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FORGING THE RISK MANAGEMENT PATH

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INTRODUCTION

Quality, Safety and Compliance are the foundations which build the organizational culture of Makati Medical Center (MakatiMed). The MakatiMed community, both clinical and non-clinical, forges the Risk Management path to proactively reduce or eliminate the potentially harmful impact of known or possible risks.

The Governance (Board of Directors) and Hospital Leadership (President and CEO, Medical Director, Division Heads and Directors of Medical Group), through the Senior Quality Management Council (SQMC), provides oversight in the establishment and implementation of the Risk Management Program. The Department/Division Leadership and the Quality, Safety and Compliance Champion (QSCC) implement the Department/Division Level Risk Management activities.

The Quality Management Division-Clinical Safety and Risk Management (QMD-CSRM) assists in the implementation of the Hospital and Department/Division Levels Risk Management activities.

AIM

- Identify, assess, prioritize potential risks that could have the greatest impact on patient and staff safety and on the quality of patient care
- Manage risk by selecting appropriate controls, implementing the planned methods, and evaluating its effectiveness.
- Communicate the risk management activities to the hospital leadership and staff.

RESULTS

Enterprise Risk Management (ERM) - - - - -

The SQMC examined the 2019-2020 events which occurred. Risks which impacted the safety of patients, staff members, visitors and resulted to damage or loss to the organization were identified through: Incident Reports, Complaints, Satisfaction Surveys, Records Review, Accreditation and Regulatory Surveys, Division/Department Monitors.

Priority risks were related to **Human Capital, Financial, Operational and Facility Management**. Strategies on Manpower Recruitment, Retention and Competency Building, Sales Target Increase, Facility Rehabilitation, Information Technology Service Availability were included and monitored annually in the hospital 3-year Strategic plan.

Root Cause Analysis (RCA) - - - - -

Safety events are reported by staff members voluntarily in the hospital automated reporting system. Multidisciplinary Root Cause Analyses (mRCA) for safety events which involved several departments were facilitated by the QMD-CSRM with process owners and the respective QSCCs to drill down on the root causes and identify preventive strategies.

In 2021, 32 mRCAs were conducted and resulted to policy revisions, reorientations, process improvements, technology, and facility upgrading. For continuing education, RCA lecture and workshop were provided to 370 QSCCs and line heads last July 2022 to reinforce their competence. Also, for recognition, 66 departments/units with complete preventive strategies implementation were awarded during the September 2022 World Patient Safety Day celebration. In 2022, the conduct of mRCAs has increased by 125%.

Business Continuity Plan (BCP) - - - - -

Divisions/Departments established their BCP that outlines strategies to initiate activation, identify coordinators and communication officers, facilitate relocation, and/or continuity of operations and recovery of functions. Creation of the BCP form and orientation were done in Q1 of 2021. In November 2021, data from 68 department level BCPs were collated. **Department level BCP submissions were noted at 51% in 2021 and at 56% in 2022.** Identified risks were clustered to determine and prioritize the top 3 risks related to natural disasters, equipment breakdown, and power outage. Strategies were established and implemented. BCP refresher was conducted last July 2022 for 370 QSCCs and line heads. Updating of the BCPs was communicated to the QSCCs in November 2022. Challenges in data collation were identified. Automation of the system is planned for 2023.

Failure Modes and Effects Analysis (FMEA) - - - - -

The QSCCs of the identified high-risk process owners organized the risk assessment team, analyzed the current and new/to be process, identified the risks and risk management strategies. Data were documented using the FMEA Form, Risk Management Strategy (RMS) Form, and RMS Implementation Report. **The number of FMEAs conducted for 2021 and 2022 are 14 and 8 respectively.** Processes were both clinical and non-clinical: Paperless/E-signature project, Medication management, Pediatric emergency cart transfer, Patient Assistance staff.

METHOD

The program framework revolves around the Vision, Mission and Quality policy of the hospital and has the following components: Risk Identification and Assessment, Risk Prioritization, Risk Reporting, Risk Management, Claims management, Evaluation.



Risk Assessment Tools such as the following are utilized across the hospital:

- **Enterprise Risk Management (ERM)** for Strategic Planning, every 3 years: structured analytical method and process to manage risk instituted by the hospital leadership
- **Root Cause Analysis (RCA)** for Safety Events, as necessary: process for identification of the basic or causal factors that underlie variation in performance
- **Business Continuity Plan (BCP)**, annually: strategy and capability of the organization to continue delivery of products or services within acceptable time frames at pre-defined capacity during a disruption
- **Failure Modes and Effects Analysis (FMEA)** for new high-risk process, as necessary: systematic, proactive method for evaluating a process to identify Failure Modes, Failure Causes, Failure Effects

Information regarding these risk management tools were disseminated through hospital memos and infographics.

CONCLUSIONS

Risk management is routine in most industries. Organizations try to avoid financial loss or failure to meet production expectations by implementing strategies to prevent such events.

Similarly, hospitals utilize a variety of methods for managing risks. Success depends on the stakeholders co-producing solutions, creating and maintaining safe systems of care, designed to reduce adverse events and improve human performance.

Makati Medical Center has the Culture of Safety, Quality and Compliance that supports a structured work environment for high quality care.

A clinician, along with everyone else who works in a hospital, has a responsibility to take the correct action when they see an unsafe situation or environment. Also, working in teams at the different levels of the organization will redound to collective impact.

REFERENCES

Makati Medical Center, Risk Management Program

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