Risk Management

นพ. สมจิตต์ ชี้เจริญ

ผู้เยี่ยมสำรวจ สถาบันรับรองคุณภาพสถานพยาบาล (องค์การมหาชน)

บรรยายในที่ประชุมเชิงปฏิบัติการ “การพัฒนาคุณภาพสถานพยาบาลตามมาตรฐาน HA/AHA”

13 กรกฎาคม 2559

“Risks are uncertain future events that could impact on the organization's ability to achieve its objectives.”

Getting on Board, A governance resource guide for arts organizations, prepared by Graeme Nahkies for Creative New Zealand, Revised Edition, 2014.

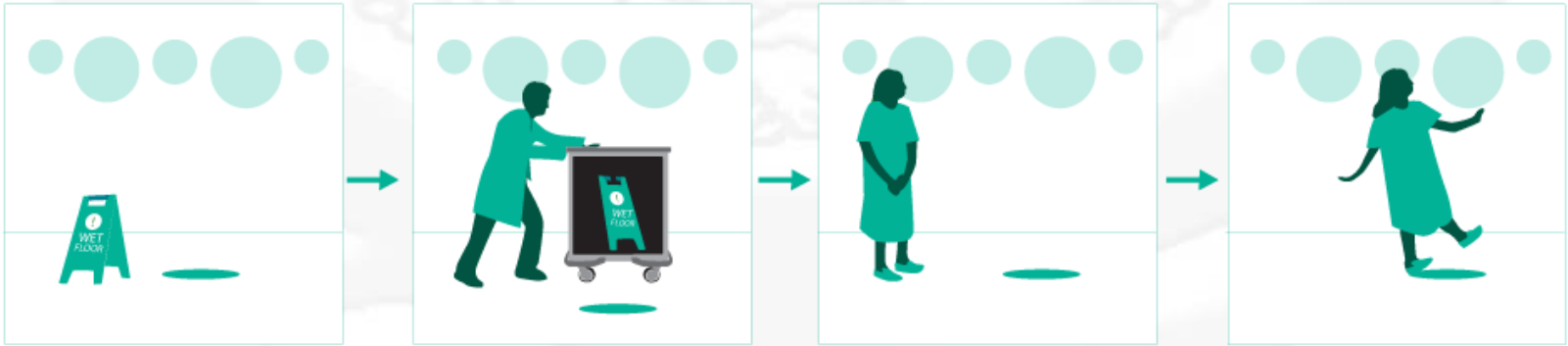
Health Care Defects

In the U.S. health care system:

- 7 percent of patients suffer a medication error
- On average, every patient admitted to an intensive care unit suffers an adverse event
- 44,000 to 99,000 people die in hospitals each year as the result of medical errors
- Over half a million patients develop catheter-associated urinary tract infections resulting in 13,000 deaths a year
- Nearly 100,000 patients die from health care-associated infections (HAIs) each year, and the cost of HAIs is $28 to $33 billion per year
- Estimated 30,000 to 62,000 deaths from central line-associated blood stream infections per year

How Can These Errors Happen?

- People are fallible
- Medicine is still treated as an art, not a science
- Systems do not catch mistakes before they reach the patient



Introduction to Adverse Events

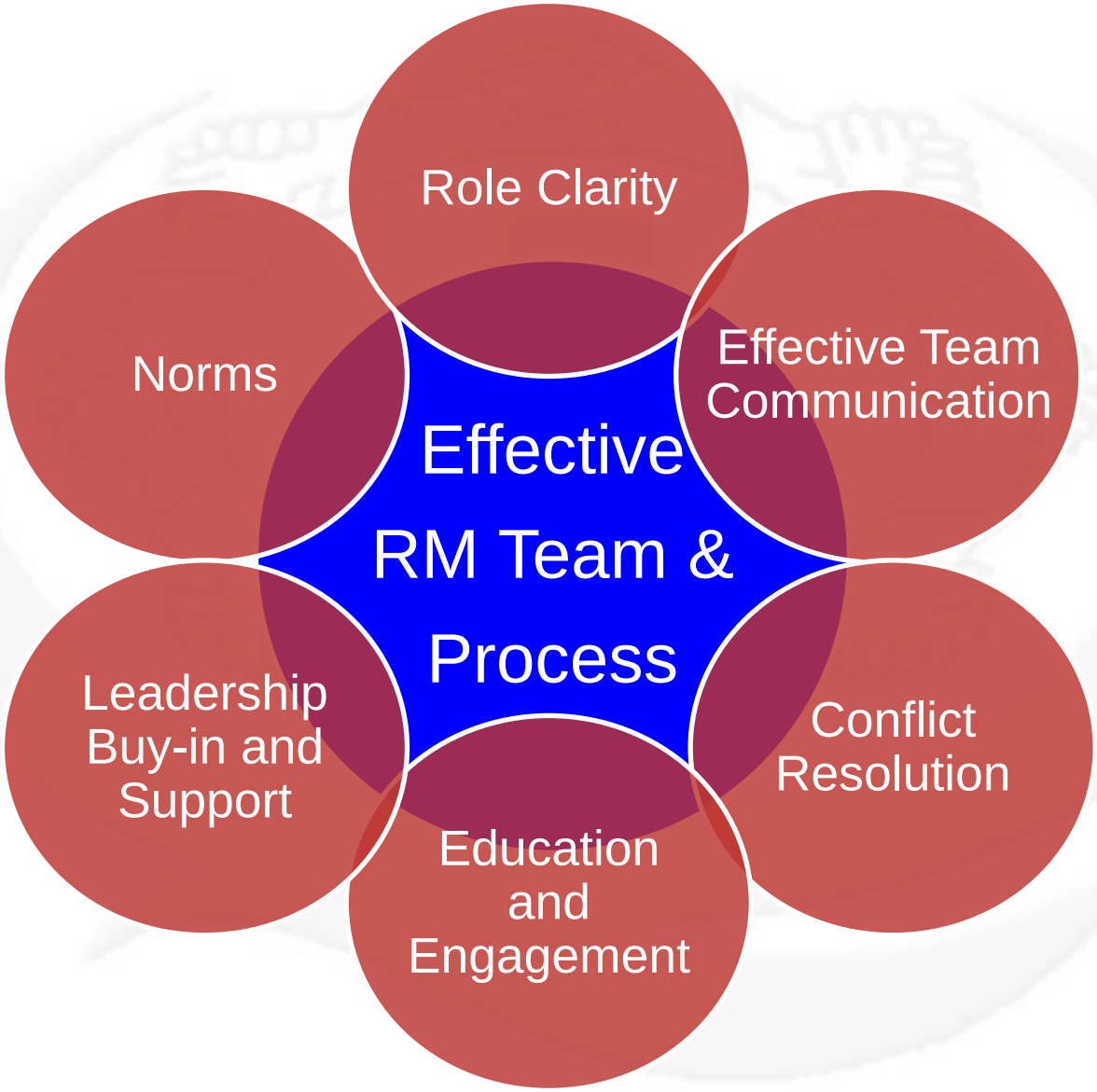
- Adverse event: An injury to a patient caused by medical intervention rather than by the underlying disease or condition of the patient
- The mission of health care providers is to help and care for patients without harming them, but adverse events happen
- When an adverse even occurs, it can be difficult for a health care worker to take ownership and communicate with the patient and family
- Prompt, compassionate, and honest communication with the patient and family after an adverse event is essential

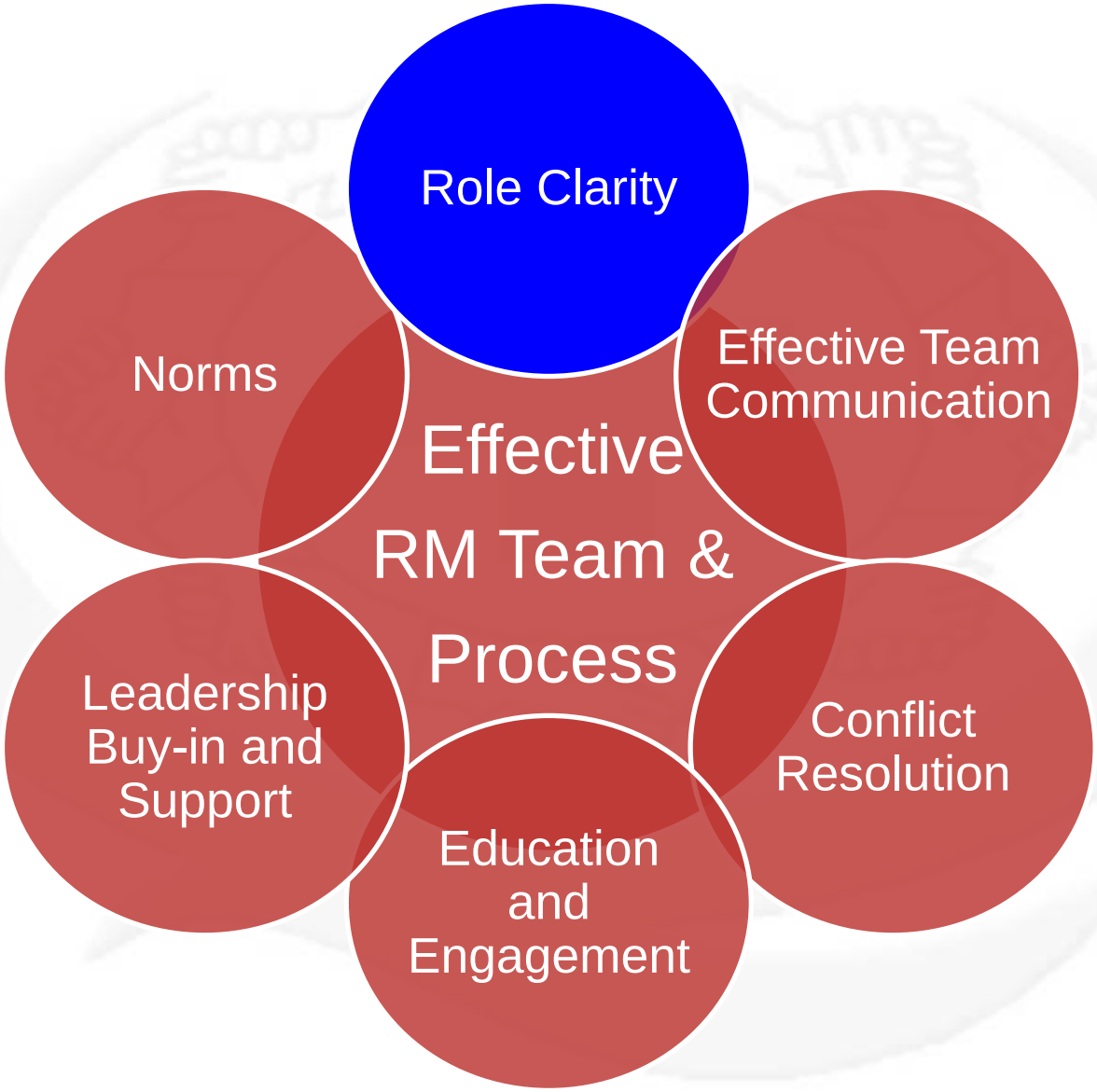
Immediate Response to an Adverse Event

- Care for the patient
- Report to the appropriate parties
- Communicate with the patient (who, what, when, where, and why)
- Document the event in the medical record

Next Steps in Responding to an Adverse Event

- Investigation
- Continued communication with the patient and family
- Apology and remediation
- System and process improvement
- Measurement and evaluation
- Education and training


Role Clarity
Norms
Effective Team Communication
Effective RM Team & Process
Leadership Buy-in and Support
Conflict Resolution
Education and Engagement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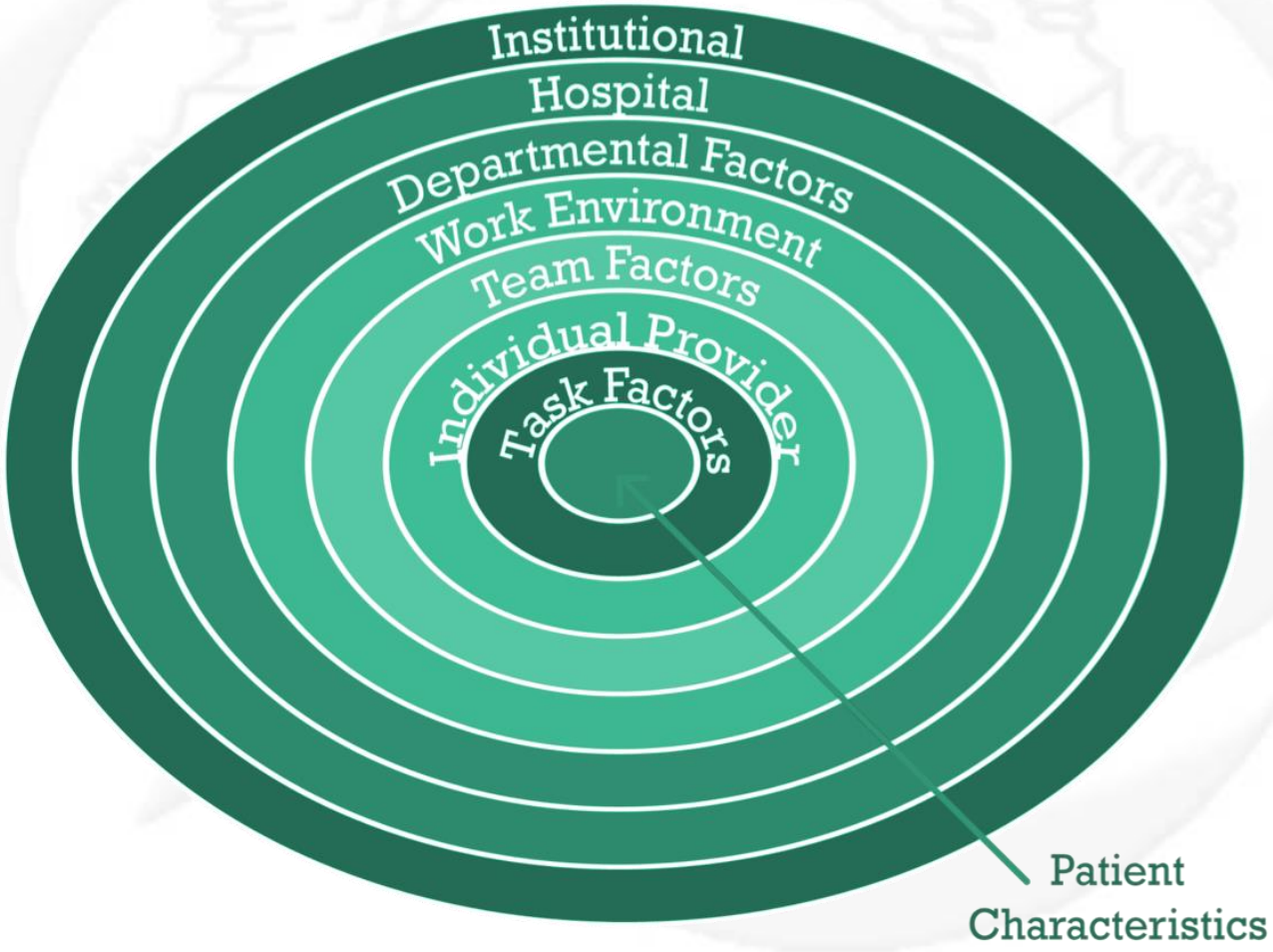
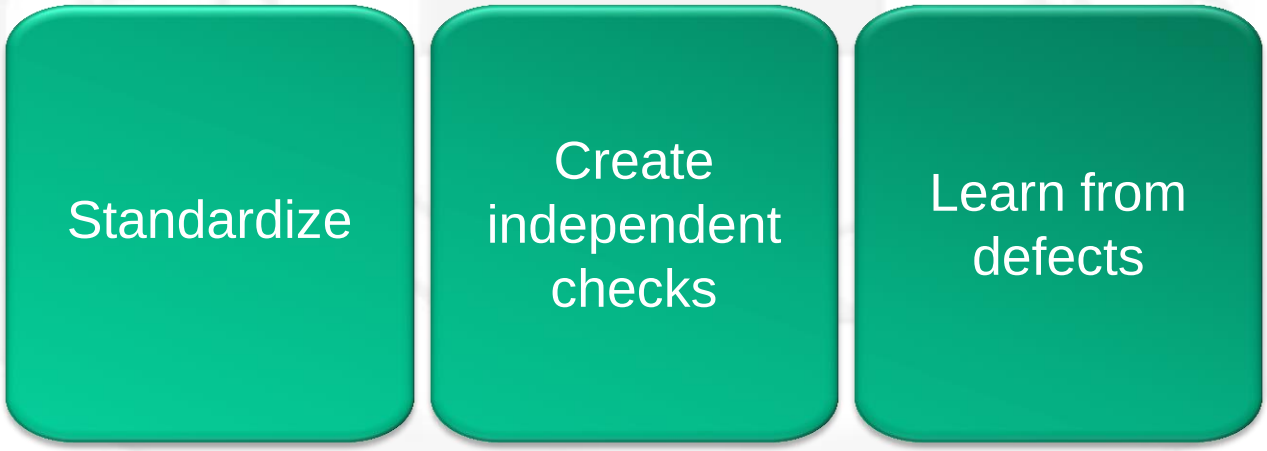
The Science of Safety

- Every system is perfectly designed to achieve its end results
- Safe design principles must be applied to technical work and teamwork
- Teams make wise decisions when there is diverse and independent input

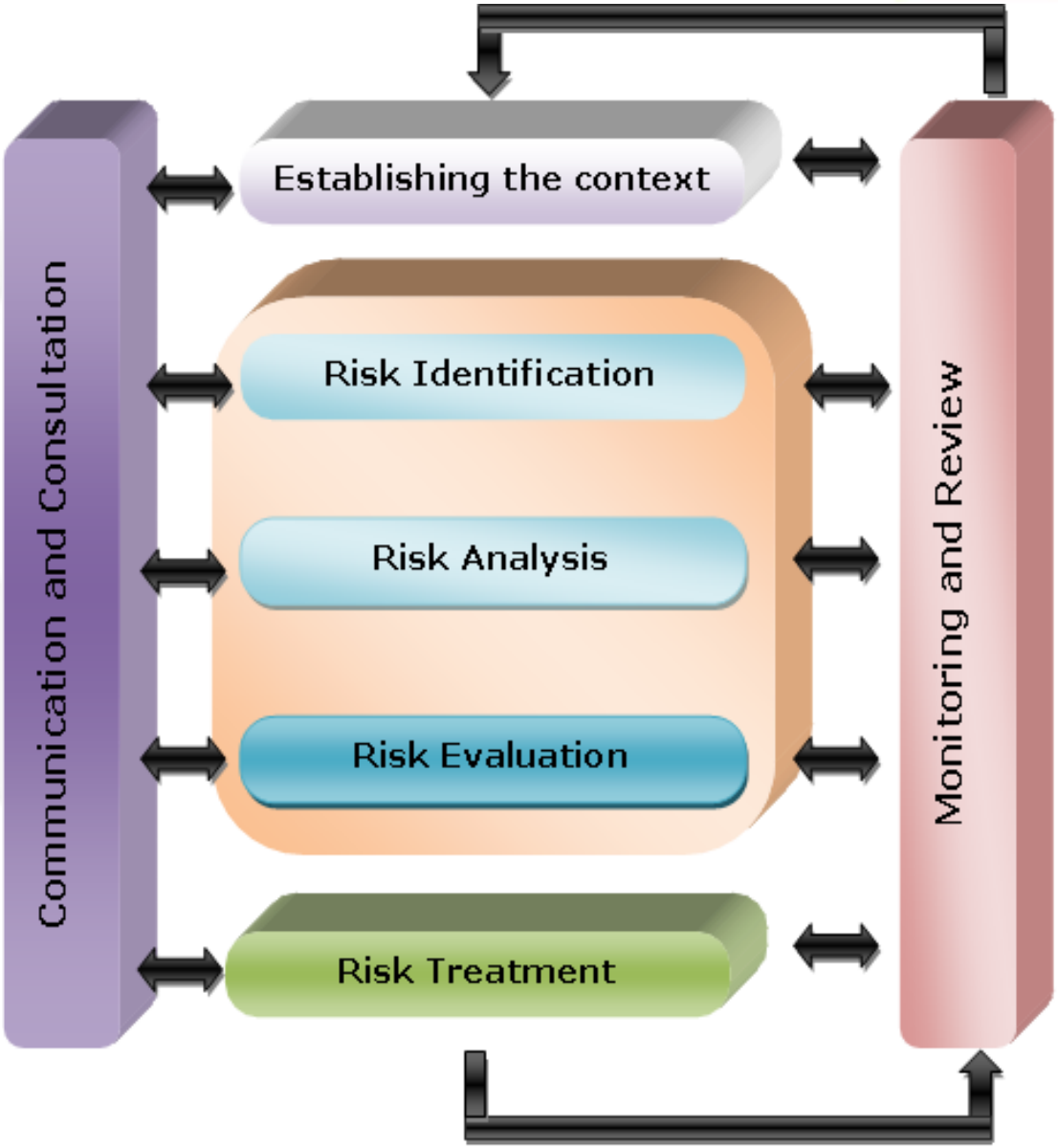
System-Level Factors Affect Safety



Three Principles of Safe Design



Five-stage Process:


Establishing the context
Risk Identification
Risk Analysis
Risk Evaluation
Risk Treatment
Communication and Consultation
Monitoring and Review


Communicate and consult
Who are the stakeholders and what are their objectives?
Establish the context
What do we need to take into account, what are our objectives?
Identify the risks
What might happen? How, when and why?
Analyse the risks
What will this mean for our objectives?
Evaluate the risks
In what order should we deal with them?
Treat the risks
How should we best deal with them?
Monitor and review
Have the risks and controls changed?

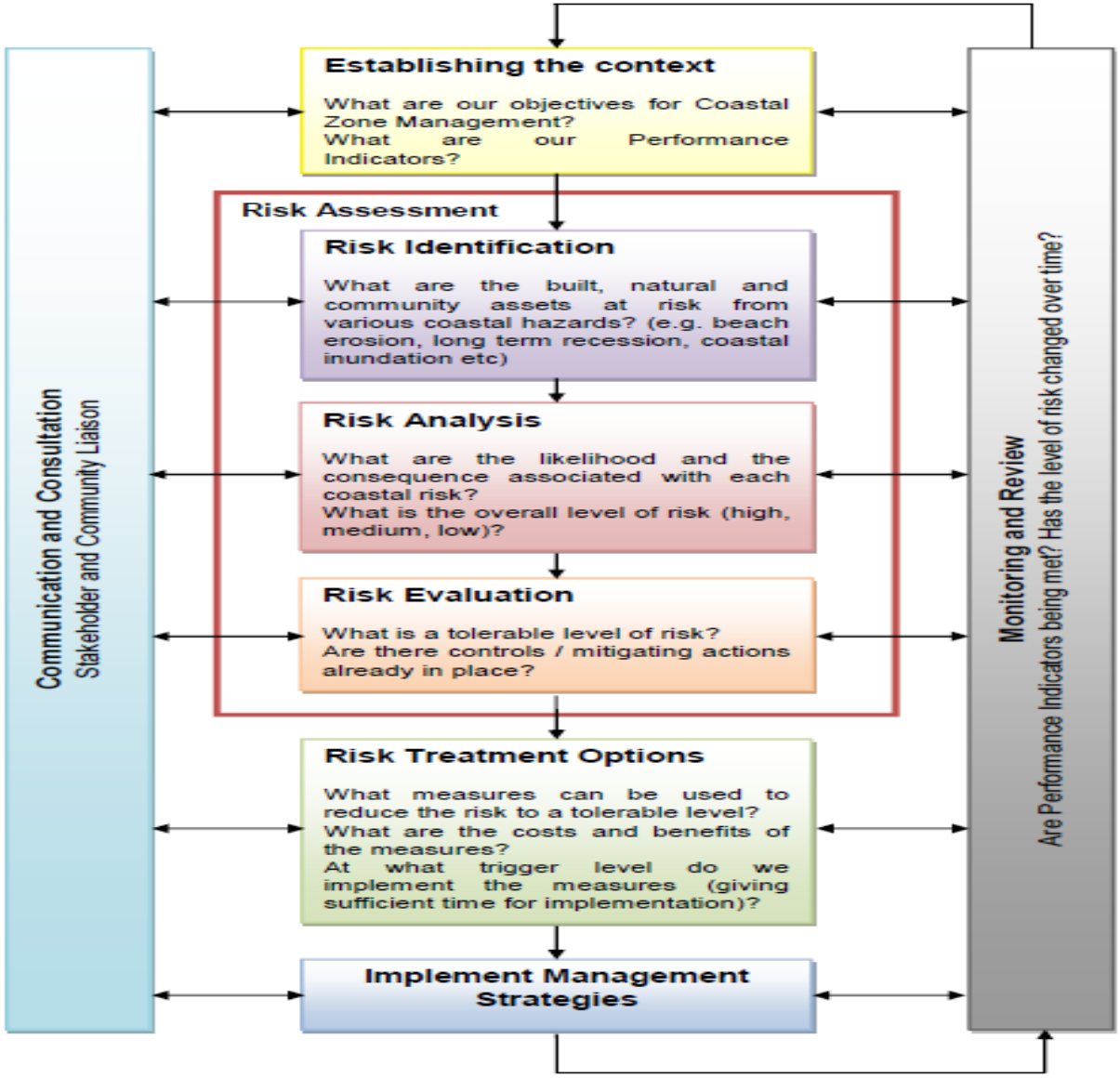
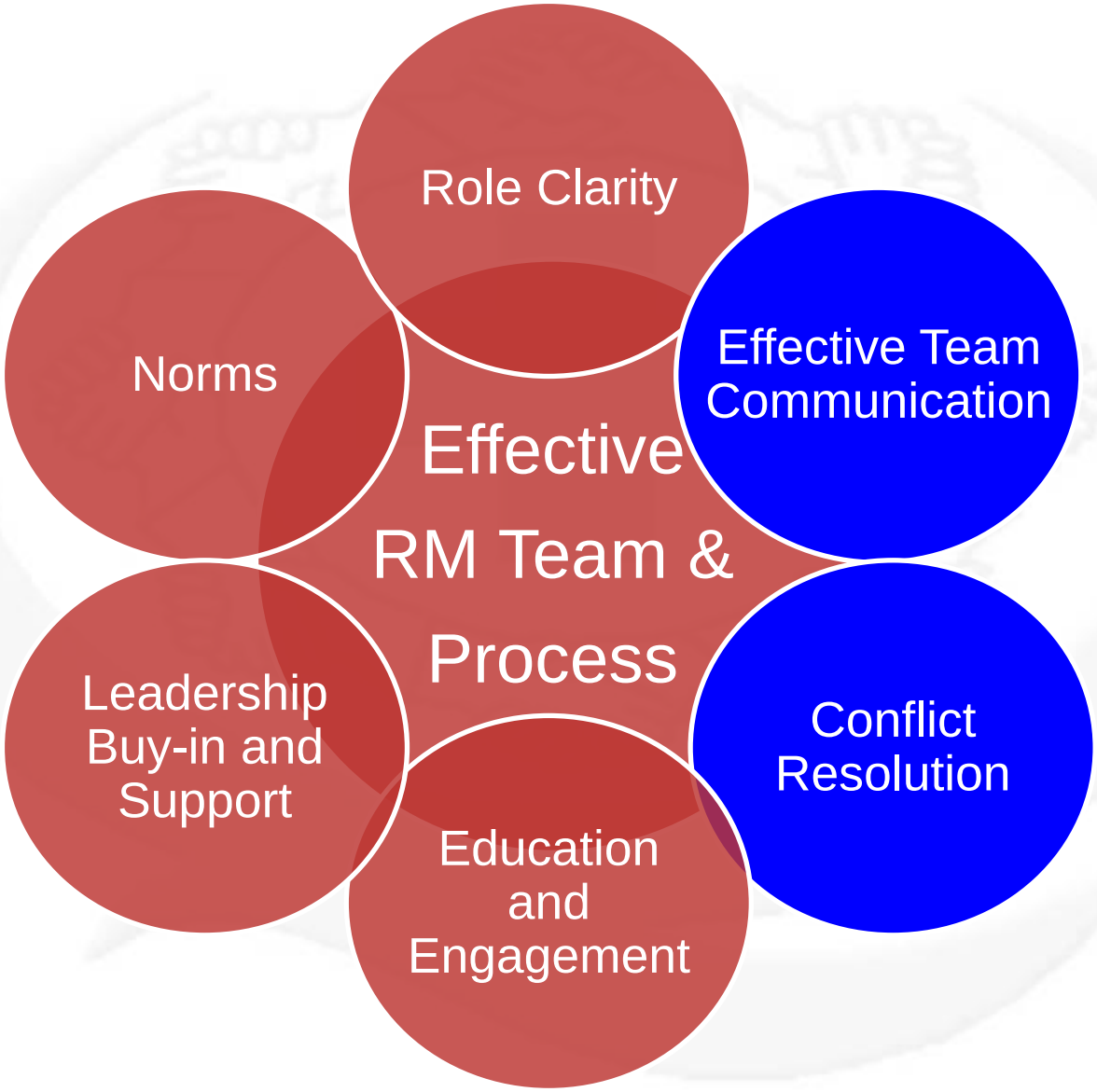


Figure 1 ISO 31000:2009 Risk Assessment Framework Adapted to Coastal Management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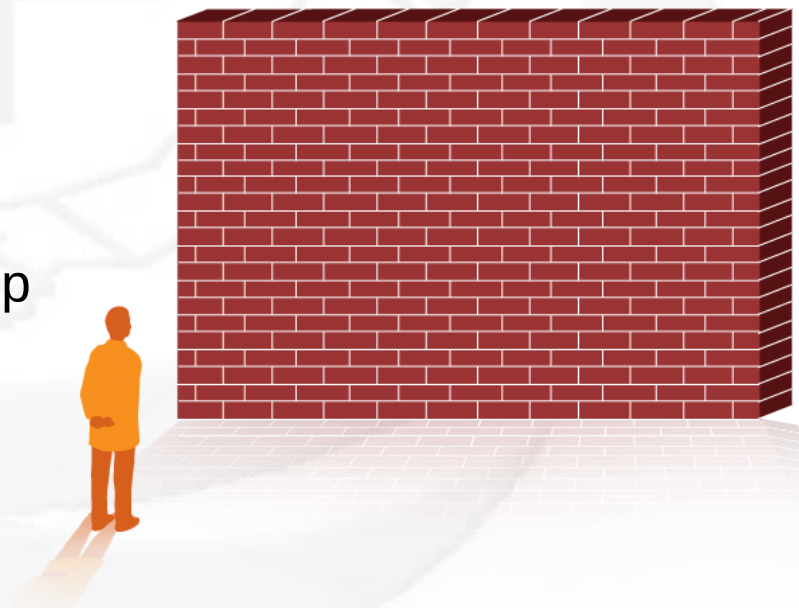
Keys to Assembling the Team

- Understands that patient safety culture is local
- Composed of engaged frontline providers who take ownership of patient safety
- Includes staff members who have different levels of experience
- Tailored to include members based on clinical intervention
- Meets regularly (weekly or at least monthly)
- Has adequate resources

Barriers to Team Performance

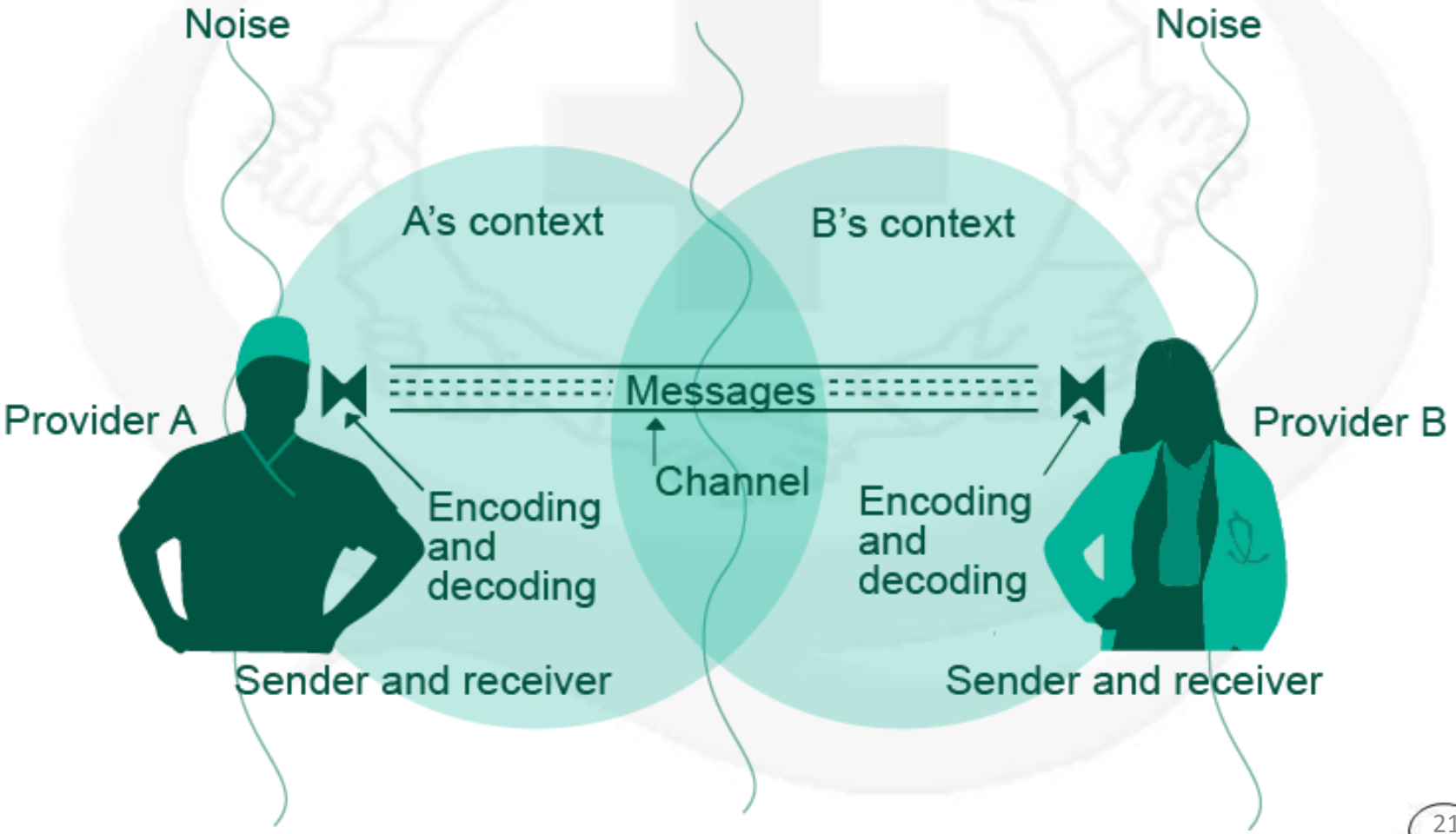
- Inconsistency in team membership
- Lack of time
- Lack of information sharing
- Hierarchy
- Varying communication styles
- Presence of conflict
- Lack of coordination and follow-up
- Misinterpretation of cues
- Lack of role clarity



Communication Breakdowns Cause Treatment Delays

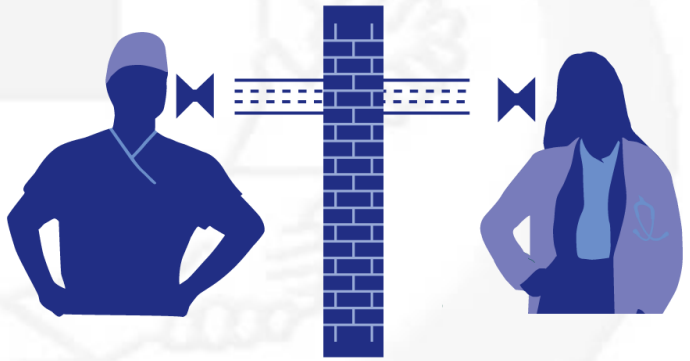
Root Causes of Treatment Delays (1995-2004)

Basic Components and Process of Communication[11]



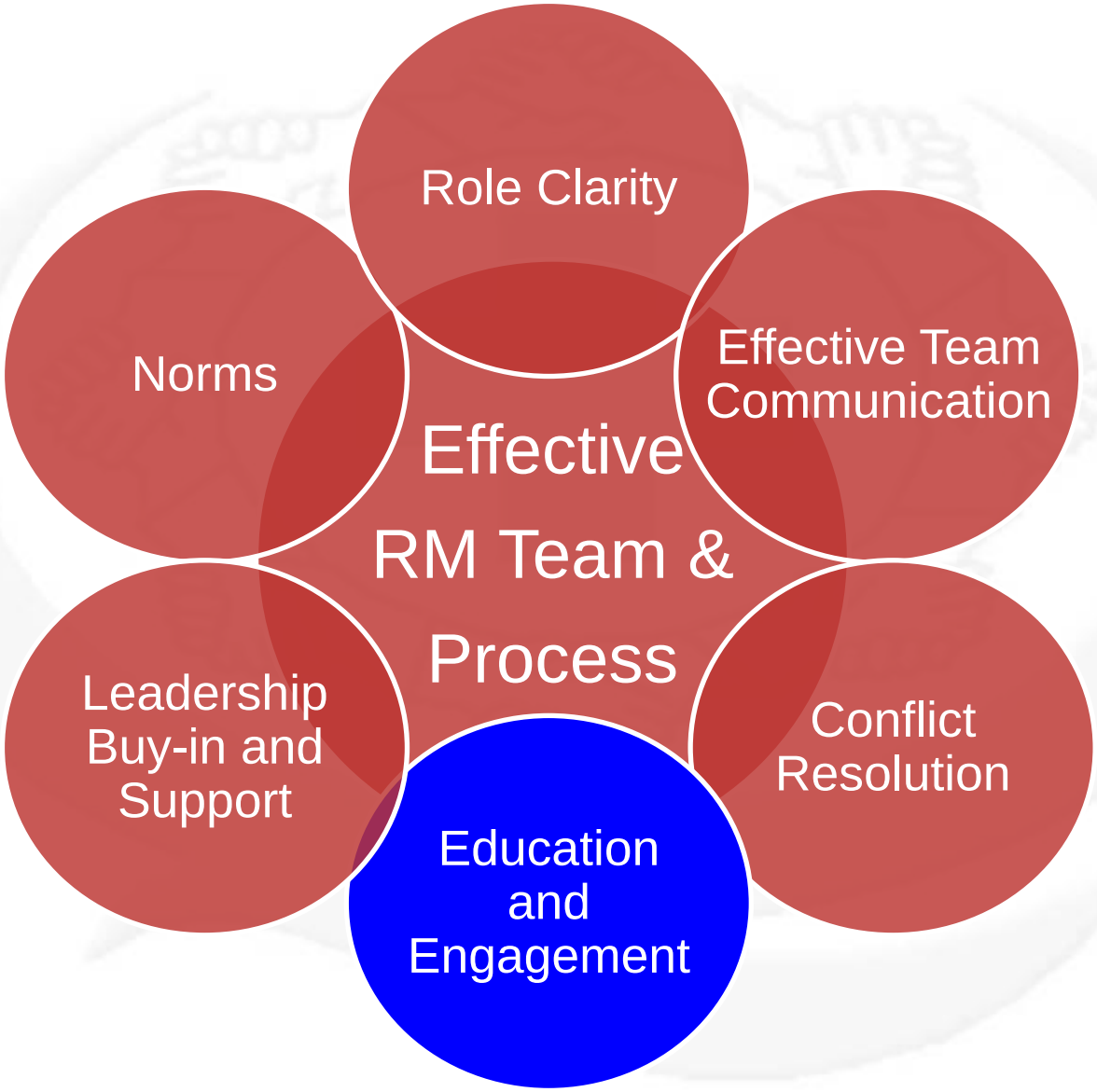
Elements That Affect Communication and Information Exchange

- Interruptions
- Task absorption
- Verbal abuse
- Fatigue
- Not following plan of care
- Ambiguous orders or directions
- Change in team members
- Work load



How to Communicate About an Adverse Event

- Speak slowly and use clear language
- Give an advance alert (“I’m afraid I have some news to share with you.”)
- Give the news in a few, brief sentences
- Quietly wait for the reaction
- Watch and listen for response signals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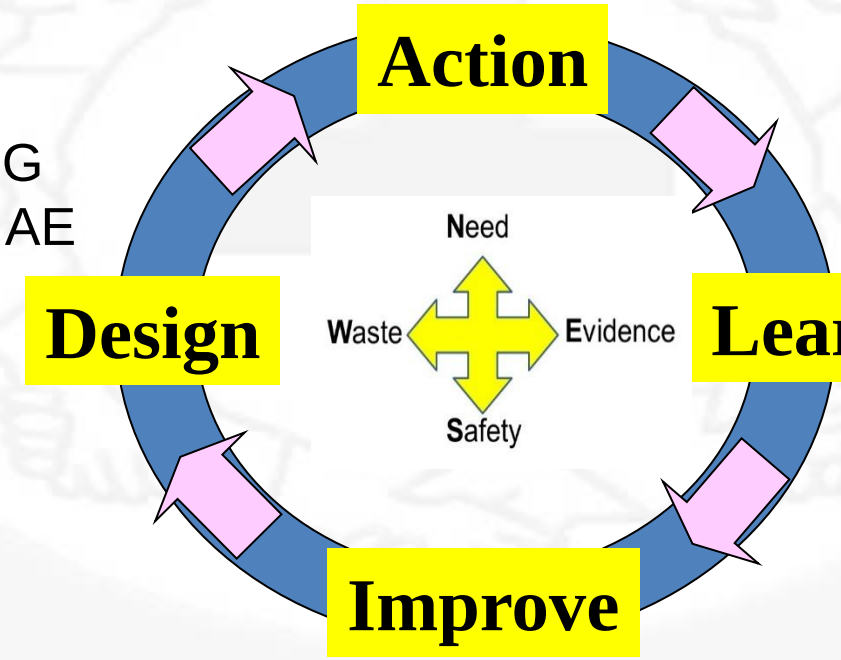
DALI & Risk

Mindfulness
(ต่อมเอ๊ะ)



Evidence: SIMPLE PSG
Risk: potential serious AE
: past AE
: process analysis

Monitor
Trace
AE Review
- Reported AE
- Trigger Tool

CUSP and Sensemaking Tools

CUSP Tools	Sensemaking Tools
Staff Safety Assessment	Discovery Form
Safety Issues Worksheet	Root Cause Analysis
Learn from Defects Form	Failure Mode and Effects Analysis
	Probabilistic Risk Assessment
	Causal Tree Worksheet

Sensemaking Overview

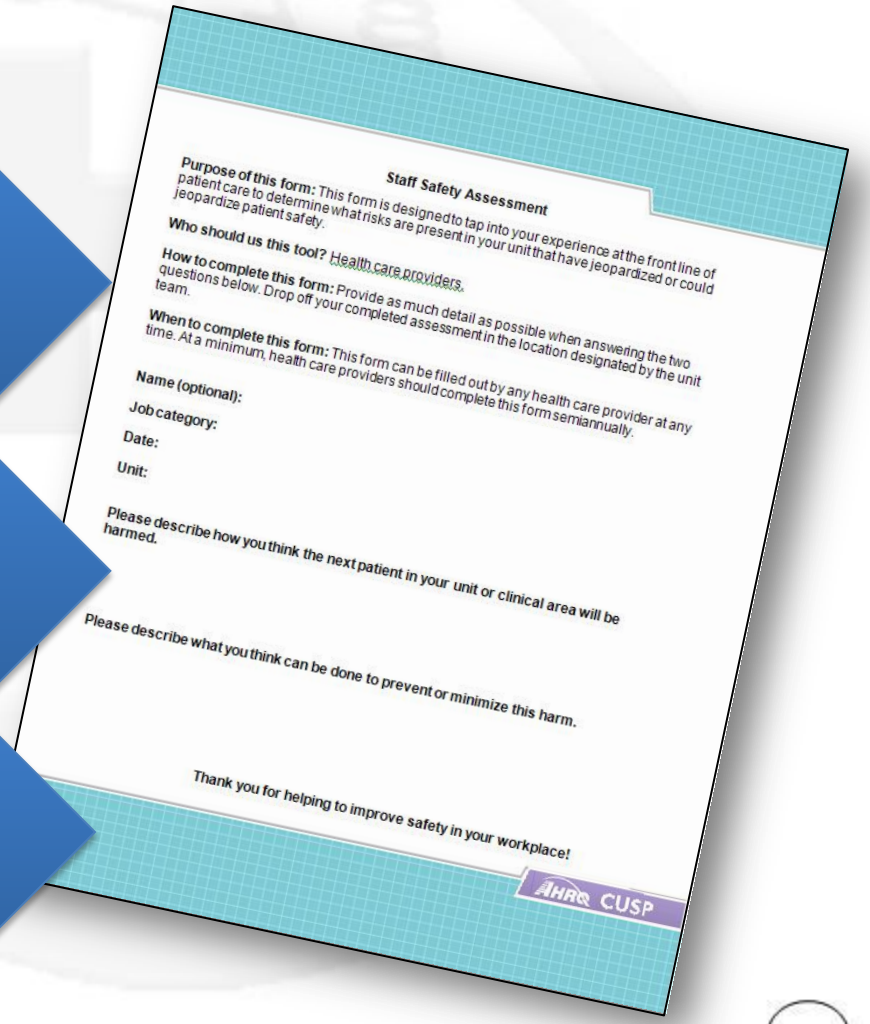
- A conversation among members of an organization involved in an event/issue
- The purpose is to reduce the ambiguity about the event/issue - literally to make sense of it
- Each person brings their experience of that event/issue to the discussion
- The conversation is the mechanism that combines that knowledge into a new, more understandable form for the members
- Members develop a ***similar representation*** in their minds that allows for ***action*** that can be implemented and understood by all who have participated in the conversation

Staff Safety Assessment

Step 1. What are clinical or operational problems that have or could have jeopardized patient safety?

Step 2. How might the next patient be harmed in our unit?

Step 3. What can be done to minimize harm or prevent safety hazards?



Staff Safety Assessment

Purpose of this form: This form is designed to tap into your experience at the front line of patient care to determine what risks are present in your unit that have jeopardized or could jeopardize patient safety.

Who should us this tool? Health care providers.

How to complete this form: Provide as much detail as possible when answering the two questions below. Drop off your completed assessment in the location designated by the unit team.

When to complete this form: This form can be filled out by any health care provider at any time. At a minimum, health care providers should complete this form semiannually.

Name (optional):

Job category:

Date:

Unit:

Please describe how you think the next patient in your unit or clinical area will be harmed.

Please describe what you think can be done to prevent or minimize this harm.

Thank you for helping to improve safety in your workplace!

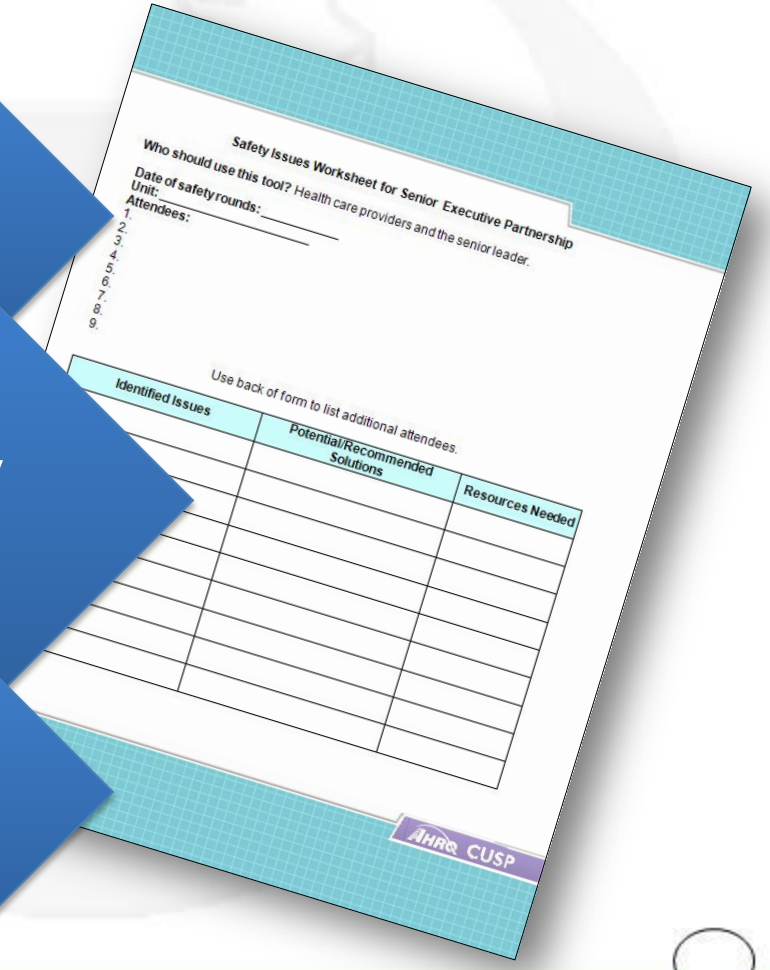
AHRQ CUSP

Use the Safety Issues Worksheet for Senior Executive Partnership

Step 1. Engage the senior executive in addressing the safety issues identified on the form.

Step 2. Use the form during safety rounds to identify safety issues, identify potential solutions, and identify resources.

Step 3. Keep the project leader apprised of the information on this form.

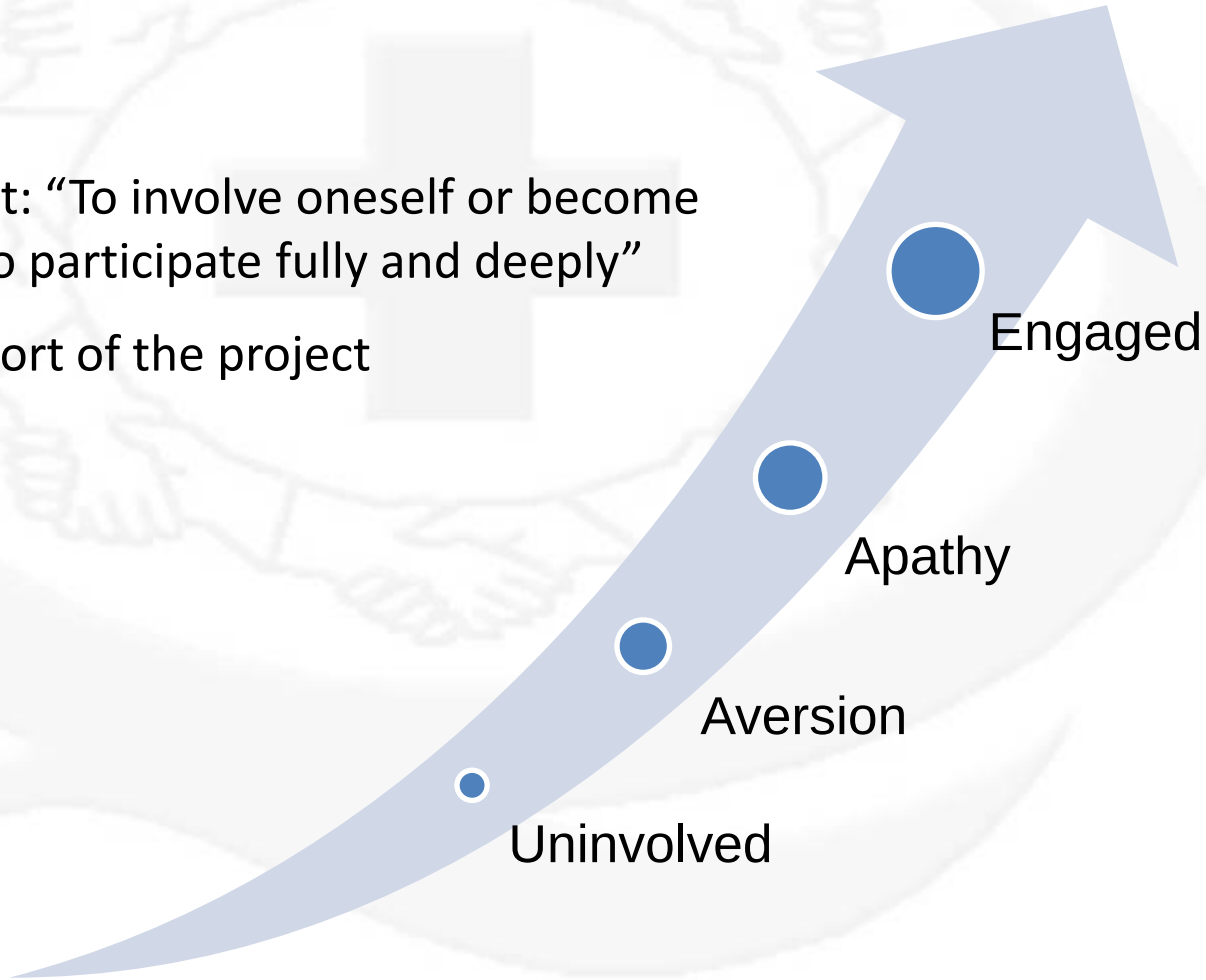


Learning From Defects: Four Questions

1. What happened?
2. Why did it happen?
3. What will you do to reduce the risk of recurrence?
4. How will you know the risk is reduced?

Stages of Engagement

- Engagement: “To involve oneself or become occupied; to participate fully and deeply”
- Active support of the project

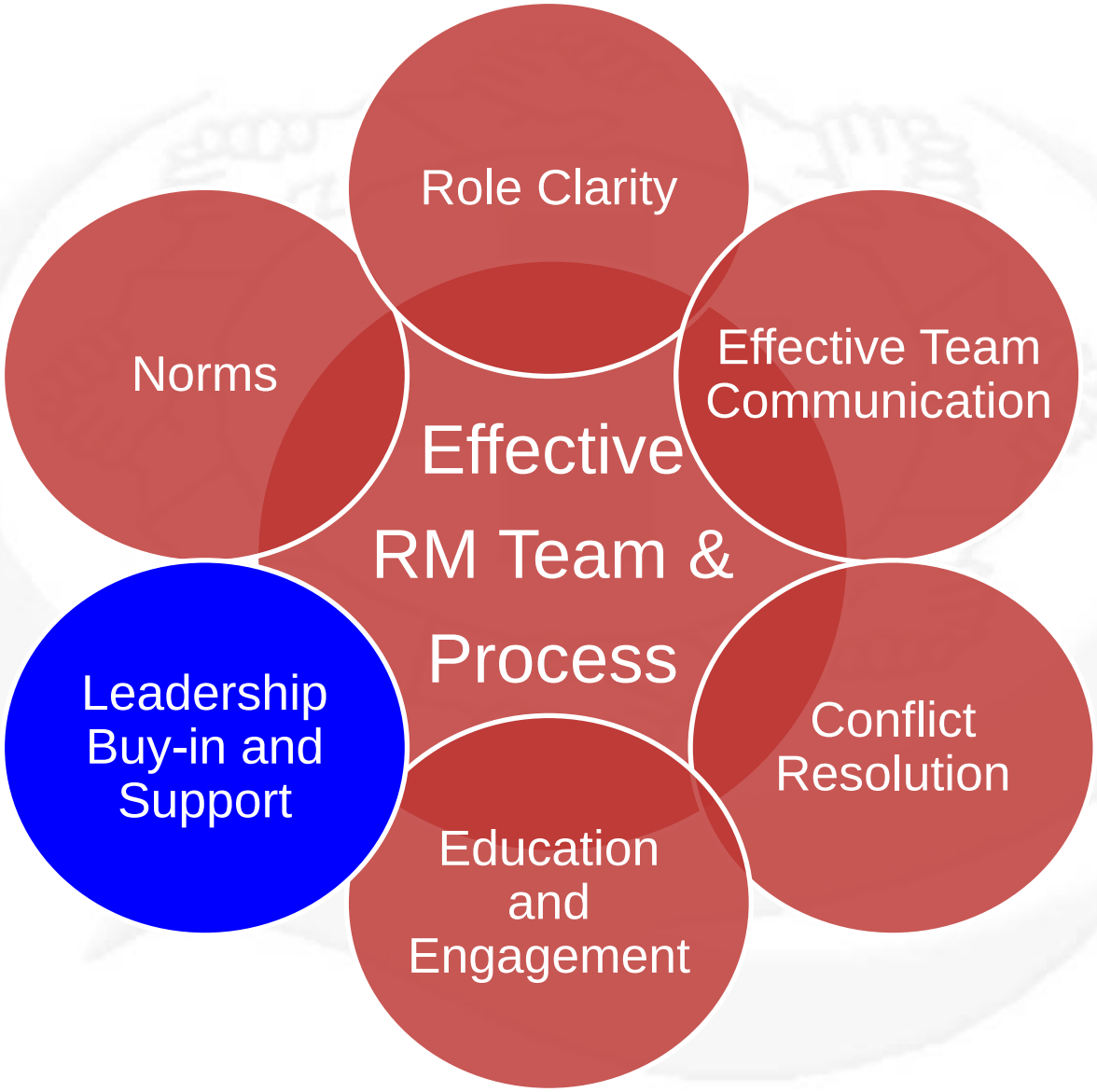


The Second Victim: Health Care Workers

- Health care workers involved in an adverse event experience their own trauma
- Health care workers should request ongoing support from their hospital and peers
- Hospitals have developed Employee Assistance Programs and Medically Induced Trauma Support Services

Engage Physicians on the Team

- Identify physician leaders
- Create an understanding of this role
- Listen to physician concerns
- Develop plans to address concerns
- Reward physician leaders
- Create a vehicle for communication
- Develop a plan for communications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สร้างขวัญกำลังใจให้กองทัพ

กำหนดพื้นที่และความรับผิดชอบ

Collective Leadership

ทำความเข้าใจเครื่องมือ HA (Review & DALI)

เรียนรู้มาตรฐาน A-HA

ใช้ Scoring Guideline เพื่อเพิ่ม maturity

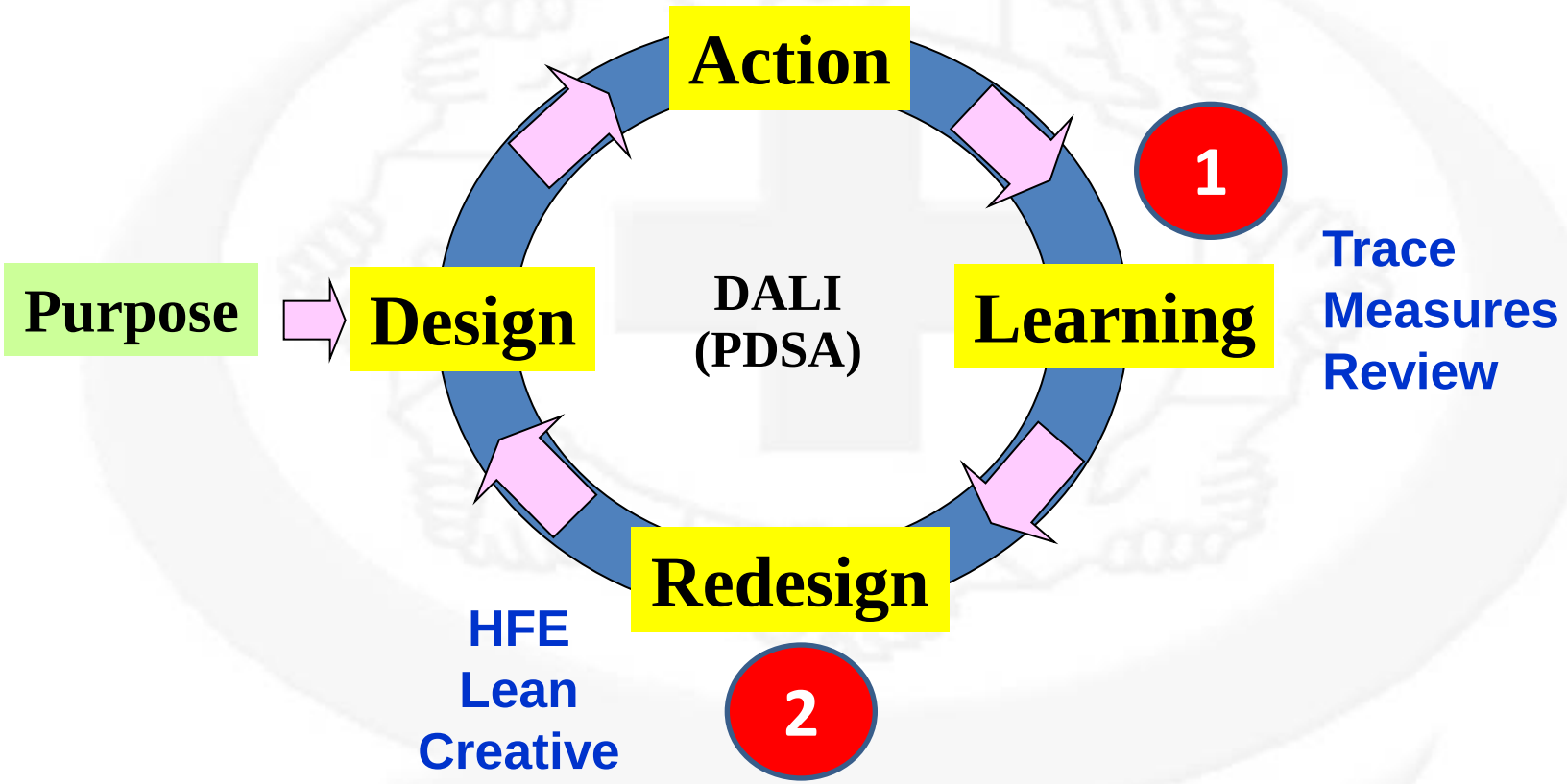
สนับสนุนให้เสาะหา Assessment Tool มาใช้

สนับสนุนและใช้ประโยชน์จากระบบวัดผล

จัดให้มีระบบ Management Review

หมุน DALI โดยเริ่มจาก L

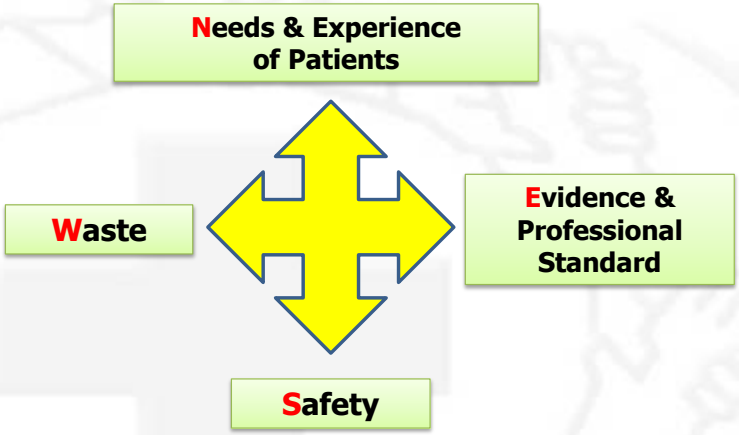
10. หมุนวงล้อ DALI โดยเริ่มจาก L



ตามรอยเพื่อชี้โอกาสพัฒนา

การชี้ประเด็นพัฒนา

NEWS



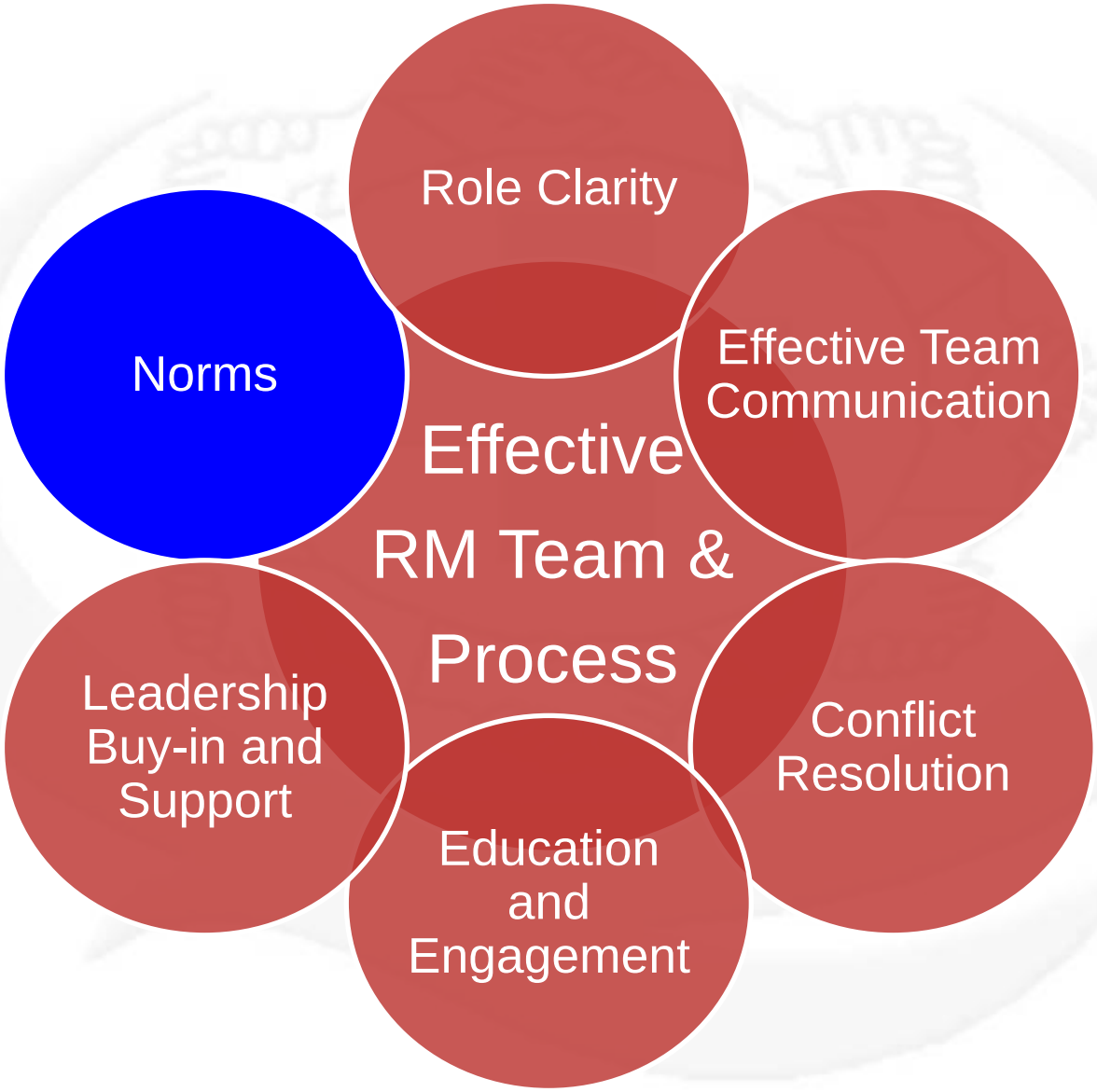
แนวคิดการพัฒนา

HIMR: Holistic Innovation Multidisciplinary Review

BR: Benchmarking Research

บทบาทของผู้นำ

- มีใจรัก (รักที่จะสร้างการเปลี่ยนแปลง สู่เป้าหมายที่ยิ่งใหญ่ มีจิตใจเป็นบวกต่อสิ่งที่จะเกิดขึ้น)
- ชักชวนทำ (ใช้หลักกัลยาณมิตร: น่ารัก น่าเคารพ น่าเจริญใจ รู้จักพูดให้ได้ผล อดทนต่อถ้อยคำ แถลงเรื่องลึกล้ำได้ ไม่ชักนำในทางอฐาน)
- นำและสนับสนุน (ความรู้ ข้อมูล ทรัพยากร โอกาส อำนาจตัดสินใจ)
- คุ้นเคยรับฟัง (ความฝัน ความรู้สึก ปัญหา ความสำเร็จ)
- เสริมพลัง ให้กำลังใจ ใส่ตัวกวน
- ชวนติดตาม (monitor, trace)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Understanding Risk and Human Behavior

Human Error: Inadvertently completing the wrong action; slip, lapse, mistake

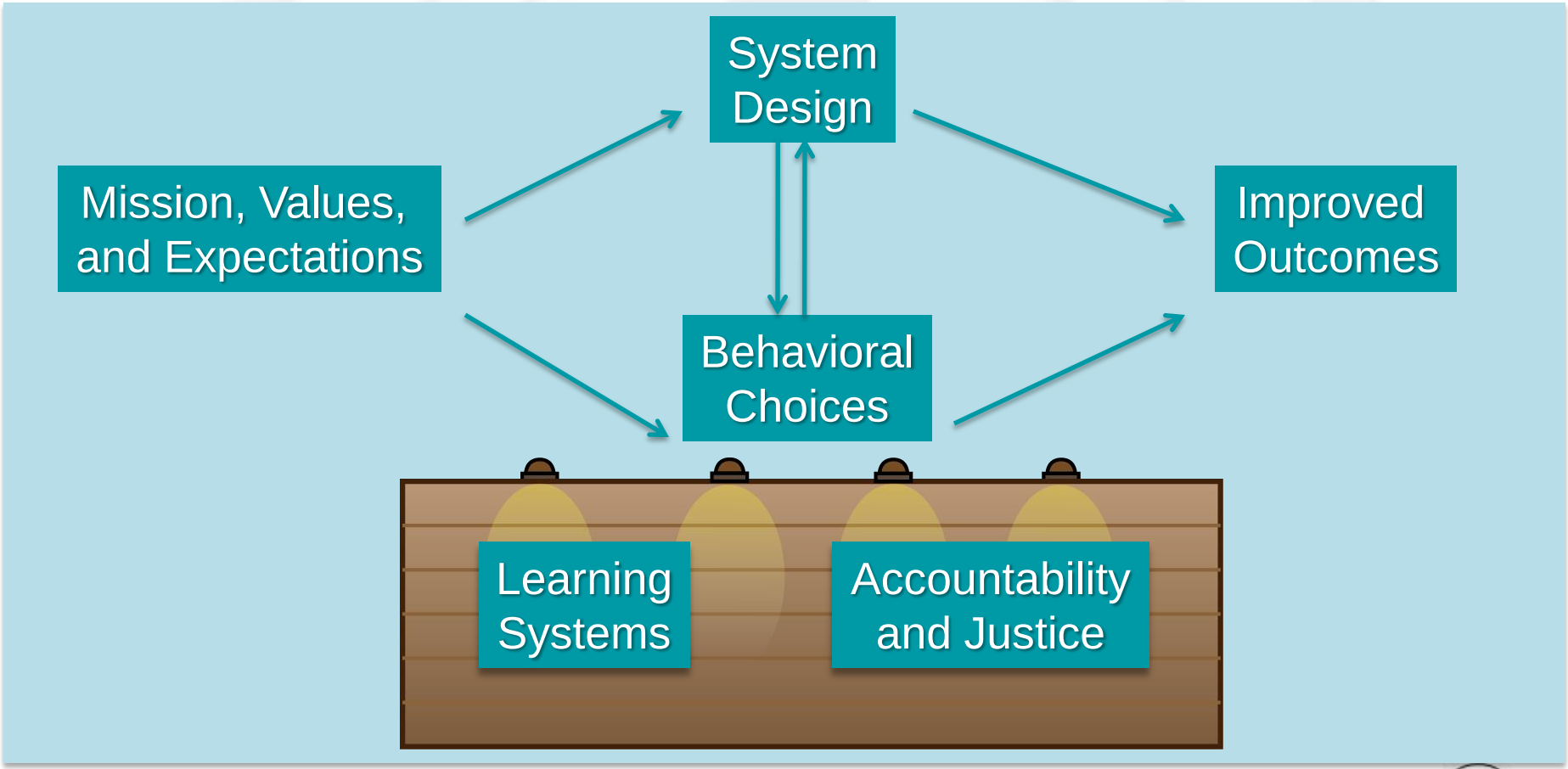
At-Risk Behavior: Choosing to behave in a way that increases risk where risk is not recognized, or is mistakenly believed to be justified

Reckless Behavior: Choosing to consciously disregard a substantial and unjustifiable risk

Managing Error and Risk

Human Error	At-Risk Behavior	Reckless Behavior
Product of our current system design and behavioral choices Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	*A choice: risk believed insignificant or justified* Manage through: • Removal of incentives for at-risk behaviors • Creation of incentives for healthy behaviors • Situational awareness	*Conscious disregard of substantial and unjustifiable risk* Manage through: • Remedial action • Punitive action
Console	**Coach**	**Punish**

Systems and Behaviors Work Together To Improve Outcomes



Engineering System Design to Support Behavior Choices

Just Culture

- A system that:
  - Holds itself accountable
  - Holds staff members accountable
  - Has staff members who hold themselves accountable


RISK
REWARD
ISO:
RISK
BASED
THINKING
2015 EDITION
CERM Academy Series
on
Enterprise Risk Management

What is "Risk-Based Thinking

- Risk-based thinking is something we all do automatically and often sub-consciously
- The concept of risk has always been implicit in ISO 9001 – the 2015 revision makes it more explicit and builds it into the whole management system
- Risk-based thinking is already part of the *process approach*
- Risk-based thinking makes *preventive action* part of the routine

- *Risk is often thought of only in the negative sense. Risk-based thinking can also help to identify opportunities. This can be considered to be the positive side of risk*

Why Should I adopt "Risk-Based Thinking"?

- To improve customer confidence and satisfaction
- To assure consistency of quality of goods and services
- To establish a proactive culture of prevention and improvement
- Successful companies intuitively take a risk-based approach

Key Points to Remember

Risk Based Thinking = Preventative Action

Risk Based Thinking is everybody's business!

- Risk Based Thinking is not just the responsibility of management
- Risk Based Thinking must become an integral part of the organizational culture

What Should I Do?

- Analyse and prioritize the risks and opportunities in your organization
  - *what is acceptable?*
  - *what is unacceptable?*
- Plan actions to address the risks
  - *how can I avoid or eliminate the risk?*
  - *how can I mitigate the risk?*
- Implement the plan – *take action*
- Check the effectiveness of the actions – *does it work?*
- Learn from experience – *continual improvement*

Is Your Hospital Safe?

- Would you want a loved one to be a patient at your hospital? Your unit?
- Would you want to be a patient in the unit where you work?
- Can you say with 100 percent certainty that you believe that your hospital does everything it can to protect its patients?