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Depuis plusieurs années, la gestion des risques occupe une place importante dans les établissements de santé et de services sociaux du Québec. Ce processus repose sur deux principes directeurs : la culture juste et le concept de non-responsabilité, et fait partie intégrante de la Loi sur les services de santé et les services sociaux. Cependant, malgré toute son utilité, le processus actuel de gestion des risques comporte certaines limites et critiques. Pour pallier ces faiblesses, l'association de l'éthique organisationnelle au processus de gestion des risques représente une option intéressante. L'utilisation des concepts et des outils de l'éthique organisationnelle permet de surmonter les limites de la gestion des risques et même de l'optimiser. Il s'agit dans les deux cas de processus organisationnels ayant de nombreux objectifs et liens communs, et tous deux fournissent des outils pour la prise de décision. La combinaison de l'éthique organisationnelle et de la gestion des risques élargit le champ d'application de la gestion des risques. Pour permettre la meilleure optimisation possible, une grille d'analyse est proposée et des recommandations sont faites pour l'inclusion de l'éthique dans la gestion des risques.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Including Organizational Ethics in the Risk Management Process: Towards Improved Practices and Analysis

Laurie Bouchard[a], Marianne Dion-Labrie[b]

Résumé
Depuis plusieurs années, la gestion des risques occupe une place importante dans les établissements de santé et de services sociaux du Québec. Ce processus repose sur deux principes directeurs : la culture juste et le concept de non-responsabilité, et fait partie intégrante de la Loi sur les services de santé et les services sociaux. Cependant, malgré toute son utilité, le processus actuel de gestion des risques comporte certaines limites et critiques. Pour pallier ces faiblesses, l'association de l'éthique organisationnelle au processus de gestion des risques représente une option intéressante. L'utilisation des concepts et des outils de l'éthique organisationnelle permet de surmonter les limites de la gestion des risques et même de l'optimiser. Il s'agit dans les deux cas de processus organisationnels ayant de nombreux objectifs et liens communs, et tous deux fournissent des outils pour la prise de décision. La combinaison de l'éthique organisationnelle et de la gestion des risques élargit le champ d'application de la gestion des risques. Pour permettre la meilleure optimisation possible, une grille d'analyse est proposée et des recommandations sont faites pour l'inclusion de l'éthique dans la gestion des risques.

Mots-clés
gestion des risques, qualité, éthique organisationnelle, réseau de la santé et des services sociaux, soins de santé, gouvernance

Abstract
Risk management has played an important role in Quebec's health and social services organizations for several years. This process is based on two guiding principles: the just culture and the no-blame concept and is an integral part of the *Act respecting healthcare and social services.* However, for all its usefulness, the current risk management process has certain limitations and criticisms. To overcome these weaknesses, the association of organizational ethics with the risk management process represents an interesting option. The use of organizational ethics concepts and tools overcomes the limitations of risk management and even optimizes it. Both are organizational processes with many common objectives and links, and both provide tools for decision-making. The combination of organizational ethics and risk management broadens the scope of risk management. To enable the best possible optimization, an analysis grid is proposed, and recommendations are made for the inclusion of ethics in risk management.

Keywords
risk management, quality, organizational ethics, health and social services network, healthcare, governance

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INTRODUCTION[1]

Ensuring the quality and safety of care and services is a cornerstone of the mission of organizations in Quebec's health and social services network. This is achieved through risk management (among other initiatives), which can be defined as an organizational process aimed at reducing the risk of incidents and accidents for users. Since the 2000s, risk management has become increasingly present in Quebec's health and social services organizations. In 2002, the province even amended its *Act respecting healthcare services and social services* to include risk management as an integral part of annual reporting (1,2). Risk management results, data and processes are monitored by the management committees and boards of all organizations, as well as by the Ministry of Health and Social Services (3-5).

Despite the presence of a risk management approach in organizations, thousands of incidents and accidents occur every year in Quebec. An 'incident' is defined as an action or situation that has no effect on a person's state of health or well-being, but whose outcome is unusual and which, on other occasions, could lead to consequences such as injury, further examinations, prolonged hospital stays or financial loss. The risk has not yet occurred or is close to occurring (1,2). For example, this could be an unlocked door in a protected unit, or a wet floor where a user might have slipped, but an employee saw it just in time. An 'accident' is an action or situation where a risk is realized and is, or could be, the cause of serious consequences for a person's state of health or well-being. Accidents may or may not have consequences for a user's health. These consequences,

[1] This article considers risk management and organizational ethics in the health and social services network. Thus, risk management and business ethics, present in industrial organizations, are not addressed. Integrated risk management, still under development in the health and social services network, is not addressed either. Here, risk management is focused on patient safety and the same processes are used across different healthcare sectors. Furthermore, in the province of Quebec, especially in the health and social services network, the field of organizational ethics is still developing and has not yet been sectorized. The link between risk management and organizational ethics is thus in the early stages of development.

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the same as those mentioned above, may be temporary or permanent (1,2). For example, it could be a fall resulting in a fracture, or a side effect caused by a medication error.

Table 1 provides an overview of the number of incidents and accidents reported in Quebec health and social services organizations between 2017 and 2022 (6-9):

Table 1: Number of incidents and accidents reported in Quebec between 2017 and 2022

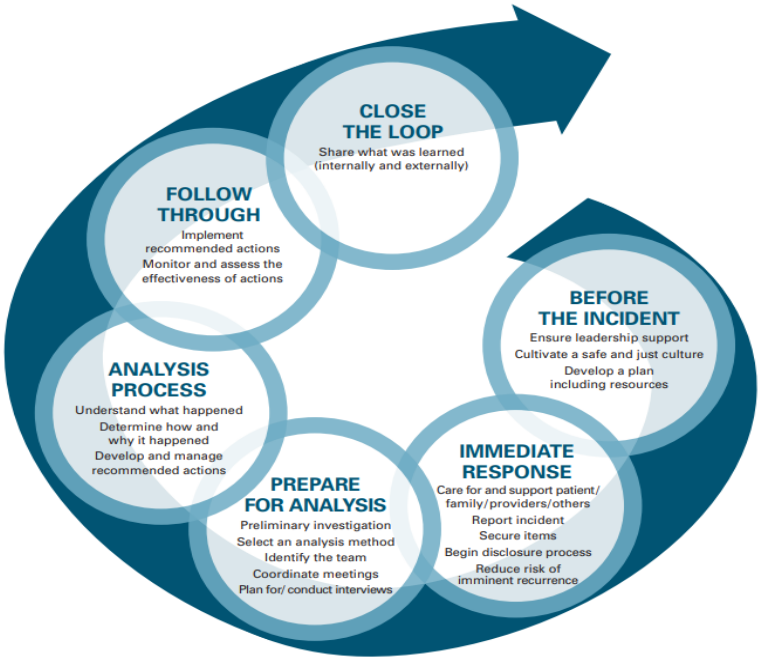
Financial year	Number of incidents and accidents reported	Variation rate
2017-2018	513,357	N/A
2018-2019	500,502	-2,50%
2019-2020	495,652	-0,97%
2020-2021	442,725	-10,68%
2021-2022	444,756	0,46%

With an average of 479,393 events reported annually, it's easy to see the scope incidents and accidents that occur in health and social services organizations. According to the literature, 50% of these incidents and accidents are avoidable (10); and the vast majority of incidents and accidents are due to flaws in clinical or organizational processes, a lack of communication or inadequate employee training (10). As such, the importance of good organizational risk management process is evident.

RISK MANAGEMENT ANALYSIS PROCESS

The risk management analysis process involves reviewing each incident and accident to ensure that corrective measures are in place to prevent recurrence. Figure 1 shows the main steps involved in analyzing an incident or accident (11):

Figure 1: Incident and accident monitoring model for risk management



Before an incident or accident can be analyzed, it must be declared and disclosed. The aim of declaring (or reporting) is to make the organization aware of the occurrence of an incident or accident. The declaration is made using a form (AH-223), which the witnessing staff member must complete in accordance with article 233.1 of the *Act respecting healthcare services and social services* (12). Depending on the seriousness of the event, the incident or accident must be disclosed to the user or their legal representative, informing them of the nature of the event and the means put in place to avoid its recurrence (12); this disclosure obligation is set out in the Act (article 8).

Some accidents are unfortunately more serious, and even result in the death of the user. These are commonly referred as "sentinel events", that is:

1. An accident with permanent consequences for the user;
2. An accident with a potentially catastrophic outcome. The user has no permanent consequences, but came very close;
3. A problematic situation that keeps recuring and can end up causing major damages to users (1,2).

When this type of event occurs, an exhaustive analysis is carried out. This analysis is generally the responsibility of a risk management adviser and focuses on examining possible failures in organizational processes that may have played a role in, or contributed to, the occurrence of the sentinel event. In addition to examining organizational processes, a comprehensive analysis also involves the participation of the user, their relatives, care and services providers or employees involved in the accident (11). Depending on the case, the latter may give their version of the facts and make suggestions, since they know their workplace well. Recommendations are then made, and an action plan implemented to ensure that corrective measures are taken to prevent recurrence.

Risk management guidelines

Risk management in health and social services organizations is based on two principles: *non-blame* and *just culture*. The first principle, non-blame, aims to develop a non-punitive environment where risks and their management can be discussed openly (1,2). It is recognized that errors are inevitable, and that they are often due to a number of factors, such as incomplete policies and procedures, lack of appropriate training, understaffing, etc. (13).

A just culture is the hallmark of an organization that recognizes the difference between an act committed in good faith and one that is reprehensible. Differences are established between intentional actions, recklessness and unforeseen circumstances of the complications of care. The development of a just culture is more effective in ensuring sound risk management because practitioners know that they will be treated fairly, and that they will be held accountable for their actions and behaviours towards service users (11).

Limits and criticisms of risk management

Risk management is now well established in the health and social services network. It has a positive influence on the quality of care and services provided to users (3,5,14). This process aims to improve various programs, protocols and clinical processes, as well as care and service trajectories. For example, the analysis and documentation of events associated with suicide risk management has helped to improve interventions and programs, with the result that health and social services organizations now have more tools at their disposal to prevent suicide. Despite its many positive aspects, the risk management process is not without its critics.

An impression of control

Risk management, through the application of its processes, can give organizations the impression that they are fully in control of risk. This impression can help ease organizational anxiety, since it provides a satisfactory response to the intangible thing that is risk (15). What's more, since risk is everywhere, risk management will be everywhere, reinforcing an organization's sense of control (15). Organizations want to perform better while meeting the necessary accreditation and reporting requirements, such as Accreditation Canada, for example. And they want pragmatic approaches that work in practice. Risk management presents reliable, validated indicators (number of incidents and accidents per year, types of incidents and accidents, level of severity of incidents and accidents, etc.) (16), further increasing the sense of being in control of risk and even having the possibility of achieving "zero" risk. An adverse consequence of this impression of control include excessive paternalism toward users and the non-respect of their autonomy, even if this starts by good intentions (15,16). Another consequence is that the impression of control can bring a kind of blindness towards risks: we are controlling them, so nothing can go wrong (15,16).

Partial management with its own risks and fear of risk

Risk management considers only certain aspects of a situation, notably best clinical and organizational practices, costs, availability of resources, the law and codes of ethics (15-18). But risk management can also entail its own risks. People in highly vulnerable situations may not receive the care and services they need because of the additional risks brought about by interventions targeted to them. An interesting example is that of intervention models for people with borderline personality disorder, one of the characteristics of which is impulsivity (19), something that can make practitioners wary of the risks involved in targeted interventions. Instead, caregivers use less risky interventions and intervene in a paternalistic manner (20, 21); for fear of the risk, they ignore the benefits inherent in these targeted interventions for users (20-21). Risk management may also encourage teams to carry out the least risky intervention possible, rather than the one that is the most appropriate (20,21). Exaggerated risk management can also lead to a fear of risk, with the result that an organization may find itself paralyzed by its own cumbersome policies and procedures (14). Risk management can also cultivate fear, mistrust, and the practice of defensive medicine, where clinicians no longer do what's best for the user, but simply seek to protect themselves from the (imagined) risk of lawsuits (22).

Risk management with little user involvement

Risk management focuses mainly on members of the care team, not on users (22). There is little collaboration with users (23), and who are not encouraged to express themselves if they do not understand the situation or why a professional is committing an unexpected act (24). Several observations made in health and social services organizations show that the analysis of incidents and accidents in risk management is often very clinical and procedural. With the exception of certain pilot projects, it does not take into account the participation and active involvement of users and their families. Given this lack of direct user involvement, there is a real risk that staff will see risk management as a mere administrative process (22). Yet, the active

involvement of users in the risk management process can provide a more comprehensive view of the situation and help identify avenues for improvement that had not been mentioned by members of the care team (15,16,20,25-28).

Management that brings fear of reprisal

Despite the fact that risk management advocates a just culture with the aim of continuously improving the quality of care and services, some staff members still fear possible reprisals. They may fear that if they make mistakes and dare to disclose them, that they will suffer reprisals not only from managers and colleagues, but also from users and their families (24,29). These reprisals can take the form of a warning from the manager, or even dismissal, a formal complaint from a user or a disclosure to the professional order. This finding is also consistent with reality in the field: when the time comes to report an undesirable event, sentinel or otherwise, staff members admit to fearing the reaction of their manager, colleagues and users. This makes it difficult to gather all the information needed to analyze the event, as the staff members involved sometimes have the reflex of withholding information for fear of reprisals (24,29).

Cumbersome management

Finally, a recurring criticism from many healthcare organization staff, whether employees or managers, is that the risk management process is bureaucratically cumbersome (29). Further, while staff members are aware of the importance of risk management, they sometimes feel that this process encroaches on already limited clinical time (user care, follow-up for users, progress notes, etc.).

USING ORGANIZATIONAL ETHICS TO IMPROVE THE RISK MANAGEMENT PROCESS

The risk management process is an intrinsic organizational process in health and social services organizations. To address the limitations of this process, it would be useful, even necessary, to draw on tools and strategies from the field of organizational ethics. The choice of organizational ethics as the flagship approach associated with the field of risk management was a natural one. First, risk management is an organizational process, so organizational ethics – which is concerned with organizations – operates at the same level as risk management. Further, organizational ethics is a means of responding to demands for transparency and accountability in the management and organization of healthcare; and it supports the efficient delivery of care and services in an increasingly complex social, financial, and regulatory environment (30-32).

Definition of organizational ethics

Organizational ethics is based on two concepts: *ethics* and *organization* (33). Organizational ethics involves reflection on the choice of values to guide management decisions that influence user care and services, as well as their evolution in a changing environment and clinical practice (33,34). Organizational ethics refers above all to administrative, management, compliance, governance, and shared values issues within an organization (31,32,35-51). It aims to influence organizational decisions by adding a form of ethicality (41,42). These decisions have repercussions for users, staff, and the community to which the organization belongs. Organizational ethics is thus the articulation, application, and evaluation of the implementation of an organization's values and moral positions (26,34,36,39,40,52), which are mentioned in organizational documents, such as mission statements, managerial code of ethics or a list of organizational values and their definitions.

Organizational ethics is concerned with the ethical issues faced by an organization's managers and board members, and the implications of decisions for users, staff, and the community (31,35,44,46,53). By contrast, traditional clinical or biomedical ethics are more concerned with individual issues, such as ethical issues/value conflicts between individuals, like a physician (or any other worker in the health system) and the user or the user and a member of their family (31). Organizational ethics, on the other hand, enables managers to assume their decision-making responsibilities while respecting the principles of distributive justice and equity of access to services (30,37,39,40). The principle of distributive justice in health and social services refers to whether care and services are provided according to individual needs and available resources (26,27,37,39,40), without discrimination and with constant and consistent application of the rules (42). Organizational ethics also promotes decision-making based on analysis of the facts, identification of the values at stake, and knowledge of obligations (ethical and legal) in order to make organizations ethical. The human rights inherent in decision-making must be understood; these rights are embodied in the law, but also in an organization's values (47).

Organizational ethics is a means of increasing the transparency and accountability of organizations in healthcare management because it works to create value and guarantee the sustainability of an organization; it is also a lever for motivation and adhesion, as commitment is voluntary and not based on obedience or imposition, another advantage for organizations (42). The broad aim is to support the effective delivery of care in an increasingly complex social, financial, and regulatory environment (30-32,35,36,54). Organizational ethics can help organizations achieve their goals in terms of performance or quality of care and services, and to promote ethical conduct (29,30,32-34,42,49,55) – it can thus help managers effectively tackle complex issues (30).

Organizational ethics can help build or restore public trust in health and social service organizations (31,32,36,42,49,53,56,57). It can prevent or mitigate conflicts of interest, and define the behaviours expected of an organization's managers and employees, for example, through the implementation of a robust code of ethics and the definition of core institutional values (58). It also helps to reduce risks (42). An organization that promotes organizational ethics in its culture empowers staff members to report events related to user safety, as they are less fearful of the consequences for them (29).

Organizational ethics helps develop leadership and ethical competencies, facilitating the resolution of conflicts between the interests of the user and those of the organization. It also promotes quality of action, cooperation in action, living together and institutional integrity, and reconciles ethical requirements (e.g., the quality of care and services provided, the ideal of justice and respect) with the practice of a health and social services organization (35,36,42,44).

Limits and criticisms of the application of organizational ethics

Despite the necessity of ethics for an organization providing health and social care, the implementation of organizational ethics can be subject to criticism. In many organizations, ethical knowledge is disseminated through various ethics committees and their members (16,36), but there is frequently a lack of awareness about the existence and role of these bodies. This becomes a practical barrier to engagement in organizational ethics (16,36); and it can create a gap between theory and practice (43). What's more, the efficacy or impact of ethics, including organizational ethics, may also be difficult (even impossible) to measure (16,59); and if a problem is solved in a "technical" way, we are no longer in the field of ethics, including organizational ethics (59). For many, everything organizational is considered real when it is absolute, measured and quantified. Ethics, including organizational ethics, doesn't have this quantifiability (59). As such, those of us working in organizational ethics need to get our message across differently, emphasizing, for example, the importance of values and principles for developing an ethical organizational culture. Although organizations have structuring documents on ethics, principles, and values, these are rarely used in day-to-day activities. It is important to bring these principles and values to life so that they are applied (36,59,42,43), and there is a need to find a way of translating ethical principles with operations in the field, which is not always obvious (59).

Like the risk management process, organizational ethics can also sometimes be described as incomplete. There is a risk of ethics being associated solely with a management tool, rather than a goal or an end in itself. Organizational ethics also considers how people interpret the meaning of their actions; if only the principles and values defined by management are considered, organizational ethics becomes a partial, merely administrative process (60).

COMBINING ETHICS AND RISK MANAGEMENT: MISSION (IM)POSSIBLE?

Organizational ethics and risk management are two central aspects of (health and social services) organizations (3). Risk management provides the tools to guide organizations and their employees towards the best possible quality and risk decisions, which is also the role of organizational ethics (14,61,62).

Risk management without ethical consideration is impossible, considering that it involves working with people and the aim is to protect them (20). Without an ethical focus, risk management is incomplete and fragmented (22), and becomes simply an administrative process that brings with it fear of reprisal and defensive care. The workers are not doing what's best for users, but for them, to protect themselves. An ethical focus brings the focus back on users and the protection they have the right to expect from workers (22). Risk management is present in all fields (14,27). It is everywhere, forcing attention to the consequences that professional decisions can have (or have had). It is also collaborative, requiring clear articulation regarding the decisions taken. It's multidimensional (63) and is linked to the principle of non-maleficence, which means not harming a user (64-69). Risk management involves ensuring the safety of users and teams, including the prevention of complaints or lawsuits.

As with risk management and its two guiding principles (just culture and no blame), the right to make mistakes is present in organizational ethics (70). A mistake is a situation characterized by the recognition that one is doing something the wrong way, stopping when this is noticed and learning from the event. An error, by contrast, involves doing the wrong act or making a mistake and continuing despite this awareness, which can turn to neglect (70). For example, a psychosocial intake worker does not associate a request from a user with a loss of autonomy with the home support program, even though there have been changes in the computer system and the user has not been notified. The distinction is made with fault, which is described as a failure to comply with a rule, art, or discipline. By way of example, a nurse who fails to carry out a clinical assessment of a user, even though a change in that user's condition has been reported to her, may constitute misconduct and neglect. Mistakes and errors may be due to ignorance, lack of training or other aspects that are often difficult to control (71) in both ethics and risk management.

An important link between risk management and biomedical and clinical ethics is disclosure. As already mentioned, this important aspect of risk management serves to inform a user or someone close to them of an incident or accident. It is thus linked to the principle of autonomy (respect for the freedom and choice of each individual) and the right to information (one of the rights guaranteed in the *Act respecting healthcare services and social services*). There are two important aspects of ethics, including organizational ethics, and with a few exceptions, participate in determining what is the right thing to do (72-75) and the means with which to respect others (76). The purpose of disclosure is not to blame anyone, but rather to prevent possible harm and promote transparency. Usually, users want to know all the facts associated with an event (11); this becomes a choice for users (if they want to know what happened in an event), which is why disclosure is linked to the principle of autonomy.

Ethics should be an integral part of risk management (42,61,62,64,76,77), as these two approaches share common objectives: the maintenance and trust of various partners, the public and users, and the concrete application of organizational values to the continuous improvement of practices to help decrease risks and promote the development of specific judgment and decision-making skills. Organizational ethics enables the deployment of an ethical culture that promotes expected ethical

behaviours and motivates people to adopt these out of positive intent (31,78), and not just out of fear of sanction. It can also offer a constructive approach by bringing to the organisation socially expected behaviours, for example (76). The link can be made with risk management, with its principle of user safety, which has a positive influence on the quality of care and services but can gives rise to fears of sanctions. In this way, organizational ethics can overcome the fear of sanction, described earlier in this text.

Organizational ethics is a component of quality risk management because the user becomes the target of an intention, one with intrinsic dignity and considered as a whole person, not only a “disease” or a “problem” (79,80). The goal is to deliver quality healthcare and protect users, which are core values or moral commitments of an organization. Organizational ethics can also be the subject of risk management. Indeed, the concept of “ethical risk management” implies that ethics, including organizational ethics, is concerned not only with the philosophy, values and standards that guide an organization’s behaviour and actions in society, but also with formalized principles and codes of conduct (81,82). Ethical risk thus becomes an uncertainty that can lead to a situation where it becomes possible to commit a breach of an organization’s values. There is thus a gap between expected and actual behaviour. Risk management serves precisely to analyze the gaps between expected behavior and that which led to an incident or accident. The principles used in organizational ethics decision making (which might vary from one organization to another) should also guide the risk management process. The following are some examples or principles (82):

- *Dignity:* to treat each individual as an end and not a means, and therefore to respect everyone’s interests;
- *Fairness:* to be just and equitable in every decision;
- *Prudence:* exercising judgment so as not to make a situation worse, and applying that judgment when the time comes to make a decision;
- *Honesty*: to be trustworthy and avoid lying, stealing and cheating;
- *Openness:* not hiding what needs to be revealed and acting in the public interest; it also means respecting everyone’s privacy;
- *Goodwill:* showing concern for others and demonstrating kindness and tolerance;
- *Avoidance of suffering:* to minimize pain and suffering as much as possible.

Ethical risk management thus concerns everything that promotes ethical conduct by all stakeholders in an organization. This can include compliance with external legal and legislative requirements, as well as internal support and expectations. These principles should not only be used in risk management but should be lived throughout the organization to support the development of a strong institutional culture of ethics (82).

INCLUDING ORGANIZATIONAL ETHICS IN RISK MANAGEMENT

How can ethics be included in the risk management process? A first suggestion would be to introduce collective spaces for ethical reflection into the risk management process, to guarantee the transparency and traceability of decisions taken based on an ethical approach or process (79,83), where health organizations are open to integrity and value-based approaches (43). This can be in the form of collaborative training, in addition to more formal ethics training, that promotes open mindedness and meeting between people, or experiential development, which aims to develop people’s ethical awareness by emphasizing experiential learning (43). It can include some exercises to increase trust, but also to develop suspicion or a critical gaze about institutional practices (84). For example, this could mean digging below the surface of an issue to uncover the root causes of an event (important in risk management, as saw earlier), to critically reflect about the provision care, the pertinence of policies and processes, etc. (84). These can be explored through experiences where people put themselves in other people shoes, as it were (e.g., case studies, role playing), thereby leading to a better understanding of the different facets or complexity of a situation (85). Considering a situation as a whole is very important in risk management; if not, the outcome and recommendations will miss some important aspects of the event (11). This can also be done through mindfulness experiences, an exercise that can bring to our attention something that we ignore or do not usually think about (86). People can also be invited people to discuss what they see as wrong in the system, what they feel produces better results or might be better systems, like would be done via audits (87). This means that quality, of which risk management is a part, must be linked to ethical and organizational spaces for reflection, using analytical approaches and tools from the field of ethics to help identify the problem and the values in tension, and to promote deliberation and decision-making.

Another suggestion might be to apply certain aspects of the ethics of care to organizational ethics (88). Indeed, organizations, and indeed the people who make them up, must adhere to the principles of justice and equality, in a manner that is impartial and without regard to personal interest. While these are important principles, an ethics of care focuses on the individuality and needs of a particular person or group of people. In a context where interpersonal relationships and the foundations of kinship do not receive systematic attention, an ethics of care – which focuses on sympathy, compassion and a concern for the well-being of all – can help to push the analysis further in this respect (88). Bringing other important aspects to bear on an analysis of risk management, the ethics of care considers morality versus politics, the moral standpoint of the concrete and contextual versus broader principles, and private versus public life. In short, human beings are not only autonomous and equal, but also creatures in need of care. The process can be broken down into four stages: first, concern for the person and the situation, which involves recognizing needs. Second, taking responsibility for those needs, i.e., direct involvement in determining how to meet them. Third is care-giving, which means taking action to meet needs; and the fourth is care-receiving, which recognizes that the object of care responds to the care received (88).

PROPOSED ANALYSIS GRID AND RECOMMENDATIONS

Associating organizational ethics with risk management is becoming a necessity for health and social service organizations to ensure the quality of the care and services they provide. To facilitate the practical integration of ethics in risk management at the operational level, we present here a model analysis grid that lists the Steps and Details of an ethical risk management process. This grid could have practical application, particularly for risk management advisors associated with the quality, evaluation, performance, and ethics departments of health and social services organizations.

This model differs only a little from that which is currently used by risk management consultants, notably at the Centre intégré de santé et de services sociaux de la Montérégie-Est; notably, it retains the main steps of the analysis process but adds certain elements directly from the field of ethics (89). Some of the steps in the risk management analysis are virtually identical to those in certain organizational ethics grids, such as Magill and Trybil (49) or Nelson (90).

Table 2: Risk management analysis grid

Steps	Details
Get a detailed description of the event	List interventions and support measures taken; Complete AH-223 report
Make a complete and detailed chronology leading up to the event	Establish chronology
Consult all possible sources	Consult all stakeholders: • Members of the care and service teams concerned • Users and relatives • Experts (internal and external) • Best clinical practices • Other possible sources, as appropriate Refer to organizational documents: • Organizational mission, principles and values (e.g., code of ethics) • User file • Ethical consults on the issue in question • Organizational policies, procedures, and processes (including the organization's ethical framework, if it exists)
Identify the policies, procedures, processes, and principles/values involved	Establish the list of policies, procedures, processes, and principles/values involved
Examine underlying systems, including value systems	Establish contextual elements: Internal and external guidelines, best practices (clinical, administrative or conduct related), values involved, legal considerations, precedents, cultural elements…
Identify contributing factors	List the contributing factors (root causes), including the principles and values involved, as appropriate
Establish formal recommendations for action to improve processes or systems	Propose recommendations. Justify decision (principle, values, benefit-risk ratio, etc.)
Enter conclusion and recommendations	Implement recommendations: action plan with deadlines, the people responsible, expected results
Establish communication channels to share improvements and lessons learned	The organizational values underlying the recommendations. They must be transparently communicated to those involved (hence the accountability/transparency piece of organizational ethics)

Finally, in addition to this proposal, recommendations can be made regarding the inclusion of organizational ethics in risk management:

- **Provide ethics training and support for risk managers**. Health and social services organizations (50,52,91,92) have introduced initiatives to integrate ethics in their organizations. Among these are training courses given by ethics advisors, and can include case studies, analytical models, experiential development (43), discussions on organizational values and improving practices. Such training could be given to risk management advisors, thereby enhancing their knowledge of ethical principles and applicable laws. In addition, training courses should include discussions on improving current practices (how to do things right), a central aspect of risk management analysis.

- **Strengthen the link between ethics and risk management**. There is a significant gap between the ethics and risk management vocabulary (93), an observation regularly made in practice. A translation or linking between their respective vocabularies is thus needed, with one such being the concept of quality. For example, by improving intensive rehabilitation practices for people with stroke, risks are reduced, and quality of life improves. This improvement is a direct application of the principle of beneficence, given that improving quality of life brings benefits to users. Similarly, bringing benefits to users is one of the goals of the principle of beneficence. Thus, using an ethical approach or reasoning in health and social services also means taking a stand in the field of quality of care and services (94). Setting up collective ethical spaces (or introducing risk management into existing collective ethical spaces) is also a way of increasing this link, as too is collaborative training (43).

- **Ensure the active involvement of users and their families in the risk management process** (11,13,37,64,95). Users' contribution to risk management enables a more complete analysis of the situation and concrete recommendations that reflect their own experience and perception of the situation (96). Some users may even mention aspects of analysis that professionals had not considered (15,16,20,27). Users play an important role in risk management, since they can express how the environment affects them, their understanding of risks, and then propose interesting solutions to reduce risks and thereby improve quality (13,20). Thus, by involving users and their families, risk management would cover more aspects and so respect the ethical principle of autonomy. As explained above, users want to know and to understand what and why an event occurred, and they need to be actively involved in the care process, of which risk management is a part (11,13). In addition, it should be remembered that the process of user inclusion is largely a matter of organizational ethics (49,55). Risk management advisors should ensure this involvement by consulting with patient partners on the implementation of such a model.

CONCLUSION

Risk management is an organizational process that aims to reduce the risks of occurrence of adverse events for users of the health and social services network, and also reduce the severity of the consequences of these risks. It has a positive influence on the quality of care and services offered in health and social services organizations (3-5,14). Despite its importance and the clarity of its concepts and processes, risk management has been criticized regarding aspects of its practice. For its detractors, risk management does not consider all the stakeholders involved and does not sufficiently review all the aspects of an event (incident or accident) as it should. How then might we better conduct risk management and compensate for or mitigate its limitations?

Drawing on organizational ethics resources is the solution. More specifically, we argue that it is the field of organizational ethics that offers the most appropriate response. Organizational ethics concerns administrative and management issues, as well as the values of an organization. Further, it is linked to quality and performance, just like risk management, and it helps with building trust among all the members of the organization (42). The two concepts are therefore closely linked: organizational ethics can be seen as a means of doing risk evaluation of an organization (ethical risk management), just as risk management can be inspired by ethics (the ethics of risk management) (3). Further, not only are the two key concepts linked, but organizational ethics can ensure the quality of risk management (79,80) at the analysis level, as elements of ethics have been integrated into the risk management analysis. Given that elements of organizational ethics can be integrated into risk management analysis, and that ethical risks exist, it is reasonable to argue that organizational ethics can contribute to the enhancement of other risk management tools, and that by being included in the event analysis process, it can help to identify more risks and help in their mitigation.

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