Introducing and Populating Risk Registers in Four Clinical Units in a Teaching Hospital – A Quality and Safety Initiative.

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Citation
Milliken S. Introducing and Populating Risk Registers in Four Clinical Units in a Teaching Hospital – A Quality and Safety Initiative. [MSc Thesis]. Dublin: Royal College of Surgeons in Ireland; 2014.
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A Dissertation submitted in part fulfilment of the degree Of MSc Leadership and Management Development, Institute of Leadership, Royal College of Surgeons in Ireland

2014
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MSc Leadership and Management Development


Student ID: 05005043
Submission Date: 14th May 2014
Word Count: 15,943
Facilitator: Mr Brett Lynam
Table of Contents

Table of Contents...........................................................................................................3
Abstract............................................................................................................................7
Acknowledgements.......................................................................................................8

Chapter 1: Introduction to the Dissertation..............................................................9
  1.1 Introduction...........................................................................................................9
  1.2 The Organisation and Context of Change.........................................................10
  1.3 Rationale............................................................................................................11
  1.4 Project Description, Aim and SMART Objectives...........................................14
      1.4.1 Project Description.....................................................................................14
      1.4.2 Project Aim...............................................................................................15
      1.4.3 SMART Objectives..................................................................................15
  1.5 Role of the Student in the Organisation and Project........................................16
  1.6 Remaining Chapters.........................................................................................17
  1.7 Conclusion.........................................................................................................17

Chapter 2: Literature Review....................................................................................18
  2.1 Introduction.......................................................................................................18
  2.2 Search Strategy................................................................................................18
  2.3 Adverse Events in Healthcare..........................................................................19
  2.4 Leadership.........................................................................................................21
  2.5 Safety Culture..................................................................................................26
  2.6 Communication...............................................................................................30
  2.7 Conclusion.......................................................................................................33
Chapter 3: Methodology...............................................................................................34

3.1 Introduction........................................................................................................34
3.2 HSE Change Model..........................................................................................34
3.3 Initiation............................................................................................................36
  3.3.1 Preparation..................................................................................................36
  3.3.2 Force Field and SWOT Analyses..............................................................37
  3.3.3 Audit of Compliance in Similar Sized Hospitals.......................................40
  3.3.4 Building the Project Team.........................................................................43
  3.3.5 Further Preparatory Work Over Christmas..............................................47
  3.3.6 Information and Communication Technology........................................47
3.4 Planning............................................................................................................48
  3.4.1 Preparation for the First Team Meeting..................................................48
  3.4.2 The First Team Meeting...........................................................................49
  3.4.3 Increasing Readiness and Capacity for Change.......................................51
  3.4.4 Momentum...............................................................................................53
  3.4.5 Plan for Implementation and Organisational Politics............................53
3.5 Implementation..................................................................................................54
  3.5.1 Risk Register Population.........................................................................55
3.6 Mainstreaming...................................................................................................57
  3.6.1 Embedding and Mainstreaming...............................................................57
3.7 Conclusion..........................................................................................................58

Chapter 4 Evaluation:..............................................................................................59

4.1 Introduction........................................................................................................59
4.2 Action Learning, PDSA Cycle and the Project Team......................................60
  4.2.1 PDSA Cycle..............................................................................................61
4.3 Workshops.........................................................................................................62
Table of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AS / NZS 31000: 2009 Risk Process</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>HSE Change Model</td>
<td>35</td>
</tr>
<tr>
<td>3</td>
<td>Force Field Analysis</td>
<td>38</td>
</tr>
<tr>
<td>4</td>
<td>Strengths, Weaknesses, Opportunities and Threats Analysis</td>
<td>39</td>
</tr>
<tr>
<td>5</td>
<td>Stakeholder Analysis</td>
<td>43</td>
</tr>
<tr>
<td>6</td>
<td>Project Team’s Knowledge / Experience of Risk Registers pre Implementation</td>
<td>63</td>
</tr>
<tr>
<td>7</td>
<td>Project Team’s Knowledge / Experience of Risk Registers post Implementation</td>
<td>63</td>
</tr>
<tr>
<td>8</td>
<td>Risk Register Questionnaire Results</td>
<td>68</td>
</tr>
<tr>
<td>9</td>
<td>Audit of Risk Register Comparison with 4 Similar Sized Hospitals</td>
<td>69</td>
</tr>
</tbody>
</table>
Abstract

Robust risk management is critical in reducing preventable errors or adverse events in healthcare. Risk register compilation is one component in the risk management process and allows for risks to be identified that pose a threat to an organisation meeting its objectives. The change project involved the introduction and population of risk registers in four clinical units in a teaching hospital. This led to further compliance with national healthcare policy on risk register implementation throughout the organisation and created a more visible risk profile. Using the Health Service Executive (HSE) Change Model risk registers were introduced by initiating, planning, implementing and mainstreaming the change project. Tools such as force field, Strengths, Weaknesses, Opportunities and Threats (SWOT) and stakeholder analyses were employed. A multidisciplinary project team was established and team meetings were held every two to three weeks until risk registers were introduced. The organisation’s risk register template was made available on the hospital intranet for each unit manager to build the risk register. Workshops were held at clinical unit level and also at senior staff monthly meetings to educate staff regarding risk identification, qualitative analysis and evaluation. Action learning and the Plan, Do, Study, Act cycle were used to achieve implementation. Audit of team members’ knowledge and experience of risk registers showed improved knowledge following the project as was the risk awareness and safety culture of staff following workshops. More time is needed to allow for embedding to occur and an organisational risk register policy would further support a multidisciplinary approach to hospital wide introduction.
Acknowledgements

Firstly I would like to thank my organisation for giving me the opportunity to partake in this programme and further my knowledge. Following on I would like to sincerely thank all of the staff at the Institute of Leadership, RCSI for their support and hard work over the last 2 years. I would like to convey my gratitude to Ms Sibéal Carolan and Mr Steve Pitman for all their support but also in particular my sincere thanks to Mr Brett Lynam, my ALS facilitator. I have such fond memories of our ALS days and this has been also widely on account of the wonderful peers with whom I shared those days, so many thanks and best wishes go out to you all.

I cannot forget the support shown to me by my sponsor, the project team members and all the staff who worked with me on this project, to each and every one, a sincere thankyou. Also I wish to acknowledge all my colleagues where I work who also have supported, advised and guided me at times when needed.

I wish to thank my mother sincerely for being so patient and understanding regarding my time constraint preventing me spending more time with her during these last 2 years and also thank my extended family and many friends for their kindness and support. To my son, Andrew, even though halfway across the world, your constant humour and assistance as always is fantastic, thankyou so much!

I dedicate this work to my late father, James, a keen advocate of education who from his hospital bed encouraged me to take this journey.
Chapter 1: Introduction to the Dissertation

1.1 Introduction

Delivering safe high quality care is critical in healthcare (Edozian, 2013). Given the global economic downturn in today’s world, healthcare leaders and indeed all healthcare professionals are challenged in providing and ensuring delivery of safe high quality yet cost effective healthcare to service users. However healthcare, by its very nature is a risky business (Holohan, 2014) therefore it is essential that risk management systems are in place to prevent the occurrence of adverse events, mishaps or errors (Crawford & Stein, 2004).

One component of a risk management system is the population of risk registers, this allows for identification of potential risks in order to mitigate against an adverse event occurring. Putting in place controls to reduce the likelihood and impact of an identified risk occurring will lead to a reduction in errors thus improving quality and safe care. The purpose of this change quality initiative is to introduce and populate risk registers in four multidisciplinary team clinical areas that are managed by nursing staff.
1.2 The Organisation and Context of the Change

The organisation is a major teaching hospital and employs approximately 3000 staff of many disciplines with varying levels of education and expertise. The hospital is also a centre for national referral of many specialties. The Mission Statement of the organisation includes ‘Quality’ as one of its main core values. In seeking to deliver care by the core value of ‘Quality’, the organisation strives to ensure all people within the organisation (service users, visitors and staff) are kept as safe and free from harm as is reasonably possible. Early in 2013 Joint Commission International (JCI) conducted a three year survey review and the hospital achieved JCI accreditation award status recognising the organisation’s adherence to JCI standards and high quality care provision.

There is an established risk management policy within the hospital. A reporting system is in place to record and evaluate near miss incidents and actual events through completion of a risk management occurrence form. Adverse events are monitored through Key Performance Indicator sets. This information is relayed on a monthly basis to the Quality Risk and Consumer Affairs (QRCA) department. A corporate risk register is established within the organisation and also one within the Executive Nursing Team, the Department of Pathology and Laboratory Medicine along with Allied Healthcare Professional Departments. Quarterly risk register reports are submitted to the Group Chief Executive Officer’s office via the risk advisory committee.
There is a need to develop risk register population in clinical areas managed by nursing staff as presently this gap in risk identification leads to a deficit of information on the risk profile of the organisation. This in turn prevents the organisation being able to truly assess and monitor all risks of high priority thus creating vulnerability to adverse event occurrence. Risk register population in these clinical areas is the closing loop of risk management within the organisation and is a national requirement led by the Quality and Patient Safety Directorate of the Health Service Executive (HSE) (HSE, 2009).

1.3 Rationale

Healthcare, like aviation, nuclear power generation, oil and gas, military and transport is a high risk industry (McElhinney and Heffernan, 2003), however while other safety critical organisations (SCO) are recognised for their safe procedures, adverse event rates in healthcare globally continue to be a leading cause of injury and death (Sheps & Cardiff, 2011). In fact the rate of error is reported to be far higher in healthcare than in other high risk industries (Natarajan, 2006) with statistics showing that between 4% and 16% of patients admitted to hospitals suffer an adverse event, half of which could have been prevented (Department of Health & Children (DOHC), 2008).

Public expectations and media coverage of breaches in professional conduct throughout the world have led to healthcare institutions having to put in place robust risk management systems to address the avoidable adverse error rate. When considering
the global economic downfall and the challenge this presents for healthcare organisations in providing a high quality and safe service it is all the more pertinent to address adverse event rates from a financial aspect also. Costs of increased lengths of stay in hospitals and litigation from serious harm caused by medical negligence are causing a stressful financial burden to healthcare providers around the world (Crawford & Stein, 2004; Storey & Buchanan, 2008).

Ireland is no different and has its own fair share of bad news stories. One of the most emotive reports is the case of Savita Halappanaver who died in an Irish hospital on 28th October 2012. The report into her untimely death identifies inadequate assessment and monitoring as Key Causal Factor 1(HSE, 2013a). Following swiftly on the heels of this report came the Chief Medical Officer’s report on perinatal deaths in Portlaoise Hospital (Holohan, 2014). Delay in recognising clinically significant deterioration of patients’ conditions, particularly foetal distress with poor clinical decisions and failure to escalate care were identified as causative factors in devastating outcomes. It is reported that the HSE itself failed to have ‘external oversight’ regarding the weak systems of clinical governance within Portlaoise Hospital (Holohan, 2014) as the breast cancer misdiagnosis errors occurred within the same time frame resulting in the suspension of the breast cancer services in Portlaoise Hospital (O’Doherty, 2008). Other inquiries that rocked the nation and damaged the reputation of Irish healthcare include the Leas Cross Nursing Home investigation (Department of Health (DOH), 2009) in which case the nursing home was ultimately closed down on account of such poor practice and lack of safety and of course the report of the 58,000 unreported X-rays leading to delayed
diagnosis in the Adelaide and Meath Hospital, Dublin, incorporating the National Children’s Hospital (Tallaght Hospital) (HSE, 2010b).

Any wonder there is an increasing focus on ensuring that ‘quality’, ‘safe care’ and ‘risk management’ are embedded in the culture and practice of healthcare organisations in Ireland. The National Service Plan (NSP) (HSE, 2014) published by the Directorate of the Health Service states at the very outset the commitment of the Irish Health Department to the provision of a high quality and safe delivery of care to the people of Ireland. The HSE has established a policy for the management of risk and published guidelines ‘Developing and Populating a Risk Register’ (2009). Health, Information and Quality Authority (HIQA), in their publication of National Standards for Safer, Better Healthcare (2012) address the importance of risk identification and management. Risk management is integral to providing safe high quality care and risk register population is part of this process.

Strong external driving forces are pushing the absolute necessity for healthcare organisations to demonstrate risk management processes and policies are in place. Regulatory bodies such as the Irish Medical Council, The Nursing and Midwifery Board of Ireland, the Irish Medicines Board and the Radiological Protection Institute of Ireland lend further credence to the urgency for risk management respect and awareness in order to improve the delivery of safe, high quality care. The organisation of the writer is
obliged to introduce risk register population throughout to evidence comprehensive evaluation of potential harm.

1.4 Project Description, Aim and SMART Objectives

1.4.1 Project Description

The project involved the development of a multidisciplinary risk register project team. The writer chaired the team meetings to drive and lead the introduction and population of risk registers in four clinical areas of the hospital which are managed by Clinical Nurse Managers (CNM). These CNMs (including the writer) are members of the risk register project team along with other invited multidisciplinary professionals. Terms of Reference were agreed amongst the project team and team meetings took place every two to three weeks until implementation of risk registers in the clinical areas had been achieved.

Workshops were held by the writer at clinical areas to support each CNM in introducing risk registers as a regular item on agendas of monthly multidisciplinary team (MDT) meetings. The clinical risk register template was developed further and made available to the CNMs on the hospital’s intranet therefore access to download the template and commence risk register compilation at clinical area was afforded. A process for escalation of identified risks requiring added controls outside the remit of the MDT of the
clinical area was developed. Risk identification, assessing, monitoring and review processes were established to reduce the likelihood or impact of an adverse event occurring thus allowing the organisation to further comply with the HSE policy on risk management, JCI Patient Safety Goals and meet HIQA standards.

1.4.2 Project Aim

To introduce and populate risk registers in four clinical areas of the hospital which are managed by nursing staff.

1.4.3 Objectives

- To increase patient safety awareness amongst staff.
- To develop a positive safety culture within the 4 clinical units.
- To develop staff knowledge in risk identification, analysis, evaluation and treatment through workshops, using the risk register template on the hospital intranet for departmental risk register compilation.
- To improve organisational compliance with national policy on risk register population and development.
- To achieve equal status with other similarly sized hospitals on risk register implementation in clinical units.
- To prepare a draft policy on risk assessment and the management of risk registers within the organisation.
1.5 Role of the Student in the Organisation and Project

The student is the clinical nurse manager of the interventional cardiology department within the organisation. The student came to the organisation in 1991 to develop and open the then new cardiac catheterisation laboratory. Over the years there have been many developments in interventional cardiology from technology advancements to new procedures. Interventional cardiology carries its own risks and the patient cohort can be acute, unstable and critically unwell therefore the student is all too aware of the need for speedy but safe, high quality care delivered by a highly trained and collaborative multidisciplinary team within the department.

The role of the student within the project is to lead out on the introduction and management of risk registers in the four identified multidisciplinary clinical areas managed by CNMs. The student must ensure the aim and objectives of the organisational development project are met. A further role will be to engage and bring together multidisciplinary professionals, who may be new to each other, to form the risk register project team so that the project will be both enjoyable and successful for all. Finally, through education the student will heighten awareness of staff throughout the hospital in the value of risk awareness, relevance to patient and staff care, organisational reputation and financial benefit.
1.6 Remaining Chapters

Chapter 2 will consist of a systematic review and critique of relevant literature to the project topic area where the writer will explore three common strands appearing throughout the literature. Chapter 3 will take the reader through the methodology of the project implementation using the HSE Model for Change. Evaluation of the project will be described in Chapter 4 linking results to the stated objectives in Chapter 1. Finally, Chapter 5 will provide a discussion of the experience of the writer in implementing the change project, the impact the project has had on the organisation whilst making linkage and reference to previous chapters. Personal reflections on the experience of the project implementation (both successes and challenges) will be conveyed within this chapter also along with recommendations for future improvements for healthcare delivery.

1.7 Conclusion

Safety in healthcare is a real concern around the world. Healthcare organisations are required to demonstrate risk management policies and processes are in place. The HSE operates a national policy to ensure an integrated risk management process is in place so that key risks are identified, assessed, reviewed and monitored (HSE, 2009). To fully comply with HSE policy on risk management the organisation of the writer must introduce risk register population and management in clinical areas managed by nursing staff. This is the change management project assigned to the writer.
Chapter 2: Literature Review

2.1 Introduction

This Chapter will provide a literature review of the subject area. A search strategy will be provided followed by background review of global adverse event rates in healthcare and the ensuing costs of litigation. The role of leadership in risk management and the impact organisational safety culture has on adverse event rates will be explored through the literature review. Communication is vital to the success of improved patient safety outcomes and will be evidenced through the literature review. The chapter will close with a conclusion of the literature review.

2.2 Search Strategy

It is reported that the origins of risk identification stem from gambling back as far as the 1600s (Mobey & Parker, 2002), however the writer set a parameter of reviewing literature since the year 2000 forward; apart from that of the Institute of Medicine’s document ‘To Err is Human’ (Kohn et al, 1999). Search engines such as CINAHL, PUBMED, Science Direct and Emerald were utilised although Emerald provided the lion’s share of information. Google and Google Scholar were also employed. References provided within publications, government documents and health care investigations and inquiries were explored as certain works appeared time and again despite the passage of time. Government documents and reports of national interest in
healthcare inquiries were extensively reviewed with a global approach although mainly from Ireland and the United Kingdom (UK). Search terms used included ‘risk management’, ‘risk register’, ‘adverse events’, ‘quality AND patient safety’, ‘safety culture’, leadership AND patient safety’, ‘medical negligence AND litigation’, ‘engagement, teamwork AND risk policy’. English was chosen in all literature, hundreds of articles were examined, greater than 50 articles were chosen based on their relevance to the subject and being within the date parameter.

2.3 Adverse Events in Healthcare

As far back as the 1990’s concerns in the United States of America were being expressed regarding the rate of medical errors in healthcare leading to long term injury and death of patients. The Institute of Medicine’s report ‘To Err Is Human’ (Kohn et al, 1999) estimated that as many as 98,000 Americans die each year due to medical error with total national costs of $50 billion on account of adverse events. To address the issue of preventable error and risk management The Quality in Healthcare in America Committee of the Institute of Medicine (IOM) recommended the implementation of internal control measures to safeguard against the likelihood of errors occurring.

Adverse event rates in healthcare across the globe report unacceptably high levels. In a landmark report , An Organisation with a Memory, (DOH, 2000) the Department of
Health in the UK reported adverse event rates causing harm to be estimated in the region of 10% of hospital admissions – or 850,000 people annually. Apart from the human toll, the financial cost to the health service is estimated to be £400 million on account of additional hospital stay. Williams & Smart (2010) concur with these statistics citing 10.8% adverse event rates in two National Health Service (NHS) hospitals with prolonged hospitalisations increasing mean length of stay by 8 days.

Similar to the horrific cases of poor quality care in the Irish healthcare system outlined in the Rationale of Section 1, the English healthcare system was equally disturbed by the scandals and inquiries of the Bristol Royal Infirmary (2001) where the incidence of paediatric mortality post cardiac surgery exceeded national norms and the Harold Shipman case of unlawful killing of hundreds of elderly people in a primary care trust (The Shipman Inquiry, 2002). Perhaps the most damning and recent report of adverse event causing harm and death in the NHS has to be the Mid Staffordshire NHS Foundation Trust Public Inquiry or ‘Francis Report’ (2013) where, to quote Robert Francis in his forward to the UK Secretary of State,

‘the story it tells is first and foremost of appalling suffering of many patients’ (pp:3).

The Canadian health care system experienced a similar situation in Winnipeg in 1994 when children died during or following heart surgery (Gillies & Howard, 2005). The Australian Council for Safety and Quality in Health Care (ACSQHC) published a report
in 2002 on adverse events in Obstetrics and Gynaecological services in a Western Australian hospital where one or more clinical errors occurred in more than 47% of cases with 50% of these being very serious (Gillies & Howard, 2005). The most recent report from the ACSQHC (2013) states that up to 1.5 million Australians suffer harm each year due to taking a medicine, adverse event rates in hospitals surprisingly appear to remain unchanged over the previous decade (Sheps & Cardiff, 2011). Abrahamson et al (2013) go so far as to say healthcare is lagging behind other safety critical organisations in error reduction suggesting the reason being that healthcare works off a singularly skilled 'heroic practitioner' approach to safety. Both Härenstam et al (2009) and Nielsen et al (2013) concur with this thinking that leadership and leadership style are critical to the success of safety performance and risk management in safety critical industries.

2.4 Leadership

Leadership has been recognised as central to effecting change (DOH, 2011a). In healthcare the heroic leadership style of yesteryear has lost its place in today’s world and a more shared or distributed leadership style is sought involving clinicians and managers working together. The desire of this being that there is leadership throughout the health service, top down and bottom up. Hay Group (2011) concurs with this thinking, heroic leadership has no place in progressing quality care. Followers are now leaders and vice versa depending on the skills, knowledge and roles of the individuals in
the moment, and good followers contribute to the effectiveness of the leader (Avolio et al, 2009; Grint & Holt, 2011).

Although risk register maintenance and management is recognised for being the role of the local manager (HSE, 2009, HSE, 2011a, Savage, 2013), it takes effective leadership to introduce this concept and embed it in practice. It is an integrated practice that requires commitment at every level of the organisation to embrace and support its success in implementation, both bottom up and top down (McElhinny & Heffernan, 2003). Currently in Ireland, the HSE guidance on populating risk registers is in accordance with the Australian / New Zealand (AS / NZS) 4360:2004 Risk Management Standard. There is however a revised version, the AS / NZS 31000:2009 (Joint Technical Committee 03 – 007, Risk Management, 2010) outlining the need to develop an ‘Enterprise – wide Risk Management Framework’. This further confirms the value for shared leadership across organisations to ensure effective risk management. Senior executives, middle and line managers along with each individual are all accountable for patient safety and indeed safety of their staff.

While the HSE acknowledges that risk is identified and captured from line management level or ‘bottom up’, risk escalation procedures and serious incident management guidelines for National Directors (HSE, 2010a) are also in place demonstrating the top down responsibility to risk management. This is demonstrated in figure 1 extracted from AS / NZS Standard 31000:2009.
The National Service Plan (HSE, 2014) addresses quality and patient safety outlining once more the accountability of front line staff right up to national directors for the delivery of a safe and reliable service. HIQA (2012) through Theme 3, ‘Safe Care and Support’, and Theme 5, ‘Leadership, Governance and Management’ set out their standards of the role of service providers; and the line of accountability in the provision of safe care is clearly stated. Future Health (DOH, 2012b) identifies the need for effective risk management processes to be developed but leadership development also is required, both at clinical and strategic level to ensure delivery of a safe, high quality service.
The UK has taken similar approaches to leadership development recognising its vital role in ensuring safe care delivery and effective risk management. Since the Bristol Inquiry there was renewed attention on the provision of quality care as part of the UK’s NHS modernisation. Clinical governance was developed and seen as central to reducing adverse healthcare event rates (DOH, 2000). Publications on guidance for risk register population and conducting risk assessments in the UK clearly refer to the absolute necessity for leadership development at every level to ensure effective risk register management (Hulme, 2002; Savage, 2013).

The development of the NHS Leadership Framework (DOH, 2011b) is applicable to all staff regardless of their position or discipline in the healthcare service, the vision being that leadership would be everyone’s responsibility, shared and distributed for the benefit of the service and that high quality and safe care is assured to all. Savage (2013) recommends mandatory training in risk management on induction to promote leadership at every level and advises that risk registers should be on the agenda for all staff meetings. In High Quality Care for All (DOH, 2008) Lord Darzi communicated his vision for senior clinical leadership within the NHS outlining the benefits this would bring to improving quality of care, while at the same time addressing the fact that all staff are responsible for safety. Clarke (2012) concurs with this and goes further with reference to medical leadership and engagement in that it is not just an NHS aspiration, but a global one.
Leadership theory and models have been much examined over the last 20 years and reviewing them in the context of risk management is no different. Nielsen et al (2013) report that staff working in safety critical organisations benefit from different leadership styles. Supervisory leadership can allay staff concerns regarding their safety and lead to improved job satisfaction. Contingency style leadership can reduce the impact of something going wrong by being aware of changes that may affect the organisations ability to meet its objectives (Simpkins, 2009). Safety specific transformational leadership style has been found to reduce occupational injury.

Transformational leadership is central to effecting organisational change such as risk management development (Parker & Mobey, 2004). The Health Foundation (2011) had similar findings in that patient safety also was improved where there were transformational leaders. Through developing effective working relationships with their staff and promoting a safety climate, authentic leaders create followers. However conversely risk management can actually curtail innovation and organisational change by the presence of strict policies and controls. Borgelt & Falk (2007) suggest that leaders need to develop a knowledgeable workforce in order that an equilibrium is established which allows for risk to be taken safely. The benefits of training and educating staff at every level in risk identification and risk register development is well recognised (Hulme, 2002; Savage, 2013).
Interestingly, Casserly & Critchley (2010) suggest a paradigm shift in leadership development is required to one of ‘sustainable leadership’. That leaders’ physical and psychological health contributes to effective performance and organisational success. The notion that self-care, knowing oneself, along with reflecting on practice and being psychologically aware are crucial to sustaining not just the leader, but also in developing a sustainable organisation. However, when organisations are penalised financially for not meeting healthcare targets, the focus of patient safety is not the priority and neither is the well-being of the staff. A negative culture is in itself a risk to the organisation as high stress levels, burn out and fatigue leads to poor decisions, errors and adverse event occurrence.

### 2.5 Safety Culture

Effective leadership and a positive organisational safety culture go hand in hand but even the most stalwart of leaders can find implementing change to be a huge challenge if the culture of the organisation is not conducive. Organisational culture is defined as ‘that which is shared between colleagues in an organisation, including shared beliefs, attitudes and norms of behaviour’, or in other words, ‘the way things are done around here’ (Davies et al., 2000). Characteristics of positive safety culture include openness, trust, communication and a common perception of the importance of safety (DOHC, 2008). The Health Foundation (2011) concur with this thinking and add that safety climate, a subset of safety culture describes patient safety attitudes of staff, however
safety culture and safety climate can be used to describe either term. What is reported is that there is a 15% increase in patient length of stay with every 10% decrease in safety climate (The Health Foundation, 2011).

In the UK awareness of safety culture came about with the publication of ‘An organisation with a memory’ (DOH, 2000). Lack of learning from mistakes was highlighted as one factor contributing to repeated patient safety incidents. This was found to be due to the culture of blame that pervaded the health care service. Reporting adverse events was not encouraged, cover up of errors and a culture of nondisclosure existed through the health service hence no learning took place. The National Patient Safety Agency (NPSA) (NPSA, 2004) in developing ‘seven steps to safety’ acknowledged the relevance of positive safety culture in reducing adverse events and harm to patients by prioritising the development of building a safety culture as Step 1. The NPSA concur with the DOH (2000) that the reporting of events and development of a safety culture that is open and fair is critical to reducing incidents of harm.

Promoting a culture of no blame encourages sharing of information which also contributes to reducing patient safety incidents. In further recognition of the importance of promoting safety culture and educating staff regarding same, the NPSA endorsed the Manchester Patient Safety Framework (MaPSaF) (NHS, 2006) as a learning tool for healthcare teams to assess the development of a safety culture within their organisations. In Ireland the Quality and Patient Safety Directorate of the HSE
published the ‘National Policy on Open Disclosure’ (HSE, 2013b). The policy is supported by professional regulatory bodies such as the Irish Medical Council and the Nursing and Midwifery Board of Ireland in their Codes of Professional Conduct and Ethics and aims to demonstrate top down the importance of developing a culture of no blame in order that patient safety incidents will be dealt with in an open and fair manner.

Crawford & Stein (2005) acknowledge how difficult it is to achieve change in culture and the UK and Ireland are not alone in experiencing this. Council of Europe Committee Ministers (Council of Europe, 2006) in considering that ‘access to safe health care is the basic right of every citizen in all member states’ recommended that all governments promote a culture of safety at every level of healthcare and ensure that safety is central to quality policy developments. In describing a patient safety culture improvement approach in five Belgium hospitals the establishment of a patient safety committee that would lead out on promoting patient safety awareness was identified as critical to promoting a patient safety culture (Hellings et al, 2010).

Education of staff and involvement of senior professionals is essential in leading and promoting a culture of patient safety throughout an organisation. Abrahamson et al (2013) reported perception of safety climate to be increased in units where there were nurses with further education, registered nurses and consistency of experienced staff present. There is no doubt that promoting a ‘no blame’ culture is considered to be a

However in a study reviewing the effectiveness of a training programme to change staff attitudes and culture on safety, Harvey et al (2001) found that more than one safety culture can exist in an organisation with different attitudes to safety between floor staff and managers which in turn can curtail development of a blame free culture. Williams and Smart (2010) allude to this concept in referring to the different priorities corporate governance and clinical governance have in viewing what is risk. With a focus on finance and targets, the higher authority or top down (macro level) can negatively impact patient safety by demanding an organisational culture that meets their corporate objectives rather than organisational ones, losing sight of patient safety as a risk priority. This was all too clear in the case of the Mid Staffordshire Public Inquiry (Francis, 2013) into the failings of patient care and as Robert Francis QC identified there was ‘a culture of doing the system’s business – not that of the patients’ (Francis, 2013, pp:4) but Francis (2013, pp:4) also identified ‘a failure of communication between the many agencies to share their knowledge of concern’.

Developing a culture of quality, knowledge sharing and risk management takes patience and time (Jones, 2005; Trerise, 2010) and really does require commitment top down and bottom up in developing trust, openness and frank communication. With this in mind Walston et al (2010) agree that a positive safety climate leads to improved patient
outcome but also suggest that communication is key to improving safety. Culture affects the flow of communication which in turn impacts on patient safety and risk of adverse event occurrence.

### 2.6 Communication

Prioritising risks is central to risk management and communication is central in this process. Information and knowledge sharing within and between departments and indeed organisations allows for identification of risk and risk mitigation (Williams et al, 2006). The HSE Final Report (HSE, 2013a, pp:79) identified poor communication (in the form of handover reports) between disciplines as a contributing factor in the death of Savita Halappanaver and also identified poor quality documentation as an incidental factor (HSE 2013a, pp:81). Holohan (2014, pp:48 & pp:68) also reported poor communication, documentation and clinical handover in contributing to negative outcomes for patients. Francis (2013, pp: 25) makes reference to lack of learning from previous inquiries and reports, with similar negative patient safety outcomes as a concern going forward. Even prior to this the UK Government response to the recommendations of the Shipman Inquiry’s Fifth Report in 2007, highlighted then the concerns regarding the lack of learning and information sharing throughout the NHS as the Neale, Ayling and Kerr / Haslam abuse cases were published (DOH, 2007). Sharing of experience and information regarding patient care and safety incidents just does not seem to happen leading to repeat error.
Much of the literature alludes to this, Rhee (2008) suggests that leaders are critical in encouraging organisational risk communication but all too often risk is managed in department silos and not shared across an organisation (Sheps & Cardiff, 2011). Opportunity for organisational learning is lost through independent departmental silo risk management yet a collective understanding of organisational risk leads to development of an organisational wide risk identification portfolio. Ensuring risk registers are available on organisational intranet sites would allow for risk registers to be available to all staff in all departments and is recommended (Savage, 2013). Certainly organisations should have software to support risk register information sharing across all areas to facilitate knowledge sharing and learning (Hulme, 2002). Risk portfolios allow commonalities and links between departments to be found which in turn aids in assessment of organisational risk exposure (Loosemore, 2010).

Edozien (2013) supports this thinking in that learning from mistakes is critical but admits it takes effort. Ensuring escalation and reporting of identified risks which prevent an organisation from meeting its aims and objectives is critical to reducing adverse events and all policies reviewed have outlined an escalation pathway (Hulme, 2002; HSE, 2009; Savage, 2013). Knowledge must be shared but to do so a learning environment must be nurtured and communication encouraged in order that change can occur from that learning. Goh et al (2011) agree that learning from mistakes is critical to reducing adverse event rates but recognise that collaborative teamwork with effective communication is central to risk reduction.
In reviewing how to improve safety culture in 5 Belgian hospitals Hellings et al (2010) found open communication and teamwork both within and across departments critical to improving safety culture. Alhatmi (2011) also found that development of effective communication is crucial to improving patient safety outcomes. Both Fraser & Henry (2007) and Loosemore (2010) suggest the value of risk identification and assessment through workshops. This method of dialogue facilitates understanding between disciplines but only if there is freedom of open communication. Hulme (2002) concurs with this notion that workshops are vital to developing risk register population skills and improving safety awareness. JCI (2014, pp: 141) also stress the importance of effective communication and training of staff in the identification and management of risk in order that quality and patient safety remains on the organisational radar as a priority.

The development of effective communication and sharing of information is well documented by HIQA (2012) in National Standards for Safer Better Healthcare and also the NHS Leadership Framework (DOH, 2011b). The purpose of the HSE National Policy on Open Disclosure (HSE, 2013b) is to ensure timely and open communication with service users and their families following an adverse event. Leadership communication skills are critical to supporting a positive patient safety culture that in turn promotes interaction and collaborative participation of staff in patient safety initiatives and improving patient safety outcomes (Goh et al, 2013).
2.7 Conclusion

Robust risk management processes are required in healthcare in order that risk identification and analysis can be achieved to prevent and reduce the incidence of error. Risk registers are integral in this process in that early identification and sharing of knowledge supports organisational risk profile priority. Adverse event rates are unacceptably high in healthcare throughout the world. In all of the reports and inquiries into adverse events reviewed, each one reported poor leadership skills, negative organisational culture and ineffective communication to be factors contributing to poor quality care. One critical success factor is hinged on the presence of the next and all are intertwined. Without effective leadership or a just culture or effective open communication, errors and loss of life will continue to occur as lessons will not be learnt. What is clear is that risk management and risk register population are the responsibility of all, top down and bottom up, from ‘sharp enders’ or frontline clinical staff to the ‘blunt end’ or governance level (Sheps & Cardiff, 2011; Edozien, 2013).
Chapter 3: Methodology

3.1 Introduction

This chapter will provide an overview of the methodology and change methods used as part of the organisational development (OD) conducted by the writer. The reader will be guided through the OD by application of the 4 stages of the HSE Change Model. These include Initiation, Planning, Implementing and Mainstreaming. To commence, a short review of the HSE Change Model will be provided supporting the rationale for choosing the HSE Change Model as the most suitable model for this OD.

3.2 HSE Change Model

It is said that implementing change is never easy and indeed Kotter (2007) reports that 50% of companies he has observed fail in the early stage. Young (2009) also reports failure rates as high as 70% in introducing change initiatives. The HSE Change Model was designed specifically to be used in the healthcare context and indeed most particularly the Irish healthcare context which is currently experiencing unprecedented change. By providing a consistent approach to implementing change across the entire healthcare system the model can be applied by leaders and managers throughout, from national level to area and local level (HSE, 2008, pp:5). This supports change
implementation on a wide scale and allows for familiarity with the model across the healthcare sector. Throughout the HSE Change Model it is evident that teamwork is essential to success and this will be demonstrated in the project throughout the chapter as the change methodology unfolds. Building commitment and engaging colleagues is crucial. Overall the model is based on an organisation development approach hence the model fits well with the assigned project.

Figure 2: HSE Change Model
3.3 Initiation

The initiation stage of the HSE Model is the time at which preparation to lead the change is developed. Identifying the need to change and the drivers for this change are key to providing a sound foundation for a successful change initiative. By assessing the degree of urgency and readiness for change whilst identifying key stakeholders and influencers, an initial assessment of the impact of the change can be completed followed by an outline of objectives and outcomes of the change with agreed resource requirements. Investing in this stage is critical and provides for the outline of a business case for change (HSE, 2008, pp:20).

3.3.1 Preparation

In reality preparing to lead the change took time. It was late November 2013 by the time progress had been made and a direction established regarding the subject of the change to be implemented. This was due to a paradigm change in the proposed change project to be implemented. Communication and stakeholder engagement cannot be over emphasised (Kotter, 2007; Boesso & Kumar, 2009) and as the writer was being advised regarding the change subject it was vital that the senior stakeholders and influencers were and are active supporters of the project otherwise the project would be doomed to fail (Kotter, 2007).
A business plan on the population and introduction of risk registers was submitted to the Executive Nursing Team on 2\textsuperscript{nd} December 2013, this was later developed into the Project Initiation Document. With the support of the line manager, agreement was reached to implement risk registers in 4 clinical areas managed by nurses with an MDT approach rather than the entire organisation as originally considered. Mandate for the OD was agreed, a vision was in sight and a sponsorship form signed off. Resource need was discussed and acknowledged. Ethical approval was not required (Appendix 1). Advice was afforded to the now established project leader regarding the development of a multidisciplinary project team.

### 3.3.2 Force Field and SWOT Analyses

Through the development of the business plan each point on the Initiation stage of the HSE Change Model was addressed. A force field analysis was completed identifying the driving forces for and resisting forces against the OD. Force field analysis was developed by Kurt Lewin in recognising that for change to occur the driving forces for change must outweigh the resisting forces to maintain the status quo (Hardiman, 2010, pp:237 – 238). Force field analysis evidenced the external factors at play in driving the absolute need to implement the OD, in particular the need for further compliance with national policy on risk register population, along with the need to meet accreditation standards. Points on a scale of 1 – 5 were awarded to each identified force and the total assessed as to whether the driving forces did indeed outweigh the resisting forces (shown as Figure 3).
Figure 3: Force Field Analysis

Population and Implementation of Risk Registers in Clinical Areas Managed by Nursing Staff

<table>
<thead>
<tr>
<th>POSITIVE FORCES (+)</th>
<th>NEGATIVE FORCES (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSE Policy on Populating Risk Registers 5</td>
<td>Change fatigue 2</td>
</tr>
<tr>
<td>JCI Standards 5</td>
<td>Knowledge deficit 2</td>
</tr>
<tr>
<td>HIQA Safety Standards 5</td>
<td>Lack of interest 2</td>
</tr>
<tr>
<td>National healthcare reports and Inquiries 5</td>
<td>Culture (attitudes toward risk registers) 4</td>
</tr>
<tr>
<td>International healthcare inquiries 4</td>
<td>Time constraint 5</td>
</tr>
<tr>
<td>Organisational Policy, Procedures and Guidelines 5</td>
<td>Decreased staff level 4</td>
</tr>
<tr>
<td>Total score = 29</td>
<td>Total score = 19</td>
</tr>
</tbody>
</table>

In further support for the business plan and to aid in identifying areas for action a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis (shown as Figure 4) was also performed by considering internal factors such as strengths and
weaknesses whilst simultaneously looking at external factors such as opportunities and threats (McAuliffe & Van Vaerenbergh, 2006).

**Figure 4: Strengths, Weaknesses, Opportunities and Threats Analysis**

<table>
<thead>
<tr>
<th>Internal</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged and committed champions</td>
<td>Knowledge Deficit</td>
</tr>
<tr>
<td>Focus Group / Project Team</td>
<td>Resistance</td>
</tr>
<tr>
<td>Mission Statement of Organisation</td>
<td>Time Constraint</td>
</tr>
<tr>
<td>Support of Senior Management</td>
<td>Change Fatigue</td>
</tr>
<tr>
<td>Workshops and Educational Support</td>
<td>Attitudes and Beliefs of Staff (Culture)</td>
</tr>
<tr>
<td>Organisational Risk Management Policy</td>
<td></td>
</tr>
<tr>
<td>External Drivers</td>
<td></td>
</tr>
<tr>
<td>i) HSE Policy</td>
<td></td>
</tr>
<tr>
<td>ii) HIQA</td>
<td></td>
</tr>
<tr>
<td>iii) JCI Standards</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
<tr>
<td>Compliance with HSE Policy</td>
<td>Change in National Policy</td>
</tr>
<tr>
<td>Meeting JCI Standards</td>
<td>External Reports / Inquiries</td>
</tr>
<tr>
<td>Meeting HIQA Standards</td>
<td>Media / Publicity</td>
</tr>
<tr>
<td>Enhanced organisational reputation</td>
<td></td>
</tr>
</tbody>
</table>

39
3.3.3 Audit of Compliance in Similar Sized Hospitals

The writer contacted risk managers in 4 other similarly sized hospitals by phone in order to assess their progress on compliance with risk register implementation. The writer is not a risk manager and without specific training in risk management it was considered that while the benefits of an internal agent are familiarity with the organisation and its culture, a barrier to successful implementation could be the stakeholders opinion of the project leader’s lack of expertise in the matter of risk registers leading to resistance (McAuliffe & Van Vaerenbergh, 2006, pp:63). Following introduction and explanation of why the writer was phoning, 5 questions were asked.

- Do you have risk registers implemented within clinical areas managed by nurses in your organisation?
- Who is / was responsible for ensuring their introduction?
- What education is afforded to staff and by whom?
- What is the process of escalation of a priority risk identified?
- How often is the risk register reviewed?

Responses were consistent throughout the hospitals in that risk registers are wholly or partly introduced, but most certainly on the corporate radar for organisational wide introduction. By contacting other organisations it was evident that education was a vital aspect in ensuring implementation and also that success hinged on buy-in by all stakeholders (Kotter & Schlesinger, 2008).
Hospital 1 stated,

‘we have a corporate risk register in place and reporting takes place on a quarterly basis…risk registers are in place in one or two units but we have recently changed our management structure and they will be introduced through the Directorates by the risk manager….we have a process flow chart in place….CNMs will report to their Directorate leads and urgent risks will be communicated to the Executive Management Board and risk register manager immediately’.

Hospital 2 stated,

‘Yes, we have risk registers established. We have a Directorate structure in place led by an assistant director of nursing, a clinical director and a business director. Each Directorate has its own health and safety committee who are responsible for implementation of risk registers…new risks are flagged to the risk manager… risks highlighted are brought to the Board of Management’s attention through the monthly tabled meeting…we have a blank template… I suggest you conduct a pilot study first of implementation…if you need any help phone me again, it’s no problem’
Hospital 3 stated,

‘We have risk registers in some areas but we are changing our governance structure to one of Directorates…we held off complete implementation as we were awaiting the HSE electronic tool…we are commencing education and training of directorate leads who will be responsible for implementing risk registers in their areas…a Directorate spreadsheet with a score greater than 12 is escalated to the Executive Management Team, a score greater than 15 is escalated to the HSE via the Chief Executive Officer…there is quarterly reporting and immediate reporting of an urgent risk by the CNM to directorate leads’.

Hospital 4 stated,

‘Yes, we have risk registers in place, we operate through a Directorate governance system…the Directorate leads are responsible for implementation of risk registers within their areas…identified high score risks are escalated to the Board of Management through the Directorate leads…it takes a lot of time for this to embed and for people to accept it as it does add work to already busy areas…good luck with it anyway.’
3.3.4 Building the Project Team

With the drivers for change and the degree of urgency identified, a stakeholder analysis was completed to assess key people to contact and inform in order to gain support for the project (shown as Figure 5).

Figure 5: Stakeholder Analysis
A project team needed to be established and it is these invited people who would be key stakeholders toward the success of the project. However there are other critical stakeholders who are not project team members and they also require careful management, such as the multidisciplinary teams who would be developing the risk registers but also senior executive staff whose support for the project was critical (Loosemore, 2010).

The QRCA director was contacted and informed of the project. Representation of a QRCA manager on the project team was sought. The manager was contacted and invited to be a project team member, this was accepted. The manager had considerable experience and knowledge in risk register introduction as much work had been done before within the organisation in trying to implement risk registers across clinical areas previously. Having a chief memory officer on board would be invaluable in advising the project team of previously identified barriers to implementation (Abrahamson, 2000).

An appointment was made with the Clinical Services Manager to garner support from a multidisciplinary aspect. Much support once more was afforded to the writer and recommendation for an Allied Healthcare Professional (AHP) manager was made. This manager was then contacted and invited to join the project team, the invitation was accepted. A medical consultant also accepted the invitation to be a team member. The difficulties in engaging doctors in the management of healthcare services are well documented and yet they are seen to be central to reforming services and improving
quality and safety (Fulop, 2012). The team was developing and ‘little wins’ were welcome (Kotter, 2007).

Following this, the writer contacted the 3 CNMs of each of the identified clinical areas (the fourth area included that of the writer) and then visited the CNMs in their units to cordially invite them to be project team members, meeting them face to face. It was considered that these people would be the most challenging to persuade to join the team. Asking already profoundly busy and over stretched managers to take on another commitment and engage in an OD would no doubt be met with negativity. Resisting factors such as parochial self - interest, a low tolerance for change and a lack of knowledge regarding the change is well documented (Kotter & Schlesinger, 2008). As expected comments were expressed such as,

‘What project?’, ‘What’s it about?’, ‘No I haven’t heard about risk registers’,
‘I’m doing a study programme and may not be free to attend all of the meetings’, ‘I may not be able to attend the meetings due to staff shortage’.

Engaged staff feel they have a value and purpose, are empowered and have influence to improve care (DOH, 2012a). It was vital that the writer engaged with these colleagues. By listening to them, understanding their perspective, acknowledging their concerns and work demands (Ancona et al, 2007) whilst motivating them by offering an
opportunity to be involved in making change for the better which would improve safe care for their patients and their staff, they agreed to come on board (Kotter, 2001). Participation, involvement and having influence in the change project is one method of overcoming resistance (Ennis & Harrington, 1999, Kotter & Schlesinger, 2008).

The writer also assured the CNMs that education and workshops would be provided both to the project team and their staff in the clinical areas in the New Year to support the CNMs in the implementation of the risk registers. Persuading and influencing these colleagues by being optimistic and communicating that it would also be good to work together brought further commitment of the CNMs to the project (Hoy & Smith, 2007). One CNM was enthusiastic and supportive despite her workload and would be a key influencer in encouraging the remaining two CNMs to engage positively (HSE, 2008, pp:29). The recessionary impact of recruitment moratorium makes it all the more difficult for any enthusiasm for new projects. However, it was the week before Christmas and it was acknowledged that folk were probably tired. Hopefully the New Year would start with renewed vigour.

Time was of the essence with the festive break looming. An e-mail to all the team members was sent before the break thanking them all for agreeing to join the team, a date was fixed for the first meeting. The Terms of Reference (Appendix 2) was attached to the e-mail for the members’ perusal and agreement, as was the agenda (Appendix 3) for the meeting on the 9th January, and all were wished a very happy Christmas.
3.3.5 Further Preparatory Work Over Christmas

It was vital that the first project team meeting got off to a good start in order that the members would feel positive about the project. It would be a New Year and a new start. In order for this to occur, education and coaching of the team was critical to further development of the vision of what was to be achieved, aligning and motivating the team in one direction (Kotter, 2001). A power point presentation was prepared for delivery at the first meeting. Laminates of the HSE Risk Assessment tool were developed for each CNM to have for their departments and also to assist in further education of their MDT colleagues (Appendix 4).

3.3.6 Information and Communication Technology (ICT)

As the hospital already had risk registers managed in other departments the risk register template in use was considered for implementation in clinical areas (Appendix 5 and 6). This would lead to continued uniformity of the template throughout the organisation. The writer’s line manager (project sponsor) was not convinced that this template was going to work as it was deemed to be a causative factor in previous difficulties at implementation. The writer contacted the QRCA manager regarding the template and the template issues were corrected. Following this a meeting was arranged by the writer with the line manager to give reassurance that the template was usable and acceptable, agreement to continue with the organisational template was supported and another little win was achieved! At this point a guiding coalition had
been established and through the development of a highly professional and committed project team the change process entered its second stage.

3.4 Planning

The planning stage of the HSE model involves building the shared vision and engaging the stakeholders whilst continuously communicating change is underway. Determining the detail for change and increasing the readiness for change takes place and the implementation plan is agreed (HSE, 2008). The first team meeting would be critical to how this project would progress.

3.4.1 Preparation for the First Team Meeting

In order to ensure success at the first team meeting a reminder was sent by e-mail to the team members in the first week of January 2014 of the date for the meeting, the 9th January, and all wished a very happy New Year. The MDT room was booked to ensure a private and comfortable meeting venue (Office for Health Management (OHM), 2003) also this room has a computer and screen access for presentations and was therefore suitable for the power point presentation to be delivered. The Risk Register Team Attendance Sheet (Appendix 7) was available for all to complete. This would ensure that everyone had each other’s e-mail and telephone contact details. A hard copy of the Terms of Reference was also available as was a copy of the meeting agenda and a
copy of the HSE policy on ‘Developing and Populating a Risk Register’ (HSE, 2009). The HSE risk assessment tool laminates were available also to complete the ‘Risk Register Pack’ for each team member.

### 3.4.2 The First Team Meeting

Following welcome and introduction the first meeting got underway and set the tone for the development of the team, getting to know each other, what role or position each person held within the organisation. Effective teams are composed of a range of skills, experience and knowledge and improved delivery of quality care comes about through good quality meetings with effective communication (Borrill & West, 2000; Welford, 2006). It was clear from the outset that these team members took their role seriously and were engaged in the process, this also was very reassuring for the project leader. To establish background knowledge of risk registers the writer had prepared 4 questions for the members to answer,

- Are risk registers managed within your department?
- If not, have you ever heard about them before now?
- If so, did you receive formal education regarding their implementation and management?
- How often are they reviewed and by whom?

The AHP manager had a risk register in place within the department but no training had been afforded. Self-learning and reading had taken place to allow for implementation.
The risk register was reviewed quarterly by the Clinical Services Manager. The template used was the organisational template available on the intranet. A risk register was also established within the QRCA department. None of the CNMs or the medical consultant had any knowledge of risk registers and the same was for the administrative support staff.

Members were impressed by the attendance of the medical consultant who engaged positively with all colleagues, contributing expertise and knowledge from a medical perspective to the meeting but open to the opinion of others also. Tanco et al (2011) recognise that healthcare professionals are keen to learn whilst acknowledging differences between disciplines. Responsible followership was evident as the meeting progressed and with further meetings the leadership / followership role altered according to the experience or knowledge of an individual member. Followership is just as vital as leadership in team building (Ezziane et al, 2012). Shared leadership evolved during this meeting as discussion took place following education through the power point presentation.

Accessing the organisational risk register template on the organisational intranet was demonstrated and education was provided regarding risk identification, analysis and treatment. At this point discussion around the value of risk registers, what the intended benefit to departments were, and if there were any examples from other organisations available to guide the team took place. There were mixed views as to how to score a risk due to its subjectivity. With a mix of disciplines and specialties, all had an opinion
pertinent to their areas of concern but each was learning about another view point and the subject was under intense scrutiny. Already answers were being sought, information was being gathered and analysis taking place as to how this should move forward. Certainly it was agreed that easily controlled risks should be assessed in the start until everyone became more familiar with the process.

Although the writer was cognisant of keeping to the timeframe, a small overrun was allowed to encourage relationship building amongst the team while the subject of risk registers was discussed (Fleming, 2010, pp:188). Group dynamics require attention, participants need to be able to trust each other and feel safe in order to learn from each other in an open and honest manner and friendship should be fostered (Marquardt, 2000; OHM, 2003). The agenda was worked through and actions decided upon by members of the team. The meeting concluded with a date and venue agreed for the next meeting 2 weeks later.

3.4.3 Increasing Readiness and Capacity for Change

Risk register team meetings were held every 2 to 3 weeks through to April depending on the availability of members to attend (flexibility was important to facilitate members commitments to their own work demands). By meeting up and working through the agendas communication regarding any difficulties was addressed and discussed. Further action plans would then be decided upon.
To further increase readiness and convey that change was underway, risk register implementation was put on the agenda for the monthly Medical Division meeting which is attended by all medical clinical nurse managers and senior nursing staff and also at departmental MDT meetings. However at the January Medical Division meeting a colleague made it very clear to the writer what difficulties may be in store when an agenda page was slid across to the writer. ‘Boring’ was written beside ‘risk registers’. The colleague smiled to the writer. While it was meant as a joke it demonstrated perhaps a small example of the ‘shared tacit assumptions’ that Schein (2009) refers to as culture that probably prevailed quietly throughout the room of 30 people or more.

Survival anxiety was showing itself and resistance to change was evident. Capturing these people’s attention before they gave up on the subject was vital. Gill (2011, pp: 275) states that ‘language is one’s most powerful tool’ and the writer was prepared for this attitude and assumption by having an introductory speech requiring feedback and participation from all present to capture the attention of the audience which proved effective. Through networks established, using previous relationships built up and utilising the principle of colleagueship (Hoy & Smith, 2007) the writer gained their time and attention. Positive feedback was conveyed to the writer after the meeting which was very welcome and another little win was achieved.
3.4.4 Momentum

At the February Medical Division meeting a power point presentation was delivered and also a demonstration of the risk register developed in one of the clinical areas. This education was proving effective in engaging a wider circle of CNMs (stakeholders of the future) and communicating the reality that risk registers were here to stay. CNMs were beginning to listen and see the value for themselves and their departments. Workshops commenced in the clinical areas providing education and heightening the culture of safety awareness amongst staff. With the sharing of ideas and identified risks at both the Medical Division and the Risk Register team meetings, a knowledge sharing culture was developing (Jones, 2005) and silo management of risk was breaking down.

3.4.5 Plan for Implementation and Organisational Politics

The project team continued meeting through February and March to discuss and action any outstanding difficulties in the plan for implementation. One such concern was the pathway for escalation of identified high risks in clinical areas. Guidance was taken from the HSE policy (2009) however little could be done without the involvement of senior stakeholders. Active participation and engagement was required and to date, while there was support for the project, much of the work was seen to be the domain of the clinical area CNM. The writer met with the senior line manager once more seeking support for engagement at senior level.
‘Internal OD facilitators are engaging in organisational politics without the benefit of having the managerial authority’ (McAuliffe & Van Vaerenbergh, 2006, pp:65) and here the writer did not have the power to ensure participation at this level. The project required commitment top down also and the HSE policy (2009) along with other external drivers was utilised to convey the responsibility of all involved to ensure success. After some determined negotiation and discussion, agreement was reached and a pathway for escalation was secured. This was perceived by the writer to be a BIG win! Informing the project team regarding the agreed pathway for escalation allowed the final implementation plan to be agreed for moving forward and the change project entered its third stage at formal implementation of risk registers in 4 clinical areas managed by nursing staff.

3.5 Implementation

This stage requires supporting staff in implementation of the change initiative, assessing feedback from stakeholders as to difficulties experienced and taking action to remedy these problems. Sustaining momentum is crucial to ensure continued commitment and enthusiasm for the change initiative and monitoring also is critical to early identification of areas of concern (HSE, 2008).
3.5.1 Risk Register Population

In truth risk register population commenced as early as mid February and continued to build while project team members met up and discussed progress and barriers to implementation. The QRCA manager informed the group of the 5 top clinical incidents reported to risk management. These were:

- Slips, trip and falls
- Treatment
- Pressure Areas
- Documentation
- Communication

Other incidents included patient identification and complaints. These matters were discussed and added to the risk profiles to be addressed by the CNMs. Discussion regarding ability of all nursing staff to view each departments risk register on a shared drive to further learning, sharing of knowledge and ensure the risk profile is complete throughout each unit took place. This was agreed to be necessary and was identified as an action required. The ICT department was contacted by the project leader and presently developing a shared drive across the organisation for everyone to view all the risk registers in a read only capacity is not feasible however it has been suggested that Q-Pulse may be able to offer a solution. This is in the process of exploration.
Workshops proved to be helpful in gaining momentum and developing a learning culture amongst staff (Crawford & Stein, 2005; Fraser & Henry, 2007). Emerging themes and constant reflection on what had been achieved and what more could be done became evident and is well documented (Sheps & Cardiff, 2011). The agreed pathway of managing risks with high scores on the risk matrix, ie: amber (equal or above 6) and red (equal or above 12) was recorded on the minutes of the Medical Division meeting that took place in March. Any concerns regarding risks must be communicated to the CNMs direct manager and recorded on the risk register. This high score risk will be added to the nursing executive risk register for treatment or further escalation to the patient safety committee and / or risk committee. With a pathway of escalation requiring immediate reporting of high risks identified and a quarterly review of risk registers by the CNM and the line manager agreed it became incumbent on everyone to actively participate in this initiative.

The actions were evidencing improvements in risk register population. Risk registers were developed and building in the 4 units and a pathway for management was agreed, this wasn’t just a ‘paper exercise’ as originally thought by many. Firmly held beliefs and assumptions by most of the team at the outset regarding risk registers were being challenged and slowly altered. Through actions, the team began to see change occurring, this was the learning. Continued contact and communication with stakeholders remained critical to sustaining momentum thus the writer visited the clinical areas to provide a visible support and also telephoned regularly to offer further assistance through workshops and presentations. Communication with senior
stakeholders also was afforded through one to one meetings with the writer regarding the progress within their areas of responsibility and also by attendance at the Medical Division monthly meetings.

### 3.6 Mainstreaming

This fourth stage requires further support of the integration of the change initiative while acknowledging the success of implementation. Active leadership remains critical to support embedding of the change. By continuing to evaluate and learn from what has been achieved through the implementation stage, support structures are reviewed and clear lines of responsibility are agreed. Mainstreaming occurs when the change in practice becomes part of the way things are done as a routine and not viewed as just time consuming extra work (HSE, 2008).

### 3.6.1 Embedding and Mainstreaming

Fraser & Henry (2007) acknowledge that it takes a long time for risk management to embed and this is very much the case with this change initiative. It remains early days. The project team continues to meet to review progress and provide support for the clinical areas involved. There is no doubt that much progress and success has been achieved however time is required to allow for embedding. By continuing to keep close contact with the CNMs, the writer receives feedback from the stakeholders to hear how
the project is becoming part of everyday business. Encouraged ownership of problems and answers leads to an improved chance of the initiative becoming embedded (Crawford & Stein, 2005). Certainly this change initiative will require ongoing monitoring to ensure mainstreaming takes place throughout the year until it is considered normal practice.

Reflection on what the project team had achieved in 4 short months took place and also discussion regarding the frequency of the meetings at this stage. It was agreed that monthly meetings would be acceptable as the project team is now developing into the steering group to support organisational wide introduction and population of risk registers in all clinical areas managed by nursing staff until such a time as Directorates are established.

### 3.7 Conclusion

Hoy & Smith (2007) wrote ‘Getting others to follow is the sine qua non of leadership’ and this proved to be true when it comes to bringing about a change initiative such as introducing risk registers in 4 clinical areas managed by nursing staff with an MDT approach. The choice of change model is crucial and the HSE Change Model was the most appropriate fit for this particular initiative. The HSE model guided the writer through the change process from preparing to change through to the final stage of mainstreaming. By incorporating many aspects of other change models the HSE model
Chapter 4: Evaluation

4.1 Introduction

This chapter will describe the evaluation methods used to evidence meeting the stated aim and objectives of the change initiative as outlined in Chapter 1. The definition of excellence in healthcare is based on the quality of care delivered and the clinical outcomes achieved (Brady et al, pp: 251 – 252) Quality improvement (QI) in healthcare is based on the concepts of doing things better, improving efficiencies, being more cost effective and all the while being patient centric (Sullivan & Decker, 2005, pp: 183).

By combining action learning and the Plan, Do, Study, Act (PDSA) cycle approach to continuous improvement, evidence of working toward meeting the aim and objectives of the OD are demonstrated. Audit was carried out to assess the organisations position on risk register implementation against 4 similar sized hospitals both pre and post implementation and a second audit was conducted to evaluate the project team members knowledge and experience of risk registers both pre and post risk register population. A third audit was conducted to assess patient safety culture and risk
awareness amongst staff following implementation of risk register. Both qualitative and quantitative data will be evidenced.

4.2 Action Learning, PDSA Cycle and the Project Team

Action learning is a methodology which uses small groups or teams to progress real problems in a structured manner and is a project based approach to learning (Marquardt, 200; Marsh & Wood, 2001; Ruebling, 2007) By learning from concrete experience and critical reflection on learning, actions are decided upon to further progress the project (Zuber-Skerritt, 2002; OHM, 2003). The project team was an action learning set that met every 2 to 3 weeks to critically reflect on learning from experience and decide further actions.

The technique of action learning is mirrored by the repeated quality cycles of Deming’s PDSA model (Wang & Ahmed, 2003). By completing one cycle of PDSA, planning for change takes place (plan), the agreed action is carried out (do), the results of the action are studied (study) and thereafter acting on what is learned (act) resulting in either a change or a return to the planning stage (Moule et al, 2011). PDSA is an approach to quality improvement that also involves small teams working on real life work problems and is credited with being the most widely used QI methodology in healthcare (Walley & Gowland, 2004; Varkey et al, 2007).
4.2.1. PDSA Cycle 1

Plan: The first team meeting occurred on 9th January 2014. At the conclusion of the meeting it was agreed that the 4 CNMs would download the risk register template to the workplace computers. 3 risks would be identified using the ‘Impact, Cause and Context’ approach in consensus with the MDT in the clinical area (HSE, 2009).

Do: 3 risks were identified on each unit by the CNMs and registered on the organisational risk register template.

Study: Reports from all CNMs was that it was not as easy as first considered and that having the opportunity to meet with their teams to educate and gain consensus was proving difficult.

Act: Learning from this experience and action resulted in further decisions to work on agreed identified risks and to commence workshops on the clinical units at agreed times to facilitate education of staff and support the CNMs in implementation.

Cycles were repeated throughout to April and meetings are still ongoing, the PDSA cycle continues although at this stage risk registers are implemented in each of the 4 units with a minimum of 5 risks registered in each unit. Both action learning and the PDSA cycle of quality improvement through incremental learning has supported introduction and population of risk registers in the designated clinical units. Learning took place throughout with regard to risk analysis, assessing risks by application of the
likelihood score and impact table leading to risk matrix scoring (HSE, 2011b). In this way the aim has been achieved albeit further work is required to embed the practice.

4.3 Workshops

The value of workshops in educating staff and developing a knowledgeable workforce is well documented (Borgelt & Falk, 2007; NHS, 2007; Sheps & Cardiff, 2011). Through improving staff knowledge and education about risk registers it was envisaged that this would improve risk awareness and safety culture throughout the teams (Harvey et al., 2001; Mostafa, 2009). The HSE policy (2009) recognises the value and necessity for risk support, advice and facilitation to assist risk register implementation.

In all, 5 workshops have been provided. A workshop and power point presentation was delivered at the first project team meeting. At the outset a small audit of risk register knowledge was conducted through open questionnaire at the first team meeting. Questionnaires allow for assessing the knowledge of professionals and yields speedy data collection (NHS, 2007). As described earlier only 2 of the 7 people had any previous knowledge or experience of risk register management. This showed just 28% of the team responding positively with regard to risk register experience or knowledge. In May, following implementation of risk registers the project team were once again asked the same questions and the results showed that at this time the entire team were now very familiar with risk registers and the process of risk management thus achieving
the objective of developing knowledge in risk register population amongst the project team as shown in Figures 6 and 7.

Figure 6: Project Team’s Knowledge / Experience of Risk Registers pre Implementation

| Project Team Members Knowledge / Experience of Risk... |
|-----------------|---------------------|
| No Previous Knowledge 72% |
| Previous Knowledge 28% |

Figure 7: Project Team’s Knowledge / Experience of Risk Registers post Implementation

| Project Team Members Knowledge / Experience of Risk Registers Following Implementation |
|-----------------|---------------------|
| No Knowledge 0% |
| Knowledge 100% |

4 more workshops have been conducted, one at the Medical Division meeting in February and a further 3 in clinical areas introducing risk register population and development. Power point presentation was delivered, teaching on risk identification was afforded and the workshops were facilitated with a participatory and interactive
approach whereby the staff were invited to identify risks pertinent to the unit worked on and then evaluate the identified risks amongst themselves. This would bring more meaning to the staff and gain their interest and attention. To date through the 5 workshops conducted 63 staff have received education and information regarding risk register implementation thereby meeting the objective of developing staff knowledge in risk identification, analysis, evaluation and treatment using the organisational risk register template but further analysis of the effectiveness of the workshops for the staff was required therefore a questionnaire was conducted.

4.4 Risk Register Questionnaire

There are many patient safety culture questionnaires, one such being the Agency for Healthcare Research and Design from the US (United States) Department of Health and Human Science (2012) however due to the timeline for this project it was considered more prudent to devise a quick and succinct questionnaire to yield data regarding multidisciplinary staff opinions and knowledge regarding risk registers, and the benefit workshops may have had in improving risk awareness and therefore safety culture amongst the employees. 10 questions were asked with a ‘yes / no’ response required (shown on following page).
Risk Register Questionnaire

I would be very grateful if you would complete this questionnaire and leave in box in the clinical facilitator’s office for collection or else return via internal mail to...

1: Have you heard of risk registers before now? Yes / No

2: Have you ever worked with them in another hospital? Yes / No

3: Do you think they contribute to increased patient safety awareness? Yes / No

4: Do they help to identify risk concerns in your department? Yes / No

5: Is the template easy to use? Yes / No

6: Is a multidisciplinary team approach taken in responsibility for risk management within your department? Yes / No

7: Have risk registers improved the culture of risk reporting within your department? Yes / No

8: Have you attended a workshop on risk registers or received information / education from your manager on the management of risk registers? Yes / No

9: If you answer ‘YES’ to the above, do you feel you are more risk aware than before? Yes / No

10: What do you consider to be barriers to implementation of risk registers in your department?

______________________________________________________________________
______________________________________________________________________

Thankyou for your time.
20 questionnaires were sent out either by e-mail or within the department where the writer works. 18 completed questionnaires were returned giving a response rate of 90%. 11 of the questionnaires were returned from within the writer’s department, 9 were sent to staff on other units where workshops had been conducted. The results showed 3 people had not received any training or attended workshops but this was deemed to be valuable information regarding their opinion on the value of risk registers and its contribution to patient safety awareness and risk management within the workplace. To obtain multidisciplinary opinion and response the staff participating in the questionnaire consisted of a mix of doctors, nurses, radiographers, physiologists, healthcare assistants, portering staff and senior managers.

As demonstrated in the bar chart shown as Figure 8, 15 staff reported that they had heard of risk registers before but on further analysis of the questionnaire these included all staff who had attended a workshop. The 3 staff who had not heard of risk registers before had not attended a workshop or received training from their manager (it is not possible to identify what disciplinary background these responders are from). Interestingly all of the responders (100%) reported that they considered risk registers to contribute to patient safety awareness and also to helping risk identification within their department. This was so even with the responders who had not attended workshops leading one to believe that there is an awareness of the importance for risk identification and an appetite for robust risk management at clinical level however this assumption requires further exploration to substantiate it.
All 15 staff who had attended workshops reported that they found the organisational risk register easy to use, only 9 responders reported that there is an MDT approach to risk management within their department however 45% report positively and much work is yet to be done in embedding the project. The most rewarding information for the writer came from response to question 9 in that all 15 (100%) of staff who have attended workshops feel they are more risk aware than prior to the workshops demonstrating clearly that workshops are extremely beneficial to improving risk awareness and therefore building a patient safety culture. By conducting workshops the objectives of improving patient safety awareness and developing a positive patient safety culture were achieved.

There was a free text box available for further comments to be made on considered barriers to implementation. This also was utilised widely by the responders in that only 2 were not completed giving a response rate of 88%. In reviewing the identified barriers to implementation the more common themes to barriers reported were lack of time, need for training and education to improve awareness and concern regarding engagement of a multidisciplinary approach for responsibility in risk register management. Furthermore it is considered that the high response rates themselves convey the interest and positive attitude staff have in risk awareness and risk management, clearly it is important to them and therefore sends the message that staff are keen to do their best in providing high quality safe care and be safe themselves. A small example of the comments made in the free text box are on the following page,
‘reluctant to do more paperwork’….. ‘shortage of staff’… ‘lack of proper training’… ‘lack of awareness as staff are too busy’… ‘education awareness and training regarding risk registers’… ‘attitude of staff and spend a little time to read about it’… ‘less awareness among the multidisciplinary team, will need their input as well in reporting the risks within the department’.

**Figure 8: Risk Register Questionnaire Results**

- Have you heard of Risk Registers before now?
- Have you ever worked with Risk Registers in another hospital?
- Do you think they contribute to increased patient safety awareness?
- Do they help to identify risk concerns in your department?
- Is the template easy to use?
- Is there an MDT approach to risk management in your department?
- Have risk registers improved the culture of reporting in your department?
- Have you received information / education from your manager on risk registers recently?
- If 'yes' do you feel you are more risk aware than before?
4.5 Benchmarking and Improved Compliance with National Policy

With risk registers now implemented in the 4 identified and designated multidisciplinary clinical areas managed by nursing staff the organisation has now achieved equal compliance level on risk register population and introduction with the 4 similar sized hospitals that were contacted at the outset of the project. The risk managers contacted in the 4 hospitals stated that there was partial to full introduction of risk registers at clinical level with further work to do, this is now the position of the organisation of the writer thus meeting the objective of benchmarking equally against similar sized hospitals (shown as Figure 9).

Figure 9: Audit of Risk Register Implementation Comparison with 4 Similar Sized Hospitals
Further to this by populating and introducing risk registers within the 4 clinical areas the objective of improving organisational compliance with the HSE national policy (HSE, 2009) on populating and introducing risk registers within the hospital has been met.

4.6 Conclusion

The aim of the project was to introduce risk registers in 4 clinical areas managed by nursing staff with a MDT approach. Through action learning and using the PDSA cycle by the project team the aim has been achieved, There is much yet to do to ensure embedding which will be discussed in the next chapter and the project will continue as organisational wide introduction of risk registers in clinical areas is required. The objectives have been met, workshops have proven to be an effective method of educating staff regarding risk registers and improving risk awareness and patient safety culture. The questionnaire was a very successful tool in accessing staff opinion and views and evidencing the effectiveness of the workshops in improving knowledge about risk register population. The organisation now compares favourably to 4 other similar sized hospitals on risk register implementation in clinical areas and there is improved organisational compliance with national policy on risk register introduction. This leaves just one objective that has not been met which was to have a draft copy of an organisational policy on risk register implementation in place however the reasons for this will also be discussed in the next chapter under Discussion and Conclusions.
Chapter 5: Discussion & Conclusions

5.1 Introduction

This chapter will provide a critical discussion on the experience of the writer in introducing and implementing the OD as described in Chapter 3 and also that of the evaluation as described in Chapter 4. Reference to the relevance of the literature discussed in Chapter 2 will be provided as appropriate with the writer’s reflection supporting the discussion on experience and referenced to the reflective diary. The chapter will conclude with a discussion of the impact the change has had on the organisation with recommendations for future improvements provided.

5.2 Initiation

To commence, implementing the OD was very much a learning experience. From the very outset the spiral nature of change was evident as the paradigm shift of the OD subject in the first few months taught the writer that even at a proposal stage of change life can be uncertain and challenging. As stated earlier senior stakeholder support is critical to change success and reflections on practice of this experience will be evident in the writer’s reflective diary (pp: 4). However there was valuable learning in that getting the right OD agreed was critical. Ultimately the subject of risk register population and implementation was found to be currently very relevant in healthcare. There is
much literature to support it, in particular the national policy on risk register population and introduction (HSE, 2009) and also the recent healthcare inquiries into adverse events in hospitals in Ireland (HSE, 2013a; Holohan, 2014) referred to in Chapter 2. With reading and learning the writer truly believed in the merits of the OD in reducing the likelihood of adverse event occurrence within clinical areas of the organisation and therefore the writer became very committed to its successful implementation.

5.3 Preparation

There is no doubt that preparing to lead the change is absolutely crucial and really did lay the foundations for successful implementation. By working on the initiation stage of the HSE Change Model (HSE, 2008) as outlined in Chapter 3, preparation commenced in earnest as time had passed. In performing the 'ground work' using change tools such as SWOT, force field and stakeholder analyses the writer could identify clearly the external and internal drivers for change. In fact it was the literature in the form of policy and standards that supported the need for change such as the policy on populating risk registers (HSE, 2009), HIQA National Standards (2012) and JCI Standards (2014). Phoning risk managers in other hospitals provided valuable information to demonstrate the urgency for the project and it was encouraging to speak with risk managers who had experienced this change and had advice to offer. The information gathered allowed the first project team meeting to commence with a robust information session regarding the position of other hospitals on risk register implementation and this captured the team members’ attention from the outset.
5.4 Project Team and Impact on the Interventional Cardiology MDT

In building a multidisciplinary project team the writer developed contacts with colleagues and departments outside of the interventional cardiology department (which is a contained unit) therefore networking occurred with other managers from many disciplines throughout the hospital which was a very positive experience. It was critical that the first project team meeting was successful and this required a lot of preparatory work to engage the team members and is referenced to the reflective diary (pp: 6).

The team members themselves were professional and very supportive to the project however it must be acknowledged that the time taken to lead the project did impact on the cardiology MDT within the interventional cardiology department. Their CNM was absent from the workplace frequently to attend meetings, deliver workshops and perform actions as a consequence of decisions taken at project team meetings. Much support within the department had to be given to allow for this to occur demonstrating that leading and implementing a change project in other clinical areas outside of the remit of a busy critical care department is very challenging. Resource for the OD was discussed at the initiation stage however the writer did not anticipate the amount of personal effort and time required to lead a change project of this nature and resource need should have been revisited by the writer as the OD progressed.
5.5 Resistance

Resistance at every level was never too far away and this required constant attention to overcome. Risk registers do not enthrall staff and are viewed as burdensome paperwork which time does not allow given the workforce constraints being experienced presently. Altering the attitudes and beliefs of staff to improve safety culture and risk awareness demanded imagination on the part of the writer to engage colleagues and capture their attention. As evidenced in the literature review (Chapter 2) and lived by the writer, leadership, communication and culture are all critical factors in improving a positive patient safety culture (Crawford & Stein, 2005; Rhee, 2008; Sheps & Cardiff, 2011).

Achieving the ‘little wins’ such as acceptance of colleagues to join the project team and gaining support to use the organisational risk register template from the writer’s sponsor gave the writer a marvellous sense of achievement and a vision for success. Ultimately the ‘big’ win or achievement was the agreement for an escalation pathway for identified risks with high risk matrix scores to be established. This truly allowed for progress as there had been a reluctance at senior level that this should occur. Risk registers were perceived to be the sole responsibility of CNMs at clinical level (Mc Elhinny & Heffernan, 2003) and this is true but risks with identified added controls beyond the authority of CNMs required reporting for action at a higher level. By using education and support from literature along with determined self-belief of the writer in what should be agreed, responsibility of senior staff in the process was achieved. These achievements are included in the reflective diary of the writer (pp: 8).
5.6 Momentum

It was crucial that momentum was sustained throughout the OD. From the very outset the project required constant attention. Ensuring that project team meetings continued every 2 to 3 weeks facilitated momentum and kept the project team members focussed thus reducing the likelihood of loss of interest. Communication via e-mail regarding meeting dates, minutes recorded and decisions being acted on within an agreed timeframe contributed to maintaining momentum as did frequent visits by the writer to clinical areas to provide support, however dedication at this level is difficult to sustain in the long term. Awareness of the team members commitments to their own teams and departments (including that of the writer) cannot be under estimated and is evidenced in literature regarding the development of sustainable leaders (Casserly & Critchley, 2010).

It is early days in implementation but to date real concerns regarding maintaining momentum are surrounded by ensuring continued participation of clinical staff in the initiative. While nurses and healthcare assistants are actively engaged in the process, the notion that a full multidisciplinary team approach will occur is presently quite remote in some ward departments. This is mainly due to the plethora of various medical specialists attending any one clinical area, coupled with the work activity. Time factor is also a challenge and with ‘over stretched work regimes, too few staff’ recognised as a causative factor in barriers to implementation and management (Story & Buchanan, 2008) the initiative remains vulnerable despite implementation achieved.
### 5.7 Workshops and Education

The benefits of workshops and provision of education to the success of the OD are widely demonstrated in the literature review in Chapter 2 (Hulme, 2002; Borgelt & Falk, 2007; Savage, 2012; Abrahamson *et al*., 2013). Certainly the experience of the writer showed this to be true in that active engagement and interest of staff in risk register development was enhanced with education when improved delivery of safe care was realised as the outcome.

However difficulties in workshop delivery was a challenge and many dates for workshops had to be cancelled at the last minute due to redeployment of staff to other departments experiencing staff shortage on given days. This prolonged the process of educating staff which delayed integrative implementation on units with a team approach and to date there is still much work to do in ensuring education for all staff in all 4 units. Further to this, as mentioned above, MDT involvement is poor due to time constraint for full MDT meetings at ward level. Unavailability of staff to attend workshops and perhaps an existing culture also of it being considered to be solely the responsibility of the CNM and nursing teams to ensure safety of patients on wards / clinical areas needs addressing. Even though if asked, any member of staff would agree that reducing harm to patients is an important factor in the delivery of safe care.
5.8 Evaluation

Evaluating the success of the OD was challenging. With workshops and education proving beneficial in engaging staff it was difficult to assess the level of improved safety culture and risk awareness amongst staff. The PDSA and action learning cycles demonstrated progress to implementation. Risk registers were developed on the 4 clinical areas evidencing that the aim of the OD was achieved and also that the objective of improving organisational compliance with national policy (HSE, 2009) was also achieved. Certainly the audit of comparison with 4 other hospitals yielded good information on the position of the organisation benchmarked against similar sites demonstrating support of gap analysis and provided a drive for the objective to achieve equal status on risk register implementation in clinical areas, which was met.

Without doubt the most beneficial tool was the risk register questionnaire conducted as described in Chapter 4. There was much learning for the writer when the data was analysed and results realised. Firstly to achieve a response rate of 90% was very encouraging in that staff clearly felt this information was important and helpful however it has to be recognised that half of the questionnaires were sent to staff within the writer’s department so there may be some bias toward the response rate. Notwithstanding this to have 100% responders say they were more risk aware following attendance at workshops proved the value of education to the OD success as this reflected staff opinion throughout all participants and evidenced achievement of the objectives to improve risk awareness and develop a positive patient safety culture.
While the success of the questionnaire is greatly acknowledged, on reflection it would have been beneficial to have conducted a pre implementation questionnaire on staff perceptions of risk registers to compare with following workshop attendance. However at the outset of the OD the writer was anxious to ‘get going’ once the OD subject was agreed and building the project team was a priority considering the time factor. The learning from this for the writer is that more time should have been taken at the planning stage in performing gap analysis as this would have contributed to identifying the current situation (pre workshop opinion of risk register) and readiness for change against the desired future vision of successful implementation and a positive post implementation opinion of risk registers. In addition a wider study to include every member of MDT staff on all 4 units in a questionnaire would have yielded rich information in response rate and opinion on risk awareness, attitude toward MDT involvement and benefit of risk register introduction.

5.9 Impact of Project on Organisation

The impact on the organisation has been steady and progressive. Risk register population is new to clinical areas and it will take some more time before the organisational impact is fully felt. It is a developing process but there is no doubt that impact has commenced at the 4 clinical areas where risk awareness and patient safety culture is heightened. Staff in these areas are much more cognisant of their practice, their decisions for care and conscious to identify potential hazards in the workplace and report them.
By networking and developing a reputation for being the ‘risk register person’ the writer has continued to communicate that risk registers are coming to all clinical areas, so much so that staff in some departments throughout the hospital are contacting the writer regarding commencing implementation. This has been quite an organisational impact. Risk registers are now a staple on the Medical Division monthly meeting and also the Cardiac Department monthly MDT meeting and nursing team meetings in clinical areas. Knowledge sharing and communication has increased dramatically regarding identifying and controlling risks across clinical areas. There is talk of risk registers where there was not before.

In implementing risk registers in the 4 clinical areas further impact for the organisation has been improved compliance with the national policy on risk register population (HSE, 2009) and this will continue to build as risk registers develop throughout all clinical areas within the organisation. The organisation now compares favourably to similar sized hospitals regarding risk register implementation in clinical areas. The risk profile of the organisation is developing from a clinical perspective which is critical for the organisation to assess where resources should be prioritised. Future organisational impact will be both improved safety for all and also reduced cost of increased lengths of stay or possible litigation.

Further to this, impact on the organisation is improved compliance with JCI (2014) standards on risk management and HIQA National Standards (2012). In so doing the
reputation of the organisation is further enhanced as it can demonstrate complete and robust risk management processes in place throughout, meeting its own identified core value or providing ‘quality’ care.

5.10 Recommendations for Future Improvements

Going forward and being aware that risk registers must be introduced across all clinical areas of the hospital there are a number of recommendations the writer wishes to convey based on the experience of introducing risk registers in 4 clinical areas managed by nurses with an MDT approach.

Bearing in mind that the organisation, like others, is transitioning its clinical governance structure to one of Directorates it is vital that each Directorate team will take responsibility for risk register introduction and implementation within their Directorate. Risk registers are a line manager’s responsibility however the introduction of risk registers to all clinical areas of a large organisation requires senior management and risk staff commitment to support implementation (HSE, 2009) along with engagement and active participation of every member of staff regardless of discipline or seniority in order that implementation is disseminated top down throughout.
To ensure education for all staff in such a large organisation a mandatory study programme on risk registers for all staff to attend should be implemented by the QRCA department and supported by the Learning and Development Department. This should be ongoing due to the ebb and flow of staff to and from the organisation. Dissemination of information and education would be achieved throughout the organisation without delay expediting organisational implementation and therefore developing a visible risk profile on high risks requiring priority attention. Hulme (2002) recommends risk register training on induction programmes and this should be added to the risk management series already in place for all new staff commencing.

While there is an HSE policy on risk register management, the value of an organisational policy would be extremely supportive as an internal driver of implementation. An organisational policy would formally outline processes for internal review and evaluation of risk register management. This would ensure identified ownership, lines of responsibility for additional control and risk management top down and bottom up. The organisation has recently appointed a risk manager and the writer has been informed that the QRCA department will be developing an organisational risk register policy. This was the final objective of the initiative and was not completed due to the information conveyed by the newly appointed risk manager however the learning gained through the process of introducing risk registers in the 4 clinical areas will contribute to and inform policy development.
It should be possible for all clinical managers within the organisation to view all clinical risk registers. Allowing risk registers to be visible to all clinical managers will increase knowledge sharing, improve safety culture and break down silo work which will ultimately lead to reduced adverse event rates (Sheps & Cardiff, 2011; Goh et al, 2013). As described in Chapter 3 the writer has contacted the ICT department to inquire regarding the feasibility of an organisational drive enabling access of compiled risk registers in a read only capacity but to date this is not possible however it is a recommendation for the future and should be addressed as a resource need.

Finally a word of caution should be conveyed in that given the financial constraints being experienced in healthcare there is much pressure to keep within budgets. Staff in healthcare must be supported without fear of being reprimanded for identifying or reporting risks that will cost an organisation financially to treat. Developing a culture of free communication and open reporting is critical to reducing adverse event rates, the consequences of it not occurring is all too clear in the Francis Report (2013). Marrying financial constraint with provision of a top class quality and safe service comes with its challenges and the NSP (HSE, 2014) clearly states that in Irish healthcare,

‘at a time of further financial contraction, it is especially important to ensure that providing the best level of care for patients and service users, must be at the forefront of planning for and management of services’ (HSE, 2014).
5.11 Conclusion

The business of healthcare is fraught with risk, ensuring robust risk management processes are in place is central to reducing preventable adverse events. Risk register population and implementation is one vital component in reducing error rates. Ireland is not alone in being in the spotlight regarding adverse events impacting on the health and lives of patients. Global reports of incidents and errors causing harm and even death are well documented. Effective leadership, developing a positive culture of patient safety and improving communication are all found to be critical factors in improving quality care. Risk management is the responsibility of all, top down and bottom up or sharp enders to blunt enders and it is incumbent on each healthcare worker to provide the very best care at all times to all people who attend seeking better health and an improved quality of life or a dignified caring end of life. Trust is laid in the hands of healthcare workers, trust for care, trust for safety, trust for truth.

'It is vital to patient, public and staff confidence and morale that at the most challenging of times, the healthcare system performs to its highest standard. It is imperative therefore, that we continue to strengthen policy and practice in respect of patient safety and in particular our capacity to learn lessons derived from monitoring and analysis of adverse events'. (Holohan, 2014).
Reference List


Health Service Executive. (2010b). *Tallaght Hospital Review, Report of the review of Radiology reporting and Management of GP Referral Letters at Adelaide and Meath Hospital (Dublin), incorporating the national Children’s Hospital (AMNCH) [Tallaght Hospital]*. Health Service Executive.


5th February, 2014

Re: Organisational Development Project

Dear [name]

Following receipt of correspondence dated 12th December, 2013 and your subsequent discussions with [name], Clinical Audit Manager, as Chairman of the Ethics Committee I have decided that this study does not require Ethics Committee approval.

Yours sincerely,

[Name]
Chairman,
Ethics & Medical Research Committee
Appendix 2 Terms of Reference

Risk Register Project Team Terms of Reference

January 2014.

Aim of the Project Team

The overall aim of the project team is to introduce and implement Risk Register maintenance in clinical areas managed by nursing staff on a phased basis throughout the organisation. The risk register is a living tool which will identify, assess, rate and prioritise risks across the hospital which threaten the organisation from achieving its stated aims and objectives.

Objectives of the Team

- To establish risk register template availability to each clinical area via the hospital intranet (4 clinical areas to commence Jan – April 2014).

- To educate MDT staff in risk assessment, analysis, evaluation using likelihood, impact and risk matrix scoring.

- To support introduction of risk registers at monthly MDT meetings by providing workshops / education on risk registers.

- To identify common themes and ensure controls are managed in the same way throughout the organisation for streamlined risk management.

- To establish a reporting mechanism of identified risks in order to ensure high priority risks are actioned and ensure a review process is in place.

- To work with the QRCA department on risk register policy development.

- To communicate the objectives to the stakeholders.

- To monitor progress against the agreed action plans and timeframes.
Frequency of Meetings

Meetings are to be scheduled initially on a two to three weekly basis and will be planned for the month ahead. All decisions will be reported to the QRCA department, the Senior Management Team and Medical Executive.

Key Stakeholders

The key stakeholders comprise of the following:

Group Chief Executive Officer
Chief Operations Officer
Chair of Medical Executive
Director of Nursing
Lead Assistant Directors of Nursing
Assistant Directors of Nursing
Clinical Services Manager
Non Clinical Services Manager
Quality Risk and Consumer Affairs Manager
Clinical Nurse Managers

Other Internal Influencers and Supports

Occupational Health Department
Infection, Prevention and Control
Haemovigilance
Ergonomics
Health and Safety Committee
Membership

Membership includes

A .......................................... Project Lead, CNM2
B ............................................. Medical Consultant
C ........................................... Quality Manager
D ........................................... AHP Manager
E .......................................... CNM2, St A’s Ward
F .......................................... CNM2, St B’s Ward
G .......................................... CNM2, St C’s Ward

Other members / stakeholders may be co-opted as necessary for specific tasks / advice / agenda

Quorum

A minimum of four member attendance is required to render a meeting valid.

Administration Arrangements

The project team will be supported by the secretary to the cardiac cath lab. Agendas will be circulated no later than 48 hours prior to meetings and minutes circulated no later than 48 hours following meetings.

Review

These Terms of Reference will be reviewed on a monthly basis to ensure they remain fit for purpose.
Appendix 3 Risk Register Project Team Meeting Agenda

Date: Thursday 9\textsuperscript{th} January 2014

Time: 14:30 – 15:30

Location: MDT Room

AGENDA

<table>
<thead>
<tr>
<th>No.</th>
<th>Item/topic:</th>
<th>Responsible person (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Welcome and introduction of team members</td>
<td>Project Lead (A)</td>
</tr>
<tr>
<td>2.</td>
<td>Terms of Reference</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>Introduction to Risk Registers : Powerpoint Presentation</td>
<td>A</td>
</tr>
<tr>
<td>5.</td>
<td>Evaluating Risk</td>
<td>A</td>
</tr>
<tr>
<td>6.</td>
<td>Commencing risk register as item on all MDT monthly meeting agendas</td>
<td>A</td>
</tr>
<tr>
<td>7.</td>
<td>Common themes</td>
<td>A and Group</td>
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</table>

Next meeting: Thursday 30\textsuperscript{th} January 2014.
# Appendix 4: HSE Risk Assessment Tool

## 1. Impact Table

<table>
<thead>
<tr>
<th>Impact</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
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<td>Injury</td>
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## 2. Likelihood Scoring

<table>
<thead>
<tr>
<th>Likelihood Scoring</th>
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<th>Minor (2)</th>
<th>Moderate (3)</th>
<th>Major (4)</th>
<th>Extreme (5)</th>
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<td>Actual Frequency</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>At least monthly</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

## 3. Risk Matrix

<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>1.00 (Almost Certain)</th>
<th>0.20 (Likely)</th>
<th>0.05 (Possible)</th>
<th>0.01 (Unlikely)</th>
<th>0.00 (Rare/Remote)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligible</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Minor</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Major</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Extreme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### Appendix 5 Organisational Risk Register Template

**Risk Register Assessment Form (Version 02)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Primary Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section/Word/Department</td>
<td>Source of Risk</td>
</tr>
<tr>
<td>Date of Assessment</td>
<td>Date of Assessment Sign-off</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unique ID</th>
<th>Risk Owner</th>
<th>Risk Description</th>
<th>Actual/Potential Risk</th>
<th>Existing Control Measures</th>
<th>Analysis</th>
<th>Additional Controls Required</th>
<th>Analysis</th>
<th>Risk Priority H, M, L</th>
<th>Person Responsible For Action</th>
<th>Due Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issued by OICA</td>
<td>Enter Name Person</td>
<td>Describe the potential impact if the risk were materialised. Describe the external factors that could result in the risk materialising. Ensure the context of the risk is clear.</td>
<td>Enter a description of what is currently in place to mitigate the risk.</td>
<td>Enter a score 1 to 3. Rare (1), Unlikely (2), Possible (3), Likely (4), Certain (5).</td>
<td>Enter a score 1 to 3. Negligible (1), Minor (2), Moderate (3), Major (4), Extreme (5).</td>
<td>Multiply Impact by likelihood - e.g. 2 X 2 = 4. See Table on page 21 for colour code.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Risk Reduction Strategies: Consider elimination, substitution or enter ‘accept the risk’. Enter the scoring after the additional controls have been put in place.

## Appendix 6 Organisational Risk Register Template with Automatic Colour Indicators

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Owner</th>
<th>Risk Description</th>
<th>Actual/Potential Risk</th>
<th>Existing Controls Measures</th>
<th>Analysis</th>
<th>Initial Risk Rating</th>
<th>Additional Controls Required</th>
<th>Risk Priority Nin, M, L</th>
<th>Person Responsible for Action</th>
<th>Due Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td></td>
<td>Member of staff slips or falls by tripping on loose cables or slipping on wet floor.</td>
<td>Actual</td>
<td>Staff awareness of dangers. New dry area of walking/clearing. Loose cables removed from exposed floor area.</td>
<td>Low</td>
<td>3</td>
<td>6</td>
<td>Future development should have covered floor</td>
<td>Low</td>
<td>Ongoing Dec 14</td>
<td></td>
</tr>
<tr>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>2</td>
<td>2</td>
<td></td>
<td>High</td>
<td>Ongoing Dec 14</td>
<td></td>
</tr>
<tr>
<td>4.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>1</td>
<td>1</td>
<td></td>
<td>High</td>
<td>Ongoing Monthly</td>
<td></td>
</tr>
<tr>
<td>5.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td>1</td>
<td>1</td>
<td></td>
<td>High</td>
<td>Ongoing Monthly</td>
<td></td>
</tr>
</tbody>
</table>

R: Risk Register 2018  Page 1 of 1  Sheet 1
Appendix 7

Risk Register Team Attendance Sheet

Risk Register Team Attendance  Date_____________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Department</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>