RISK MANAGEMENT
A systematic approach towards safety
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Objectives

- Define Risk and Risk management
- Describe the approaches to risk management and its key dimensions
- Describe Steps of proactive risk management
- Develop SMART action plans to treat the identified risks
- Define incident, Near miss and Sentinel event
- Describe Steps of Incident identification and reporting

Risk Management approaches in SSMC

Identify risks in advance and treat them

Proactive

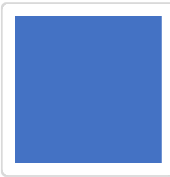
Reactive

Managing Incidents that had already occurred

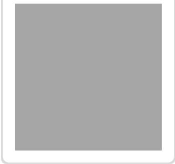
- Risk assessment and risk register
- Failure Mode Effect Analysis (FMEA)
- Good Catch

- Incidents
- Morbidity and Mortality Care reviews
- Complaint Management

Benefits of Risk management


Protecting patients, employees and others from harm

Protecting the reputation and public image of the hospital


Increasing the stability of operations

Preventing or reducing the legal liability

Part I

Proactive Risk Management

Definitions

Risk

Effect of uncertainty on objectives, a probability of a threat or damage, injury, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through pre-emptive action.

Risk Assessment

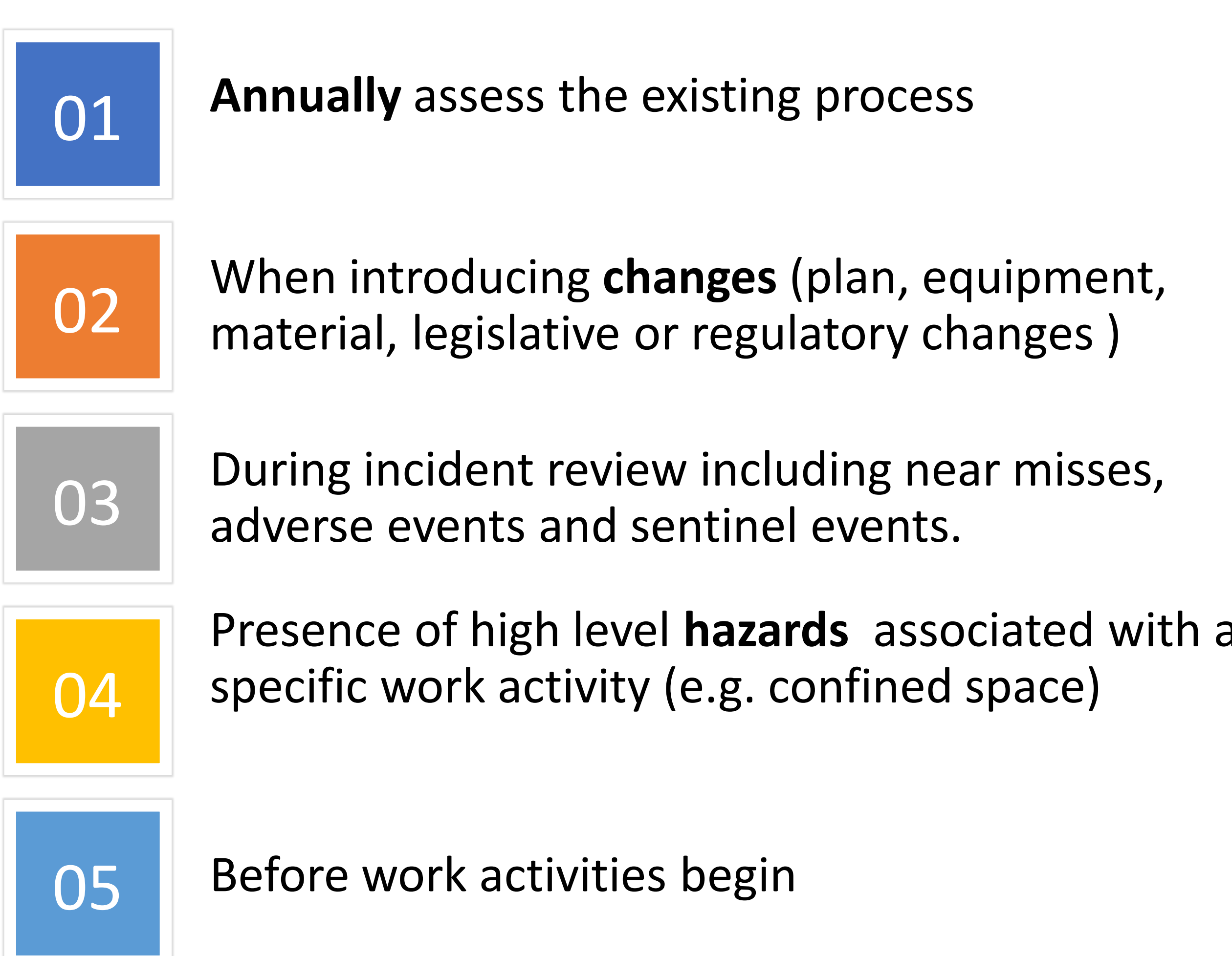
The identification and evaluation of potential failures and sources of errors in a process. This is followed by prioritizing areas for improvement based on the actual or potential impact on care, treatment, or services provided. .

Risk Management program

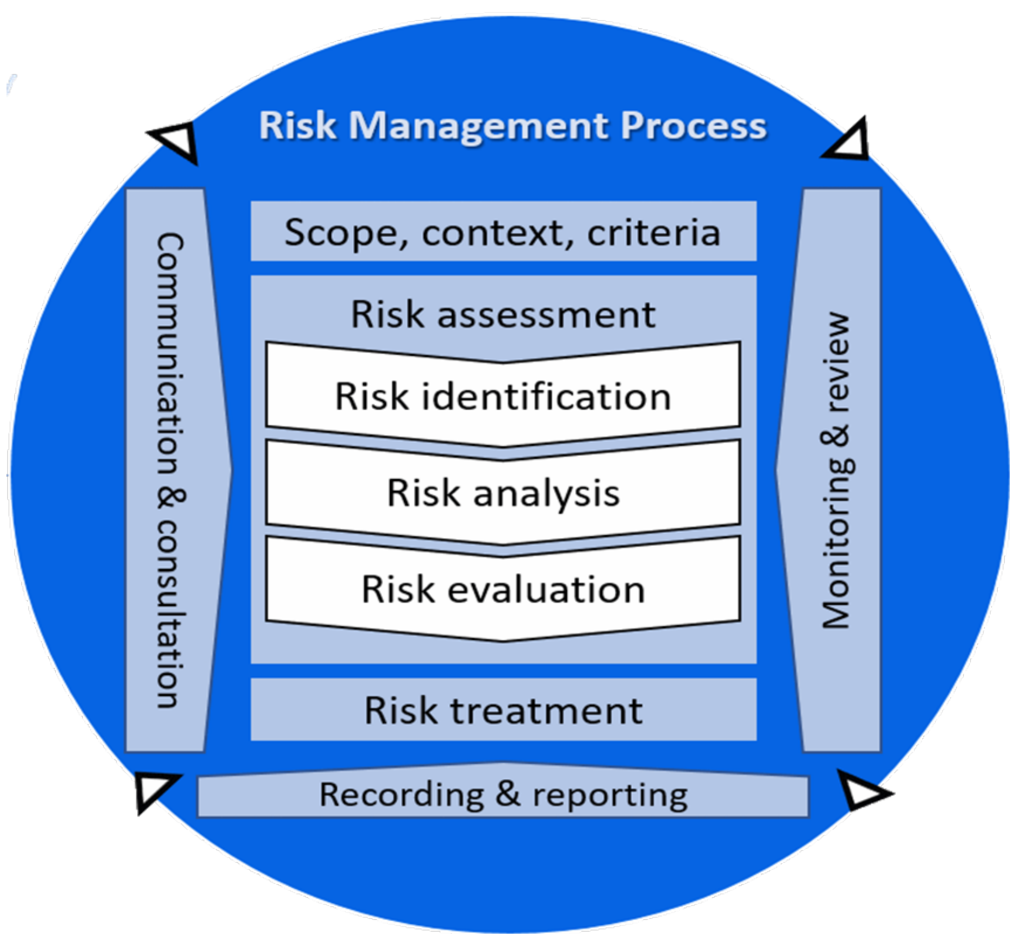
Clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself

When to conduct a risk assessment

Meet your regulatory and accreditation requirement



Risk Management Process



Reference: ISO 31000 2018 Risk management - Guidelines

Risk Assessment

How/When to identify risks

- Walk through assessments
- Risk Assessment meetings
- Failure Modes & Effects Analysis
- Incident reports, Near Miss, Sentinel Events reviews
- Complaints, Claims review
- Audit reports review
- Morbidity & mortality reviews
- Recommendations from professional bodies (e.g. external audits)

IDENTIFICATION

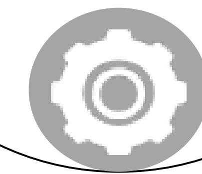
- Identify potential risks
- Determine the type of information required
- Always ask What if.. What if..

ANALYSIS

- Identify existing controls
- Determine the likelihood and impact on patients, or staff or organization
- Define the factors that may increase or decrease risk level

EVALUATION

- Determine the level of risk (score all identified risks in to the following four risk matrix
- Decide if the risk is acceptable
- Prioritize the risks in a list for treatment



Risk Evaluation

Risk Scoring : 5*5 Matrix (Impact x Likelihood)

Impact

SSMC Modified Risk Assessment Matrix (V2, March 2021)

Domains	Impact score (severity levels) and examples of descriptors				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety of Patient, staff, Visitors (Physical or Psychological harm)	Minimal injury requiring no/Minimal intervention or treatment No time off work	**Patients:** No injury Increased length of stay(LOS) or increased level of care **Staff:** No lost time or restricted-duty injuries or illnesses **Visitors:** Evaluated and no treatment required or refused treatment	**Patients with actual or potential:** Increased LOS. Increased level of care for 1 – 2 patients **Staff:** 1 or 2 staff w/medical expenses, lost time, or restricted –duty injuries or illness **Visitors:** Evaluation and treatment for 1 – 2 visitors (less than hospitalization	**Patients with actual or potential:** Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying conditions (i.e., acts of commission or omission) Disfigurement Surgical intervention required Increased length of stay (LOS) for 3 or more patients Increased level of care for 3 or more patients **Staff:** Hospitalization of 1- 2 staff 3 or more staff with lost time or restricted-duty injuries or illnesses **Visitors:** Hospitalization of 1 or 2 visitors	**Patients with actual or potential:** Death or major permanent loss of function (sensory, motor, physiologic or intellectual) not related to the natural course of the patient's illness or underlying condition (i.e., acts of commission or omission) Suicide (inpatient or outpatient) Haemolytic transfusion reaction Surgery/procedure on the wrong patient or wrong body part Infant abduction or infant discharge to the wrong family Death or major permanent loss of function that is a direct result of injuries sustained in a fall; or associated with an unauthorized departure from an around-the-clock treatment setting; or the result of an assault or other crime **Staff:** Death or hospitalization of 3 or more staff **Visitors:** Death or hospitalization of 3 or more visitors (includes outpatient)
Equipment or facility	Damage less than AED 5,000	Damage more than AED 5,000 but less than AED 10,000	Damage more than AED 10,000 but less than AED 100,000	Damage equal to or more than AED 100,000	Damage equal to or more than AED 250,000

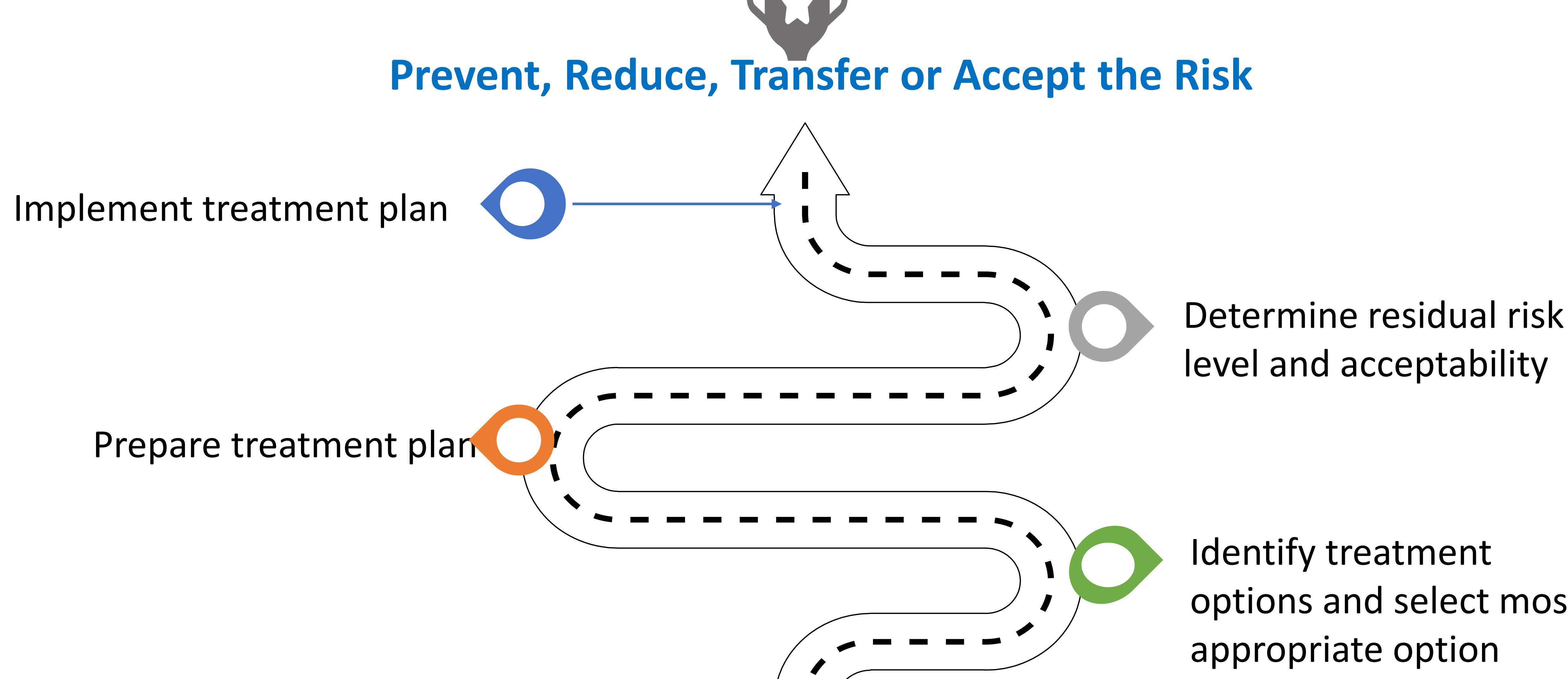
Likelihood

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency

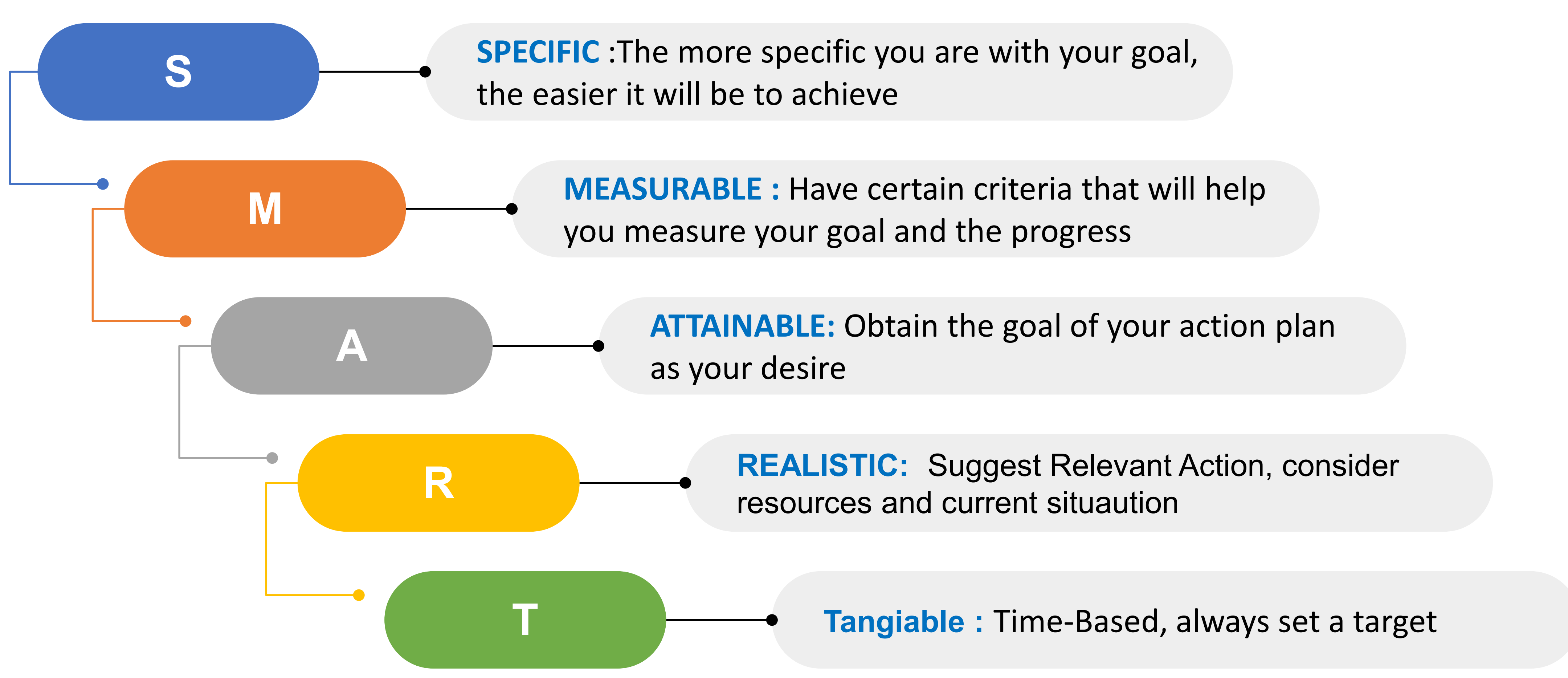
Likelihood score	1	2	3	4	5
Descriptor	Rare	Remote	Uncommon	Occasional	Frequent
Probability of event recurring	This will probably never happen	Unlikely to occur (may happen again in 5 to 30 years)	Possible to occur in time (may happen again in 2 to 5 years)	Probably will occur in time (may happen 2-4 times in 1 to 2 years)	Likely to occur within a short period of time (may happen >5 times in one year)

Score	Risk level	Action
1 - 3	Low risk	Maintain controls (if already implemented)
4 - 6	Moderate risk	Team review of controls with update as required & record with review date
8 - 12	High risk	Team review of controls with implementation & record with review date
15 - 25	Extreme risk	Team implementation of controls with record & review date

Risk Treatment

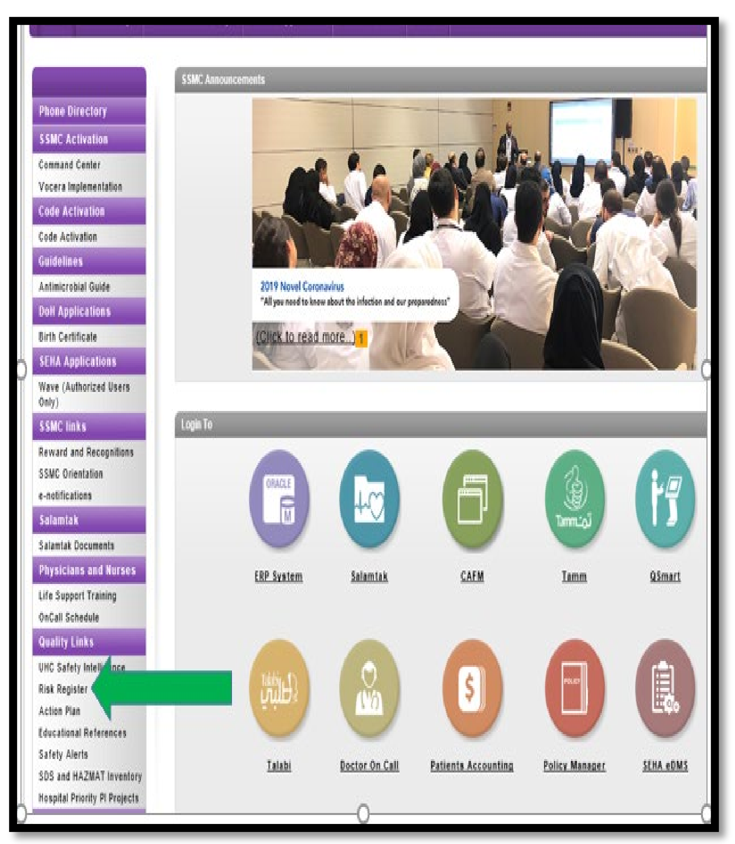


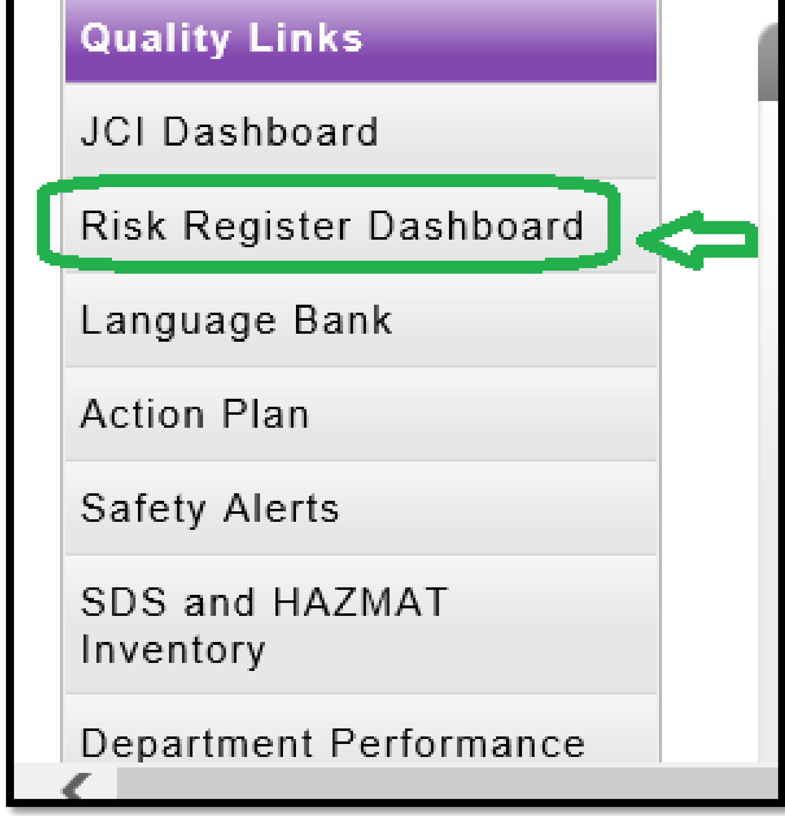
SMART Treatment Plan

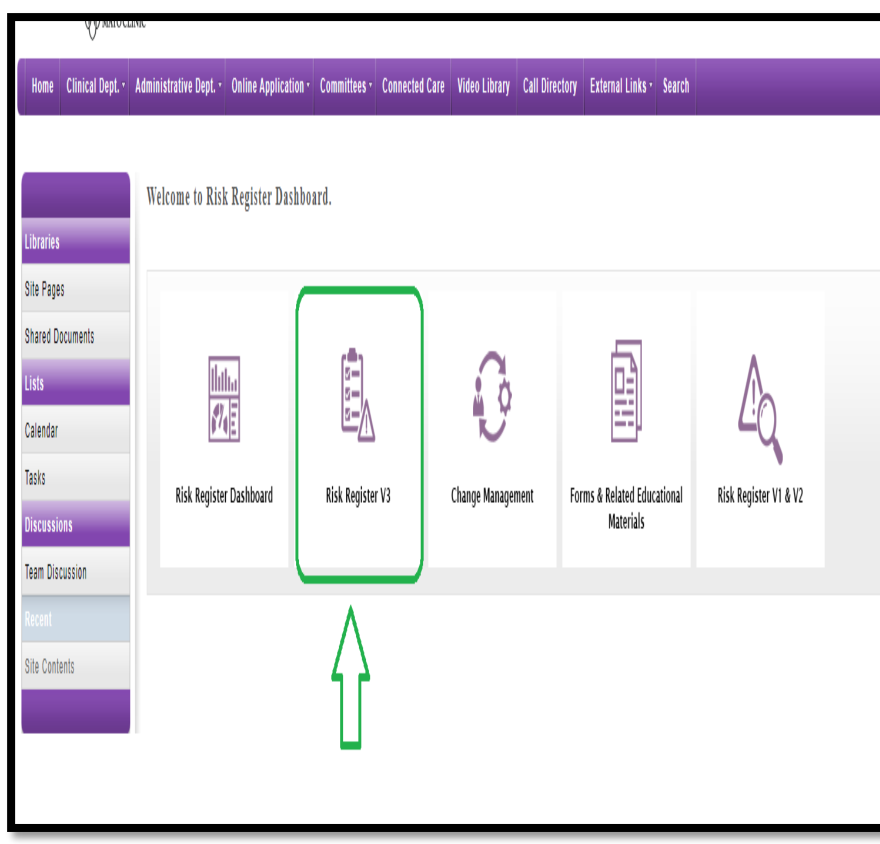


Risk recording, Reporting and Communication

Risk Register –Enter all identified risks and treatment plan on the risk register

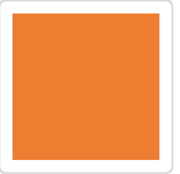






Risk Monitoring & Review

Risk re-assessment

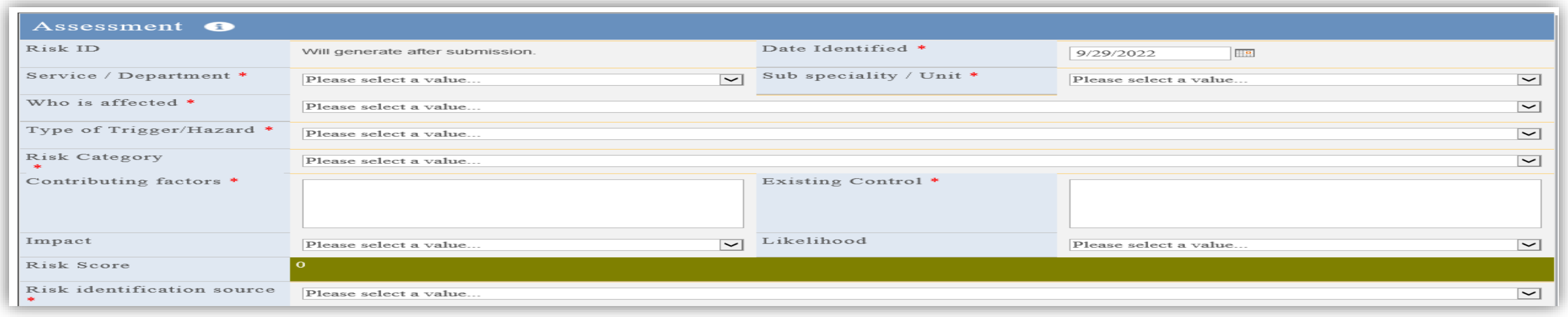


Tracers and Inspections

Internal/external Audits and Program evaluation

Incident review and investigation

Risk Register



Assessment
Risk ID
Will generate after submission.
Date Identified *
9/29/2022
Service / Department
Medicine
Sub speciality / Unit *
Who is affected *
Please select a value...
Type of Trigger/Hazard *
Clinical Trigger
Type of Trigger
Specific Triggers
Risk
Risk Category *
Contributing factors *
Existing Control *
Impact
Likelihood

Please select a value...
Allergy
Cardiology
Dermatology
Endocrinology
Gastroenterology and Hepatology
General Medicine
Haematology
Infectious diseases
Medical services
Nephrology
Neurology
Oncology
Respiratory
Rheumatology and Immunology
TB5 - Medical
TB6 - Medical
TB7 - Medical
TB8 - Medical
TD6 - Stroke
TD7 - Oncology

Who is affected *
Type of Trigger/Hazard *
Risk Category *

Please select a value...
Patient
Staff
Visitor
Contracted Staff
Environment & FMS
All
Other

Type of Trigger/Hazard *
Risk Category

Please select a value...
OSH Hazard / Environmental effect
Clinical Trigger

Who is affected *
Type of Trigger/Hazard *
OSH Hazard
Risk Category *
Contributing factors *
Impact
Risk Score
Risk identification source *
Treatment
1 - Action Plan *

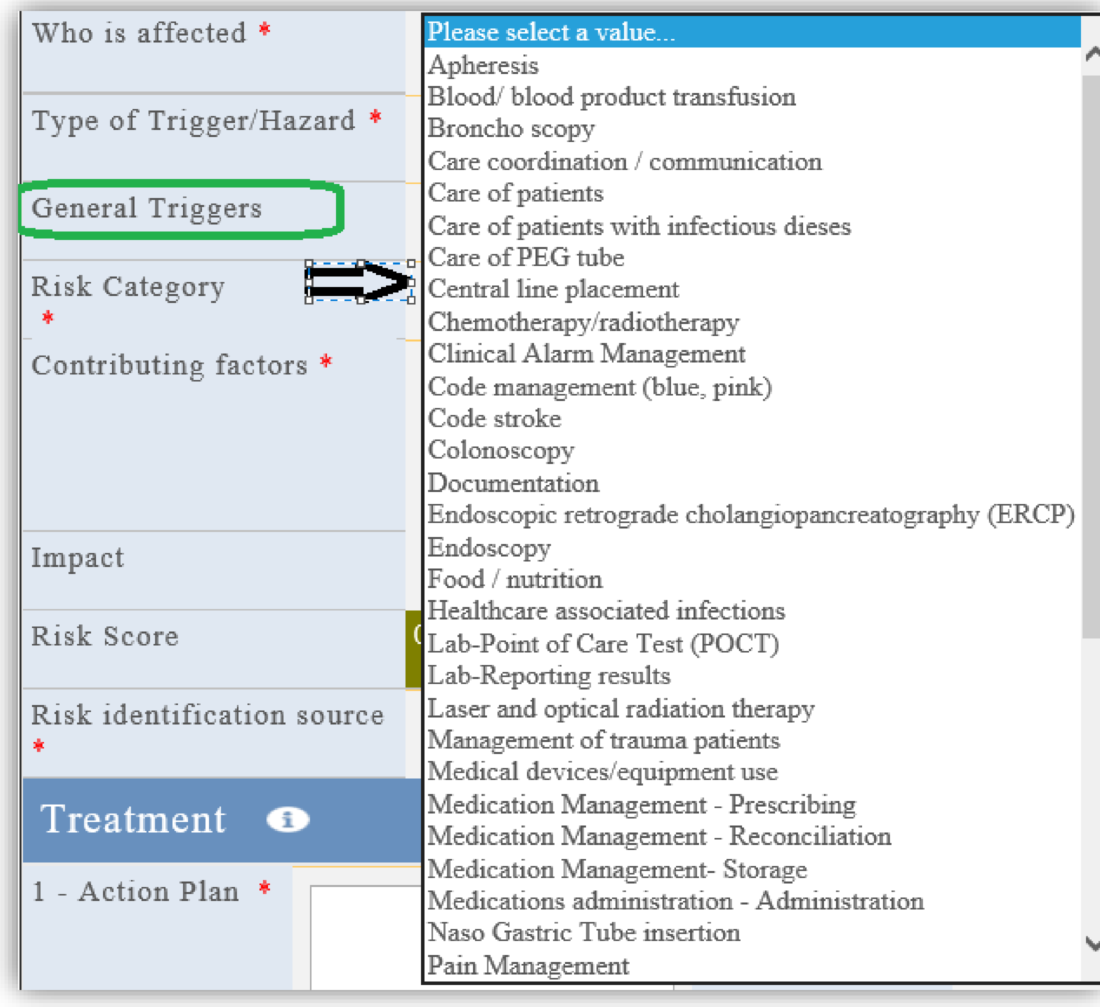
Please select a value...
Air
Biological Agents
Chemical Agents
Compliance environment
Confined Space working
Construction and renovation
Display screen equipment
Electricity
Emergency and disaster management
Equipment or Machinery
Ergonomic Hazards
Financial controls
Fire
Fire Safety
Hazardous Material and Waste
Hazardous Substances/ chemicals
Heating, Ventilation & Air-conditioning
Hot water
Inclement Weather
Ionizing Radiation
Latex Gloves
Lone Working/out of hours work
Loose and Damaged ceiling
Manual / Patient Handling
Medical Equipment
Medical gas
Medical waste
Noise
Non-Ionizing Radiation

Impact
Risk Score
Risk identification source *
Treatment
1 - Action Plan *

Please select a value...
Walk through assessments
Risk Assessment meetings
Change Management
Incident reports
Complaints
Claims
Audit reports
Sentinel Events
Morbidity & mortality reviews
Near Miss
Process Review
Accreditation reports
Recommendations from professional bodies
Failure Modes & Effects Analysis

Risk triggers

General Triggers



Specialty specific Triggers

Assessment

Risk ID: Will generate after submission.
Date Identified *: 9/29/2022
Service / Department *: Operating Room
Sub speciality / Unit *: Main Operation Theatre - MOT
Who is affected *: Please select a value...
Type of Trigger/Hazard *: Clinical Trigger
Type of Trigger
Specific Triggers: Surgery / procedure
Risk
Risk Category *: Please select a value...
Contributing factors *
Existing Control *
Impact: Please select a value...
Likelihood
Risk Score: 0
Risk identification source *: Please select a value...

Treatment

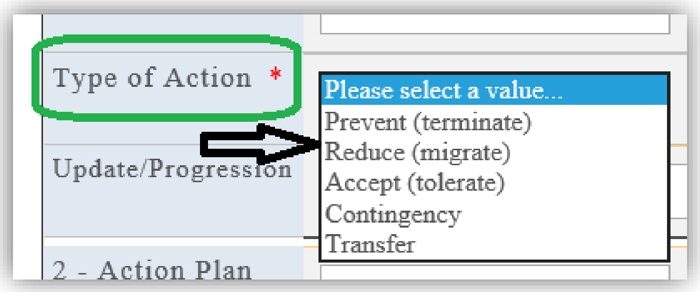
1 - Action Plan *
Assigned to *

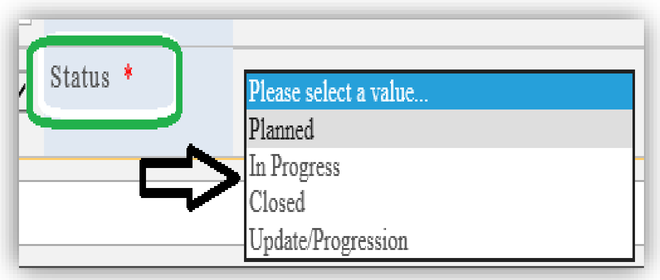
Please select a value...
Air embolus
Break in sterile technique
Cancellation of procedure/surgery after arriving inside OR
Cardiac/circulatory event
Central nervous system event
Corneal dryness or ulcers
Count incomplete or not done
Count incorrect
Cross Contamination of Infection in the theatre
Dehiscence, wound/flap/graft failure or disruption
Gastrointestinal complication
Hemorrhage requiring unexpected transfusion or return to OR
Iatrogenic pneumothorax
Incisional hernia
Other
Performing wrong Procedure, wrong Patient, wrong site.
Pressure injury to the soft organs, nerves and eyes etc.
Procedure started and not completed
Radiation exposure
Renal/urinary event
Respiratory failure requiring unplanned support < 24 hours after procedure
Surgical fire
Surgical site infections
Transplant complications
Unexpected Death in during surgery
Unintended blockage, obstruction, or ligation
Unintended laceration or puncture
Unintentional Retained objects
Unplanned removal of organ

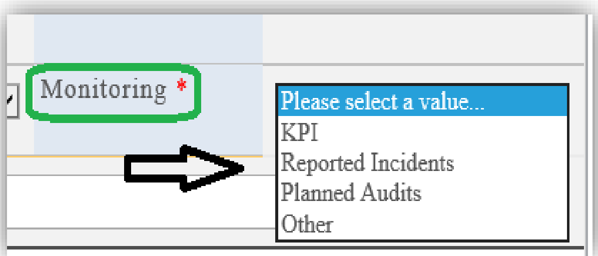
Risk treatment

Treatment

- Action Plan *		Assigned to *		Target Date *	
Type of Action *	Please select a value...	Status *	Please select a value...	Monitoring *	Please select a value...
Update/Progression					
2 - Action Plan		Assigned to		Target Date	
Type of Action	Please select a value...	Status	Please select a value...	Monitoring	Please select a value...
Update/Progression					
3 - Action Plan		Assigned to		Target Date	
Type of Action	Please select a value...	Status	Please select a value...	Monitoring	Please select a value...
Update/Progression					







Risk treatment

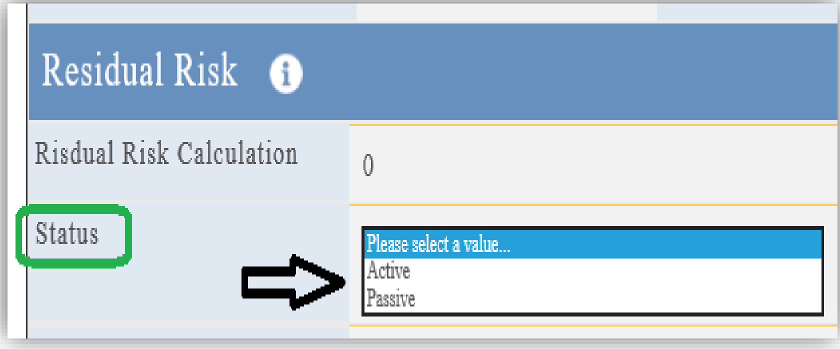
Adjusted Risk Score

Impact	Please select a value...	Likelihood	Please select a value...	Priority	0

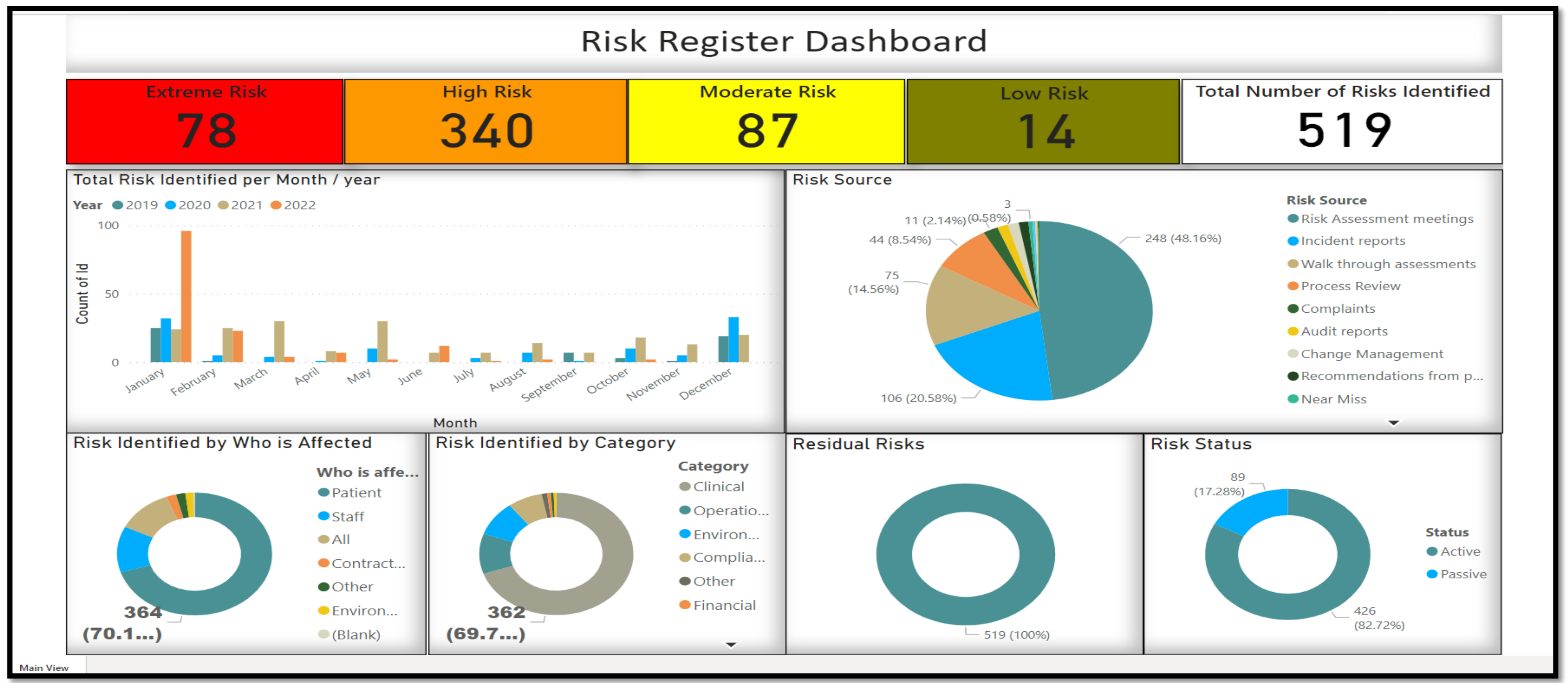
Residual Risk

Risdual Risk Calculation	0		
Status	Please select a value...	Attachments	Add Attachment
Comments			

SAVE FOR LATER | ADD NEW RISK | SUBMIT | CANCEL



Risk Register dashboard



Risk Register Dashboard link

Part II

Reactive Risk Management (Incident Management)

Definitions

Incident

Incident: is an unexpected occurrence which is not consistent with the desired operation of the healthcare system, requirement or standard.

Near Miss

Near-miss: any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome.

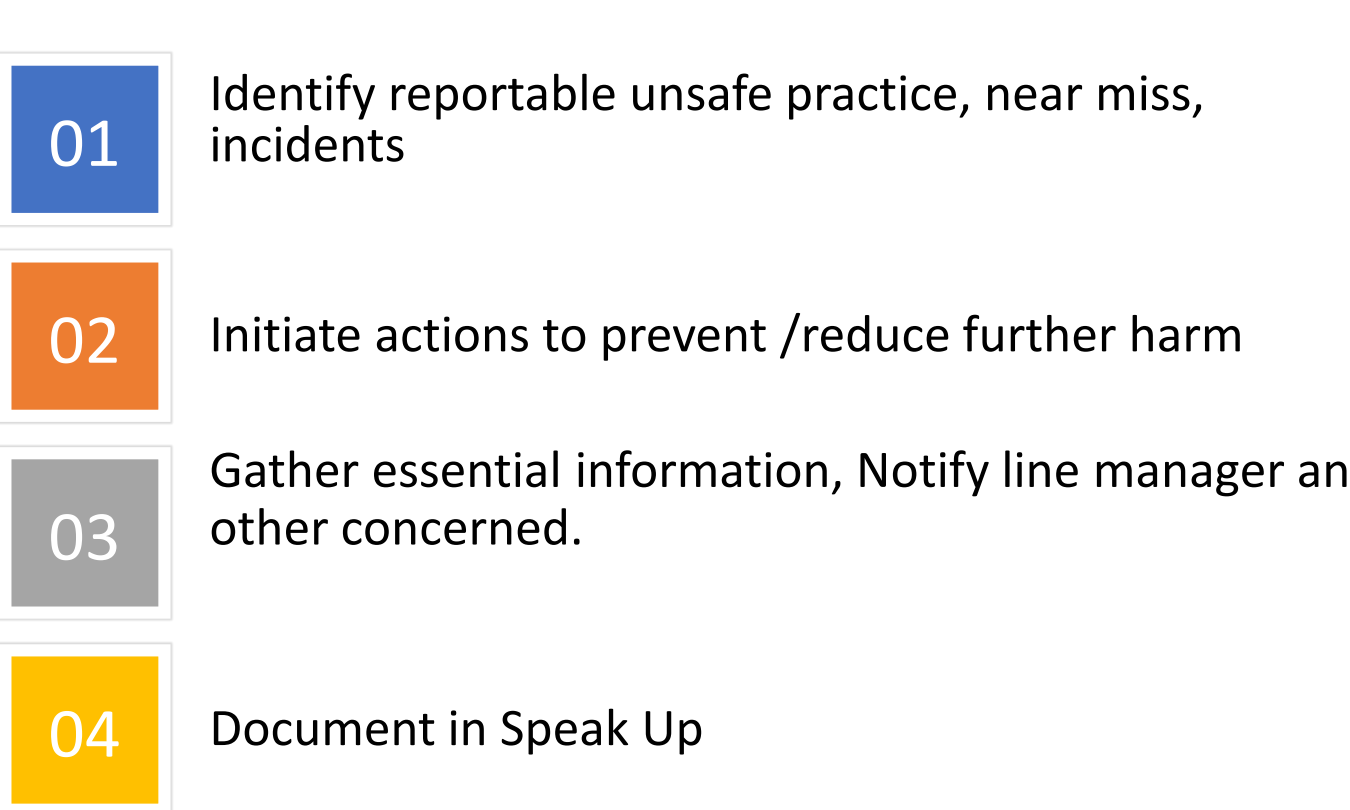
Sentinel event

Sentinel event: a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

Refer to SSMC Sentinel Event policy for more details.

Reference: SSMC incident management policy.

Incident identification and reporting



Speak up (Safety Intelligence)

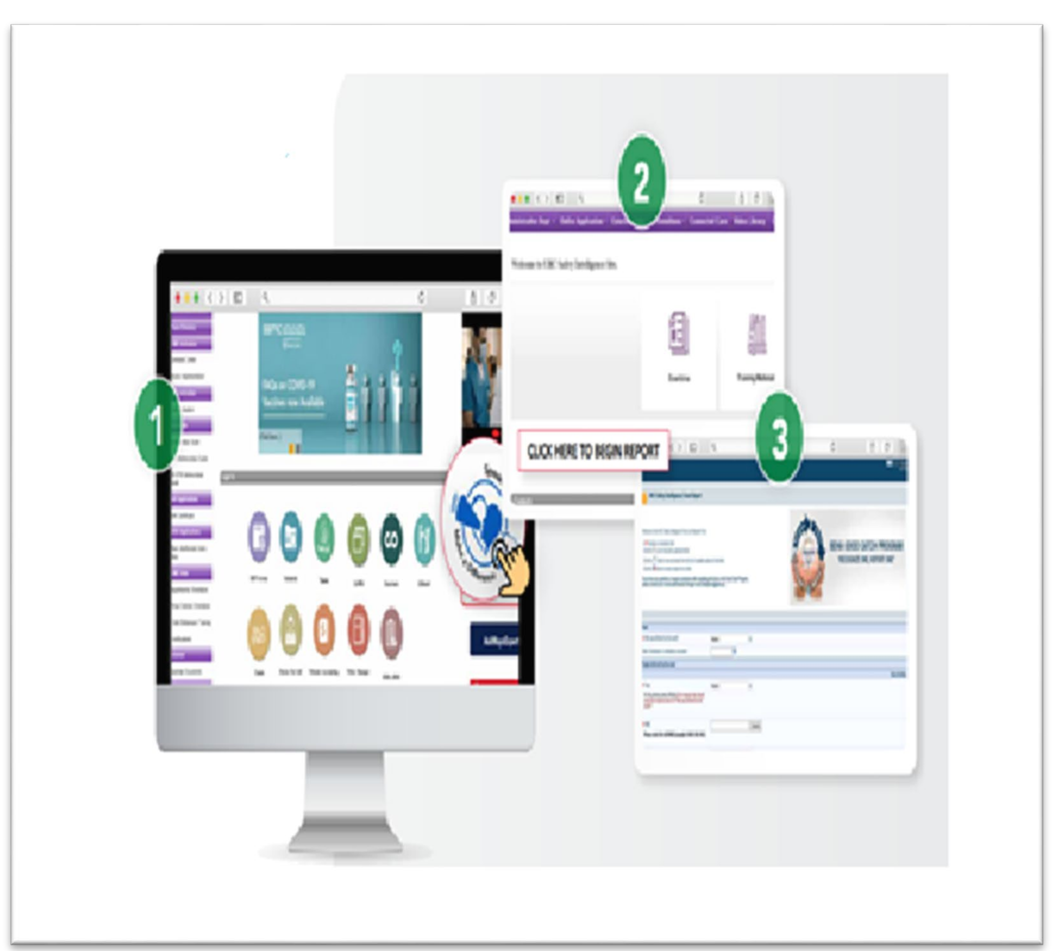
Who can report incidents ?

- All Employees
- Contact staff

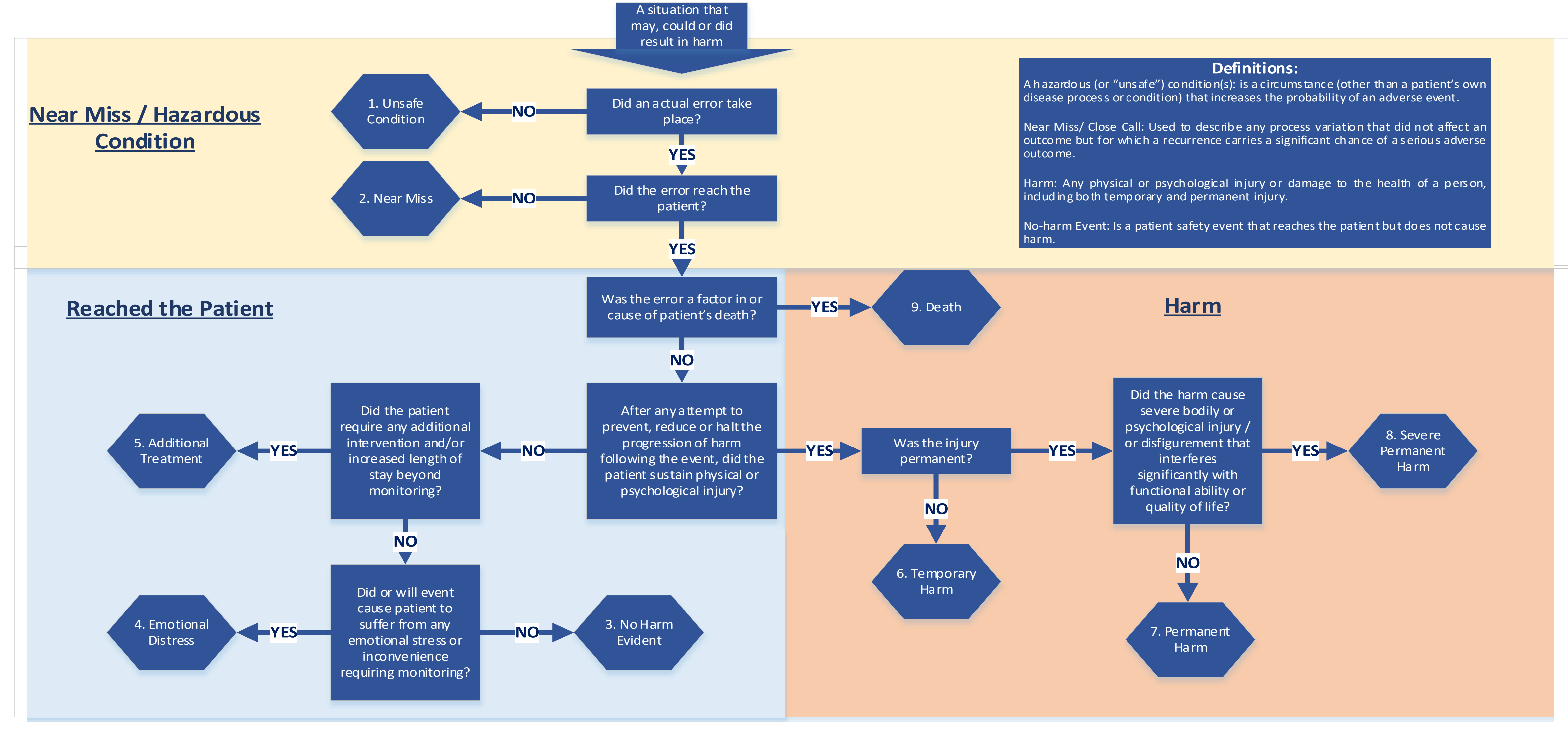
What can be reported in Speak Up?

Any unsafe practice, near miss or Incidents related to;

- Patient
- Staff
- Visitor
- Unsafe conditions



How to identify what to report ?



Speak up (Safety Intelligence)

UHC psn — UHC Patient Safety Net®
An AHRQ-listed Patient Safety Organization

HARM	
9	**Death** Dead at time of assessment
8	**Severe permanent harm** Lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life. Prognosis from time of assessment
7	**Permanent harm** Lifelong bodily or psychological injury or increased susceptibility to disease. Prognosis from time of assessment
6	**Temporary harm** Bodily or psychological injury, but likely not permanent. Prognosis from time of assessment
REACHED THE PATIENT	
5	**Additional treatment** Injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury. Treatment since discovery, and/or expected treatment in future as a direct result of event
4	**Emotional distress or inconvenience** Mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing including phlebotomy; and/or imaging studies). Distress/ inconvenience since discovery, and/or expected in future as a direct result of event
3	**No harm evident, physical or otherwise** Event reached patient, but no harm was evident
NEAR MISS	
2	**Near Miss** ☐ Fail-safe designed into the process and/or safeguard worked effectively ☐ Practitioner or staff who made the error noticed and recovered from the error ☐ Spontaneous action by a practitioner or staff member (other than person making the error) prevented the event from reaching the patient ☐ Action by the patient or patient's family member prevented the event from reaching the patient
1	**Unsafe Condition**

Incident Management System-Work Flow

Incident Management -PSIRG review process

- Triage and categorize every adverse event on weekly basis using SPECIFIC criteria

Patient Safety Team

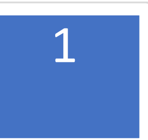
Patient Safety Incident Review Group (PSIRG)

- Review all presented cases and recommend on disposition based on the SPECIFIC criteria
- Decision on the category based on a risk matrix.

- Notify the process owner about events identified for review and support the review process conducted by assigned service
- Follow up and ensure implementation of the action plan and proposed monito the loo

Patient Safety Team

Good Catch Program



Purpose of Good Catch Program

To promote Safety culture, the leadership recognize and reward those staff who prevented major events from reaching patients.

Good catch awards and staff recognition

Monthly two good catches selected from all reported near misses to appreciate the “Good catch stars” of the month .

Communication of lessons learned

Good catch event summary and preventive/ corrective measures published in Quality comer, Quality news letter

Be the next good catch safety star!

Report all near misses in Speak Up and be the next winner

Sharing of Lesson Learned

RM: Lessons Learned

Lessons learned should bring about a change in the organization's procedures. Organizational learning should translate into the updating or development of standards, procedures, policies or standard operating procedures (SOPs) in an organization.

"The only mistake in life is the lesson not learned"

Albert Einstein

(PAHO/WHO, 2015), (NHS, 2017)

- What and how it happened?
- Why did it happen?
- What was the impact on patient/staff?
- What can we learn?
- What can be done to prevent/reduce from reoccurrence?

Thank You