

until their family arrive to take them home.

On two occasions we have utilized a volunteer to follow a cataract patient into the O.R. and sit with him during the procedure. The patient may have otherwise had to have a general anaesthetic because of fear or apprehension and the inability to lie quietly. He knew and trusted the volunteer because she had been with him preoperatively. It worked beautifully.

Follow-Up Phone Calls

On post-operative phone calls that I make to a cross section of all patients, I receive comments such as these:

- "My son said the best part of the operation was 'the lady who played soldiers with him'".

- "Please thank your volunteer person. She put me at ease and kept my mind occupied."

From the volunteers themselves I hear:

- "E.N.T. day is a grandmother's heaven with all those little children, I love them all!"

- "With cataract patients I get such a feeling of satisfaction when I can comfort them and make them less afraid." *Note: the volunteer remains with the patient when the anesthesiologist injects the freezing.*

- "I enjoy people, young or old. I felt a need to do something for the community. In our busy life-style of the 90's, no one seems to have time to really listen. As a volunteer I take time to just listen, to share and to accept them as they are and, hopefully, lessen some of the uncertainties. A problem shared is a problem halved! Feedback has been positive and I feel a great deal of anxiety has been reduced through the work of a great team of medical personnel in Stony Plain. I've enjoyed it greatly!"

Acknowledgement

I wish to acknowledge our volunteers, past and present, for their dedication and care to our surgical patients:

Doris Stonehouse	Shelly LeFebvre
Doris Larsen	Tammy Bishop
Carole Woloshyn	Marilyn Ulmer
Isobel Baron	Vi Criss
Betty Marshall	

I must also recognize Maureen Eykelenboom, the volunteer coordinator who began this program here at Stony Plain Municipal Hospital and who approached me with a question, "Do you think there could be any place for volunteers with surgical patients?"

There absolutely is a very important place for them. Thanks, Maureen.

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Risk Management

By Darlene Beaudet, RN, BScN

Introduction

Risk is encountered by everyone everyday. Since the beginning of time, humans have had to deal with risk. Controlling and eliminating the known risks are what we call risk management.

Risk management (RM) dates back 6000 years. In Babylonia in 4000 B.C., evidence has been discovered which indicates that efforts were made to minimize damage by fire and cargo loss at sea. Still, health care risk management is relatively new. In 1965, the case of Darling vs. Charleston Community Memorial Hospital set a precedent. In that case, the Illinois Supreme Court held that a hospital could be liable if the nursing staff failed to notify medical and hospital administration when they knew that a patient was receiving inadequate care from a physician, or if the hospital failed to review and monitor treatment by physicians, and failed to enforce medical staff bylaws requiring physicians to obtain consults when necessary. The private physician in this instance was a general practitioner who had been allowed by the hospital to practice orthopedics even though his competence had not been reviewed in more than 30 years (Southwick, 1988).

The medical malpractice crisis of the mid-1970's in the U.S. emphasized the need for risk management in health care.

RM, QA, CQL & TQM

What is risk? The Oxford dictionary defines risk as an " exposure to chance of injury or loss". Risk management may therefore be defined as " a management function aimed at the identification, evaluation, and treatment of risks that could result in a loss (Youngberg, 1994)." The purpose of risk management is to maintain the financial viability of the organization.

How does this differ from quality assurance? QA is " a process of systematic evaluation to ensure excellence in health care (Meisenheimer, 1992)." The goal of QA is continuous improvement of patient care.

Continuous quality improvement or CQI is meant to continuously monitor, improve and account for quality of performance. TQM, total quality management, "is a systematic way of ensuring that organized QA activities occur, and that they occur not only to ensure quality of care, but also to continuously improve care. This approach includes collaboration of individuals from all disciplines at all levels of the organization" (Meisenheimer, 1992).

Purpose of QA & RM

Quality assurance strives for improvement but does not count the cost or the risks, whereas, risk management may not make us feel better, but it might keep us out of trouble.

Risk management is a system or a process. There are six basic steps to follow in risk management:

1. Identification of a risk or problem,
2. Analyze the problem or risk identified,
3. Develop alternate techniques or corrective actions,
4. Choose the best techniques or corrective actions,
5. Treat the risk or implement corrective action, and
6. Evaluate the strategies.

Author

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Risk Identification

Risk identification is a first step in the decision making process in which the risk manager becomes aware of risks that constitute potential loss exposures for the institution; i.e., property loss, net income loss, liability loss and personnel loss. Some sources of this information can be obtained from:

- Incident reports
- Infection reports
- Occurrence screening in conjunction with the QA program
- Walk through inspections
- Past accreditation and licensure surveys
- External consultants reports
- Occupational Health and Safety reports
- Informal discussion with staff employee incident reports, and
- Preventive maintenance records.

The first step of the risk management process, risk identification, makes certain that reports are made of any adverse occurrence. Therefore, staff must be educated to recognize and reliably report any such occurrence.

Probably the greatest obstacle to overcome is resistance from medical and hospital staff to get involved in risk identification. The risk manager must have the ability to plan and coordinate activities so everyone is involved. An example is the strides that anaesthesiologists have made through implementing standards in monitoring. Professional associations, such as the Canadian Anaesthesiology Society, adopted minimal monitoring standards that require the use of pulse oximetry during anaesthesia to reduce the risk of injury from hypoxia.

Risk Analysis

In this step of risk management, an assessment is made of the potential severity of a loss associated with an identified risk, and the probability that a loss will occur. Some risks have a high frequency of occurrence, but low severity, such as lost personal property. Other risks have low frequency of occurrences, but high severity of loss when they do occur, i.e., a surgical mishap. The severity of a loss usually refers to direct financial loss, however, damage to a hospital's reputation could lead to economic losses in the future.

FREQUENCY	
LOW	HIGH
Visitor Falls	Most medication errors
Some Adverse Reactions	Most Patient Falls
Some Equipment-Related Issues	Lost Dentures and Other Personal Property
SEVERITY	
LOW	
Surgical/Anaesthesia Mishap	Fatal or Severe Medication Error
Birth-Related Problems	Fracture or Neurological Injury from Patient Fall
HIGH	
Emergency Service Related Problems	Failure to Diagnose Fractures/Disease

Development of Alternative Techniques or Corrective Actions

- Risk treatment falls into two categories:
1. Risk control to stop, reduce, or minimize losses
 2. Risk financing or risk transfer to pay for losses.
- Control is equal to loss prevention aimed at reducing the frequency of loss and loss reduction aimed at reducing the severity when it does occur. This may include exposure avoidance in which an institution may choose to not provide a high risk service, or risk transfer, in which independent contractors are hired.
- Some other measures that can be used as risk control are staff education, policy and procedure development and revision, preventive maintenance, and use of universal precautions in patient care.

Selection and Implementation

The selection of the best techniques for managing risks often result in a combination of risk control and

risk financing strategies. Risk control strategies require support and cooperation from department heads, physicians, and employees. Risk management must involve key people early in the process to make implementation a successful phase.

Monitoring and Evaluation

Once again, involve the key personnel. The risk manager must use empirical evidence to evaluate the effectiveness of a chosen method. These can be claims activity reports, surveys, incident reports, reports to safety and QA committees. Monitoring is on-going. Watch for trends from occurrence screening reports. Get feedback from physicians and nurses. Are procedures being followed? Are additional corrective actions necessary? Provide feedback to staff members on the results so that reporting will continue.

Risk Management Functions

The activities of risk managers usually include some or all of the following: •risk identification •loss prevention •loss reduction •Occurrence and incident reporting and investigation •overall insurance and claims management •involvement in the discovery process (e.g., interrogation, deposition scheduling) •educating all medical, executive, volunteer and employee staff in the process of liability control •reviewing new products/services to identify and assess potential risk •ensuring compliance with accreditation standards •ensuring compliance with federal, provincial, and local laws and regulations (ECRI, Perspectives 1,1992).

Staff Education

- The risk manager must educate staff at all levels on the purposes and goals of risk management, as well as on specific risk issues. He/She must coordinate educational programs with medical, nursing and technical schools if working in a teaching facility. When preparing for a presentation, the risk manager should work closely with the department head or supervisor to ensure that information provided is relevant to the day to day operations and concerns of the department.
- Two goals of risk management education are:
1. Foster support and cooperation on the part of staff for the risk management program, and,
 2. prevent or reduce the frequency and severity of incidents and accidental losses through the provision of information and feedback (ECRI, Perspectives 1, 1992).

Do not exclude those on off shifts and weekends. Remain visible and accessible.

Other Actions to Manage Risk

Risk financing is comprised of two essential strategies. As a companion of various risk control actions, it provides a financial safety net to cope with incidents that were not anticipated. Risk financing falls into two groups:

1. the facility retains the financial obligation, or
2. transfers the obligation to another organization (Wilson, 1992).

- When the facility retains control of the financial obligation, that is known as risk retention. Risk retention options include:
- use of a current account to finance minor claims such as belongings or equipment,
 - a funded reserve for larger damages or claims out of which payment is made,
 - borrowing through a prearranged line of credit to pay for losses incurred, or,
 - an insurance fund in which the program carries commercial insurance for claims over a certain amount.

In risk transfer, commercial insurance is purchased by the hospital which is allowed to participate for a variety of liabilities and obligations. This transfers the financial risk to another corporation as opposed to transferring the risk control. This transfers to another corporation the financial burden for loss (Wilson, 1992).

The Essentials of Facility Wide RM

The responsibility for risk is everyone's. Everyone is a risk manager.

Risk management is not new to health care. Facilities already operate programs whose sole function is to address a risk. For example, Occupational Health and Safety deals with environmental hazards, accidents to staff, and patients or visitors. Infection Control deals with nosocomial infections or contagious diseases. QA monitors and evaluates performance and improvement. In addition, risk is being managed in many ways in line departments each day. Kitchen sanitation, radiation protection, employee screening, Workplace Hazardous Materials Information System (WHMIS), are all part of risk management. Many facilities however, lack the crucial element of risk management. There is no one specific person who knows what risk events are occurring, what risks are being addressed,

and how effective the facilities RM activities are. Many facilities have risk management as a responsibility shared by many as part of their jobs, but neither supervised nor shared.

As an alternative to setting up another committee or program, senior management could create a system that confirms management's role in handling risks, sets standards on how it will be done, and receives reports and provides feedback to existing programs.

At the same time, management must empower department heads to manage risks within their departments, monitor and evaluate activities that make them more effective, identify aspects of the facilities operations where risks are not being managed, and, fulfil the obligation of the governing body to ensure that risks to patients, residents, staff, visitors and property are being managed effectively (CCHFA, 1991).

The CEO may designate him/herself or someone within the facility as the Risk Manager.

The picture of the facility-wide risk management that emerges is of risks, wherever they occur, being addressed by means of a standard process through either line risk management, or one of the risk management programs, and communicated to the risk manager, who will be responsible for the effective operation of the risk management system (CCHFA, 1991).

This distributed system of risk management respects the efforts of existing programs to manage risks. It promotes communication between risk management, line departments and their programs, and supports their activities. It also supports the motto "everyone is a risk manager", and empowers employees to manage risks. In this way, utilizing existing programs, management and staff, additional costs are limited to what the facility can afford.

Conclusion

In conclusion, this article wants to emphasize the idea that everyone is responsible for risks, and is therefore a risk manager. Education is a key component, however. If all staff at all levels understand the importance of minimizing financial loss for the institution, they then can understand that this may in fact impact on their own positions within that institution. In order to function, institutions must remain financially viable. This allows them to be in a position to provide safe, effective patient care with the right amount of resources. This in turn also allows them to be an active part of the community which they are meant to serve.

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Parse's Nursing Theory and the Practice of Perioperative Nursing

By Kimberly Andrus, R.N.

As a registered nurse with experience in perioperative nursing, I have my own philosophy of nursing consistent with theorists such as Dr. Martha Rogers and Dr. Rosemarie Rizzo Parse, in the simultaneity paradigm. In her nursing theory *Man-Living-Health: A Theory of Nursing*, Dr. Parse states that nursing is a human science and "the human sciences aim at understanding the connectedness of life itself" (Parse, 1981, 11). I, however, was educated with Roy's Adaptation Model and have been practising using that model. I did not realize, until studying theories such as Rogers' *Unitary Human Being Model* and Parse's *Human Becoming Theory*, why I was so frustrated with my nursing career. My philosophy of nursing, which is congruent with Dr. Parse's view, had been grossly inconsistent with the venue in which I practice nursing.

It is because of this theoretical work that I feel enlightened and encouraged to take my practice of

perioperative nursing into a more productive and appropriate direction. I hope to utilize my interpersonal skills to more accurately reflect my philosophical beliefs in the simultaneity paradigm. This paper describes my philosophy of nursing as it relates to Parse's *Human Becoming Theory* within the nursing metaparadigm.

The Human and the Environment

Based on my personal observations of people and human nature, coupled with my years of experience in perioperative nursing, I feel that every individual is unique. Although we share some similarities, no two individuals experience or react to life in exactly the same way. I also believe that because of their uniqueness, people continually make individual choices in their lives and must assume ultimate responsibility for their choices. This concept is consistent with Parse's opinion that "a person is viewed as an open being who is more than and different from the sum of the parts" (Wesley, 1995, 131) and "in having to choose how he will comport himself in a given situation, man is a thinking, feeling being, who bears responsibility for his choices" (Parse, 1974, 20).

Furthermore, like Parse, I believe that the human and his environment cannot be separated. An individual reacts to his environment in his own unique way, therefore, the two elements (the human and the

Abstract

Many nurse theorists have emerged in the midst of the Nursing Profession's struggle for recognition as a science. To gain autonomy we as nurses must first examine our personal philosophies of nursing. Then we can examine why so many nursing professionals experience "burn out" so early in their careers. I propose that we must change how we define our practice from the use of the medical model to our own model. Although we work closely with medicine, we are not physicians or medical aids; we are nurses.

Author

Kimberly Andrus, R.N., is a perioperative nurse at Mount Sinai Hospital in Toronto.