MANAGING RISK

Title Slide

RISK ?

- You know all the angles.
- You've done it a thousand times.
- It comes naturally to you.
- You could do the job blind-folded!.....

.... Nothing could possibly go wrong, right ?

Let audience read the slide line by line (leading to joke in Slide 3 . . .)

THINK AGAIN !

JOKE!

OBJECTIVES

To promote awareness of:

- Legal Duties
- Risk issues
- Control Measures
- Policy & Reporting Procedures

... Leading to a "Safety Culture"

NHS 4

Give an overview of the content of the presentation

By achieving the 4 points above the organisation will have moved significantly towards promoting a safety culture and awareness thereby providing a safer environment for all

LEGAL DUTIES

HEADING SLIDE

EMPLOYERS

HASAWA 1974 - Section 2(1) & 3

Have a duty to ensure, *so far as is reasonably practicable*:

The Health, Safety & Welfare of all their employees at work;

- Maintaining a Healthy & Safe working environment
- Maintaining Safe systems and equipment
- Ensuring articles & substances are moved & stored Safely
- Providing Health & Safety Information & Training

That those not employed, but who may be affected by their work, are not exposed to Health & Safety risks.

NHS 6

Employers
Explain legal duties of employers under Health and Safety Law

"so far as is reasonably practicable" is applicable in UK law and explain the term or refer to in slide 8/9.

Examples for the bullet points:
Appropriate toilets, ventilation, lighting
Protocols, manual handling procedures, properly maintained equipment
Safe storage of medicines, chemicals, medical gases, clinical waste, general waste
Manual handling training, fire training, supervision by managers, on the job training

NB: This responsibility extends to non-employees, e.g. visitors, patients, contractors on site, intruders!

EMPLOYEES HASAWA 1974 - Section 7

Have a duty to:

Take reasonable care for the Health & Safety of themselves and others who may be affected by their acts or omissions.

- Using (and not interfering with) safety equipment provided
- Working safely and adhering to policies & procedures
- Reporting accidents, incidents or hazards

Co-operate to enable their employer to comply with legal requirements.

NHS 7

Employees

Explain legal duties of employees under Health and Safety Law

Examples for bullet points:

Wedging open fire doors, removing window restrictors, not wearing gloves/aprons for appropriate tasks, not using hoists, lifting with sheets/blankets, moving gas cylinder in wheelchairs
Respond to fire alarms, follow manual handling policy, segregate waste, take heed of safety signs
(give examples of areas where known under-reporting occurs e.g. violence & aggression)

Employees must co-operate with employers, e.g. attend training, and assist with audits and risk assessments.

HASAWA Section 37

- Offences by Directors, Managers etc….

Where a corporate offence has been committed with consent or neglect on the part of any 'Manager' - then he, as well as the corporate body, is guilty of that offence and liable to prosecution.

Offences by Directors, managers, secretaries etc

Let them read the slide and read out the highlighted sections from article from Jan/Feb 99 Health and Safety Bulletin on "Director Disqualified for breach of Provision of Work Equipment Regulations (PUWER) under the Director Disqualification Act 1982

*

BURDEN OF PROOF

HASAWA (Sections 17 & 40)

Employers can find themselves Guilty until proven Innocent

LEGAL DUTIES

- Everyone Should….
  - Understand the risk associated with their work
  - Use controls to protect against those risks

Legal Duties

Read out the summary of the Health & Safety at Work Act given on the slide.

REASONABLY PRACTICABLE

The Risk must be balanced against the sacrifice, in terms of time and trouble needed to avert it.

Only if the risk is insignificant in relation to the sacrifice can precautions be considered…

…'Not Reasonably Practicable'

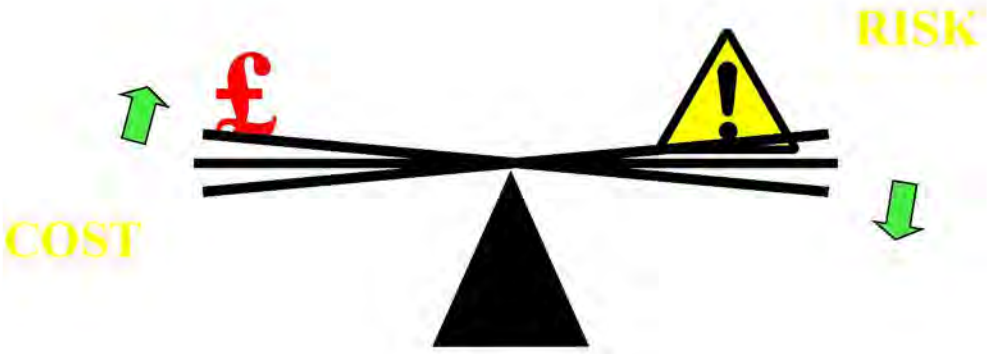
NHS 11

Reasonably practicable

Let audience read the slide and explain that this is UK and not European Law.

(** find example within the Trust of something that needs altering and has more than one solution on how to do it – explain why the solution was chosen e.g. cost, efficiency)

RISK & COST



Scales

Explain the need to balance the hazard, the injury and the dangers against the time, cost and inconvenience of preventing the hazard occurring.

HAZARD & RISK

Hazard and Risk

Hold up can of Coke – ask if this is a hazard (No)

Shake can and walk around room looking as though you are about to open it – ask again if this is a hazard.

The can is a hazard but only once it's shaken. The coke can doesn't become a risk the circumstances, likelihood and severity are the risk.

HAZARD

Something with the potential to cause harm.

Hazard

Leave them to look at slide

RISK

(Likelihood x Consequences)

It can arise from:

- CLINICAL CARE provided,
- EQUIPMENT used,
- PEOPLE employed by or visiting the Trust,
- BUILDINGS occupied by the Trust
- MANAGEMENT SYSTEMS of the Trust.

NHS 15

Risk

Probability of incurring harm or loss:

Examples:

Clinical care – giving wrong blood, cross-infection
Equipment used – iv pumps, damaged electrical flex
People – arson, running
Buildings occupied – asbestos, Legionella, unrestricted windows
Management systems – incorrectly labelled food (allergies)

RISK MANAGEMENT

... must be an integral part of the Trust's business objectives and can be described as:

"A proactive approach to the management of uncertainty".

South & West NHS Insurance Consortium - Terms of Reference - 1996

Risk Management

Read slide.

In order to manage its risks the Trust has policies and procedures as a guide to safe/best practice. The need for new/revised policies and procedures is identified by changes in legislation, working practice and equipment and co-ordinated by the Risk Management Team.

RISK MANAGEMENT STRUCTURE

Risk Management Structure

Insert Trust's flowchart of risk, health and safety committees, Clinical Governance and their reporting structure.

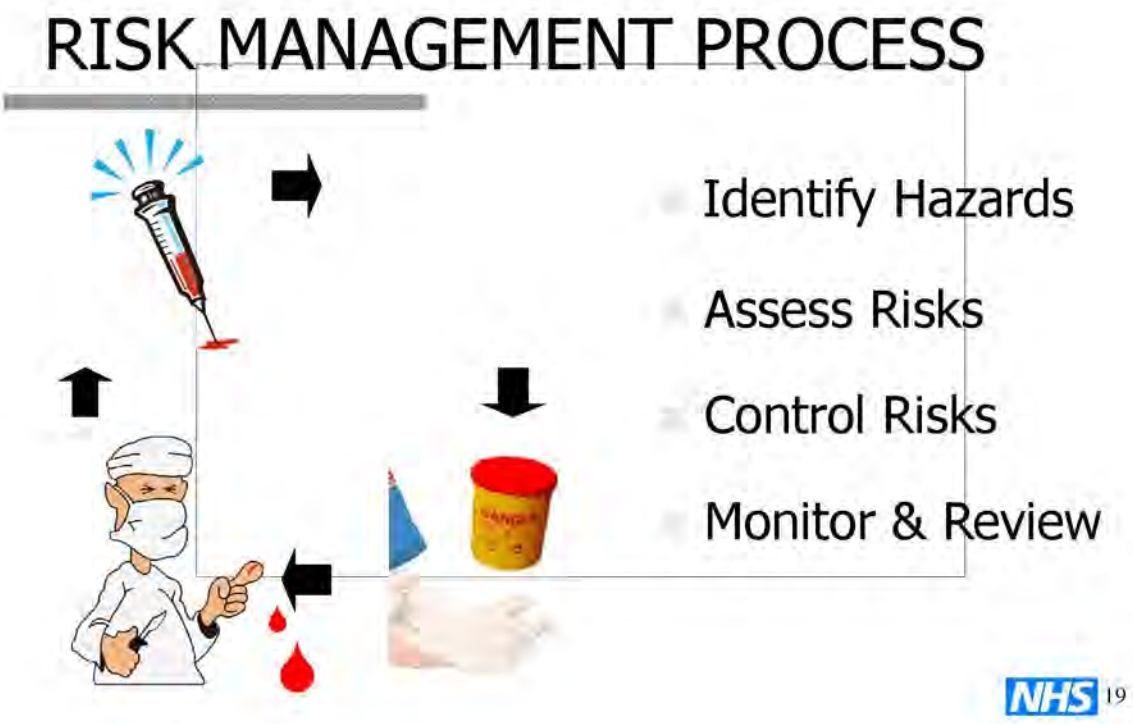
RISK MANAGEMENT PERSONNEL

Risk Management Personnel

Insert details of :

Director responsible for Risk
Director responsible for Clinical Governance
Trust's risk manager
H&S Advisor
Fire Advisor
Occupational Health
Infection Control

Etc.



Risk Management Process
Click on Mouse for each section of slide to be revealed:
Section 1: Identify hazards – "things with potential to cause harm"
How do we do this? – risk assessment, audit, inspections and reporting

Section 2:Assess risks and reiterate likelihood x consequences

Section 3:Control the risks – by policies, procedures, training, replacing, equipment, preventative maintenance

Section 4:Monitor and review – supervise, audit to check it is happening,

Section 5:The sections form a cycle which is a control loop that needs to be closed.

ACCIDENTS & INCIDENTS

Accidents and Incidents

Header slide

ACCIDENT

- An incident **plus** it's consequences.
- An unplanned, untoward or unexpected event resulting in adverse effect or loss.

ie:

Physical Injury or Ill-health
Mental Ill-health
Material Damage
Legal Proceedings (Criminal or Civil)
Financial Loss
Reputation Damage

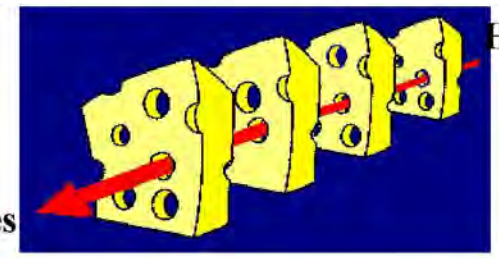
NHS 21

Accident

An accident is rarely a single event and it is usually a sequence of things going wrong which result in an accident, (like dominoes falling over). For it to be an accident there has to be a loss which could be one of the list on the slide:

INCIDENT

- An untoward or unexpected sequence of events or actions which interferes with orderly progress or activity and results in, or could have resulted in:
  - An Accident or
  - A Near miss



An organisation with a memory 2000

NHS 22

Incidents

Is another model which - the Swiss cheese which shows that within each process (slice of cheese) there may be sporadic unsafe acts and conditions which in themselves may not cause an incident but when they come together may cause an accident/incident

ADVERSE EVENT

- An event or omission causing physical or psychological injury.

Adverse Event

** if you use the term adverse event rather than accident use this slide

NEAR MISS

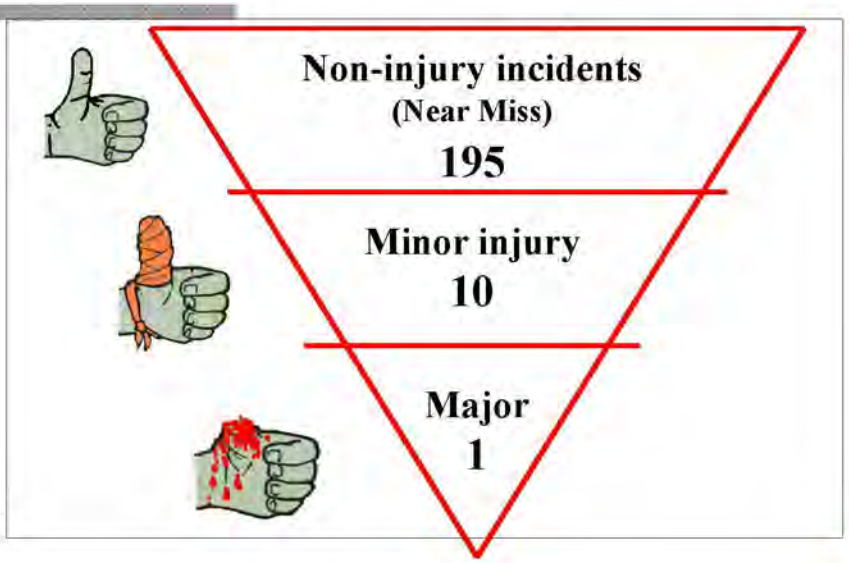
- An event, omission, or sequence of events or omissions, which fails to develop further *(whether or not as a result of compensating action)* thus preventing injury.

NHS 24

Near Miss

Read definition

REPORTING



HS(G)96

NHS 25

Reporting

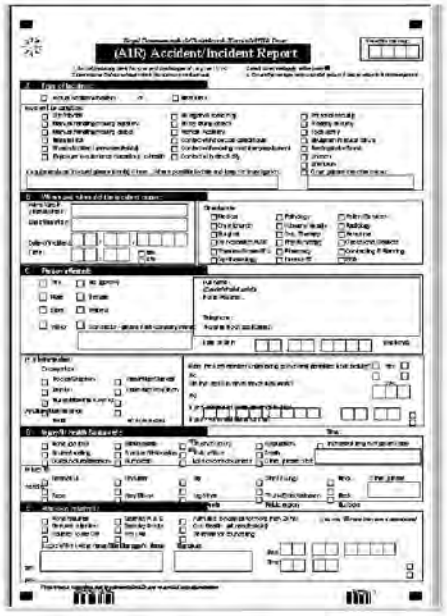
The HSE document on the cost of accidents demonstrates that:
(Click for each section of slide)
Section 1: For every 195 near-misses you get …

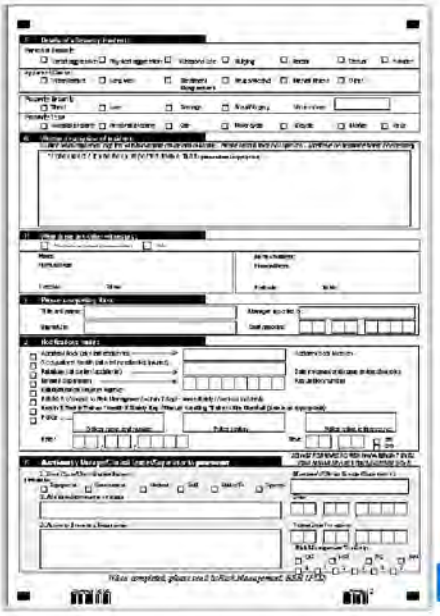
Section 2: 10 minor injuries in similar circumstances to the near misses and …

Section 3: 1 major/fatal injury in similar circumstances

So you get 195warnings for every 1 major accident. This is why it is important to report near-misses in order that the warnings can be noted and acted upon to prevent a recurrence.

AIR FORM

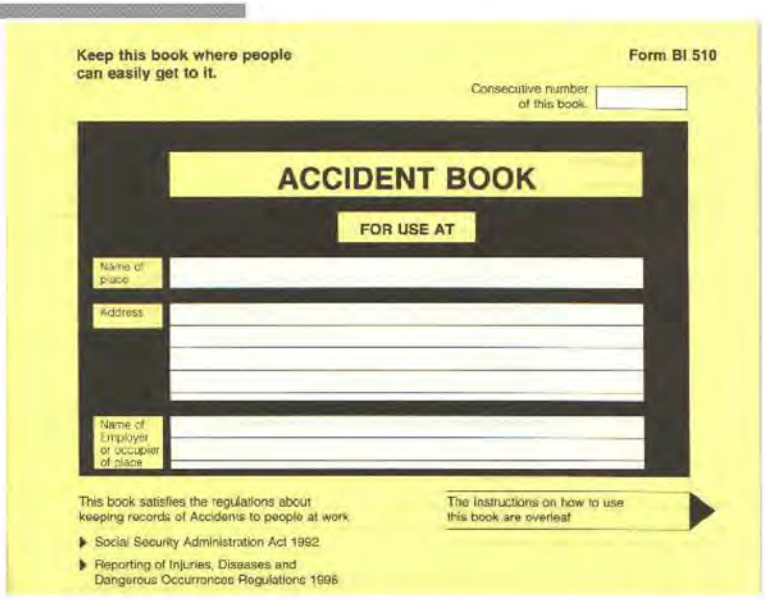

(AIR) Accident/Incident Report



Trust Accident Forms

Scan in copies of Trust Accident Forms

STAFF ACCIDENT BOOK



Keep this book where people can easily get to it.

Form BI 510

Consecutive number of this book

ACCIDENT BOOK

FOR USE AT

Name of place

Address

Name of Employer or occupier of place

This book satisfies the regulations about keeping records of Accidents to people at work

- Social Security Administration Act 1992
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1996

The instructions on how to use this book are overleaf

Accident Book

BI510 – to be used to record staff accidents for the DSS. Need not be used if Trust accident forms are numbered and contain all the information required of the Accident Book.

CRITICAL INCIDENT FORM

STRICTLY CONFIDENTIAL

CRITICAL INCIDENT REPORTING

Patient Name ..... Patient No. .....

Date of Incident ..... Time of Incident .....

Ward/Dept. .....

Please describe the incident as clearly as possible as a statement of fact

Box 49-179

P.T.O.

NHS 28

Critical Incident Form

Explain Trust's Critical Incident Reporting procedure

CORPORATE GOVERNANCE

- Is the system by which organisations are directed and controlled.
- It involves:
  - Internal financial controls
  - Effective & efficient operations
  - Compliance with laws & regulations

Corporate Governance

Explain that it's a Government/NHSE-led directive. Corporate Governance definition given. Explain how it interfaces with your Trust's risk management structure and systems.

CLINICAL GOVERNANCE

A management systems framework, through which NHS organisations are accountable for continuously.....

- Improving the quality of services
- Safeguarding high standards of care
- Creating an environment where clinical excellence will flourish

Clinical Governance

Explain that it's a Government/NHSE-led directive. Clinical Governance definition given. Explain how it interfaces with your Trust's risk management structure and systems. Give examples of some of the Initiatives underway.

CONTROLS ASSURANCE

... is a process designed to provide evidence that NHS organisations are:

doing their 'reasonable best'

to manage themselves so as

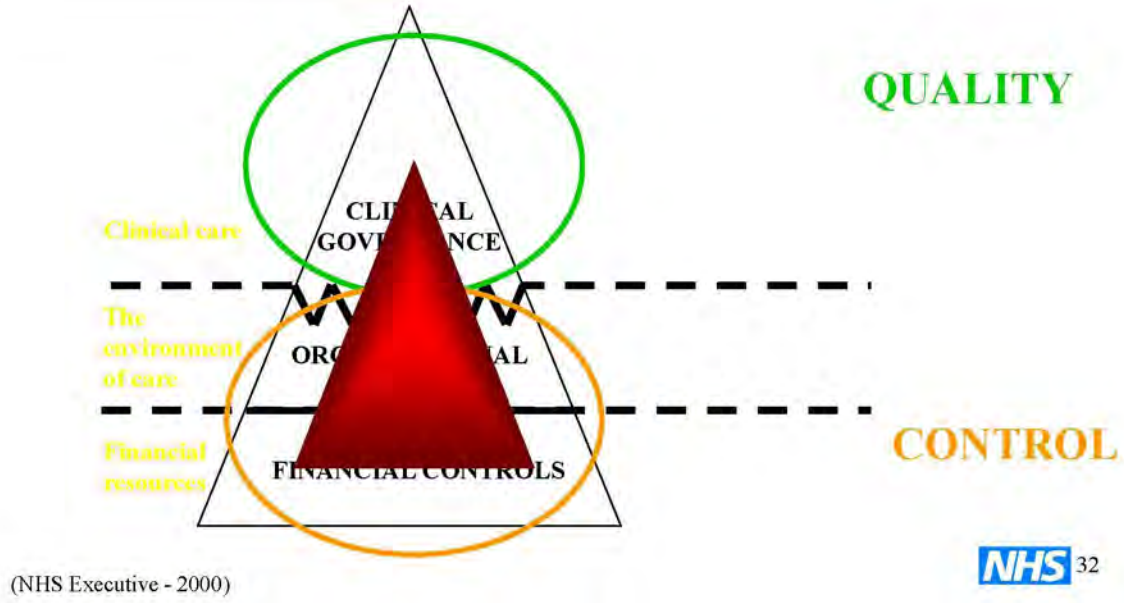
to meet their objectives and protect against risk.

NHS 31

Controls Assurance

Explain that it's a Government/NHSE-led directive. Controls Assurance definition given. Explain how it interfaces with your Trust's risk management structure and systems. Give examples of some of the Standards

RISK MANAGEMENT



(NHS Executive - 2000)

Risk Management

Slide explains how risk management fits in with Controls Assurance and Clinical Governance as part of Corporate Governance. Demonstrates the link between quality and control and that risk management forms the core of Corporate Governance activity.

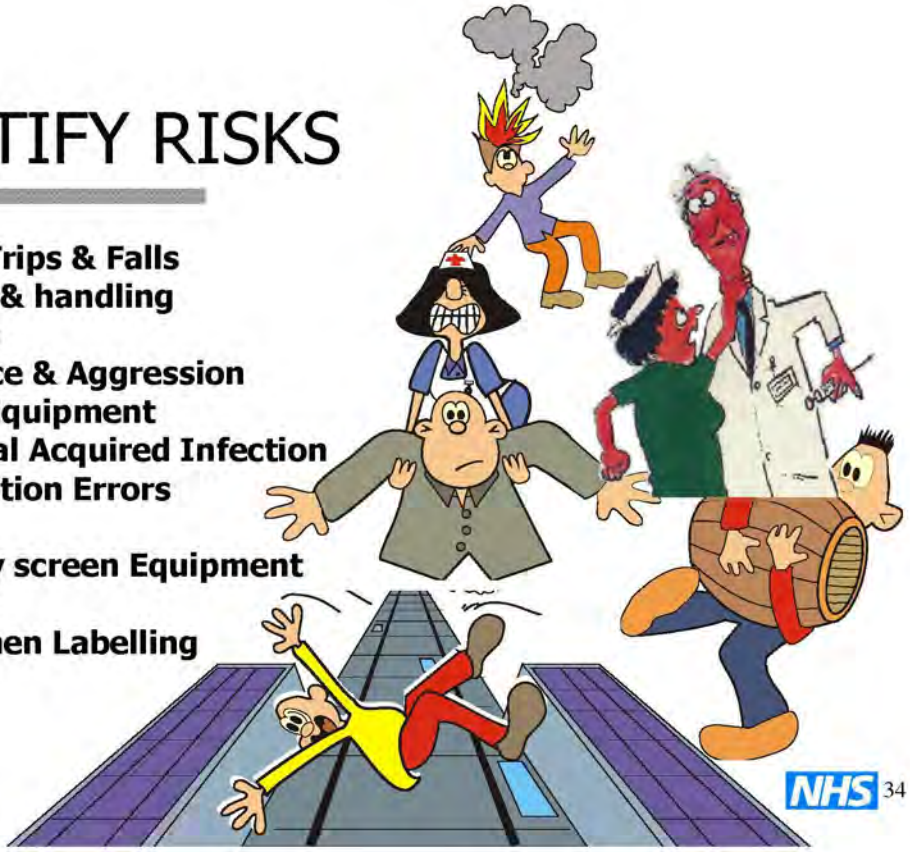
IDENTIFY RISK

Identifying Risk

Title Slide

IDENTIFY RISKS

- Slips, Trips & Falls
- Lifting & handling
- Sharps
- Violence & Aggression
- Work Equipment
- Hospital Acquired Infection
- Medication Errors
- Fire
- Display screen Equipment
- Stress
- Specimen Labelling



NHS 34

Identifying Risks (2)

Slide identifying common risks. You may wish to add some of your own.

FREE LESSONS

When things go wrong, the lessons which could be learnt are ignored

The aim is to:

- Learn from our failures
- View near misses as 'Free Lessons'

NHS 35

Free Lessons

There is a huge opportunity for learning from mistakes, failures and near-misses which on the whole are ignored and therefore control measures are not reviewed, evaluated and amended to prevent the accident occurring/recurring.

EVALUATE RISKS

Evaluate Risks

Title slide

"BLUNDERS KILL 40,000 a YEAR"

Sunday Times, 19 Dec 1999

- Medical error is the third most frequent cause of death in Britain after cancer and heart disease .....

..... kills four times more people than die from all other types of accident.

Blunders Kill …

Example of ignoring warning signs and the need to stop this sensationalisation by getting our house in order. Let audience read slide.

ADVERSE EVENTS

An Australian study revealed:

- 16.6% of admissions resulted in an adverse event.
- 50% of those were considered preventable.

- These accounted for 8% of all hospital bed days!

Adverse Events

Let audience read slide. Key point is last bullet point in that in Australia 8% of hospital bed days are taken up due to event caused by the hospital once patients are admitted. (Adverse Events are clinical and non-clinical incidents).

STATISTICS

Evidence suggests that:

850,000 adverse events
occur each year
costing the NHS more than
£2 billion

Statistics

Cost of adverse incidents in the UK.

CLAIMS

Claims

Insert the number and cost of claims in your Trust split by clinical and non-clinical

ACCIDENT ICEBERG

HS(G)96

NHS 41

Accident Iceberg

Slide explains that for every £1 of obvious costs there are £36 of "hidden" costs (it's 36 times more than you think it is).
NB: As a rule of thumb it will be 5% of your Trust's Annual budget.

RISK EVALUATION

	0	0	0	0	0	0
	0	1	2	3	4	5
	0	2	4	6	8	10
	0	3	6	9	12	15
	0	4	8	12	16	20
	0	5	10	15	20	25

Risk Evaluation

Shows the risk assessment matrix from the Controls Assurance CD ROM. If your Trust uses a different matrix insert this in its place. (NB to be followed by Slide 43)

RISK EVALUATION

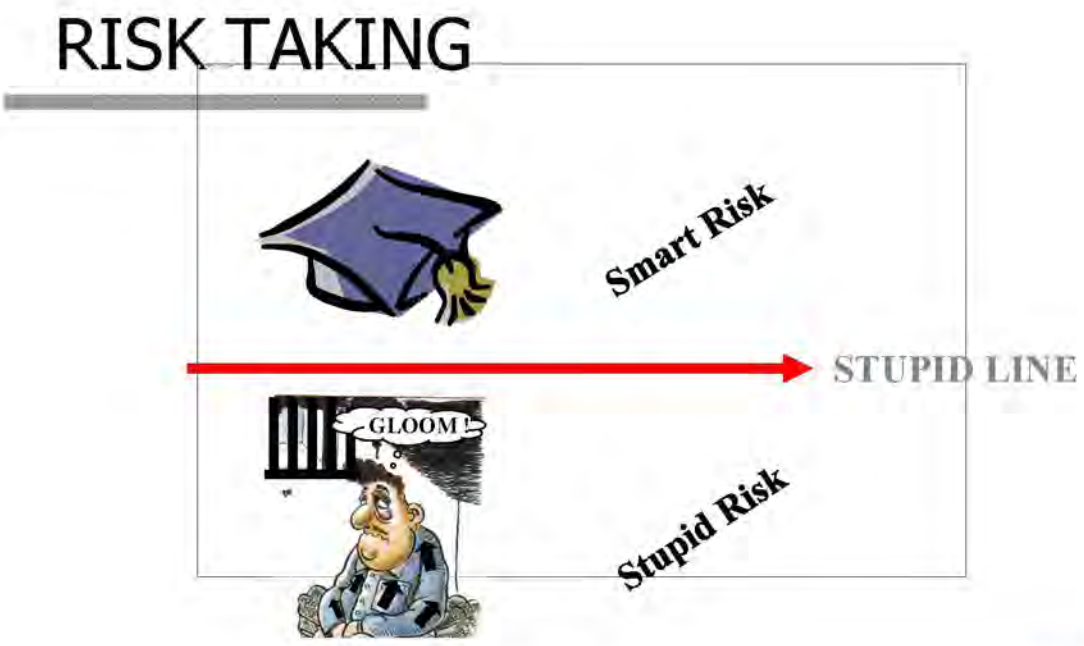
	0	0	0	0	0	0
	0	1	2	3	4	5
	0	2	4	6	8	10
	0	3	6	9	12	15
	0	4	8	12	16	20
	0	5	10	15	20	25

No Risk	Low Risk	Mod. Risk	Sig. Risk	High Risk	Above Tolerance
0	1 - 3	4 - 6	8 - 12	15 - 25	20 - 25
Do Nothing	Act Last	Act Later	Act Soon	Act NOW	STOP Activity

NHS 43

Risk Evaluation(2)

Shows the priority for action against the risk assessment outcome.



Risk Taking

Discusses the fact that we do not suggest that all risk should or can be eliminated. Risk taking is appropriate once risks have been identified and evaluated so that risks taken are informed "smart" decisions and stupid risk (where the risks are not fully known, or too hazardous to take) are not taken - i.e. don't cross the "stupid" line.

RISK DISCOVERY

It is possible to:

- identify common themes in failures.
- use them to predict further adverse events.
- take steps to avoid them.

Some 70% of health-care incidents are considered preventable

… and all errors can be minimised.

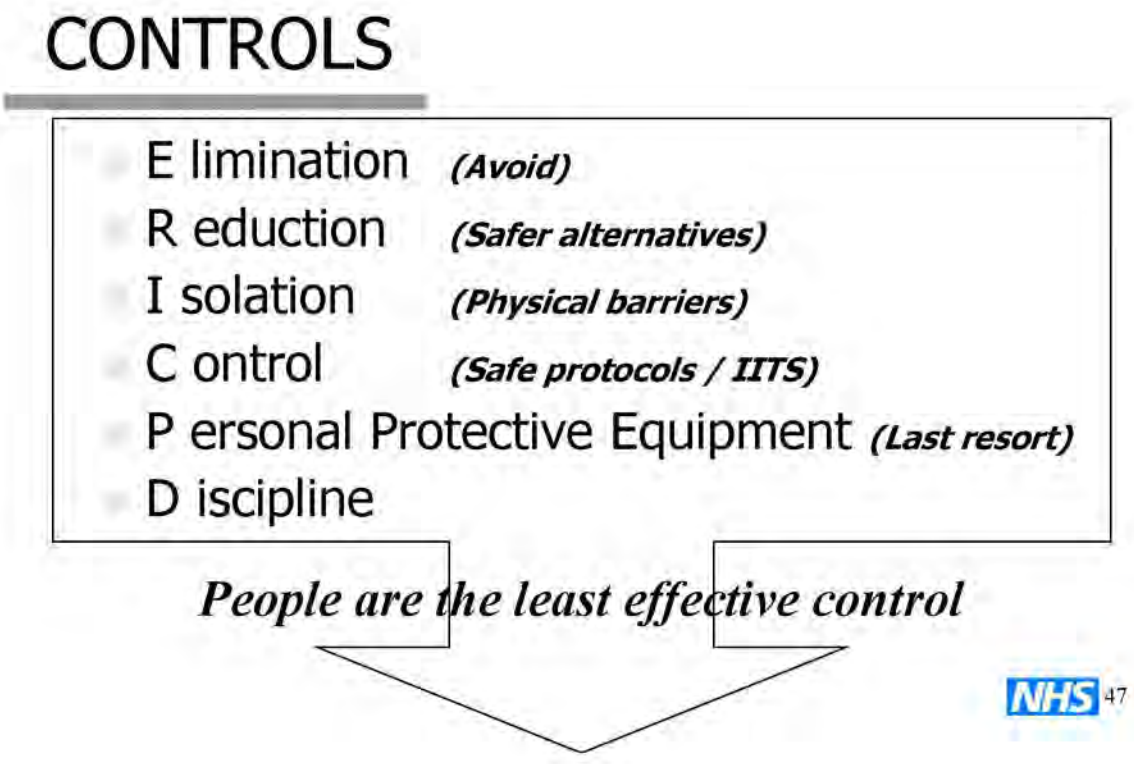
Risk Discovery

Shows that it IS possible to theme incidents in order to predict future events and implement appropriate controls

CONTROL RISKS

Control Risks

Title slide



Controls

Lists the hierarchy of control measure to be taken to control risk. Note the order of control measures is displayed to identify that the least effective control measures are those that rely on people (because of the possibility of human error occurring).

CLINICAL GOVERNANCE

There are practical ways of analysing where, when and how mistakes may occur, and then taking steps to avoid them.

It's about

Working at getting things right first time, every time.

NHS 48

Clinical Governance

There are themes in clinical risk. When looking at control measures it is important to ensure that the root cause is controlled (which is not always the most obvious cause). The symptom may not necessarily always be the root cause of the problem.

Prevention will only be achieved if the root causes are controlled.
Cause and effect ie
(Treat the root cause to prevent recurrence)

AWARENESS

Awareness of the nature, causes and incidence of failures is a vital component of prevention…

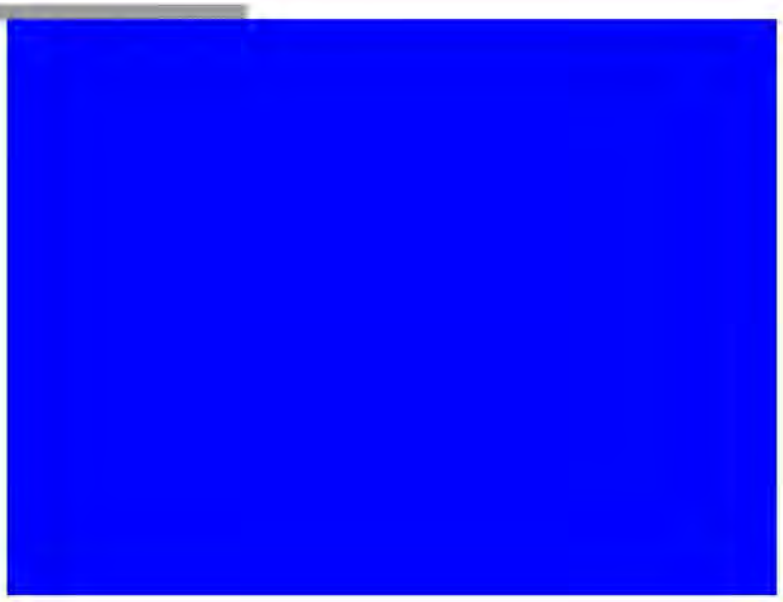
…. And prevention is cheaper than cure.

NB: Some learning, and therefore prevention, can occur simply as a result of being made aware that an incident has taken place

Awareness

Explains that costly controls are not always necessary merely informing people that the risk is present can reduce the likelihood of recurrence

WORK EQUIPMENT



NHS 50

Work Equipment

(JOKE) Opportunity to discuss, with humour, whether the appropriate hierarchy of control was used to control this risk. (Hand-free set)

Fault

Demonstrates that systems failure (unsafe conditions) account for the cause of approximately 85% of incidents and only 15% are human error (unsafe acts).

FAULT

Although most mistakes are due to organisational factors,

rather than individuals...

...organisations persist in blaming people.

Fault (2)

Unfortunately most organisations do not use this information to implement preventative measures appropriately and invariably implicate people.

FAULT

Research shows that a person-centred approach to prevention of accidents is the more dominant tradition:

- 98% time focused on individual failures
- 2% time focused on Organisational failures

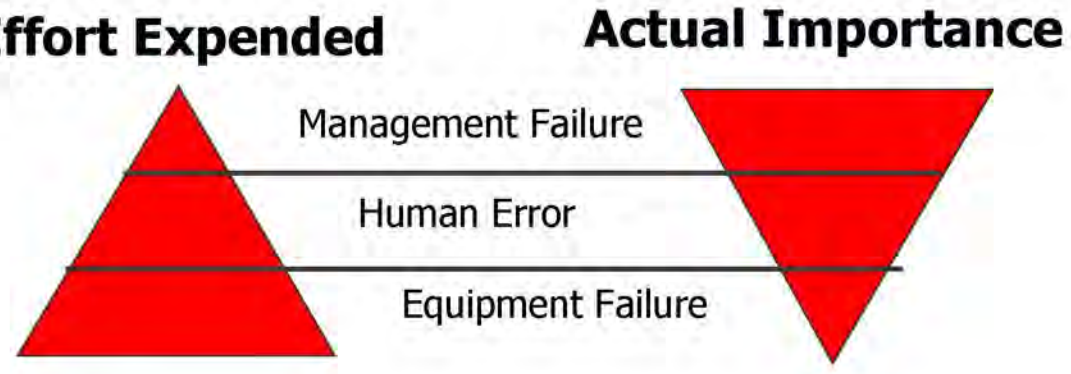
(Jo Wilson - 2000)

NHS 53

Fault (3)

When taking preventative action organisations only spend 2% of time and effort addressing systems failure (unsafe conditions) but spend 98% of time addressing human error.

CONTROLS PARADOX

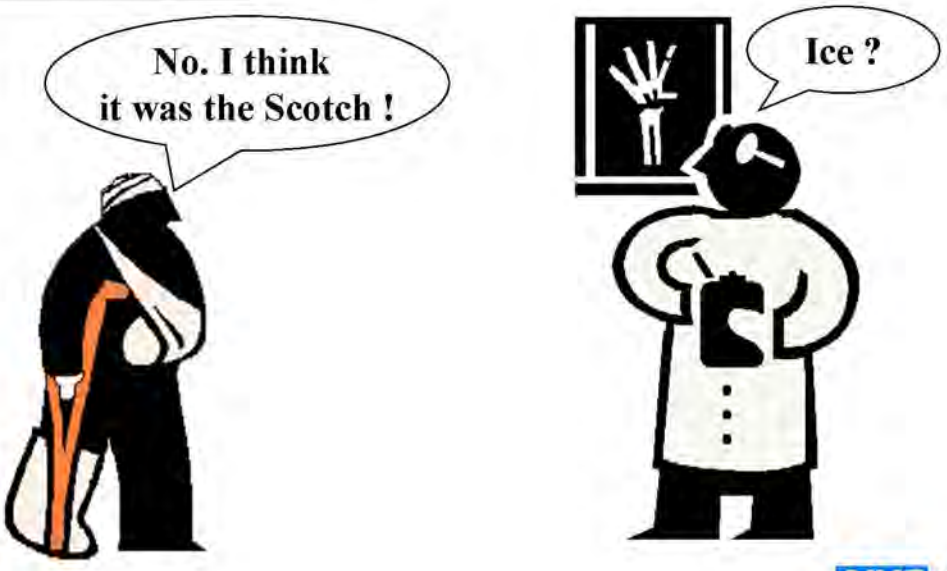


World Bank 1988

Controls Paradox

The World Bank (1988) demonstrated the effort expended on identifying the cause of failure against the actual importance of each type of failure.

INVESTIGATION - Root Cause



NHS 55

Investigation

(JOKE) Investigation of the cause of incidents should delve to identify the root cause rather than just the immediate/most obvious cause. Addressing the root cause will enable the most effective control to be implemented. To identify the root cause keep asking why something happened until you cannot ask why anymore. This is the root cause.

ROOT CAUSE - Medical Errors

Of the first 112 root cause analysis summaries the JCAHO reviewed, the root causes were:

65 - Orientation / training
50 - Patient assessment process
44 - Communication
43 - Physical environment
35 - Information not available
28 - Staff competency
25 - Equipment factors
25 - Staffing levels
18 - Storage / access issues

NHS Executive 2000

NHS 56

Root Cause – Medical Errors

In 2000 the NHSE listed the top 9 root causes of medical error

CLAIMS MANAGEMENT

At the scene of, or following an incident:

- Don't encourage people to make a claim.
- Don't comment on cause or blame.
- When investigating an incident:
  - Identify ALL potential causes. *(ie: faults on all sides)*
  - Identify the 'Root Cause'.
  - Suggest remedial action(s) to prevent recurrence.
- When making a statement:
  - State facts.
  - Avoid making judgements or assumptions.
  - Distinguish between what you have '***Witnessed***' or '***Heard***'

RECORDING

- Good Documentation = Good Defence
- Some Documentation = Some Defence
- Poor Documentation = Poor Defence

If it is not written down - it did not happen

MDU - 1997

NHS 58

Recording

Good documentation assists as a control not only in terms of evidence and defence but also as part of preventative measures.

LITIGATION

There is an association between
Communication skills and Litigation

Litigation:

Highlights the fact that in medical negligence cases it is often not solely poor medical outcome that leads to a claim. Normally there is a large element of poor communication which causes the level of dissatisfaction required to trigger a claim.

SIGNAGE

e.g.










NHS 60

Signage

Safety signs are a method of controlling the hazard. This slide gives examples of the types of safety signs used around the organisation. Can ask audience to give example of each type of sign (before each example is shown on the slide).

MONITOR & REVIEW RISKS

Monitor and Review Risk

Title slide

REVIEW

Audit and Reassess to check that controls:

- really are in place
- are actually reducing risk

Don't underestimate the power of leadership in achieving a change in culture

NHS 62

Review

Review is necessary to ensure the controls that have been put in place are being used and are working. Leadership is essential to ensure controls are sustained and a culture change effected (turning a blind eye to incorrect practices will often lead to failure).

RE-ASSESS & REVIEW?

- When things changes
  - New staff
  - New procedures
- When things go wrong
  - Accident
  - Incident/Near-miss

Re-assess and Review

Explains when controls should be reviewed.

REPORTING

- Trust Reporting System
  - **Trust** - Report forms
- Statutory Reporting Systems
  - **DSS** - Accident book
  - **HSE** - RIDDOR forms
  - **MDA** - Report forms
  - **HA** - Major incident reports
  - **NHSLA** - CNST, LTPS, PES

Re-assess and Review

Explains when controls should be reviewed.

QUESTIONS

?