Why clinical risk is relevant to patient safety

Risk management is routine in most industries and has traditionally been associated with limiting litigation costs. Many corporations try to avoid financial loss, fraud or a failure to meet production expectations by implementing strategies to avoid such events. Hospitals and health organizations use a variety of methods for managing risks. The success of a risk management programme, however, depends on the creating and maintaining safe systems of care, designed to reduce adverse events and improve human performance [1]. Many hospitals have well-established systems in place for reporting patient falls, medication errors, retained swabs and misidentification of patients. Nevertheless, they are only beginning to focus on all aspects of clinical care to see opportunities for reducing risks to patients.

A medical student, along with everyone else who works in a hospital or clinic has a responsibility to take the correct action when they see an unsafe situation or environment. Taking steps to ensure a slippery floor is dry and preventing a patient from falling over is as important as ensuring that the medication a patient is taking is the correct one. In the event of a patient falling on a slippery floor or receiving the wrong medication, it is equally important for a student to report these events so that steps can be taken to avoid future incidents.

Effective risk management involves every level of the health service, so it is essential that all health-care workers understand the objectives and relevance of the risk management strategies and their relevance to their own workplace. Unfortunately, even though a hospital may have a policy of reporting incidents such as medication errors, the actual reporting of them is often sporadic. Students can begin to practise reporting by talking with the health-care team about medication errors and the strategies in place to manage and avoid them.

Research shows that nurses are more likely to report an incident than other health professionals, certainly more so than doctors. This may be because the blame culture in medicine is a strong deterrent to reporting. Today, most risk management programmes aim to improve safety and quality in addition to minimizing the risk of litigation and other losses (staff morale, loss of staff, diminished reputation), but the degree of their success depends on many factors.

Clinical risk management specifically is concerned with improving the quality and safety of health-care services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks. The following simple four-step process is commonly used to manage clinical risks:

1. identify the risk;
2. assess the frequency and severity of the risk;
3. reduce or eliminate the risk;
4. assess the costs saved by reducing the risk or the costs if the risk eventuates.

Medical students, along with all other health professionals will be mainly concerned about the risk to patients. The first topic in this Curriculum Guide outlines the extent of the harm done by health care. It is against this backdrop that organizations are concerned about managing clinical risks. Clinical risk management allows identification potential errors. Health care itself is inherently risky and although it would be impossible to eradicate all harm, there are many activities and actions that can be introduced that will minimize opportunities for errors. Clinical risk is relevant to medical students because it recognizes that clinical care and treatment are risky and incidents may to occur during clinical care and treatment. Students (as well as all other
health-care professionals) must actively weigh up the anticipated risks and the benefits of each clinical situation and only then take action. Students should seek out information about past risks and actively participate in efforts to prevent them recurring. For example, compliance with a handwashing protocol so that the spread of infection is minimized. In this sense students are acting proactively to avoid problems and not merely reacting to a current problem.

**Keywords**
Clinical risk, reporting near misses, reporting errors, risk assessment, incident, incident monitoring.

**Learning objective**
Know how to apply risk management principles by identifying, assessing and reporting hazards and potential risks in the workplace.

**Learning outcomes: knowledge and performance**

What students need to know (knowledge requirements):
- the activities for gathering information about risk;
- fitness-to-practice requirements;
- personal accountability for managing clinical risk.

What students need to do (performance requirements):
- know how to report known risks or hazards in the workplace;
- keep accurate and complete medical records;
- know when and how to ask for help from a supervisor, senior clinician and other health-care professionals;
- participate in meetings that discuss risk management and patient safety;
- respond appropriately to patients and families after an adverse event;
- respond appropriately to complaints.

**WHAT STUDENTS NEED TO KNOW (KNOWLEDGE REQUIREMENTS)**

What are the activities for gathering information about risk?

Medical students working in hospitals may not be immediately aware of a risk management programme in their hospital or clinic. Nevertheless, most countries today will have a range of mechanisms to measure the harm to patients and staff as well as avoid known problems. Some countries have well-developed state and national data sets of incidents. In Australia, the Advanced Incident Management System is a comprehensive approach to reporting incidents and analysing the various types of incidents. The Veterans Affairs Administration of the US Department of Veterans Affairs has established a National Center for Patient Safety that uses a structured approach called root cause analysis to evaluate, analyse and treat the problems. See topics 5 and 7 for more information about the root cause analysis methodology.

The principle underpinning root cause analysis is that the actual (root) cause of a particular problem is rarely (immediately) recognizable at the time of the mistake or incident. A superficial and biased assessment of any problem usually does not fix the problem and more incidents will occur involving others in similar situations. An essential part of any root cause analysis is the implementation of the findings of the root cause analysis process. Many hospitals and organizations fail to complete the process because either the recommendations involve resources that are not available or there is no commitment by the senior hospital management to carry through the recommendations.
Some health-care organizations that mandate reporting of incidents can become so overloaded with reported incidents with the consequence that many remain unanalysed due to inadequate resources. Even the introduction of a triage system to distinguish serious incidents from others has not resolved this dilemma in some systems. Many systems now have borrowed from the Veteran Administration and introduced a severity assessment code to help identify those incidents that indicate the most serious risk to the organization.

Below are some common activities used to manage clinical risk.

Incident monitoring
Incident reporting has existed for decades. Many countries now have national databases of adverse events pertaining to different specialties such as surgery, anaesthesia, maternal and child health. WHO defines an incident as an event or circumstance that could have or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage. The main benefit of incident reporting lies in the information about prevention rather than the frequency of the incident; other quantitative methods are required for that.

Facilitated incident monitoring refers to the mechanisms for identifying, processing, analysing and reporting incidents with a view to preventing their recurrence [2]. The key to an effective reporting system is to have staff routinely reporting incidents or near misses. However, unless staff trust that the organization will use the information for improvement and not to blame individuals, they will not report. Trust includes the belief that the organization will also act upon the information. If a medical student reported an incident to a senior nurse or doctor who dismissed their effort and told them not to bother, then the student is less likely to make a report again. Even when this happens, students should be encouraged by faculty staff to continue to report. One day the student will be a senior doctor and their actions will be highly influential on younger doctors and students. Facilitated monitoring is designed to identify a greater proportion of incidents and to produce reports that are aimed at improving care. This type of monitoring is a continuous activity of the clinical team involving the following actions:

• discussion about incidents is a standing item in the weekly clinical meetings;
• there is a weekly review of areas where errors are known to occur;
• a detailed discussion about the facts of an incident and follow-up action required is done with the team;
• the discussion is always educational rather than attributing blame;
• identifies the system issues so they can be addressed and other staff made aware of the potential difficulties.

As well as reporting actual incidents, some organizations encourage the reporting of “near misses” because of the value they bring about new problems and the factors that contribute to them, and how they may be prevented, before serious harm is done to a patient. A near miss is an incident that did not cause harm. Some people call “near misses” “near hits” because the actions may have caused an adverse event, but corrective action was taken just in time or the patient had no adverse reaction to the incorrect treatment. Talking about “near misses” may be easier in some environments where there is a strong blame culture because no one will be able to be blamed because there was no adverse outcome to the patient. See Table 14 for more analysis of incident monitoring.

Sentinel events
A sentinel event is an unexpected occurrence involving death or serious physical or
psychological injury to a patient and includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome [4]. The current trend in many countries in analysing adverse events is to rank the seriousness of the event. A sentinel event is reserved for the most serious ones.

Many hospitals and clinics have mandated the reporting of these types of events or events because of the risk of a repeat. These are often called “never events” that should never be allowed to happen because of the potential for death or significant harm. Catastrophic event is another term used and these make up half of all the sentinel events reported in the United States and over two thirds of those reported in Australia [3].

Table 14. Types of issues identified by incident monitoring

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>% of reports*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>29</td>
</tr>
<tr>
<td>Injuries other than falls (e.g. burns, pressure injuries, physical assault, self-harm)</td>
<td>13</td>
</tr>
<tr>
<td>Medication errors (e.g. omission, overdose, underdose, wrong route, wrong medication)</td>
<td>12</td>
</tr>
<tr>
<td>Clinical process problems (e.g. wrong diagnosis, inappropriate treatment, poor care)</td>
<td>10</td>
</tr>
<tr>
<td>Equipment problems (e.g. unavailable, inappropriate, poor design, misuse, failure, malfunction)</td>
<td>8</td>
</tr>
<tr>
<td>Documentation problems (e.g. inadequate, incorrect, not completed, out of date, unclear)</td>
<td>8</td>
</tr>
<tr>
<td>Hazardous environment (e.g. contamination, inadequate cleaning or sterilization)</td>
<td>7</td>
</tr>
<tr>
<td>Inadequate resources (e.g. staff absent, unavailable, inexperienced, poor orientation)</td>
<td>5</td>
</tr>
<tr>
<td>Logistic problems (e.g. problems with admission, treatment, transport, response to emergency)</td>
<td>4</td>
</tr>
<tr>
<td>Administrative problems (e.g. inadequate supervision, lack of resource, poor management decisions)</td>
<td>2</td>
</tr>
<tr>
<td>Infusion problems (e.g. omission, wrong rate)</td>
<td>1</td>
</tr>
<tr>
<td>Infrastructure problems (e.g. power failure, insufficient beds)</td>
<td>1</td>
</tr>
<tr>
<td>Nutrition problems (e.g. fed when fasting, wrong food, food contaminated, problems when ordering)</td>
<td>1</td>
</tr>
<tr>
<td>Colloid or blood product problems (e.g. omission, underdose, overdose, storage problems)</td>
<td>1</td>
</tr>
<tr>
<td>Oxygen problems (e.g. omission, overdose, underdose, premature cessation, failure of supply)</td>
<td>1</td>
</tr>
</tbody>
</table>

* More than one type of incident may be assigned to a report.

Source: Runciman B et al. [3]

The role of complaints in improving care

A complaint is defined as an expression of dissatisfaction with their health care by a patient or a family member. Because medical students will be treating patients under supervision they may be named in a complaint from a patient or family member. Students may feel exposed when this happens and may feel that they will be blamed for their actions. Students and all health professionals may feel embarrassed, remorseful, angry or defensive if they are the subject of a complaint. While complaints from patients or their families may be uncomfortable to deal with, they are a very good opportunity for improving clinical practice [5] and restoring a trusting relationship between the patient, their family and the health-care team. Complaints often highlight problems that need addressing such
as the common problems of poor communication or suboptimal clinical decision-making. Communication problems are common causes of complaints as are problems with treatment and diagnosis. Students are learning about clinical decision-making and patient management and are seeing just how complex these tasks can be. So it is not surprising that miscommunication or suboptimal care may sometimes occur. Patient complaints help to identify areas in the processes of care that could be improved. The information from complaints can also be used to educate and inform health professionals about problem areas.

Other benefits of complaints include that they: [5]
- assist to maintain standards;
- reduce the frequency of litigation;
- help maintain trust in the profession;
- encourage self-assessment;
- protect the public.

Students should be aware that most doctors will receive complaints in their careers and that it is not an indication of incompetence—even the most conscientious and skilful clinicians can and do make mistakes. Medical error is a subset of human error; all humans make mistakes. Legal and ethical obligations are reinforced when a complaint is in the hand.

If a student is involved in a complaint, or if they receive one when they are doctors, they should be open to discussing the complaint with the patient or family. It is a good idea to have a more senior person present during these discussions. If a student is required to provide a written statement about their actions, it is important that the statement is factual and relates directly to the student’s or doctor’s involvement. It is important to always check with a supervisor if a written complaint is received and a statement required. The hospital or clinic will most likely have in place a policy for managing complaints.

Complaints and concerns where the individual is responsible
From a patient’s perspective individual patients should be able to have their concerns examined to see if there has been a departure from professional standards. After examination or investigation it may be that system issues are at the heart of the problem but the treating doctor or health-care team may also have been at fault—for example by cutting corners and breaching accepted protocols. The standard of care may be low resulting in suboptimal care. Guidelines may not have been followed or hospital rules broken.

An example is failure of a staff member to wash their hands, resulting in transmission of infection from one patient to another. While the initial approach to the investigation should adopt a systems-based view, individuals are also required to meet their professional responsibilities—it may be that the staff member was indeed directly at fault through failing to adhere to accepted standards of care. Reason [6] defined a violation as a deviation from safe operating procedures, standards or rules.

Coronial Investigations
Most countries have some system for establishing cause of death. Specifically appointed people, often called coroners, are responsible for investigating deaths in situations where the cause of death is uncertain, or thought to be due to unethical or illegal activity. Coroners often have broader powers than a court of law and after reporting the facts will make recommendations for addressing any system-wide problems.

Fitness-to-practise requirements
Medical students and all health professionals are accountable for their actions and conduct in the clinical environment. They are responsible for their actions according to the circumstances in which they find themselves. Related to
accountability is the concept of “fitness to practise”. Why is fitness to practise an important component of patient safety?

Of the many factors underpinning adverse events one factor relates to the competence of clinicians. Many mistakes leading to adverse events are associated with the fitness of a doctor to practise. Are they competent? Are they practising beyond their level of experience and skill? Are they unwell, suffering from a stress or a mental illness? Most countries will have a system for registering doctors, dealing with complaints and maintaining standards. It is important that medical students understand why it is important to be vigilant about their own fitness and that of their colleagues. Medicine as a profession places duties and obligation upon doctors with the aim of keeping patients safe.

Selecting the right students to study medicine is the first step in making sure that the people who are choosing medicine as a career have the professional attributes for safe and ethical practice. Many medical schools now have OSCE-type (Objective Structured Clinical Examination) processes to help identify those students who in addition to their examination results also have the attitudes and behaviours best suited to medicine and patient safety. Doing medicine because of family expectations or a desire for high status or money is often insufficient to sustain a career in medicine. Attributes such as compassion, empathy, a vocational aspiration to do good and to provide benefits to society are the sustaining qualities.

The duties of a doctor (and medical student) extend to reporting a peer or colleague who is unsafe because of either incompetence or unprofessional or unethical behaviour. Some countries require mandatory reporting of practitioners if they are unfit, while others rely on individuals to use their conscience in this regard.

Hospitals and health-care organizations also have responsibilities to ensure that only competent and qualified doctors treat patients. They are required to check that a doctor has the right qualifications and experience to practise in the area they nominate. The processes for doing this follow.

**Credentialling**
Credentialling is the process of assessing and conferring approval on a person’s suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual’s licence, education, training, experience and competence (Australian Council on Healthcare Standards). Many hospitals have credentialling processes in place to check whether a doctor has the required skills and knowledge to undertake specific procedures or treatments. Hospitals will restrict the type of procedures offered at a hospital if there are no qualified personnel or if the resources are not available or appropriate for the particular condition or treatment.

**Accreditation**
Accreditation is a formal process to ensure delivery of safe, high-quality health care based on standards and processes devised and developed by health-care professionals for health-care services. It can also refer to public recognition of achievement by a health-care organization of requirements of national health care standards.

**Registration**
Most countries require medical practitioners to be registered with a government authority or under a government instrument. The principal purpose of a registration authority is to protect the health and safety of the public by providing mechanisms designed to ensure that medical practitioners are fit to practise medicine. It achieves this by ensuring that only properly trained doctors are registered, and that registered doctors maintain proper standards of conduct and competence.
Personal accountability for managing risk

More senior medical students will begin to establish clear roles and responsibilities as members of health-care teams when they spend more time on the wards, clinics and in the hospitals. Close to the completion of their medical training they will be required to demonstrate competence in a number of basic clinical tasks. The following activities are not exhaustive or indeed prescriptive. They are offered to give some idea of the competencies students require when they complete their medical degrees and start working in a hospital or clinical environment.

- Know how to organize a request for consultation from another doctor or health-care team. These skills include using correct identification procedures, accurate summary of the patient’s background and the reason for admission, current clinical problem and the results of any investigations. Only include relevant and necessary information and write legibly.
- Know how to make a telephone call to a primary care doctor. The student should make sure they are supervised during this activity. Practising providing accurate information about the patient, correctly pronouncing medical terminology, using techniques to ensure the person on the telephone has understood what the student was saying, seeking information about concerns and writing a summary of the telephone conversation for the medical record.
- Know how to write a prescription accurately and following the hospital policy. It is a good idea to routinely check with pharmacists who may be working in the hospital.
- Know how to write a letter when a patient’s care is being transferred to another health provider or team. The letter should contain the relevant patient identifying information, dates of admission and discharge, and the name of the doctors responsible for the care of the patient while they were in hospital, accurate summary of the patient’s stay in hospital, the final diagnosis, key investigations, reason for admission, and the status of the patient’s clinical problems, describe the therapeutic interventions undertaken, the outcome, follow-up arrangements and outstanding investigations. An accurate and complete list of medications including dose, route, and planned duration of therapy and be completely legible.

The role of fatigue and fitness to practise

There is strong scientific evidence linking fatigue and performance. Students should be aware that when they are fatigued they will be less alert, and not be able to perform as normal in a variety of psychomotor tasks because of poor quality sleep and inadequate time for them to recover.

- Studies in the Ireland and the United Kingdom also show that fatigue can impact on the well-being of residents affecting their mood (depression, anxiety, anger and confusion) [7];
- Recent controlled studies have confirmed the findings that sleep deprivation can negatively impact on clinical performance [8];
- Fatigue has also been linked to increased risk of medical errors [9] and motor vehicle accidents;
- A 2004 study by Landrigan et al. [10] was one of the first to measure the effects of sleep deprivation on medical errors. They found that interns working in the medical intensive unit and coronary care unit of Brigham and Women’s Hospital (Boston, United States) made substantially more serious mistakes when they worked frequent shifts of 24 hours or more than when they worked shorter
shifts. Other studies show that sleep deprivation can have similar symptoms to alcohol intoxication [11].

Stress and mental health problems
Students are also prone to stress caused by examinations, part-time work, family and workplace concerns.
- Strong evidence suggests physicians are prone to mental health problems [12], particularly depression, in their first postgraduate years as well as in later years. Students also suffer from stress and associated health problems that they carry with them when they start practising as doctors;
- While rates of depression and mental health problems among doctors are higher than those experienced by the general population, the literature shows that when interns and residents are supported by fellow house officers and senior clinicians, and are members of well-functioning teams, they are less likely to feel isolated and suffer stress;
- Performance is also affected by stress;
- There is strong evidence indicating that inadequate sleep contributes to stress and depression, rather than the number of hours worked;
- Other stressors identified in the literature include financial status, educational debt and term allocation and emotional pressures caused by demands from patients, time pressures and interference with social life.

Work environment and organization
Hospitals and clinics can be very stressful places to the newcomer. Unfamiliar work practices and rosters can make it very difficult in the early phase of a new workplace. In addition, long hours cause fatigue.

There are well-known situations such as change-overs of shift, shift work, nights, week ends and overtime that have been noted to have an association with increased errors. The factors underpinning these errors can range from lack of supervision to tiredness. Students should be extra vigilant during these times.

Supervision
Good supervision is essential for every student and the quality of the supervision will determine to a large extent how successfully a student integrates and adjusts to the hospital or clinical environment.
- The failure of senior clinicians to supervise or arrange adequate supervision for medical students and interns and residents makes them more vulnerable to making mistakes either by omission (failing to do something) or commission (doing the wrong thing).
- Students should always request supervision if it is the first time they are attempting a skill or procedure on a patient. They should also advise the patient that they are students and request their permission to proceed to treat them or perform the procedure.
- Poor interpersonal relationships between students, other health-care professionals, interns, residents and supervisors have also been identified as factors in errors. If a student is having a problem with a supervisor, they should seek help from another faculty member who may be able to mediate or help the student with techniques to improve the relationship.
- The literature also shows that students who have problems with inadequate skills acquisition also have poor supervision. Many health professionals have learnt a procedure while unsupervised and were judged by supervisors to have poor technique and inadequate mastering of procedures. Students should never perform a procedure on a patient without sufficient preparation and supervision.
Communication Topics
Communicating accurate information in a timely way between the multiple health workers (consultants, registrars, nurses, pharmacists, radiologists, medical records and laboratory personnel) is not easy, nor are there standard ways for communicating within hospitals. The role of good communication in the provision of quality health care and the role poor communication plays in substandard care are both well documented. How successfully patients are treated will often depend on informal communications among staff and their understanding of the workplace [13]. Treatment errors caused by miscommunication, absent or inadequate communication are well known and occur daily in hospitals. The quality of the communication between patients and other health professionals strongly correlates with treatment outcomes. Checklists, protocols and “care pathways” are effective for communicating patient care orders.

Keep accurate and complete medical records
A medical record is a term used for a document that stores the different kind and types of information about a patient. Students should be aware that good quality medical records are essential to the medical care and treatment of patients. Medical records will be subject to a number of government and hospital requirements in relation to who can have access to them, who can write in them and where they are stored and for how long.

Medicals students have an ethical and legal obligation to accurately record their observations and findings to ensure good patient care. When writing in the records, students should
- provide sufficient information to identify the patient to whom the record relates so that other members of the health-care team can continue caring for the patient;
- keep note down any information relevant to the patient’s diagnosis or treatment;
- notes about information or advice given to the patient by the student.

WHAT STUDENTS NEED TO DO (PERFORMANCE REQUIREMENTS)

Know how to report known risks or hazards in the workplace
Students should seek information on the incident reporting system used in the hospital where they are practising or placed. There will usually be a specific method for reporting—either an electronic or paper form. Students should be familiar with the system in place and seek information about how to report an incident.

Know when and how to ask for help from a supervisor, senior clinician or other health professional
Many medical students fear that if they admit to not knowing something that their teachers will think less of them. It is important for students to recognize the limitations caused by their lack of knowledge and the importance of seeking help or asking for information. Students should be clear about who they report to in the hospital or in the clinic. This person will be able to assist them if they get into a situation beyond their current knowledge and skills. It is essential that students ask for help even if they feel uncomfortable about doing so. Supervisors and senior clinicians do not expect medical students or junior doctors to have the depth of learning required to independently treat...
patients. They expect students to ask for help. Asking for help in unfamiliar environments can be a bit daunting for students, nonetheless they should still ask a senior health professional. Students need to be clear about who their supervisor is and when they are available. It is very difficult having a supervisor who is rarely in the hospital. If this is the case the student should seek out another appropriate person who is on the wards or in the clinic. This can be discussed with the supervisor so they are aware of the local arrangement.

**Participate in meetings that discuss risk management and patient safety**

It will not be obvious at first which risk management programmes exist in a particular hospital. Students can request from senior hospital management the risk management programmes in place and whether it is possible to attend a meeting to see how the system works to protect patients.

**Respond appropriately to patients and families after an adverse event**

Students will not be expected to accept responsibility for disclosing adverse events to patients or their families. If they are asked to do this they should immediately seek assistance from a faculty member or senior supervisor. Many places are now introducing open disclosure guidelines. It is vital that any open disclosure process is not rushed, is transparent and involves taking steps to make sure the same mistake does not happen again.

**Respond appropriately to complaints**

All students who are involved in a complaint should write a complete and factual statement about what happened. They should be honest about their role or actions but it is important to also minimize subjective or emotional statements.

**Summary**

Doctors are responsible for the clinical outcomes of their patients. One way for doctors to manage this is to identify areas prone to errors and adverse events. The proactive intervention of a systems approach to minimizing the opportunities for errors can prevent adverse events. Individuals can also maintain a safe clinical working environment by looking after their own health and responding appropriately to concerns from patients and colleagues.

**HOW TO TEACH THIS TOPIC**

**Teaching strategies/formats**

- **An interactive/didactic lecture**
  Use the accompanying slides as a guide, covering the whole topic. The slides can be PowerPoint or converted to overhead slides for a projector. Start the session with the case study and get the students to identify some of the issues presented in the story.

- **Panel discussions**
  Invite a panel of respected clinicians to give a summary of their efforts to improve patient safety. Students could also have a list of questions about adverse event prevention and management and have time scheduled for their questions. Experts on risk management outside health care may also be invited to talk generally about the principles.

- **A small group discussion session**
  The class can be divided up into small groups and three students in each group be asked to lead a discussion about one of the types of incidents described in Table 14. Another student can focus on the tools and techniques available to minimize opportunities for errors and another could look at the role of mortality and morbidity meetings.
The tutor facilitating this session should also be familiar with the content so information can be added about the local health system and clinical environment.

**Simulation exercises**

Different scenarios could be developed about adverse events and the techniques for minimizing the opportunities for errors such as

- practising the techniques of briefings, debriefings, and assertiveness to improve communication;
- role play using a “person approach” and then a “system approach” in a mortality and morbidity meetings;
- role play a situation in theatre where a medical student notices something is wrong and needs to speak up.

**Teaching activities**

*Administration, theatre and ward activities:*

- students can observe a risk management meeting;
- students could meet with the people who manage complaints for the hospital or clinic—part of the exercise would be to ask the hospital policy on complaints and what usually happens if a complaint is made;
- students could take part in an open disclosure process.

After these activities students should be asked to meet in pairs or small groups and discuss with a tutor or clinician what they observed and whether the features or techniques being observed were present or absent, and whether they were effective.

**CASE STUDIES**

*Inadequacy in orthopaedic surgeon’s practice management systems*

*Accurate and legible records are essential for maintaining continuity of care.*

Brian was being treated by a new specialist and needed his records from the orthopaedic surgeon who operated on his knee two years earlier. When the records finally arrived, Brian’s new doctor informed him that they were not “up to scratch”.

The records were poorly documented with no meaningful notes concerning the consent discussion for Brian’s operation. There were also gaps in the information recorded in the operation report and there was no documentation of the orthopaedic surgeon’s verbal advice about the risks and complications of the operation. Brian was dismayed to discover that the surgeon had not followed up on a missed postoperative review.

**Reference**


**Acknowledgment of medical error**

*This case shows the value of open disclosure.*

Frank is a resident of an aged care facility. One night, a nurse mistakenly gave Frank insulin, even though he does not have diabetes. The nurse immediately recognised his error and brought it the attention of the other staff, who in turn informed Frank and his family. The facility took immediate action to help Frank and arranged his transfer to a hospital where he was admitted and observed before being returned to the aged care facility. The nurse was commended for fully and immediately disclosing the incorrect administration of the insulin. Following this incident, the nurse undertook further training in medications to minimise the possibility of a similar error occurring.
General practice rooms not up to standard
This case shows the importance of complaints to improving health care.

When Denise visited her local medical practice, she was shocked to see that the practice was not as hygienic as she expected. It was so bad that she complained to the New South Wales Department of Health. A health inspector noted that Dettol was stored in a drink container, drugs were stored beyond their use-by date, there was no adrenaline in the surgery to treat a heart attack, patients at times had unsupervised access to the doctor’s medical bag containing injectable narcotics and a prescription pad, paper sheets on the examination table were not changed between patients and the doctor did not wash his hands following examinations. There were also no sinks in the consulting rooms.

The Health Care Complaints Commission recommended counselling by the New South Wales Medical Board and an on-site visit to advise the staff on Department of Health guidelines on infection control and make sure the appropriate steps had been taken to protect public health. Denise was glad to learn that the centre made improvements as a result of her complaint.

An impaired nurse
This case shows how health professionals need to maintain their fitness to practise.

During Alan’s operation, a nurse knowingly replaced the painkiller fentanyl, which was ordered to treat Alan, with water. This nurse placed Alan in physical jeopardy because of the nurse’s desperate need to obtain an opiate drug to satisfy his drug addiction.

This was not the first time that the nurse had stolen Schedule 8 drugs for the purposes of self-administering them. A number of complaints had been made about the nurse while working at a
private hospital including professional misconduct, impairment for drug addiction, lack of good character and that which rendered the nurse unfit to practice.

Reference

A junior doctor with bipolar disorder
The case shows how important it is to refer colleagues who are unwell and to protect patients from clinicians who behave unethically.

Irene was upset because her new doctor verbally abused her during the consultation at the hospital clinic. She asked for another doctor and made a complaint to the hospital administration. Irene’s complaint was just one of a number of complaints against the doctor including others concerning a refusal to treat a patient, making sexual advances to staff and patients and neglecting his own diabetes condition. He also refused to comply with psychiatric treatment suggestions. One year earlier, the doctor had been investigated for prescribing errors and sexual advances to patients. At that time, the doctor was reviewed and diagnosed with a long-standing bipolar (manic depressive) disorder. He had made undertakings in relation to treatment of his mental illness, which he was obviously not observing now.

Reference

TOOLS AND RESOURCES


**HOW TO ASSESS THIS TOPIC**

A range of assessment methods are suitable for this topic including observational reports, reflective statements about surgical errors, essays, MCQ paper, SBA, case-based discussion and self-assessment. Students can be encouraged to develop a portfolio approach to patient safety learning. The benefit of a portfolio approach is that at the end of the student’s medical training they will have a collection of all their patient safety activities. Students will be able to use this to assist job applications and their future careers.

The assessment of knowledge about clinical risk management is assessable using any of the following methods
- portfolio;
- case-based discussion;
- written observations about a risk management activity, such as an pen disclosure process or incident monitoring system;
- reflective statements (in particular) about
  - how complaints are managed at the hospital or clinic;
  - the systems in place for reporting health-care errors;
  - how clinicians learn from errors.

The assessment can be either formative or summative; rankings can range from
unsatisfactory to giving a mark. See the forms in Appendix 2 for assessment examples.

**HOW TO EVALUATE THIS TOPIC**

Evaluation is important in reviewing how a teaching session went and how improvements can be made. See the Teacher's Guide (Part A) for a summary of important evaluation principles.

**References**


**SLIDES FOR TOPIC 6: UNDERSTANDING AND MANAGING CLINICAL RISK**

Didactic lectures are not usually the best way to teach students about patient safety. If a lecture is being considered, it is a good idea to plan for student interaction and discussion during the lecture. Using a case study is one way to generate group discussion. Another way is to ask the students questions about different aspects of health care that will bring out the issues contained in this topic such as the blame culture, nature of error and how errors are managed in other industries.

The slides for topic 6 are designed to assist the teacher deliver the content of this topic. The slides can be changed to fit the local environment and culture. Teachers do not have to use all of the slides and it is best to tailor the slides to the areas being covered in the teaching session.