

Checklist for implementation of RADICAL risk management framework

Raise awareness and understanding

- Simulation/scenario training is undertaken regularly in our unit
- We have a communication strategy for disseminating patient safety information
- Risk management is an important element in the induction of new staff and appraisal and of all staff
- Risk management is a key feature of our educational meetings
- We continually measure our safety climate using validated tools for doing this
- It is clear to our staff that the Trust Board prioritises patient safety

Design for safety

- Our unit has evidence-based guidelines and protocols for all common clinical conditions
- We have implemented bundles of care for selected clinical conditions
- We have formal policies for handover of care, and these are audited periodically
- Our staff have formal training on communication tools such as SBAR and readback
- Procedures are in place in all clinical areas to ensure that the right patient receives the right treatment
- The use of a peri-operative safety checklist is in place and this is audited periodically
- We have implemented all national and local safety alerts relevant to our clinical area(s).

Involve users

- Our patients are actively encouraged to report safety incidents and these are logged in our incident reporting system
- Our patients are encouraged, through information leaflets and other means, to make or initiate safety interventions
- User involvement is a standing item in our clinical governance committee meetings
- Our patient information leaflets include information which could help reduce the risk of patient safety incidents
- We periodically give feedback to our patients on the safety of the care we provide

Collect and analyse safety data

- We have an incident reporting system and it is used by all cadre of staff
- Risk assessment is prospectively conducted in all clinical areas
- The department has a risk register and major risks are escalated to the hospital-wide register
- System analysis ('root cause analysis ') is conducted for major incidents, and a database of these analyses is maintained
- We have up-to-date data on the safety of the care we provide, and can compare our performance with standards elsewhere

Learn from patient safety incidents

- In our unit, specific targets have been set for selected patient safety indicators (e.g. in relation to surgical site infection)
- The findings of every 'root cause analysis' have been widely disseminated and action plans have been implemented
- Safety climate assessment shows that we have the attributes of a learning organisation
- Our risk management, complaints and claims handling systems talk to each other
- There is demonstrable learning from safety incidents, and the learning is shared within and outside our unit