CHAPTER 23
RISK MANAGEMENT

Learning Objectives
By the end of this chapter, the participant will:

1. Recognize the value of implementing a risk management program.
2. Describe the types of error that lead to poor maternal and neonatal health outcomes.
3. Discuss the process of risk management.

Introduction

The practice of obstetrics exposes women and their health care providers to risks that may result in significant adverse outcome, complaints and potential medico-legal action. The development of a risk management program in a health care facility providing maternity care offers important benefits for improved care, provides clients with an explanation of clinical errors resulting in harm, injury, or death, and reduces medico-legal risks and costs.

Definition

Risk management is the development and implementation of strategies to optimize patient well-being and to prevent harm or limit patient injury. Its focus is to reduce errors that result in significant costs related to damage, harm, discomfort, disability, or distress to the patient, and to reduce financial loss to the individual health care provider and the organization that they represent.(Moss, 1995)

Risk management is a process that requires:

- Risk identification
- Risk assessment
- Development of risk management strategies
- Strategy implementation
- Evaluation

Patient safety can be defined as the freedom from accidental injury. Ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them before they occur. In other words, it is "the state of continually working toward the avoidance, management and treatment of unsafe acts within the health care system" (National Steering Committee, 2002).

Clinical Error: Is It a Significant Problem?

Many national and international professional associations and other organizations have produced reports suggesting that health care provider errors result in a higher number of deaths than leading causes of death such as motor vehicle accidents, breast and other cancers, and HIV infection. Some of these reports suggest that the deaths related to clinical errors are under reported. These errors result in considerable expense to the health care system and are largely preventable. There is a clearly identified need for health care organizations to develop a culture of safety by establishing priority safety goals and accompanying required organizational practices. Indeed, to achieve unconditional accreditation status, these organizations must provide evidence that specific processes and mechanisms aimed at strengthening the ability of health providers to deliver safe care are in place.

Understanding error and human behavior in organizational structure

Why does clinical error continue when educational programs, national guidelines, and standards exist? Many health care providers and hospital administrators believe that adverse obstetrical events are inevitable. Suggested reasons for this are:

- You can only get so far by telling people to be more careful.
- It is impossible to obtain human perfection, despite extensive training.
- We work in a world of flawed systems.

Health care providers work within health care systems. Although human beings may contribute to the breakdown of such systems, it is also known that sometimes these systems fail the individual (Reason, 1997). There is a need to understand the causes and conditions of the systems that contribute to risk.

Health care systems have both defenses and safeguards. Table 1 outlines these in relation to individuals as well as to the system.

Table 1 – Individual and system defenses and safeguards

Individual: Defenses and Safeguards	System: Defenses and Safeguards
• Training • Knowledge • Judgment • Manual Dexterity • Vigilance	• Credentialing • Peer review • Protocols, pathways, policies • Special teams • Continuing medical education • Risk management, quality management • Audit activities

Classification of errors

Errors that lead to clinical error can be divided into two categories —Individual and System—as outlined in Table 2.

Table 2 – Individual errors and system errors leading to clinical error

	Individual	System
Types of error	• Errors due to mental fatigue • Mistakes • Procedural violations	Human factors • Lack of vigilance: fatigue, stress, being rushed, need to be in several places at same time • Lack of dexterity • Practicing outside the scope of training. • Failure to consult Environmental factors • Working under undue time pressures • Inadequate tools • Poor communication and teamwork • Impractical procedures and protocols • Leadership shortcomings. • Insufficient training • Long hours Organizational factors Strategies and top-level decisions made by: • Governments • Regulating bodies • Organizational administrators
Specific examples	• Administration of the wrong drug, dosage, etc. • Misinterpretation of an electronic fetal monitoring pattern.	• One patient receiving care from several serial health care providers = Issues of information transfer and lack of identification of the most responsible caregiver • Tired professional = Lack of vigilance due to fatigue • New nurse on nights = Lack of experience and lack of knowledge of work environment • Similar medication labels = Lack of familiarity with drug labels, inability to distinguish indications and side effects accurately

It is estimated that 80% of performance problems can be attributed to the work environment whereas approximately 15% are attributed to a lack of skills by health care providers (More OB, 2007). The following aspects of the work environment contribute to errors that may expose a health care provider to risk.

For the obstetrician or doctor:

- May be on-call alone and have to care for too many patients
- May be the only consultant available for all midwives on-site or in the health care station or health facility
- There may be no protocols or the protocols that exist may not be adequate or may not be evidence-based
- Even if an individual is able to recognize fatigue, there may be no option but to keep on working because no other staff is available to assist or take over care

For the midwife:
- Often works alone in a rural area
- May not have consistent access to medications and equipment
- Referral systems are often not in place or are not adequate
- Transportation may not be available to transfer women, if when appropriately identified as needing advanced care
- May not have regular access to continuing and current education
- May recognize fatigue, but must keep working because no other health care provider is available to assist or take over care
- May work with other health care providers who are less skilled or is unable to supervise other health care providers

For the nurse
- Often working alone as the receiving staff at health care stations or facilities
- May not be empowered by "standing orders" to initiate emergency treatment
- May not be able to readily get assistance in emergencies from midwife or obstetrician or physician who may work in private offices off-site
- May be the only health care provider for all patients on-site
- May recognize fatigue, but must keep working because no other health care provider is available to assist or take over care
- May not have regular access to continuing and current education

Risk management strategies do not completely or consistently prevent loss. They help to limit the size of the impact or consequences of the loss. The intention of risk management is to anticipate risk, and to prevent or limit the risk. The purpose of risk management is to lessen the chance of adverse outcome and the chance of loss.

The Process of Risk Management

Risk management consists, as the term suggests, of a management system or process. It has five basic steps (Dickson, 1995):

1. Risk identification
2. Risk assessment
3. Development of risk management strategies (taking action to manage risks)
4. Implementation of risk management programs
5. Evaluation of risk management activities

1. <u>Risk identification</u>
- This is an essential first step because risk management is a proactive strategy.
- Identify all aspects that may threaten and/or jeopardize the patient, health care provider, and health care facility.
- Patients and providers are best served by informed anticipation of problems.
- Risk is identified with reference to history. Has it, or something like it, happened before?
- Risk can also be identified when health care providers are informed about particular risks of their group.

2. <u>Risk assessment</u>
- This is an evaluation exercise that describes the baseline of the current situation.
- It provides answers to the questions of how many or how often (frequency of risk), how much (cost of risk) and under what circumstances (likelihood of risk).
- Answers to these questions are essential to provide appropriate risk management programs.

3. Development of risk management strategies

i) Five risk control strategies

Three risk control strategies are categorized as no loss.

AVOIDANCE of risk
PREVENTION of risk
TRANSFER of risk

Two risk control strategies are categorized as some loss.

REDUCTION of risk
SEGREGATION of risk

Description

Avoidance of risk

A person can stop carrying out a function that is associated with a high degree or incidence of risk.

Prevention of risk

Hospitals and maternity health care providers can take steps to prevent completely or significantly lower the possibility of mistakes or perform risk prevention. Prevention is putting into place programs that will prevent events from occurring that could lead to adverse outcomes. For example, clinical practice guidelines may reduce errors in clinical judgement, the number of lawsuits, or may make them easier to defend.

Transfer of risk

A high-risk case can be transferred to a higher level of expertise for appropriate care.

Reduction of risk

Reduction is the strategy that begins immediately after the damaging event has occurred. One of the most important risk reduction strategies is the immediate care of and attention to the persons threatened or injured. Losses attended to immediately can often be mitigated (lessened).

After the event, losses can be reduced in a number of ways. For example, through early investigation and documentation (legal liability) and the provision of full and honest disclosure (reputation), loss can be reduced.

Segregation of risk

Segregation of risk takes place when health care providers take care not to invest all their energies into one specific approach or problem-solving solution. In a difficult situation, when different steps have to be undertaken, a consultation could be obtained to verify the proposed management plan. Segregation is usually more applicable to facilities than to maternity caregivers (e.g. Level I, II, and III hospitals).

ii) Risk financing

Many organizations have mechanisms to manage their risk financing. Institutions, individuals, and governments pay premiums to insurance agencies or defense organizations that assume the responsibility for the financial compensation awarded by the courts.

4. Implementation of risk management programs

A program is implemented based on the best risk management strategies, awareness of current practice, and of alternatives that are practical and compatible with the objectives of care. It might be attractive from a risk management perspective to stop some high-risk procedures (risk avoidance). However, the nature of practice may make such an alternative unacceptable, such as abandoning all forceps deliveries. An important strategy that aims to manage or reduce the risk of bad outcomes is the implementation of activities such as maternal

morbidity or mortality audits. The audit process focuses on enabling health care providers to learn from no-harm and harm events in an objective and non-punitive environment. This audit process is important because the investigation attempts to address all potential causes or circumstances surrounding a maternal death, not only those attributable to individual human error but also to those that may be attributed to system-based failure.

An environment that is safe for patients is an environment in which avoidable adverse events are acknowledged and then investigated to identify their systematic causes. A collaborative effort, aiming to reducing the number of injuries and deaths related to adverse events, should be oriented toward learning, sharing, and implementing interventions that are known to be efficient for avoiding another similar situation. A no-blame approach will contribute to improving the safety culture and will also improve the quality of work life for the health care team.

5. Evaluation of risk management activities

Evaluation refers to the periodic reviews of activities conducted and of the whole experience, with the risk management strategy. Reviews should be as frequent as required. A committee may be appointed to monitor general or specific activities. Reports should be provided to document the lessons learned in the initial attempts to implement the risk management program.

Risk management is a continuous process. It starts with identification and analysis of risk, proceeds to the implementation of strategies to manage risk, ends with the evaluation of risk management activities and their results; the process is then repeated.

Health Care Provider Participation

Joint committees need to be established between hospital administration and health care providers to manage risk. A health care facility must have the full participation of its maternal health care providers in order to have an effective risk management system. Health facility administrators should not address liability questions that arise in the course of obstetrical care without the health care provider's full participation. Nursing or health record departments should not initiate incident recognition and risk reports without consultation with health care providers. Maternity health care providers will only contribute to risk management activities if they are aware of the positive benefits of these activities for their patients and themselves. Practice environments that support shared decision making and collaborative care teams, and provide stimulating learning opportunities can enhance professional practice and inspire a culture of patient safety.

Conclusion

1. Establish risk management strategies in your practice and in your health care facility.
2. Participate actively in health facility based risk management programs.
3. Professional associations and health care facilities should develop risk management programs.
4. Local, provincial, and national clinical guidelines and policy statements should be used to develop risk management programs.

Key Message

1. Implementing a risk management strategy creates an improved work environment that benefits everyone: the woman, the health care provider, and the administration.

Suggestion for Applying the Sexual and Reproductive Rights Approach to this Chapter

Adopting a Reproductive and Sexual Rights Approach to your daily clinical practice is a form of risk management. Try it!

Resources:

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