Implementing Healthcare Risk Management – the RADICAL Framework

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Introduction

• Clinicians’ fundamental principle: “first do no harm”

• 1 in every 10 patients suffers a medical accident

• Systems should be in place to reduce the risk of harm and to mitigate the consequences of error

• Patient safety initiatives should be integrated
Risk management is....
....a **systematic** approach to reducing risks & improving patient safety

Risk management is not....
....just about avoiding litigation
....limited to incident reporting
RADICAL

An *integrated systematic* framework for

- introducing risk management
- monitoring risk management
- facilitating learning from patient safety incidents
RADICAL

Raise Awareness
Design for safety
Involve service users
Collect & Analyse patient safety data
Learn from patient safety incidents
RAISE AWARENESS

Promote awareness and understanding of patient safety; engage clinicians

- Epidemiology and psychology of error
- Training and education
- Team work
- Risk management forums
- Communication strategy
- Appraisal and accountability
Deliver women’s health care in a way designed to protect patient safety

- Standardisation (guidelines, protocols)
- Effective communication: SBAR (Situation, Background, Assessment; Recommendation/Request)
- Consent
- Crew resource management
- Care bundles
- Handover
- Debriefing
COLLECT AND ANALYSE

Provide efficient systems for collecting and analysing data on safety of care

• Safety culture measurement
• Proactive/prospective risk analysis
• Incident reporting
• Case notes review
• ‘Root cause analysis’
• Benchmarking
INVOLVE USERS

Involve service users in enhancing the safety of women’s health care

- Awareness of hazards in care pathway
- Making patient safety interventions
- Reporting patient safety incidents
- Feedback on safety of care
Nurture an environment that facilitates learning from patient safety incidents

- Safety leadership at Board level
- Identification and pursuit of patient safety indicators
- Feedback from risk analyses
- Evidence of learning from risk analyses
- Develop evidence base for safety interventions
- Safety climate monitoring
- Integrate risk analysis with clinical audit, complaints, claims and training
- Learning at organisational, team and individual levels
RAISE AWARENESS
Promote awareness and understanding of patient safety; engage clinicians
- Training and education
- Team work
- Risk management forums
- Communication strategy
- Appraisal and accountability

DESIGN FOR SAFETY
Deliver women’s health care in a manner designed to protect patient safety
- Standardisation (guidelines, protocols)
- Effective communication: SBAR (Situation, Background, Assessment; Recommendation/Request)
- Crew resource management
- Care bundles
- Handover
- Debriefing
- Operating theatre safety checklist

COLLECT AND ANALYSE
Provide efficient systems for collecting and analysing data on safety of care
- Safety culture measurement
- Proactive/prospective risk analysis
- Incident reporting
- Case notes review
- ‘Root cause analysis’
- Benchmarking

INVOLVE USERS
Involve service users in enhancing the safety of women’s health care
- Awareness of hazards in care pathway
- Making patient safety interventions
- Reporting patient safety incidents
- Feedback on safety of care

LEARN FROM INCIDENTS
Nurture an environment that facilitates learning from patient safety incidents
- Safety leadership at Board level
- Identification and pursuit of patient safety indicators
- Feedback from risk analyses
- Evidence of learning from risk analyses
- Develop evidence base for safety interventions
- Safety climate monitoring
- Integrate risk analysis with clinical audit, complaints, claims and training
- Learning at organisational, team and individual levels
Checklist for implementation of RADICAL risk management framework

Raise awareness and understanding
- Simulation/scenario training is undertaken regularly in our unit
- We have a communication strategy for disseminating patient safety information (through ward meetings, newsletters, departmental meeting, notice-boards, etc)
- Risk management is an important element in the induction of new staff and appraisal and of all staff
- Risk management is a key feature of our educational meetings
- We continually measure our safety culture using validated tools for doing this

Design for safety
- Our unit has evidence-based guidelines and protocols for all common clinical conditions
- We have implemented bundles of care for selected clinical conditions
- We have formal policies for handover of care, and these are audited periodically
- The use of a peri-operative safety checklist is in place and this is audited periodically
- Our staff have formal training on communication tools such as SBAR and readback.

Involve users
- Our patients are actively encouraged to report safety incidents and these are logged in our incident reporting system
- Our patients are encouraged, through information leaflets and other means, to make or initiate safety interventions
- User involvement is a standing item in our clinical governance committee meetings
- Our patient information leaflets include information which could help reduce the risk of patient safety incidents
- We periodically give feedback to our patients on the safety of the care we provide

Collect and analyse safety data
- We have an incident reporting system and it is used by all cadre of staff
- Risk assessment is prospectively conducted in all clinical areas
- The department has a risk register and major risks are escalated to the hospital-wide register
- System analysis (‘root cause analysis’) is conducted for major incidents, and a database of these analyses is maintained
- We have up-to-date data on the safety of the care we provide, and can compare our performance with standards elsewhere

Learn from patient safety incidents
- In our unit, specific targets have been set for selected patient safety indicators (e.g. in relation to surgical site infection)
- The findings of every ‘root cause analysis’ have been widely disseminated and action plans have been implemented
- It is clear to our staff that the Trust Board prioritises patient safety
- Safety culture assessment shows that we have the attributes of a learning organisation
- Our risk management, complaints and claims handling systems talk to each other
References


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