# 4. Understanding & Managing Risk

Objectives:

▪ Define Clinical Risk

▪ Identify Different Channels To Gathering Information About Risk.

▪ Keep The Confidentiality Of Accurate And Complete Health-care Records

▪ Explain How To Communicate Appropriately To Patients And Families After With Adverse Event.

▪ Appreciate The Importance Of "Fitness-To-Practice" As A Component Of Patient Safety.

▪ Identify Importance Of Maintaining Their Own Health And Well-being.

Important | **Doctors' notes** | **Extra** | ***New terminology***
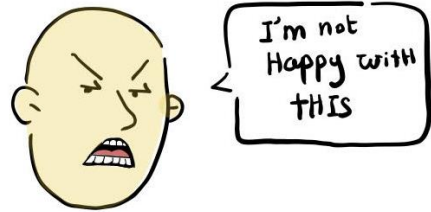
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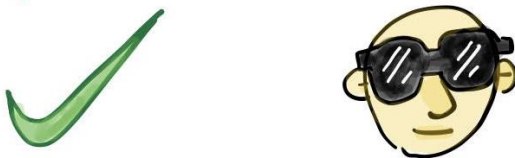
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Hazard → ↑ Risk
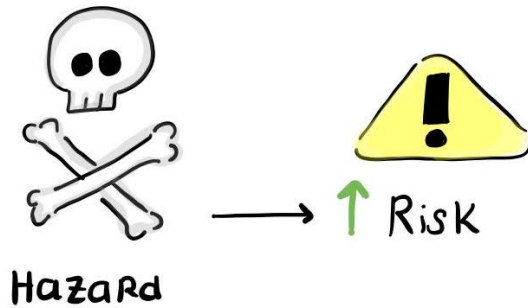
« Risk management »

- Process used to manage Clinical Risk

- Activities used to manage Clinical Risk

- The Role of Complaint

I'm not Happy with tHis

- Fitness to Practice ✓

- Credentialing
- Accreditation
- Registration

Introduction

- Risk management is routine in most industries
- Associated with limiting litigation costs:
    - Patients taking legal action against a health professional or hospital
- To avoid problems, hospitals and health organizations use a variety of methods to manage risks
- Hospitals are potentially dangerous places for patients as well as medical workers
- There are a lot of potential hazards in hospitals,

1. Define clinical risk

Clinical Risk Management

- **Hazard:** is any activity, situation or, substance that potential to cause harm, including ill health, injury, loss of product and/or damage to plant and property.
    - **Blood borne Pathogens**
    - **Hazardous Chemicals**
    - **Stress**

        It means the **danger** either it's blood, urine or chemical substances.

Risk: is the probability that harm (illness or injury) will actually occur. Risk: hazard احتمالية حصول

- **Risk Management:** Organizational effort to identify, assess, control and evaluate the risk to reduce harm to patient, visitors and staff and protect the organization from financial loss

3. Keep the confidentiality of accurate and complete health-care records

Purpose Of Risk Management

- Improve organizational and client safety
- Identify and minimize the risks and liability losses
- Protect the organization resources
- Support regulatory, accreditation compliance
- Creating and maintaining safe systems of care, designed to reduce adverse events and improve human performance

Any hospital with an accreditation it most have a Risk management department, other than they assess and evaluate the risks, they also responsible for **(incident reporting).**
Incident reporting give them hint about where the risk is.

For Example: medication safety
Look alike, sound alike.
من وظائف ال risk management التنبيه والتفريق بين الادوية سواء المتشابهة في النطق او المتشابهة في الشكل، فيفرقون بوضع labels عليها او علامات تحذيرية.

Process Used To Mange Clinical Risks:

1. **Identify the risk**

2. **Assess the frequency and severity of the risk**

3. **Reduce or eliminate the risk.** We do an action plan to reduce the risk.

4. **Assess the costs: saved by reducing the risk or the costs of not managing the risk.**

1. Identify The Risk:

Sources for risk identification:

- Adverse event reports.   Incidents reporting: تخص الموظفين فقط ليس لها علاقة بالمرضى
- Mortality and morbidities reports.
- Patient complaints reports.   Patient complaints is the one related to patients
- Assess the frequency and severity of the risk;

2. Assess The Frequency And Severity Of The Risk:

They use it to determine the hazard: is it sever, moderate or Minor?
And based on that they manage the risk from the most important to the least.

SAC (Severity Assessment Code) Score: مهمة جدا (ركزوا على ربط التعريف بالمصطلح المناسب له)

it is a matrix scoring system/ numerical scores are given to the severity and likelihood of risks and these scores are multiplied to get a rating for the risk

This table is only for you information:

STEP 1 Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

		Serious	Major	Moderate	Minor	Minimum
CLINICAL CONSEQUENCE	Patient	Patients with **Death** unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: ■ **Suspected suicide**[1] ■ **Suspected homicide**[2] or any of the following: **The National Sentinel Events** ■ Procedures involving the wrong patient or body part ■ Suspected suicide in hospital ■ Retained instruments ■ Unintended material requiring surgical removal ■ Medication error involving the death of a patient ■ Intravascular gas embolism ■ Haemolytic blood transfusion ■ Maternal death associated with labour and delivery ■ Infant discharged to the wrong family	Patients suffering a **Major permanent loss of function** (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Suffering significant disfigurement as a result of the incident ■ Patient at significant risk due to being absent against medical advice ■ Threatened or actual physical or verbal assault of patient requiring external or police intervention	Patients with **Permanent reduction in bodily functioning** (sensory, motor, physiologic, or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Increased length of stay as a result of the incident ■ Surgical intervention required as a result of the incident	Patients requiring **Increased level of care** including: ■ Review and evaluation ■ Additional investigations ■ Referral to another clinician	Patients with **No injury or increased level of care or length of stay**
CORPORATE CONSEQUENCE	Staff	Death of staff member related to work incident or suicide, or hospitalisation of **3** or more staff	Permanent injury to staff member, hospitalisation of **2** staff, or lost time or restricted duty or illness for **2** or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for **1** or more staff	First aid treatment only with no lost time or restricted duties	No injury or review required
	Visitors	Death of visitor or hospitalisation of **3** or more visitors	Hospitalisation of up to **2** visitors related to the incident / injury or pending or actual WorkCover prosecution	Medical expenses incurred or treatment of up to **2** visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
	Services	Complete loss of service or output	Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	Services: No loss of service
	Financial	**Loss of assets** replacement value due to damage, fire etc > $1M, **loss of cash/investments/assets** due to fraud, overpayment or theft >$100K or **WorkCover claims** > $100K	**Loss of assets** replacement value due to damage, fire etc $100K-$1M, **loss of cash/investments/assets** due to fraud, overpayment or theft $10K-$100K or **WorkCover claims** $50K-$100K	**Loss of assets** replacement value due to damage, fire etc $50K to $100K **or loss of cash/investments/assets** due to fraud, overpayment or theft to $10K	**Loss of assets** replacement value due to damage, fire etc to $50K	No financial loss
	Environmental	Toxic release off-site with detrimental effect. Fire requiring evacuation	Off-site release with no detrimental effects or fire that grows larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Nuisance releases

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 3 SAC Matrix

LIKELIHOOD	CONSEQUENCE				
	Serious	Major	Moderate	Minor	Minimum
Frequent	1	1	2	3	3
Likely	1	1	2	3	4
Possible	1	2	2	3	4
Unlikely	1	2	3	4	4
Rare	2	3	3	4	4

Example: the handle in KKUH

قبل خمس سنوات ما كان موجود handle بعدها المستشفى عملوا SAC to assess the risk

الي وضح لهم ان اكثر المرضى الي كانوا يطيحون كانوا من قسم النساء والولادة،

لما سووا management to the risk وضعوا ال handle اولاً في قسم النساء والولادة.

So always start to manage the conditions with high scores then follow up.

3. Reduce Or Eliminate The Risk:

STEP 4 Action Required Table

Action Required	
1	**Extreme** risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
2	**High** risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	**Medium** risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. **Exception** – all financial losses must be reported to senior management.
4	**Low** risk – manage by routine procedures – Aggregate data then undertake a practice improvement project.

NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the DoH if there is the potential for media interest or requires direct notification under existing DoH legislative reporting requirements or NSW DoH Policy Directive.

Activities Commonly Used To Mange Clinical Risk

Why we report? because we need to do some actions related to the system or to but a guide line, policy to manage and reduce the risk.

1. Incident monitoring: (incident report) → reported by staff → to enhance the system , develop guidelines and policies → by focusing on the system Weaknesses rather than Individuals

- **An *incident* (حادثة):** as an event or circumstance that could have or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage. e.g. : (prescription of a drug by mistake or device that is not working) → may harm the patient

- *Incident monitoring:* **AKA: Incident report** refers to mechanisms for identifying, processing, analyzing and reporting incidents with a view to preventing their reoccurrence
- The key to an effective reporting system is for staff to routinely report incidents and near misses. " affected by personal relationships, e.g. when a doctor has to report mistake done by his colleague, whatever the reporter will be protected and his name will be hidden "

مهمة جدا Incident report

Table B.6.1. Types of issues identified by incident monitoring — *This table is only for you information:*

Type of incident	% of reports [a]
Falls	29
Injuries other than falls (e.g. burns, pressure injuries, physical assault, self-harm)	13
Medication errors (e.g. omission, overdose, underdose, wrong route, wrong medication)	12
Clinical process problems (e.g. wrong diagnosis, inappropriate treatment, poor care)	10
Equipment problems (e.g. unavailable, inappropriate, poor design, misuse, failure, malfunction)	8
Documentation problems (e.g. inadequate, incorrect, incomplete, out-of-date, unclear)	8
Hazardous environment (e.g. contamination, inadequate cleaning or sterilization)	7
Inadequate resources (e.g. staff absent, unavailable, inexperienced, poor orientation)	5
Logistical problems (e.g. problems with admission, treatment, transport, response to an emergency)	4
Administrative problems (e.g. inadequate supervision, lack of resource, poor management decisions)	2
Infusion problems (e.g. omission, wrong rate)	1
Infrastructure problems (e.g. power failure, insufficient beds)	1
Nutrition problems (e.g. fed when fasting, wrong food, food contaminated, problems when ordering)	1
Colloid or blood product problems (e.g. omission, underdose, overdose, storage problems)	1
Oxygen problems (e.g. omission, overdose, underdose, premature cessation, failure of supply)	1

[a] An incident may be assigned to more than one category.
Source: Runciman B, Merry A, Walton M. *Safety and ethics in health care: a guide to getting it right*, 2007 [3].

2. Sentinel Events: serious events lead to death or morbidity → reported for ministry

- Is usually unexpected and involving a patient death or serious physical or psychological injury to a patient
  - e.g. surgery on the wrong patient or body site, incompatible blood transfusion.
- Many health-care facilities have mandated the reporting of these types of events because of the significant risks associated with their repetition

5. Appreciate the importance of "Fitness - to -practice" as a component of patient safety.

Activities Commonly Used To Mange Clinical Risk Cont.

3. Fitness-to-practice requirements
- ▪Accountability
- ▪Competency of healthcare professionals.
- ▪Are they practicing beyond their level of experience and skill?
- ▪Are they unwell, suffering from stress or illness
    - ▪**Credentialing**
    - ▪**Registration (licensure)**
    - ▪**Accreditation**

can manage the clinical risk at level health care sector
(Each one will be discussed in the next slid)

4. Explain How To Communicate Appropriately To Patients And Families After With Adverse Event.

The Role Of Complaints In Improving Care

(made by patients)→not affected by personal relationships

A complaint: is defined as an expression of dissatisfaction by a patient, family member with the provided health care.

Complaints often highlight problems that need addressing, such as poor communication or suboptimal decision making.

Communication problems are common causes of complaints, as are problems with treatment and diagnosis.

Complaint types :
1) Medical → there is risk exposure(related to the patient right)→e.g. use of contaminated needle. 2)non-medical → no risk exposure → no risk management → e.g. (hospital food is not delicious).

Benefits of complaints: Read them
- ▪Assist the maintenance of high standards;
- ▪Reduce the frequency of litigation;
- ▪Help maintain trust in the profession;
- ▪Encourage self-assessment;
- ▪Protect the public.

5. Appreciate the importance of "Fitness - to -practice" as a component of patient safety.

Credentialing الامتياز (Important)

Granting a rank (e.g. consultant or registrar) →with Limited privileges and powers → based on Experience and qualifications

- The process of assessing and conferring approval on a person's suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual's license, education, training, experience, and competence.

Accreditation الاعتماد (Important)

ISQUA * grants authority → to institutions** to grant accreditation →to hospitals
*International Society for Quality in Healthcare

- Is a formal process to ensure delivery of safe, high-quality health care based on standards and processes devised and developed by health-care professionals for health-care services.
- **National Accreditation Program:** CBAHI **
- International Accreditation Program:
- Joint commission (US),**
- Accreditation Canada(Canada)**

Importance of accreditation :
accreditation indicates that the hospital follow high standards with evidence on that .

Registration (Licensure) تصنيف الهيئة (Important)

based on physician's working hours, certificates ,Exceeded examinations , CME hours
- Registration of health-care practitioners with a government authority, to protect the health and safety of the public
  e.g. Saudi Commission for Health Specialties
Proper registration/licensure is an important part of the credentialing and accreditation processes

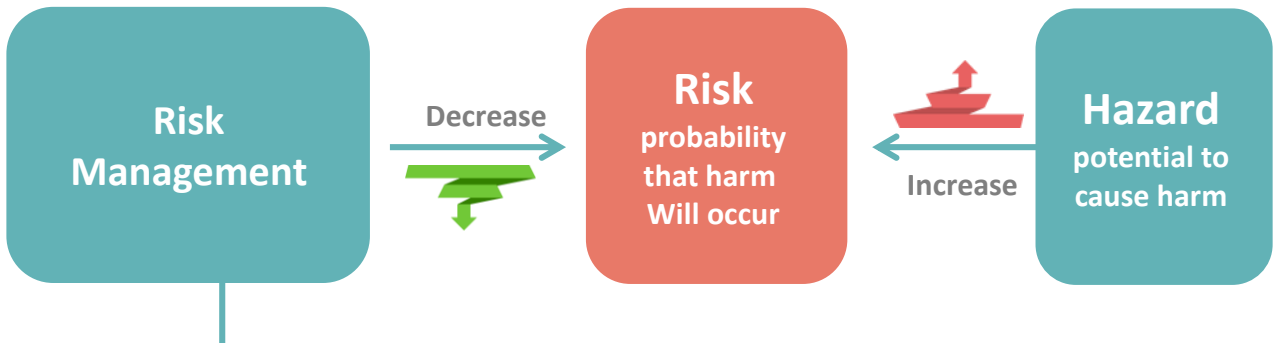## Personal Strategies for Managing Risk and Reduce Errors

Read it

- **Care for one's self** (eat well, sleep well and look after yourself);

- **Know your environment;**

- **Know your task(s);**

- **Prepare and plan (*what if*...);**

- **Build checks into your routine;**

- **Practice the good documentation:**
    - A referral or request for consultation : it is important to only include relevant and necessary information:
    - Keep accurate and complete health-care records
    - Provide sufficient information
    - Note any information relevant to the patient's diagnosis or treatment and outcomes;
    - Document the date and time

- Report any risks or hazards/incidents in your workplace

- Participate in meetings to discuss risk management and patient safety

- Respond appropriately to patients and families after an adverse event

- Respond appropriately to complaints

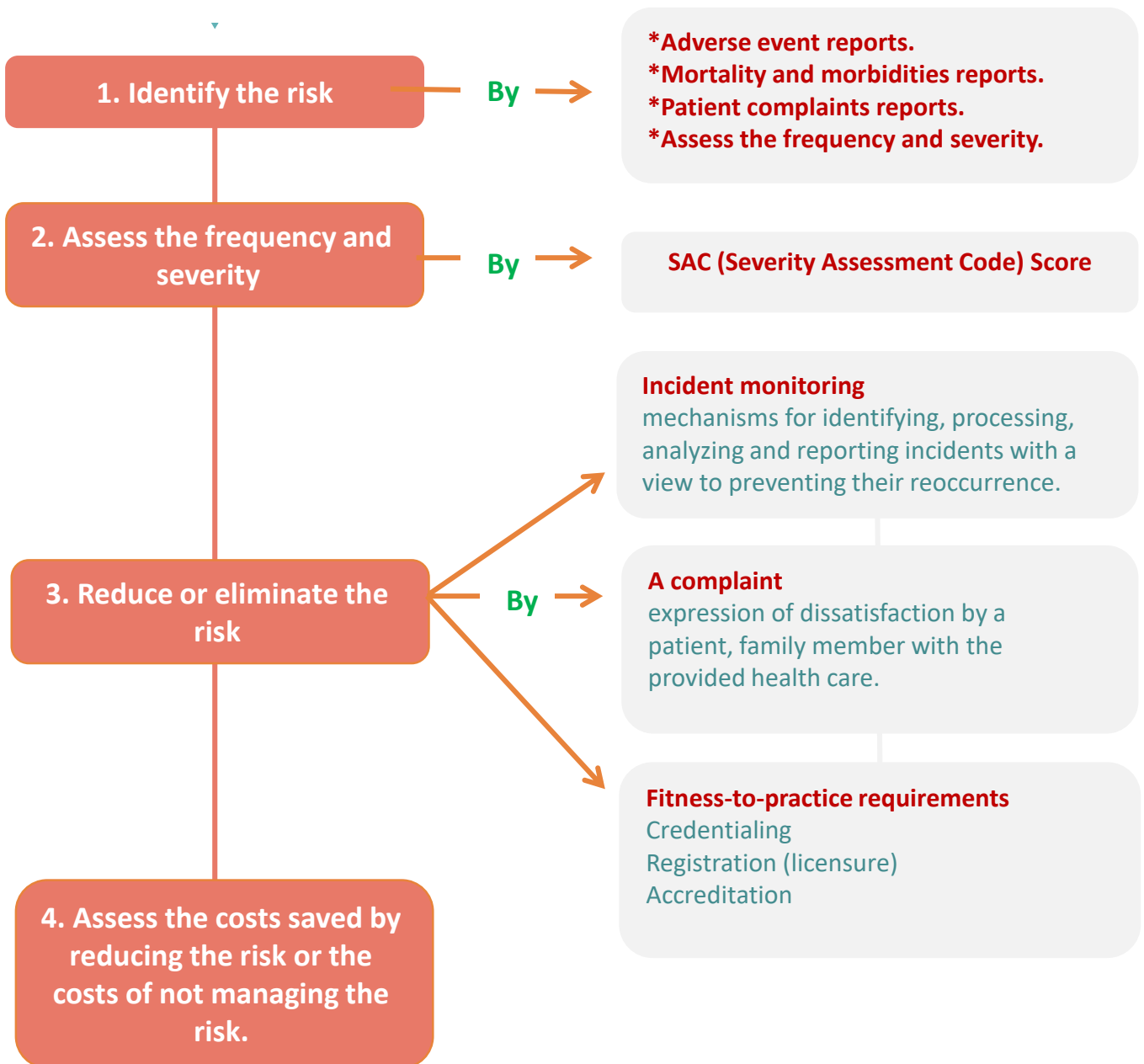- Ask if you do not know. Request that a more experienced person

Summary

- **Medical error is a complex issue, but error itself is an inevitable part of being human.**

- **These tips are known to limit the potential errors caused by humans • Avoid reliance on memory**

- **Simplify process**

- **Standardize common processes and procedures**

- **Routinely use checklists**

- **Decrease reliance on vigilance**

- **Learning from error can occur at both an individual level and an organizational level through incident reporting and analysis.**

- **Root cause analysis (RCA) is a highly structured systemic approach to incident analysis that is generally reserved for the most serious patient harm episodes**

- **Health-care professionals are responsible for the treatment, care and clinical outcomes of their patients.**

- **Personal accountability is important, as any person in the chain might expose a patient to risk.**

- **One way for professionals to help prevent adverse events is to identify areas prone to errors.**

- **The proactive intervention of a systems approach for minimizing the opportunities for errors can prevent adverse events.**

- **Individuals can also work to maintain a safe clinical working environment by looking after their own health and responding appropriately to concerns from patients and colleagues.**

Summary

Risk Management → *Decrease* → **Risk** probability that harm Will occur ← *Increase* ← **Hazard** potential to cause harm

Process Used to Manage Clinical Risks

1. Identify the risk — **By** →
*Adverse event reports.
*Mortality and morbidities reports.
*Patient complaints reports.
*Assess the frequency and severity.

2. Assess the frequency and severity — **By** →
SAC (Severity Assessment Code) Score

3. Reduce or eliminate the risk — **By** →

Incident monitoring
mechanisms for identifying, processing, analyzing and reporting incidents with a view to preventing their reoccurrence.

A complaint
expression of dissatisfaction by a patient, family member with the provided health care.

Fitness-to-practice requirements
Credentialing
Registration (licensure)
Accreditation

4. Assess the costs saved by reducing the risk or the costs of not managing the risk.

Q1: what is the difference between Hazard and Risk?

- **Hazard:** is any activity, situation or, substance that potential to cause harm, including ill health, injury, loss of product and/or damage to plant and property.
- **Risk:** is the probability that harm (illness or injury) will actually occur.

Q2: which one of the sources for risk identification is only for patients?

A. Incidents reporting
B. Patient complaints reports
C. Mortality and morbidities reports.

Answer: B

Q3: Which one of these terms is related to this definition
(It is a matrix scoring system/ numerical scores are given to the severity and likelihood of risks and these scores are multiplied to get a rating for the risk)?

A. Severity Assessment Code.
B. Risk management.
C. Incident monitoring:

Answer: A

Q4: list the benefits of complaints?

- Assist the maintenance of high standards.
- Reduce the frequency of litigation.
- Help maintain trust in the profession.
- Encourage self-assessment.
- Protect the public.

2: B – 3: A

Q5: what are the personal strategies for managing risk and reduce E Errors?

- Report any risks or hazards/incidents in your workplace.
- Participate in meetings to discuss risk management and patient safety.
- Respond appropriately to patients and families after an adverse event.
- Respond appropriately to complaints.
- Ask if you do not know. Request that a more experienced person.

Q6: what the difference betwaeen credentialing & registration?

Credentialing: the process of assessing and conferring approval on a person's suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual's license, education, training, experience, and competence.
Registration: registration of health-care practitioners with a government authority, to protect the health and safety of the public, based on physician's working hours, certificates ,exceeded examinations , cme hours.

Q7: what is the importance of an accreditation?

Accreditation indicates that the hospital follow high standards with evidence on that .

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