Year 1 Number 6

Health Governance Unit

# ABC of Governance

2016

*Towards informed and transparent societies*

Medical Research Institute
Alexandria University

## Risk Management

Risk management can be defined as the identification, evaluation and prioritization of risks followed by specific action to alter their occurrence in the future. If the risk has negative consequences, the specific action is directed towards its minimization, however, if the risk has positive consequences, the specific action is directed towards its maximization. In this issue we are writing about risks with negative consequences.

Risk management is an integral part of responsible governance and effective management. It is applied to all fields and all levels and within different contexts. Risk management is applied in industry, aviation, education, healthcare, etc. It can be applied at strategic, managerial, and operational levels. At each level it can be used within a different context, whether safety, finance, quality, liability, etc.

In healthcare, risk management is applied at system level, institutional level, and care level. At system level, ministries ensure universal health coverage through nationwide health insurance. At institutional level, governing boards guard against strategic failure through enterprise risk management. At care level, doctors and nurses ensure patient safety through clinical risk

### ABC of Governance

**AIMS AT**

creating an awareness of issues related to health governance

providing a core of knowledge that is practice-based

encouraging communication between advocates of governance

## Clinical Risk Management

Healthcare delivery, regardless of its place, is not exempt from risks. A significant number of patients suffer from adverse events during their care. This is a worldwide phenomena resulting from the complexity of the clinical processes involved in healthcare delivery.

Recognizing this has led to a more proactive approach in risk management where adverse events are anticipated and efforts are done to minimize their occurrence rather than reacting to their occurrence. Furthermore, the safety culture has moved from a blaming one to one of accountability and openness as most adverse events have been found to be related to system failures.

Clinical risk management is concerned with making clinical care and related processes such as diagnostic procedures, medication therapy, and invasive procedures safer for patients.

Clinical risk management with clinical effectiveness and clinical audit have become the main pillars of clinical governance; a framework for clinical excellence and accountability.

All are responsible for making clinical care free of any risks. However, clinicians (doctors, pharmacists, nurses) are expected to lead clinical risk management activities in a team spirit with support from management and governance.

Each clinical team within their speciality or service area has to define the sources of potential harm (hazards) and map the related clinical processes of their speciality in order to further define the probabilities (risk) of being harmed from their failure.

Clinical risk management can be performed within different contexts. The most common is patient safety (harm). However, it can also be performed within a financial or legal context where the impact is analyzed and evaluated from a cost or liability perspective.

Clinical risk management is not a one-off activity but is ongoing and is part of how clinicians do their work. Therefore, it should be documented, continuously monitored and periodically reviewed.

Ideally, clinical risk management should be aligned with risk management activities at institution and system level.

# Reading Material

- **Books**

Clinical Risk Management. Charles Vincent. BMJ. 2001

ABC of Patient Safety. John Sandars & Gary Cook BMJ. 2007

- **Guides**

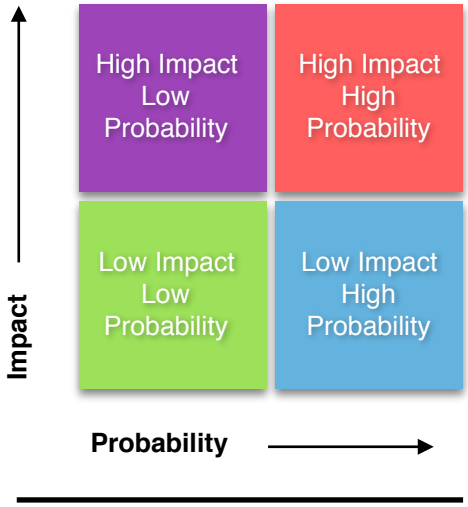
Patient safety curriculum guide. Multi professional edition. WHO. 2011

Risk management policy and process guide. NHS. 2015

- **Web Sites**

NHS improvement.
www.improvement.nhs.uk

Flying Start.
www.flyingstart.scot.nhs.uk



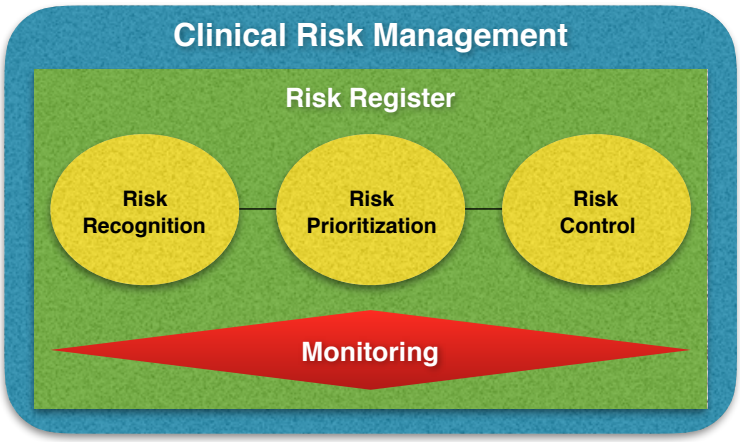

**ABC of Governance**

Produced by
Health Governance Unit
Medical Research Institute
Alexandria University

www.healthgovernanceunit.com
ABC@healthgovernanceunit.com

Contributions are welcomed and will be published

# Clinical Risk Management Steps




**Risk Recognition**

In this phase, the context of clinical risk management is defined and the sources of harm (hazards) identified.

***Context Setting***

This is about deciding from what aspect will the analysis be done (patient safety, service disruption, reputation, financial loss, etc)

***Hazard Identification***

This entails the identification of sources of harm (hazards) which could be an instrument, material, condition, process, or practice.

— — —

**Risk Prioritization**

In this phase, the risk is analyzed then evaluated to create a risk matrix that sets the priorities in dealing with the identified hazards.

***Risk analysis***

Entails the assessment of the probability of things going wrong and their impact. The impact used in analysis will depend on the context of the clinical risk management activity. A process map or flow chart may be required when analyzing risks related to clinical care.

***Risk Evaluation***

Based on risk analysis (probability and impact), the likelihood of things going wrong can be divided into different levels of risk as shown in the opposite figure. Priority is given to high impact high probability events.

— — —

**Risk Control**

In this phase, decisions are taken on how to deal with the identified risks and what controls or barriers are required to be introduced.

***Decision Making***

Usually a decision is taken to minimize the identified risks through the implementation of controls or barriers. Sometimes, if the risk is low it can be accepted with no change. However, if the risk is too high the process or responsibility can be transferred to a second party.

***Implementation***

Risk reduction can be achieved through the use of physical (doors), natural (space or time), human (double checking), or administrative (policies and procedures) controls or barriers.

— — —

**Risk Register**

A risk register can be described as a log or repository of the various risk assessments and controls performed within an organization. It is a dynamic document which enables the organization to understand its comprehensive risk profile. It provides a structure for collecting information about risks that will assist in the analysis of risks and in decisions about whether or how these risks should be controlled, managed and monitored.

— — —