Risk management in abortion care

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Aim

- To identify potential risk and thereby reduce untoward events and the loss and harm that may result

Incident

- Occurrence where there is an error in management of client
- Error leads to an adverse event
- Many errors appear to be human error
- Most errors have a systems component

Near miss

- When an incident was narrowly avoided but could easily have happened if corrective action had not been taken
- Occur at higher frequency than actual incidents, yet with limited impact
- Rich learning material: ‘free lessons’

Grading of incidents

1 = major/catastrophic

2 = moderate

3 = minor

4 = no harm done

5 = near miss

Examples of incidents

Clinical

- Procedure performed on wrong client
- Wrong procedure performed

Non-clinical

- Client traumatised

by protestors

Examples of near misses

- Wrong client brought for procedure, but discovered in time
- Failure to use sides of trolley
- Failure to use brakes on trolleys/wheelchairs
- Failure to use same/similar name sticker on case notes

Creating a no-blame culture

- Openness and participation
- Education and research
- Learning from failures
- Good practice and new approaches freely shared and received
- Consistent quality in all clinics

Incident reporting

- Self-reporting of errors
  - promotion needed, it is a positive action
  - anonymised
- Emphasis on professional accountability
- Systems failures need to be identified
- Poorly performing individuals

When harm has been done

- Be open
- Explain what happened
- Saying sorry is not admitting legal liability

Common clinical incidents seen in abortion care 1

- Drugs given without legal prescription
- Inaccurate gestational assessment at initial assessment leading to commencement of inappropriate procedure
- Undiagnosed medical condition: unsuitable for treatment at free-standing clinic

Common clinical incidents seen in abortion care 2

- Breach of confidentiality
- Procedure changed, consent not changed e.g. IUD inserted in error
- Anti-D injection not given / given in error
- Misoprostol given in error

Rare clinical incidents

- Missed ectopic pregnancy
- Unnecessary abortion (not pregnant)
- Live birth at delivery with late medical abortion
- Uterine injury in the absence of cervical priming

Analysis of incidents

- Should be done regularly
- Action is clearly needed if catastrophic incidents are occurring even at low frequency
- Also if moderately severe incidents are happening with high frequency
- Look for trends

Reducing risk - general

- Design procedures to counteract error
- Take complaints seriously

Reducing risk - specific

- Adequate consent procedures
- Routine ultrasound scanning
- Low threshold for transfer to hospital from free-standing clinics if events deviate from normal pathway
- Supplementary security measures: access control system, panic buttons, police liaison