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ical Quality & Safety

Royal Children's Hospital Melbourne

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Clinical Risk Management

What is Clinical Risk Management?

Clinical Risk Management (CRM) is an approach to improving the quality and safe delivery of health care by:

- Placing special emphasis on identifying circumstances that put patients at risk of harm, and
- Acting to prevent or control those risks.

The CRM program at RCH aims to identify clinical 'near misses,' incidents, adverse and sentinel events through the incident reporting and the adverse event screening of medical records of patients who have died or had a an unplanned transfer to the Intensive Care Unit.

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Such events are monitored and analyzed with the focus to examine the systems in which the event occurred to redesign processes or develop improvement strategies for reducing or removing the potential for a similar event in the future. The work of the CRM Team is conducted in a 'confidential' manner.

The reporting, monitoring, analyzing of incidents is best fostered within a 'just' culture. There is very good evidence that blaming individuals for adverse events does little to improve safety. Errors occur within systems and we can utilise systems to reduce the opportunity for human error.

For more information about:

- clinical risk management, see the CRM policy
- reporting process, see the Clinical Risk Reporting Process Flowchart

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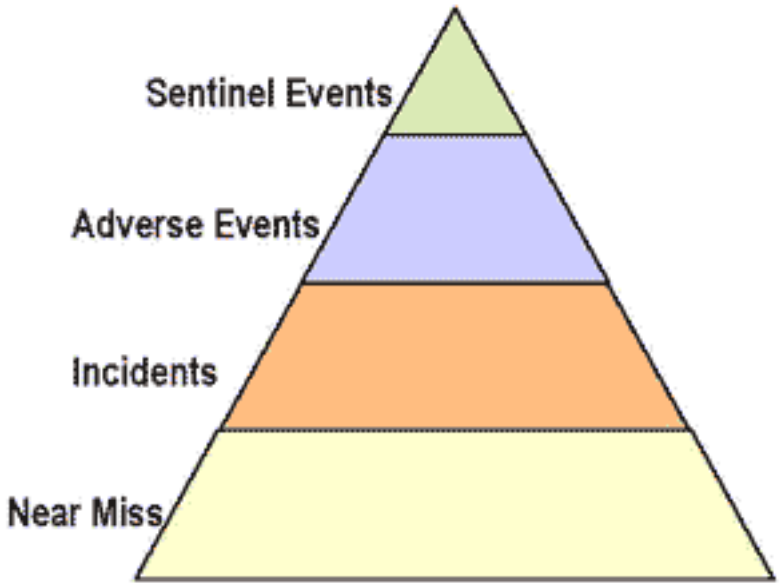
What is a Near Miss?

It is a potential for harm or error which is intercepted prior to the completion of the incident/event resulting in no harm to the patient. It is a valuable learning experience where lessons can be learned to improve patient care. At RCH we believe that near misses are the most common type of error. This is represented in the triangle below:



How do I report a Near Miss?

A Near Miss can be reported by using a Riskman• Incident Form. Click here for a printable version of the form riskman

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What is an Incident?

An incident is "any event that has caused harm, or has the potential to harm a

patient or visitor, for any event which involves malfunction, or loss of equipment or property, and for any event which might lead to a complaint". *Australian Incident Monitoring Study - Australian Patient Safety Foundation*

How do I report an Incident?

An incident can be reported by using a Riskman• Incident Form. Click here for a printable version of the form

The identifying staff member and a medical officer where appropriate, complete the incident form as directed, then the staff member responsible for the unit/department will comment in their section provided. Incidents are reviewed and acted upon by Unit/Department Manager, then sent to Clinical Quality & Safety to be entered onto the database.

If an incident occurs in one department/ward, and the patient is transferred to antother department/ward where the incident is identified an incident form is filled in. This form is sent back to the unit/Department Manager where the incident occurred for notification, investigation and action.

A brief objective description of the incident including the immediate actions and patient outcome are to be documented in the medical history at the time of occurrence by the identifying clinician. Comments by medical staff may be required.

What happens next?

All incidents are classified and reported to Patient Safety or Medication Safety Committees where recommendations are improvement strategies are decided and monitored.

The Clinical Incident Manager is available for notification and discussion of all incidents.

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What is an Adverse Event?

An Adverse Event is an unintended injury or complication, which results in disability, death or prolonged hospital stay and is caused by health care management rather than the disease process. To some extent, it can be quantified in terms of causality and preventability with each event having from low to high causality and low to high preventability.

How do I report an Adverse Event?

We strongly encourage clinicians to notify cases involving an Adverse Event either in person or writing to Annie Moulden, Karen Dunn, Ed Oakley

The focus of our Adverse Event review is to examine the systems in which the event occurred to develop mechanisms for reducing or removing the potential for a similar

event in the future.

What happens next?

After an Adverse Event is identified, feedback is sought from staff involved in the case and it is then discussed at the Patient Safety Committee, Medication Safety Committee or Medical Emergency Advisory Committee.

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What is a Sentinel Event?

A Sentinel Event is a subset of adverse events specified by the Department of Human Services (DHS). These events rarely occur but are more serious and are therefore reported to DHS and investigated immediately using a Root Cause Analysis process.

DHS describes a Sentinel Event as a relatively infrequent, clear-cut event that occurs independently of a patient's condition. They commonly reflect hospital systems and process deficiencies and result in unnecessary outcomes for patients.

DHS has specifically outlined 9 Sentinel Events, which must be reported:

1. Procedures involving the wrong patient or body part
2. Intravascular gas embolism resulting in serious neurological damage or mortality
3. Haemolytic blood transfusion resulting from ABO incompatibility
4. Patient suicide in hospital *
5. Retained instrument or other material after surgery, requiring re-operation or further surgical procedure
6. Medical error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
7. Maternal death or serious disability associated with labour or delivery
8. Infant discharged to wrong family
9. Other

* Episodes of suicide that are reportable under the Mental Health Act (1986) should continue to be reported to the Chief Psychiatrist.

More information can be found at the DHS Clinical Risk Management Website

How do I report a Sentinel Event?

If a Sentinel Event occurs, contact your clinical manager immediately who will then notify Clinical Incident Manager, or after hours the Nursing Supervisor.

What are the Department of Human Services requirements?

Sentinel means: "one who watches or guards". A Sentinel Event is a more serious

error, which demands NOTICE.

All Sentinel Events must be reported to DHS within 15 working days. A "Root Cause Analysis" is completed and is submitted to DHS within 45 working days.

What is "Root Cause Analysis'?

Root Cause Analysis (RCA) is a method of investigation. The purpose is to identify organisational deficiencies that may not be immediately apparent and which may have contributed to the cause of the event. A RCA report also includes risk reduction strategies to reduce the chance of a similar event occurring again.

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What do I tell the patient and family?

It is hospital policy that Adverse Events be discussed in an open and honest manner with families.

For more information, see the Open Disclosure Policy

For support or assistance, please contact the Consumer Liaison Officer on ext 5676

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How can parents be involved?

Parents can be involved. Parents in are often in a good position to identify errors as they are with their child while care is being delivered.

A parent information pamphlet titled 'Promoting Safer Healthcare at RCH' is available and should be provided to each family on admission to the ward areas.

The parent booklet '10 tips for safer healthcare' is also available and can be provided to each family on admission to the ward areas. This booklet is available by calling the Australian Council for Safety and Quality in Health Care on 02 6289 4244 or email on admin@safetyandquality.org

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How is the information reported?

- Monthly reports of medication incidents to the Medication Safety Committee

- Monthly reports of non-medication incidents and Adverse Events to the Patient Safety Committee meetings
- Quarter reports to the Quality and Safety Committee
- Bi-monthly reports to the Board Quality Sub-committee
- Sentinel Event reporting to Department of Human Services, the Board Quality Sub-committee, and Victorian Managed Insurance Authority (VMIA)
- Annual reports of activities for DHS Annual Quality Reportt
- Reports for Accreditation

On request, reports are available. Please contact the Clinical Incident Manager.

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What is the vision for Clinical Risk at RCH?

- Provide education to all staff of Clinical Risk Management principles
- Promote a cultural change in the organisation by encouraging clinical and non clinical staff to proactively identify potential risks and facilitate process redesign to reduce risk
- Further encourage a 'just' culture where the emphasis is on process and system redesign to improve safety
- Implement a web-based database to improve efficiencies and enhance reporting for clinicians

Last Updated 05-Sep-2005. Authorised by: Annie Moulden. Enquiries: Olive Lee.