Designing a risk register
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Introduction

A risk register is part of the process of recording how you will manage the risks in your work area or organisation. Each risk that is identified should be recorded in a register that summarises:

- a description of the risk
- its cause and impact
- the existing controls for the risk
- an assessment of the consequences and likelihood of the risk happening with the existing controls
- the risk rating: low, medium, high or very high and the overall priority of the risk

Purpose

To enable ED leaders to develop a risk register and understand its purpose in maintaining patient safety.

Objective 1	***Action***	***Evidence and Resources***
Identifying risks for the register.	Identifying risk is important as risks have wide implications within the healthcare sector.	*The identification of risk, and use of a risk register, enables senior management of the organisation to prioritise individual risks and to structure efforts and resources into reducing risk and thereby improve quality and standards of care. Sources to identify risk include incident reporting, serious incidents, patient feedback and complaints. It is essential that frontline staff understand the role of the incident reporting system and the risk register.* *In many organisations, the risk register is populated by a risk manager to reflect complaints, litigations, inspection, reports and trends within incident reports within a service area or directorate.* *This guide for risk managers on how to populate a risk register has case studies and examples of how to identify risk within an organisation. It explains the purpose of assessing risk and how to integrate the risk register into the trust organisational structure.* **Making it Happen: A Guide for Risk Managers on How to Populate a Risk Register,** CASU and Risk Register working group of Keele University, 2002. http://www.dhsspsni.gov.uk/guidance_on_register.pdf *The Northern Irish Assembly, Department of Health, Social Service and Public Safety has a clinical governance section explaining the development of the risk register from how to populate the register to how to assess risk.* **The Department of Health, Social Services and Public Safety**, ***Risk Register Guidance*** http://www.dhsspsni.gov.uk/governance-risk

Objective 1	***Action***	***Evidence and Resources***
continued		*The Health Services Executive Ireland gives an overview of the risk register development process from department level to organisation level.* **Health Services Executive Ireland, *Developing and Populating a Risk Register Best Practice Guidance*** http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/devrr.pdf
Objective 2	***Action***	***Evidence and Resources***
To be aware of the available resources for risk assessment.	Risk assessment is the process that supports organisations in understanding the range of risks they have, their ability to control these risks, the likelihood of occurrence and the potential impact of these risks.	***The National Reporting and Learning Service (NRLS) and NPSA (National Patient Safety Association)*** *have produced a range of resources to help managers and staff with risk assessment/management relating to patient safety, including:* *This risk management programme comprises an overview and specific guides for practice-based commissioning and commissioners of out-of-hours services. It describes the NRLS's risk assessment work programme and suggests tools and techniques that local NHS organisations can use in their risk management approach.* **Risk assessment overview programme**, National Patient Safety Agency, November 2006 http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60102&type=full&servicetype=Attachment *This document promotes vigilance in identifying risk and the ways in which risk can be minimised. It describes the difference between a hazard and a risk, and sets out the five steps to easy risk management. In addition it contains an example risk matrix and action required to reduce risks to an acceptable level.* **Healthcare risk assessment made easy,** National Patient Safety Agency, March 2007 http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60138&type=full&servicetype=Attachment *This risk matrix helps NHS risk managers implement an integrated system of risk assessment. The document includes guidance on consequence scoring, guidance on likelihood scoring, risk scoring and grading, relationship with incident scoring and a model matrix.* **A risk matrix for risk managers**, National Patient Safety Agency, January 2008. http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60149&type=full&servicetype=Attachment *On Friday 1 June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority.* **The NHS Commissioning Board, *Patient Safety*** http://www.commissioningboard.nhs.uk/ourwork/patientsafety

Objective 2	*Action*	*Evidence and Resources*
continued		*NHS Scotland has a quality improvement tool on the risk register. This includes templates and methods of assessing risk.* **NHS Scotland Quality Improvement Hub, *Risk Register*** http://www.qihub.scot.nhs.uk/knowledge-centre/quality-improvement-tools/risk-register.aspx *This website contains interactive learning tools on risk management.* **Flying Start NHS, *Managing Risk*** http://www.flyingstart.scot.nhs.uk/learning-programmes/safe-practice/managing-risk.aspx *This document provides a template for the analysis of risk.* **The Australia / New Zealand Model** (AS/NZS 4360: 1999) www.dhsspsni.gov.uk/guidance_on_analysis.doc
Objective 3	***Action***	***Evidence and Resources***
To understand methods of risk management.	Once identified and assessed, risks need to be managed. Some risks can be managed others cannot and need mitigating.	*Organisations have risk management teams who collate and respond to the documentation of risk as identified by health care professionals at local level and integrate the highest risks (usually those with a score of 15 or more) into the trust or organisation's risk register.* *The NHS Litigation Authority regularly assesses NHS Trusts against its risk management standards. Trusts at Level 1 are assessed once every two years and those at Levels 2 and 3 at least once in any three year period. Trusts that fail an assessment are re-assessed within a year. Trusts at Level 1 in the risk management standards receive a 10% discount on their CNST and RPST contributions, with discounts of 20% and 30% given to those achieving Levels 2 and 3 respectively.* **NHS Litigation Authority, *Standards*** http://www.nhsla.com/Safety/Standards/Pages/Home.aspx *The CNST (Clinical Negligence Scheme for Trusts), administered by the NHS Litigation Authority, provides an indemnity to members and their employees in respect of clinical negligence claims. The Risk Pooling Schemes for Trusts (RPST) covers non-clinical risks. These schemes are funded by contributions paid by member trusts and contributions are calculated on an annual basis.* **NHS Litigation Authority, *Clinical Claims*** http://www.nhsla.com/Claims/Pages/Clinical.aspx *This document addresses risks in the healthcare sector and provides some good ideas on how to deal with them. It is an initiative by the health promotion bodies and the Health Services Advisory Committee.* **Risk assessment at work: Practical examples in the NHS,** NICE: 1997: http://www.nice.org.uk/niceMedia/documents/risk_assment_examples.pdf.

Objective 3	*Action*	*Evidence and Resources*
continued		*In this risk management standards document Figure 3.1 'Risk management process in detail' and the definitions are particularly useful.* **Australian and New Zealand Standards - Risk Management**, AS/NZS 4360:2004, http://www.mwds.com/AS4me_files/AS-NZS%204360-2004%20Risk%20Management.pdf
Objective 4	***Action***	***Evidence and Resources***
To appreciate the need to document and maintain the risk register.	The risks identified need to be documented and shared with the organisation so that action can be taken to mitigate the risk.	*Datix is a good example of an electronic "integrated risk reporting system" already used by many trusts in the UK for incident reporting. Now some trusts are developing the system further for managing their risk registers. However it is only as good as the information entered. It is a 'live system' and open for everyone (with access) to see. It is in constant flow, updating all the time, allowing new risks to be added when identified and old risks to be down -graded or even archived when changes have been implemented. It may be possible in the future that the risk registers will be uploaded to the NRLS as happens with the incident reporting.* **Datix** http://www.datix.co.uk *Prior to the development of systems like Datix the risk register was usually kept as a folder in the department and the risks reviewed at intervals - usually yearly. The below link is an example risk register from St Emlyn's Virtual Hospital.* **St Emlyn's Virtual Hospital** http://www.stemlyns.org.uk/download.php?dtType=media&fileID=547
Objective 5	***Action***	***Evidence and Resources***
To appreciate the teaching and learning required for good risk identification and assessment.	Frontline staff need to understand the role of the incident reporting system and the risk register in improving safety.	*The identification of risks for the register is only as good as the information available. Clearly if areas of risk exist which are not reported or recorded then the register will be less valid. Equally, the assigning of the priority order of risks may be subjective. These limitations can be reduced by high level of clinical ownership of the process.* *Many Trust held training programmes or workshops are offered by the Risk Management Team.* *There are many examples of NHS Trust guidance on risk assessment and management on the internet, for example:* **Royal Cornwall Hospitals NHS Trust, *Policy and Guidance for Risk Assessment and Risk Registers 2012*** http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/QualityAndSafety/RiskAssessmentPolicy.pdf

Objective 5	*Action*	*Evidence and Resources*
continued		**East Cheshire NHS Trust, *Risk Assessment and Risk Register Policy 2012*** http://www.eastcheshire.nhs.uk/About-The-Trust/policies/R/Risk%20assessment%20and%20risk%20register%201730.pdf ***Royal College of Physicians*** *and* ***NPSA*** *have produced a Teaching Module for FY1/FY2 on Risk assessment which includes:* Instructions: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61911& Slides: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61910&type=full&servicetype=Attachment *The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.* **NHS, *The Central Risk Alerting System*** https://www.cas.dh.gov.uk