RISK MANAGEMENT

Risk Management is a process used to identify and monitor potential preventable and non-preventable occurrences which may impact adversely upon the practice. Monitoring techniques are designed to minimize the frequency or severity of incidents. This monitoring process allows for early detection and evaluation of areas of concern, identifying recurring adverse events. Minimizing risks to patients, employees, and visitors can help NGOC achieve a high quality of patient care.

Risk Management is an integral part of the Quality Management Program. The purpose of incorporating Risk Management into the program is to reduce the risk of potential liabilities to the organization, the employees, the patients and the family members/caregivers through a proactive approach. All incidents are reviewed by the Quality/ Risk Management Nurse. Quarterly tracking will be reported to the Director of Clinical Operations and as necessary the Medical Director; incidents will be evaluated for trends and an appropriate action plan developed when trends are identified.

1. Incidents may include, but are not limited to:
    a. Catheter or Access Device complications
    b. Research Protocol Deviation
    c. Infections (related or non-related to Access Device use)
    d. Medication errors
    e. Supply Errors/problems
    f. Equipment errors/problems
    g. Laboratory errors
    h. Adverse drug reactions
    i. Employee injuries
    j. Needle stick injuries or body fluid exposures
    k. Exposure to hazardous and infectious wastes
    l. Patient injuries/falls
    m. Errors in compliance with physician's orders or -biohazardous waste
    n. Communication or non-communication of information
2. Documentation and action taken related to incidents is part of Northwest Georgia Oncology Center's Quality/ Risk Management Program and shall be maintained and secured as confidential.
3. Copies of an Incident Report shall not be placed into an employee's personnel file or medical file or provided to outside entities.
4. All incidents that occur within the office or in the delivery of patient care are documented on an Incident Report form by the person who observes or first becomes aware of the situation.
5. The immediate supervisor must receive a verbal report of all incidents at the time of the incident or as soon as possible. This must be followed up with a written Incident Report within 24 business hours.
6. The written Incident Report should be forwarded to the department supervisor and then to the Director of Quality Management. No additional copies shall be made or kept in any other file.
7. Any incidents that result in death, dismemberment, loss of sense (vision, hearing, etc.) should be reported to the appropriate physician, immediate supervisor, and Director of Clinical Operations immediately.
8. The Director of Quality Management shall follow-up on each Incident Report, track all reports submitted on a quarterly basis, and present the information to the Director of Clinical Operations quarterly or more frequently as needed.
9. Trends, actions, follow-up shall be reported to the Board of Directors on at least a quarterly basis by the Director of Clinical Operations.
10. The Incident Report shall be used:
    a. to identify and document any situation that jeopardizes the health or well-being of a patient, significant other, caregiver during the patient's course of therapy or care provided by the office staff;
    b. to identify and document any situation that jeopardizes the health or well-being of a NGOC employee during their employment;
    c. as a record of actions taken by NGOC employees, as well as help to identify possible problem areas or unfavorable trends within the organization in order to reduce the likelihood of these errors recurring.
11. The incident may be considered resolved and closed upon determination that it has been thoroughly documented, investigated and all necessary corrective actions and/or follow-up have been completed.

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