

## Risk Management

Originally considered as a means for controlling litigation, evolved to having a primary focus of patient safety. Integral to the concept of Clinical Governance.

Why bother? Adverse events / medical errors have huge costs – to NHS (financial – ICU admissions and prolonged stays more important than litigation), NHS organisations (star ratings), to staff (stress, being sacked), and patients (physical, emotional, financial, etc). Estimated cost of adverse drug events in US is \$4-5 billion/year. Adverse events are common – occur in or associated with ~4-16% of hospital admissions. EDs usually high up the list of hospital locations where they occur.

No universally accepted definitions for medical errors, adverse events, critical incidents, clinical incidents, etc, hence difficult to compare rates between studies. One definition of critical incident : “any incident that has an actual or potentially harmful effect on the outcome for a patient or group of patients”. Others would include only those occasions where actual harm occurred, and others would include harm occurring to staff or property.

Distinction sometimes made between clinical (eg diagnostic error, prescribing error, failure to act on abnormal result etc) and non-clinical (eg verbal abuse to staff, patient falls, lift breaks down, needlestick injuries, fire, back injury to staff caused by lifting, etc) adverse events.

Systems approach – recognises that humans will always make mistakes, therefore need to build failsafe mechanisms at all levels of systems to minimize quantity/ impact of these.

Some examples of RM measures in A&E :

### 1. Minimizing occurrence of critical incidents

- Appropriate staffing levels
- Shift patterns, leading to ....
- Supervision of juniors
- Environment – eg lighting, equipment, security, bedrails
- Training – eg Med school, SHO induction/ teaching, ALS etc, + nursing equivalents; simulator training increasing in popularity especially in US
- Use of protocols – eg DVT pathways, chest pain
- Certain patients only seen by middle grades/ seniors – eg unbooked returns, ?DVTs, chest pain (at Hope, all chest pains have to be D/W Cons or Reg before discharge)
- Communication with colleagues – formal handover
- Communication with patients – verbal and written (advice leaflets)
- Communication in notes – eg arse-covering documentation of patients leaving against advice

## 2. Minimizing impact after a critical incident has occurred

- X-ray reporting / recall
- ECG / blood result reviews
- Early follow-up for certain patients – eg limping child
- A&E card review for all patients (eg MRI) or selected (eg seen by new SHOs, or all who had ECG, or whatever)
- Health Visitor follow-up for under 5's

## 3. Learning from failure

- Critical incident reporting – departmental or hospital (may include “near-misses”, where actual harm not occurred, said to provide “free lessons”)
- TARN
- Complaints / litigation review
- Audit

As an example of Trust incident monitoring, the way it works at Hope is : Clinical / non-clinical adverse incident entered electronically. Looked at initially by Trust “Clinical Governance Facilitator”, who have clinical background and special clinical governance training. For less serious incidents, they enter it into database and decide who would be best person to deal with it eg ED nursing manager or clinical director, or Trust Health and Safety Officer. For more serious incidents, also inform Health & Safety and Clinical Risk Managers. These will then arrange for the incident to be investigated and recommendations made, and the adverse incident reviewed at a meeting of the Trust Corporate Governance and Risk Management Committee.

See also CNST – fully covered by Joff