

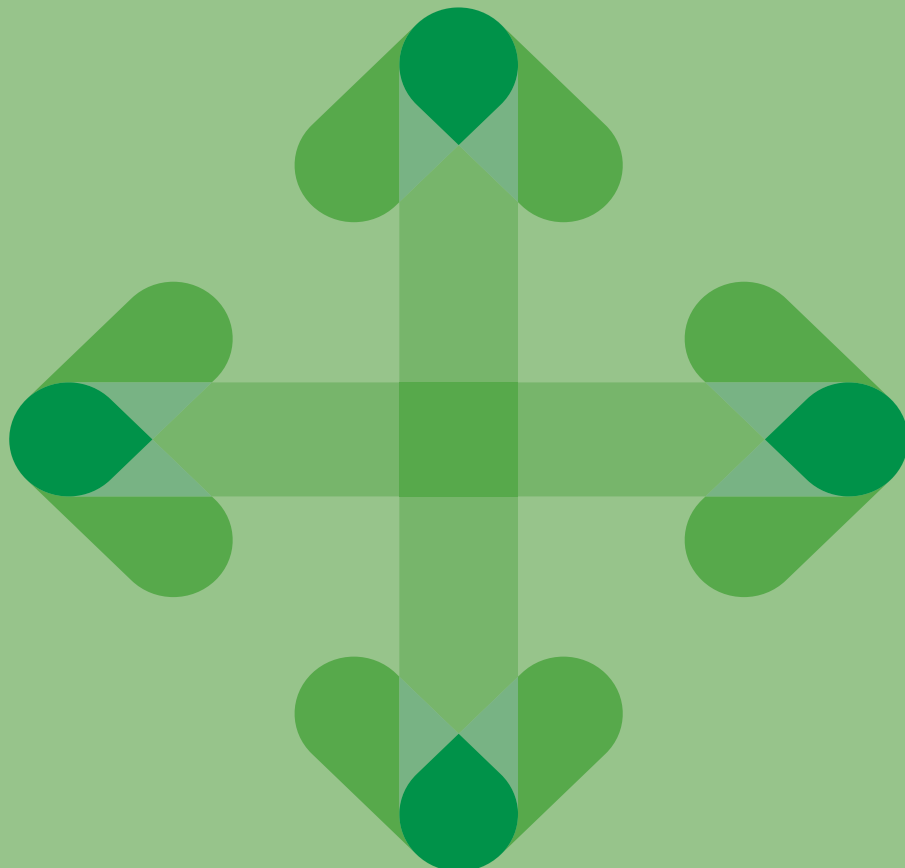


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Integrated Risk Management Policy

Part 1

Managing Risk in Everyday Practice Guidance for Managers



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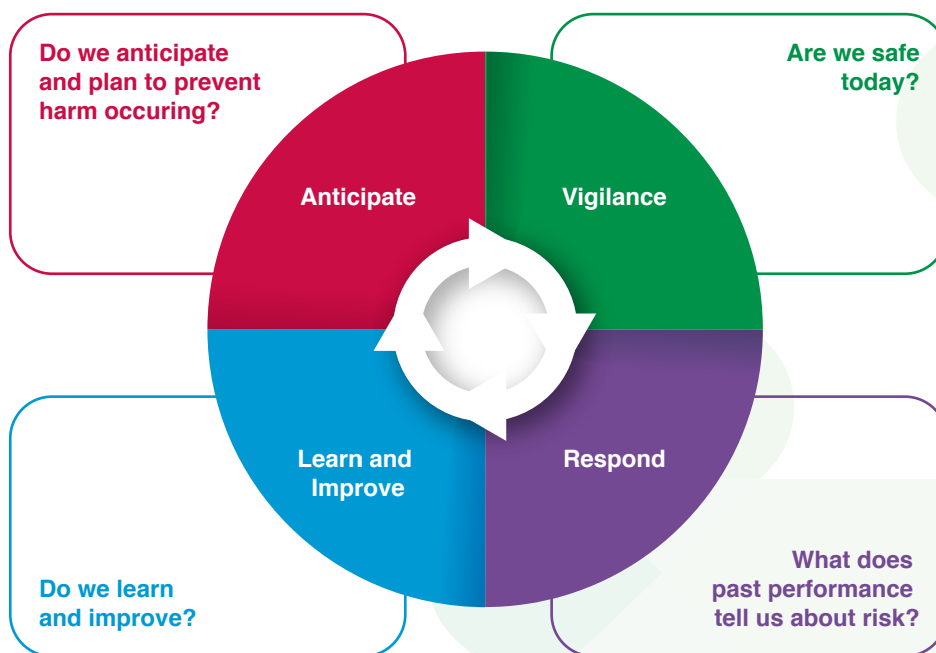


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1. Introduction

A key feature of managing risk in everyday practice relates to recognising the risks relating to the service you manage and having in place the systems and processes to reduce the risk of these occurring or if they do, to minimise their impact.

Risk however should not only be viewed as negative but also must be seen as a positive, i.e. a framework within which decisions can be taken that, at a service level, can drive change and innovation. At the level of a service user positive risk taking can assist in building autonomy and independence. Risk avoidance can, in some instances, be detrimental to change. What is required from service managers is to create a culture which is "risk aware" and that decision making is framed in a manner which is balanced.

Risk management is not new nor indeed is it a science; it is common sense and integral to our everyday lives. We all manage risk from the way we reduce the risks associated with driving by putting on our seat belts, driving within speed limits and maintaining our cars, to more personal decisions about lifestyle habits such as diet, exercising, smoking, etc.

Risk management is basically good management as it seeks to ensure good outcomes for service users, staff and the service by anticipating and managing the things that can result in harm¹.

Whereas every staff member is responsible for identifying risk with the context of their work, the management of risk is a line management responsibility and as such must be embedded by Managers as part of everyday working at all levels in the organisation.

Risk management therefore must not be considered a task to be completed as a separate or distinct discipline. Quality Patient Safety/Risk Manager/Advisors are available to support, facilitate and advise you in relation to delivering on your management responsibilities relating to risk.

To support you in delivering on your commitments in relation to the HSE's Integrated Risk Management Policy, a number of guidance documents have been developed. These are:

Part 1. Managing Risk in Everyday Practice

Part 2. Risk Assessment and Treatment

Part 3. Managing and Monitoring Risk Registers

This is **Part 1** of the guidance suite. The purpose of this guidance is to provide you with an overview of the 'risk environment' in which you operate and to assist in raising awareness of your responsibilities in relation to delivering safe services to those accessing and working in your service.

A range of tools are also available to assist you, detail of which can be found on <http://www.hse.ie/eng/about/QAVD/>

¹ The HSE defines harm as

- 1. Harm to a person:** Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury
- 2. Harm to a thing:** Damage to a thing may include damage to facilities or systems; for example environmental, financial, data protection breach, etc.

2. Overview of the Risk Management Process

The HSE's approach to risk management is aligned to the ISO 31000 an overview of which is provided at Figure 1. below.

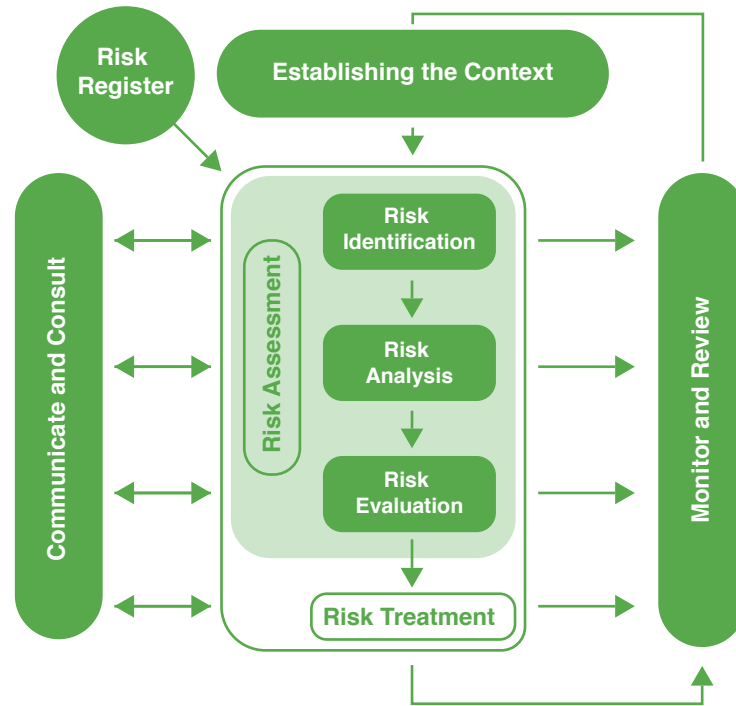


Figure 1. Risk Management Process

The process adopted requires Managers, within the context of their area of responsibility and in consultation with their staff, to identify analyse and evaluate risks and to put in place any treatment (actions) required to reduce those risks.

Where a formal management plan is required the outcome of this process is documented in the relevant risk register and monitored and reviewed by the relevant Management Team.

3. Purpose of this Guidance

This guidance is intended to provide you with an understanding of the need for and your responsibilities in relation to, managing risk within your area of responsibility. Four key questions need to be considered:

1. What could result in harm and how can you prevent it occurring?
2. Are you and your staff alert to the potential of harm occurring within your workplace?
3. What do you know about how safe care has been in the past?
4. Do you integrate your safety information for all sources, e.g. incident management, regulatory inspections etc in order to identify areas where safety improvement is required?

4. Scope of this Guidance

This guidance is for use in the management of service and organisational-related risk and applies to both HSE and HSE-funded services.

5. Definitions

A full list of definitions relating to risk management terms used in this and supporting documents is contained in **Appendix 1**.

6. Roles and Responsibilities

Whilst the management of risk is the responsibility of all staff, Line Managers have a particular responsibility with regard to the formal processes attaching to the management of risk. Risk management professionals are available to support, facilitate and advise line managers on the technical aspects of the risk management process.

7. Your Role and Responsibility for Managing Risk

You have a key leadership role in relation to safety within your service area. Risk management is a line management responsibility and you are the Risk Manager of the service you lead.

Specifically, in your area of responsibility you are responsible for:

- Supporting the implementation of the HSE's Integrated Risk Management Policy.
- Ensuring that appropriate and effective risk management processes are in place.
- Assessing the level of compliance with the HSE's Integrated Risk Management Policy and Guidance documents.
- Developing specific objectives within your service plan which reflect your own risk profile and the management of risk.
- Risk assessing all business plans/service developments including changes to service delivery.
- Ensuring that risk assessments, both clinical and non-clinical, are undertaken. The risks identified will be prioritised and action plans formulated. These action plans will be monitored through your management meetings.

- Maintaining an integrated risk register (e.g. clinical, non-clinical, financial etc). Formally notifying high and extreme risks via your manager.
- Ensuring that all staff are made aware of risks within their working environment and their personal responsibilities in the management of these.
- Identifying your own and your staff training needs to fulfill the function of managing risk.

To assist you in delivering on this aspect of your role support and advice is available from specialist quality, risk and safety professionals within your organisation.

Resources and tools are also available on the HSE Website on <http://hse.ie/eng/about/QAVD/>

8. The Importance of Leadership to Reducing Risk and Improving Quality and Safety

The importance of leadership in creating an environment where quality and safety is seen as a priority cannot be understated. It is the development of positive staff attitudes and behaviours towards quality and safety that can make a critical difference in relation to the safety of a workplace.

Leaders who are committed to quality and safety exhibit six key characteristics which are set out below. *(As you read through these, take some time to consider to what extent you model the characteristics identified):*

- a. They are safety aware and vigilant and demonstrate and reinforce this attitude with staff. They do not assume safety is inherent in the workplace and that someone will notice and attend to a safety situation.
- b. They adopt the attitude that it is better for staff to ask and be sure rather than not ask and risk being wrong. They assure all staff that speaking up is not associated with a perception that they are ignorant, incompetent or disruptive.
- c. They consistently engage the team in the conversation about quality and safety both to benefit from their expertise and to hear their concerns. Not only does this allow the team to share information and leverage their collective expertise, but it also signals you as their Manager are approachable and consequently makes it easier for them to speak up.
- d. They reinforce with staff their professional and individual accountability for the quality and safety of the service and the need to consistently engage in safe behaviours. Leaders need to know that their response will be watched widely and closely, and will send a very powerful message within the service about its safety culture.
- e. When things go wrong they treat staff fairly and in accordance with organisational policies. Fair treatment depends on staff perceiving that the response of the Manager to the incident was proportional to the error; the process applied to review the incident was procedurally fair and that in the course of managing the incident that they were treated with dignity and respect.
- f. They place importance on learning and improvement. They are concerned with risk, quality and safety and strive to proactively reduce risk and incidents through vigilance and the identification of opportunities to strengthen the systems of work.

The systematic delivery of safe and reliable care therefore requires developing a culture within the workplace where staff put quality and safety at the centre of their work. Such a culture does not develop in the absence of strong leadership and commitment from you as a Manager. You therefore need to be seen to prioritise quality and safety as a primary goal for your service.

The best way to communicate to staff your commitment to quality and safety is for you to model the behaviours which demonstrate that commitment to them. An essential part of this is addressing behaviours

amongst staff that create unacceptable risk, such as disruptive and disrespectful behaviour and making it clear that this will not be tolerated. The reaction by you to this as Manager will be closely watched and will send a very important message to staff i.e. it is you that sets the 'risk and safety tone' of your service. This will contribute to staff being comfortable about raising concerns and reporting incidents in the knowledge that they are contributing to the development of a safe, high quality service for Service Users and staff alike, in a situation where they will not be blamed.

9. Managing Risk in your Area of Responsibility

You must consider risk and safety from a number of perspectives, i.e. risks relating to individual service users and the delivery of care, risk to staff in the workplace and your role in the overall management and governance of the service.

The remainder of this section identifies **four** key safety elements where a service management focus is required i.e. anticipate, vigilance, respond, learn and improve.

9.1 Anticipate



What could result in harm and how can you prevent it occurring?

Anticipation involves thinking ahead and envisioning the things that are most likely to contribute to risk or safety failures. In a way it is like doing the NCT on your car to identify those things that may improve your safety on the road. Safety from this perspective therefore involves looking ahead and identifying the hazards and risks that may cause harm if left unmanaged.

As a Manager you know best about the type of risks in your service. These may relate to the environment of care, the way care is delivered, the vulnerability of your Service Users, the competence of your staff and the extent to which team working is the norm, etc.

For those areas you identify as being risky there is a need to consider what systems and processes you have in place to manage these risks, how reliable they are and what actions you need to take in order to further reduce their likelihood of occurrence.

In many instances the actions required will be straight forward and will form the basis for discussion and agreement with staff but in some instances these may require formal assessment to include the identification of actions required to mitigate or reduce the risk.

To assist Managers with this process a guidance on risk assessment and treatment is available for use. (See part 2. Risk Assessment and Treatment Guidance for Managers) The outcome of this process should be recorded with actions assigned to named individuals, i.e. '**Action Owners**'. Timeframes for completion of actions should be agreed with the Action Owners and adherence to these monitored within the team.

Actions which lie outside of your area of authority or responsibility should be discussed with relevant persons (often your Line Manager) and a decision taken in relation to addressing them. If you require any advice you should contact the specialist quality, risk and safety professionals within your organisation.

Part 2 of this guidance deals in more detail with the process of **risk identification**.

Resources available to assist managers

Quality and Safety Prompts for Multidisciplinary Teams:
<http://hse.ie/eng/about/Who/qualityandpatientsafety/>

9.2 Vigilance



Are you and your staff alert to the potential of harm occurring within your workplace?

Risk is a feature of service delivery on a day to day basis and staff manage this as an implicit part of their working day. Health and social care staff monitor service users continually watching for signs of deterioration or improvement in their physical or mental wellbeing. As a Manager you too will be alert to possible risks in day-to-day operations e.g. staff shortages, new staff, equipment failures, service user waiting times etc.

Vigilance in this context refers to the heightened sense of awareness that you need to adopt and engender within the workplace to ensure ongoing safety in the delivery of services. This as it relates to individual service users can include the consistent checking of service user identity when delivering treatment or medication, the monitoring of service users e.g. vital signs, early warning scores, antecedents to self-harm or behavioural problems, tissue viability, falls risk etc.

From a service perspective this can relate to awareness of the broader issues that can affect care delivery e.g. staff fatigue due to long shifts, the availability of necessary equipment and supplies, to distractions and wider organisational issues that might impact on service delivery in the short term.

A safe service is one where staff continually develop a dynamic picture of the current situation and are aware and interact with each other to ensure safety. One of the key points at which such systems fail is that of service transition e.g. where a service user is transitioning from one service to another or at key times of the day such as shift changes. The importance of concise yet detailed handover is critical.

Resources available to assist managers

QuickPrompts: <http://hse.ie/eng/about/Who/qualityandpatientsafety/>

Walk arounds: <http://hse.ie/eng/about/Who/qualityandpatientsafety/>

Safety Pause: <http://hse.ie/eng/about/Who/qualityandpatientsafety/>

ISBAR: <http://hse.ie/eng/about/Who/qualityandpatientsafety/>

9.3 Respond



What do you know about how safe care has been in the past?

Whilst this guide is primarily about the proactive management of risk it is useful also to consider how we use information from incident management to inform a proactive approach to managing risk. For details of the incident management process you should refer to the HSE's approach to incident management.

If risk management is about anticipating what might go wrong and putting in place systems and processes to prevent this, then data relating to incidents which occur is a critical source of information about risk. Incident data can be used both to identify risk and also to monitor the effectiveness of actions taken to prevent its recurrence.

One of your responsibilities as a Manager is therefore to ensure that there is a system in place to monitor, on an aggregate basis the types and frequency of incidents occurring in your service. Too often incident report forms are seen as the business of the Quality Patient Safety Department (QPS) and line management responsibility often ceases when the form is sent from the service. The contrary is however true in that incident management, similar to risk management, is a line management responsibility.

Front line staff often complain that there is no system of feedback to them in relation to incident forms they have submitted. It is your responsibility as a Manager to provide this feedback and this can occur by including ongoing discussion in relation to incidents reported at daily staff briefings/handovers or by requesting a periodic aggregate report on incidents reported from the QPS Department, focusing staff discussion on this and what that report says about the safety of the service. Where the person reporting the incident is not a staff member e.g. an agency staff member or not assigned to that service on an ongoing basis they can request feedback in relation to the incident they identified.

Such discussions, if conducted with an emphasis on learning and improvement, contribute significantly to the development of an open and learning safety culture. In many instances the improvements required can be identified, agreed and implemented by staff without recourse to the development and monitoring of formal improvement plans.

Resources available to assist managers

Contact your local Quality Patient Safety Officer to arrange to obtain on a routine basis aggregate data in relation to incidents and complaints occurring in your area of responsibility.

Contact your local Complaints Officer to arrange to obtain on a routine basis aggregate data in relation to complaints occurring in your area of responsibility

Information in relation to the outcome of service user or staff surveys that pertain to your area of responsibility – incident type/outcomes/rating

Safety Pause: <http://hse.ie/eng/about/Who/qualityandpatientsafety/>

9.4 Learn and Improve



Do you integrate your safety information in order to identify areas where safety improvement is required?

Quality and safety is systemic: that is, it depends upon many different individuals, inputs, process and parts of your organisation. It is also, to a degree, subjective. The information and intelligence required to assess quality, therefore, needs to be drawn from many different sources, both hard and soft, to ensure that you and your team are appropriately informed.

Within your service area, there will be a wealth of existing information and intelligence, gathered formally and informally, that will tell you about the quality and safety of your service. By combining information from different sources you can often get a clearer picture of the overall agenda. For example, you will have knowledge of complaints and incidents occurring in your service, the staffing profile, absenteeism levels, coroner's reports, clinical or care indicators and in many cases inspection reports from regulators.

This information should be considered at team meetings/service governance groups and discussed to agree what, if any, steps need to be taken.

A shared view of risks to quality using available information can therefore act as:

- A prompt for further questions or action;
- An early warning mechanism of risk about poor quality; and
- A mechanism to identify opportunities to drive quality improvement.

You should not only limit yourself to information relating directly to your service but also consider learning that may relate to your service identified in reports both internal and external to your organisation.

Resources available to assist managers

- Feedback surveys – service user & staff
- Audits
- Quality & Patient Safety Walk-rounds
- Inspection reports from regulators
- Recommendations from Local/National reports
- Trend – Claims (clinical & non-clinical)
- Coroners recommendations

10. Next Steps

Having considered how the management of risk is integral to your role as a Manager the next step is to consider in more detail the process of managing risks in your area of responsibility. This should be done in the context of the HSE's Integrated Risk Management Policy and in association with the available guidance.

11. Related Policies and Guidance

HSE Integrated Risk Management Policy, 2017

Risk Assessment and Treatment Guidance for Managers – (Risk Management Guidance Part 2, 2017)

Managing and Monitoring Risk Registers Guidance for Managers – (Risk Management Guidance Part 3, 2017)

Policy and guidance are available on <http://hse.ie/eng/about/QAVD/>

Appendix 1: Definitions

These definitions are predominantly based on the terms and definitions from the International Risk Management Standard ISO 31000:2009.

Controls	A mechanism, process, procedure or action which can be verified, which seeks to reduce the likelihood and/or consequence of a risk. Controls include any process, policy, device, practice, or other actions which modify risk. They can exist or be required as additional in order to further mitigate the risk.
Establishing the Context	Defining the external and internal parameters to be taken into account when managing risk, and setting the scope and risk criteria for the risk management policy.
Hazard	A potential source of harm or adverse health effect on a person or persons.
Impact	The outcome or consequence of an event affecting objectives. It can be expressed either qualitatively or quantitatively, being a loss, disadvantage or gain. There may be a range of possible outcomes associated with an event.
Likelihood	The chance of something happening (also described as the probability or frequency of an event occurring).
Line Manager	A person with responsibility for directly managing individual employees or teams. In turn, they report to a higher level of management on the performance and well-being of the employees or teams they manage.
Monitor	To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis in order to identify change.
Operational Risk	Operational risks relate to the day-to-day delivery of activities, operational business plans and objectives. Operational risks typically have a short-term focus. Whilst they may impact a number of areas of the service, this does not necessarily make them a strategic risk. Operational risks may have the ability to impact strategic and other operational risks.
Project Risk	Project risks relate to the achievement and delivery of the project objectives and outcomes. The majority of project risks are short term in nature and exist for the term of the project, whilst some will be on-going and re-classified at the end of the project. Projects can be defined as temporary, with the aim of delivering outcomes within a specified timeframe.
Residual Risk Rating	The remaining level of risk after all treatment plans have been implemented.
Risk	Risk is the effect of uncertainty on objectives. It is measured in terms of consequences and likelihood. In the context of the HSE and its services, it is any condition or circumstance which may impact on the achievement of objectives and/or have a significant impact on the day-to-day operations. This includes failing to maximise any opportunity that would help the HSE or service meet its objectives.
Risk Acceptance	Informed decision to take a particular risk.

Risk Appetite	Amount and type of risk that an organisation is willing to pursue or retain.
Risk Assessment	Overall process of risk identification, risk analysis and risk evaluation.
Risk Avoidance	Informed decision not to be involved in, or to withdraw from, an activity in order not to be exposed to a particular risk. Risk avoidance may increase the significance of other risks or may lead to the loss of opportunities for gain.
Risk Categories	The categories used by the organisation to group similar opportunities or risks for the purposes of reporting and assigning responsibility.
Risk Criteria	Terms of reference against which the significance of a risk is evaluated.
Risk Description	Structured statement of risk usually containing three elements: impact, cause and context.
Risk Evaluation	Process of comparing the results of risk analysis with risk criteria to determine whether the risk and/or its magnitude is acceptable or tolerable.
Risk Identification	A systematic process applied to the organisation's objectives and activities to identify possible risk sources and causes and potential consequences or impacts should a risk occur.
Risk Management	Coordinated activities to direct and control an organisation with regard to risk.
Risk Management Process	The systematic application of management policies, procedures and practices to the activities of communicating, consulting, establishing the context, and identifying, analysing, evaluating, treating, monitoring and reviewing risk.
Risk Matrix	Tool for ranking and displaying risks by defining ranges for consequence and likelihood.
Risk Owner	Person with the accountability and authority to manage a risk.
Risk Profile	A risk profile is a written description of a set of risks. A risk profile can include the risks that the entire organisation must manage or only those that a particular function or part of the organisation must address. (In the HSE, a services risk profile is set out in their risk register).
Risk Rating	The estimated level of risk taking into consideration the existing controls in place.
Risk Source	The source from which the risk was identified e.g. Incident Management, Audit, Health and Safety Risk Assessment, Inspection Report, Complaint.
Risk Register	A risk register is a database of assessed risks that face any organisation at any one time. Always changing to reflect the dynamic nature of risks and the organisation's management of them, its purpose is to help managers prioritise available resources to minimise risk and target improvements to best effect.
Risk Tolerance	An organisation's or stakeholder's readiness to bear the risk after risk treatment in order to achieve its objectives.

Strategic Risk	A strategic risk has the ability to impact on the achievement/delivery of the HSE's strategic objectives/directions. Strategic risks relate to the highest level of objective for the HSE, which typically have a long-term focus and are linked to the HSE's Strategic Plan.
Treatment	Additional mechanisms, processes, procedures or actions to be implemented, which seek to reduce the current likelihood and/or consequence and reach the Residual Risk Rating.
Directorate	The Directorate is the governing authority of the HSE established following the enactment of the Health Service Executive (Governance) Act 2013.

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