Risk register guidelines
Managing risk using the specimen Hospital Authority risk register

Version 1.1

Contents

1. Introduction

1.1 What is risk?

Risk is inherently adverse, or negative. However, risk is not just about the possibility of bad things happening – it is also about the possibility of good things NOT happening.

The most common definition of risk is "anything that could threaten your ability to meet your objectives." These may be personal, departmental, project or organisational objectives.

Risk is sometimes categorised as either 'strategic' or 'operational'. *Strategic risks* concern the long-term strategic objectives of an organization. They can be affected by such areas as capital availability, sovereign and political risks, legal and regulatory changes, reputation and changes in the physical environment. *Strategic risks* are quite distinct from *operational risks*, which concern the day-to-day issues that an organization is confronted with as it strives to deliver its strategic objectives.

In health care, risk is sometimes also categorised as either 'clinical' or 'non clinical'. For practical purposes, *clinical risks* can be thought of as risks affecting patient safety.

Risk is measured in terms of likelihood and consequences (see Section 2).

1.2 Why manage risk?

Managing risk is a fundamental and integral aspect of good management and clinical practice. It should not be viewed as an 'add on' extra.

It is essential that risks are properly managed to minimise the chances of, for example, personal harm, property damage or loss, or not meeting individual, departmental or organisational objectives. In some instances, e.g. occupational safety and health (OSH), it is a legal requirement to mange risk. In delivering health care it is essential that 'clinical' risks are properly managed in order to enhance patient safety.

1.3 What are the potential benefits of good risk management?

Within the Hong Kong Hospital Authority context, the following are just some of the potential benefits of good risk management:

- √ A more open culture
- √ A more informed workforce
- √ Audit Committee and HA Board reassurance
- √ Better decision making at all levels

√ Better managed projects
√ Better outcomes
√ Better patient care
√ Better resource planning and utilisation
√ Cluster Chief Executive reassurance
√ Compliance with legislation
√ Fewer complaints
√ Greater rationality and transparency in decision-making
√ Identification of organisational weaknesses
√ Improved communication with stakeholders
√ Improved internal communications
√ Improved public perception and confidence
√ Improved reputation
√ Less likelihood of unexpected events
√ Less management time spent 'fire fighting'
√ Reduction in errors
√ Reduction in staff turnover

1.4 Fundamentals of risk management

The HKHA risk management standard sets out the key requirements for implementing an integrated risk management system across the Hospital Authority.

The fundamentals of risk management are set out in the Australia/New Zealand risk management standard 4360:2004 (see additional reading, Section 1.5). Figure 1 shows the risk management process contained in the Australia/New Zealand Standard.

Following the risk management process set out in Figure 1 requires that:

- the context within which risk is to be managed is properly identified and understood. In this instance, the context is the entire range of activities of the Hong Kong Hospital Authority, it's hospitals and staff;
- risks are identified, analysed and evaluated. The combination of components of the risk management process is commonly termed 'risk assessment'. Risks should be assessed in terms of their likelihood and potential consequences should they materialise;
- risks that cannot be accepted are treated so that they are either eliminated, transferred or effectively controlled;
- there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and
- all aspects of the risk management system are periodically monitored and reviewed to ensure the system is working effectively and to promote continuous improvement.
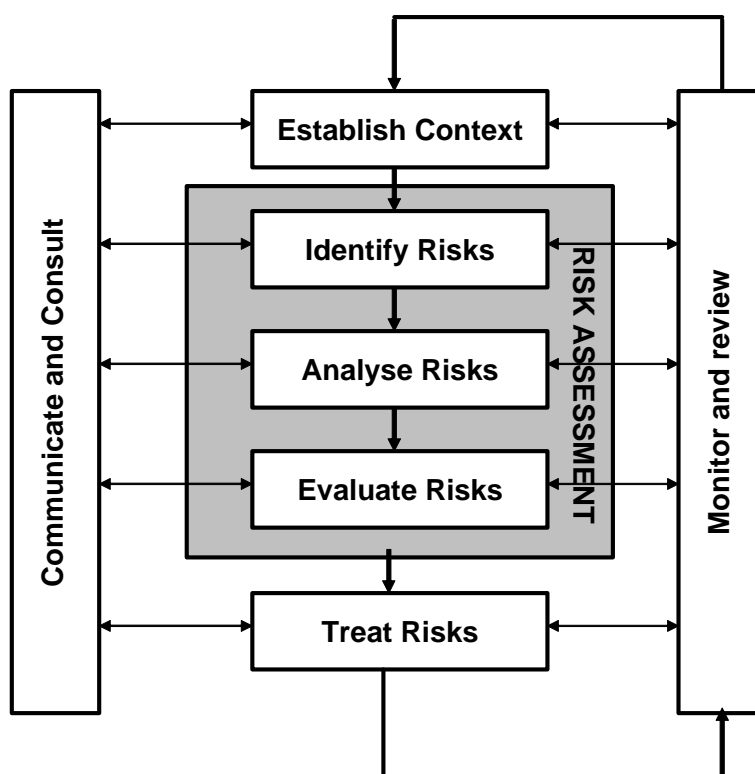
Figure 1 – Risk management process (AS/NZS 4360:2004)

1.5 The specimen HKHA Risk Register

The key tool for communicating and managing risk within any organisation is the 'Risk Register'. A specimen Risk Register applicable to HKHA is provided. This is a computer-based (Microsoft Excel) repository for information on all aspects of risk and risk management (see Figure 2). Risk registers should be maintained by each department on an ongoing basis. Periodically, these risk registers can be 'aggregated' to produce 'corporate' risk registers on a hospital, cluster and overall HKHA basis (see Section 3).

Copies of the specimen HKHA Risk Register can be obtained from the Intranet or directly from Dr David Lau (dhlau@ha.org.hk). Note that it is not mandatory to use the specimen risk register provided. What is important is that the fundamental risk management principles contained in the Australian/New Zealand risk management standard, AS/NZS 4360:2004, are followed. Some hospitals and clusters have already developed their own local approach. One example, which is provided as a case study as part of the Hospital Authority risk register training package, is Kowloon West Cluster (KWC).

Risks can, typically, either be systematically identified and assessed by individual departments or may be communicated, potentially anonymously, via some form of local 'risk suggestions scheme'. In either case, risk details should be entered onto the local Risk Register. Details on completing the specimen HKHA Risk Register are given in section 2 of this guidance document.

The HKHA Risk Register contains various options to help manage all types of risk. The specimen risk register can capture a range of information, classified as either 'essential', 'desirable' or 'potentially useful'. The following general categories of information can be entered onto the specimen risk register:

1. Risk ownership, definition and existing controls
2. Initial risk rating
3. Proposed risk reduction strategies
4. Residual risk rating
5. Implementation of risk reduction strategies
6. Monitoring, communication and contingency
7. Miscellaneous potentially useful information

Figure 2 – Specimen HKHA Risk Register

1.6 Additional reading

The following documents provide additional practical information on risk management:

1. HKHA Risk Management Standard.
2. AS/NZS 4360:2004 – the Australian/New Zealand risk management standard (priced publication, available at www.riskmanagement.com.au)
3. HB 436:2004 – Risk management guidelines: Companion to AS/NZS 4360:2004 (priced publication, available at www.riskmanagement.com.au)

2. A step by step guide to populating the specimen risk register

2.1 Risk ownership, definition and existing controls

2.1.1 Identifying risks

The first step in populating any risk register is to identify the risks. Risks should be identified on a continuous basis using a systematic process. Figure 3 describes a range of 'sources' to help identify risks.

When a risk has been identified, information associated with the risk should be entered onto the relevant risk register. It will usually be the responsibility of a departmental or hospital 'designated person[1]' to enter information into the Risk Register so that the register can be properly used as a tool for communicating and managing risk.

A 'frequently asked question' by many organisations is 'how many risks should we be identifying?'. There is no hard and fast answer. Departments should attempt to identify as many 'significant' risks as is possible, bearing in mind that risk identification is a continuous process and new risks will keep appearing. As a rule of thumb, many departments should find that they have around 10-25 significant risks on their local risk register at any one time. Some may have more – others less. Across a cluster as a whole, there may be some 100-200 significant risks present in the organisational or corporate risk register at any time. Some departments and organisations find it helpful to only actively deal with the identified 'top ten' risks at any point in time.

REACTIVE

INTERNAL

Patient adverse incidents

Staff adverse incidents

Other adverse incidents

Complaints

Claims

Root cause analyses

Risk Register

Internal audits and inspections

General risk assessments

Patient consultation

Staff consultation

Specialist risk assessments

Facilitated workshops

PROACTIVE

Hazard warnings

Safety alerts

Coroners reports

Incidents etc. occurring 'elsewhere'

Inquiry reports

Accreditation standards

External audits, reviews etc.

Benchmarking

Conferences, Seminars, etc.

External stakeholder consultation

Books

EXTERNAL

Figure 3 – Potential sources of risk (not exhaustive)

[1] The designated person is the person within the department or hospital with designated responsibility (and authority) for maintaining the local Risk Register.

2.1.2 Describing risk – the 'three C's'

It is important that a <u>brief</u> description of each risk is provided that accurately and comprehensively ensures the exact nature and magnitude of the risk is communicated to stakeholders. Risk can be described in accordance with the 'three C's':

- Describe the potential **consequences** if the risk were to materialise
- Describe the **causal factors** that could result in the risk materialising
- Ensure that the **context** of the risk is clear, e.g. is the risk 'target' well defined (e.g. staff, patient, department, hospital, etc.) and is the 'nature' of the risk clear (e.g. financial, safety, physical loss, perception, etc.)

Some examples of risk descriptions, based on workshops with HKHA staff, are given below.

<u>Examples of risk descriptions</u>

a) Direct patient-related risks

- Premature discharge of patients leading to death or poor outcome due to bed shortage
- Delay or missed diagnosis/treatment resulting in increased mortality and morbidity
- Long waiting lists resulting in increased morbidity and complaints
- Medication error resulting in death or serious harm to patient
- Making unsound clinical judgment after long hours of duty
- Malfunctioning of resuscitation equipment due to lack of maintenance
- Patient falling off a trolley causing harm to patient or a member of staff
- Wrong patient label on ECG leading to wrong treatment e.g. wrong patient being given thrombolytic
- Ineffective resuscitation of ill patient due to low staff competency, ineffective team co-ordination during resuscitation; inadequate preparation of resuscitation equipment, inadequate documentation, inadequate knowledge on use of resuscitation drugs or ineffective team collaboration during neonatal resuscitation in labour ward
- Administration of incompatible blood to patients due to unlabeled or incorrectly labelled blood samples or wrong blood unit issued by blood bank

b) Other risks

- Increasing service demand and public expectation placing excessive pressures on finite staff capacity resulting in stress and low morale
- Harm to staff due to violent patients
- Staff sustaining needlestick injuries when resheating due to time pressures, unpredictable patients, etc.
- Virus spreading throughout the HA computer network causing lengthy system shutdown
- Breach of computer data security causing
- Financial loss due to payments to fictitious staff

- Grey areas in HA-wide charging policies that give rise to inconsistent charging practices across hospitals
- Failure of electrical distribution system within hospital due to cable fault or switchgear failure

In the context of the risk register, when defining risk, in addition to a good description, it is helpful to specify the type of risk and also identify whether it is an 'actual' or 'potential' risk. An 'actual' risk is one that has materialised before. A 'potential' risk is one that hasn't materialised before, but could do so in the future. The type of risk should, ideally, be selected from the HKHA common risk language shown in Figure 4.
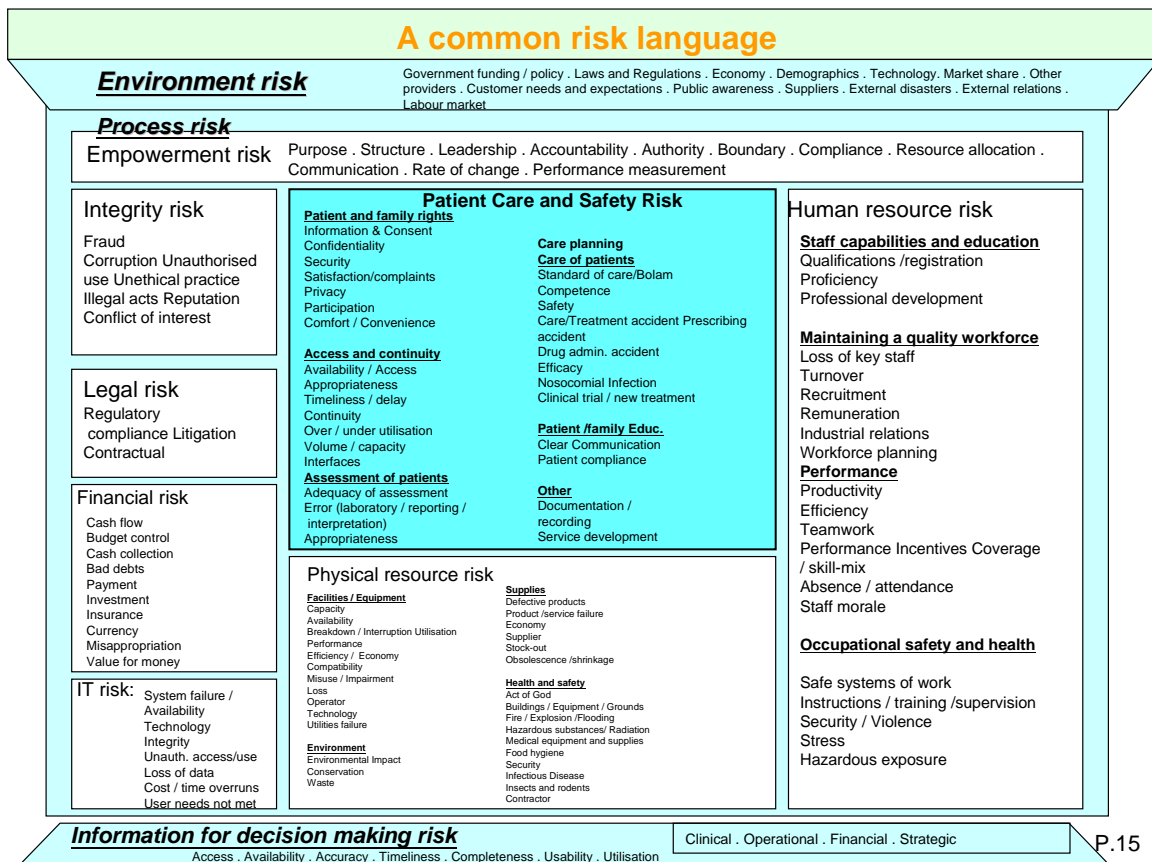

A common risk language

Environment risk — Government funding / policy . Laws and Regulations . Economy . Demographics . Technology. Market share . Other providers . Customer needs and expectations . Public awareness . Suppliers . External disasters . External relations . Labour market

Process risk

Empowerment risk — Purpose . Structure . Leadership . Accountability . Authority . Boundary . Compliance . Resource allocation . Communication . Rate of change . Performance measurement

Integrity risk
Fraud
Corruption Unauthorised use Unethical practice Illegal acts Reputation Conflict of interest

Legal risk
Regulatory compliance Litigation Contractual

Financial risk
Cash flow
Budget control
Cash collection
Bad debts
Payment
Investment
Insurance
Currency
Misappropriation
Value for money

IT risk: System failure / Availability Technology Integrity Unauth. access/use Loss of data Cost / time overruns User needs not met

Patient Care and Safety Risk

Patient and family rights
Information & Consent
Confidentiality
Security
Satisfaction/complaints
Privacy
Participation
Comfort / Convenience

Access and continuity
Availability / Access
Appropriateness
Timeliness / delay
Continuity
Over / under utilisation
Volume / capacity
Interfaces

Assessment of patients
Adequacy of assessment
Error (laboratory / reporting / interpretation)
Appropriateness

Care planning
Care of patients
Standard of care/Bolam
Competence
Safety
Care/Treatment accident Prescribing accident
Drug admin. accident
Efficacy
Nosocomial Infection
Clinical trial / new treatment

Patient /family Educ.
Clear Communication
Patient compliance

Other
Documentation / recording
Service development

Physical resource risk

Facilities / Equipment
Capacity
Availability
Breakdown / Interruption Utilisation
Performance
Efficiency / Economy
Compatibility
Misuse / Impairment
Loss
Operator
Technology
Utilities failure

Environment
Environmental Impact
Conservation
Waste

Supplies
Defective products
Product /service failure
Economy
Supplier
Stock-out
Obsolescence /shrinkage

Health and safety
Act of God
Buildings / Equipment / Grounds
Fire / Explosion /Flooding
Hazardous substances/ Radiation
Medical equipment and supplies
Food hygiene
Security
Infectious Disease
Insects and rodents
Contractor

Human resource risk

Staff capabilities and education
Qualifications /registration
Proficiency
Professional development

Maintaining a quality workforce
Loss of key staff
Turnover
Recruitment
Remuneration
Industrial relations
Workforce planning
Performance
Productivity
Efficiency
Teamwork
Performance Incentives Coverage / skill-mix
Absence / attendance
Staff morale

Occupational safety and health
Safe systems of work
Instructions / training /supervision
Security / Violence
Stress
Hazardous exposure

Information for decision making risk — Access . Availability . Accuracy . Timeliness . Completeness . Usability . Utilisation

Clinical . Operational . Financial . Strategic

P.15

Figure 4 – HKHA Common Risk Language

2.1.3 Entering basic ownership, definition and existing controls information

The following information should be entered onto the risk register:

- **Unique ID** - for the purpose of transferring risks elsewhere and also for the purpose of aggregation, every risk on the risk register should have a unique ID reference. Typically this will be a combination of a code representing the department or project together with a reference number.

- **Date** – This is the date that the risk was initially identified and/or assessed.

- **Risk owner** - This is the individual who will be held accountable for the risk and its effective control. The maxim of 'the risk taker is the risk owner' should be adopted.

- **Risk type** - The type of risk should be categorised in accordance with the 'Common Risk Language' developed by the HKHA (Figure 4).

- **Risk description** – a brief 'one sentence' description of the risk – see Section 2.1.2, above.

- **'Actual' or 'Potential' risk?** – is this a risk that has materialised in the past (i.e. an 'actual' risk'), or is it a risk that has not materialised to-date, but could at some time in the future (i.e. a 'potential' risk)?

- **Existing controls** - a brief description of the existing controls, or arrangements in place to mitigate the risk.

2.2 Initial risk rating

Each identified risk should be analysed, or rated, in terms of its potential consequence, or severity of impact should it materialise, and the probability, or likelihood of the risk materialising. ***Wherever possible, risks should be assessed by a group of individuals rather than by a sole individual.*** In this way a more objective, consensus view of risk can be determined.

Risks should typically be assessed in terms of their potential impact on the department etc. concerned. Occasionally, risks should be assessed in terms of their potential impact on the Hospital Authority as a whole.

For each identified risk an assessment needs to be made of:

1. the 'most likely' potential consequences of the risk, were it to materialise; and
2. the likelihood of the risk giving risk to the 'most likely' consequences.

Note that likelihood may be assessed on the basis of either actual frequency of occurrence of a risk, or estimated probability (percentage) that a risk might materialise. This is a professional judgement issue.

On occasion, there may only be one individual assessing a risk. In such circumstances, the individual should make an assessment of the consequences and likelihood that they feel is 'right'.

Figure 5 shows the HKHA risk quantification matrix, which describes terms for likelihood and consequence and shows the relative risks as high, medium or low.

Each identified risk should be 'graded' in terms of consequence/severity of impact and likelihood in accordance with Figures 6 and 7. ***All identified risks should be rated in light of existing controls, i.e. the arrangements already in place to mitigate the risk (e.g. policies, protocols, training, equipment, staff, etc.).***

On the specimen HKHA Risk Register, under the **Initial Risk** columns, enter the numeric values for **Consequences** and **Likelihood**. The **Initial Risk Rating** will be automatically calculated and a risk colour coding will be assigned in accordance with Figure 5.

Example: A patient falling off a trolley causing harm to the patient is a risk that materialises on an almost monthly basis (i.e. it is an 'actual' risk) and has on a number of occasions resulted in 'major' patient injury. From Figures 6 and 7, therefore, the consequence would be assessed as 'Major' and the likelihood as 'Almost Certain'. The numerical values for these are 4 and 5, respectively. Hence the risk, in accordance with Figure 5, is numerically equivalent to 20, i.e. 'high risk' (red).

Example: Harm to staff and patient from violent patients within a particular care delivery setting might be a very frequent occurrence with a range of different consequences as identified in Figure 8. In this case, the 'worst case' consequence (i.e. 'Major') would be selected and the 'Likelihood' would be 'Almost Certain', resulting in a risk rating of 20.

RISK QUANTIFICATION MATRIX

Consequence

Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Extreme 5
Almost certain - 5					
Likely - 4					
Possible - 3					
Unlikely - 2					
Remote - 1					

RISK ■ Low ■ Medium ■ High

Figure 5 – HKHA Risk quantification matrix

CONSEQUENCE TABLE V1.0: GUIDANCE ONLY – PLEASE USE ONLY THE MOST APPROPRIATE ATTRIBUTE(S)[1]

ATTRIBUTE	Insignificant	Minor	Moderate	Major	Extreme
Patient injury	No injury	Minor injury	Temporary morbidity	Significant morbidity	Death or major permanent loss of function / disability
Staff injury/ill health	No injury	Minor injury Minor treatment No lost time or restricted duties	Temporary Morbidity Simple treatment Lost time or restricted duties or injury/illness for 1-2 staff	Significant morbidity Hospitalisation of 2 staff, or lost time or illness for >2 staff	Major permanent loss of function / disability or death Hospitalisation of ≥3 staff
Visitor injury	No injury	Minor injury Minor treatment	Temporary Morbidity Simple treatment Treatment of up 1-2 visitors not requiring hospitalization	Significant morbidity Hospitalistion of 2 visitors	Major permanent loss of function / disability or death Hospitalisation of ≥3 visitors
Operation interruption (Critical, e.g. electricity, water, gas, IT)	<1 min	< 5 min	< 10 min	< 30 min	> 30 min
Operation interruption (Non-critical)	<1 hour (non-critical)	<1 day	1 - 7 days	> 1 week	Permanent loss of service/facility
Financial impact	<HK$1k	<HK$1k-50k	HK$50k<1M	HK$1M-10M	>HK$10M
Environmental impact	Nuisance releases	Minor off site release contained without outside assistance	Moderate off site release contained with outside assistance	Major off site release with no detrimental effect. Fire or other environmental hazard requiring no evacuation.	Toxic release off site with detrimental effect. Fire or other environmental hazard requiring evacuation.
Reputation	Minor morale issues, 1-2 staff	Low staff morale within a unit/department	Low morale and dissatisfaction amongst majority of staff	Medium term impact on public memory Serious staff concern Corporate image significantly affected	Enquiry by public body, e.g. Legislative Council. Criminal prosecution
Media attention	None	Media enquiries only	One-off newspaper article or radio/television mention	Sustained media attention for 3 or more days	Political intervention

[1] E.g. if the risk relates to patient safety, use only the 'Patient injury' attribute for assessment purposes. Some risks may, however, require to be assessed against 2 or more attributes. In this case, choose the most severe consequence to establish whether Insignificant, Minor, Moderate, Major or Extreme.

Figure 6 – Consequence table

LIKELIHOOD TABLE

	Likelihood	
	Actual frequency	Probability
Almost certain	At least monthly	99%
Likely	Bi-monthly	90%
Possible	May occur every 1-2 years	50%
Unlikely	May occur every 2-5 years	10%
Remote	May occur every 5 years or more	1%

Figure 7 – Likelihood table

CONSEQUENCE TABLE V1.0: GUIDANCE ONLY – PLEASE USE ONLY THE MOST APPROPRIATE ATTRIBUTE(S)[1]

ATTRIBUTE	Insignificant	Minor	Moderate	Major	Extreme
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Financial impact	<HK$1k	<HK$1k-50k	HK$50k<1M	HK$1M-10M	>HK$10M
Environmental impact	Nuisance releases	Minor off site release contained without outside assistance	Moderate off site release contained with outside assistance	Major off site release with no detrimental effect. Fire or other environmental hazard requiring no evacuation.	Toxic release off site with detrimental effect. Fire or other environmental hazard requiring evacuation.
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[1] E.g. if the risk relates to patient safety, use only the 'Patient injury' attribute for assessment purposes. Some risks may, however, require to be assessed against 2 or more attributes. In this case, choose the most severe consequence to establish whether Insignificant, Minor, Moderate, Major or Extreme.

Figure 8 – Example

2.3 Proposed risk treatment

Having identified and rated a risk, the risk will need to be controlled, or managed. Fundamental to managing risk is 'treating' the risk through implementation of appropriate risk reduction strategies. There are four basic approaches to risk treatment:

- **Eliminate** the risk by, for example, ceasing the activity that gives rise to the risk;
- **Transfer** the risk to another party, e.g. through insurance or by 'contracting out' a service;
- **Control** the risk by putting in place an appropriate risk reduction strategy or strategies (i.e. additional controls); or
- **Accept** the risk.

If the risk is to be 'controlled', then in light of the initial risk rating, risk reduction strategies, or additional controls, should be identified. These should be controls that would be effective in mitigating risk and could range from new policies or protocols to additional human or physical resources. A brief description of these proposed additional controls should be entered on the risk register.

In most instances, introducing controls will typically serve to reduce the likelihood of the risk materialising, but will do little, if anything to reduce the potential consequences should the risk materialise. However, in some instances it is possible to introduce controls that will reduce the potential consequences. For

example, introduction of health and safety control measures can significantly mitigate the potential consequences of regulatory action.

2.4 Residual risk rating

Similar to the 'initial risk rating' calculated in 2.2, above, a 'residual risk rating' should be calculated based on the assumption that the additional controls are in place and working effectively. In many instances, implementing additional controls will serve to reduce the likelihood, but may not reduce the consequences should the risk materialise.

2.5 Implementation of risk reduction strategies

- **Approximate financial resources required**

Enter the approximate cost of risk treatment as one of the following cost ranges: <HK$1k; HK$1k-50k; HK$50k-1M; HK$1M-10M; >HK$10M.

It is not usually necessary to attempt a detailed costing exercise for this. In many instances, managers would be expected to have some idea of the approximate cost of treating a risk.

- **Priority (H/M/L)**

The priority for implementing risk reduction strategies can be 'simply' assigned as High, Medium or Low. Assignment of priority will be a professional judgement based on a combination of factors, including whether the risk is 'actual' or 'potential', the initial risk rating, the initial consequences (any risk having potentially 'extreme' consequences is immediately 'flagged up' as red by the risk register), the residual risk rating and consequential potential for reducing risk, and the approximate financial resources required to implement the risk reduction strategies.

- **Person responsible for action**

Enter the name of the person who is responsible and who will be held accountable for any actions necessary to mitigate risk. This person could be the **Risk owner**, or may be someone else.

- **Due Date**

Enter the date by which implementation of the actions to mitigate risk are due.

- **Review Date**

All risks should be periodically reviewed, based on the nature of the risk and its magnitude. Some risks may require only infrequent review, e.g. bi-annually or

annually, whereas others may require more frequent monitoring, e.g. monthly or quarterly.

- **Completion date**

When all the actions required to implement the risk reduction strategies have been completed, enter the completion date.

- **Progress**

Following any review (see **Review Date**), enter brief details of progress. It may, for example, be that several additional controls need to be implemented over a period of time and review dates are set to monitor progress of implementation.

2.6 Monitoring, communication and contingency

- **Key Indicators**

Key indicators can help demonstrate the success, or otherwise, of the controls in place to mitigate risk. For example, in our 'patient falling off the trolley' example above, a simple indicator could be the number of trolley falls per month. In terms of occupational safety and health, key indicators might include the number of IoD events per 100 staff, or lost time hours due to injury or ill health. It is important that for each key risk sufficient thought is given to exactly how the success of risk mitigation strategies, or controls, can be measured. The number of key indicators should be kept to a minimum. In most instances, only one or two indicators should be necessary to demonstrate success.

- **Monitoring & Review**

Enter brief details as to how the risk and the associated controls will be monitored and reviewed on a periodic basis. Some risks will be monitored locally by management within departments, etc. Other, more major risks may need to be monitored by a relevant committee or group. At a cluster or HA-wide level 'cross cutting themes' will need to be identified, i.e. similar risks that exist across different departments, hospitals, clusters etc. Identification of cross cutting themes is a specialist monitoring activity.

- **Communication strategy(ies)**

Enter brief details on key internal and external stakeholders and communication strategies. For example, a key internal stakeholder may be the Audit Committee and communication about risk may be a quarterly summary report based on the 'corporate' risk register.

- **Contingency Plan(s)**

In some instances it may not be possible to implement any additional controls for whatever reason, or you may be concerned that even with additional controls in

place, something might still go wrong. A contingency plan is in itself a form of control, but it can be viewed as a control of 'last resort' – often it is a control that 'mops up the mess'. For example, in the case of a severe infection outbreak the contingency plan may be to close the affected area(s). Note that it will not always be the case that a contingency plan is needed. You must make a judgement on those risks which, even after implementation of appropriate risk control measures, would require some kind of plan to deal with, in most cases, the 'unthinkable'.

2.7 Miscellaneous potentially useful information

- **Risk source**

Identify from the list below how the identified risk was 'sourced', i.e. did it come from a risk suggestion scheme, or a facilitated workshop, etc.

- Incident or incident review
- Complaint or complaints review
- Claim or claims review
- Root Cause Analysis
- Suggestion scheme
- Facilitated workshop
- Audit/Inspection report
- Standards non-compliance
- Checklist
- Safety Alert
- Other

- **Risk status**

The status of the risk is either 'open', 'closed' or 'transferred'. When the risk is 'closed' it should still remain on the Risk Register', but should not form part of any prioritised plan. When the risk is 'transferred' it should state clearly in the **Notes** where the risk has been transferred to, i.e. which department, etc.

- **Location category (user definable)**

This is a 'user definable' field where physical locations can be specified and subsequently utilised to help break down the risks contained on the risk register by location.

- **Location sub-category (user definable)**

This is a 'user definable' field where physical locations can be sub-categorised and subsequently utilised to help break down the risks contained on the risk register by location.

- **Risk category (user definable)**

This is a 'user definable' field where risk categories can be specified and subsequently utilised to help break down the risks contained on the risk register by location.

- **Risk sub-category (user definable)**

This is a 'user definable' field where risk sub-categories can be specified and subsequently utilised to help break down the risks contained on the risk register by location.

- **Notes**

Enter any brief notes that could communicate potentially useful information to stakeholders reading the Risk Register.

2.8 The HKHA 'Post-It^TM note' approach to eliciting risk information

A special 'Post-It^TM note' approach to eliciting key risk information from group risk self-assessment exercises has been developed for the Hospital Authority. Figure 9 shows a specimen note and Figure 10 shows how the notes can be 'posted' onto a complementary, specially designed large scale risk matrix in order to visually identify risk ratings, both initial and residual. The risk ratings can be transposed from the position of the note on the matrix to the equivalent descriptive and numeric consequence and likelihood details and written onto the note. This approach helps improve the efficiency of group self-assessment risk assessment exercises. For further information contact Annie Au at awyau@ha.org.hk

1. Risk type: OSH

2. Risk description: Staff sustaining needlestick injuries when resheating due to time pressures, unpredictable patients, etc.

3. Existing controls:
-Staff induction training
-Ongoing training
-Reminders at team meetings

4. Initial consequences: Major (4)
5. Initial likelihood: Likely (4)
6. Additional controls:
-Improved induction and ongoing training
-Promotion of greater awareness at team meetings and notices on noticeboards
-Purchase 'safe' needles for sole use by all staff

7. Residual consequences: Major (4)
8. Residual likelihood: Unikely (2)

Figure 9 – Specimen risk information 'Post-It^TM note'

Figure 10 – Practical use of 'Post-It^{TM} notes'

3 Using the specimen risk register to help manage risk

3.1 Introduction

As mentioned in Section 1, the risk register is a key tool for communicating and managing risk within any organisation. But the risk register is only a tool. Used properly and effectively, it will help achieve the benefits associated with risk reduction.

Risk registers should be maintained by each department on an ongoing basis. Periodically, these risk registers can be 'aggregated' to produce 'corporate' risk registers on a hospital, cluster and overall HKHA basis.

3.2 Aggregating individual risks registers to give a 'corporate' view of risk across individual hospitals and clusters

Figure 11 shows the concept of aggregating risks using risk registers across the HA. Front line staff help ensure that local departmental risk registers are maintained up-to-date. Periodically, these departmental risk registers can be aggregated to produce a risk register for an individual hospital. In turn, hospital risk registers can be aggregated to produce a risk register for a cluster. Ultimately, the cluster risk registers can be aggregated to produce a corporate risk register for the Hospital Authority as a whole.

The object of this exercise is not simply to communicate information on all risks to successive higher levels of management – although this may be desirable if only to provide assurances that risks are being managed. Rather, it is to communicate information on significant risks that, for financial or other reasons, are outwith the direct control of individual departments or hospitals. The aggregation of information on significant risks to successive levels enables senior management to get engaged in decision-making about allocating resources to deal with these risks. It also enables 'cross cutting' risk themes to be identified for dealing with at a corporate level.

Aggregation of risk registers are usually carried out in accordance with the following general rules:

- All risks with an 'initial risk rating' or 'residual risk rating' from 16 to 25 (i.e. RED, or HIGH risks) are automatically included in the aggregated risk register .
- All risks with an 'initial' or 'residual' 'consequences' (i.e. severity of impact) of 5 (i.e. RED) are automatically be included.

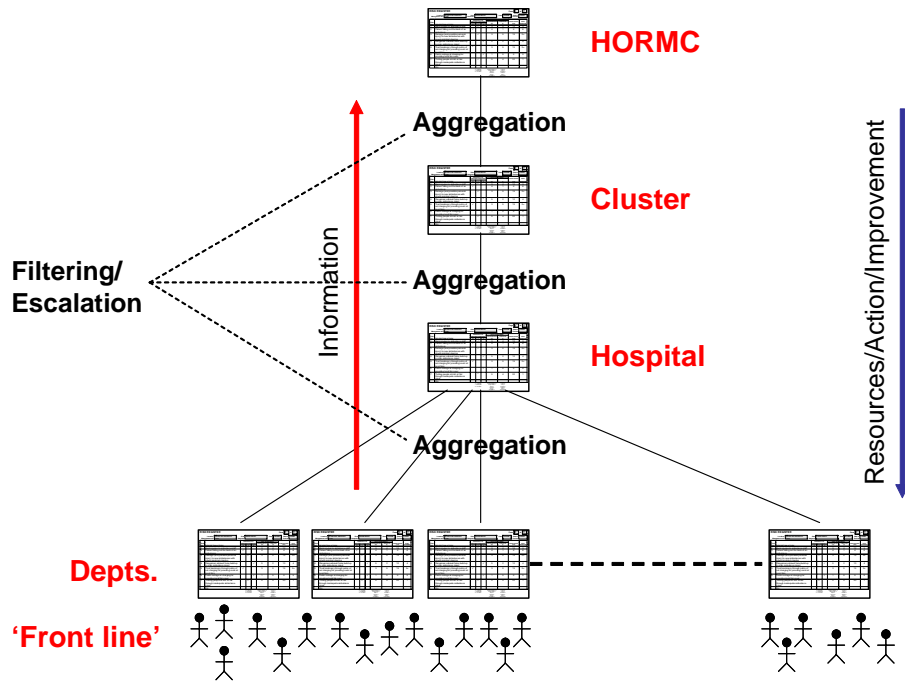Other risks may be included in the aggregated risk register as deemed necessary by senior management.

Figure 11 – Aggregating risk registers across the HA

4. Embedding risk management

Risk management is everybody's business. According to the latest draft for public comment of AS/NZS 4360:2004, "*To be most effective, risk management should become part of an organization's culture. It should be embedded into the organization's philosophy, practices and business processes rather than be viewed or practiced as a separate activity. When this is achieved, everyone in the organization becomes involved in the management of risk.*"

The following checklist[2] describes some tips and tactics for ensuring that risk management becomes embedded within the culture of Hong Kong Hospital Authority. Risk management should be:

- supported by the HA Board, publicly and privately;
- communicated to everyone within Head Office and across clusters;
- sponsored by the senior management team within the Head Office, clusters and individual hospitals;
- supported by experts in risk areas within the Authority;
- 'clinical/business-led' – in the ownership of clinicians and management, rather than specialist departments or functions such internal audit;
- linked to clear strategic objectives at the top level and to clear operational objectives throughout the clusters and hospitals;
- a priority for everyone – because no matter what their job, everyone has some responsibility for risk management – and measured as a personal objective;
- built on business processes already in place such as strategy reviews, planning, budgeting, insurance reviews, project appraisal and performance appraisal;
- expressed in a common risk language accessible to everyone across the Authority;
- given quality time by key management, including reports to cluster chief executives and the HA Board;
- kept as simple and as concise as possible – risk management is not rocket science!

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[2] This checklist is based on The Housing Corporation's Risk Management Topic Paper No. 2 : '*Embedding risk management – some tips and tactics*', by Gill Bolton and Sarah Blackburn. www.housingcorplibrary.org.uk