

QUALITY IN HEALTH CARE

Editorial

Clinical risk management: one piece of the quality jigsaw

Risk management is an organisational response to a need to reduce errors and their costs. It is now regarded as an "important activity" in all parts of the National Health Service (NHS) in the United Kingdom and no longer an "optional extra."¹ In its widest sense risk management includes the procedures necessary to reduce risk from all hazards, not simply clinical hazards. Thus security and fire risks and the operation of the health and safety at work regulations all come within the remit of risk management. But the application of risk management to clinical practice is a subject that merits specific attention and is the focus of this issue of *Quality in Health Care*.

Risk management is developing in a receptive climate in the United Kingdom. With the growth of clinical audit, reviewing the structure, process, and outcomes of treatment is now commonplace, although few audits examine adverse outcomes in any detail. As in the United States, the rising rate of litigation has also been a major stimulus to the development of risk management. Now that hospital trusts are carrying the liability for claims made against them, albeit with the help of a central negligence scheme, they have a strong inducement to reduce the level of those claims.

Clinical risk management programmes aim at (a) reducing the occurrence of preventable adverse events, (b) reducing the chance of a claim being made after an adverse event, (c) controlling the costs of claims that are made, and (d) minimising the damage caused by adverse events. At the heart of most programmes are methods for early identification of adverse events, using either staff reports or a systematic screening of records. Serious incidents are reported before claims are initiated, while memories are still fresh, and the reports are used to create a database to identify common patterns and prevent future incidents. Ideally, patients and relatives are also informed about adverse incidents and action is taken to minimise both the physical and psychological trauma. Effective clinical risk management therefore has links with quality improvement and quality assurance initiatives, but more than other quality initiatives it places a special emphasis on the costs and consequences of poor quality care.

Philosophy of risk management

The philosophy of risk management in the clinical arena is similar to that in manufacturing and industry. Compared with those in health care, the costs of errors in industry may be easier to calculate in monetary terms, less distressing and damaging to life, and more easily spread over time and borne by outside agencies. Thus some of the language of risk management may seem unfamiliar to those who work in health care. But, although the consequences of clinical errors may be different, the causes and prevention of such errors – in

terms of organisational and individual behaviour and action – are likely to be the same as for mishaps and errors in other enterprises. The principles of risk management – namely, identification, analysis, and control – apply as much in health care as in other organisations. These principles are outlined in the first paper of this issue by Gordon Dickson, chairman of the Institute of Risk Management (p 75).²

Risk management in hospitals was initially primarily considered a means of controlling litigation, which has been a major worry for clinicians in the United States for over twenty years and a growing problem in the United Kingdom in the past decade. The cost of medical negligence is rising, currently costing the NHS almost £150m each year. The opportunity costs to the health service of this "wasted" £150m are difficult to calculate; limiting errors and their effects could be cost effective and benefit everyone. However, the real justification for investment of time and resources in risk management lies not so much in the costs of litigation but in the costs of the adverse events that sometimes, rarely in fact, give rise to litigation. Many more patients are injured or traumatised by their treatment than ever even consider legal action. Adverse events are much more common than is generally realised, occurring in the United States in almost 4% of admissions. For 70% of patients the resulting disability is slight or short lived but for 7% it is permanent, and 14% of patients die partly as a result of their treatment.³ In a medium sized district general hospital with 50 000 admissions a year in the United Kingdom this would suggest 1850 adverse events, including 75 deaths and 37 cases of permanent disability each year – each in some way a result of the treatment received. This is clearly a major problem, irrespective of the level of litigation a trust may experience.

Any adverse event involves costs to the patient, the staff, and the organisation. Patients may require additional investigations and treatment, which may cost a great deal more than any damages that may have to be paid. There are huge costs in the form of increased disability payments and other benefits, which are likely to far outweigh the costs to individual hospitals. Adverse events also entail a huge personal cost to the people involved, both patients and staff. Many patients suffer increased pain, disability, and psychological trauma, which cannot be adequately compensated with monetary payments. Staff may experience shame, guilt, and depression after making a mistake, with litigation and complaints imposing additional burdens.

Open approach

The narrow view of risk management, at worst both negative and defensive, holds that its aim is primarily to protect the hospital from claims, with little regard for the

origins of those claims or for the wellbeing of the patients concerned. The more positive, broader view, apparent throughout this issue, is that risk management is fundamentally a particular approach to improving the quality of care which places special emphasis on occasions in which patients are harmed or disturbed by their treatment. Of course, reducing litigation and its costs is one of the objectives of risk management programmes. However, other components of risk management, such as the good, prompt management of complaints, early settlements of damages and, where possible, avoidance of litigation should benefit patients as much as provider units. Although the introduction of clinical risk management was partly a response to the escalating costs of litigation, the strategy that has emerged is a positive one that includes mechanisms for reducing mishaps and the incidence of harm; encouragement to identify and report any untoward events as soon as they are identified; and, importantly, a positive caring approach to patients who have been harmed or injured.

Effective clinical risk management depends on reporting systems that enable people to look for adverse events and to declare errors as they occur. A similar, positive approach to error that encourages people to value the lessons that can be learnt from errors and mistakes is a feature of a continuous approach to quality improvement.⁴ Thus a broad approach to clinical risk management – that looks beyond the problems of litigation – should merge naturally with other quality improvement initiatives. Developing a risk management strategy as part of a wider approach to quality within a hospital or other healthcare organisation should help to emphasise the positive aspects of risk management.

The interplay of human and organisational factors that result in errors is complex.⁵ Understanding the types of errors, how and why errors happen, and the circumstances of their occurrence is an important part of risk management. Adverse occurrences in clinical care are common,⁶ and, although only a small proportion of these result in significant damage or distress and even fewer in litigation, much unnecessary distress arises from failure to deal honestly and effectively with such events as they occur.⁷ Often patients are denied what they need most – an explanation of what happened – and when this fails to materialise they are forced into lodging a formal

complaint. The complaints procedure may be protracted, even when it does not proceed beyond the local system. The costs of even minor mishaps in terms of distress and time and anxiety can escalate wildly. Dealing promptly and effectively with clinical complaints is part of risk management. To do this an open approach to complaints and their antecedents – adverse events and mishaps – is needed.⁸

The aim of this focused issue of *Quality in Health Care* is to stimulate and guide the development of risk management in clinical practice and to consider its relation to other quality improvement initiatives. The papers are arranged in three sections: the principles of risk management; the application of risk management in three clinical specialties; and, finally some aspects of the implementation of risk management. The topics covered include analysis of the human factors in adverse events, the North American experience of risk management, and the development of alternative approaches to mediation, as well an examination of risk management in some defined clinical areas. Clinical risk management is much more than adopting a defensive approach to litigation and it involves everyone, not just those closest to the mishap when it happens. It is a subject for all those involved in health care.

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- 2 Dickson G. Principles of risk management. *Quality in Health Care* 1995;4:75–9.
- 3 Hiatt HH, Barnes BA, Brennan TA, et al. A study of medical injury and medical malpractice: an overview. *New Engl J Med* 1989;321:480–4.
- 4 Berwick D. Continuous quality improvement: an ideal in health care. *New Engl J Med* 1989;320:53–6.
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- 6 Bennett J, Walshe K. Occurrence screening as a method of audit. *BMJ* 1990;300:1248–51.
- 7 Bark P, Vincent C, Savory J, Jones A. Clinical complaints: a means of improving the quality of care. *Quality in Health Care* 1994;3:123–32.
- 8 Allsopp J, Mulcahy L. Dealing with clinical complaints. *Quality in Health Care* 1995;4:135–143.

The articles in this issue and additional articles will be published together as a book on clinical risk management in the autumn.