HOSPITAL RISK MANAGEMENT SELF-ASSESSMENT

Hospital Name _________________________________________________________________

Name of person completing assessment _____________________________________________

Title ____________________________ Phone Number ______________________

E-mail Address _____________________ Date assessment completed ________________

This assessment tool is intended to help administrators, managers and physicians involved in hospital operations identify potential risks in their hospital. Time spent on this assessment can be very beneficial. Consider involving key staff members in conducting the assessment, allowing them to see first hand the results of their efforts and areas where improvement would be helpful.

How to Use this Assessment:

1. Be honest, objective and self-critical. The assessment is designed to help you identify and begin correcting risk management weaknesses in your hospital systems, policies and procedures. It will be only as effective as you allow it to be. Analyze your systems carefully and respond accurately.

2. Many hospitals discover that although there are policies in place, compliance is low. If you are unsure whether an established policy is effective, check with staff members most directly responsible for its implementation.

3. This assessment addresses risk management issues most often seen in malpractice claims. It does not cover all possible problems in hospital systems that could lead to patient injuries and lawsuits.

4. The assessment does not evaluate hospital quality of care issues. These should be monitored through the appropriate quality assurance and credentialing mechanisms in your hospital.

Instructions:

1. Please fill in the appropriate response to the attached questions. Please type or print your responses. If additional space is needed, extra pages may be added.

2. If the answers to questions vary between hospital sites or departments, please so indicate. The following sections have been separated from the general Risk Management assessment. Please forward these sections to the appropriate person within your facility to complete the responses.
   a. Surgery and Anesthesia
   b. Emergency Department
   c. Outpatient Procedures
   d. Obstetrics and Neonatal

3. Retain a copy of the Self-Assessment for your records.

4. Please return the completed Self-Assessment and the section specific Self-Assessments to your MMIC Risk Management Consultant as soon as possible.
### Governing Board

The Governing Board of any health care organization is ultimately responsible and accountable for the quality of care provided, the performance of physicians and staff, and the effectiveness of the organization's patient safety, risk management and quality performance programs. The Board carries out its responsibilities through its mission statement, goal prioritizations and allocation of resources.

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a current organizational chart reflecting lines of authority and the Board’s overall responsibility for the organization.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>2. Governing Board bylaws are reviewed on a routine basis and revised as necessary.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. Bylaws address the Board’s role and authority for quality of care.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. Governing Board approves the Risk Management/Quality Improvement/Patient Safety plan.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>c. The Board routinely reviews RM/QI/Safety reports.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>3. There is a formal process for contract approval in place.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. Governing Board approves contractual agreements or delegates responsibility to CEO/Administrator.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. All contracts include HIPAA provisions for business associate agreements.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>4. Governing Board approves the medical staff bylaws, rules and regulations.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>5. Governing Board approves medical staff credentialing recommendations and makes final determination for granting privileges.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>
Administration

Top level management demonstrate support for risk management/quality performance and a commitment to patient safety by having processes and policies in place conducive to promoting an environment that protects patients from injury.

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a written chain of command policy that includes 24-hour administrative responsibility. (The Chain of Command policy statement identifies the process clinical staff should follow to go up the hierarchy within the organization when they have concerns about the quality of care a patient is receiving or if the physician is unable to or doesn't respond.)</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>2. There is a zero-tolerance policy addressing workplace abuse that defines acceptable and non-acceptable behaviors by physicians and facility staff which could cause disruption to patient safety.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. The policy identifies reporting processes and defines management of non-acceptable behaviors.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. The policy prohibits retaliation against those who report non-acceptable behaviors.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>3. There are written and approved job descriptions in place for all hospital positions that reflect the knowledge, skills and abilities required to perform the job.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. Written performance review of all staff, based upon the job description, is conducted and addresses competency to perform job requirements.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. There is documentation of staff education related to new policies and procedures.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>4. Qualifications, references and licenses (when licensure is required) are verified for all hospital employees prior to hire.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>5. Criminal background checks are conducted for all potential employees prior to hire.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>6. All administrative and department facility policies are reviewed on a routine basis and updated to reflect current standards and practice.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>7. Outdated policies and procedures are retained pursuant to your state statute of limitations.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>8. An orientation program is in place for all hospital employees upon hire.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. An orientation program is in place for all temporary/agency workers. (N/A applies only if temporary/agency workers are never utilized.)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9. Policies are in place describing how to identify and manage impaired employees whose job performance may be affected by mental or physical health or who may be impaired due to use or abuse of chemicals (medications, drugs, alcohol).</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>
10. Staff are trained on usage of new equipment prior to usage.  

11. Training and competence is documented.

## Medical Staff

An effective risk management/quality performance plan requires the active participation of the medical staff.

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical staff bylaws, rules and regulations are reviewed on a routine basis.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>2. Credentialing process is monitored for compliance with the established criteria.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. The credentialing process includes allied health professionals (CRNA, CNM, NP, CNS &amp; PA). (N/A applies only if you do not have allied health professionals in your facility.)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b. The credentialing process includes locum tenens. (N/A applies only if you have no locum tenens coverage.)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>c. Liability insurance coverage is annually verified for adequate limits and tail coverage.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>d. Criminal background checks are conducted for all physicians/allied health professionals (CRNA, CNM, NP, CNS, PA) prior to appointment.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>3. Reappointment and delineation of clinical privileges are done at least every two years.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. Reappointment procedure includes review of physician's/allied health professional's quality improvement activities and is used in granting of privileges (complication rates, patient complaints, compliance with medical staff bylaws, etc.).</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>4. Program is in place to identify and manage physicians and allied health professionals whose performance may be affected by mental or physical health or who may be impaired by chemical use and/or abuse.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>5. The bylaws or medical staff policies address zero-tolerance standards for workplace abuse and define acceptable and non-acceptable behaviors for physicians and allied health professionals which could cause disruption to patient safety.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>a. The bylaws/policies identify how reports of workplace abuse will be managed.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. The bylaws/policies prohibit retaliation against those who report non-acceptable behaviors.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>
6. Risk Management/Quality/Patient Safety reports are routinely reviewed by the medical staff.
   a. Meeting minutes reflect review/action and/or recommendations.
7. Medical staff bylaws/policies identify persons determined to be qualified to perform medical screening examinations.
Risk Management/Quality Performance

Accountability and responsibility for risk management/quality performance responsibilities vary with individual facility characteristics. Regardless, all risk management plans will need to identify reporting relationships and systems to recognize and manage risks.

1. There is an integrated and written Risk Management/Quality/Safety Plan in place.
   a. Interdisciplinary committees are in place to support the purpose and functions of the plan.

2. RM/QI/Safety reports are prepared, analyzed and presented to the Governing Board, medical staff, safety committee and other committees as appropriate throughout the facility.
   a. Minutes of the governing board, medical staff and various committees reflect actions taken.

3. There is a written process in place for reporting, tracking/trending and investigating incidents/occurrences/events.

4. Staff members and physicians receive specific education in identifying and reporting patient safety concerns, adverse events, near misses and medical errors.
   a. Feedback is provided to staff members and physicians who identify or report patient safety concerns.

5. There is a plan in place to provide support to individuals coping with the emotional aspects of being involved with an adverse event or medical error.

6. Written policy is in place describing how legal documents, correspondence, investigation and potential claims are handled.
   a. A person is designated to accept service of summons and complaint, subpoena or other legal documents.
   b. Protocol is in place for reporting to MMIC all lawsuits, claims, Board of Medicine complaints and other incidents that have potential to develop into claims.
   c. Communication with MMIC and defense attorneys is kept in a separate correspondence file, not the patient medical record.
   d. Patient medical record is protected from alteration when a potential claim has been identified.
   e. Medical equipment and devices involved in a patient injury are identified and sequestered.
      1. Equipment is removed from the service area
      2. Equipment is not sent to the manufacture
3. A third party is used to exam equipment

7. Risk management reviews all clinical contracts.
   a. Clinical contracts are reviewed for hold harmless agreements.
   b. Clinical contracts contain provisions for performance expectations.
   c. Clinical contracts contain provisions for participation in risk management/quality improvement activities.
   d. Clinical contracts include competency standards and licensing requirements.

8. There is a facility policy on photographing and videotaping.
   a. Policy includes the camera function of cell phones.

9. There is a written policy governing provider and employee activity on social networking (i.e. facebook, MySpace or twitter).

10. There is a policy addressing the use of cell phones by employees, patients and visitors.
### Culture of Safety – Patient Safety

Historically, hospital safety programs have focused on environmental safety. Since the IOM report, “To Err is Human: Building a Safer Health System” (1999), hospital safety programs have emphasized the organizational “culture” and clinical patient safety initiatives. “Culture of Safety” characteristics include a value on safety over productivity, open communication throughout the organizational hierarchy, value on learning as opposed to punishing, and value on improving system performance rather than on individual blame.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Culture of Safety” surveys are periodically conducted.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>a. Governing board members, medical staff and employees throughout the organization are invited to participate.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. Patient satisfaction is periodically measured, analyzed, reported and actions taken as appropriate.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. Patient and families are informed of the process to report concerns about safety.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4. Fall prevention program is in place.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>a. Compliance monitoring occurs to assure action is taken to reduce the risk of falling and to reduce the risk of injury should a fall occur.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. Policy on use of restraints is in place.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>a. Compliance monitoring occurs to assure adherence to the policy.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6. Hospital-wide protocol for latex allergy is in place.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7. Hospital-wide policy on the use and monitoring standards for moderate (conscious) sedation is in place. <em>(N/A applies only if moderate/conscious sedation is never used except in surgery.)</em></td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>8. Written policy is in place prohibiting the use of dangerous abbreviations, acronyms and symbols throughout the organization.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>a. A standardized “do not use” list of abbreviations (such as ISMP) has been adopted.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b. Use of abbreviations, acronyms and symbols is prohibited on all medication orders and prescriptions.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>c. Use of abbreviations, acronyms and symbols is prohibited on all orders and notes identifying procedures, surgeries, site verification and on the written consent.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>d. Compliance monitoring occurs to assure adherence to the policies.</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9. Written policy is in place prohibiting turning off alarms on any equipment.</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
10. Policy is in place that defines critical test results and reporting processes.
   a. Policy is in place requiring the person receiving critical test results to record and then “read-back” the test results.

11. A process is in place to monitor/verify appropriate follow-up for abnormal test results.

12. Policy is in place to reduce the dependency upon verbal and telephone orders.
   a. Policy is in place requiring the person receiving all verbal or telephone orders to record and then “read-back” the complete order.

13. Policy is in place to standardize and have pre-printed/electronic orders available to the extent possible.

14. Written policy is in place that requires use of at least two patient identifiers when providing care, treatment or service — i.e., name and birth date.
   a. The policy prohibits room number as one of the identifiers.
   b. The policy applies to medication administration.
   c. The policy applies to anytime the patient is transported, i.e., radiology.
   d. The policy applies to collection of laboratory specimens.

15. There is a policy on pressure ulcers that addresses admission assessment, photographing and documentation of ulcers present on admission and during course of treatment and treatment intervention.

16. Policy is in place to reduce the risk of air embolism. Policy includes:
   a. The placement, removal and care of central catheters (N/A applies only if central catheters are never used)
   b. Radiology procedures (N/A applies only if contrast radiology procedures are never provided)

17. Policy and procedures in place to reduce the risk of urinary tract infections acquired from indwelling urinary catheters.
   a. Policy follows CDC Guidelines

18. Policy and procedures are in place to reduce the risk of DVT/PE.
Culture of Safety – Communication

Health care has become more complex, increasing the potential for patient injuries and malpractice claims due to communication failures. Internal communication systems are essential to ensure that all providers are working together as a team to provide safe, efficient patient care. Active patient participation in all health care decisions requires a continuous dialogue between health care providers and patients about all aspects of care.

1. The hospital has a Rapid Response Team or, in the case of a critical access hospital, a Recognize, Respond and Treat program.  
2. All staff members, physicians and managers receive specific education in teamwork and communication techniques.  
3. A standardized approach to “hand-off” communication between shifts, including an opportunity to ask and respond to questions, has been established.  
4. A standardized approach is used for reporting to physicians updates or changes to the patient status. (An example would be the use of SBAR.)  
5. There is a policy on communicating an adverse outcome to patients and families that includes disclosure of medical errors.  
6. Interpreters trained in medical terminology are available for hearing impaired patients and for patients that do not speak or understand English.  
7. All patient education materials are written at the 5th grade reading level and are legible, concise and individualized for the specific patient.  
8. All physicians and staff receive education on health care literacy and techniques such as “teach back” to promote patient understanding and active participation in health care decisions.  
9. All physicians and staff receive education on cultural diversity to increase awareness of the influence of cultural beliefs in health care decision making.

Environmental/Equipment Safety

1. Written safety plans are in place (fire, tornado, bomb threat, internal disaster, pandemics and disaster recovery).  
2. Written plan in place to manage hazardous materials and waste.  
3. All equipment is inspected, tested, and maintained based on established criteria.  
4. Preventive maintenance is provided by qualified staff or vendor.
5. Documentation is maintained on all testing and quality control performed on equipment.

6. There is a policy in place for handling defective or malfunctioning equipment.

7. Emergency power is available for critical patient equipment and critical areas of hospital.

8. There is a policy and procedure in place to manage product, device and medical equipment notices and recalls.

---

**Medications**

1. All medication orders and discharge prescriptions are required to have the medication use or purpose written on the prescription.

2. Written policy is in place identifying “high risk” medications and the permitted practices related to use. Policy includes:
   a. Removal of concentrated electrolytes from patient care areas.
   b. Standardization of available drug concentrations available.
   c. Listing of look-alike/sound-alike medications and the precautions to be utilized to prevent confusion.

3. Policy is in place to require a label for all medications, medication containers (syringes, medicine cups, basins) or other solutions both on and off the sterile field. This includes all areas – surgery, radiology, patient care units, outpatient areas.

4. Pediatric dosing chart is readily available for physicians, pharmacists and nursing staff in all hospital clinical areas (“rule of six” is not an acceptable standard).

5. Medication reconciliation program is in place.
   a. Complete list of medications is provided to the “next” provider of service (another facility, MD office, home health, etc.).
   b. Complete list of medications is provided to the patient at discharge.

6. Medication errors are jointly reviewed by nursing and pharmacy.
## Infection Prevention and Control

1. A designated person is assigned responsibilities for infection control activities.  
   
2. There are written infection control processes, policies and procedures that demonstrate surveillance, recognition, investigation and control of infections to prevent the onset and spread of infection.  
   a. Documentation is present reflecting corrective action to improve processes and outcomes.  
   
3. Staff receives education on Hand Hygiene protocols following the CDC hygiene guidelines.  
   a. Patients and families are educated on importance of facility staff following hand-washing protocols prior to providing patient care.  
   
4. Standardize policies and procedures are in place for cleaning and disinfecting medical equipment, devices, and supplies.  

5. Sterilization protocols follow manufacturer’s guidelines and infection control standards.  

6. When reprocessing single use devices, the practice is consistent with regulatory and professionals standards.  
   *(NA applies only if single use devices are never reprocessed.)*  

7. There is an identified protocol to prevent infections related to IV therapy.  
   a. Protocol follows CDC guidelines

## Outpatient Procedures

1. Patients are assessed and screened for appropriateness of treatment as an outpatient.  
   a. ASA classification  
   b. age (extremes)  
   c. psychosocial difficulties  
   d. limitations of surgical facility or providers  
   e. hypothermia  
   f. sleep apnea
2. A process is in place to conduct pre-anesthesia evaluation prior to day of surgery admission as an outpatient.

3. A process is in place to provide preoperative education prior to day of surgery.

4. A process is in place to validate informed consent prior to day of surgery.

5. A written policy defining discharge criteria is in place.
   a. Patients who receive other than local anesthesia are discharged with a responsible adult.
   b. Responsible adult is documented in the medical record.

6. There is a written policy in place for inpatient admission or transfer in the event the patient requires a higher level of service.
Effective systems and processes within a hospital can reduce patient injuries and malpractice claims. Core processes within the hospital include documentation, managing patient data, patient relations and communication.

This assessment tool is intended to help administrators, managers and physicians involved in hospital operations identify potential risks in the surgery and anesthesia area. Time spent on this assessment can be very beneficial. Consider involving key staff members in conducting the assessment, allowing them to see first hand the results of their efforts and areas where improvement would be helpful.

**How to Use this Assessment:**

1. Be honest, objective and self-critical. The assessment is designed to help you identify and begin correcting risk management weaknesses in your systems, policies and procedures. It will be only as effective as you allow it to be. Analyze your systems carefully and respond accurately.

2. Many hospital departments discover that although there are policies in place, compliance is low. If you are unsure whether an established policy is effective, check with staff members most directly responsible for its implementation.

3. This assessment addresses risk management issues most often seen in malpractice claims. It does not cover all possible problems in hospital systems that could lead to patient injuries and lawsuits.

4. The assessment does not evaluate quality of care issues. These should be monitored through appropriate quality assurance and credentialing mechanisms.

**Instructions:**

1. Please fill in the appropriate response to the attached questions. Please type or print your responses. If additional space is needed, extra pages may be added.

2. Retain a copy of the Self-Assessment for your records.

3. Please return the completed Self-Assessment to your facility Risk Manager as soon as possible.
### Anesthesia

1. Written anesthesia policies and procedures are in place and current.  
   - Y  N  NA: 0 0 0
2. Policies and procedures adhere to American Society of Anesthesiologists (ASA) and American Association of Nurse Anesthetists (AANA) standards.  
   - Y  N  NA: 0 0
3. Anesthetic agents and medications are in a secured area.  
   - Y  N  NA: 0 0
4. Policy regarding control, accountability and distribution of narcotics and anesthetic agents is in place.  
   - Y  N  NA: 0 0
5. There is documentation of pre-anesthesia evaluations/visits.  
   - Y  N  NA: 0 0
   a. Pre-anesthesia evaluation includes criteria to assess patients at risk for post-anesthesia complications from sleep apnea.  
      - Y  N  NA: 0 0
   b. Pre-anesthesia evaluation includes criteria to assess patients at risk for hypothermia.  
      - Y  N  NA: 0 0
6. There is documentation of post-anesthesia care.  
   - Y  N  NA: 0 0
7. Informed consent for anesthesia is obtained and documented by anesthesia personnel.  
   - Y  N  NA: 0 0
8. There is a written policy that requires anesthesia equipment be checked prior to each case to ensure proper function.  
   - Y  N  NA: 0 0
9. There is an established standardized approach for “hand-off” communication between anesthesia providers, when anesthesia personnel change during a procedure. *(NA applies only if there is never a change of anesthesia personnel during a procedure.)*  
   - Y  N  NA: 0 0 0
10. A written policy defining discharge criteria is in place for PACU.  
    - Y  N  NA: 0 0

### Surgery

1. Written surgery policies and procedures are in place and current.  
   - Y  N  NA: 0 0
2. Informed decision-making (consent) for the specific procedure is documented in the medical record.  
   - Y  N  NA: 0 0
3. Informed decision-making is obtained from patient prior to permitting any vendors and/or visitors in the surgery suite.  
   - Y  N  NA: 0 0
4. A current list of approved clinical privileges for medical staff and allied health professionals is available in the surgical area.  
   - Y  N  NA: 0 0
   a. There is a policy requiring review of the approved privilege list prior to scheduling.  
      - Y  N  NA: 0 0
b. There is a policy requiring notification of manager/RM/QI or the person in authority for any request outside of the approved list of clinical privileges.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

c. There is a policy defining the process for reviewing requests for additional privileges and for making decisions for adding surgical procedures to the facility’s scope of services.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

5. Protocols for latex sensitive patients are in place.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

6. Patient identification is verified and documented by surgical personnel according to Universal Protocol using the following five steps:  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Use of 2 patient identifiers.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. Patient identification is confirmed and verified prior to entering OR suite.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>c. There is site marking by physician prior to patient entering OR suite.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>d. There is verification of patient, procedure and surgical site after patient enters OR suite.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>e. There is a “Time Out” in the OR suite after patient is prepped and draped that involves the entire team.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>i) “Time Out” requires each person in the room to verbally acknowledge participation.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

7. A checklist is used prior to starting a procedure to assure all required blood products, implants, devices and special equipment are available.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

8. The medical record reflects all facility and non-facility personnel in attendance during procedure(s).  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

9. Sponge, sharp and instrument counts are conducted and documented in accordance with AORN standards.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Only radiopaque sponges and devices are used.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>b. Standardized counting procedures are utilized including sponge counts for vaginal procedures.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>c. High-risk conditions/situations are identified and require visual inspection prior to closure.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

10. There is a policy in place on retained devices and fragments.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Instruments/devices are inspected to assure all parts are intact and removed from the surgical site.</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

11. All medications, medication containers (e.g. syringes, medicine cups, basins) or other solutions on and off the sterile field are labeled.  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

12. There is a policy to prevent surgical site infections. Policy includes:  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Appropriate use of antibiotics</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

Copyright 2012   1453   12/6/12
b. Appropriate hair removal
   Y N NA
       O O O

c. Perioperative glucose control
   Y N NA
       O O O

d. Perioperative normothermia
   Y N NA
       O O O

13. Guidelines are in place on how to control heat sources, manage fuels and minimize oxygen concentration.
   Y N NA
       O O O

14. OR staff, anesthesia personnel and physicians have annual surgical fire safety training.
   Y N NA
       O O O
Effective systems and processes within a hospital can reduce patient injuries and malpractice claims. Core processes within the hospital include documentation, managing patient data, patient relations and communication.

This assessment tool is intended to help administrators, managers and physicians involved in hospital operations identify potential risks in the Emergency Department. Time spent on this assessment can be very beneficial. Consider involving key staff members in conducting the assessment, allowing them to see first hand the results of their efforts and areas where improvement would be helpful.

How to Use this Assessment:

1. Be honest, objective and self-critical. The assessment is designed to help you identify and begin correcting risk management weaknesses in your systems, policies and procedures. It will be only as effective as you allow it to be. Analyze your systems carefully and respond accurately.

2. Many hospital departments discover that although there are policies in place, compliance is low. If you are unsure whether an established policy is effective, check with staff members most directly responsible for its implementation.

3. This assessment addresses risk management issues most often seen in malpractice claims. It does not cover all possible problems in hospital systems that could lead to patient injuries and lawsuits.

4. The assessment does not evaluate quality of care issues. These should be monitored through appropriate quality assurance and credentialing mechanisms.

Instructions:

1. Please fill in the appropriate response to the attached questions. Please type or print your responses. If additional space is needed, extra pages may be added.

2. Retain a copy of the Self-Assessment for your records.

3. Please return the completed Self-Assessment to your facility Risk Manager as soon as possible.
Emergency Department

1. Written emergency policies and procedures are in place and current.  
   Y N NA
   O O

2. A current list of approved clinical privileges for medical staff and extended practitioners is available in emergency department.  
   Y N NA
   O O

3. Each patient presenting to ED receives a complete assessment by a physician, or allied health professional (PAs, NPs) or registered nurse qualified and defined by the medical staff bylaws to perform a medical screening exam according to EMTALA requirements.  
   Y N NA
   O O

4. There is an ED physician on-call list.  
   Y N NA
   O O

5. All pregnant females presenting to the ED receive an assessment of fetal status.  
   Y N NA
   O O

6. Staff trained and certified in life support is available 24 hours/day.  
   Y N NA
   O O

7. All transfers are monitored to assure compliance with EMTALA regulations.  
   Y N NA
   O O

   a. Medical records are monitored to assure documentation is complete and comprehensive.  
      Y N NA
      O O

8. Ancillary service (i.e., radiology, laboratory, respiratory) staff are readily available either in-house or on-call.  
   Y N NA
   O O

9. There are follow-up systems for laboratory results received after patient discharge and for radiology over-reads.  
   Y N NA
   O O

   a. The system for notifying the primary physician of test results/over-reads is monitored to assure effectiveness.  
      Y N NA
      O O

10. The follow-up system includes direct notification of patients who do not have a primary care physician or are visitors to your community.  
    Y N NA
    O O

    a. There is documentation in the medical record of patient notification.  
       Y N NA
       O O

11. There is a system for handling telephone calls from patients that have been seen in the ED but who request clarification on treatment, medication, follow-up, etc.  
    Y N NA
    O O

    a. There is documentation in the medical record or in a log demonstrating additional assessment, treatment advice, referrals, etc., provided to the patient.  
       Y N NA
       O O

12. Discharge instructions are written at 5th grade reading level and are legible, concise and individualized for the specific patient.  
    Y N NA
    O O

13. There is an emergency plan in place for management of mentally ill patients and intoxicated patients pending stabilization or appropriate placement.  
    Y N NA
    O O

14. There is a policy in place prohibiting telephone advice to callers to the ED who may have questions regarding general health issues, symptoms, treatment recommendations or the need to be seen.  
    Y N NA
    O O
a. If telephone advice is provided, there are written physician approved protocols to support the advice. *(N/A applies only if telephone advice is never given.)*

b. If telephone advice is provided, there is documentation reflecting the nature of the advice. *(N/A applies only if telephone advice is never given.)*

c. There is compliance monitoring of the policy.
Effective systems and processes within a hospital can reduce patient injuries and malpractice claims. Core processes within the hospital include documentation, managing patient data, patient relations and communication.

This assessment tool is intended to help administrators, managers and physicians involved in hospital operations identify potential risks obstetrical and neonatal area. Time spent on this assessment can be very beneficial. Consider involving key staff members in conducting the assessment, allowing them to see first hand the results of their efforts and areas where improvement would be helpful.

**How to Use this Assessment:**

1. Be honest, objective and self-critical. The assessment is designed to help you identify and begin correcting risk management weaknesses in your systems, policies and procedures. It will be only as effective as you allow it to be. Analyze your systems carefully and respond accurately.

2. Many hospital departments discover that although there are policies in place, compliance is low. If you are unsure whether an established policy is effective, check with staff members most directly responsible for its implementation.

3. This assessment addresses risk management issues most often seen in malpractice claims. It does not cover all possible problems in hospital systems that could lead to patient injuries and lawsuits.

4. The assessment does not evaluate quality of care issues. These should be monitored through appropriate quality assurance and credentialing mechanisms.

**Instructions:**

1. Please fill in the appropriate response to the attached questions. Please type or print your responses. If additional space is needed, extra pages may be added.

2. Retain a copy of the Self-Assessment for your records.

3. Please return the completed Self-Assessment to your facility Risk Manager as soon as possible.
Obstetrical Services

1. Written OB policies and procedures are in place and current. *(N/A applies only if you facility does not provide OB services.)*
   - Y N NA
   - O O O

2. A current, approved list of clinical privileges for medical staff and extended/allied health professionals is available in the obstetrics department.
   - O O

3. There is a policy in place prohibiting telephone advice to callers with questions regarding potential complications (such as bleeding, abdominal pain), active vs. false labor, etc.
   - O O
   a. If telephone advice is provided, there are written physician approved protocols in place to support the advice. *(N/A applies only if telephone advice is never given.)*
      - O O O
   b. If telephone advice is provided, the call is documented in the medical record and provided to the physician. *(N/A applies only if telephone advice is never given.)*
      - O O O

4. A written policy requiring fetal heart monitoring on all active labor patients is in place.
   - O O

5. Written criteria for pathologic examination and retention of the placenta and umbilical cord are in place.
   - O O

6. Policy requires physician to be readily available during augmentation of labor.
   - O O

7. There is capability to begin a C-section within 30 minutes from decision to incision.
   - O O

8. Transfers comply with EMTALA regulations.
   - O O

9. Prenatal records are received from physician’s office prior to delivery (6 weeks).
   - O O

10. Physician, anesthesia personnel and surgical team are immediately available as stated by ACOG standards for VBACs. *(N/A applies only if VBACs are not within your facility’s scope of services.)*
    - O O O

11. There is a facility/department policy on photographing and videotaping specific to obstetrical and neonatal services.
    - O O

12. Sponge counts are completed and documented for vaginal procedures.
    - O O

Neonatal Services

1. Written nursery policies and procedures are in place and current. *(N/A applies only if neonatal services are not provided.)*
   - Y N NA
   - O O O
2. Infant and mom are immediately ID banded at time of delivery.  
   Y  N  NA  
   O  O  

3. ID bands are checked and verified whenever infant is taken to mom.  
   Y  N  NA  
   O  O  

4. Delivery records reflect Apgar scores, eye treatment and administration of Vitamin K.  
   Y  N  NA  
   O  O  

5. A written plan to prevent infant abduction is in place.  
   Y  N  NA  
   O  O  
   a. Drills are performed at least annually.  
      Y  N  NA  
      O  O  

6. A complete newborn physical assessment is performed within two hours of delivery.  
   Y  N  NA  
   O  O  

7. Transfers comply with EMTALA regulations.  
   Y  N  NA  
   O  O