Quality in healthcare – Part 3

Risk management

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Life is a risk.

Whenever we take up an activity, we run a risk; for e.g. when you go out, you risk being run down by a bus (probably private). You can reduce this risk by being extra careful when crossing the road. Though not as serious, it is more likely you will get wet. You can't stop the rain, but by anticipating and taking an umbrella, you can reduce its effect. This is risk management (RM) in everyday life.

RM in healthcare is almost as simple; unfortunately it has been made to sound complicated.

What is risk?

Risk is the chance of something untoward happening.

What is RM?

There are several official definitions, the joint Australian/NZ one is given below:

It is 'the culture, processes and structures that are directed towards realizing potential opportunities whilst managing adverse effects'.

If you want to be simpler and practical:

RM is a process by which you anticipate and evaluate impending harmful events, and plan to reduce their occurrence and/or impact.

Or, in plain English:

RM is asking 'what could go wrong?' and then doing something about it.

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Practical steps in RM (as practised in the UK)

In practice, this is done by asking a series of questions;

1. What has and could, go wrong? Recognition.

   Information is fed by a system of adverse incident reporting (reactive); and also by anticipation, by considering mistakes of others and warnings issued by statutory bodies such as Patient Safety Agency; Defence Unions; GMC and the Dept of Health (proactive).

Exercise:

Newspapers reported that in one hospital, a patient was booked for nephrectomy of a non-functioning kidney. The surgeon removed the good one!

In another incident, a patient with primary infertility was booked for laparoscopy and dye test on the day surgical list, as were others for laparoscopic sterilisation. The surgeon clipped her tubes!

(true incidents!)

Q: Given this information, what changes would you make in your department's practice?

2. How do they happen, how frequent and how serious are they? *Analysis, assessment and evaluation*

   Even simple events, if frequent and recurrent need attention, (e.g. habitual late starting of inductions). The more serious ones, even if infrequent, certainly do. They are looked into in detail by a process called 'root cause analysis' (e.g. intrapartum foetal death, maternal death). This outlines the factual account

of what happened, where things went wrong and why, and more importantly suggests recommendations on prevention. This would lead to either new guidelines or changes to the existing ones. *Prevention/Reduction*

3. What if we can't prevent them (like the rain)? *Acceptance*

   Then we could try to *minimise the impact* (take an umbrella). We have no control over a power failure; but we could provide good back up by having a stand-by generator, which is regularly serviced and checked.

How is it all done?

In a typical General Hospital in the UK, there would be:

an Obstetric Risk Manager, usually a senior midwife with some managerial experience;

a Gynae Risk Manager, usually senior Nurse with similar experience and

Lead Consultants for obs and gynae risk.

There would be small RM committees, which would meet regularly to review the recent adverse incident reports and decide on appropriate action. Ideally they would also act proactively (see above).

Every department holds a monthly RM meeting, to which all employees are required to attend, unless on emergency duty. (All elective work is cancelled). A summary report of the RM issues over the previous month is presented, along with recommendations and lessons to learn. A robust discussion ensues, leading to (hopefully) a consensus and a change in policy.

The culture is one of lessons to learn rather than of 'finger-pointing', which is actively discouraged.

A similar process is repeated in every department. Thus, it is apparent that the NHS Trusts invest a lot of resources, financial and manpower, in to RM. This is considered money well spent, as the cost of not doing it would be far greater.

In Sri Lanka, we have a long way to go but at least the big teaching hospitals should make a start.

How did it all start?

The concept of 'risk management' originated in the airline industry, as a way of reducing crashes. They were in a unique position in having access to the data on 'what went wrong' by way of the famous 'black box'. Anaesthetists in Australia and New Zealand were the first to apply it to their practice, from which it spread to other areas of clinical medicine.

What keeps it going? (*'The drivers'*)

By early 1990s, the govt got interested in 'quality' and 'accountability' in health care, leading to the concept of *clinical governance*. Safety was a vital part of this. But by far the most important driver was the *fear of litigation*, especially in obstetrics. Currently, a brain damaged baby due to negligence would cost over 5 ½ million pounds sterling. It became increasingly difficult for individual Trusts to foot such bills. So, they have joined an insurance scheme for such eventualities. (CNST - Clinical Negligence Scheme for Trusts in England and WRP - Welsh Risk Pool in Wales). They dictate their own protocols for continuing the insurance cover and for keeping the premiums down (just like in car insurance).

Although a lot of noise is made of RCOG and NICE guidelines, the Trusts are not obliged to implement them. On the other hand, CNST and WRP criteria must be met, in order to survive.

Having a properly organised RM system is a fundamental part of the insurers' protocols. This might explain why it is slow to be established in SL; we are not (yet) threatened with litigation for medical negligence.

Adverse incident reporting

This is a vital part of the RM process. An adverse incident *is an unplanned event which could cause actual or potential harm.* When an incident actually causes harm, it becomes an *accident*.

In the UK, it is considered the duty of all health professionals to report such incidents and adverse incident forms are provided in all clinical areas. These are collated by the risk manager, analysed and presented at the next meeting of the RM team, which would then act as described above.

Failures

Incidents and accidents happen as result of failures of which there are two types: *Personal and system*

Personal failures arise when individuals depart from accepted practice. This could be due to *Errors or Violations*.

Errors:

Are due to ignorance, forgetfulness, genuine mistake, stress, etc. They are involuntary, isolated and easily correctible.

Violations:

Occur when individuals intentionally depart from accepted practice. They tend to be repetitive, more difficult to address and may need some disciplinary action, as well as supportive.

Personal failures are suitable to be addressed by a one to one approach.

System failures are of wider significance. E.g. frequent breakdown of vital equipment due to lack of proper servicing, lack of proper guidelines on the management of acute situations e.g. eclampsia. This is where the RM team really could make a difference, by implementing change and cascading information.

(Sometimes personal failures are described as 'active' and system ones as 'latent'. I feel 'personal' and 'system' failures are more descriptive and explanatory).

When an accident happens

A rational honest stepwise approach is required.

1. *Recognise:* as early as possible, for e.g. making a hole in the bladder.
2. *Stop escalating it.* Ask for senior help.
3. *Repair:* It is sensible to inform your superior asap even if you are capable of dealing with the problem.
4. *Record:* This is absolutely vital and should be done asap following the incident. Make accurate, clear and comprehensive notes. Do not forget to fill the adverse incident form.
5. *Reflect* and review your practice and/or systems.
6. Counsel the patient.

In conclusion

Risk management is not high science; it is simple and practical. We take an umbrella to protect us from the rain. So, why don't we take appropriate precautions to protect the patients? We should.

Appendix

Exam questions

In the MRCOG, the questions relating to RM almost always appear as OSCEs. They are in one of two formats.

1. A particular scenario is given and you are asked how you would investigate it.

e.g. In your Unit, there have been 3 instances of accidental foetal injury at CS during the last two weeks. You have been asked to investigate and report.

Discuss with the examiner how you would go about it.

2. A sequence of events is described culminating in a clinical disaster. You are asked to provide a risk management report.

e.g. 25-year old primigravida was booked to deliver in a peripheral hospital, laboured spontaneously at 41 weeks and 6 days. She progressed normally until 7cm dilatation but then stayed at 7 cm for 4 hours and was transferred to your hospital. Reached full dilatation after 6 hours of syntocinon but did not deliver after two hours of maternal efforts.

Registrar was busy doing a caesarean section for foetal distress and the SHO delivered her with forceps but had shoulder dystocia and eventually managed to deliver the baby after five minutes.

Baby was 'flat' with a one minute Apgar score of 3 and the paediatric SHO was busy in theatre with the foetal distress baby and hence the Paediatric Registrar was bleeped who attended the baby and resuscitated with difficulty. Baby was admitted to special baby care unit where he started fitting. The survival chances are slim.