Risk Management Introduction

by Capella Healthcare

WHAT'S COVERED

In this lesson, you will learn about risk and the goals of risk management in healthcare. Specifically, this lesson will cover:

1. Risk in Healthcare
2. Goals of Risk Management

1. Risk in Healthcare

Risk is a threat of damage, injury, or liability loss that is caused by vulnerabilities within the healthcare system that could be avoided through preemptive action. The ways in which humans interact with the system can pose a threat primarily because of complex technology and procedures, high demand on services, time pressure, high expectations of customers, and the hierarchical nature of training and responsibilities.

The World Health Organization estimates that 1 in 10 patients is harmed while receiving hospital care. The Agency for Healthcare Research and Quality Disparities Report in 2003 indicated that the rate of harm for hospital admissions was 25.1 per 100 admissions, or about 1 in 4.

Some of the major contributors to the hospital acquired conditions were adverse drug events, patient falls, central line-associated infections, ventilator-associated pneumonia, catheter-associated urinary tract infections, and pressure ulcers. Predominantly, the underlying causes of these errors include:

- Communication problems
- Inadequate information flow
- Human related problems
- Organizational transfer of knowledge
- Staffing patterns and workflows
- Inadequate policies and procedures
- Technical failures

Investigators need to examine all aspects of the process rather than concentrating on human error. If you focus on the outcome and work backwards (hindsight bias), it may look like the path to failure was foreseeable or predictable, when in fact it was not. It is important to remember to take a systems approach as described in earlier modules to look at the processes that contribute to medical errors. Remember that ninety-nine percent

of errors occur because of system and process failures, not bad people.

2. Goals of Risk Management

Kuhn & Youngberg suggested that patient safety improvement is the number one goal of the modern healthcare risk management movement. The American Society for Healthcare Risk Management (ASHRM) and The Joint Commission are encouraging the profession to work toward “Getting to Zero” serious safety events, or SSEs. As defined by ASHRM, a serious safety event, in any healthcare setting, is a deviation from generally accepted practice or process that reaches the patient and causes severe harm or death, according to ASHRM (Hoppes & Mitchell, 2012). To achieve the aim of zero SSEs, organizational leaders must implement and support a just culture with psychological safety so that mistakes can be discussed openly and risks can be addressed. These leaders also must become "systems thinkers" who demand robust analyses of safety issues to identify opportunities that build a safer healthcare system. This module will explore how risk management will play a significant role in achieving zero harm and delivering safe, reliable, and effective care.

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Support

If you are struggling with a concept or terminology in the course, you may contact **RiskManagementSupport@capella.edu** for assistance.

If you are having technical issues, please contact **learningcoach@sophia.org**.