# Position statement

Risk management

## Preamble

Clinical errors occur commonly in hospitals. The potential for harm in anaesthesia is great because of the physiological trespass associated with surgery and the nature of the work. An understanding of risk management is essential to practice safely[1]. Risk management is defined as the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects[1].

A clinical error can be defined as an unintended deviation from management that may or may not lead to an adverse event. An error requires both an active deviation from intended practice and the simultaneous context that allows this to occur[1]. Risk management provides a framework to identify, report and analyse processes and situations with the intent of either minimising the potential for risk or maximising the practitioner's awareness of the risk prior to an adverse event. This enables contingent actions to be planned, rehearsed and implemented – to mitigate adverse impacts.

Risk management and continuous quality improvement are interrelated concepts in the context of health services and patient safety. Applying these concepts is good professional practice.

## Cultural changes

Risk management is applicable to any process or situation where a level of risk exposure is high or the potential consequences are significant. Risks include, but are not limited to:

- Patient safety.
- Physical and psychological safety of colleagues and staff.
- Patient, family and carer dissatisfaction or distress.
- Property or asset damage.
- Adverse media reporting.
- Financial loss.
- Corporate reputation.

Risk management is most effective when part of a 'just culture'[2] that seeks a balance between blamelessness and accountability. An open and transparent environment that acknowledges human error is required to facilitate reporting of errors and potential harm. System errors and 'at risk' or reckless behaviours, need to be ideally identified before they manifest as patient harm[2]. Implementing a team approach that sets appropriate expectations, incorporates safety values in all activities and maintains a robust shared accountability model constitutes good risk management. This means anaesthetists should:

- Comprehend and practise the process of risk analysis.
- Communicate effectively and frequently with their team and patients.
- Use documented standard procedures and check lists.
- Record events and incidents routinely to maintain reliable databases.
- Adopt an open disclosure 'no blame' and 'just culture'.

- Implement a robust open disclosure process if an adverse event has occurred.
- Adopt a framework for dealing with the aftermath of an adverse event.
- Perform routine clinical audits, investigate complaints, mortality and morbidity reports.
- Maintain contingency plans.
- Regularly rehearse plans and procedures.
- Implement and evaluate continuous quality improvement initiatives through education, training and competency assessments.

## Benefits of risk management

- Promotes the safest and highest quality of care for patients.
- Develops an 'outcomes' focussed healthcare system that rewards creativity, innovation and safety whilst maintaining shared accountability for system and behavioural problems.
- Reduces the opportunities for litigation.
- Takes care of the potential 'second victim' and reduces the potential harm to 'third victims' in the aftermath of an anaesthetic catastrophe[3].
- Reduces occupational stress.
- Reassures patients and the public thereby reducing pain, suffering and anxiety.
- Improves the defensibility of any claim.

## Principles

These principles of risk management need to be adapted to be contextually relevant.

Every clinical or administrative process may have some latent inherent risk. Often the front-line operator may be best placed to conduct a risk assessment. This involves identifying opportunities as much as mitigating or avoiding adverse outcomes.

The role of the anaesthetist includes managing risk. This includes risk assessment, communication and working in teams to mitigate, contain, control and avoid risks. The role of a manager includes thorough orientation to inform healthcare workers of expectations, values and processes for maintaining shared accountability. The role of safety engineers is to develop systems with appropriate barriers, redundancies and recovery strategies. Teams working collaboratively and sharing responsibility manage risk best.

## Application of risk management

Risk assessment starts with determining the context of the situation or circumstances. This includes consideration of geographical location, staff and equipment available, provisions for continuity of care, back up or transfer contingency plans. Potential risks may be identified by asking what, how and when on the background of one's own scope of practice and experience.

Each identified risk has a different likelihood and consequence – combined these may have minimal or catastrophic effect.

Assess risks by priority of impact. Focus first on those risks with the most severe impact and those most likely to occur.

Decide on a treatment option that is appropriate for the context.

## Conclusion

Clinical risk management is part of the anaesthesia safety culture involving a multidisciplinary, systems approach that aims to identify potential risks or opportunities, adopt and implement mitigating strategies and critically evaluate through practice audit, and reporting and continuous quality improvement. The 'just culture' that acknowledges human and system error whilst maintaining shared accountability for 'at risk' and reckless behaviour by all stakeholders, is also important.

## References

1. Luoma AMV and Wilson SR (2015), 'Clinical risk management for anaesthetists', *Contin Educ Anaesth Crit Care Pain*; 15(1): 14-19.
2. Rogers E, Griffin E, Carnie W, Melucci J and Weber RJ (2017), 'A just culture approach to managing medication errors', *Hospital Pharmacy*, 52(4): 308-315.
3. Steigler MP, 'When things go wrong in medicine: The second and third victim', accessed May 10th, 2019, https://www.marjoriestieglermd.com/adverse-events-second-victim-and-third-victim-ethics-of-care/

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