



RISK MANAGEMENT GUIDELINES

Purpose of Guidelines

These guidelines outline the way South West Healthcare operates its Risk Management Program and are to assist the organisation, its divisions, departments and units in the development of risk management plans. These guidelines have been adapted from the policy and guidelines developed by Bendigo Health Care Group (2000), Bayside Health (2002) and are based on the AS/NZS 4360: 2004 risk management standards. They are to be read in conjunction with the South West Healthcare MAPP's policies SP&E 5.1 (Injury/Incident Reporting) and 5.16 (Sentinel Events).

Risk management is a vital component of good management practice and, to be most effective, should become part of an organisation's culture. Rather than being viewed as a separate program, risk management needs to be integrated into an organisation's philosophy, practice and business plans. The integration of risk management into the organisation's operations ensures that risk becomes the business of every employee.

The risk management model (figure 1) incorporates several distinct steps to be carried out when managing risks (retrospectively or prospectively) in any part of the organisation. In this way, a consistent approach will be ensured so that the organisation has a thorough and commonly understood methodology, which it can rely upon as a basis for effectively managing its risks. The risk management model includes clinical risk management.

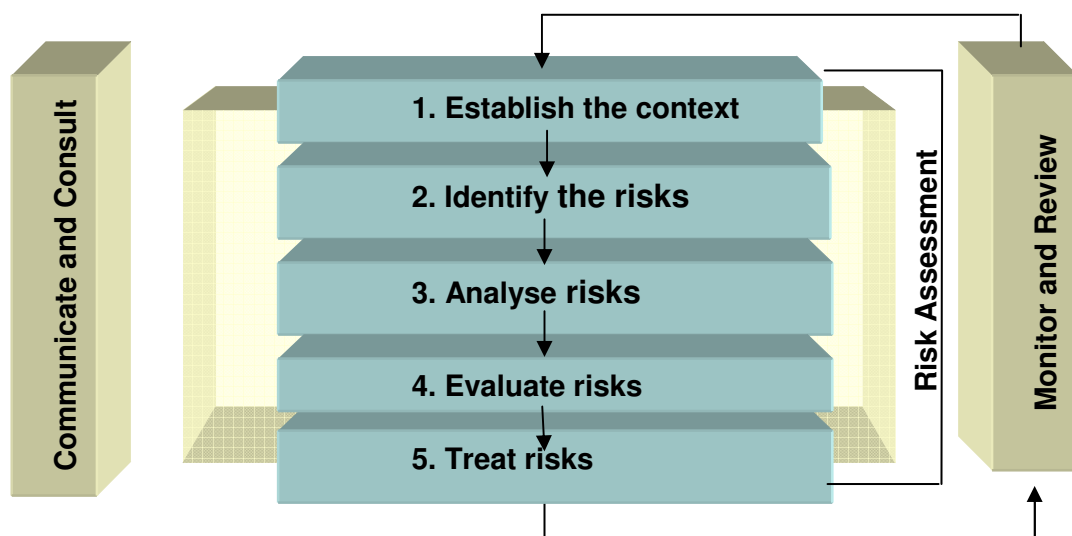


Figure 1. Risk management model (from AS/NZS 4360: 2004 risk management standards)

Definitions of Key Terms

Incident:

A healthcare incident is an event or circumstance resulting from healthcare (treatment), which could have, or did lead to unintended and / or un-necessary harm to a person, and/or a complaint or loss. Incidents include:

- near misses (did not cause harm)
- errors – (human error)
- accidents or mishaps
- iatrogenic harm (arising from or associated with health care rather than an underlying disease or injury). Includes consequences of omission (failing to do the right thing) as well as commission (doing the wrong thing)
- adverse events – an incident in which harm resulted to the person receiving healthcare (WA Health Dept, 2005).

Other incidents may be defined as any occurrence, which is not consistent with the routine operation of the Service. It is defined as any occurrence in the course of duty which:

- i. compromises the physical and/or psychological health of staff, clients or visitors of South West Healthcare. This decision will be based on clinical judgement
- ii. results in property loss or damage.

A serious incident is one which threatens staff or clients in a lethal or potentially lethal manner, poses a danger to the general public and which has important implications for the organisation and/or the management of an individual case. Generally the significance of these events extends beyond the workplace.

Risk:

The chance that an adverse event will occur during a stated period of time. (Royal Society, 1991 VMIA)

A risk can be defined as an event that, if it is realised, will have the potential to interfere with the objectives of the organisation as a whole, or the objectives and its operational / functional core units (departments, centres, employees).

In this context, there are three (3) major categories of risk – Corporate, Environmental and Clinical.

Risk Management:

Is the culture, process and structures that are directed towards effective management of diverse events or incidents.

Integrated Risk Management:

Is the systematic application of the risk management process in all activities undertaken at all levels of the organisation.

Clinical Risk Management:

Clinical Risk Management (CRM) is an approach to improving the quality of safety in health care by:

- placing special emphasis on identifying circumstances that place patients at risk or harm, and
- taking action to prevent or controlling those circumstances and risk.

Corporate Risk Management:

Corporate Risk relates to the potential for:

- major loss of financial viability or business continuity
- causing environmental or personal damage
- compromising the health and safety of staff and service users
- misleading or defrauding clients (other staff and others)
- loss of reputation
- loss of revenue or assets.

Environmental Risk:

Environmental risks may include such things as:

- slips and falls reduction and investigation; manual handling
- infection control; air / water quality; radiation safety.

1. Establish the Context

The first step in a risk management plan is to establish the context of the environment within which the organisation, department or unit operates. The environment in which health facilities operate is an extremely complex one and a number of factors need to be considered when determining the parameters within which risks must be managed. (See appendix 1).

2. Identify Risk

Each department is required to assess itself at least annually against the relevant risk context areas listed in Appendix 1 – to ensure risks are being identified even in a changing environment.

Retrospective Risk Identification

The identification of risk may occur in a retrospective manner - looking back over completed work or tasks. These risks are identified through review processes that are designed to detect episodes of risk such as the consequences of non-compliance with a policy, data inaccuracy and system failures.

Units/divisions are encouraged to schedule ongoing screening (e.g. equipment safety inspections, account audits, incidents, complaints) that requires retrospective review. This should occur through the relevant risk management committee, or in a standing agenda item in the divisional or unit management meeting as well as at executive committee level.

Incident reports are to be completed for ALL incidents – either clinical or non-clinical utilising the Riskman database. Once reported, the incidents will be analysed for risk ranking. Adverse events, where indicated, can be further analysed utilising a root cause analysis framework. Sentinel events, which must be reported to DHS, form part of retrospective risk identification for clinical units. These events are defined in Appendix 5.

Prospective Risk Identification

Identifying potential risks before they present challenges is the ideal method of minimising risk- this is known as prospective risk identification. A well structured, extensive and systematic process for identifying risks is vital, as risks not identified at this stage are excluded from being further analysed and managed; risks that are not necessarily under South West Healthcare control should also be included e.g. political, environmental.

The South West Healthcare Risk Workbook has been developed as a self-assessment tool to aid in risk identification and analysis and can be used in conjunction with the Risk self assessment tool. (See Appendix 2.) Both prospective and retrospective risks are to be documented in the Risk Workbook. Both types may require reporting to other areas, once detected. For example, all staff risks are to be reported to the O H & S Committee.

3. Analyse the Risk

Once risks have been identified, they are analysed and the severity of each risk is determined. First, on a scale of 1-5 rate the consequences of the risk – what will be the result if the risk eventuates? (See Table 1)

Then, also on a scale of 1-5, assess the likelihood rating – how likely is it that the event will occur or with what frequency? (See Table 2)

Lastly, the overall level of risk is determined by combining the consequence rating and the likelihood rating. (See Table 3)

All risks analysed as an **Extreme** or a **High** risk must be discussed with your line manager.

Root Cause Analysis (RCA)

RCA is a process analysis method, which can be used to identify the factors that contributed to an adverse patient outcome or near miss events. The root cause is the earliest point at which action could have been taken to reduce the chance of the incident happening.

RCA should be undertaken for high risk, high impact events such as sentinel events/or other E or H ranked incidents. A reportable near miss sentinel event is managed in the same way.

Commissioning a Root Cause Analysis

Ultimate responsibility for responding to serious clinical incidents lies with the appropriate Executive member who manages the delivery of clinical care. Executive commission RCA investigations and notify the Chief Executive Officer and Quality Committee.

A register is kept of all RCA investigations and subsequent outcomes, including risk reduction plans. If a similar event were to occur, the Executive member would review the previous RCA before commissioning another.

Responsibility for undertaking a Root Cause Analysis lies with the Quality Manager or Quality Co-ordinator PSD who will assist with drawing together the team and completing relevant documentation.

4. Evaluate the Risks

The aim of this step is to decide whether the risk is tolerable or not.

Risk may be tolerated if:

- The level of risk is so low that specific treatment is not appropriate within available resources
- The risk is such that there is no treatment available. For example, the risk that a project might be terminated following a change of government is not within the control of an organisation.
- The cost of treatment, including insurance costs is so manifestly excessive compared to the benefit that acceptance is the only option. This applies particularly to lower ranked risks.
- The opportunities presented outweigh the threats to such a degree that the risk is justified.
- There are sufficient identified controls in place.

Risk that is regarded as not tolerable must be actively managed. Even if the risk is regarded as tolerable however, it must still be monitored.

5. Manage the Risks

South West Healthcare wishes to integrate risk management with all our quality improvement initiatives. The management proposal will therefore be written up in the form of an integrated business / quality plan which will be carried out annually (see Appendix 3 for an example of an incident specific quality action plan) and implemented as such. Any risk analysed at program level as an **Extreme** or a **High** risk, must, after completion of the plan, be discussed with the responsible executive or designated delegate as shown in the risk management reporting model in Appendix 4.

If it is agreed by the responsible director / manager that the risk is **Extreme** or **High**, a copy of the risk workbook page and the associated quality action plan is to be forwarded to the designated risk management committee. There the management plan will be discussed and ratified or modified as appropriate. Executive staff will inform the Chief Executive Officer of all risks rated **Extreme** or **High**.

Recommendations arising from coroner's cases will be managed in all cases as if they were rated **Extreme** or **High** even if the actual risk may be rated lower.

Sentinel events (as defined in the DHS Clinical Risk Management Strategy) will always be treated for reporting purposes as an Extreme risk. Detail of the reporting mechanisms for these events are given in Appendix 5.

5.1 Options for Managing (Treating) Risk

- a) *Avoid the risk* by deciding, where practicable, not to proceed with the activity likely to generate risk.
- b) *Modify the risk – Action to reduce the likelihood* of the event. For example:
 - Audit and compliance programs
 - Inspection and process controls
 - Preventative maintenance
 - Structured training
 - Technical / engineering controls
 - Design features
 - Contract conditions
 - Project management
 - Supervision
 - Testing
 - Quality improvement, management and standards
- c) *Action to reduce the consequences*. For example:
 - Contingency planning
 - Design features
 - Engineering and structural barriers
 - Contractual arrangements
 - Disaster recovery plans
 - Public relations
- d) *Transfer the risk*
This involves another party bearing or sharing some part of the risk. Mechanisms include the use of contracts, insurance arrangements and organisational structures such as partnerships and joint ventures.
- e) *Accept the risk*
After risks have been reduced or transferred, there may be residual risks, which are retained. Plans should be put in place to manage the consequences of these risks if they should occur, including identifying a means of financing the risk.

5.2 Assessing Risk Management Options

Options should be assessed on the basis of the extent of risk reduction and the extent of any additional benefits and opportunities created. Selection of the most appropriate option involves balancing the cost within the economic, social and political consequences. Where large reductions in risk may be obtained with relatively low consequences, such options should be implemented.

In many cases, there is not likely to be any one 'best solution', but rather a combination of solutions for a particular problem. Risk management options should consider how affected parties perceive the risk.

National Open Disclosure Standard

South West Healthcare prefers open communication when things go wrong in health care to those affected by the incident. This could be the patient, their family and their departmental staff.

Elements include:

- Expression of regret
- Confidentiality
- Consequences of the event
- Recognition of reasonable expectations of patient & family
- Support for staff
- Factual explanation of what happened
- Steps being taken to manage the event and prevent recurrence
- Openness and timeliness of communication

5.3 Reporting Risks and their Management Plans

South West Healthcare wishes to integrate risk management with all our quality improvement initiatives. The management proposal will therefore be written up in the form of an integrated business/quality plan which will be carried out annually (see Appendix 3 for an example of an incident specific quality action plan) and implemented as such. Any risk analysed at program level as an *Extreme* or a *High* risk, must, after completion of the plan, be discussed with the responsible executive or designated delegate as shown in the risk management reporting model in Appendix 4.

Risk Controls

Risk controls should be commensurate with the level of risk. For example, a high or extreme risk should not be solely managed by administrative controls, rather higher level controls which guarantee the risk is mitigated should be used. When assessing we need to consider the following:

What is the Nature of the Control? Does it:

- i. prevent incidents on all occasions?
- ii. Prevent transactions continuing until the requirement is satisfied?
- iii. Identify expectations that need discretionary decisions made?
- iv. Identify trends or repeated incidents that need attention?
- v. Require human intervention to implement the control? i.e. does it require a person to identify if an incident/expectation exists and to identify and select appropriate courses of action.

6. Monitoring and Review

Few risks remain static. Monitoring and review of risk is an essential component, having identified and implemented risk reduction practices (closing the loop). The risk management options chosen must be monitored to ensure they are achieving the desired outcomes (see figures 1 & 4).

The questions to ask are:

- Has risk been reduced? If not, why not?
- Are there other measures that could be implemented?

Some risks, depending on the level of overall risk, may require very regular review. This will be determined in the development of the quality improvement plan.

As a general guide, a moderate risk may require quarterly or bi-monthly review to ensure the likelihood or consequences have not altered. High risks will be reviewed monthly or bi-monthly depending on the likelihood rating, and an extreme risk may need to be reviewed weekly or more often, if the likelihood of occurrence is very high.

**Table 1. CONSEQUENCE RISK RANKING MATRIX
(Riskman Incident Reporting Database)**

Rating		AREA OF IMPACT				
		Financial	Customer Service/Business Continuity	Regulatory/Legal	Reputation & Image	Injury
ISR 1	Catastrophic / Extreme	Financial loss equal to or in excess of \$250,000	Critical Service failure and/or key revenue source removed	Significant breach of regulations with major consequences to personnel and organisation	Criminal negligence or misconduct by officers; Culpable mismanagement.; Appointment of Administrators; Loss of confidence in organisation from government/public/media	Death(s); Severe (permanent) disability to patient/visitor/staff; Sentinel event
ISR 2	Major/High	Financial loss between \$25,000 and less than \$250,000	Service or provider needs to be replaced for essential service and/or contract >\$100k	Breach of minor consequences to personnel and organisation	Sanctioning of Board or senior officers; Widespread media coverage; Significant loss of reputation	Severe injury/disability requiring significant medical/surgical intervention
ISR 3	Moderate / Medium	Financial loss between \$2,500 and less than \$25,000	Service interruption	Breach causing no harm but has consequence to meeting safety and quality standards	Adverse media coverage; Significant legitimate complaints; Significant detriment to stakeholders; Organisation plans / KPIs not met	Moderate injury/impairment; Increased length of stay; Additional operative procedure
ISR 4	Minor	Financial loss between \$1,000 and less than \$2,500	Brief service interruption	Breach causing no harm, reported internally	Stakeholder/consumer complaints; Response required to adverse reports or findings	Minor Injury may require medical attention or lost time injury; No impairment
ISR 5	Insignificant / Near Miss	Financial loss up to \$1,000	Brief reduction or loss of service, up to 112 hours	Breach causing no harm monitored by regular audits	Unfounded minor complaints; No detriment to stakeholders	Minor first aid / no injury/near miss

Table 2. LIKELIHOOD

Level	Descriptor	Detail description	
5	Almost certain	The event is very likely to occur – will occur on at least an annual basis	0-1yr
4	Likely	The event will probably occur– will occur at least once every 3 years	1-3yr
3	Occasionally	The event could occur at some time – will occur at least once every 10 years	3-10yrs
2	Unlikely	The event has not occurred but could occur once in 30 years	30yrs
1	Rare	The event may occur once in 100 years	100yrs

Table 3: CALCULATION OF LEVEL OF RISK

		CONSEQUENCE				
	LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
5	Almost certain	H	H	E	E	E
4	Likely	M	H	H	E	E
3	Occasionally	L	M	H	E	E
2	Unlikely	L	L	M	H	E
1	Rare	L	L	M	H	H

- Key** **E** = Extreme risk; immediate action required/needs active management now
H = High risk; senior management attention needed/regular monitoring (half yearly/quarterly)
M = Moderate risk; management responsibility must be specified/at least annual monitoring
L = Low risk; manage by routine procedures/ no major concern

Appendix 2

South West Healthcare Risk Management Workbook									
South West Healthcare: Campus/Division.....							Date.....		
STEP 1.		STEP 2.		STEP 3.			STEP 4.		STEP 5.
Risk Area	Identify Failures What system gaps or failures are present?	Identify Risks What could happen and how could it happen?	Analyse Risks Rate as per Likelihood, Consequence and Risk Rating charts			Evaluate Risks Is Risk Tolerable or Not Tolerable? Tick	Reported to Line Manager and Quality Unit (Complete if risk is an 'E' OR 'H' Rating or response to coroner)		
			Current controls	Risk after taking current controls into account (actual risk)					
		Risks identified		L	C	R	T	NT	Sent
Clinical Risk Management									
OH&S									

South West Healthcare Risk Management Workbook

South West Healthcare: Campus/Division..... Date.....

STEP 1.		STEP 2.	STEP 3.			STEP 4.		STEP 5.
Risk Area	Identify Failures	Identify Risks	Analyse Risks			Evaluate Risks		Reported to Line Manager and Quality Unit
	What system gaps or failures are present?		What could happen and how could it happen?	Rate as per Likelihood, Consequence and Risk Rating charts				
			Current controls	Risk after taking current controls into account (actual risk)		Is Risk Tolerable or Not Tolerable?		(Complete if risk is an 'E' OR 'H' Rating or response to coroner)
		Risks identified		L	C	R	T NT	
Financial								
Environmental								

South West Healthcare QUALITY ACTION PLAN (for specified adverse events only)

These can be incorporated into the annual Business/Quality Plan

South West Healthcare: Campus/Division.....

Date.....

Source	Aim	Objective	Action	Measurable Outcome	By when & whom	Risk rating After new controls in place		
						L	C	R

SOURCE KEY: Accred - Accreditation standards (eg EQuIP), Ext. review – External reviews/audits, Sentinel Event, Cor. Rep. - Coroners Report, Prospective - Prospective Risk Analysis