NORTHERN IRELAND

HEALTH & PERSONAL SOCIAL SERVICES

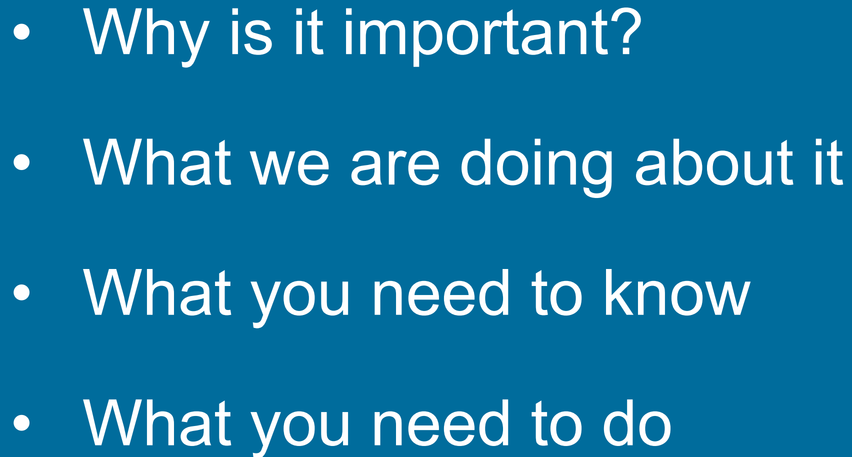
Risk Management Induction & Awareness: What You Need to Know

Produced by
North & West Belfast HSS Trust

Special Thanks to Capita Consulting and the Risk Managers Facilitator Forum

CAPITA
CONSULTING

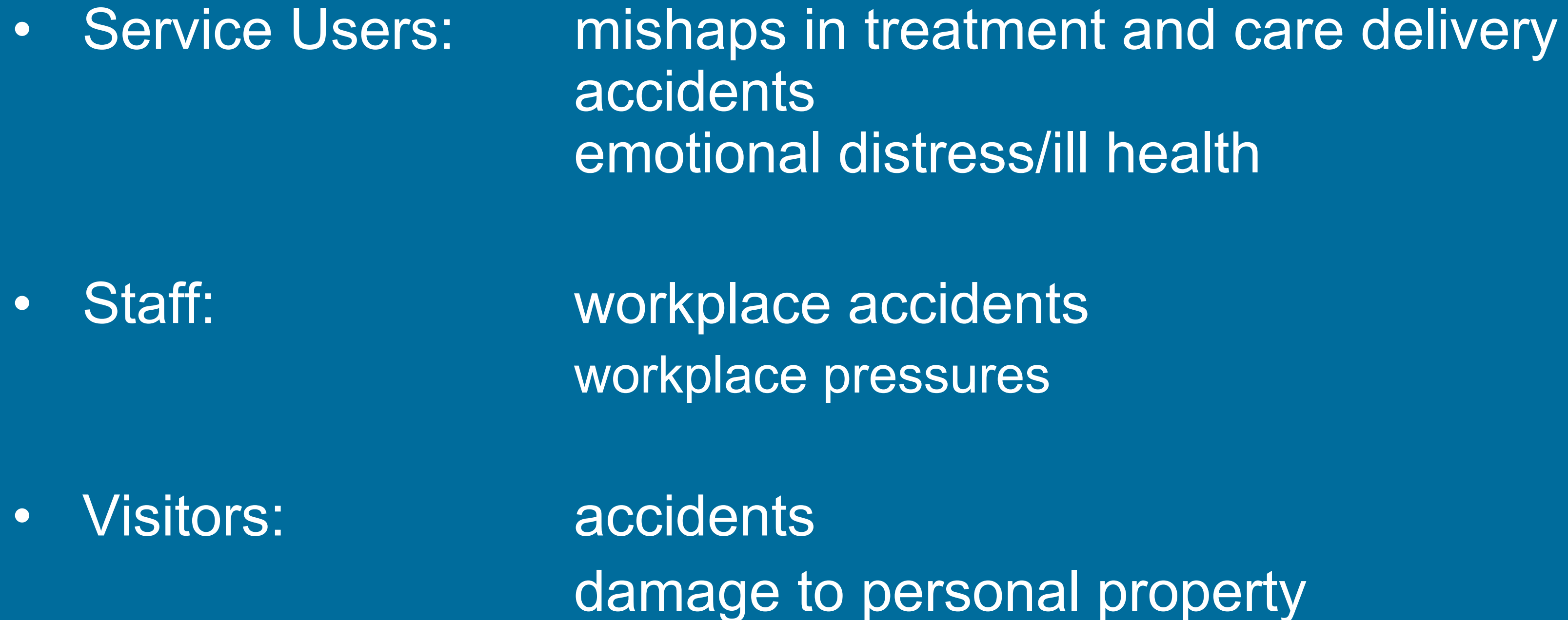
Objectives



Safety and Risk : what does it mean to you?

- As a user of Health & Social Services have you or anyone you know ever:
  - Had the wrong notes?
  - Had the wrong diagnosis?
  - Missed an appointment?
  - Had to spend longer in hospital than anticipated?
  - Made a complaint about health / social care?

What types of risk exist in health and social care organisations?



Who / what suffers?

- Quality of Service
- People
- Resources
- Reputations

Definition of Risk

The chance of something happening that will have an impact upon objectives. It is measured in terms of likelihood and impact."

What is Risk Management?

A process which involves planning, organisation and direction of a programme that will identify, assess and ultimately control risks

Mary Burrows 2002

The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects

Why Risk Management is Important

To:

- Enhance quality of treatment and care services
- Improve staff morale and productivity
- Provide safer environment for staff
- Improve public image
- Prevent future incidents
- Reduce costs of replacement, repair, and claims

Why is Risk Management an Issue in the NHS

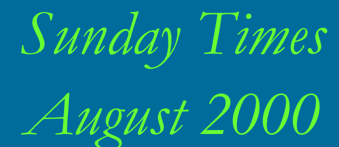
- 10.8% patients experienced an adverse event,

Of these
- **49% judged preventable**
- **34% developed injury or complication with moderate impairment**
- **6% permanent impairment**
- **Contributed to death 8%**

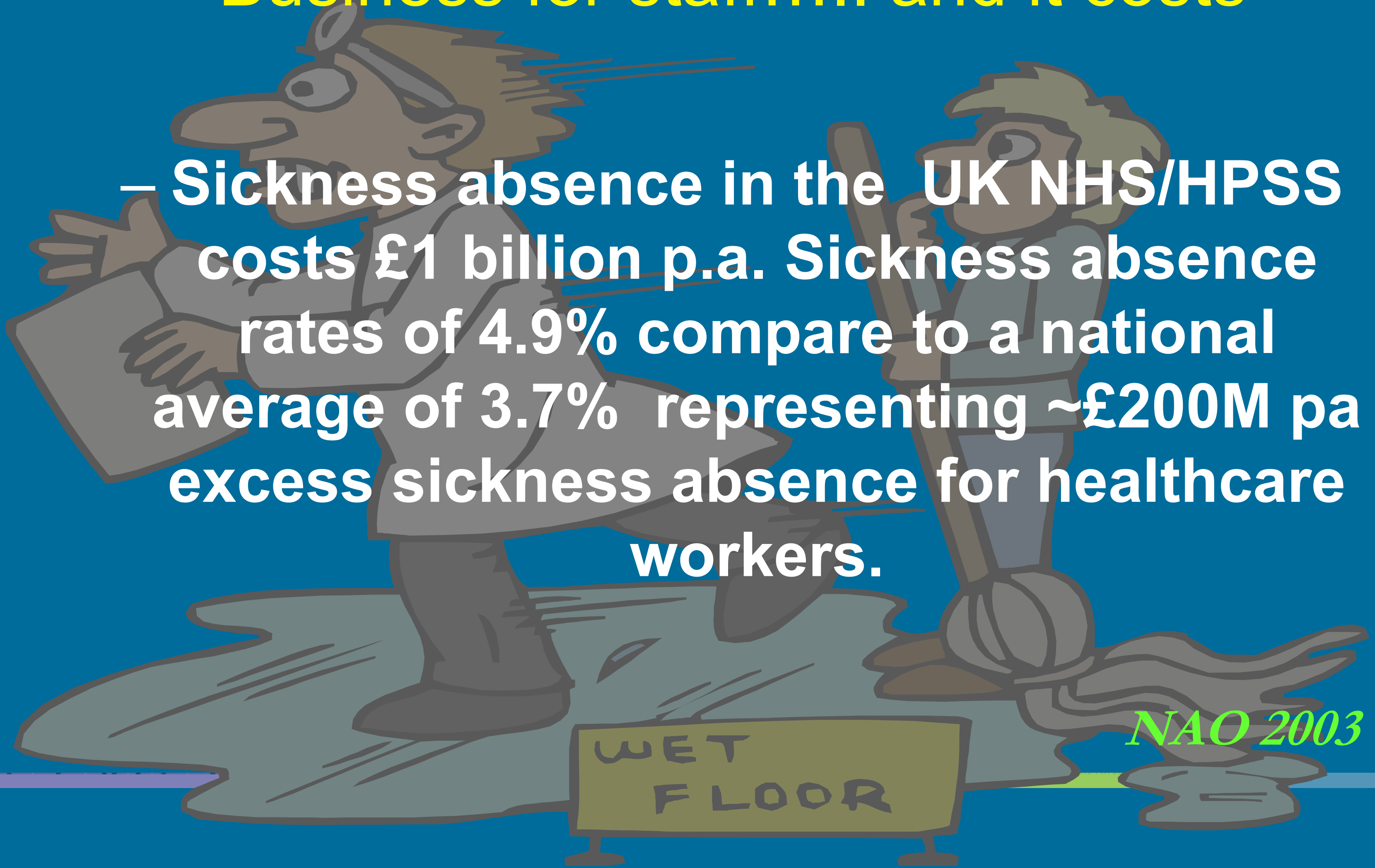
UCL 1999

Media Headline

- Medical error kills ~ 40,000 a year in the UK and is the third most likely cause of death after cancer and heart disease (Vincent et al 1999)



Health and Social Care is a risky Business for staff….. and it costs



- **Sickness absence in the UK NHS/HPSS costs £1 billion p.a. Sickness absence rates of 4.9% compare to a national average of 3.7% representing ~£200M pa excess sickness absence for healthcare workers.**

NAO 2003

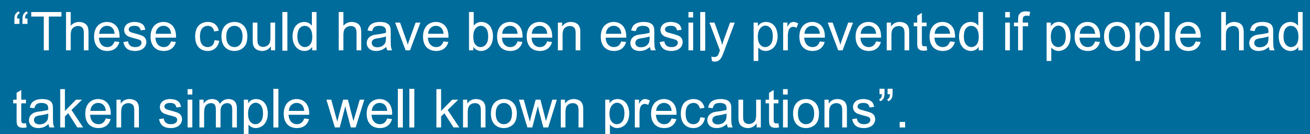
Health and Safety At Work in the NHS/HPSS

The Health & Safety Executive has reported that every year, on average, there are:

- 135,000 accidents 2001/2
- 27 fatal accidents (mostly service users)
- 2,000 non-fatal major injuries (60% service users)

NAO 2003

"These accidents follow similar patterns year after year"



"These could have been easily prevented if people had taken simple well known precautions".

Cost of Work Related Accidents

- £173 million!
  - Work related sickness/absence
  - Permanent injury benefits
  - Ill health retirements
  - Out of court payments

Adverse Events/Incidents
Some Important Definitions

HAZARDS	Something identified with the potential to cause harm.
RISK	The likelihood that those harmful consequences occur

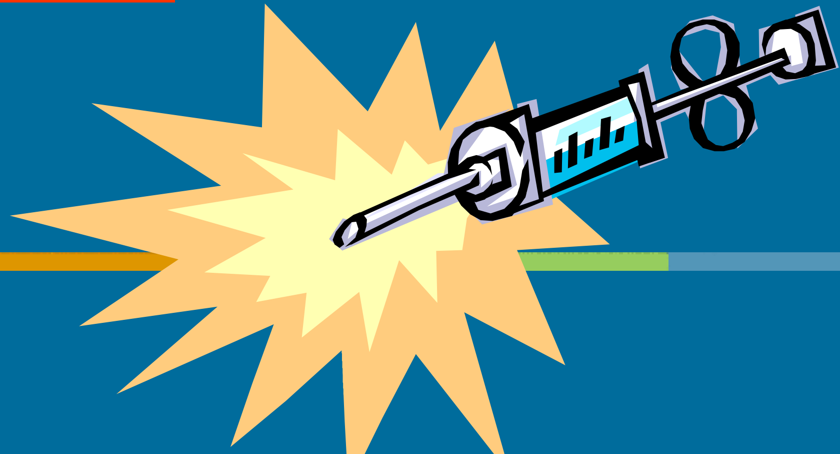
Definitions

Incidents — Any event that has given or may give rise to actual or possible personal injury, to patient/client dissatisfaction or to property loss or damage

Near Miss — Any event that did not lead to personal harm but could have, an occurrence which but for luck or good management, would in all probability have become a fully blown incident.

An Example

- An unsheathed needle lying on the floor is a **hazard**
- The **risk** is that someone receives a needlestick injury
- If the needle is picked up by a member of staff who places it, without injury, in a sharps box it was a **near miss**
- If someone picks it up and injures themselves before putting it in a sharps box this is an **incident**



Incidents, Events and Near Misses

Adverse incident

Did it cause harm or loss?

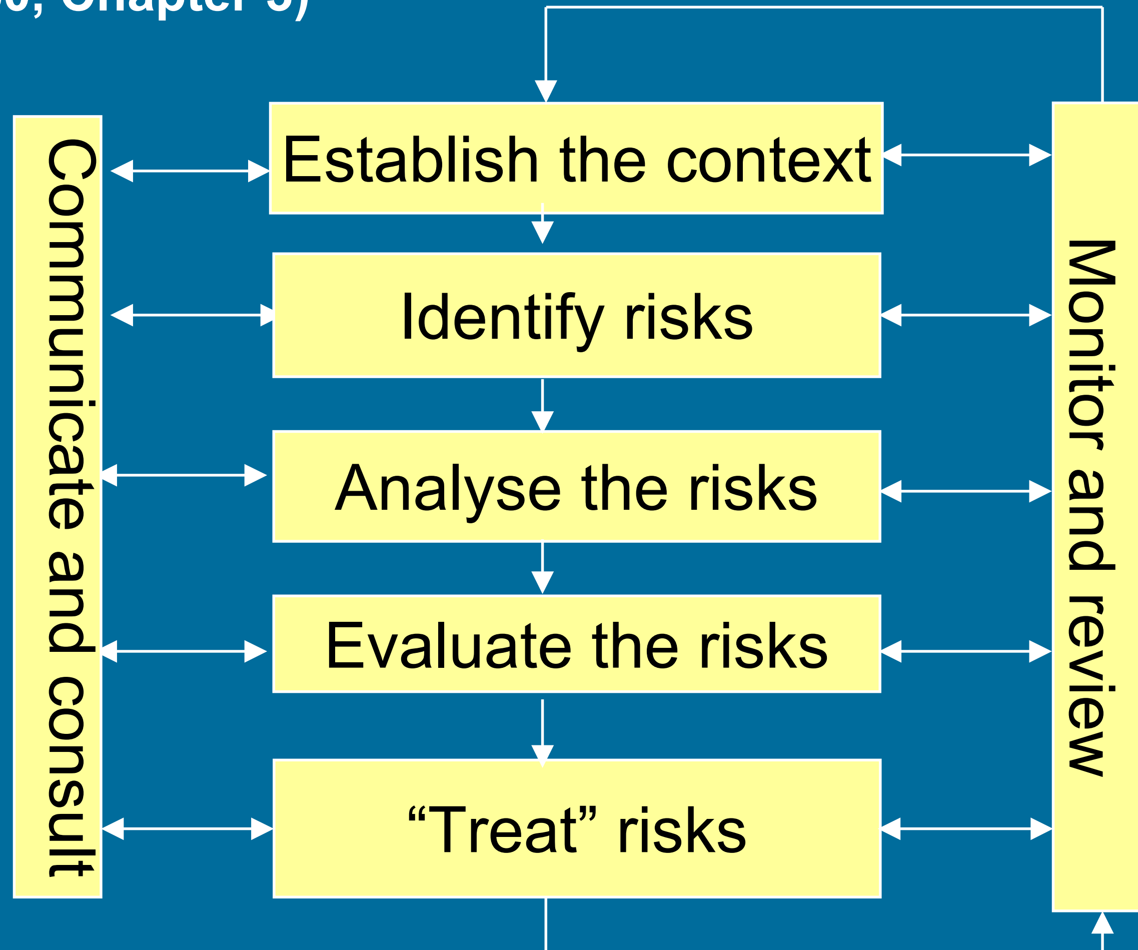
Yes

No

Event

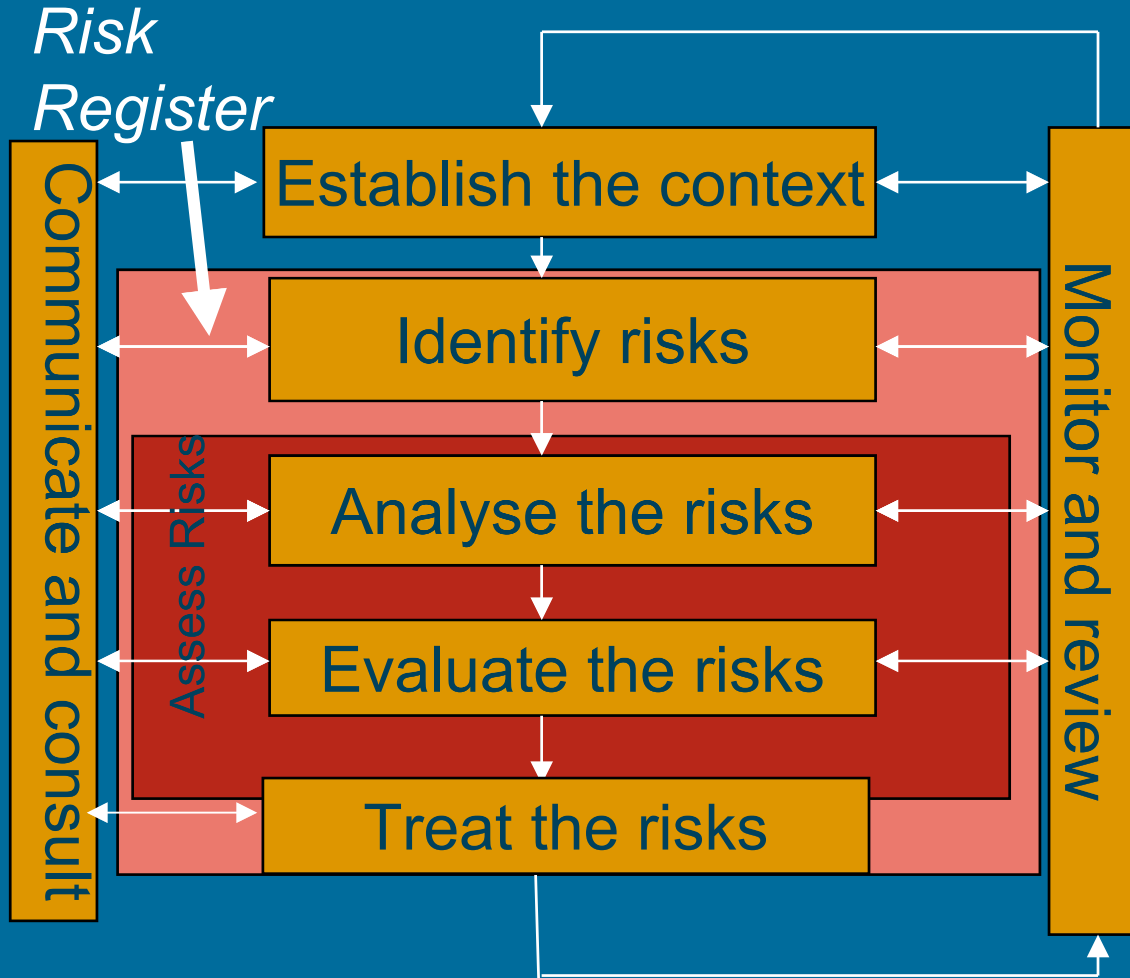
Near Miss

The Risk Management Process
(AS/NZS 4360, Chapter 3)

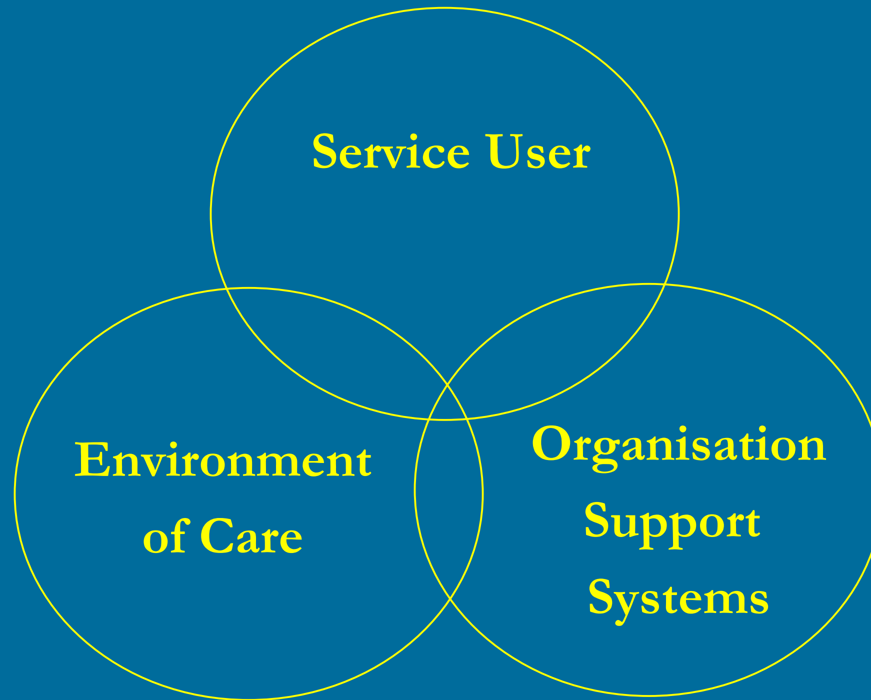


Risk Management Process

Risk Assessments & Risk Registers



Identifying risks: where?



Risk Identification: how?

Internal

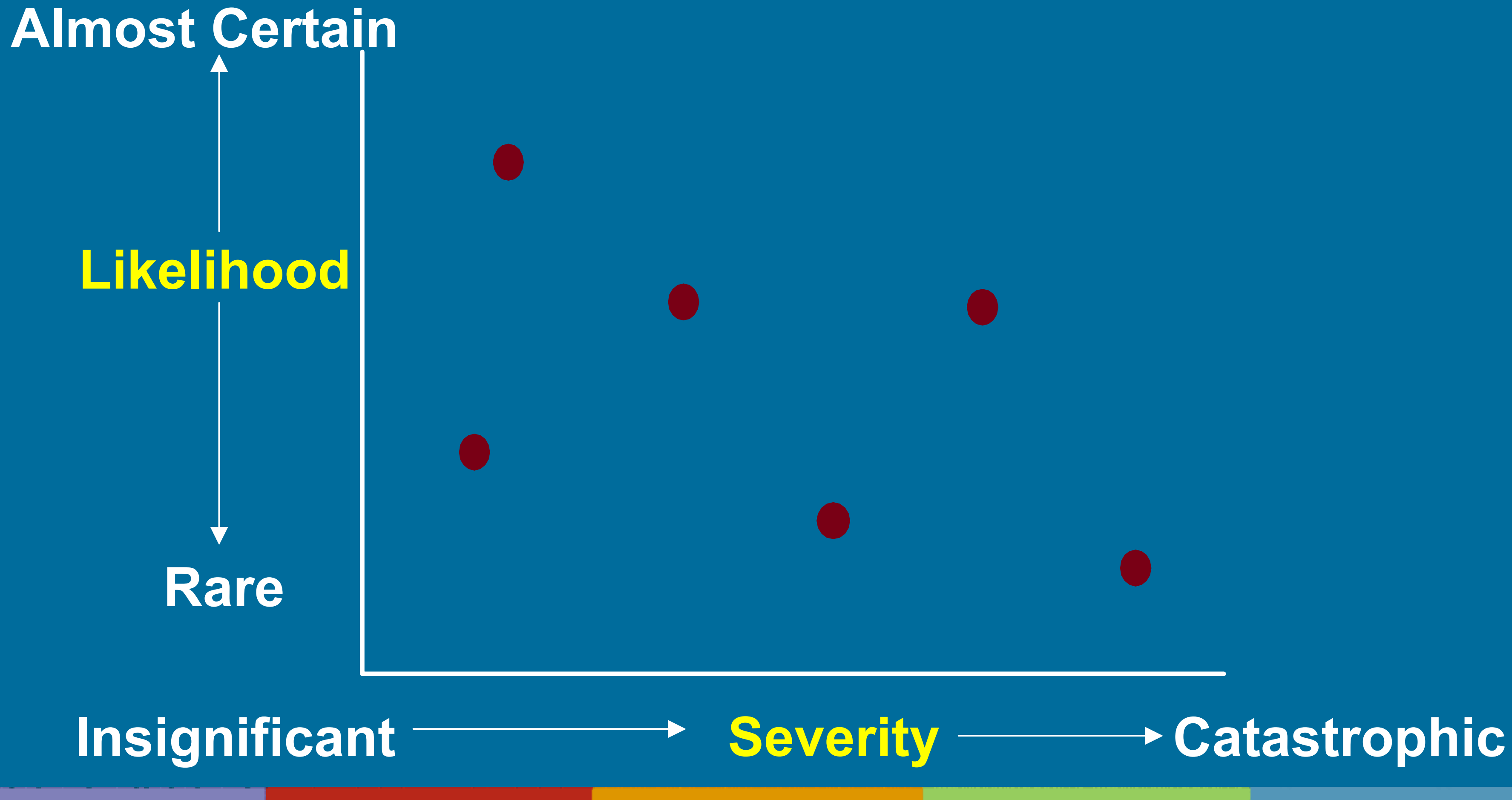
- Incidents
- Complaints
- Sickness absence / staffing levels
- Risk assessments
- Audits
- Team meetings / workshops

External

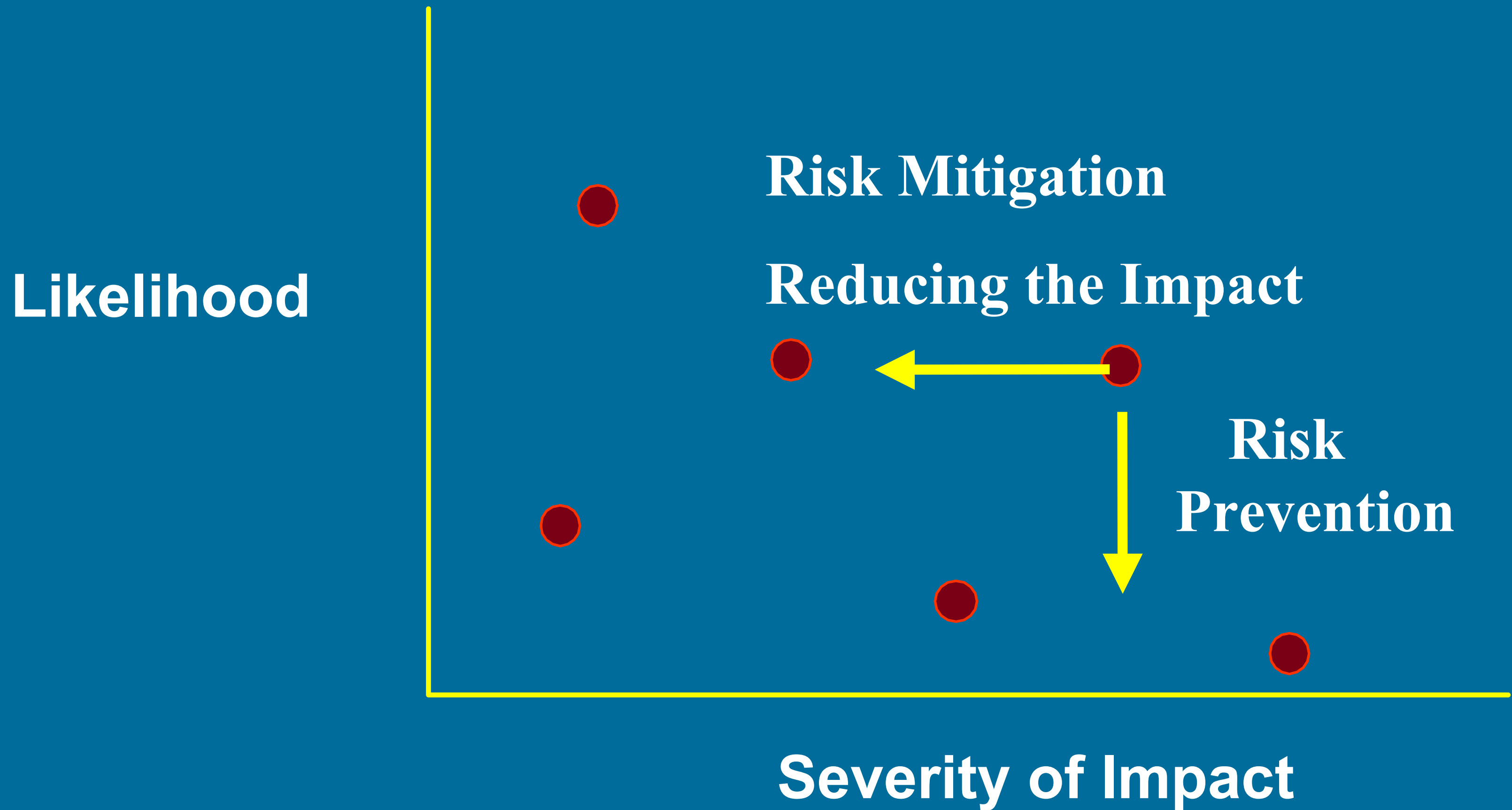
- Audits
- External Inspections
- New legislation and policy
- Mental Health Commission
- Hospital Advisory Service
- Health & Social Services Regulation & Improvement Authority

Risk Analysis

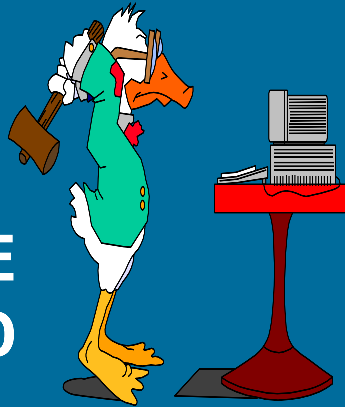
Using information to determine the likelihood of reoccurrence and severity of impact



The response: Controlling / Treating Risk

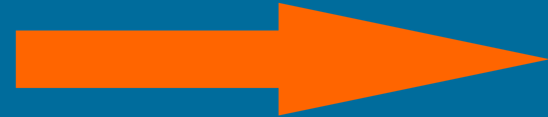


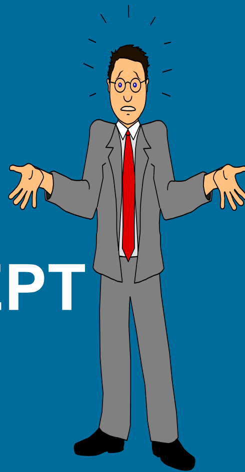
Risk Treatment Options



ELIMINATE
or AVOID

TRANSFER





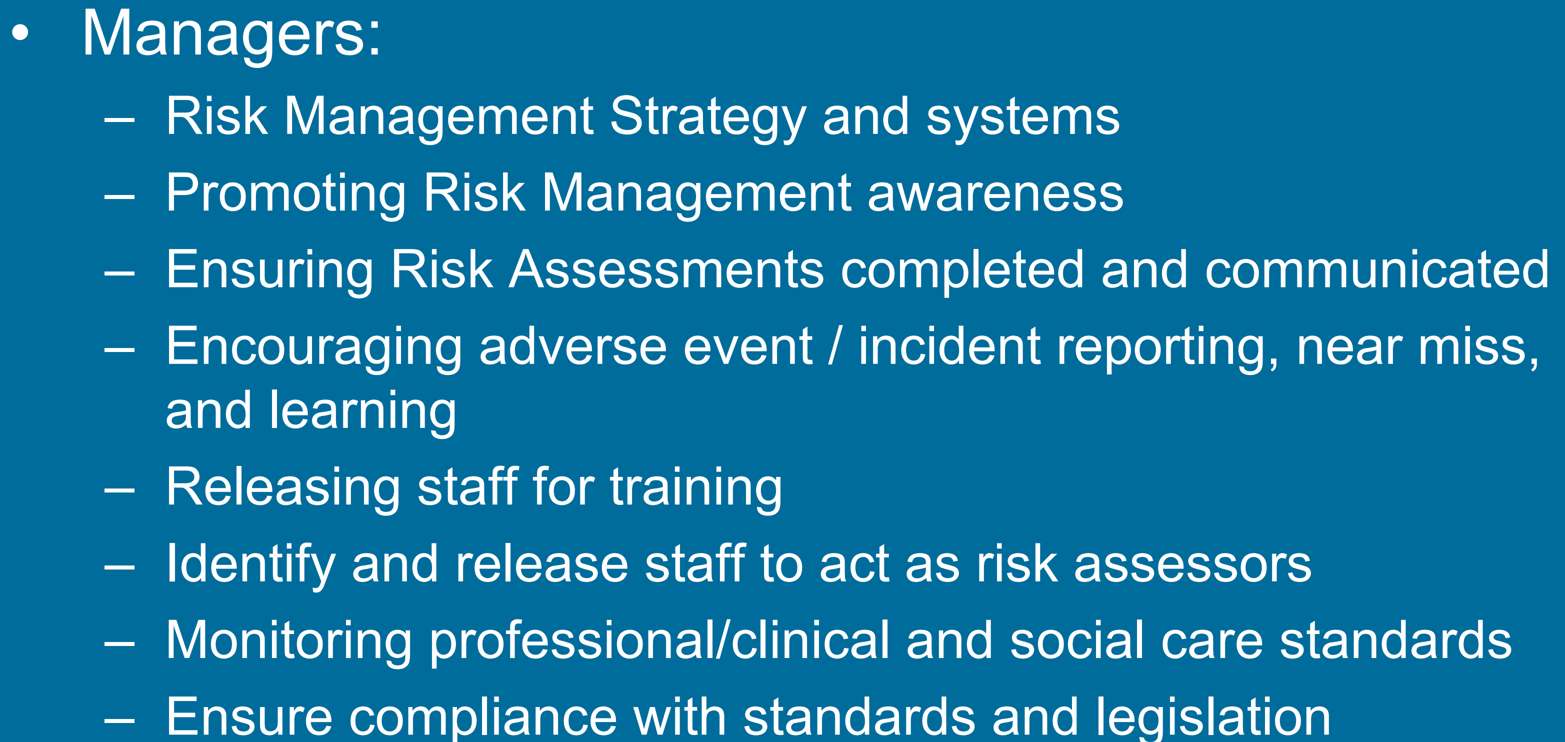
ACCEPT

REDUCE

The Role and Responsibility of the Trust

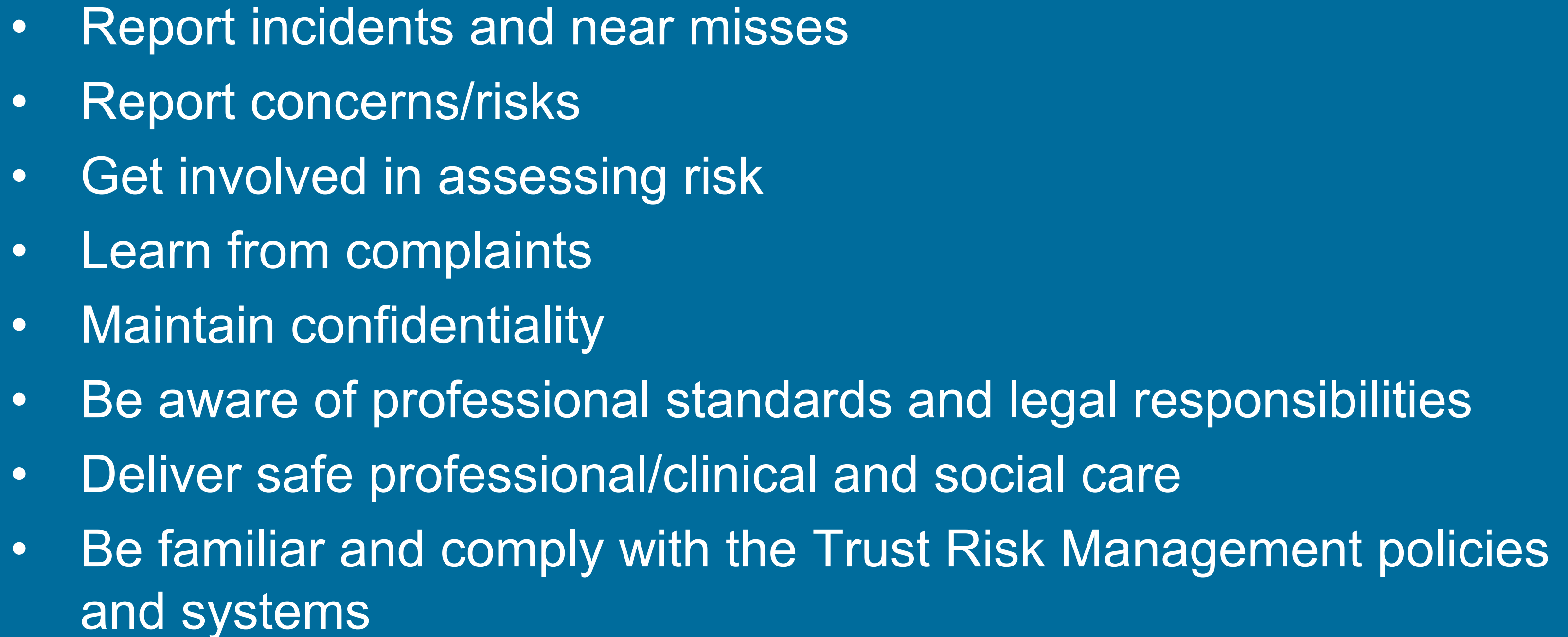
- Organise for risk management
- Establish policies and procedures
- Training and education
- Gather information
- Share information
- Manage incidents, claims and complaints
- Learn from these
- Prevent future adverse incidents

The Role and Responsibility of Managers



- Managers:
  - Risk Management Strategy and systems
  - Promoting Risk Management awareness
  - Ensuring Risk Assessments completed and communicated
  - Encouraging adverse event / incident reporting, near miss, and learning
  - Releasing staff for training
  - Identify and release staff to act as risk assessors
  - Monitoring professional/clinical and social care standards
  - Ensure compliance with standards and legislation

Your Role and Responsibility



The Trusts' commitment to you: Trust Policy Statement – Incident Reporting

The Trust believe that the systematic identification, analysis and control of risk will be facilitated by effective incident recording, which will be afforded a high priority within the Trust

An educational process and the establishment of a supportive, open and learning culture that encourages staff to report mistakes, incidents and near misses through the appropriate channels will underpin this.

Trust Policy Statement – Incident Reporting

The Trust supports an open and fair culture that means:

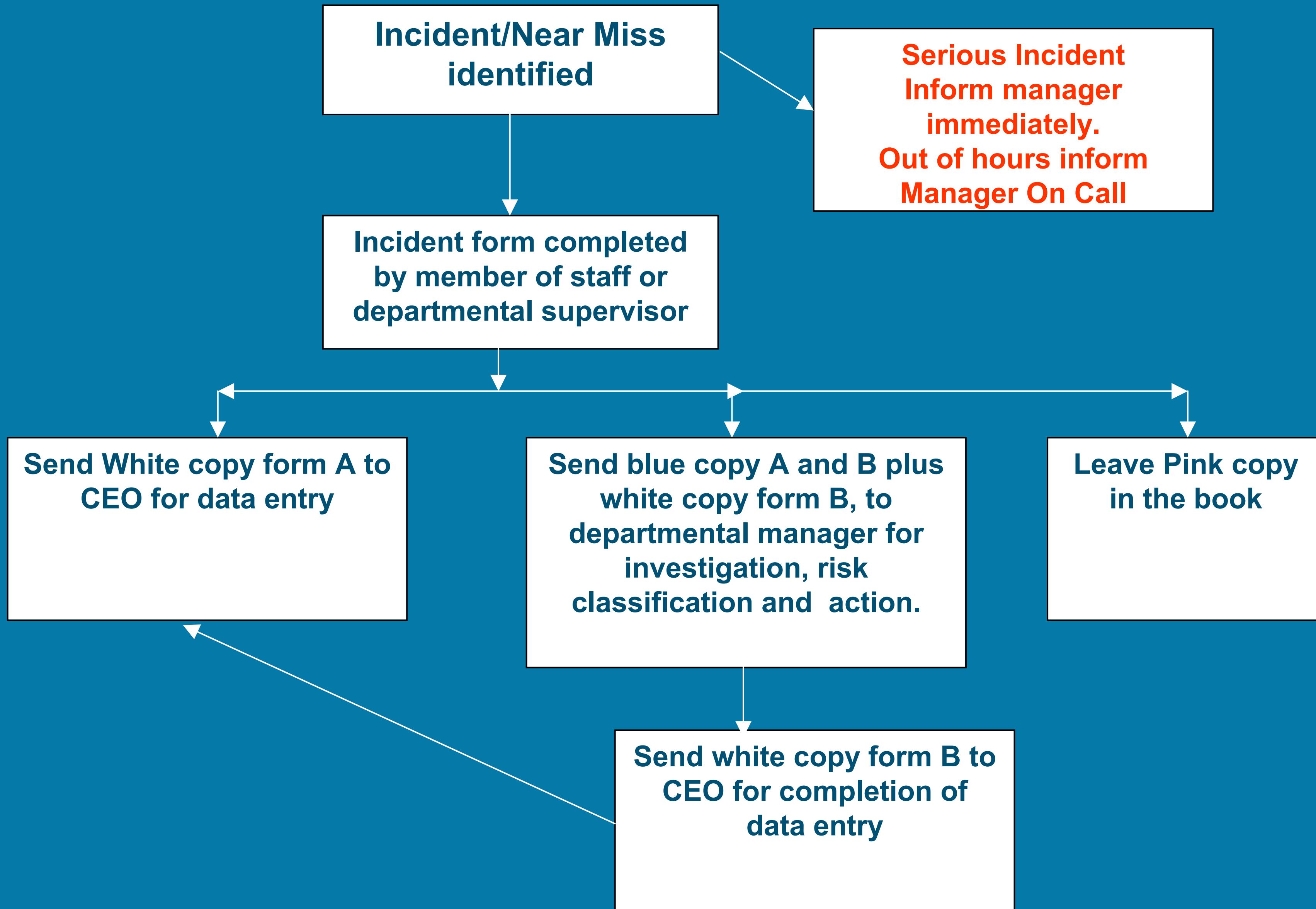
Staff who make a prompt and honest report in relation to an incident, near miss or mistake will not be disciplined except under the following circumstances :

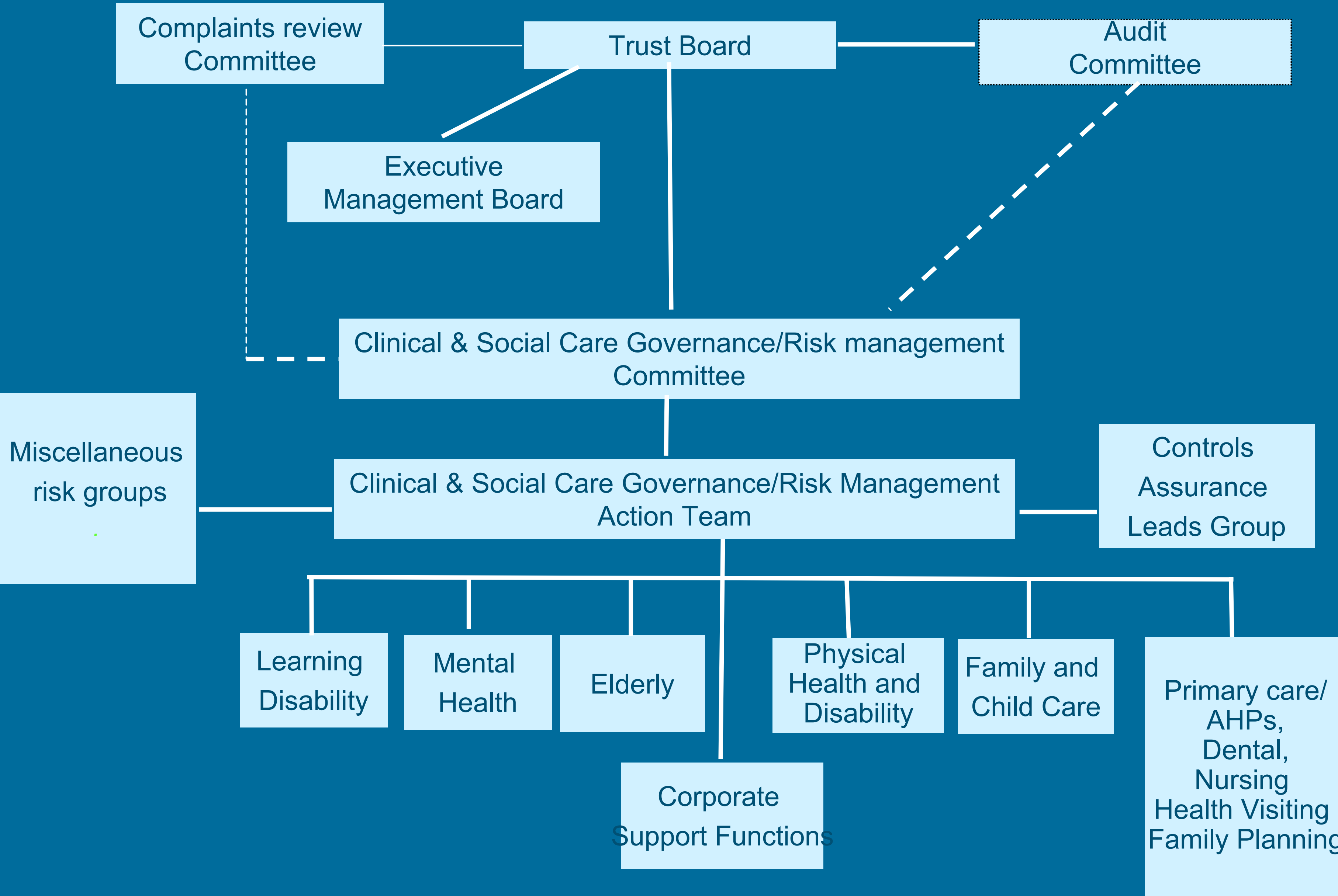
Where the member of staff acted in a criminal deliberate or malicious manner

Where the member of staff is guilty of wilful or gross carelessness or neglect contravening the Trust policies and procedures and/or professional codes of conduct and could reasonably be expected to appreciate the direct consequences of his/her behaviour

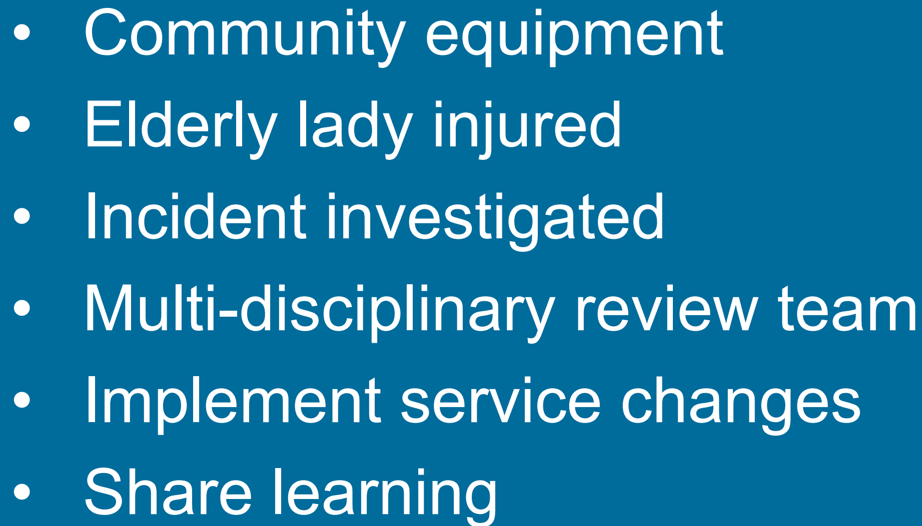
Where an incident follows other similar incidents of a similar nature and the Trust has provided all necessary training, counselling and supervision to prevent a reoccurrence

Flow of Information




Complaints review Committee
Trust Board
Audit Committee
Executive Management Board
Clinical & Social Care Governance/Risk management Committee
Miscellaneous risk groups
Clinical & Social Care Governance/Risk Management Action Team
Controls Assurance Leads Group
Learning Disability
Mental Health
Elderly
Physical Health and Disability
Family and Child Care
Primary care/ AHPs, Dental, Nursing Health Visiting Family Planning
Corporate Support Functions

Learning lessons: a practical example



Not sure what to do ?

If in doubt – contact your line manager!!

Thank you

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