QUALITY OF HEALTHCARE CONFERENCE · IVA 2026 · RISKY BUSINESS

From Risk to Results: Keeping It Simple

Making Risk Management Understandable and Usable

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DRIVEN BY STRENGTH. FOCUSED ON QUALITY.



Risk is everybody's business

If a system is too complicated, people work around it.



Complexity creates shortcuts. Shortcuts create risk.

The shift in mindset

THEN

- Documentation
- Compliance
- Reactive Approach
- Corrective Action
- Passing Audits

→

NOW

- Risk-Based Thinking
- Prevention
- Continual Improvement
- Patient Safety
- Leadership & Culture
- Safer Outcomes

Documentation remains important. Daily practice gives it meaning.

The question changed

From reacting to problems to preventing them.

BEFORE

"What went wrong?"

- Investigate
- Correct
- Document

Reactive mindset

→

TODAY

"What could go wrong?"

- Anticipate
- Prevent
- Improve

Proactive mindset

THE FOCUS SHIFTED · From correction to prevention

Simple means usable

PEOPLE CAN'T MANAGE RISKS THEY DON'T UNDERSTAND.



Risk management starts with understanding.

One practical building block at a time



Essential Priorities

Clear Communication

Practical Training

Teamwork

Shared Ownership

What these five create:

- Better understanding
- Stronger ownership
- Greater confidence
- More consistent action
- Safer patient care

Change does not have to happen overnight.

COMPLEXITY CREATES RISK

What we see is often only the surface.



WHAT WE SEE

The visible systems and structures

- Procedures & Policies
- Audits & Inspections
- Compliance & Standards

WHAT WE DON'T SEE

Hidden operational risks that drive incidents

- Confusion
- Workarounds
- Stress & Pressure
- Communication Gaps
- Disengagement

> "Hidden operational risks often develop **below the surface.**

Understand the real risks

Address what's below the surface

Strengthen systems, improve patient safety

Better Care. Safer Outcomes.



The Journey That Changed My Perspective

Where We Started

Quality already existed. Confidence and ownership had not yet grown.

Hesitation

People were unsure where to begin.

Uncertainty

The requirements felt difficult to translate.

Quality = extra work

Quality was often seen as paperwork, not daily practice.

Reactive thinking

The focus was more on correction than prevention.

Perceived complexity made the first step difficult.

A Different Approach

We stopped implementing quality for people…

…and started building it with them.

Communication → **Teamwork** → **Training** → **Simple Processes** → **Ownership**

People support what they help create.

We focused on essential priorities, moved one step at a time and built confidence gradually.

The Lasting Impact

Accreditation confirmed the system. Culture helped sustain it.

Risk awareness

Risks became more visible in daily work.

Shared ownership

Quality was no longer owned by one department.

Continuous improvement

Teams started thinking beyond compliance.

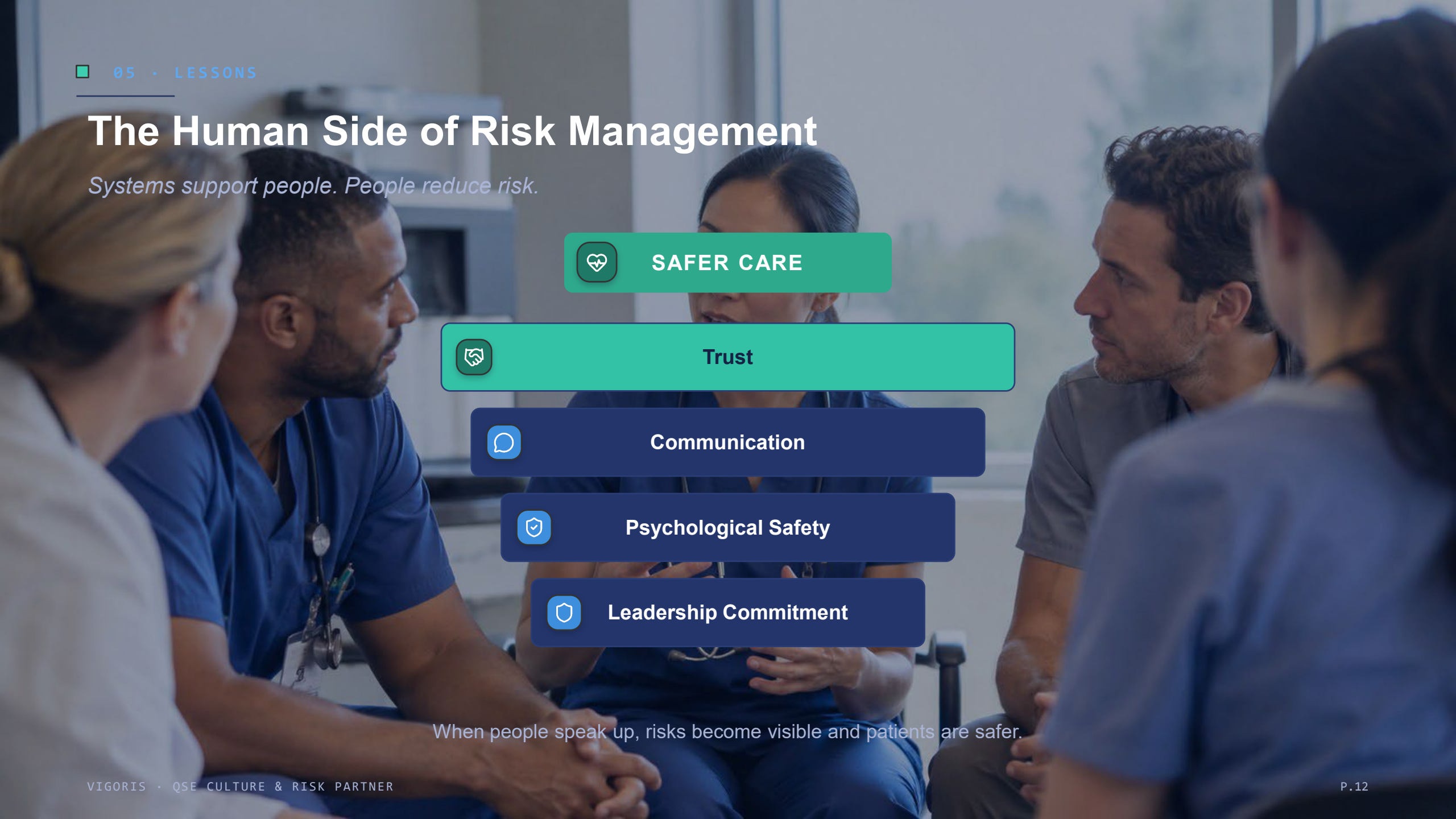
Stronger quality culture

The change lasted beyond the audit.

Culture is what remains after the audit is over.

The Human Side of Risk Management

Systems support people. People reduce risk.



When people speak up, risks become visible and patients are safer.

Four Lessons From 20+ Years in Quality, Safety & Risk Management

Complexity creates resistance

People avoid systems that feel too difficult.

Simplicity creates sustainability

Clear, practical systems are easier to keep alive.

Risk management must be practical

Risk thinking has to support daily work.

Culture change takes time

Lasting improvement is built step by step.

The goal is not more systems. The goal is safer, better care.

THANK YOU

What is the greatest risk you are not addressing today?

Sometimes, the greatest risk is standing still.

Keep it simple. Make it practical. Make it sustainable.