Property Loss or Damage	• Loss or damage of medical equipment and supplies resulting in financial loss to IHSC or potential safety risks.
Death	• Death due to unexpected and unrelated to the natural course of an illness
Dental Care	• Any incident related to dental care that has the potential to cause harm or has caused harm to the patient.
Documentation Error	• Failure to accurately document a detainee/resident's condition, mediations administered, or other patient care activity • Documenting in the wrong detainee/resident's chart • Adding wrong documents to a chart
Drug Diversion/Lost or Missing Narcotic Medication	• Controlled substance that is unaccounted for • When any individual unlawfully transfers controlled substance to another person for any illicit use.

REL0000034179

Type of Incident/Occurrence	Definitions/Examples
Exposures	• Airborne: Exposed to pathogens transmitted through air (i.e. tuberculosis) • Bloodborne: Percutaneous exposure to pathogenic microorganisms via human blood (needle stick; cut with a sharp object) • Contact: Exposure to infectious pathogens to the eye, mouth, or other mucous membrane or non-intact skin • Radiation: Unexpected exposure to radiation out of the normal processes (Example: pregnant female exposed to radiation due to lack of shielding, etc.)
Equipment	• Malfunction*: A medical device has not functioned as intended leading to harm or potential harm to detainee/resident • Not Available: A medical device/product is ordered and was not available leading to delay in care **The Public Health Safety and Preparedness (PHSP) Unit should be notified of all equipment malfunction incidents.*
Facility to Facility Transfer	• Process failures related to transfers between facilities
Falls from Top Bunk	• Specifically. a fall from a top bunk witnessed or unwitnessed. All other non-medical falls should be reported under "Falls"
Falls, Medical	• Witnessed or unwitnessed fall with medical process failures
Falls, Non-Medical	• Witnessed or unwitnessed fall without any medical process failures
Hunger Strike with Medical Intervention	• Hunger strike resulting in interventions to include, but not limited to, forced feedings at the initiation of a court order
Inappropriate Surgery/ Invasive Procedure	• The wrong or inappropriate surgery or invasive procedure is performed on a detainee/resident. This also includes wrong site procedures.

REL0000034179

Type of Incident/Occurrence	Definitions/Examples
Involuntary Administration of Psychotropic Medication	• Detainee/Resident receives psychotropic medication against his/her consent • Incomplete documentation related to the involuntary administration of psychotropic medication • Identified process failure related to the Emergency Psychotropic Medication Administration Policy
Lab Error	• Lab test not completed secondary to collection, submission or labeling error etc. • Lab test incorrectly collected
Medication Error	• Wrong Detainee: Error with the administration of medication (i.e. Detainee A was given medication ordered for Detainee B) • Wrong Dose: (i.e. Provider ordered Lisinopril 10 mg, but the detainee was given Lisinopril 20 mg) • Wrong Medication: (i.e. Detainee ordered Tylenol, but was administered Ibuprofen) • Wrong Route: (i.e. Provider ordered Ativan 2 mg IM, but the detainee received Ativan 2mg by mouth/PO) • Wrong Time: (i.e. Provider ordered the medication to be given every 8 hours, but the medication was given every 4 hours) • Transcription Error: Errors related to ordering medication for the wrong detainee/resident, the wrong medication, dose, quantity; Pharmacy errors related to dispensing medication (i.e. inconsistencies or deviations from the prescription order such as incorrect drug, dose, dosage form, quantity, labeling; confusing or inadequate directions for use; incorrect or inappropriate preparation, packing, storage of medication prior to dispensing); OR transcription errors in or between IT systems
Miscount	• Controlled Substances: Discrepancy in accounting of medications (control or non-controlled) • Sharps: Discrepancy in accounting of sharps (including dental instruments)
Omission or Delay	• Omission or Delay: An Intended Appointment - Appointment not scheduled or missed resulting in delay of care • Omission or Delay: Perform a Diagnostic Test - Test not performed due to scheduling or lack of ordering the test • Omission or Delay: Perform a Procedure - The procedure not performed due to scheduling or lack of ordering the procedure.

REL0000034179

Type of Incident/Occurrence	Definitions/Examples
	• Omission or Delay: Provide Treatment - Scheduled or ordered treatment not performed • Omission or Delay: Refer to Higher Level of Care - Referral to appropriate level of care was not provided as indicated by patient's clinical presentation (i.e. to the emergency room, consultation with APP/CD) • Omission to Refer to Mental Health - Referral to appropriate level of care was not provided as indicated by patient's clinical presentation
Pharmacy/Medication Lost or Missing	• When any medication other than a controlled substance is unaccounted for
Radiology	• Wrong Detainee – A diagnostic radiologic procedure was completed on a detainee that did not have an order • Duplicate Test - detainee exposed to radiation due to chest x-ray duplicated in error
Recreation Injury	• An injury to a detainee that occurred during recreation time.
Referral to Higher level of care-Acute Care Hospital	• Referral of a detainee/resident to a higher level of care (Acute care hospital setting)
Referral to Higher level of care- Behavioral Health/ Psychiatric	• Referral of a detainee/resident to a higher level of care (Behavioral Health/Psychiatric setting)
Sexual Assault	• Physical Contact: Any type of sexual contact or behavior involving a detainee/resident • Non-Contact: Any type of unwanted verbal or non-verbal communication of sexual nature
Suicide Attempt	• Detainee/resident attempts to take his/her life

REL0000034179

Type of Incident/Occurrence	Definitions/Examples
Superficial Laceration/Cutting	• Cuts made to own's body that does not involved muscle or fat tissue and may necessitate placement of a suture
TB Case Management Errors	• Any process vulnerabilities related to TB clearance and management
Use of Force Injury	• Injury sustained when attempting to restrain a detainee (Example: Detainee sustained a cut to his/her arm when being restrained by custody staff. Of note, use of force is only conducted by custody staff).
Work Related Injury (Detainee Only)	• Injury sustained while in the work setting (Example: Detainee obtained a first degree burn to his/her hand while working in the kitchen)

REL0000034179

Appendix C: Severity Score Chart

Severity Score	1	2	3	4	5
Descriptor	*Negligible*	*Minor*	*Moderate*	*Major*	*Catastrophic*
Impact on the safety of detainee	An event resulting in no harm to the detainee without process related vulnerabilities	An event that has the potential to cause harm to the detainee, which is also known as a near-miss	An unexpected outcome unrelated to the natural course of an illness requiring medical intervention or monitoring within the detention center	An unexpected outcome unrelated to the natural course of an illness resulting in incapacitation or disability to the detainee, requiring hospitalization or monitoring in an acute care setting	An unexpected outcome unrelated to the natural course of an illness resulting in death
National Patient Safety Agency (2008). A Risk Matrix for Risk Managers.					

REL0000034179

Appendix D: Probability Score Chart

Likelihood Score	**0**	**1**	**2**	**3**	**4**	**5**
Descriptor	*None*	*Rare*	*Unlikely*	*Possible*	*Likely*	*Almost Certain*
Frequency (How often might it/does it happen)	N/A (No process vulnerability)	This will probably never happen/ recur	Do not expect it to happen/ recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/ recur but it is not a persisting issue	Will undoubtedly happen/ recur possibly frequently
National Patient Safety Agency (2008). A Risk Matrix for Risk Managers						

Appendix E: Risk Matrix

Consequence	0	1	2	3	4	4
Likelihood	None	Rare	Unlikely	Possible	Likely	Almost Certain
5 Catastrophic	0	5	10	15	20	25
4 Major	0	4	8	12	16	20
3 Moderate	0	3	6	9	12	15
2 Minor	0	2	4	6	8	10
1 Negligible	0	1	2	3	4	5
National Patient Safety Agency (2008). A Risk Matrix for Risk Managers						

	0	None
	1-3	Low Risk
	4-6	Moderate Risk
	8-12	High Risk
	15-25	Extreme Risk

REL0000034179

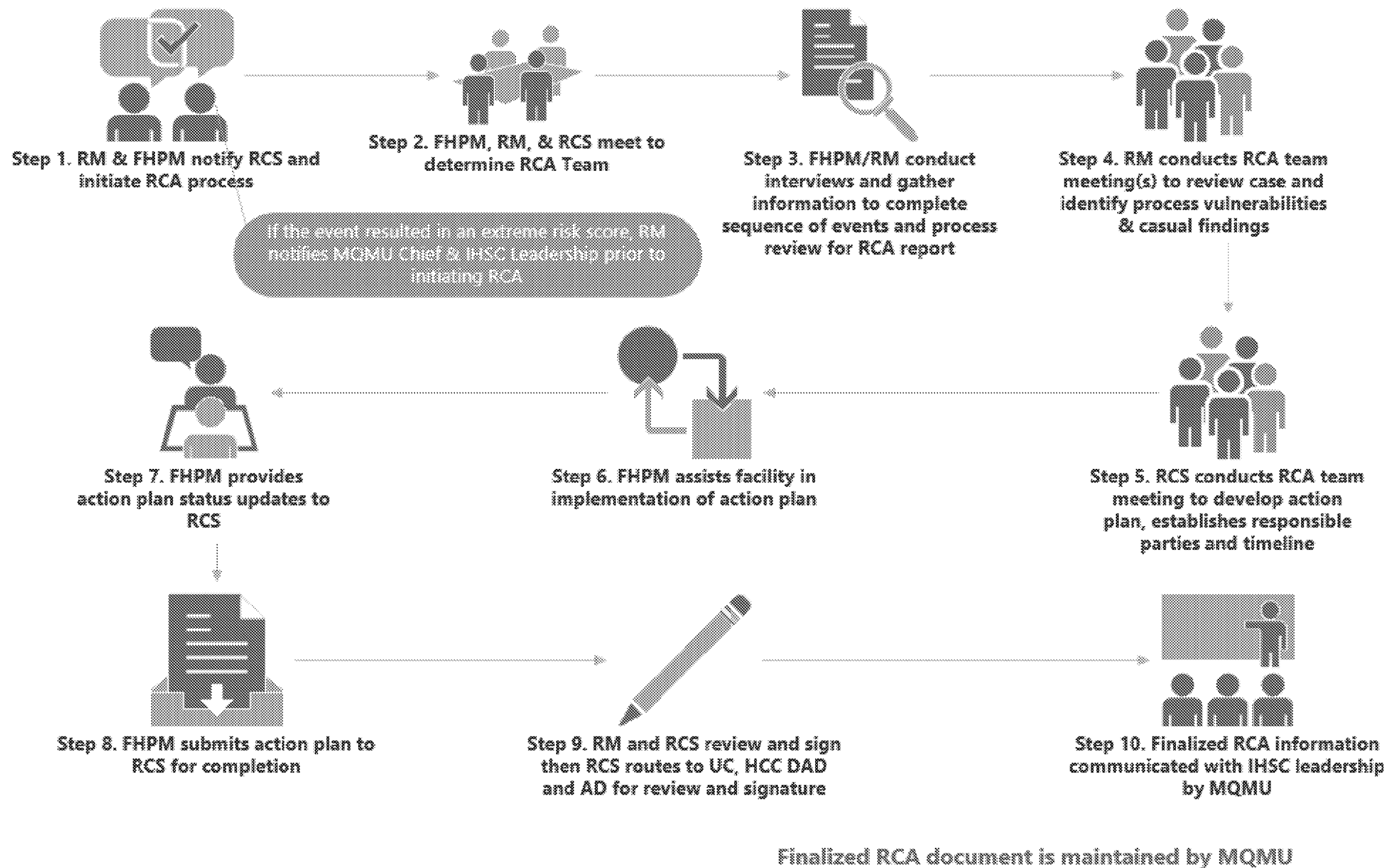
Appendix F: Examples of Calculating the Risk Score

Risk Examples	Event Description	Severity Score	Probability Score	Risk Score
Low Risk	A detainee/resident missed a specialist appointment due to the correctional staff performing a mass detainee count. The appointment had to be rescheduled for the following week.	Negligible (1): An event resulting in no harm to the detainee/resident without process related vulnerabilities.	Unlikely (2): Do not expect it to happen/recur but it is possible it may do so.	Negligible/Unlikely (2): Indexed as a low risk for local tracking and trending via monthly meetings and quarterly QI report. The assigned RM will review the reports submitted and track and trend nationally.
Moderate Risk	A detainee/resident received an extra dose of blood pressure medication that resulted in monitoring of the blood pressure, but the detainee remained normotensive.	Minor (2): An event that has the potential to cause harm to the detainee/ resident, which is also known as a near miss.	Possible (3): An event that might happen or recur occasionally.	Minor/Possible (6): Indexed as a moderate risk, which would indicate track and trending by the FHPM. RM will review submitted report and track and trend nationally. 3 or more moderate risk scores of the same event type result in notification to RCS and initiation of an RCA.
High Risk	A detainee/resident with a history of suicide attempts lacerated his wrist in an attempt to commit suicide that required stitches to be placed in the emergency room without hospital admission.	Moderate (3): An unexpected outcome unrelated to the natural course of an illness requiring medical intervention or monitoring within the detention center.	Possible (3): might happen or recur occasionally.	Moderate/Possible (9): Indexed as a high risk which would indicate an RCA. The FHPM would refer all high- risk score incidents to the RM, RCS, and local triad (i.e. HSA/AHSA/CD and NM) for a collaborative review of the incident.

REL0000034179

Extreme Risk	A detainee/resident with complications to a chronic medical condition, was seen in the emergency room and recommended to have outpatient management. However, there is a delay in obtaining an appointment with the local specialist due to scheduling issues. As a result, the detainee/resident had worsening of the disease state resulting in irreversible impairment (i.e. loss limb, vision, or death).	Moderate (3): An unexpected outcome unrelated to the natural course of an illness requiring medical intervention or monitoring within the detention center.	Possible (3): might happen or recur occasionally.	Moderate/Possible (9): Indexed as a high risk, which would indicate an RCA. The FHPM would refer all extreme risk score incidents to the RM, RCS and local triad (i.e. HSA/ AHSA/CD and NM) for collaborative review of the incident. RM will notify MQMU Chief and IHSC Senior Leadership of all extreme risk score events for determination of interim actions, if needed

REL0000034179



REL0000034179

Appendix G: IHSC Root Cause Analysis and Action Plan Template

Facility:	Date & Time Event Discovered:	Location of Event:	Type of Event:

Brief Summary of Event *(Use page 3 of this document to provide the Sequence of Events)*:

(b)(7)(E)

☐ Event Review Only ☒ Full RCA

Outcome of Event:

☐Death ☐ Permanent Harm ☐ Severe Temporary Harm ☐ No Significant Harm with Additional Monitoring ☐ No Harm

HEADQUARTERS USE ONLY

RCA Meeting Dates: 1st Meeting ____________________ 2nd Meeting ____________________ 3rd Meeting ______________________

Assigned HQ Risk Manager	Assigned FHPM	Assigned RCS	Assigned HSA/AHSA	Date RCA Initiated
				Click here to enter a date.

REL0000034179

Sequence of Events Log

Date	Time	Provider	Sequence of Events

Process Review

Process	**Steps** (Document each step in the process)	**Process Vulnerabilities** (Behavioral Choices-reckless behavior, at risk behavior, human error, staffing, equipment, staff performance, communication,)	**Incidental/Contributing Factor/Root Cause**

REL0000034179

Root Cause Analysis
Root Cause Analysis Committee Composition

#	Name	Discipline	Title
1			
2			
3			
4			
5			
6			
7			
8		Click here to enter text.	Click here to enter text.

REL0000034179

Action Plan Development

Contributing Factors or Root Cause	Risk Reduction Strategies (Action Plan)	Classification of Action Plan	Responsible Party	**Measurement Strategy and Expected Outcome** (i.e. What will be measured? How long it will be measured? What is the expected level of compliance?)	Implementation Due Date	Action Plan Follow Up Date	Compliance Level Achieved	Complete
	Action Item #1:							Choose an item.
	Action Item #2:							Choose an item.
	Action Item #3:							Choose an item.
	Action Item #4:	Choose a classification.			Click here to enter a date.	Click here to enter a date.		Choose an item.
	Action Item #5:	Choose a classification.			Click here to enter a date.	Click here to enter a date.		Choose an item.

If compliance levels were not met, what actions were taken?

	Comments:

What immediate improvement measures have already been implemented?

	Comments:

Headquarters Recommendations for National Implementation

REL0000034179

Signatures	
	DAD of HCC
	Unit Chief
	Regional Compliance Specialist
	Risk Manager
	AD (as needed)

Appendix I: Sample IHSC Root Cause Analysis and Action Plan

Facility:	Date & Time Event Discovered:	Location of Event:	Type of Event:
Choose a facility.	Click here to enter a date.	Click here to enter the location.	Choose an event type.

Brief Summary of Event *(Use page 3 of this document to provide the Sequence of Events)*:

This root cause analysis is being conducted due to a medication error that resulted in a hospital referral. A fifty-five-year-old male with a past medical history of MI and hypertension arrived at a detention center on October 2. During the intake screening, the patient informed the nurse that he was previously taking 50mg of metropolol twice a day for his blood pressure but ran out of the medication a few days ago. He reviewed the transfer summary, which was consistent with what the detainee reported. The nurse pulled the metropolol 25mg tabs from over stock and transcribe the order as "Metropolol 50 mg one-tab PO BID". On October 3, the advance practice provider exam the detainee and reviewed the intake screening along with the MAR. Then the APP prescribed metropolol 25mg PO BID. The detainee reported to sick call on October 8th with complaints of a headache and leg swelling. At that time his blood pressure was 210/100 with a heart rate of 90. He was referred to the provider. During the visit with the provider, his blood pressure was 200/110 with a heart rate of 100 and his SPO2 was 91%. The detainee presented with bilateral pitting edema, diminish breath sounds bilaterally and complaints of shortness of breath with exertion. The detainee was referred to the hospital for evaluation where he was treated for CHF exacerbation.

(b)(7)(E)

☐ Event Review Only (Sequence of Events) ☒ Full RCA (Sequence of Events and Process Review)

Outcome of Event:

☐ Death ☐ Permanent Harm ☐ Severe Temporary Harm ☒ No Significant Harm with Additional Monitoring ☐ No Harm

HEADQUARTERS USE ONLY

Assigned HQ Risk Manager	Assigned FHPM	Assigned RCS	Assigned HSA/AHSA	Date RCA Initiated
Click here to enter a name.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.

REL0000034179

Sequence of Events Log

Date	Time	Provider	Sequence of Events
10/2/2018	1930	Nurse	Pre-Screen Detainee arrived from another facility with a transfer summery without medication.
Select date.	Time	Click here to enter text.	Intake Screening History of Present Illness: Hypertension and MI in 2016 Current Medications: Metropolol 50mg 1tab BID/ HCTZ 25mg PO qd Past Medical History: Hypertension and MI in 2016 Allergies: NKDA Vital Signs: BP: 150/96, HR: 90, RR: 18, SPO2 95%RA and weight: 220. Examination: Diminished breath sounds bilaterally, +1 pitting edema on BLE, S1 S2 Assessment: Hypertension Treatment: Metropolol 25mg PO BID, HCTZ 25mg qd taken from the night cabinet. Schedule for PE-C in AM. The on-call provider was not consulted per the case/care plan.
Select date.	Time	Click here to enter text.	Complex Physical Exam Reason for the Appointment: Hypertension and history of MI in 2016 Surgical History: Denies history of surgery Social History: Denies ETOH and drug use Allergies:NKDA Hospitalization/Major Diagnostic procedures: MI 2016 with stent placement Review of Systems: Unremarkable Vital Signs: BP: 138/88, HR: 70, RR: 18 and SPO2 93% Exam: No remarkable findings Assessment: Hypertension Treatment: Metropolol 25mg PO BID, HCTZ 25mg PO daily, labs ordered, EKG ordered and follow up in 3 weeks.

REL0000034179

Select date.	Time	Click here to enter text.	Sick Call Reason for Appointment: Headache, leg swelling and shortness of breath on exertion History of Present Illness: Detainee complained of a headache for the past two days and noticed that he was short of breath while walking to the rec yard. Current Medications: Metropolol 25mg PO BID and HCTZ 25mg PO daily (last dose at 6am) Past Medical History: Hypertension and MI in 2016 Review of Systems: SOB with exertion, headache, swelling in both legs and 10/10 HA, no chest pain Vital Signs: BP: 210/100, HR: 90, RR: 20, SPO2: 90% and weight: 228 lbs. Exam: Diminished lung sounds bilaterally with use of accessory muscles, +2 pitting edema on BLE, S1 S2 Assessment: elevated blood pressure Treatment: Referred to provider
Select date.	Time	Click here to enter text.	Urgent Encounter with APP: Reason for Appointment: sick call referral for elevated bp, headache, leg swelling and shortness of breath on exertion x 2 days History of Present Illness: Detainee complained of a headache for the past two days and noticed that he was short of breath while walking to the rec yard. Current Medications: Metropolol 25mg PO BID and HCTZ 25mg PO daily (last dose at 6am) Past Medical History: Hypertension and MI in 2016 Review of Systems: SOB with exertion, headache, swelling in both legs and 10/10 HA, no chest pain Vital Signs: BP: 200/110, HR: 100, RR: 20, SPO2: 91% and weight: 228 lbs. Exam: Diminished lung sounds bilaterally with use of accessory muscles, +2 to 3 pitting edema on BLE, S1 S2 Assessment: Hypertensive Urgency and Edema Treatment: Referred to ER for further eval/management
Select date.	Time	Click here to enter text.	Hospital Update: detainee admitted to Cardiac floor for congestive heart failure.

Process Review			
Process	**Steps**	**Process Vulnerabilities** (Behavioral Choices-reckless behavior, at risk behavior, human error, staffing, equipment, staff performance, communication,)	**Incidental/ Contributing Factor/ Root Cause**
Medication Reconciliation	Step 1: Detainee arrives with transfer summary and was previously taking medication		
	Step 2: RN calls the on-call provider reports the patient's medication history and transcribes the medication information from the transfer summary to the telephone encounter	Transfer summary indicates that detainee was previously taking metoprolol 50mg PO BID and HCTZ 25mg PO daily. Nurse transcribed metoprolol dose incorrectly by documenting "Metoprolol 25mg PO BID."	Contributing Factor
	Step 3: Provider agrees to continue medication for three days		
	Step 3: Nurse transcribes the order in the telephone encounter		
	Step 4: Nurse conducts verbal order read back		
	Step 5: Nurse signs off on the telephone encounter.		
	Step 6: Second nurse verifies the MAR against the order		
	Step 7: Second nurse places initials on MAR		
	Step 8: Nurse pulls medication from the night stock.		
	Step 9: Nurse administers the medication.		
	Step 10: Signs off on the telephone encounter for the verbal order.	Provider did not review the intake screening or the transfer summary prior to signing off on the telephone encounter.	Root Cause
	Step 11: During the PE-C, provider reviews intake notes, MAR and transfer summary.	Provider reviewed the intake screening and noticed the discrepancy between current medication and medications under treatment. Transfer summary sent to MRT and unavailable for the provider. The provider orders the metoprolol from treatment section of the intake screening.	Root Cause
	Step 12: Provider continues the medication clinically indicated.		

REL0000034179

Root Cause Analysis Committee Composition

#	Discipline	Title
1	Administration	HSA
2	Nursing	Clinical Nurse, Nurse Manager
3	Provider	APP and CD
4	Click here to enter text.	Click here to enter text.
5	Click here to enter text.	Click here to enter text.
6	Click here to enter text.	Click here to enter text.
7	Click here to enter text.	Click here to enter text.
8	Click here to enter text.	Click here to enter text.

REL0000034179

Action Plan

Contributing Factors or Root Cause	Risk Reduction Strategies (Action Plan)	Implementation Due Date	Classification of Action Plan	Responsible Party	Measurement Strategy and Expected Outcome	Action Plan Follow Up Date	Compliance Level Achieved	Complete
Contributing factor	Action Item #1: **Finding:** Transfer summary indicates that detainee was previously taking metprolol 50mg PO BID and HCTZ 25mg PO daily. Nurse transcribed metoprolol dose incorrectly by documenting "Metoprolol 25mg PO BID" • Corrective Action 1: **Nurse Medication verification process:** During the verification process of the MAR generated during Intake by the nurse, the nurse will review the transfer summary and compare it to the order written on the MAR.	11/1/2018	Training and LOP	Nurse Manager and/or designee	**Measurement Strategy:** Review MARs that are generated from Intake for 1 month to see if the medications are the reconciled correctly (i.e. no discrepancy in the medication transcription). This will be done by performing random checks of MARs. A total of 30 MARs will be reviewed within a 4-week period. **Expected Outcome:** 100% of MARs will be reconciled correctly without transcription errors.	12/15/18	Yes; Audits of charts showed 100% compliance	Yes; Supporting Documentation sent to MQMU on 12/15/18
Root Cause	Action Item #2: **Finding:** The provider did not review the intake screening or the transfer summary prior to signing off on the telephone encounter. Corrective action #2	11/1/2018	Training and LOP	Clinical Director and/or designee	**Measurement Strategy:** The site will review 30 transfer summaries and associated PE-C documentation within a 4-week period. All transfer summaries will	12/15/18	Yes, audits of transfer summaries and PE-Cs were 100%	Yes; Supporting Documen-tation sent to MQMU on 12/15/18

REL0000034179

	Provider Medication Reconciliation process: All transfer summaries with medication should be routed to a provider for review and signature prior to being scanned into the detainee's chart. The provider will chart the review of the transfer summary medications and dosages in the initial PE-C narrative.				have a provider signature and all PE-Cs will reflect correctly reconciled medications. Random selection will be utilized **Expected outcome:** (a) 100% of all transfer summaries will have signatures (b) 100% of all medications will be correctly reconciled during the PE-C visit			
Root Cause	Action Item #3 **Finding:** The provider reviewed the intake screening and did notice the discrepancy between current medication and the medications listed under treatment. The provider did not have access to the transfer summary because it was sent to the MRT so that it could be scanned into the EHR. The provider order the metoprolol that was list under the treatment section of the intake screening. Corrective action #3 **Provider Medication Reconciliation process:** All transfer summaries with	See action item #2	See action item #2	See action item #2	See action item #2	See action item #2	12/15/2018	Yes; Supporting Documen-tation sent to MQMU on 12/15/18

REL0000034179

	medication should be routed to a provider for review and signature prior to being scanned into the detainee's chart. The provider will chart the review of the transfer summary medications and dosages in the initial PE-C narrative.							
Click here to enter a date.	Action Item #4: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.
Click here to enter a date.	Action Item #5: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.
Click here to enter a date.	Action Item #6: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.
Click here to enter a date.	Action Item #7: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.
Click here to enter a date.	Action Item #8: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.
Click here to enter a date.	Action Item #9: Click here to enter text.	Click here to enter text.	Choose a classification.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter a date.	Choose an item.

REL0000034179

If compliance levels were not met, what actions were taken?	Comments:
Click here to enter text.	Click here to enter text.

What immediate improvement measures have already been implemented?

Click here to enter text.	**Comments:** Click here to enter text.

Headquarters Recommendations for National Implementation

The Regional Compliance Specialist has recommended to the Medical Records division of IHSC to train all MRTs to route any transfer summary with medications to providers for review and signature. An online request has been placed via eCW HITU team feature request on SharePoint for the consideration of adding a transfer summary review verification within the PE-C template. Recommended response options: (a) No transfer summary received/reviewed during this encounter and (b) transfer summary received and reviewed during this encounter.

Signatures	
	DAD of HCC
	Unit Chief
	Regional Compliance Specialist
	Risk Manager
	AD (as needed)

REL0000034179

Appendix J: Definitions

Action Plan (AP) – A strategy for correcting or eliminating a problem that has already occurred or been identified (as opposed to a preventive action plan which defines the steps taken to eliminate the root cause of a problem). An action plan may arise from an RCA

Adverse Events – Any type of error, mistake, incident, accident or deviation, regardless of whether it resulted in patient harm.

Facility Triad: includes the Health System Administrator/Assistant Health System Administrator, Clinical Director & Nurse Manager

Health Care Personnel or Providers – Health care personnel or providers are credentialed individuals employed, detailed, or authorized by IHSC to deliver health care services to detainees. It includes federal and contract staff assigned or detailed (i.e. temporary duty) who provide professional or paraprofessional health care services as part of their IHSC duties. (IHSC Operational Definition).

Near Miss – An event or situation that could have resulted in harm to the patient but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the patient.

Patient Safety – Avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.

Risk Management – Risk management is a process and system that includes clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the risk of injury to patients. It involves identification of risk potential, prevention of risk exposure, and the management of real or potential adverse incidents.

Risk Management Incident Reporting System – A tool utilized by IHSC health care facilities to report an unusual occurrence, particularly an error or accident that has or may have adverse consequences affecting the health of the detainee/resident. This reporting system should exclude information regarding IHSC health care personnel or providers, government service, and contracted employee injuries, illnesses, and deaths.

Risk Score – The risk score is comprised of severity level and probability of recurrence scores and will be assigned by the RMP and FHPM. After determining the level of severity and probability of recurrence, the RMP and FHPM will utilize the Risk Matrix Chart multiplying the level of severity score and probability of recurrence score yielding the overall risk score. The risk score determines the applicable intervention to the incident. Low and moderate risk scores result in tracking and trending, while high and extreme risk scores result in a root cause analysis.

Root Cause Analysis – A multidisciplinary analysis tool utilized to identify basic and/or contributing causal factors associated with an unwanted outcome and sentinel event

Unusual Occurrence – Unexpected occurrence related to an individual's medical treatment and not related to the natural course of the patient's illness or underlying disease condition.

REL0000034179