

# Clinical Risk Management

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# Francis Inquiry



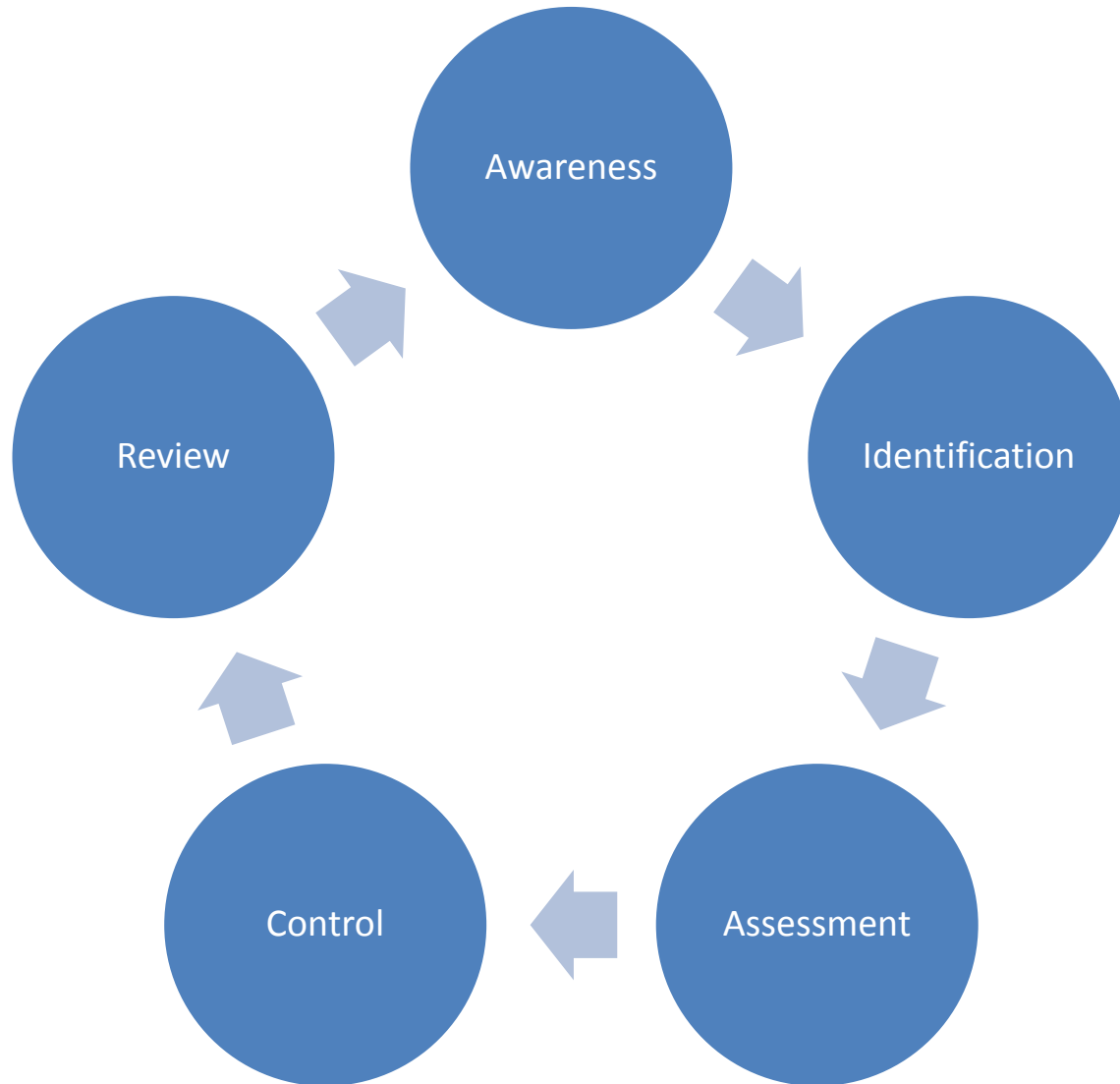
Normalisation of Deviance

# Clinical Risk Management

A systematic process for the identification, analysis and control of actual and potential risks and their resource implications.

This will include risks to people, structure, reputation and any other issues which could impact upon or compromise the ability of the organisation to carry out its normal activities in a safe and effective manner

# Clinical Risk Management



# Safety Culture

‘ A culture where staff have a constant and active awareness of the potential for things to go wrong. It is open and fair and encourages people to speak up about mistakes. In organisations with a safety culture people are able to learn about what is going wrong and put things right. It influences the overall vision, mission and goals of an organisation’

# Clinical Risk Identification

- Mortality
- Morbidity
- Incidents / SIs
- Complaints / Claims / Compliments
- EBM / reliability
- Competence
- Quality Indicators
  - Process
  - Outcome
- Staff wellbeing
- PROMs / PREMs
- Regulatory compliance
- Evidence based practice
- Risk assessments



# Clinical Risk Assessment



Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

- 1-3 Low risk
- 4-6 Moderate risk
- 8-12 High risk
- 15-25 Extreme risk

# Risk Scoring Matrix

Catastrophic = 5	5	10	15	20	25
Major = 4	4	8	12	16	20
Moderate = 3	3	6	9	12	15
Minor = 2	2	4	6	8	10
None = 1	1	2	3	4	5
Severity ↑	Rare = 1	Unlikely = 2	Possible = 3	Likely = 4	Certain = 5

Likelihood →

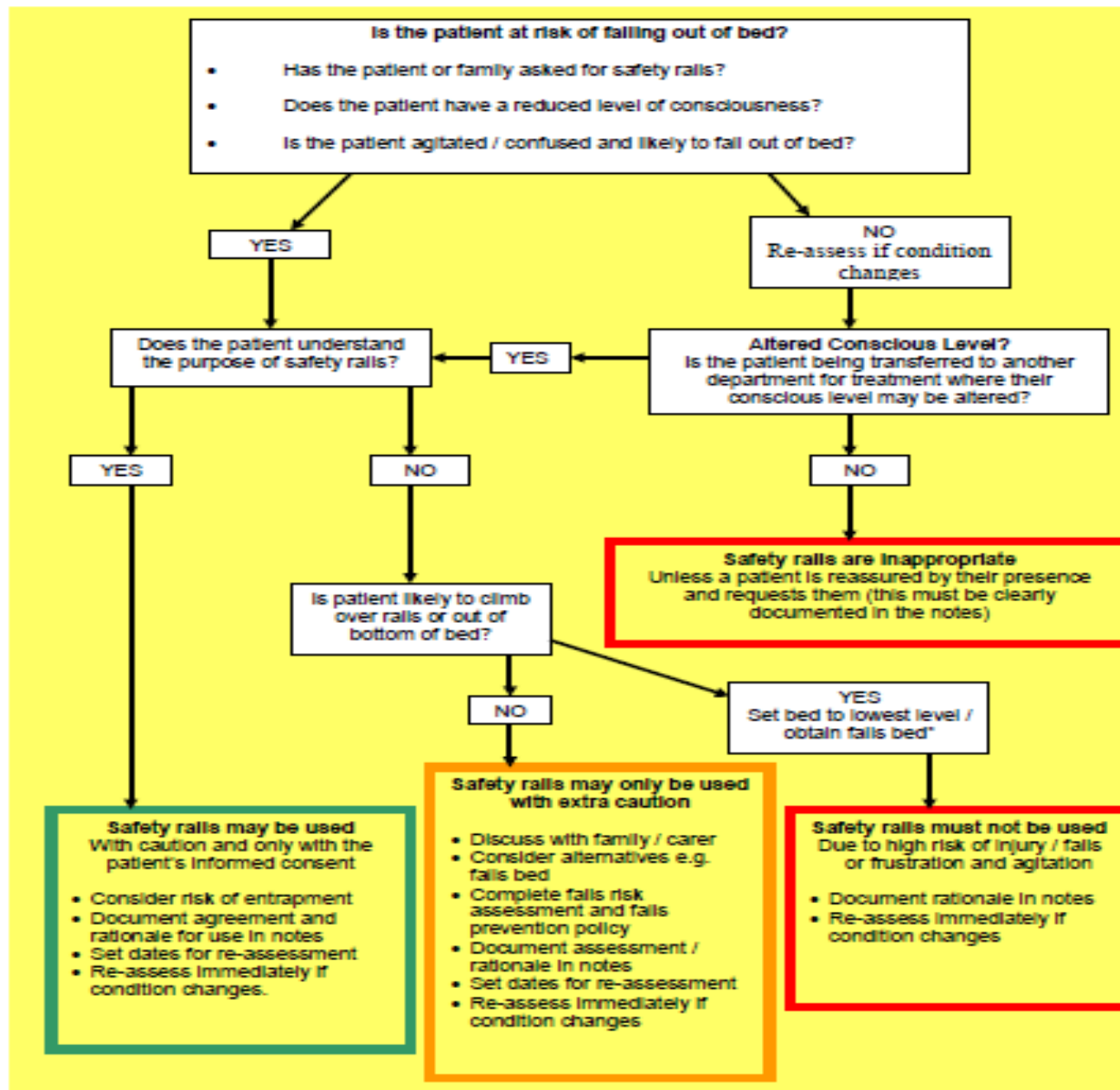
Likelihood	Description
Almost Certain	Will undoubtedly recur, possibly frequently
Likely	Will probably recur but is not a persistent issue
Possible	May recur occasionally
Unlikely	Do not expect it to happen again but is possible
Rare	Can't believe that this will ever happen again

For description of severity grading for differing types of risk, please see Appendix B, overleaf

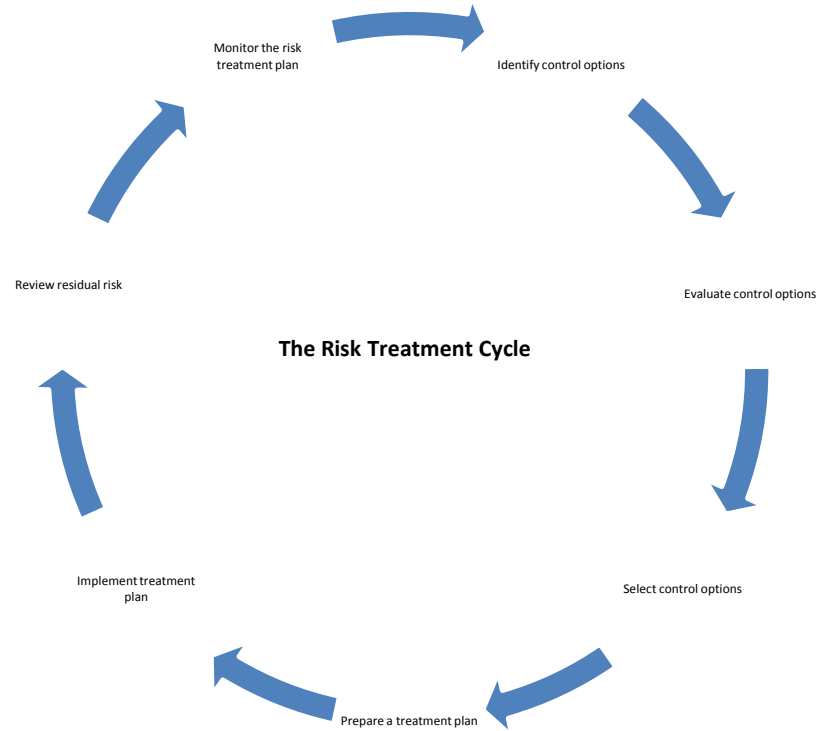
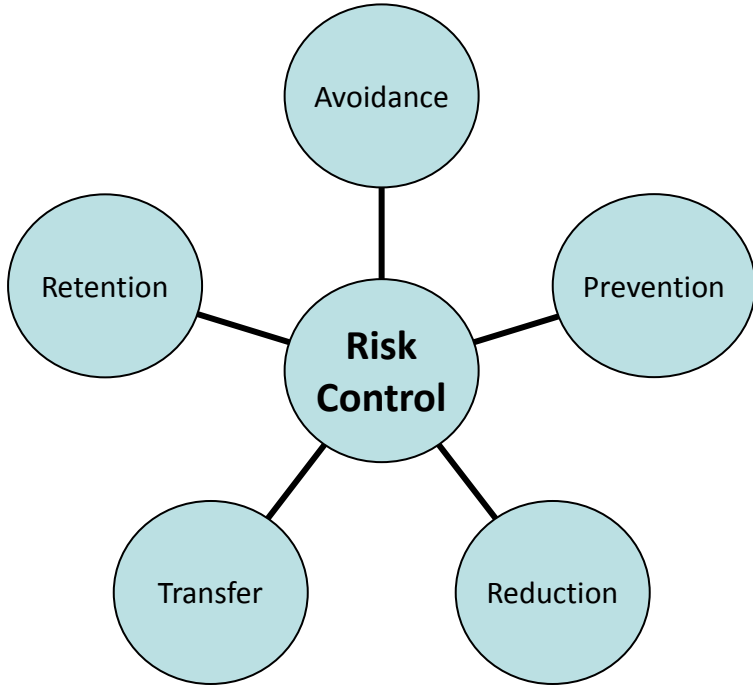
Risk Rating Score	Level	Action Level
1-3	Very Low Risk	Accept Risk. To be managed by local management.
4-10	Low Risk	Address Risk: To be managed by local management.
11 - 16	Medium Risk	Management action required to reduce risk level to low risk level.
17 - 25	High risk	Significant Risk. Board Level Action/Awareness required



## Safety rails flowchart – Assessment of immediate risk



# Risk Control



# Clinical Risk Management

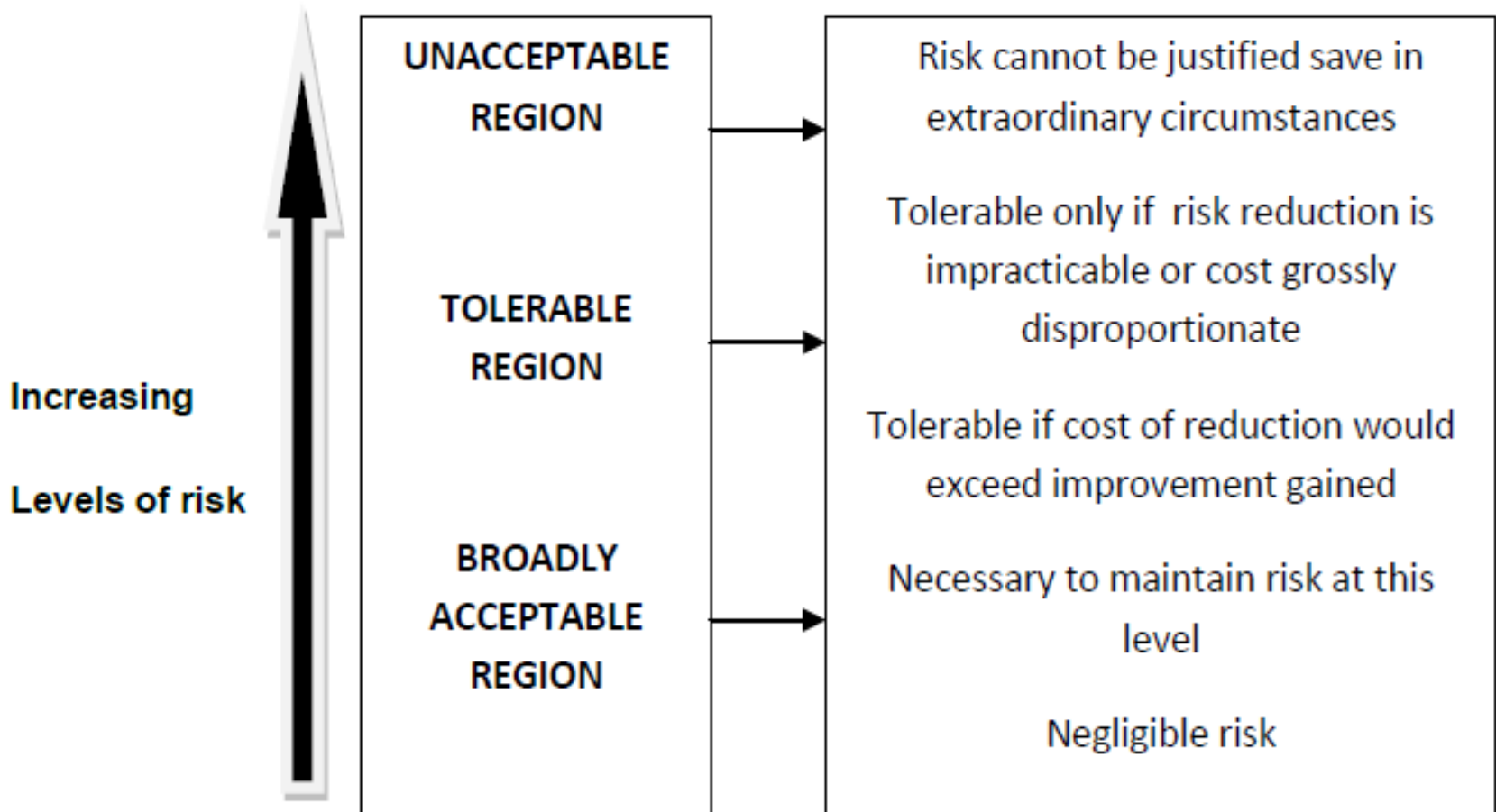
Hierarchy of controls



# Risk Review

Objectives	The link between strategic objectives and key risks for more major risks
Description of specific risk	This may be a simple phrase to describe the risk or a more detailed and complete description
Location	Where in the organisation this particular risk is an issue
Risk rating ( likelihood x consequence)	Colour coding is used to group risks into general categories of risk and then within these risks may be ranked by number to allow more specific focus ( see chapter 4 risk assessment) on significant risks
Lead individual / department	Risk must be assigned to a lead individual or department who ' owns ' the risk and is responsible for ensuring that the risk is monitored and mitigated or controlled
Existing Controls	This describes what is currently in place to reduce the risk
Action / treatment plans	This describes what resources are required to mitigate the risk to an acceptable level. IT may include a target risk rating which is the overall aim and level which would be considered acceptable
Sources of assurance	How the organisation will be assured that the controls / treatments in place are effective
Dates	The timeframes for implementation of any new controls and for review of the existing levels of risk
Cost-benefit analysis	To demonstrate that the controls are cost effective . This may guide the approach taken if more than one solution is possible
Acceptance / Completion	Necessary to show which risks are still active or have been accepted at the current level or closed
Comments	For supplementary information such as relevant policies or dates of meetings at which a particular risk was discussed.

# Risk Tolerability



# High Reliability Organisation

- Systems that recognise the cost of failure and benefits of reliability
- Actively seek to know what they don't know
- Make knowledge related to a problem available to all staff
- Learn quickly and efficiently
- Train staff to respond to abnormalities
- Empower staff to act



HRO expects its organisation and its sub-systems to fail and works hard to avoid failure while preparing for the inevitable in order to minimise the impact of failure

# Reliability

- Current improvement methods are highly dependent on vigilance and hard work
- Permissive clinical autonomy creates and allows wide performance margins
- The use of deliberate designs to achieve articulated reliability goals seldom occurs



# Geisinger Healthcare



## PROVENCARE BY THE NUMBERS

### ELECTIVE CORONARY ARTERY BYPASS GRAFT

Program went live: February 2006

Number of procedures in first year: 181

Percentage of patients eligible to participate: 34% (under Geisinger Health Plan)

Proven Care by the Numbers (18 months)	Before Proven Care	With Proven Care	% Improvement/ Reduction
Average total length of stay	6.2	5.7	-
30-day readmission rate	6.9%	3.8%	44%
Patients w/ any complication	38%	30%	21%
Patients w/less than 1 complication	7.6%	5.5%	28%
Incidence of atrial fibrillation	23%	19%	17%
Neurological complication	1.5%	0.6%	60%
Any pulmonary complication	7%	4%	43%
Blood products used	23%	18%	22%
Re-operation for bleeding	3.8%	1.7%	55%
Deep sternal wound infection	0.8%	0.6%	25%



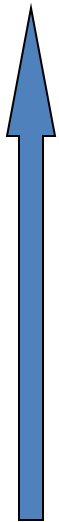
# Plan for Safety

Situation awareness

Resource effectiveness

HIGH

HIGH



**Avoid**

(identify hazards a long way off)

**Trap**

(procedures to deal with hazards when they occur)

**Crisis Manage**

(React to the consequences)

LOW

LOW

‘Its fine to celebrate success but it is more important to heed to lessons of failure’

