Hello and thank you for viewing this webcast about incident management and risk management. My name is Ann Ligi and I work for the Office of Developmental Programs. I will be your narrator for this webcast.

This is the first webcast in a series about incident management and risk management in Pennsylvania. Each webcast in the series will have a specific focus so that you can view the ones that pertain to you. This first webcast provides general information about incident management and risk management. Other webcasts will focus on specific topics and will be announced through ODP Communications when available for viewing.
Please adjust your computer volume to a comfortable listening level for you.

While viewing this webcast, there is a pause and rewind button available at the bottom of the viewing pane that can be used as needed to view the presentation.
At the end of the webcast, you will be able to:

- Define risk management (RM)
- List the components of ODP’s RM core functions
- Define Incident Management (IM)
- Describe what an incident is
- Describe the relationship between IM and RM
ODP has learned that there is a need to provide consistent information about the practice and concepts of incident management and risk management. This need was identified from:

- ODP’s review of incident reports
- Discussions with providers and Administrative Entities or AEs
- Review of ODP, provider and AE incident analysis reports and
- Feedback from provider and AE incident and risk managers.

Therefore, it was decided to offer a series of webcasts about incident management and risk management. This first webcast provides general information about incident management and risk management.

The Incident Management modules are intended to provide basic concepts, activities and ODP expectations associated with the response to and the management of incidents upon discovery and occurrence.

The Risk Management modules, likewise, will provide basic concepts about risk mitigation and management strategies, utilizing demographic information and incident data analysis. Two strategies will be used in the Risk Management modules, person-centered strategies and population-based evidence strategies. Person-centered strategies are specific to an individual's risk factors and population-based evidence strategies are specific to an organization's risk management business operation.

Both the Incident Management and Risk Management tracks will state ODP’s expectations in regard to the particular topics presented.
There are different definitions of risk that could be used. For our purposes, the definition from the Pennsylvania Department of Health, Bureau of Statistics is the one best aligned with the approach ODP takes to manage risk.

The definition of risk is “The presence of a factor [which] increases the probability that [an]...adverse outcome results. Likewise, the removal of the factor reduces the probability of an adverse outcome occurring.”

The definition mentions the presence of a factor. A factor is a descriptive characteristic for a person. An adverse outcome, which we will also refer to as an adverse event, is also mentioned in the definition and it is an undesirable outcome.

So you may be wondering what this looks like in real life. Demographic information such as age, gender, and ethnicity are some of the factors that can be associated with someone being at risk for an adverse event. For example, as you age you have a greater chance of developing a chronic illness such as heart disease or diabetes. In the example, age is the factor and the adverse event is developing heart disease or diabetes.
We’ve looked at what the definition of risk is. Let’s now think about what the definition of management is. Simply put, management is the act or art of conducting or supervising something or the judicious use of means to accomplish an end.
In its simplest form, risk management is minimizing the impact of factors associated with adverse events.

Let’s look at the five core functions of risk management.
The critical component of risk management is determining who is at risk and what the person is at risk for. A good beginning point is to analyze incident data. The data can be organized and analyzed to answer specific questions such as how many falls were reported in a year, who experienced those falls, were there any injuries associated with those falls, were there serious injuries such as fractures, did anyone experience more than one fracture in a year, etc. We can also look at the environmental conditions associated with falls such as when did the fall occur, where did the fall occur, what time of day was it, what time of year was it, what were the weather conditions, etc.

Understanding the answers to these questions helps us to identify factors that put people at risk for falls. In analyzing and understanding the data, let’s say we found potential risk factors that a majority of people had in common such as age, gait, medications, muscle strength, rugs in the home, surface conditions such as levelness of the ground or a broken sidewalk, and icy conditions outside.

Risk management also includes determining what prevents falls or reduces the likelihood of falling. Strategies intended to prevent or minimize falling are put in place. Let’s look at Ivan. Ivan is going down the driveway to the mailbox to get the mail and it has been snowing and there is ice on the driveway. A preventive strategy for Ivan, who has impaired muscle tone due to dystonia, would be to make sure Ivan has on his snow boots and is supported by staff while walking. A preventive strategy for other people with similar risk factors as Ivan would be to implement similar preventive strategies such as addressing the hazardous walking conditions in the environment.

Once the preventive strategies have been implemented, the next critical component of risk management is to monitor the outcomes or results. In our example about Ivan and others getting the mail when it is snowing, this means determining if the strategies implemented prevented falls, reduced the number of people falling or reduced the number of fractures associated with falls under similar conditions.

The final piece of risk management then is reporting the results, trends and lessons learned from implementing different strategies intended to prevent or reduce the likelihood of falls.

All of these components will be more fully explored throughout future risk management webcasts.
Many times when we look at one situation we may not see a pattern that is present. However, when looking at many similar situations, a pattern may emerge. So, the challenge is what can we learn from a single incident which will help to guide us to identify risk factors and preventive strategies for others.

So we need to see not only the tree in the forest, but also the pattern among the trees present within the forest.
Within the intellectual disability service system, risk management addresses behavioral, clinical and safety risks. Behavioral, clinical and administrative activities are developed and implemented to prevent adverse outcomes and lessen risk. Activities include identifying, evaluating, and intervening with the risk factors that contribute to injury, harm, negligence or loss to individuals, personnel, and the organization.
One key reason to follow risk management practices is to identify issues before they become problematic thereby reducing the potential for adverse outcomes. For example, risk management practices may have identified that Joan has trouble differentiating depths when stepping off a curb or down steps when outside. Falls might be prevented by encouraging Joan to use hand rails and to take her time when going down steps.

By preventing the number of falls Joan has, fractures may be prevented, thereby enhancing Joan’s health and well-being.

If Joan is worried about going down steps outside because she has fallen multiple times, she may begin to avoid doing things she enjoys if she knows there will be steps involved to get into and out of the building. This could limit what Joan does and decrease her quality of life. If the risk of falls could have been identified before Joan began falling, this would have allowed her to easily maintain her desired quality of life.

Risk management also supports efficient and cost-effective use of resources. In Joan’s example, by preventing repeated falls and fractures Joan may not need additional staff supports due to broken arms or legs and health-care costs for treatment of fractures may not be incurred.
Let’s now look at the essential activities of risk management. These four activities accomplish the core functions of risk management. Let’s look at each one in more detail.

1. Identify factors that put people at risk for illness, injury, abuse, neglect and exploitation.
2. Determine who is at risk.
3. Ongoing analysis and monitoring of incident and population data.
The first essential activity is to identify factors that put people at risk for illness, injury, abuse, neglect and exploitation. Remember that different factors put different people at risk for different things.
The essential activity is to determine who is at risk. We look at this from two different angles, the individual and a group or population.

First, let's look at the individual. We would want to identify factors that put a person at risk before something happens. If we continue with thinking about falls, potential individual factors could include the person’s age, gait, medications he or she is taking, muscle strength, and environmental conditions such as rugs in the home, levelness of the ground, broken sidewalk, etc.

There are then risk factors that are common to a group of individuals that may share other common factors such as services, demographics, or environment. For example, in group home situations loose throw rugs on the floors or broken sidewalks could potentially put others with similar risk factors at risk for falls. This is an example of how information from one individual's occurrence can be used systemically to impact more than just one individual.

A system level response then could be for others residing in the same residence; others residing at other residences in the same geographic location; those residing at residences run by the same provider within that county, or wherever that provider delivers the same type of residential service across the state or even nationally, if the provider is a national entity.
The third essential activity is to conduct ongoing analysis and monitoring of incident and population data. This is done to identify trends and monitor the effectiveness, success, and impact of prevention strategies. It’s important to monitor to make sure that the things put in place are working. Monitoring is also done to inform about emergent patterns or trends that may require more in depth examination. Considering that risk management is proactive, monitoring looks for potential problems before they become serious events or high frequency occurrences.

Let’s continue with our example of falls in the group home. Throw rugs were removed and the broken sidewalk was repaired. After these steps were taken, fall incidents were monitored, not only for the person of concern, but also for others living in the same home and other homes run by that provider agency. We would need to monitor the number of falls after the changes were made to see if the changes really did make a difference.
The fourth essential activity is to promote best practice. When you discover what is effective and works, it is important to implement that as best practice. Sometimes it may make sense for best practices to become policy.

For example, a provider agency may implement a different strategy to deal with falls at three homes. Then through monitoring and analyzing the impact of the different strategies, the agency discovers one strategy that is more effective than the others and implements that as a best practice within the agency. The agency may then share what they have learned with other provider agencies.

One challenge is that even though a best practice has been found, it may not work in all situations. When this happens, an agency may need to tailor the best practice to work in a particular situation.
We’ve been focusing on risk management thus far. Let’s now take a look at incident management beginning with a definition of what an incident is.

Simply put, an incident is something that happens, an event or an occurrence.
Pennsylvania Code requires the reporting of unusual incidents. An unusual incident is defined by the various regulations listed on the slide.
Here are some examples of unusual incidents. Take a moment and review them.
The Office of Developmental Programs Incident Management Bulletin describes incidents as being reportable or optionally reportable events.

A reportable incident is an event that requires reporting. There are 18 primary categories that are required by the bulletin to be reported. Two of the 18 categories are designated as site reports. These are Emergency Closure and Fire.

Reportable categories must be entered into the Home and Community Services Information System or HCSIS within 24 hours. Only the categories of Restraint and Medication Errors have up to 72 hours to be entered into HCSIS.

The other type of incident is one that falls into the category of an Optionally Reportable Event. Optionally Reportable Events can be used by provider agencies to track information that is pertinent to managing risk or informing the agency about their business operations related to quality of care or health and safety. There are four fields available in HCSIS that provider agencies can use to record Optionally Reportable Events. This information can supplement aggregate data providers retrieve from HCSIS for analysis and monitoring trends.
ODP utilizes the term “critical” when referring to those incidents that require a certified investigation as per the Incident Management Bulletin. Examples of a critical incident from the Incident Management Bulletin are abuse, neglect and misuse of funds.
The Incident Management Bulletin states that “The primary goal of an incident management system is to ensure that when an incident occurs, the response will be adequate to protect the health, safety and rights of the individual.” The bulletin also mentions ensuring appropriate and timely responses.

Management of incidents then is assuring that all the steps that need to be taken to assure the person’s health and safety are adequate, appropriate and timely.

If someone falls and has an open wound that is bleeding profusely, it would not be appropriate or adequate to apply a band-aid when it is stitches that are needed to assure the person’s health and safety. It would not be timely to wait until the next day to get medical attention. In order to be timely in this situation, first aid would be provided until the person receives medical attention.

In other words, adequate, appropriate and timely are making sure everything that should have been done was done.

More information about these three terms will be provided in future webcasts about incident management.
Each incident requires a response to assure the health, safety and protection of rights of individuals. The Incident Management Bulletin provides specific requirements and expectations for the management of that response.

Once the response to the incident has been fully implemented, there is a point during the staff review of the incident when the discussion turns to what can be done to prevent recurrence. There is an opportunity within each event to learn about factors that contributed to the incident occurring.

This information, translated into knowledge, becomes the foundation for actions taken to prevent recurrence. Although the management of a single incident and the management of risk are two different things, they are intrinsically linked when what is learned from understanding the circumstances of that single event, combined with what is known about the individual and his or her Everyday Life environment are used to strategize preventive measures.
Even though incident and risk management are related, there are some distinct differences between them. Incident management is reactive in that it is focused on correction and remediation. Risk management on the other hand is proactive as it aims to prevent adverse events and/or minimize risk.

Look at the terms in the incident management column – crisis management, facts focus on incident description, and compliance monitoring. All of these items are focused on reacting to that one event that has occurred.

Look now at the terms in the risk management column – involves planning and having a strategy for how to proceed, the focus is on the cause and contributing factors, and prevention and improvement are the focus. All of these items focus on how to take the knowledge learned from reviewing various incidents to prevent or decrease the risk in the future.

The key words to keep in mind then are that incident management is reactive and risk management is proactive.
Thank you for viewing this webcast which provided an introduction to incident management and risk management. This webcast is the first in a series designed to provide consistent information about incident management and risk management to the intellectual disability system in Pennsylvania.

In regard to risk management, this webcast defined what risk management is, explained the importance of risk management and reviewed the core functions and essential activities of risk management.

In regard to incident management, this webcast described and defined what an incident is.

The relationship between incident management and risk management was explored as well.

Have a good day.