Building a Better Health Service

Quality Assurance and Verification Division

Healthcare Audit Summary Report

Audit of the Integrated Risk Management Process based on the HSE Integrated Risk Management Policy

Audit Reference Number: QAV003/2017

Title	**Audit of the Integrated Risk Management Process based on the HSE Integrated Risk Management Policy**	
Number	QAV003/2017	
Timeframe	June 2017 – November 2017	
Team Members	Mr. Alfie Bradley, Healthcare Auditor, Quality Assurance and Verification Division (QAVD) (Lead Auditor)	
	Mr. Cathal Reilly, Healthcare Auditor, QAVD (Co-Auditor)	
Approved by	Ms. Cora McCaughan, Assistant National Director (AND), Healthcare Audit, QAVD	
Audit Liaison	Ms. Cornelia Stuart, AND, Office of the National Director, QAVD	
Source of Evidence	**Site Visit and Request for Evidence**	**Date of site visit**
	CHO Area 5 UL Hospital Group Acute Hospitals Division CHO Area 1 Mental Health Division RCSI Hospital Group	27 July 2017 03 August 2017 09 August 2017 17 August 2017 23 August 2017 27 September 2017

Report Distribution	
Date: 19 December, 2017	
Name	**Title**
Ms. Anne O'Connor	National Director, Mental Health Division
Mr. Liam Woods	National Director, Acute Hospital Services
Mr. Pat Healy	National Director, Social Care
Mr. John Hennessy	National Director, Primary Care
Dr. Stephanie O'Keefe	National Director Health and Well Being
Mr. Patrick Lynch	National Director, QAVD
Ms. Aileen Colley	Chief Officer, Community Health Organisation Area 5
Professor Colette Cowan	Chief Executive Officer, UL Hospital Group
Mr. John Hayes	Chief Officer, Community Health Organisation Area 1
Mr. Ian Carter	Chief Executive Officer, RCSI Hospital Group
Ms. Cornelia Stuart	Assistant National Director, Office of the National Director QAVD
Ms. Cora McCaughan	Assistant National Director, Healthcare Audit, QAVD

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ABBREVIATIONS

CO	Chief Officer
CHO	Community Healthcare Organisation
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IRMP	Integrated Risk Management Policy
LHO	Local Health Office
ND	National Director
QAVD	Quality Assurance and Verification Division

1. Background and Rationale

"The Health Service Executive (HSE) is committed to ensuring that risk management is seen as the concern of everyone and is embedded both as part of normal day to day business and informs the strategic and operational planning and performance cycle" (HSE Integrated Risk Management Policy (IRMP), 2017). Furthermore, the HSE is committed to ensuring that risks are managed appropriately and in line with statutory, mandatory and best practice requirements.

The HSE IRMP has been updated regularly since its publication in 2007. The latest revision took place in 2017 and incorporates an overview of the risk management process, which is aligned to 'ISO31000 Risk Management – Principles and Guidance'[1]. The IRMP documents the roles and responsibilities of each person involved in risk management, and sets out what it considered a 'consistent approach to the assessment and management of risk'.

The risk management process incorporates several stages, including *inter alia* risk identification, risk assessment, risk treatment, recording of risk (the Risk Register), and risk monitoring. Risk Registers are tools that enable services to assess key risks, determine priorities for action, anticipate likely areas of impact (with mitigation where possible), and track the management response to the identified risk.

This audit was requested by the National Director (ND) for the Quality Assurance and Verification Division (QAVD) to obtain assurance that Risk Registers are in place, that risk is being given appropriate consideration by management, and that risk management is evidence-based and operating effectively.

2. Aim and Objectives

The aim of this audit was to provide assurance to the ND QAVD that the IRMP was being implemented. The objectives were:

(1) To establish, on a sample basis, whether risks had been appropriately identified, assessed, treated, recorded and monitored at Divisional, Acute Hospital Group, and Community Healthcare Organisation (CHO) area levels as per the IRMP.

(2) To determine for selected facilities whether, based on available evidence, risk had been considered appropriately by management, and whether effective communication and notification of risk had taken place as per the IRMP.

Note: the scope of the audit, for all sites, was to review risks already identified, not to determine whether there were other risks that should have been included on the Risk Register.

3. Methodology

Each site selected for audit was asked to provide a copy of their Risk Register, and the auditors selected a sample of two risks from each Register provided. Evidence of the implementation of a risk management process aligned to the IRMP was determined through:

- A request for evidence (RFE) issued to the nominated audit liaisons in advance of a site visit seeking:
    - Documentary evidence of implementation of the stages of risk management as laid down in the IRMP, with particular emphasis on the sampled risks;

[1] https://www.iso.org/iso-31000-risk-management.html - (link to site for reference)

- Documentary evidence of communication of the identified risk and of notification to other levels of management within the sites selected and nationally as appropriate.

- Site visits were undertaken to all six sites and included:
  - A review of risk management process documentation.
  - Semi-structured interviews with the audit liaisons and other relevant personnel.
  - Exit meetings held at or after the conclusion of each site visit with the site liaison and relevant personnel to outline the preliminary findings of the audit at that site.
- Draft audit reports were forwarded to each site for review of factual accuracy, comment and management response to the recommendations made (Appendix 1).
- Finalised audit reports were circulated to relevant personnel.

4. FINDINGS AND RECOMMENDATIONS

The audit sites included two national divisions, two hospital groups and two CHO Areas. These choices allowed review of the notification process between national and hospital group/CHO level as well as the internal management of risk and this is reflected in the report.

Objective 1: To establish, on a sample basis, whether risks had been appropriately identified, assessed, treated, recorded and monitored as per the HSE IRMP.
Evidence demonstrated that at three of the six audit sites, risks were appropriately identified, assessed, treated, recorded and monitored as per the HSE IRMP (Acute Hospitals Division, Mental Health Division, and UL Hospital Group (ULHG)). CHO 5 showed deficits in the recording and monitoring of risks. CHO 1 did not have a unique corporate risk register. RCSI used a bespoke risk assessment form and risk register, neither of which aligned fully with the requirements of the IRMP.

Risk Identification and Assessment:

Evidence for the sample risks demonstrated that risk was appropriately identified and assessed at all six sites.

Risk assessment sheets for the sample risks were reviewed at all sites, and in five of the six sites, the assessment was completed correctly using the prescribed form. The RCSI Group used a non-standard form and did not record the risk owner, or the "due date" for the controls identified.

Elements within the risk assessment sheets included:

- *Risk identification (risk description)*: Herein the clinician or manager who drafted the risk assessment identified the risk by describing how it had arisen and detailing the current status (current at the time of the development of the risk assessment). Evidence showed that risk identification aligned to the IRMP in all cases.
- *Risk analysis*: This provided an analysis of the actual and/or potential impacts associated with the risk, e.g. harm to patient, staffing issues and non-compliance with regulation and/or policy. Evidence showed that risk identification aligned to the IRMP in all cases.
- *Risk evaluation*: This included:
  - Identifying existing risk controls, e.g. policies and procedures already in place that may mitigate the risk. It was not within the scope of this audit to determine the effectiveness of existing controls but rather to review whether controls had been identified and subsequently reviewed. In all cases the controls had been identified and in five of the six

sites it was clear that controls had been reviewed on an ongoing basis. CHO 5 demonstrated some evidence of review of controls but did not document this adequately on the Risk Register.

- Rating (scoring) the risk: the risk rating procedure followed the IRMP Impact/Likelihood risk measurement at all sites. Of the 12 risks reviewed, 11 were categorised as red, and were allotted scores between 16 and 25. Evidence demonstrated that these risks had been re-evaluated on an ongoing basis in five of six sites. Evidence of re-evaluation was not clear in CHO 5. The remaining risk was categorised as 'closed', meaning that it no longer posed a substantive risk to the organisation. The auditors deliberately chose a closed risk to allow review of the risk's pathway from inclusion, to successful mitigation, to closure at corporate level, even if it might still remain on a local Risk Register. The risk chosen was an 'estates' risk in CHO 1, and it was clearly demonstrated that the risk was continually re-evaluated (from 2010 to 2017) and that through gaining appropriate funding, the estate to which the risk referred was eventually upgraded to the required level.

Risk Treatment:

The identification of existing controls to enable risk treatment was evident as above. 'Additional controls' are those actions identified over and above the existing risk controls to mitigate ('treat') the risk. It was not within the scope of this audit to determine the effectiveness of additional controls, but rather to review whether they had been identified and subsequently reviewed.

The presence and review of additional controls was evident at five of six sites. In CHO 5 however, although additional controls were identified (as per their risk assessment sheets), they were not adequately recorded on the Risk Register.

Recording of Risk:

Mental Health Division: adhered to the recommended IRMP format.

Acute Hospital Division: adhered to the recommended IRMP format. The division had introduced an electronic Risk Register, the eRegister, in March 2017. The Acute Hospital Division was the pilot group for divisional level. This allowed real-time reviews and updates of the Risk Register.

ULHG: adhered to the IRMP format. However, evidence showed that ULHG employed a different format for their divisional risk registers and had not migrated to the recommended IRMP format. They stated that they felt that their current divisional risk registers had some advantages such as being able to include hyperlinks enabling direct links to risk assessment sheets.

CHO 5: At the time of the audit the CHO 5 Risk Register was not completed appropriately. There were blank worksheets in the Risk Register workbook, and blank columns in the Risk Register worksheet itself. CHO 5 accepted the auditors' recommendations.

CHO 1: At the time of audit, there was no corporate-level Risk Register in CHO 1. Risks were maintained on Local Health Office (LHO) level Registers which followed the IRMP recommended format, with on-going oversight by the Chief Officer (CO) and the Executive Management Team. The LHO-level Registers were the de-facto CHO-level Risk Register. In mitigation of the above, the CO stated at interview that the CHO area was in a period of transition, and that a process had started to realign quality and patient services to include risk management.

RCSI Hospital Group: use a bespoke Risk Register, published online, with an appearance broadly similar to the format recommended by the IRMP. It does not however display the risk owner or risk co-ordinator for each risk, nor does it record the extra information recorded on the other worksheets of the recommended Excel version.

Monitoring of Risk:

Monitoring of risk involved ongoing review of risk by the appropriate management team to determine whether controls were effective and to take appropriate action as required. Monitoring of risk was clearly demonstrated in five of six sites. In CHO 5, the deficits in recording the risks, as above, made it difficult to ascertain whether risks were appropriately monitored.

Recommendations:

National Directors for the Acute Hospital Division, Mental Health, Social Care, Primary Care and Health and Well Being should ensure that:

1. Hospital groups, CHOs and other facilities have Risk Registers in place, and;
2. That all Risk Registers comply with the IRMP.

Objective 2: To determine whether risk had been considered appropriately by management, and whether effective communication and notification of risk had taken place as per the IRMP.
Evidence reviewed demonstrated that at four of the six sites, risk was considered appropriately by management, and that effective communication and notification of risk had taken place. The absence of a Corporate Risk Register and associated escalation system in CHO 1 meant that appropriate consideration of risk was not allowed for. In CHO 5, insufficient documentation was available to demonstrate that actions had been implemented, and there was no evidence that Action Plans were in place for red-rated risks.

Risk Governance

Overall responsibility for risk management fell under the remit of the most senior accountable person at each site. Evidence showed that risk was discussed and actioned at senior management team meetings at all sites and was a standing item on the agenda of these senior teams, usually under the heading of 'Quality'. At all sites, senior management was supported by quality and risk committees which undertook responsibility for risk management in the first instance. At all sites there was a quality and safety lead person named as having responsibility for risk management.

As highlighted earlier, CHO 1 risk management is aligned with the former LHO structures, and this was seen as a potential deficit in that risk was not aligned to the divisional structures. However, it is noted by the auditors that the proposed realignment of services nationally next year will have implications for risk management structures in all CHOs.

Communication of Risk:

Communication pathways for risk management were evident within each site visited. Risk assessment typically began with a clinician and/or manager, supported by risk management staff, documenting and analysing a risk. Risk assessment sheets were completed and followed by discussions at divisional/hospital/Local Health Office level on whether the risks assessed, or the actions associated with them, needed to be notified (escalated) to the next level. In the hospital groups and the CHOs it was stated that staff at all levels had access to risk registers through either soft copy, for example Q Pulse, or hard copy at workstations (this was not part of the aim or objectives of this audit and evidence was not sought to support it).

Notification (escalation) of Risk:

The IRMP includes for the possibility that "escalation" of risk will be required. In essence, in each case where a risk requires additional controls (i.e., controls additional to what is already in place), the controls proposed need to be recorded on the Register, together with information about who

is going to put them in place, and by when. If the proposed controls cannot be resourced internally, for example if a hospital group cannot put in place a particular control until extra resources are received, then that fact also needs to be recorded on the Register, and needs to be communicated to the next level (escalated). The risk itself, however, remains with the original authors, i.e., the hospital group in this case. It is possible that a given risk may have a number of associated additional controls, some of which are to be put in place by the organisation in question, and some of which can only be put in place with assistance from the next level.

Evidence reviewed displayed that this process worked satisfactorily within the sites visited, and where appropriate, between different levels. There are reporting structures in place between CHOs and the Divisions nationally, and between the hospital groups and the Acute Hospital Division, and while some staff interviewed suggested that communication about risk between levels could be improved, there were no significant failings identified in the process. The two National Divisions, in particular, seemed satisfied that while some work is still outstanding, Risk Registers were steadily becoming an operational management tool.

CHO 5 and CHO 1 separately concluded that it would be very helpful for their Quality/Risk staff to have access to a forum/discussion group of some kind (possibly facilitated centrally) that would allow Quality/Risk staff to meet and discuss risk. Both sites, and ULHG, suggested that more training on the new policy may be beneficial.

Other matters:

It was necessary, after carrying out the site visits, to make recommendations to management in three of the six sites (see Section 6: Management response to recommendations). In two of those sites, the recommendations were accepted, and a timeline for implementation was agreed, together with the identification of a person responsible for the implementation, the other group did not inform the audit team of an agreed implementation date or the person responsible for implementation.

Recommendation: No recommendations under this objective.

5. CONCLUSION

Objective 1:

Reasonable assurance can be given that three sites (Acute Hospitals Division, Mental Health Division and UL Hospital Group) had appropriately identified, assessed, treated, recorded and monitored risk as per the HSE IRMP. Reasonable assurance can also be given that RCSI Group processes aligned to the IRMP, even though it was noted that the manner in which certain information was recorded (or not recorded) on Risk Assessment sheets and on the Risk Register was not in accordance with IRMP.

CHO 1 appropriately identified, assessed, treated and monitored risk, but the absence of a corporate-level Risk Register allows that only limited assurance can be given.

CHO 5 risk management documentation contained deficits which allow only limited assurance to be given with regards to alignment to the IRMP.

Objective 2:

Reasonable assurance can be given that four of the six sites considered, communicated and notified risk in alignment with the IRMP.

CHO 1 can be given only limited assurance due to the absence of a corporate-level Risk Register and the escalation system that would have accompanied it did not allow for appropriate consideration of risk at CHO level.

CHO 5 can be given only limited assurance as there was insufficient documentation available to demonstrate that actions had been implemented, and no evidence that action plans were in place for red-rated risks.

Acknowledgements:

The audit team wish to acknowledge the co-operation and goodwill afforded to them by all those participants in the audit.

Lead Auditor	Alfie Bradley
Signature	
Date	19 December 2017
Assistant National Director	Ms Cora McCaughan
Signature	
Date	19.12.17

6. MANAGEMENT RESPONSE TO RECOMMENDATIONS

Management response should be completed by the senior most accountable person with the authority to effect the actions outlined by the recommendations listed hereunder.

Audit Site	Recommendation	Management response	Agreed implementation date	Person responsible
Acute Hospitals Division	No Recommendations	N/A	N/A	N/A
CHO 1	A stand-alone Risk Register for CHO 1 should be established, containing only those risks that are appropriate to a CHO area-level risk register, rather than LHO area-level risk register.	CHO Area I are committed to developing a stand-alone risk register containing only those risks that are appropriate to a CHO area level risk register. Work to this end has already commenced.	End of February 2018	Mr John Hayes Chief Officer, CHO Area 1.
CHO 5	1. The deficiencies in the Divisional Risk Registers, and the consequent deficiencies in the corporate Risk Register as highlighted in Table 1 and throughout this report, should be addressed by management as a matter of urgency. 2. All actions undertaken to mitigate risk should be recorded on the Risk Register. 3. Action Plans should be developed, as per the IRMP, for each red risk, and recorded with the relevant risk on the register.	1. Since the start of this audit the QPS team has been re-aligned into a divisional format. Subsequently the Q&S advisors in those divisions have been actively working on a complete validation of each risk register. This was chosen early in the formation of the team as one of 3 major projects for development in 2017 This includes the conversion of all risk registers to the IRMP XL Format and the validation of all historic risks to provide a fully validated risk register. 2. At the time of the audit the conversion from the existing records to the new XL Template was under way. On the older template the additional controls combined with the existing controls would represent the management plan. As some of the risks were historical it would have indicated that either the management plans had not worked and had not been revised or that the risk was no longer valid. Hence the extensive validation process undertaken in each division to ensure going forward that the registers contain up to date, validated information and action plans. Therefore the Actions could not be completed at that point. As risks are validated then actions taken will be logged on the new template. The last Risk register to complete this will complete by the 09/11/2017 3. We take on board the requirement of the IRMP for an Action	21/11/2017 09/11/2017	David Green QPS Manager CHO5 David Green QPS Manager CHO5

		Plan for each "Red" risk. To assist with this process and to help in identifying responsibilities and accountabilities 1. A workshop will be held locally on the 14/11/2017 at which such Action plans will begin to be developed. 2.Monitoring of the scheduled risk returns to National QPS Teams will be undertaken by the Q&S Divisional advisors 3.Risk registers and risk management are standing agenda items on the QPS meetings throughout all divisions 4.Audit of Risk Registers set against the standards of the IRMP will take place on an annual basis	14/11/2017 Quarterly Monthly July 2018	Heads of Service General Managers/Service Managers
Mental Health Division	No Recommendations	N/A	N/A	N/A
RCSI Hospital Group	RCSI Group must identify 'Risk Owners' on the risk assessment forms, and 'due dates' for any actions designed to mitigate risk.	1. On page 4 of the draft report you have outlined that the format of the RCSI Hospital Group Risk Register does not align to the HSE Integrated Risk Management Process as additional actions to manage risk have not been assigned to a single person as risk owner. It is inaccurate to assign a single risk owner to progressing the additional controls in either of the two risks audited, 2. You have also pointed out on page 4 of the draft report that neither risk has been assigned a due date for the completion of additional actions to control the risk. Both risks are consistently being monitored, managed and mitigated. However to suggest a due date for completion can be assigned to either is to misunderstand the nature of both risks.		
UL Hospital Group	No Recommendations	N/A	N/A	N/A