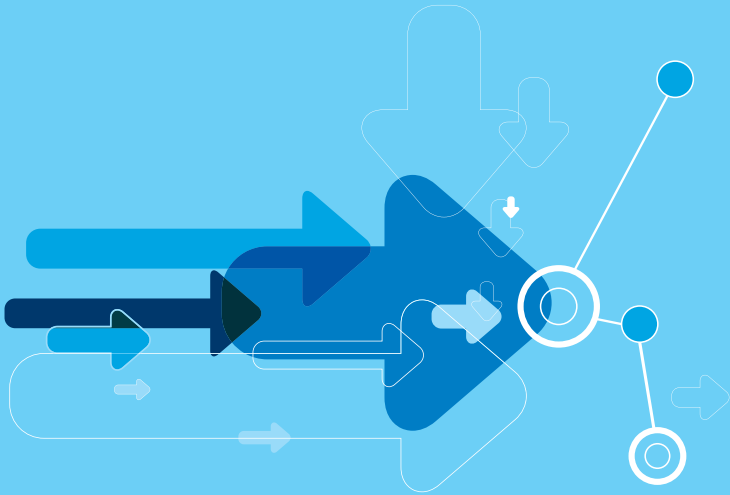


# Healthcare risk assessment made easy



March 2007

## **The purpose of this document is to provide:**

1. an easy-to-use risk assessment tool that helps promote vigilance in identifying risk and the ways in which risk can be minimised;
2. guidance that will encourage greater consistency in the way risk assessment is applied across the NHS.

The tool is intended to encourage greater use at practice level, and increased awareness and understanding of risk assessment at all levels. Frontline staff may use the tool to assess any risk to a patient or patients in their care.

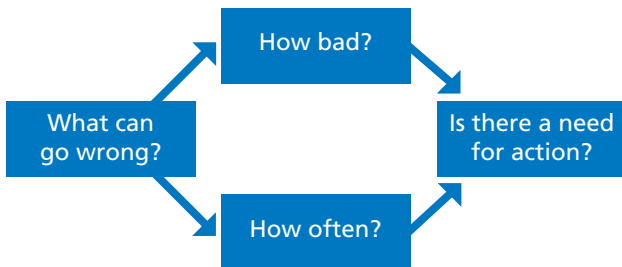
Created with acute care in mind, this tool is equally applicable and easily adapted for use in a primary care setting.

Before you start to assess risks make sure you have a good understanding of your organisation's risk management policy/strategy.

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## What is risk assessment?

A risk assessment seeks to answer four simple, related questions:



It is not usually possible to eliminate all risks but healthcare staff have a duty to protect patients as far as 'reasonably practical'. This means you must avoid any unnecessary risk. It is best to focus on the risks that really matter – those with the potential to cause harm. Keep risk assessment simple – do not use techniques that are overly complex for the type of risk being assessed.

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## In risk assessment we look at:

- **hazards** – which are situations with the potential to cause harm; and
- **risks** – which are defined as the probability that a specific adverse event will occur in a specific time period or as a result of a specific situation.
  - **Risk** is the combination of likelihood and consequence of a hazard being realised.
  - A **clinical risk** or healthcare risk is the chance of an adverse outcome resulting from clinical investigation, treatment or patient care.

For each hazard identified, it is important to decide whether it is significant and whether appropriate and sufficient controls or contingencies are in place to ensure that the risk is properly controlled.

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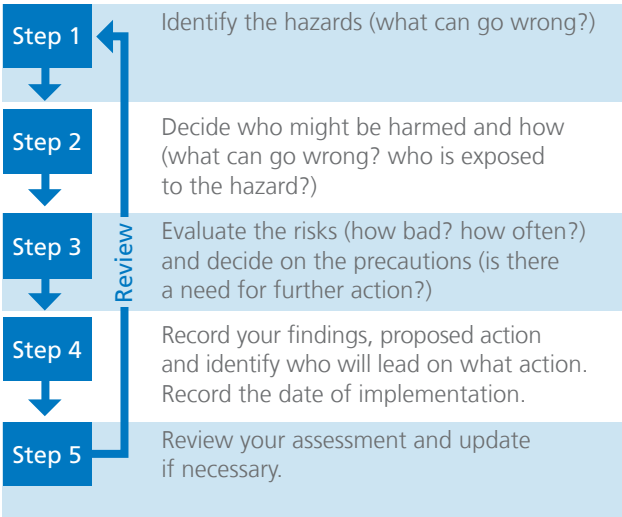
## **Understanding the difference between a hazard and a risk – an example**

A medicine could be described as a hazard if it has the potential to cause harm. However, the risk of that harm may be very small provided effective controls/measures are in place. If a patient could suffer harm as a result of taking the drug, the adverse event may be described as a clinical risk, and as a patient safety incident if harm occurred unintentionally or unexpectedly.

It is important that you identify and have a clear understanding of the significant risks of each particular hazard. To avoid confusion, describe each risk separately and clearly. For example, when considering the hazard of selecting the wrong drug because of similar (look-alike) packaging, there is risk to the patient, risk to the staff involved and risk to the organisation. Failure to describe or define each risk clearly is a common pitfall that can lead to problems when carrying out risk assessment.

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# Five steps to easy risk assessment



## **Step 1 Identify the hazards (what can go wrong?)**

To prevent harm it is important to understand not only what is likely to go wrong but also how and why it may go wrong. Consider the activity within the context of the physical and emotional environment, and the culture of the organisation and the staff who perform the activity.

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Take into account things that have gone wrong in the past and near-miss incidents. Learn from the past.

1. Walk around the workplace or clinical area and talk to patients and staff.
2. Map or describe the activity to be assessed.
3. The risk assessment may require a multi-disciplinary team.

## **Step 2 Decide who might be harmed and how (what can go wrong? who is exposed to the hazard?)**

People will make mistakes. It is necessary to anticipate some degree of human error and try to prevent the error from resulting in harm.

1. Consider the number of patients that might be affected over a stated period of time. When quoting the number of patients affected you should always state the length of the assessment period.
2. Remember that the most vulnerable patients are more likely to suffer harm.
3. Think about the complexity of the task.

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### **Step 3 Evaluate the risks (how bad? how often?) and decide on the precautions (is there a need for further action?)**

Consider both consequence (how bad?) and likelihood (how often?). Is there a need for additional action? The law requires everyone providing a service to do everything reasonably practical to protect patients from harm.

1. Use your organisation's risk matrix (an example risk matrix is on page 10).
2. Decide on the precautions (controls) that will most effectively reduce consequence and/or likelihood.
3. Re-evaluate the risks assuming the precautions (controls) have been taken.

### **Step 4 Record your findings, proposed action and identify who will lead on what action. Record the date of implementation**

Risk assessments and action planning should be reviewed and changed when necessary. This is easy only if the assessment is well-recorded and the logic behind the decisions transparent. An efficient and succinct system of documentation is essential.



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You need to show that:

1. a thorough check was made to identify all the hazards and treat all the significant risks;
2. the precautions are reasonable and the remaining risk is acceptable;
3. the solutions are realistic, sustainable and effective.

It may be reasonable to accept some degree of preventable risk, if the benefits to be gained outweigh the risk.

## **Step 5 Review your assessment and update if necessary**

Good documentation is important because things are always changing. Research and new developments increase the pace of change, and those changes can alter existing and/or introduce new hazards.

Review your risk assessment:

1. when you are planning a change;
2. routinely at least on an annual basis;
3. when there has been a significant change.

## Example risk matrix

Consequence	Catastrophic	Yellow	Orange	Red	Red	Red
	Major	Yellow	Orange	Orange	Red	Red
	Moderate	Green	Yellow	Orange	Orange	Red
	Minor	Green	Yellow	Yellow	Orange	Orange
	Negligible	Green	Green	Green	Yellow	Yellow
		Rare	Unlikely	Possible	Likely	Almost certain
		Likelihood				

**Consequence** – For example catastrophic means death or debilitating permanent injury and minor means requiring first aid.

**Likelihood** – This must be estimated over a stated period or related to a given activity.

	1	2	3	4	5
Frequency	Rare	Unlikely	Possible	Likely	Almost certain
How often might it happen (per procedure/episode or within a specified timeframe)?	Can't believe that this will ever happen or recur	Do not expect it to happen or recur but it is possible	Might happen or recur occasionally	Will probably happen or recur but it is not a persistent issue	Will undoubtedly happen or recur, possibly frequently

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For the definitions of adverse event and patient safety incident see page 13.

**Risk scoring** – The risk scores are not intended to be precise mathematical measures of risk, but they are useful when prioritising control measures for the treatment of different risks.

**Low risk (green)** – Quick, easy measures implemented immediately and further action planned for when resources permit.

**Moderate risk (yellow)** – Actions implemented as soon as possible, but no later than a year.

**High risk (orange)** – Actions implemented as soon as possible and no later than six months.

**Extreme risk (red)** – Requires urgent action. The trust Board is made aware and it implements immediate corrective action.

The above information is not meant to be prescriptive but is intended for guidance. The trust Board is responsible for defining the level of acceptable risk.

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## Action required in reducing risks to an acceptable level

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

It is best to use your organisation's approved risk assessment forms. As not all organisations have developed risk assessment forms, model forms are provided on the National Patient Safety Agency's website ([www.npsa.nhs.uk](http://www.npsa.nhs.uk)).

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Any significant residual risk should be recorded in the organisation's risk register. The organisation's risk register should be subject to regular review by the trust Board.

## Definitions

**Risk management** is assessment, analysis and management of risks. It is simply recognising which events (hazards) may lead to harm in the future and minimising their likelihood (how often?) and consequence (how bad?).

An **adverse event** is any event or circumstance leading to unintentional harm or suffering.

A **patient safety incident** is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.

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**Inherent clinical risk** is the permanent or currently unavoidable clinical risk that is associated with a particular clinical investigation or treatment. It is the risk from undergoing a particular procedure in ideal conditions and performed by the best staff using the most up-to-date research, equipment and techniques.

The inherent clinical risk can be considered permanent or currently unavoidable when used for the purpose of risk assessment. The risk that should be targeted by clinical risk assessment is the risk that is added to the inherent risk and results from, for example, a poor safety culture, poor communication and teamwork, inadequate supervision of inexperienced staff, unreliable equipment or an unsuitable environment.

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- Guy's and St Thomas' NHS Foundation Trust
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### **Feedback**

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