

Managing the Environment - Risk

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Aim of this session

To promote and highlight the nurse's responsibility for managing risk

Objectives

At the end of the session students will be able to: -

- Understand their role in managing risk
- Understand how risk management affects nursing care
- Outline current developments including policy regarding risk management
- Understand the role of the nurse within the management structure with regard to quality assurance, resource and risk management

Background

- The New NHS – Modern and Dependable (DOH,1998)
- A First Class Service (DOH,1998)
- NHS Plan (DOH,2000)
- An Organisation with a Memory (DOH,2000)
- Building a Safer NHS for Patients (DOH,2001)
- Supporting Safer Services (DHSSPS,2006)

Why Risk Management is Important

- To enhance quality of treatment and care services
- Provide safer environment for staff
- Improve public confidence and Trust's reputation
- Learn from what has gone wrong
 - Reduce costs of replacement, repair, and claims

An organisation which reports many incidents does not necessarily mean that this organisation is unsafe but rather the converse may be true i.e the organisation may have achieved more in terms of supporting an open and learning culture

Supporting Safer Services DHSSPS June 2006

Definition:

(AS/NZS 4360: 1999)

Risk Management (The Standard)

Risk – the chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood

Risk Management – the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects

Hazard and Risk

- A **HAZARD** is something with the potential to cause harm
- A **RISK** is the likelihood of the hazard being realised

Incidents and Near Misses

Incident Any event that has given or may give rise to actual or possible personal injury, to patient/client dissatisfaction or to property loss or damage

Near Miss Any event that did not lead to personal harm but could have, an occurrence which but for luck or good management, would in all probability have become a fully blown incident

Example

- An unsheathed needle lying on the floor is a hazard
- The risk is that someone receives a needle stick injury
- If the needle is picked up by a member of staff who places it, without injury, in a sharps box it was a near miss
- If someone picks it up and injures themselves before putting it in a sharps box this is an incident



Risk Management Cycle/Process

- Risk Identification
- Risk Analysis
- Evaluating the Risks
- Treat Risks
- Monitor and Review
- Communicate and consultation

Methods of Identifying Clinical Hazards



What do I do if I Identify a Hazard?

- Check if a risk assessment is already completed –if not advise line manager
- Complete an incident form
- If the hazard involves or potentially involves a patient or client ensure it is recorded in the care plan

How is Risk Rated/Analysed?

Risk is measured in terms of likelihood and impact (severity of harm)

Risk Assessment Matrix

Likelihood	IMPACT (Consequence/Severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	H	H	E	E	E
Likely (4)	M	H	H	E	E
Possible (3)	L	M	H	E	E
Unlikely (2)	L	L	M	H	E
Rare (1)	L	L	M	H	H

Low

Manage by routine procedure

Moderate

Management responsibility must be specified

High

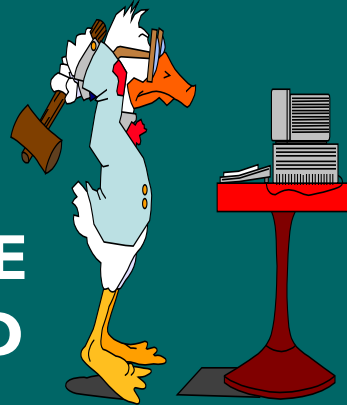
Senior management attention needed

Extreme

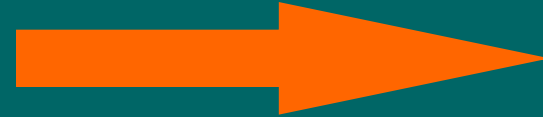
Immediate action required

Risk Treatment Options

**ELIMINATE
or AVOID**

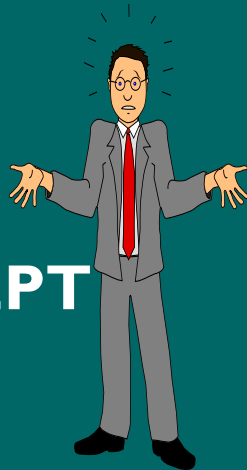


TRANSFER



REDUCE

ACCEPT





Health and Social Care Policy on Incident Reporting

Health and Social Care Trusts are concerned
with preventing adverse incidents occurring,
not with blame or liability

N.B Professional and Statutory
obligations



Health and Social Care Policy on Incident Reporting

- The Risk Management system is facilitated by effective incident recording, which must be a high priority
- A supportive, open and learning culture that encourages staff to report mistakes, incidents and near misses through the appropriate channels underpins this

Cost of Incidents

- £2 billion alone in costs for additional hospital stays for patients who have suffered harm
- 10% of admissions suffer harm to some degree

DOH An organisation with a memory 2000

Why Report Incidents and Near Misses?

- Can help protect staff and the Trust
- Professional accountability
- One of the most important ways you can tell your organisation about risks and help improve services for patients, your colleagues and yourselves
- Lessons can be learned and trends assessed

Why Report Incidents and Near Misses?

- Health and Safety Legislation, including RIDDOR
- Onward reporting to external bodies e.g. DHSSPS, EHSSB, RQIA
- Incidents involving equipment may require to be reported to NIAIC, possibly for regional action
- Trust policy



Reporting Incidents

- **Who ?** - Any member of staff can report
- **Where ?** - On an incident form
- **When?** - As soon as possible after the event

Examples of Potentially High/Extreme Clinical Risk Incidents

- Incorrect patient identity
- Inadequate documentation
- Failure to observe adequately
- Failure to Refer

Evidence of Communication

- Report and record anything you did or anything that could have caused risk to patients or clients
- Don't be tempted to 'keep it quiet' because a trusted colleague is involved N.B Duty of care to patients and clients
- Communicate fully (written and verbally) to other health professionals regarding patients'/clients' care on a day to day basis

Familiarise Yourself With...

- The Risk Management Strategy
- Risk Management Policies and Procedures
- Staff information leaflets

...in the area you are working

Words of Advice...

- Do not accept that incidents/accidents are inevitable
- Be proactive rather than reactive to aim to prevent harm from incidents

PRIMUM NON NOCERE Florence Nightingale 1863

Most importantly cause no harm

Suggested Further Reading...

- National Patient Safety Agency Website www.npsa.nhs.uk/
- DHSSPS Paper: Supporting Safer Services 2006
- DOH Organisation with a Memory 2000
- DHSSPS Paper: Safety First: A Framework for Sustainable Improvement in the HPSS 2006

Quality

“Quality is doing the right thing for the right person at the right time and getting it right first time, every time”

Crosby 1990

Food for Thought

YET!

30-40% of patients do not receive care in line with current scientific evidence and,
10% of hospital admissions are due to adverse incidents

Safer Patient Initiative 2004

“Believe it or not, quality is free”

Crosby 1990



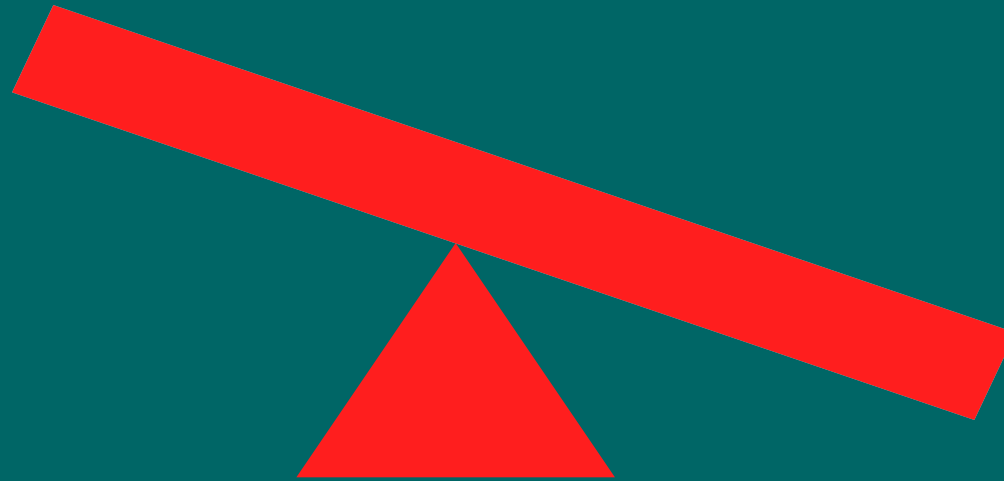
Know Your Job/Role



- Understand your job/role
- ➔ Recognise potential risk
- Awareness of relevant policies/
procedures/guidance

Governance...

QUALITY



RISK

...meeting the needs of patients, clients, visitors and colleagues in the safest possible way.

What happens when we get it wrong?

- **Bristol Heart Surgery**
- **Kent & Canterbury**
- **Victoria Climbié**
- Dr Shipman
- Sperrin & Lakeland Trust Review Report(s)
- Endoscope Review
- Janine Murtagh

Impressions...

- For the Patients/Clients
- For the Organisation



Behaviour

A close-up photograph of a woman with short, curly brown hair, wearing a black top. She is holding a black mobile phone to her ear with her right hand and has a wide, open-mouthed expression, appearing to be shouting or speaking very loudly. Her eyes are wide and looking slightly to the side. The background is dark and out of focus.

! The words we speak

! Our intonation

! Our non-verbal gestures

- Eye contact
- Body language

Ensuring A Good Quality Service

Quality Improvement Initiatives...

- Audit
- User consultation
- Setting standards
- Best practice
- Complaints, comments and suggestions