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Minimising clinical risk

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Summary Many clinical interventions carry the risk of unexpected or unwanted outcomes, and the cost of dealing with these is a significant burden on healthcare resources. Paediatric cases have their own specific problems, related to issues like physiological immaturity and patient size, and complex family dynamics with third parties like guardians or parents. Risk management is the systematic process of identifying, evaluating and addressing potential and actual risk, and building up an organisational culture of being pro-active towards safety. Techniques such as risk analysis and significant event audits can be used to develop strategies. Risk management brings benefits in reducing adverse clinical outcomes and litigation. In the past, the National Health Service (NHS) has sadly failed to learn from its errors, but in the future it will develop methods to document and record adverse events, which although confidential, are unlikely to be anonymous.

Practice points

- The delivery of clinical care involves numerous sources of risk, including facilities and buildings; equipment; procedures; staff issues
- Many procedures in modern healthcare can never be rendered completely risk free, but when untoward events happen, it is better to make sure that the organisation makes these learning experiences and not just damage limitation exercises
- Stages in a risk management programme include: developing a pro-active safety culture; securing the co-operation of key staff; identifying risk; analysing risk on grounds of likelihood, impact and cost of alternative approaches; implementing an action plan and periodically re-visiting that plan
- Consider media training for several key staff, and try to be pro-active in dealing with the media

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What is risk?

Risk can be defined as hazard, danger, exposure to mischance or peril. It implies the potential for unexpected or unwanted outcomes. Negligence traditionally equates with failure to act according to the standards of a reasonably competent practitioner. For a successful negligence claim, a litigant must establish three things:

- that a duty of care is owed (this may include telephone advice and care provided by deputies or locums). In some cases a duty may be owed to people other than the patient (e.g., meningitis prophylaxis for close contacts);
- that there was a breach of that duty. Traditionally, under the Bolam rules this means that the practitioner had not acted 'in accordance with a practice accepted as proper by a responsible body of medical men.' But this may change as we move into the era of not only quality assurance, but continuous quality improvement in healthcare;
- that there was a causal link between this negligence and any harm sustained.

This model is based on the need to identify which, if any, individual, was negligent. It does not explicitly set out to prevent future adverse effects. Risk management is the systematic process of identifying, evaluating and addressing potential and actual risk, with the organisational objective of preventing, controlling and minimising risk exposure. This includes the timely identification and management of existing risk to protect all parties, patients, staff and the public, including visitors and outside contractors. Risk management is concerned with all risks to the continued survival and integrity of an organisation, such as recruiting and retaining suitable staff, commercial competition, financial loss, ensuring that important information is backed up and disaster recovery planning. In this article, I will specifically deal with clinical risk management concerned with providing the minimum level of legally and professionally acceptable care. But first, a little history lesson, which does involve children…

The runaway train

On 12 June 1889, the Great Northern Railway of Ireland operated an excursion from Armagh to the seaside resort of Warrenpoint, as the annual treat for the local Methodist Sunday School. A little over 3 miles along the journey the train stalled on a steep bank. The crew decided to divide their load, take the leading coaches onto the next station, leave them in a siding, and come back for the rest. When they started the engine, the rear portion ran away, and collided with a following regular train, throwing its engine off the track. The rear three coaches of the excursion disintegrated, and 80 passengers died at the scene or from their injuries later. The papers seized on the pathos, as 22 were children of 15 years or under.[1] There are several themes in this accident which are pertinent to clinical risk management:

- Inadequate equipment: a goods engine, slow but powerful, should have been used, but somehow Dundalk engine shed provided a passenger engine, with a nice turn of speed, but little power in reserve.
- Poor communication: the Armagh station master suggested that the train wait about 20 min for assistance from the regular train. This was lightly loaded, so its engine had spare capacity. Unfortunately, he did so in a way that made the driver think his skills were being called into doubt, and he declined.
- Failure to seek advice: neither the driver (who had expressed concern about the load), nor the official in charge of the excursion, nor the station master sought help from more senior staff.
- Inadequate safety standards: the line was worked on the principle of defined times (not distances) between despatching trains from stations. On this line, passenger trains could follow each other at 10 min intervals. The braking system was continuous (it acted along the whole train) but not automatic (it ceased to act on any vehicles becoming detached).
- Staff called upon to perform duties beyond their training: a porter was promoted to 'assistant guard' to help the regular guard, but may have been unfamiliar with the use of the hand brakes.
- Disregard for procedures: the company's regulations expressly forbade the division of trains on inclines.
- Failure to exercise caution when things began to go wrong: the guard of a disabled train normally walked back and placed 'detonators' on the rails: these went off with a loud gunshot sound to warn any approaching driver, but because everyone was too busy dividing the train, he failed to do this.
- Sheer bad luck: the engine had stopped with the cranks and pistons in such a position (dead