

Risk Management

FREQUENTLY ASKED QUESTIONS (FAQs)

Risk Management Plans/Risk Management Committees

When are annual Risk Management Plans due?

The complete Risk Management Plan (RMP) must be submitted to KDHE annually at a minimum of 60 days prior to the license renewal date of the healthcare facility. It is recommended to submit the RMP 90 days prior to the KDHE license renewal date to avoid any licensing delays.

If changes are made to the Risk Management Plan after the annual KDHE approval, does the plan need to be submitted to KDHE again?

Per KAR 28-52-1(f), After an initial plan is approved, any amendments to the plan shall be submitted to the department.

Who should be on a facility's Risk Management Committee?

KAR 28-52-3 states, "Risk management committee. (a) Each medical care facility shall designate one or more executive committees responsible for making and documenting standard-of-care determinations with respect to each incident report, pursuant to K.A.R. 28-52-2. The jurisdiction of each risk management committee shall be clearly delineated in the facility's risk management plan, as approved by the facility's governing body." Larger facilities may find it appropriate to establish more than two committees while the smaller facilities may need only one committee. Those facilities that have one committee should ensure that the committee is multi-disciplinary, such as: two physicians, two registered nurses, a representative from ancillary services etc. Appropriate consulting physicians may also be appointed to this committee. Please make sure to list all members of the Risk Management Committee(s) in the Risk Management Plan.

How is the Quality Manager included in the Risk Management process?

65-4922 states, "Each medical care facility shall establish and maintain an internal risk management program which shall consist of:

- (1) A system for investigation and analysis of the frequency and causes of reportable incidents within the facility;
 - (2) measures to minimize the occurrence of reportable incidents and the resulting injuries within the facility"
- The language used to address this in the Sample Risk Management Plan states, "Data relevant to reported variances/incidents will be compiled by the risk manager in a statistical summary and will be presented quarterly to the Quality Assurance Performance Improvement Director to be used for identifying trends in practice and patient care. The Quality Assurance Performance Improvement Committee will analyze the frequency and causes of incidents and pursue measures to minimize recurrence through the active cooperation of facility staff, medical staff and administration."

If the Quality Manager is on the Risk Management Committee, please make sure to list them as a member of the committee in the Risk Management Plan.

Does the Risk Management Committee need to review all incidents, including SOC 1 and SOC 2 determinations?

Per KAR 28-52-4(c), Standard-of-care determinations made by individual clinicians and subordinate committees shall be approved by the designated risk management committee on at least a statistical basis.

Risk Management Reporting & Documentation

Should there be evidence that the Risk Manager has received an incident?

KAR 28-52-2 states, "Incident reporting. (a) Each medical care facility shall identify a written form on which employees and health care providers shall report clinical care concerns to the risk manager, chief of staff, or administrator. The original or complete copy of the incident report shall be sent directly to the risk manager, chief of staff, or administrator, as authorized in the facility's risk management plan.

(b) The risk manager, chief of staff, or administrator shall acknowledge the receipt of each incident report in writing. This acknowledgment may be made in the following manner:

- (1) file stamping each report;
- (2) maintaining a chronological risk management reporting log;
- (3) signing or initialing each report in a consistent fashion; or
- (4) entering pertinent information into a computer database."

Is there a protocol for the timeframe in which incidents should be reported?

The facility's Risk Management Plan should contain a protocol for the medical care facility to follow regarding response time. You would be held accountable to that process.

How should duplicate incident reports be handled?

Please make sure the details of each report match (such as involved providers) and make sure to document that there is a duplicate report. Do not leave a report blank. Example: "Incident 1235 is a duplicate report, please refer to Incident 1234 for investigation details."

Can Social Security Numbers or Employee ID numbers be used to identify individuals involved in an incident?

KDHE believes it is best practice to assign a nonidentifiable number to a provider involved in a Risk Management incident. A nonidentifiable number preserves the confidentiality of the process and the provider's identity.

How long does Risk Management documentation (i.e. logs, incident reports, quarterly reports, etc.) need to be maintained by the facility?

Per KAR 28-52-2(c), Incident reports, investigational tools, minutes of risk management committees, and other documentation of clinical analysis for each reported incident shall be maintained by the facility for not less than one year following completion of the investigation.

Does Risk Management documentation need to be kept confidential?

KSA 65-4925 (a)(1-4) states, "65-4925. Reports, records and proceedings confidential and privileged; licensing agency disciplinary proceedings. (a) The reports and records made pursuant to K.S.A. 65-4923 or 65-4924, and amendments thereto, shall be confidential and privileged, including:

- (1) Reports and records of executive or review committees of medical care facilities or of a professional society or organization;

- (2) reports and records of the chief of the medical staff, chief administrative officer or risk manager of a medical care facility;
- (3) reports and records of any state licensing agency or impaired provider committee of a professional society or organization; and
- (4) reports made pursuant to this act to or by a medical care facility risk manager, any committee, the board of directors, administrative officer or any consultant.”

Standard-of-Care (SOC) Determinations

Who/what needs to receive a standard-of-care determination?

28-52-4 states, “Standard-of-care determinations. (a) Each facility shall assure that analysis of patient care incidents complies with the definition of a "reportable incident" set forth at K.S.A. 65-4921. Each facility shall use categories to record its analysis of each incident, and those categories shall be in substantially the following form:

- (1) Standards of care met;
- (2) standards of care not met, but with no reasonable probability of causing injury;
- (3) standards of care not met, with injury occurring or reasonably probable; or
- (4) possible grounds for disciplinary action by the appropriate licensing agency.

(b) Each reported incident shall be assigned an appropriate standard-of-care determination under the jurisdiction of a designated risk management committee. Separate standard-of-care determinations shall be made for each involved provider and each clinical issue reasonably presented by the facts.”

Can an “SOC 5” be assigned for non-clinical incidents?

Per KAR 28-52-4, each facility shall assure that analysis of patient care incidents complies with the definition of a "reportable incident" set forth at K.S.A. 65-4921. Each facility shall use categories to record its analysis of each incident, and those categories shall be in substantially the following form:

- (1) Standards of care met;
- (2) standards of care not met, but with no reasonable probability of causing injury;
- (3) standards of care not met, with injury occurring or reasonably probable; or
- (4) possible grounds for disciplinary action by the appropriate licensing agency.”

There is no standard of care “5” designated in KAR 28-52-4. Citations have been written for more than one survey because “NCI” was used when an incident should have been assigned an SOC determination. If your facility does use “SOC 5” or “NCI,” please be sure that the incident truly does not meet the requirements for reporting. Please avoid phrases like “Not Patient related” and “Not Applicable” when using “SOC 5.” Incidents can be reportable even if a patient isn’t involved. If staff members are reporting incidents that don’t fall under Risk Management, please educate them on what the definition of “reportable incident” is per KSA 65-4921(f): "Reportable incident" means an act by a health care provider that: (1) Is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient; or (2) may be grounds for disciplinary action by the appropriate licensing agency.”

Can an “SOC 0” be assigned to a fall where all preventative measures were taken?

If a fall occurred and the standard of care was met, it should be assigned an SOC 1.

Per KAR 28-52-4, each facility shall assure that analysis of patient care incidents complies with the definition of a "reportable incident" set forth at K.S.A. 65-4921. Each facility shall use categories to record its analysis of each incident, and those categories shall be in substantially the following form:

- (1) Standards of care met;
- (2) standards of care not met, but with no reasonable probability of causing injury;
- (3) standards of care not met, with injury occurring or reasonably probable; or
- (4) possible grounds for disciplinary action by the appropriate licensing agency.

There is no standard of care "0" designated in KAR 28-52-4.

Is KDHE working on Interpretive Guidelines for standard-of-care determinations?

Interpretive guidelines, if written, would be the responsibility of the regulatory agency. Currently, KDHE is not developing Interpretive Guidelines for Risk Management.

When assigning standard-of-care determinations, who is an appropriately credentialed clinician?

KAR 28-52-4(c) states, "Each standard-of-care determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the designated committee."

The intention of the regulation is to ensure that an individual with the same or similar training and education is reviewing incidents. Example: while a Registered Nurse (RN) may have extensive training in the same or similar area as a Doctor of Medicine, the standard of care based off their roles and responsibilities would be different. For instance, a standard RN would not be able to adequately review a Risk Management incident that occurred due to an anesthesiologist not keeping a patient under anesthesia during surgery as the levels of training and credentialing differ significantly.

Are electronic signatures/authentication accepted as proof of an appropriately credentialed clinician signing and dating standard-of-care determinations?

KAR 28-52-4(c) states, "Each standard-of-care determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the designated committee."

Electronic authentication is acceptable, but typing something with no proof of who typed it is not acceptable.

Can a reviewer assign their own standard-of-care determination if there isn't a peer within the facility?

KAR 28-52-4(c) states, "Each standard-of-care determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the designated committee."

If there is not another peer within your facility, we recommend that you reach out to an affiliated facility, your corporate office, or Kansas Foundation for Medical Care, Inc. so that an appropriately credentialed clinician can complete the review.

Clinicians should not review their own patient care. Clinicians also should not review a relative's patient care.

Risk Management Surveys

How often is KDHE completing Risk Management surveys?

KSA 65-4922 states, "(c) The department shall make or cause to be made such inspections and investigations as it deems necessary to reasonably assure that each medical care facility is implementing the internal risk

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management program required by this section. In making such inspections and investigations, the department may review and copy the reports and records of all executive committees designated to investigate reportable incidents under this act.”

KDHE/Bureau of Facilities and Licensing plans to complete to the extent possible an initial RM survey of all Kansas medical care facilities supported by the Kansas Health Care Stabilization Fund. The frequency of additional surveys and the frequency is yet to be determined.

If the Risk Manager isn't on site during a Risk Manager survey, who can assist with the survey process?

It is our recommendation that each facility has a procedure in place for who is responsible to assist a Risk Management surveyor when the Risk Manager and/or CEO is unavailable. The procedure should include instructions for how the individual can obtain the necessary documentation for the surveyor.

Who completes the Risk Management surveys?

There are four KDHE surveyors who are completing Kansas Risk Management surveys.

Are Risk Management surveys completed during a licensure survey?

Risk Management surveys are separate from other surveys.

Does KDHE perform mock Risk Management surveys?

No, KDHE will not be performing mock surveys. Please refer to the Risk Management 101 webinar under the resources tab at <https://www.kdhe.ks.gov/2191/Risk-Management>. This webinar will give an overview of the Risk Management survey process.

If citations are written following a Risk Management survey, what happens next?

KDHE provides instructions and an Example Plan of Correction (POC) with the survey results letter and the Statement of Deficiencies. Surveyors have also been reviewing these documents with facilities during the exit conference to help set facilities up for success in writing their POC. The POC is due within 10 calendar days after receipt of the survey results. If the POC requires revisions, the revised POC is due within 5 calendar days after receipt of the POC review. If the due date falls on a weekend day or a holiday, the due date is extended to the next business day.

Surveys are completed to ensure compliance with Risk Management statutes and regulations. If noncompliance is discovered, the goal is for the facility to get back into compliance as soon as possible so that is why there are deadlines. If extensions are needed, please reach out to Cecilia and Kelly via riskmanagement@ks.gov and the request will be considered.

Cecilia and Kelly will schedule Teams calls with facilities if a POC cannot be approved after two submissions.

Does KDHE cite for quarterly reports that are submitted after the due date?

Yes, citations are written for quarterly reports that were not submitted on time.

KSA 65-4923(d) states, “(d) Each review and executive committee referred to in subsection (a) shall submit to the secretary of health and environment, on a form promulgated by such agency, at least once every three months, a report summarizing the reports received pursuant to subsections (a)(2) and (a)(3) of this section. The report shall include the number of reportable incidents reported, whether an investigation was conducted and any action taken.”

The Quarterly Report form states, "Reports are due to KDHE within 30 days of each completed quarter."

QUARTER	PERIOD	REPORT DUE BY
1st	January - March	April 30
2nd	April - June	July 30
3rd	July - September	October 30
4th	October - December	January 30

What resource documentation can be provided for Risk Management citations?

The Risk Management citations are based on the Risk Management statutes and regulations. The statutes and regulations can be found at <https://www.kdhe.ks.gov/2191/Risk-Management>.

Miscellaneous

How do facilities implement Just Culture principles and be compliant with Risk Management Statutes?

Facilities are required to adhere to Risk Management statutes and it is KDHE's opinion that Just Culture does not conflict with the principles of Kansas Risk Management statutes and regulations.

Are the Kansas Risk Management statutes being updated?

KDHE is not currently in the process of updating the Risk Management statutes.

What electronic programs do facilities use?

There are a variety of programs that facilities use across the state of Kansas. When choosing a program, KDHE recommends that you make sure the program can meet the Kansas Risk Management statutes and regulations. For program-specific questions, please contact a representative from the program.

When is Risk Management education to be provided to staff?

KAR 28-52-1(i) states, "Plan publication. The plan shall be disseminated to personnel in accordance with the plan."

Surveyors will look to see whether the facility is following what their Risk Management Plan states regarding plan distribution and education.