FOREWORD

Risk management is an important activity for all parts of the NHS. With all the changes in recent years, including the loss of crown immunity, it is no longer an optional extra.

I believe risk management has two major contributions to make. It can play a valuable role in ensuring that we provide a high quality, safe service to our patients. It can also help towards the provision of a more cost effective service by eliminating, or reducing, unnecessary costs.

A comprehensive risk management programme needs to address all parts of the service, from clinical services to the management of waste. This manual provides a structured approach to a complex subject. It is aimed at the general manager who needs a clear overview of risk management, rather than being a technical guide.

I recommend this manual to all chief executives and their staff.

Sir Duncan Nichol
Chief Executive
NHS Management Executive

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BACKGROUND

This manual has been prepared by Merrett Health Risk Management Ltd for the National Health Service Management Executive (NHSME) to give guidance to health care organisations on the need for and methods of introducing the management of risk in health care. The NHSME commissioned two pilot studies to inform the preparation of this manual. The pilot studies, one at the then Leeds Community and Mental Health Services Unit and the other at Essex Rivers Healthcare NHS Trust, were completed in January and February 1993. The methodology used in the pilot studies is outlined in chapter 4 of the manual.

How to use this manual

The manual is divided into 34 chapters, each covering an aspect of risk management. Chapters 1 to 22 cover the principles of risk management and give guidance on how risks can be identified and analysed in health organisations. Chapters 25 to 34 form a practical guide to the implementation of a risk management process.

The manual gives:

- an assessment of the value of risk management to the National Health Service as a whole, and in particular to all health care provider units managing acute general hospital, community, mental health and learning disabilities services. This focuses on the costs of poor quality and identifies the quality improvements and financial benefits of having a risk management programme in place;

- guidance on the issues to be addressed by a risk management survey, with specific examples, to illustrate the application of the principles in key areas and in different types of organisation;

- an outline of the principles of risk identification, analysis and control;

- guidance on the key information which may be collected and monitored by different groups, at appropriate levels, to assure themselves that risks in their systems are effectively managed, controlled and monitored. These groups include chief executives of NHS trusts, trust boards, unit general managers, departmental managers, groups of clinicians and purchasers.

All chapters contain ■ **Action Points** to help managers to identify the action which they should be taking.

This manual is not a technical guide to nor textbook on risk management. It is written for managers of health care organisations, not for risk management professionals. References to case law and legislation are up to date at September 1994, but readers should be aware that the legal framework is constantly changing and should ensure that they remain updated. The manual is not intended to contain legal advice or to be a complete statement of the relevant law, but merely to provide a subjective statement of the most important principles. Legal advice should be sought as appropriate in relation to specific circumstances, preferably before rather than after the event.

Why is risk management relevant to health care services?

By its very nature, health care is a risk activity. Indeed, doctors and other health professionals should not be discouraged from taking some risks in developing more effective methods of treatment and care for patients and clients. But it is important that such risks are taken as a result of a positive decision to do so, on the basis of good information and a sound understanding of the possible consequences and the likely outcome of treatment. Of course, whenever possible, this should be done with the knowledge and consent of the patient or client concerned.

Similarly, the most effective managers are those who are prepared to take calculated risks, deliberately choosing to make such judgements from a range of fully detailed options.

What is of concern is the wide range of risks which occur by accident rather than design, and through mischance, mishap or mistake. Even more worrying are those untoward incidents which result from the lack of clear policies, deficient working practices, poorly defined responsibilities, inadequate communications and staff working beyond their competence. Most clinical negligence is caused not by individual clinical error but as a result of that type of systems failure, or a combination of several small mistakes occurring at the same time.

The challenge for managers and clinicians alike is to eliminate, or at least reduce, the potential for such misfortunes, by being proactive in the future management of risk.

Why proactive? Because being reactive is simply not good enough. Whether considering a brain damaged baby, the administration of the wrong drug, the absence of fire fighting equipment, the lack of training in lifting techniques, or inadequacy of the emergency generators, it is morally indefensible to say "It was just one of those things" if it was possible to foresee and prevent the incident from happening - even once.

Risks will vary according to the precise nature of the health care organisation, and the risk management techniques suitable for any individual organisation will depend upon the culture of the organisation and the availability and expertise of the personnel employed.

The management of risk must be accepted by all NHS managers as one of their key responsibilities. By being proactive in their approach, they will bring significant benefits to patient care, and to the organisation as a whole. Risk management is now viewed as an essential Quality system and one which is a fundamental part of a total approach to quality improvement. It brings with it quality benefits to the whole range of health services; to acute general hospitals, to mental health and learning disabilities services, and to primary care and community services.

Additionally, and very importantly, risk management is a financial system which protects the assets and earnings of the organisation. It reduces unnecessary costs and minimises losses from material damage, professional negligence, and injuries to staff and visitors, and ensures that income is not reduced through lost facilities.

Risk management is not a negative concept. It should not lead to "defensive medicine" and it is not about interfering with clinical freedom, although it can and should be used to pinpoint deficiencies in clinical systems which may need to be improved. Furthermore, the results of the risk management process should not be used for punitive or disciplinary purposes. They need to be addressed in a positive way, using people's mistakes as opportunities for eliminating those errors in future.

We all manage risks every day, but largely on an ad hoc basis and in an unco-ordinated way. What needs to be recognised is that there are major benefits to be gained, in future, in doing so in a more co-ordinated, systematic and focused way. Risk management leads to better communication and co-operation throughout the organisation and ensures that all staff understand that awareness is everyone's business.

CHAPTER 1

INTRODUCTION TO RISK MANAGEMENT

This chapter explains the place of risk management as a modern management tool, with particular relevance to the management of health services.

It is divided into three sections:

- the nature of risk management
- the need for risk management
- the way forward.

Risk will not be totally eliminated by an effective risk management programme, but good risk management allows managers to be aware of potential risks and offers the explicit opportunity to address them before any loss occurs.

The nature of risk management - what is it?

Risk (which is defined by the Collins Concise Dictionary as "**the possibility of incurring misfortune or loss**") is present throughout any organisation:

- the **buildings** which an organisation owns or occupies may give risk to risk
- the **equipment**, chemicals or other hazardous substances used in the operation of the business may give rise to risk
- the **people** employed by the organisation or visiting it as a patient or client, visitor or business guest may give risk to risk
- the **systems or management** of an organisation may give risk to risk.

Risk management is mainly concerned with harnessing the information and expertise of individuals within the organisation and translating that with their help into positive action which will reduce loss of life, financial loss, loss of staff availability, loss of availability of buildings or equipment and loss of reputation.

Risk management is a proactive approach which:

- **addresses** the various activities of an organisation
- **identifies** the risks that exist
- **assesses** those risks for potential frequency and severity
- **eliminates** the risks that can be eliminated
- **reduces** the effect of those that cannot be eliminated

- **puts into place** financial mechanisms to absorb the financial consequence of the risks that remain

A key aim of risk management is reducing the cost of risk; a by-product of that is safer practices, safer systems of work, safer premises and greater staff awareness of danger and liability. The key aim of any quality management system is conducting business to the best possible standard and providing the highest possible quality of care; the by-product of this is a reduction in the cost of risk. So risk management and other quality systems have the same objective, but viewed from different perspectives.

The need for risk management - why do we need it?

In many industries, a percentage of staff are motivated mainly by a sense of altruism. The percentage in the health care industry is probably higher than that found elsewhere. It is not only the corporate responsibility of the health care provider to give the highest possible standard of care to patients and clients, but that responsibility is also an individual personal and professional aim for a large number of staff. Regardless of the duty to provide a safe and risk-free environment placed on us by legislation, we have a desire as individuals to see safe and environmentally friendly practices being carried out in our work place. Staff who accept risk may do so through ignorance of the risk rather than passive acceptance of it.

The British public is now much more inclined to take legal action than was the case in the past. Changes in the regulations on Legal Aid mean that more actions are likely to be taken on claims involving minors (such as allegations of mishaps during birth) since a minor's entitlement to Legal Aid is no longer based on the parents' finances. Awards of over £1 million have been made for children whose brains were injured at birth. But claims do not only come from patients or clients: in 1992 a nursing assistance was awarded £203,000 damages for a back injury sustained while lifting a patient.

It is easily seen from major incidents over the last few years, such as the fires at Kings Cross and Bradford Football Club, Hillsborough, the Herald of Free Enterprise and the Clapham rail disasters that the public rightly expect systems to be in place to ensure their safety. It something goes wrong, "trial by media" can significantly influence the feelings of the general public.

All organisations are expected to comply with legislation such as the Health and Safety at Work Act 1974, and the removal of most of the last vestiges of Crown Immunity in 1991 has left the National Health Service as vulnerable to the consequences of failure to comply with legislation as other organisations. Failure to comply can result in fines or injunctions and the prosecution of individual managers. The emphasis should be on assessing explicitly the risks; spending money on eliminating risk and improving safety and maintenance levels can have knock-on benefits over and above the original purpose.

With the recent reforms of the NHS, more of the financial consequences of risk failure rest directly with NHS trusts and health authorities that was the case previously, and it is obvious that any monies used to pay for the consequences of untoward incidents will be unavailable for patient care. In addition, Crown Indemnity was introduced in January 1990. This means that hospitals are now vicariously liable for acts of negligence or omissions by medical staff as well as other staff. They are also responsible for meeting the resultant claims settlement and indirect expenses. These expenses can include:

- the time taken by staff to investigate an incident, make statements or appear in court
- the cost of hiring temporary staff, who may also be less effective and increase the risk
- loss of reputation: with the advent of the internal market, purchasers including GP fundholders will look less favourably on providers where there are known deficits in patient or client care.

All of these factors present a pressing case for effective management of risk. The financial success or failure of a hospital can depend on good risk management.

The way forward - what should we do?

When weighing the priority of different uses for a finite amount of money, it is tempting to take the view that, since nothing has gone wrong in the past, the same will apply in future. Before making decisions, it is important to consider whether the organisation has successfully managed risk or has simply been lucky.

A risk management programme must actively involve all the staff in an organisation; it is not something just for "someone else" to do. There are a number of different elements and techniques which can be used, and there is no set blueprint which will fit perfectly the needs of all healthcare purchasers and providers.

This manual is a practical guide to the action which trusts and health authorities can take to minimise risk and to maximise the resources available for patient or client care.

CHAPTER 2

PRINCIPLES OF RISK MANAGEMENT

This chapter describes the four stages which comprise the principles of risk management. Risk management is generally thought of as a four-phase cycle and the chapter is divided into four sections, each describing one of the phases:

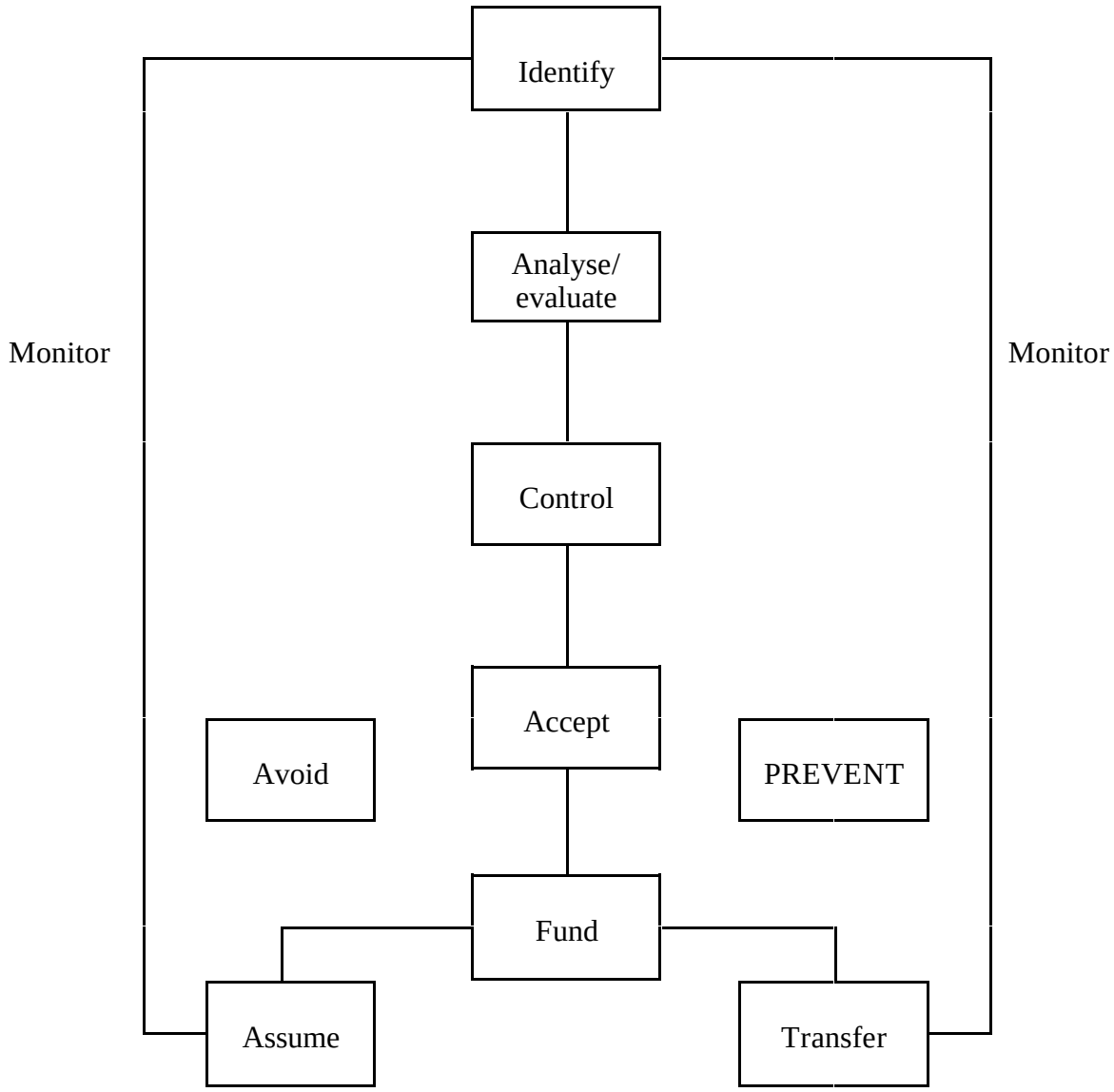
1 risk identification

2 risk analysis

3 risk control

4 risk funding

Figure 1



1. Risk identification

Identification could be summarised as answering the questions:

- what could go wrong?
- how could it happen?
- what would be the effect?

Risk may arise from single factors or from a combination of seemingly unrelated elements. There are **physical hazards** which may arise from the environment itself, for example the premises being in a poor state of repair, or as a result of the use of the premises, for example storage of explosive gases or flammable and corrosive liquids.

Risk may arise from **working practices** where there could be a risk of personal injury to staff, patients, clients or visitors. If there is inadequate provision for the training of staff in lifting and handling procedures, or if drugs are administered to patients or clients without proper procedures being followed, there is a risk of serious personal injury. Working practices may also give risk to risks which do not involve personal injury as such, but may cause other difficulties, for example a failure of adequate communication between health care professionals and local authorities resulting in a patient or client being discharged to an unsuitable environment with inadequate ongoing care.

Significant risk can result from the **relationship between environment and practice**. A working practice which is entirely suitable in one environment can be quite unsuitable in another; for example, sterilisation of endoscopes using glutaraldehyde should not take place in a poorly ventilated area.

There are a number of different techniques which can be used to identify risk, and these are dealt with in detail in chapters 3 and 4.

2. Risk analysis

When the risks have been identified, they then need to be analysed to ask:

- how often are they likely to happen?
- how much are they likely to cost?
- how severe would the effect be?

Risk analysis techniques are examined in detail in chapter 3 but some aspects are summarised here.

The word "analysis" implies that there is a foolproof method of calculating the frequency, severity and probability of risk occurring. Sophisticated analysis methods may be helpful in establishing past trends, but in attempting to compare unlike events they are time consuming and not always accurate. An educated guess may be just as valid.

It is important to try to avoid subjectivity when evaluating risks. A multi-disciplinary team should identify and evaluate risk since no one person can reasonably be expected to know everything about all subjects, and it is often easier to view a subject with which one is unfamiliar in an objective way. The team should agree definitions: how often is "frequent"? What is classed as "severe"? But no evaluation can be considered absolute: twice in three years (October 1987 and January 1990) the South East of England experienced storms which were previously considered likely to happen only once in three hundred years.

3. Risk control

Once risks have been identified and analysed, it is necessary to consider how they can be controlled:

- how can they be eliminated?
- how can they be avoided?
- how can they be made less likely?
- how can they be made less costly?

There are many techniques for controlling risk, many of which require little or no financial outlay. There are **physical controls**, for example drugs and valuable items can be locked away. There are also **system controls** which may involve restricting access to hazardous areas only to authorised staff, or recording the attendance of staff at lifting and handling courses.

The **cost/benefit** relationship of controlling risk must be considered and to do this it is essential to have a system of prioritising risk control because there will always be only a limited budgets to address these issues. Chapter 30 of this manual gives further guidance on prioritisation techniques.

Earlier in this chapter, there was a recommendation that a multi-disciplinary team should address risks so as to avoid subjectivity; this is particularly important when prioritising because different people will have different ideas on the relative significance of risk. There will be individual views that top priority should be given to the one which is breaking the law, the most expensive, the least expensive, the most frequent, the most disruptive, the least disruptive, or the one which most worries staff.

4. Risk funding

Even when all reasonably practicable measures have been taken to eliminate or reduce risk, there will always be a residual risk which has to be addressed. The organisation must consider how the residual risk is paid for and how the available money is best spent.

Until April 1991, health care providers or purchasers were not permitted to buy insurance. The NHS reforms have made this possible for NHS trusts, but it is still not possible at the time of preparation of this manual to purchase insurance covering liabilities arising from medical negligence claims or business interruption (except for non-NHS work and activities). It is, however, proposed that insurance against clinical negligence will become an option available to trusts in the form of a central fund to which trusts could pay premiums. It is

likely that independent managers, with specialist underwriting and claims management expertise, will be appointed to run the fund. There are a number of options for funding other risks:

- full commercial insurance - transferring the risk
- commercial insurance with an "excess" - sharing the risk
- self insurance - retaining the risk

Full commercial insurance involves exchanging a known annual premium for part of the unknown cost of future claims. Although this is a superficially attractive option, it must be borne in mind that insurance companies charge premiums which will cover their own administration costs and will include a profit element. Insurance does not provide cover against every risk or eventuality; there are always risks which insurers will regard as "commercial" or too imprecise or potentially expensive and will refuse to cover. There are likely to be minor exceptions even to what appears to be wide cover. Before any insurance contract is entered into, great care must be taken to ensure that the cost of the insurance premium is reasonable and does in fact give sufficient cover to be an attractive option. It must also be borne in mind that such insurance has a tremendous potential for complacency, because managers may be less aware of the cost of adverse events and may not take remedial action to prevent a recurrence.

Most insurance companies will offer a reduced premium if the policy has an **"excess"** or "deducible" under which the insured bears a specified amount of each claim. This option is attractive in the case of major losses, but the insurance company will be careful to set the excess at a level which will require the insured party to process a significant number of minor claims. If this cost is passed on it may act as an incentive to managers and budget holders to seek to address potential problems in their own areas of responsibility.

Self insurance may be achieved by dedicating a rolling fund for future losses. Although this provides a strong incentive to manage risk effectively, a fund could be severely depleted by one large claim. Some public bodies are not permitted to set up self insurance funds since they have to close their accounts each year, for example directly managed units.

An organisation may also choose to retain the risk by paying for any losses from departmental budgets as and when they occur, rather than setting aside a contingency fund. This is often the case with small, frequent, one might say "expected" losses.

It is also possible that an organisation may consider that a risk is so remote that it is prepared to bear the financial consequences should the risk occur. However, the possibility of a catastrophic loss should not be ignored, and insurance cover for such contingencies should be considered.

CHAPTER 3

RISK IDENTIFICATION AND ANALYSIS - UNDERTAKING AN INITIAL SURVEY

Warning: Managers will be aware that there is a requirement under the Management of Health and Safety at Work Regulations, effective from 1 January 1993, to make formal risk assessments in the workplace. This manual takes a holistic view of risk management and the guidance in it should not be construed as a full methodology for undertaking such assessments.

The first step in identifying and analysing risk is to undertake an initial survey. This chapter gives guidance on the individuals and agencies who might be involved in such a survey and ways in which the survey might be carried out. It identifies:

- the risk assessors
- risk identification and analysis techniques

The risk assessors

In any organisation, **the leaders in risk management must be the managers and staff of the organisation itself.** Although there are a number of others whose expertise can be used, it is essential that risk management is seen as a line manager's responsibility. Later chapters of this manual (chapters 24 to 31) stress the need for commitment from the top of the organisation (chair, board and chief executive) if risk management is to be implemented successfully.

Several commercial companies offer **specialist risk management consultancy** skills, some relating specifically to health services. These companies can offer professional help across the whole range of risk management and often have input from health professionals, which can help to make the process more effective and relevant to health organisations.

Insurance brokers and **insurers** can advise on insurance, but their input on wider aspects of risk management is often limited to those areas which are insurable and will not cover areas such as medical negligence. Care needs to be taken when selecting advisers to ensure that they offer wide-ranging and impartial advice which is tailored to the need of the individual client.

There are many **other specialists** who can offer advice in their own areas of interest and expertise. With the removal of Crown Immunity in 1991, it became even more important to seek and act on the advice of specialists in order to avoid criticism and bad publicity, fines, closure or prosecution of individual managers. Specialists whose advice should be particularly noted include:

- the Health and Safety Executive
- local authority environmental health and building control departments
- fire brigades and police crime prevention officers
- in-house specialists such as control of infection and occupational health staff

- individual members of staff, who have an intimate knowledge of their own area of work and have much to contribute to the debate on risk management, particularly those in professions allied to medicine.

Risk identification and analysis techniques

There are many techniques which can be used when undertaking a risk analysis survey, ranging from the very simple to the complex. Chapter 4 describes in detail the methodology used in some pilot projects which were undertaken to inform the preparation of this manual, but the following gives a brief outline of the techniques which can be used:

- interviews

  interviews are very valuable when conducted by a trained, perceptive lay person asking staff who have detailed knowledge of their area of work simple questions such as "How do you…" and "What happens if…". This will often identify problems which people working in an area may have overlooked through familiarity, or may have discarded because of this inability to influence them, and may highlight potential risks, the significance of which their managers may not full appreciate;

- observation and physical inspection

  an experienced assessor will notice hazards and risks while walking around a department or other area and by asking questions which are not necessarily included in a standard checklist. It is important that an assessor does not become interested in the detail of one particular issue and lose sight of more fundamental problems;

- analysis of historic information

  historical data about previous untoward incidents and near misses can be analysed to identify particular problems areas. A good example of this is analysis of accident report forms, which may reveal a large number of unobserved falls in a particular ward at a certain time of day. This could be followed up in an attempt to establish why this should be and what could be done to remedy the situation. In an organisation where a large number of people are involved in the completion and scrutiny of incident report forms, it is possible to overlook similarities; recommendations later in this manual about the recording of incidents (chapter 27), which involve designating one person to receive reports and the keeping of a data base, allow trends to be recognised at an early date and acted upon. It is fair to say that many organisations have vast quantities of such data which has never been analysed, or collected centrally, to provide useful management information;

- documentation review

  A review of standards, policies and procedures, and random audit of documentation such as health records are valuable activities in the identification of risk. The simple act of asking various staff and managers for copies of or access to policies and procedures will reveal the extent to which such documents are in existence, known about and used. It would not be uncommon for there to be several versions of a particular procedure in use, with varying dates or no dates at all. The importance of

health records and of policies and procedures is dealt with in detail in chapters 6 and 29 respectively;

- questionnaires

  in an age when superficial surveys and badly designed questionnaires abound, it is easy to regard the questionnaire as "yet another piece of paper", but a properly prepared and validated questionnaire can provide information from a wide sample of people, some of whom would feel unable to make comments when identified face to face, but respond to the anonymity of a written questionnaire. Questions can elicit simple yes or no answers such as "I feel safe when working in my employer's premises at night", or present a choice of answers which they can place in order of preference. It cannot be stressed too highly that there is no place for questionnaires designed or analysed by inexperienced people, since these can give misleading results;

- checklists

  An aide-mémoire which lists known potential risks and noting any existing risk control measures is a valuable aid to risk identification and analysis, but care must be taken that it is not regarded as an exhaustive list, causing people to miss other risks which are not listed. Checklists which are completed frequently (as action checklists should be, since they only provide a snapshot of a situation) are in danger of being seen as a routine chore, and being completed superficially. NHS organisations are required to submit a number of routine reports on various activities to different levels, and it is easy to fall into the trap of "ticking the boxes" without thinking through what the answer should be;

- grids

  a simple method of identifying risk is a grid of hazards and potential victims of them. A matrix showing hazards on one axis and targets on the other quickly identifies through its intersections the areas which should be examined. An example of a grid is shown at **Figure 2.** This may be as simple or as complex as required;

Figure 2

A typical home **Partial identification of risk**

TARGETS / HAZARDS	Pets	Buildings	Furnishings	Central heating	Income	TV/VCR	Spouse	Visions	Car
Explosion		✓		✓		✓			✓
Fire		✓	✓	✓		✓			✓
Impact		✓				✓			✓
Inflation					✓				
Physical injury	✓						✓	✓	
Leakage			✓	✓					
Redundancy					✓				
Storm		✓							
Theft	✓		✓			✓			✓

- fault trees

  a fault tree is a diagrammatic representation of all the ways in which an event could happen. The process is usually described in a flow chart and a tree is then produced to identify the likely causes quickly and accurately. An example of a fault tree is shown at **Figure 3.**

If the lamp inside a refrigerator does not light up, there are two likely causes:

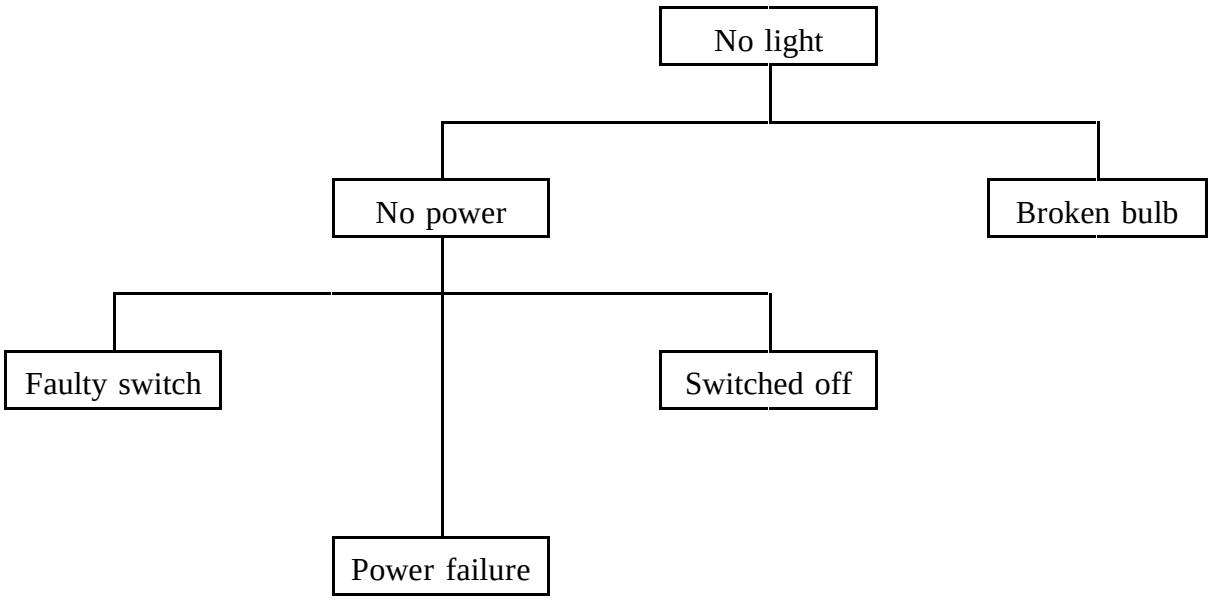
i) no electrical power
(ii) broken filament in the bulb

for i) there are three possible causes:

a) faulty switch
b) power failure
c) supply switched off at the socket

Figure 3

Fault tree



- hazard and operability (HAZOP) study

  This is a technique used in industries where the processes are so complex that analysis is only feasible for component parts which may in themselves be multi-faceted. Although it is unlikely that this technique would be used for general risk management matters in a health care organisation, it is possible that it might be appropriate for technical areas where quality control is vital, such as pathology laboratories or pharmaceutical manufacturing. The technique involves:

  - describing the intention of a specified part of the process, for example flow or temperature
  - identifying possible deviations from that intention
  - listing all possible causes of each such deviation
  - evaluating the consequences of each cause
  - specifying the action necessary to control those consequences;

- visible management

  it is important that managers at all levels know not only what policies and procedures exist but also the extent to which they are observed. An advantage of this approach is that staff are more likely to be able to relate to a manager whom they see reasonably frequently and might be more inclined to report potential hazards before an accident happens.

CHAPTER 4

RISK IDENTIFICATION AND ANALYSIS - METHODOLOGY USED IN PILOT PROJECTS

This chapter explains the methodology used to identify and analyse risk in the two pilot projects which informed this manual.

It is important to remember that different organisations will need different methods of producing a risk management strategy, depending upon their composition, style and approach to risk, but the framework set out here proved to be robust when dealing with two separate NHS trusts, one based on acute hospitals and another on community health, mental health and learning disabilities.

Each of the pilot studies was carried out in two phases. The purpose of **Phase I** was to:

- establish a risk profile of the trust and make recommendations to reduce risk
- recommend methods of implementing an effective, indigenous risk management programme, which reflected the specific requirements of the trust and was compatible with existing quality initiatives
- identify individuals whose experience and personal qualities would commend them to extend their role, by forming the focus of the trust's risk management approach.

The purpose of **Phase II** was to:

- assist in the implementation of an effective, indigenous risk management programme
- train and develop a small team of trust staff in a wide range of specific risk management techniques

Risk identification and analysis

The techniques used to identify risk in the pilot projects were **questionnaires, interviews and observation.**

Questionnaires were sent to 500 staff and the results were analysed before visits to the site were made. Approximately 100 members of staff were interviewed, and the team visited a representative cross-section of wards and departments in each of the trusts. During the visits, the team observed and examined the premises which were in existence, the relationships between different parts of the organisation and between individuals.

Risks were also analysed by inspecting policies and procedures and a sample of the documentation used, for example health records, incident report forms, claims files and complaints.

Modules of focus

The pilot projects revealed that there is a cornucopia of information which needs to be considered in compiling a risk management profile. This material was divided into four main modules of focus, and the layout of this manual reflects those modules:

- risks having a direct impact on patient well-being (chapters 5 to 10)
- risks having an indirect impact on patient well-being (chapters 11 to 15)
- health and safety (chapters 16 to 21)
- organisational risks (chapter 22).

Project reports

The reports on the two pilot projects identified the major issues arising from the interviews which had been conducted and the locations which had been visited. Each report ran to more than 100 pages and included:

- **an analysis of the responses to the questionnaire**

  together with comparisons of the responses with the average of a number of other organisations, the analysis included observations under a selection of headings such as security, occupational health and hygiene, basic training, fire, lifting and handling, waste, health and safety, resuscitation, Control of Substances Hazardous to Health (COSHH) and reporting arrangements;

- **an analysis of patient or client incidents and claims**

  The team reviewed patient or client incident reports occurring over a six-month period (there were approximately 1,000 incidents in each of the two provider units). Claims were also analysed. The team was able to make recommendations on the management of incident reporting and claims;

- **an analysis of staff incidents and claims**

  these amounted to approximately 400 incident reports in each provider over the same six-month period. The team was able to draw conclusions and make recommendations about areas which should be addressed to minimise recurrence of such incidents;

- **a summary of recommendations**

  recommendations within the main body of the reports were listed and amounted to almost 300 in one provider and over 300 in the other. These varied in significance from relatively minor points to areas requiring immediate action, and, after discussion with the trusts, a broad spectrum grouping of the recommendations according to severity/probability was prepared.

The key features needed for the successful implementation of risk management were identified by the risk management teams themselves: a change in attitudes and culture throughout the organisation, and commitment from all staff.

The on-site questionnaires and activity stimulated the awareness of many staff involved, and reinforced the organisations' own risk management initiatives.

CHAPTER 5

IDENTIFYING RISKS RELATING TO STANDARDS OF CARE

Purchasers of health care and patients or clients expect that the care which is provided should be in accordance with accepted standards. These standards are laid down in a variety of ways, and the publication of the Patient's Charter in 1991 made it explicit that patients or clients must be informed of the standards which they should expect. The development of health care contracting arising from the NHS reforms has fostered the preparation of quality standards and specifications by purchasers and providers.

This chapter deals with issues concerning standards of care, including:

- the duty to exercise reasonable skill and care (the Bolam Test)
- resuscitation
- staffing issues

Staffing issues are dealt with in more detail in chapter 8.

The Bolam Test

It was established as long ago as 1822[1] that a medical practitioner has a duty to exercise reasonable skill and care in his treatment of a patient or client. This applies even if he acts without being asked to, for example treating the victim of a road accident. In some cases, he may owe a duty to third parties, for example a practitioner treating a pregnant woman owes a duty of care to the unborn child.

In the Bolam case[2], it was found that "a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view"[3].

The courts have confirmed more recently[4] that the court is the final arbiter of a professional standard, this being defined as acting "in accordance with a practice rightly accepted as proper" by a body of skilled and experienced medical practitioners.

The standard of skill and care is determined by reference to the state of medical knowledge/science at the time of an incident, together with the specialisation of the medical practitioner and the application of the Bolam Test.

Although the Bolam Test applies specifically to medical staff, the principles can also be applied to other professional staff.

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(1) Pippin -v- Sterrad, 1822
(2) Bolam -v- Friern Hospital Management Committee, 1957
(3) McNair J, p 122 at B [1957] The All England Law Reports
(4) Sidaway -v- Bethlem Royal Hospital and others, 1984

Resuscitation

It is generally thought that an "acceptable standard of care" includes the rapid identification of and response to a cardiac or respiratory arrest affecting a patient or client who is undergoing care, surgery, treatment or test. The extent of the response may differ dramatically from one health care provider to another and yet still be considered reasonable. The nature, extent and standard of response to an arrest in a theatre suite would be considerably different from that in a community home for people with learning disabilities. Provided that in each case rapid identification and response occurs in accordance with the practice "rightly accepted as proper" (see above), it is unlikely that a court would decide that there had been a negligent act or omission.

All premises where health care is provided should have a resuscitation policy, which should be known to all relevant staff. Surveys of 60 health care providers have shown that, of staff who described themselves as clinicians or professions allied to medicine or technicians involved in direct patient care:

- over 30% of all staff and over 20% of staff who consider it relevant **are not confident they can identify** a cardiac/respiratory arrest

- nearly 15% of all staff and nearly 10% of staff who consider it relevant **do not know how to summon qualified help** in the event of cardiac or respiratory arrest

- over 50% of all staff and over 43% of staff who consider it relevant **have not been trained** in resuscitation procedures by their current employers

- over 41% of all staff and over 32% of staff who consider it relevant **do not feel confident and competent** to participate in cardiac/respiratory resuscitation

These percentages are disturbing and reveal a lack of knowledge about basic safety procedures.

The first point to be addressed by a resuscitation policy is whether or not resuscitation should be attempted by staff in the immediate vicinity. In some small, non-acute units it may b e appropriate that an ambulance be summoned rather than resuscitation being attempted by those unfamiliar with the techniques. A protocol covering the drugs to be used, the treatment to be administered and the extent to which a resuscitation attempt is to continue are also key features of an effective resuscitation policy. The lack of a written policy may place staff in a dilemma and lead to uncertainty and valuable time being lost in treating the patient or client.

Resuscitation equipment is often subject to vandalism or "borrowing" or, conversely, overstocking. There are numerous examples of "crash trolleys" having drugs missing or out of date, or equipment not working correctly. All resuscitation equipment and supplies should be checked regularly, and a record kept of such checks.

■ **Action points**

There should be in each clinical area a written resuscitation policy, which includes the following elements:

- **the action to be taken immediately a cardiac or respiratory arrest is suspected**

- **arrangements for training and refreshing staff in resuscitation techniques and/or procedures**

- **an inventory of the equipment and drugs for resuscitation in each clinical area**

- **arrangements for checking equipment on at least a weekly basis, and a written record of such checks**

Staffing issues

Staffing levels are often a matter of concern to professional staff, since they may feel that levels (and skill mix, which is dealt with in detail in chapter 8) may be too low to provide safety for patients or clients and staff, particularly at certain times of the day. This is especially true of night cover, and at times of peak activity.

Purchasers and patients or clients will expect that the numbers of staff on duty in a health care provider will be sufficient to allow an acceptable standard of care and supervision to be given to all patients or clients. The required levels will, of course, vary with the number and type of patient or client concerned.

With increasing emphasis on increasing the efficiency and value for money of health care, and with the need to keep a recognised budget, managers sometimes decide to reduce staffing levels. It is important for managers to remember that financial pressures may not be an acceptable defence against a claim for negligence.

■ **Action points**

Managers must satisfy themselves that there are at all times sufficient and appropriately trained staff available to provide a safe level of service.

Other issues for consideration

Other areas which are worthy of consideration include:

- adequate supervision of minors and people of impaired mental ability

- privacy and dignity, which are considered to be matters of quality, not risk, at present

CHAPTER 6

IDENTIFYING RISKS RELATING TO ASCERTAINING THE FACTS

This chapter highlights the importance of health records. The record contains a number of different documents, including medical notes, nursing notes, test requests and results, medication records, consent to treatment forms and correspondence between health care staff.

This chapter is divided into four main sections:

- ensuring correct treatment guidance on record keeping
- securing confidentiality
- defending claims
- guidance on the preservation and storage of health records

Ensuring correct treatment

Errors in diagnosis and treatment can occur if the information in health records is either absent or illegible. A series of studies have shown that notes made by medical staff are not always signed in full and dated, are often illegible and may use unrecognisable or ambiguous abbreviations. Continuation sheets often do not bear the patient or client's name and identification number, giving rise to the risk of their being affixed to another patient or client's notes. Any corrections should be crossed through with a single line, initialled and dated. Correction fluid should not be used in health records.

Laboratory tests and other investigations are requested by medical staff to assist them in diagnosis or treatment. If the test is to be of use, the medical staff must see the results and decide on appropriate action. If the test results are not initialled by the doctor, there is no check or proof that they have been seen. Not only is this important so that correct treatment may be given, but also such documentation could be valuable in defending an allegation of medical negligence.

Drugs can generally only be administered when prescribed by a doctor and a medication record should be completed for each patient or client. The medication orders in the patient's record should be clear, describe the drug and the dosage, and contain details of the patient or client, including the name, identification number, height and weight and details of any allergies. All orders must be signed and dated by the prescribing doctor. Nursing staff who administer the drugs should indicate the time and details of each dose and give reasons for the non-administration of any dose. The medication record must be signed, indicating clearly the nurse administering the drug. Midwives can possess and supply certain drugs which they can administer on their own responsibility.

■ **Action points**

All clinical staff should be reminded of the importance of:

- **writing legibly and frequently in patient or clients' health records**

- **dating and signing in full all entries in health records**

- **writing the patient or client's full name and hospital number on each medical record continuation sheet**

- **initialling all test reports as having been seen prior to filling in the medical record**

- **exercising care in filling in medication records.**

Particular issues arise in connection with psychiatric records and those of people with learning disabilities. Decisions are often taken about the level of personal risk which it is acceptable to allow people to run, since a balance must be struck between the acceptable risks of a "normal life" and the greater vulnerability of these people. It is advisable for records to be kept of any decisions about the degree of risk which is considered to be acceptable for any one individual. It is also desirable to document the involvement of the individual concerned and their relative or advocate as appropriate.

Securing confidentiality

The obligation to retain the confidentiality of information about patients or clients rests with the trust or health authority which manages the service concerned. Any breach by an employee could lay the employer open to legal action.

The confidentiality of patient information can be compromised in a number of ways:

- insecure storage of health records

  records should be stored securely, away from observation by the public and preferably in locked storage units. There are many instances of records, particularly "dead" notes being stored in corridors or other areas to which the public has ready access. Equally, access to computerised information should be restricted;

- carelessness by staff in dealing with active records

  records should not be left unattended in areas used by the public. This applies to wards, out-patient departments and offices. Health records left in full view in medical and other professional staff's cars are particularly vulnerable;

  records should be put away at night in a drawer or other reasonably secure place;

  there should be an effective and compulsory tracking system for patients' and clients' records so that the whereabouts of a particular set of notes is known at any time. The system should be simple and quick to use, so that busy staff are not tempted to avoid it;

- careless talk

  discussions about individual patients or clients between health professionals have to take place all the time but care should be taken not to breach confidentiality. Patients have commented that it is often embarrassing to hear detailed discussions about their

fellow patients or clients and staff should be aware of the risk that may arise from visitors and other casual observers hearing clinical information about patients or clients;

- electronic transmission

  extracts of health records and test results may be transmitted by facsimile or electronic mail to ensure a speedy service. It is important to ensure that the information is sent to the correct location and that only the intended recipient will be able to access it. It is not unknown for facsimile machines to connect with the wrong number. Procedures should be developed to check that the information has reached the intended recipient.

Many hospitals and other health care providers require staff dealing with personal information to sign a confidentiality agreement. The need for confidentiality should be reinforced by managers at frequent intervals.

There may be particular problems about maintaining confidentiality when other agencies are involved in the care of patients or clients. The assessment procedure which is now required under Community Care legislation should be carried out by professionals from health, social services and other agencies. Staff of other agencies are, of course, bound by their own confidentiality code, but health staff have prime responsibility for details about the patient or client's health and, although information should be shared, health staff should be careful to share only that information which is relevant and with only those people who need to know it in order to perform their function.

■ **Action points**

- **records should be stored securely, out of sight of casual observers**

- **a simple and compulsory tracking system should be used for health records which are withdrawn for any reason**

- **staff should be mindful when discussing details of patients or clients of their right to confidentiality**

- **staff should restrict themselves to releasing only relevant information about patients or clients to other agencies and only to those who need to have it**

Defending claims

Health records are the principal documents recording what is the intended and actual care and treatment of a patient or client, together with its outcome. For this reason, they are vital to the management of any claim for negligence. Discharge plans form an integral part of health records, and should not be discarded.

Negligence claims may often be notified for the first time several years after the relevant event. Staff change their jobs and clinical staff will see hundreds or thousands of patients during their work in any one place, so it is unreasonable to expect staff to be able to

remember, unaided, events which happened some time ago. Accurate and available health records are vitally important in establishing what happened.

In order to defend successfully a negligence claim, the provider of the care should be able to prove clearly that it has not been negligent. Alternatively, where negligence is obvious, a speedy settlement can be reached without incurring unnecessary legal costs.

Preservation and storage of health records

Health records may need to be used over a number of years. In addition, they should be preserved for the minimum periods specified in current Department of Health guidance [HC(89)20]. They should be stored in suitable conditions where they will not deteriorate, particularly maternity and children's records which should be retained for 25 years. Effective management of health records archiving and storage, whether in microfiche or original form, will ensure that notes are available for use in the event of patients or clients returning for further treatment or in the event of a negligence claim.

It is important that health records, whether paper, or computerised, are protected from fire, or other accidental or malicious damage. Fire detection is of particular importance given the large volume of papers which may be stored in one area. It is advisable that backups of computerised information are held securely in a separate location.

The filing of case notes often causes concern. Loose papers can be found inside torn covers, small items such as cardiotocographs and electrocardiographs can be lost. The back pocket of some record folders contains a variety of loose items and there are examples of health records being held together with "sandwich ties" or string.

There is an increasing incidence of patient or client held records, particularly child health records, which present their own problems when considering content, confidentiality and future availability.

- **Action points**:

  - **health record folders should be kept in good condition so that the covers act as a protective container for the important documents inside**

  - **no papers should be filed without being secured to the body of the folder**

  - **suitable wallets should be provided for small items such as CTGs and ECGs**

CHAPTER 7

IDENTIFYING RISKS RELATING TO CONSENT TO TREATMENT

There is a wealth of case law and guidance on the subject of consent to treatment by patients and clients and this manual does not purport to give a comprehensive guide to the subject. Guidance is contained in "A Guide to Consent for Examination or Treatment", issued under cover of HC(90)22. Legal advice should be sought in relation to any specific case in which health care professionals are in doubt.

Obtaining consent to treatment is an area almost entirely under the control of professional health care staff and not one in which managers are generally involved. But managers have a responsibility to ensure that professionals are fully aware of their obligations and understand the legal framework in which they are operating.

This chapter identifies the principal elements which need to be considered by health professionals treating patients or clients.

It covers the following areas:

- the duty to ask patients or clients for their consent
- the information which should be shared, both orally and in writing
- when and by whom information should be shared
- understanding and assimilation of information
- documentation

Advising the patient

It is a health care professional's duty to ask patients or clients specifically for their consent to any treatment. Consent is needed in all circumstances.

Regarding Sidaway -v- Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and Others (1984), in the report of the appeal to the House of Lords in 1985 it was stated that "the Bolam test applicable to diagnosis and treatment also applies to the doctor's duty to warn his patient of risks inherent in treatment recommended, in accordance with a practice accepted at the time by a responsible body of medical opinion. Although the decision on what risks should be disclosed, for the particular patient to be able to make a rational choice whether to undergo that treatment, is primarily a clinical judgement, the disclosure of a particular risk of serious adverse consequences might be so obviously necessary for the patient to make an informed choice that no reasonably prudent doctor would fail to disclose it".

It is a clear duty of the doctor concerned to provide the patient or client with information relating to all substantial or unusual risks involved in the particular procedure. It has long been established that patients or clients often fail to remember information given to them orally by doctors, and there has been an increasing tendency to provide written information

to patients or clients in the form of leaflets about the procedure. These may be either locally or more widely produced, for example by self-help groups.

Although the use of leaflets is to be commended, it should not be seen as an alternative to a thorough oral explanation by the doctor who will be undertaking the procedure. Doctors should encourage patients or clients to ask questions, and should answer them readily to the best of their ability.

■ **Action point**

- **doctors should be reminded of their legal obligations to advise patients or clients of any substantial or unusual risks arising from their treatment**

When and by whom should information be shared?

Patients should be given sufficient information, in a way they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent at any time. In the case of procedures carrying any substantial risk or substantial side-effect, written consent should be obtained. The Department of Health has issued model forms which can be used or adapted for this purpose (HSG(92)32).

In one of the pilot studies, it was noticed that in some cases consent was sought and the form signed during an out-patient clinic a week before the operation. It is possible that insufficient time is available during a busy out-patient clinic to discuss the matter fully with the patient or client. Failure to explain procedures fully may result in litigation.

In the event of prior discussions having taken place at pre-admission clinics, this information should be verified immediately prior to the start of the relevant clinical procedure.

■ **Action points**

- **appropriate forms should be used to record patients' or clients' consent to all forms of treatment involving a substantial or unusual risk.**

Research and training

Consent should be sought when there is involvement of medical staff and other health care students in the care of patient. This would also apply to involvement in articles to be used for publication, whether in print or on film.

Local Research Ethics Committees often require patients or clients to complete a consent form prior to taking part in clinical trials. Consent for this form of treatment should be obtained in the same way as consent to operations or other procedures.

Special consideration s

It is clear in emergency situations in which the patient or client's life is immediately threatened that, irrespective of the consent of the patient or a parent or guardian, the doctor may perform the necessary surgery or administer necessary drugs.

In circumstances where the person being treated is a minor, or a religious minority, or mentally impaired, the situation becomes more complex.

In respect of children's consent, following the Gillick case and the Children Act 1989, children over the age of 16 are entitled to give their own consent, or not, as the case may be. Children of "sufficient understanding" under that age may also give their own consent which will override that of their parents. The position is complicated, however, as already the courts in the case of Re B A Minor 1992 and other cases have modified this basic principle, giving a local authority or others with parental rights or responsibilities the right to give consent on a child's behalf. Special considerations may also apply where a child **refuses** (as opposed to consents to) treatment. The position is clearly complex and confusing, but if medical staff are in any doubt, they should seek legal advice as soon as possible with a view to applying to the High Court for a Declaration of the law in a particular case.

Adult consent for non-emergency treatment is more straightforward. Any individual of sound mind, has the right to refuse treatment for whatever reason, whether religious, cultural or personal. Refusal to comply with such a patient's or client's wishes by the doctor may constitute an assault. There are exceptions to this basic principle, particularly relating to patients or clients with mental impairment. Where a patient or client has a learning disability and is not able to make his or her own decisions, consent from the patient or client's guardian may be necessary

However, where a patient's or client's mental impairment has led to aggressive or seriously irresponsible conduct, they may be compulsorily detained under the Mental Health Act. In this case, the need for consent is waived in respect of medical and nursing care for the patient's or client's mental disorder, but not for unassociated physical disorders. A guardian may be appointed on the patient or client's behalf and they will have considerable discretion over the patient or client's lifestyle. This is a very complex area, and reference should be made to the Mental Health Act 1983, particularly Sections 57, 58, 62 and 63.

Failure to take into account the above factors when obtaining consent in such special circumstances will be damaging to the relationship of trust and confidence between doctor and patient or client. It may also lead to otherwise avoidable legal action and the cost and adverse publicity that would result.

- **Action point**

  - **medical and, where appropriate, other clinical staff should be aware from whom they must obtain consent for treatment**

  - **medical and other clinical staff must be fully aware of the legal considerations involved in obtaining consent.**

<u>Understanding and assimilation of information</u>

As mentioned earlier in this chapter, patients or clients do not always fully understand or retain information given to them by medical staff. Aids such as leaflets or tapes may help in this situation but should not be relied on as a substitute for careful explanation. Patients or clients may be unable to read. In strange and stressful surroundings, people retain only a little of what is said to them (maybe as little as 3 items of information per interview) so

professionals should not be afraid to **repeat** important items several times and on several occasions, **write down** important issues so that the patient can re-read them at home, or get the GP or health visitor or other suitable person (for example, a specialist nurse) to **visit** later and repeat what has been said. Any such visit must be recorded.

In areas where there are significant numbers of ethnic minorities, consideration should be given to the use of interpreters and/or multi-lingual leaflets so as to ensure that patients or clients have every opportunity of understanding clearly what it is that they are consenting to. Cultural differences should also be borne in mind.

The needs of physically or mentally impaired patients or clients also need to be taken into account.

Managers should be aware of the potential for medical staff themselves being difficult to understand due to technical jargon or heavy accents and doctors should be careful to use the simplest possible language to patients or clients, using medical terminology only if the patient or client is able to understand what is meant.

■ **Action points**

- **care should be taken to consider the special needs of individual patients or clients which may affect their ability to understand fully what is to be done**

- **in areas with large numbers of ethnic minorities, consideration should be given to using interpreters familiar with medical terminology and the implications of differing cultural values.**

CHAPTER 8

IDENTIFYING RISKS ARISING FROM WORKING BEYOND ONE'S COMPETENCE

Patients or clients and purchasers of health care are entitled to expect that the staff employed to carry out health care will be competent to practise. This chapter identifies some common issues which may compromise the competence of staff.

It addresses:

- the position of newly appointed staff who may be inexperienced in a particular area of practice
- training, supervision and support
- skill mix
- locum and agency staff

Professional accountability

In general, experience is no defence to an allegation of negligence and the standard of skill expected of a doctor would be that expected of practitioners with whom he claims to have similar skills. In the action Wilsher -v- Essex Area Health Authority (1986), the Court of Appeal held that a practitioner must display the standard of skill to be expected from a person holding his post in the hospital. It was irrelevant that he was new to the post and still in training. If a novice undertakes procedures in which he is not experienced, other than in an emergency, he is effectively claiming the skills of a suitably trained practitioner and will be judged against that standard. A junior doctor may avoid an allegation of negligence by consulting his senior colleagues; if an inexperienced doctor does not seek that advice of his senior when a prudent junior would have done so, he may be considered negligent.

Likewise, the UKCC Code of Professional Conduct for Nurses, Midwives and Health Visitors states that in the exercise of their professional accountability they should "acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner". The Code also states that they should "report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice" and "report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided".

Training, supervision and support

In the same way that patients or clients may reasonably expect to receive their care from competent staff, staff may reasonably expect that they will be suitably trained to do their jobs and that they will receive advice, appropriate supervision and support.

There is a possibility that managers may assume the staff transferring from another health employer will have received appropriate training for the job which they performed. But

there are examples of staff being appointed to posts for which they are not trained. Managers should ensure that newly appointed staff have received appropriate training at a suitably recent date.

Managers should ensure that staff attend training courses, even though this may cause difficulties in maintaining adequate levels of staff on duty. The pilot studies referred to in earlier chapters of this manual revealed several instances of staff carrying out functions for which they had not been adequately trained. In one instance, some medical staff involved in administering and controlling radiation had not attended recognised training courses as required by legislation relating to ionising radiations.

Support may be provided in the form of readily available written guidance and clinical protocols. This will help to ensure a consistent approach to diagnosis and treatment, particularly in areas of high staff turnover.

There should always be sufficient qualified staff available to give appropriate supervision, advice and support to less experienced staff. Failure to provide or utilise access to such advice places staff in a very vulnerable position, as discussed earlier in this chapter, and may be considered to present unacceptable risks to patients or clients being treated. Problems may arise where an individual is the sole practitioner of that profession with an organisation, and has no immediate peer support with whom to discuss problems or concerns.

Concern is often expressed about the level of supervision of wards, particularly at night. In one high risk areas visited during the pilot studies, it was common for a D grade enrolled nurse to be left in charge at night on a regular basis in contravention of the nationally agreed terms on grading criteria. Although the difficulties in ensuring cover are acknowledged, such action leaves the hospital open to considerable risk in the event of an untoward incident occurring.

Practice nurses attached to GP surgeries often work with little professional supervision or support and care must be taken to ensure that they are not compromised.

- **Action points**

  - **managers should ensure that newly appointed staff have received suitable training for their post at a suitably recent date**

  - **where specialist training is mandatory or advisory in a particular area, it is the manager's responsibility to ensure that staff are trained**

  - **there should always be sufficient qualified staff available to provide advice and support to less experienced staff**

Skill mix

Hospitals and other health care providers are increasingly examining the skill mix of their staff to ensure that an acceptable standard of care is provided in the most cost efficient way. Re-profiling and the increasing use of unqualified staff can result in inadequate supervision and managers must take care to ensure that there is sufficient monitoring of these staff.

Particular problems may arise in community based premises, particularly those for people with a mental illness or learning disability, where for therapeutic purposes a decision has been made to replicate "normal" living conditions as closely as possible. Those staff who are available are expected to be multi-skilled. Care must be taken not to compromise safety in the effort to provide a more homely atmosphere and assessments of the needs and skills of individual clients should be undertaken and documented.

- **Action points**

  - **the increasing use of unqualified staff may give rise to inadequate supervision and managers should ensure that this is not the case**

  - **in the case of community homes, care should be taken to ensure that the desire to create a home-like environment does not compromise the safety and well being of residents or staff**

Locum and agency staff

There are often occasions when it is necessary to employ temporary staff to cover the absence of permanent staff. This may be done by the use of a "bank" of staff, by using an agency or by advertising.

Whichever means is used, it is essential that managers check the qualifications and registration of the temporary staff who are engaged. The onus is on local managers to ensure that the people they employ are suitably competent to carry out the work which is required, particularly since some posts receive little supervision and are themselves responsible for supervising other staff. It is not enough to think that it is the responsibility of the agency involved. Managers should remember that there are particular dangers involved for temporary staff who do not know the physical area in which they are to work and do not know whom they can ask for advice and support. There is a tendency to pay less attention to scrupulous checking of the credentials of temporary staff, since they will not be there for long. But it takes only one incident to cause major problems for the unit, and it can be argued that **more** attention should be paid when taking on temporary staff than in the case of permanent staff.

The report of the National Confidential Enquiry into Perioperative Deaths 1990 (NCEPOD)[1] found that, in 7% of the deaths, the most senior operating surgeon was a locum; similarly, of those anaesthetists working alone, 9% were locums. In some cases, the locums in both disciplines were "acting up", but often they admitted personally that they were inadequately trained or out of practice at particular procedures. A review of supervision of locum appointments at all grades in these specialties was recommended.

- **Action points**

  - **managers employing temporary staff should satisfy themselves that they are competent to fill the job and should give just as much attention to the credentials of temporary staff as those of permanent staff**

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[1] Report of National Confidential Enquiry into Perioperative Deaths 1990, E A Campling, H B Devlin, R W Hoile, J N Lunn

- **managers should always provide a basic induction for temporary or locum staff**

Care outside of specialty

Particular risk issues arise in hospitals where patients are concentrated into one ward rather than being spread in several partially filled wards. With the increased emphasis on efficiency, it is not uncommon for wards to be amalgamated, particularly at weekends, so as to minimise the number of staff required in the hospital.

Staff may be faced with caring for patients in a specialty in which they do not normally practise, with highly dependent patients, when they are not used to doing so, or with a higher proportion of dependent patients than usual, for example oncology patients in orthopaedic wards, or children being cared for in an adult-orientated ITU.

Risks can arise when nursing staff do not receive specific instructions or training regarding any specialist nursing care that may be required. It is desirable for additional written instructions to accompany patients being nursed in wards outside those designated for the specialty and which are staffed by staff who are used to dealing with patients from another specialty.

■ **Action points**

- **the risks inherent in asking staff to carry out duties to which they are not accustomed should be considered by managers and appropriate action taken to minimise the risks**

CHAPTER 9

RISKS OF INJURY TO PATIENTS OR CLIENTS ARISING FROM FAILURE OF COMMUNICATION

Communication breakdowns can lead to serious consequences for patients or clients. This chapter identifies some issues which should be addressed to ensure that risks are minimised:

- interaction between parts of the health services, for example hospital and community services
- interaction between departments
- interaction between professional groups
- information given to patients or clients

Case law

A breakdown in communications can lead to errors of omission or commission, either of which is an extremely good starting point in establishing negligence if a legal claim is being considered.

The case of Coles -v- Reading and District Hospital Management Committee (1963) identified a number of elements of communication which are relevant to this section, so it is explained in some detail.

The patient had a crushed finger and initially attended a cottage hospital to be given first aid. No anti-tetanus injection was given and he was told by the sister to go immediately to another hospital for further examination and treatment. Instead of going to the hospital, the patient went home, where he was seen by his general practitioner (GP). He subsequently died of tetanus.

The hospital was found to have been negligent on the grounds of failure of proper communication (defined by the judge as "that which was reasonably necessary for safeguarding a patient's interests). The Court held that the patient had not ben told the importance of going to hospital, nor the risk involved in not going, so it was not properly explained to him and he should have been given a document detailing his treatment and the need for an anti-tetanus injection. The responsibility of ensuring that a proper system of communication existed rested on those in charge of a hospital, not on individual members of staff without any guidance. When transferring a patient from one hospital to another, there ought to be some communication, and any system which failed to provide for this was negligently wrong.

The general practitioner was also found to have been negligent because he assumed that, since the patient had been to a hospital, all that was necessary had been done.

Interaction between component services of the NHS

The Coles -v- Reading case is a good example of communication between component parts of a health service failing; the hospital GP communication issue is one which receives a considerable amount of attention.

The main focus of communication problems between hospitals and GPs (and hospitals and other community-based health services) is the referral, admission and discharge of patients or clients. GPs often complain that they refer a patient or client for a specialist opinion and do not know if or when the patient or client receives an appointment, and also that there is slow communication of the results of a consultation. There are many examples of patients being admitted to hospital, perhaps through the Accident and Emergency Department, and discharged home without the GP knowing; it is particularly difficult for the GP when he is expected to take over the clinical management of the patient, including prescribing, if he does not know what treatment the patient has received, or what medication is currently in use.

Before a patient is discharged from hospital, a decision should be made about any continuing health or social care needs they may have. The provider unit should agree arrangements for meeting these needs with agencies before the patient is discharged, in consultation with the patient concerned. This should ensure that the services which the patient needs are already in place when they arrive home. This is particularly important where several agencies are involved, typically district nurses, social workers and home support services such as home helps and meals on wheels. Guidance is given in the document "Community Care in the Next Decade and Beyond", and in HC(89)5 and HSG(92)4.

With the increasing availability of electronic communication, there should be less reason for discharge plans and letters or treatment summaries being delayed. In the past, efforts were sometimes made to communicate with GPs and others by telephone, but if the individual was not available at that time efforts were abandoned and written communication taking several days to arrive was sent instead. Facsimile machines are increasingly used for exchange of information and have proved to be very beneficial in improving and speeding up communication. Subject to confidentiality safeguards, their use is to be encouraged.

Conversely, GPs should ensure that hospital departments to which referrals are made, particularly in the case of direct referrals such as those for physiotherapy, are fully informed of patients or clients' conditions and needs. Such referrals may be made by telephone, but should always be confirmed in writing.

- **Action points**

  - **information about patients or clients should be communicated by the most efficient means so as to ensure that their treatment can be continued effectively**

  - **all oral messages should be confirmed in writing**

Interaction between departments

It is important that all departments dealing with patients or clients are aware of all relevant information about their condition and treatment. There have been examples of patients known to be HIV positive being sent to therapy departments with open wounds, without the therapy departments being aware of their HIV status. Similarly, in one of the pilot sites the policy of not providing identity bands for accident and emergency department patients

resulted in two patients being confused by the X-ray department and receiving inappropriate examinations.

Although case notes may be transferred with patients, staff should not assume that their colleagues are able to assimilate all relevant information immediately. A brief note summarising the most important aspects will often be enough, and a simple pre-printed form could be devised. Such forms are already in use in some hospitals, and simple check boxes make it easy for receiving staff to form a quick view about the condition of the patient or client and any other relevant information on his circumstances.

■ **Action points**

- **staff should ensure that their colleagues have all relevant information about transferred patients. A simple check box form may assist**

Interaction between professional groups

In most cases, there will be a number of different professionals involved in providing the care for a patient or client. Good communication between them is vital to the efficient management of the patient or client's condition and his treatment and recovery.

In the Coles -v- Reading case, there was criticism of the fact that the nurse who saw the patient at the cottage hospital obtained advice on the telephone from the duty doctor which was not confirmed in writing.

An area where good interaction between professional groups is crucial is in maternity care, which is provided across hospital and primary care fields. It is essential that the roles and relationships between midwives, general practitioners and obstetricians are understood in order to give the woman, her baby and her family the style and type of care they require. In particular, it is important to note that the midwife has a defined sphere of practice and is accountable for that practice, which includes taking full responsibility for the care of a normal woman and baby throughout the childcaring episode.

In all cases, staff should remember that the welfare of the patient or client is more important that any professional boundaries and they should be prepared to communicate effectively to that end.

■ **Action points**

- **staff should ensure that professions liaise effectively to maximise the quality of care given to patients and clients**

Information give to patients or clients

Chapter 7 dealt in some detail with the information which should be given to patients or clients, and reference should be made to that chapter.

Coles -v- Reading again highlights an aspect of communication, that of ensuring that the patients understands the significance of the information or instructions which are being given to him.

The points made in chapter 7 about the services of interpreters are equally relevant here.

- **Action point**

  - **patients or clients should be given sufficient information about their condition to enable them to understand the importance of any instructions given by health care professionals**

CHAPTER 10

RISKS ARISING FROM DELAY IN TREATMENT

Patients or clients are able to sue health care providers for failure to provide correct diagnosis of treatment; a delay in diagnosis or treatment resulting in a deterioration of the physical or mental condition of a patient or client may give rise to a legal claim.

This chapter deals with:

- waiting time in accident and emergency departments
- admissions policy
- test results
- equipment breakdown or unavailability
- maternity departments and services for children
- availability of staff or facilities

Accident and emergency (A&E) departments

Delays in accident and emergency departments are a common cause of patient dissatisfaction in hospitals. At certain times of the day or night, there is often congestion in these departments and they are particularly vulnerable to disruption if an unusually large number of seriously ill or injured patients arrived within a short space of time.

One of the major difficulties in A&E departments is the mix of patients in the department at any one time. They will range from the very minor injury which could be treated at a GP surgery, to major trauma and life-threatening conditions. It is common practice for A&E departments to keep the seriously ill away from those with minor problems, to the extent of having separate entrances to the department, and this can lead patients to think that the staff are not working hard or that others are queue-jumping. Every patient in an A&E department will be anxious about his/her condition, and these elements often lead to aggressin against staff, increasing the stress on them.

The Patient's Charter has set a national standard for the immediate assessment of patients in A&E departments. All A&E departments must ensure that patients are examined immediately by a trained professional so that their treatment needs can be prioritised quickly. Some A&E departments are using triage as a way of performing the assessment, others are conducting brief first assessments and undertaking a full scale triage assessment later. Problems can arise at three subsequent stages:

- delay after the initial assessment while the patient waits to see a doctor
- delay in procuring investigative tests such as X-rays and the results of them
- delay if the patient needs admission and there is difficulty in finding a vacant bed

There have been numerous sensational press reports of patients waiting unaccompanied for admission for many hours on trolleys in cold corridors and there have been cases where

patients have been injured by falling from trolleys while waiting. The transfer of patients to specialist units, or neighbouring trusts if necessitated by the bed state, may also result in a delay in treatment.

Many A&E departments are coping with more patients than the number for which they were originally designed and staffed, and this presents its own pressures. Managers should consider carefully the risk which is presented to patients in some A&E departments and weigh the potential cost of a claim against the cost of making improvements in fabric or staffing. Purchasers of health care will be looking increasingly at the quality of service and failure to address this problem may lead to loss of income, particularly since a large proportion of patients admitted to hospital are seen initially in A&E.

Admissions policy

In some hospitals, it is the practice to admit all patients referred by GPs through the A&E department. This exacerbates the problems highlighted above.

An emergency admission ward adjacent to the A&E department could help to relieve the pressure on space and could allow patients awaiting admission to other wards to be accommodated in greater safety and comfort.

- **Action points**

  - **consideration should be given to the use of emergency admission wards to relieve pressure on A&E departments and beds**

Test results

Delay in interpretation of investigative test results can compromise the effective treatment of a patient. Difficulty can be experienced outside normal working hours, particularly in diagnostic departments supporting the A&E department. Medical staff, particularly juniors, should be aware of the procedures for obtaining urgent investigations and results out of normal hours.

- **Action points**

  - **junior medical staff should be aware of the procedure for obtaining investigations and tests our of normal working hours**

Equipment breakdown and availability

For diagnosis and treatment to be carried out quickly and efficiently, the necessary equipment must be readily available and in working order. The need for routine maintenance of equipment and replacement of obsolete items is emphasised in chapter 13.

In the event of equipment breaking down, arrangements should exist for it to be repaired as soon as possible and there should be sufficient equipment available for the professional staff to carry out their jobs effectively and efficiently. In one of the pilot sites, there were insufficient sets of gynaecological instruments in the operating theatres; the measures taken of sterilising some items in situ had not resolved the problem of unavailability of equipment for later operations on the theatre list.

Maternity departments and services for children

In maternity departments it is important that expert help is on hand in the event of problems arising. The most expensive legal claims tend to arise from incidents occurring at birth and which result in brain damage or other disability.

There has been much debate over the future of small, local maternity hospitals and units, with supporters arguing that childbirth is not an illness and that mothers prefer to give birth in local, more homely surroundings rather than in the sterile, high technology environment of large hospitals. Options such as home birth, and birth in midwife/GP led units are part of a woman's choice about her maternity care. The recent report "Changing Childbirth" concludes that "there is no clear statistical evidence that having their babies away from general hospital maternity units is less safe for women with uncomplicated pregnancies". While this may be true, the wishes of mothers have to be balanced against the risk to mother and baby if there is no obstetric, anaesthetic or paediatric help available on site if problems arise. Even in larger units there may be problems arising from delays between summoning assistance and its arrival.

It is equally important to ensure that there are sufficient medical staff available, particularly in paediatrics, to cover the maternity department, children's wards and A&E at all times.

Availability of staff

The arguments in favour of adequate cover for maternity and children's services apply also to other specialties. On call rotas should allow for adequate cover, and medical staff should live close enough to the hospital to be readily available in the event of problems arising.

- **Action points**

  - **managers should satisfy themselves that there are adequate arrangements for cover by medical and other staff, to minimise risks to patients**

Availability of facilities

Problems may arise if designated emergency operating theatres are not available for use. This situation often means disruption of a planned surgical list in the main operating theatres and inevitable delay or cancellation of cases.

Many older hospitals have operating theatres sited above ground floor level, necessitating the use of bed lifts, which should be well maintained and reliable, for the transport of patients to and from the operating theatres. Older bed lifts are reported to break down frequently, causing the operating theatres to become congested with post-operative patients in a recovery state. This effectively cancels the operating list until the bed lift is repaired.

At night, or at weekends, problems with availability of theatres can be further compounded by any delay in "on call" personnel travelling to the hospital to prepare and staff the operating theatres.

Where a maternity department has a designated operating theatre, it is not uncommon for this to be administered and staffed by the main operating theatre department; in certain instances, these operating theatres may be kept locked out of working hours and keys held by the main

theatre department. This precludes maternity staff preparing the theatre in the event of requiring the facilities urgently, as in the case of a caesarian section for fetal distress, when time is of the essence. Where a maternity department has a designated operating theatre managed and staffed by other than maternity unit staff, there should always be immediate access so that there is no delay when an obstetric emergency arises.

CHAPTER 11

IDENTIFICATION OF SECURITY RISKS

Hospitals and other health facilities present special security challenges. It is important that the public can gain access to them when they need to and the buildings should be welcoming and not seem like fortresses, but at the same time the health care providers have a duty to take all practicable steps to ensure that only those people with a need to be in the building are admitted, and that they are prevented from committing misdemeanours whilst on the premises.

Chairmen have been required by the Minister to "set the pace for their organisations in this field and to identify a member of the Board to take personal responsibility for security".

This chapter identifies common security risks and some solutions to them.

COMMON SECURITY RISKS

- risks to the personal safety of
  - patients or clients
  - staff, visitors and others
- risks to property
  - health service property
  - personal property of
    - * patients or clients
    - * staff and visitors
  - cash
  - vehicles

Risks to the personal safety of patients or clients

Patients or clients in hospitals and in their own homes are vulnerable and particular care needs to be taken to protect them against security risks. In recent years, there has been a disturbing increase in the number of incidents in which patients have been assaulted or abducted whilst in hospital.

Particular care needs to be taken to be vigilant in the case of especially vulnerable patients or clients, notably babies, children, elderly people and those with mental illness or learning disabilities. In the case of the latter, care should be taken to ensure that they are not exposed to undue risks by wandering outside the premises, although it is important to strike a balance between safety and individual liberty, when developing a care plan and assessing the levels of medical or nursing supervision to be given. It is preferable that, except for overriding

medical reasons, new-born babies be kept beside their mothers, and that they are not moved by unknown or unidentified people. Access to neonatal units requires particular vigilance, and intercom system are of value.

Although it is an area which is sensitive and unpalatable, it should also be acknowledged that some staff can, on occasions, present a risk to patients or clients. EL(93)51 - Guidance for staff on relations with the public and the media, contains guidance for staff in dealing with concerns that may arise about the care of patients (which could include threat to a patient's safety by a member of staff). There are a number of procedures relating to medical staff, and the Chief Medical Officer has established a Working Group to review guidance on doctors' performance to consider whether there is any need for changes to current guidance and procedures.

- **Action points**

  - **there should be a well known, confidential procedure for alerting managers to potential risks posed to patients or clients by staff**

Risks to the personal safety of staff, visitors and others

Pilot studies which have been carried out reveal that more than 10% of staff do not feel safe at work during daylight hours, rising to over half of all staff at night.

Staff in small premises such as clinics are denied the "safety in numbers" enjoyed by staff in hospitals. It is particularly important that they have means of raising an alarm if they are in difficulty.

Staff working in isolated buildings or departments, or alone at night, often feel vulnerable to attack. Consideration should be given to providing panic buttons linked to a 24-hour manned point and to the installation of intercoms or closed circuit television and remote unlocking on external doors so that staff know who they are admitting before opening the door.

Visitors to health premises are equally vulnerable to attack and theft and hospital car parks are acknowledged to be fertile grounds for unscrupulous people.

Community based staff are at risk when undertaking home visits. Staff should leave a diary of their planned visits at their base and it may be advisable for them to phone in to their base when they have completed their visits for the day. Mobile telephones are of great use in improving the safety of these staff.

Adequate external lighting can ensure that people walking in the grounds of hospitals or other health premises feel more secure and can also avoid accidents from people falling or otherwise injuring themselves in dark areas.

Reference may be made to the Lord Skelmersdale Committee report "Violence to Staff - Report of the DHSS Advisory Committee on Violence to Staff" (HMSO 1988), as required by EL(88)MB/21 and EL(89)MB/29

- **Action points:**

  - **staff should be given the means of raising an alarm if they are in difficulty. This may be by means of panic buttons, mobile telephones or other means**

  - **community based staff should leave a diary of their proposed visits at their base so that their movements are known**

  - **staff who need to allow people into restricted areas should have the use of an intercom and remote door unlocking**

Risks to property

Two overriding principles apply to the security of property:

- remove the target from sight

  at its simplest, this means putting items inside drawers and lockers, and drawing window blinds and curtains at night. Much theft is opportunistic; staff and patients or clients are often careless and do not make use of the facilities available to them.

- place the target behind barriers

  doors and windows can provide sufficient security if they are shut and locked, provided that they are reasonably substantial, have been correctly fitted in the first place and are well maintained.

Health service property: in recent years, there has been a considerable increase in the use of computers and other small portable equipment. This equipment is particularly attractive to the purposeful thief and care should be taken to conceal valuable equipment from sight of the casual observer. All valuable health property should be security marked or coded to assist recovery in the event of theft and the deterrent effect is enhanced if notices are displayed to inform visitors that such measures are in operation.

Drugs and small medical equipment such as syringes are often targeted, particularly in clinics or health centres. Particular care should be taken to conceal such items.

Staff should be careful to conceal any property left in their cars, and should be discouraged from leaving health records in unattended vehicles.

Personal property of patients or clients: patients on being admitted to hospital should be encouraged to leave valuables at home or to hand them in for safe keeping. The recording of this activity is not always dealt with rigorously and there is often no record of property which the patient insists on retaining. The record form which is signed should contain a section (to which patients' attention should be drawn specifically) where the patient accepts that any property retained by him or her is their own responsibility and the hospital cannot be held liable to any loss or damage. Care should be taken in the description of items handed in for safe keeping, for example "yellow metal ring with red stone" rather than "gold and ruby ring".

Personal property of staff: staff should be encouraged to take responsibility for their own personal property and to make use of locked storage facilities. If these are not available, they should be provided. This applies equally to resident and non-resident staff. Some employers have arrangements with insurance companies where staff taking out insurance of their personal property are offered preferential rates.

Out-patients and visitors should be reminded by the display of clear signs to be vigilant about their personal property and that the hospital or clinic is not liable for any loss or damage.

The security of patient or clients' property in their homes is a particularly difficult issue and therefore procedures need to be in place. Staff should be discouraged from giving any advice or help and from accepting any gifts from patients or clients, in order to avoid any implication of wrongdoing at a later date. Many of these patients or clients will be elderly and forgetful or confused, and much distress can be caused to both patient or client and staff if a patient or client disposes of an item and forgets that he or she has done so willingly. Staff should note any conversations about such items.

- **Action points:**

  - **staff and patients or clients should be reminded to keep property out of sight, to close doors and windows when rooms are unoccupied and to use lockable facilities provided**

  - **recording of patients or clients' property should include a section with details of items retained by the patient or client**

Security of cash

Handling of cash within the organisation will be covered by Standing Financial Instructions, which should be scrupulously observed at all times. Particular problems are presented by group homes and similar establishments and by some clinics and health centres which have cash holdings from the sale of baby foods.

- **Action points:**

  - **care should be taken to vary the days and times of movement of cash between premises, and there should always be more than one person involved in such movements.**

Vehicle security

Vehicles, whether personal property or health service property, are very vulnerable to theft and misuse. Staff should be reminded to lock vehicles, both doors and boot, at all times when the vehicle is left unsupervised and to remove valuables and keys from sight. People who would never consider leaving their vehicle unlocked if parked in a public street can have a false sense of confidence when parked on hospital property. The simple presence of large numbers of people is no guarantee of security and may indeed mean the reverse.

- **Action points:**

- **staff and patients or clients should be reminded to lock vehicles when unattended**

Other security issues

With the increasing sophistication of telephone systems, many departments will receive calls direct rather than through a switchboard. Switchboard operators should be and usually are trained to react appropriately in the event of bomb threats or other threatening calls. Care should be taken to ensure that all staff are fully aware of the appropriate response to such calls.

The importance of appropriate storage and disposal of confidential matter should not be overlooked.

■ **Action points:**

- **staff should receive appropriate training in handling threatening telephone calls**

SOLUTIONS TO SECURITY RISKS

Staff identification systems

In many of the situations mentioned earlier in this chapter, simple staff and visitor identification methods can reduce the risk of undesirable people being allowed into the building. The objective of staff identification systems for security purposes is to allow staff and patients or clients to recognise the legitimacy of individual staff members and to allow unauthorised persons to be detected. A good system will have the name, designation and photograph of the member of staff, together with a telephone number so that patients or clients being visited in the community can verify the identity of the person concerned. But it is rare to find a staff identity system which is rigorously managed, and as such these systems can be of limited use.

Name badges are compulsory under the Patient's Charter for all NHS staff who come into contact with patients. These should not be confused with staff identification systems. The issue of ID badges should be the responsibility of one department and preferably of one individual. Staff should be required to wear or, in some instances, carry their badges at all times and this instruction should be strictly enforced. The retrieval of badges when a member of staff leaves is perhaps best dealt with by their line manager.

In some long-stay areas, staff sometimes feel that the wearing of identity badges is counter-productive to the provision of a homely environment and, in the case of some psychiatric areas, can reinforce authoritarian stereotypes. There is no easy answer to this problem but it is one which should be addressed explicitly by staff and their managers and a procedure agreed, which should be adhered to.

A corollary to a staff ID system is one to identify authorised visitors, including staff such as contractors who may be present on a site for some time.

All staff should be encouraged to challenge individuals who are not wearing identification. Many people are reticent about doing this, but the overriding objective should be to ensure

that unauthorised people are not allowed access to areas where patients or clients and staff are vulnerable. Staff should be trained in procedures for dealing with people not displaying identification, or failing to produce it on request.

■ **Action points:**

- **staff and visitor identification systems should be operated rigorously, and should be the responsibility of one department**

- **staff should receive training in procedures for dealing with people not displaying identification, or failing to produce it on request**

Security of keys and use of digital locks

Security of keys is a perennial problem. Often a large number of staff have master keys, additional keys are cut and issued to staff, keys are not retrieved from staff when they leave, keys are often left lying in accessible places. The fundamental elements of a key control system are as follows:

- a register of key holders should be maintained by each department
- each department should be issued with a lockable key cabinet
- a named manager in each department should be responsible for key security, including the retrieval of keys from staff leaving
- keys should be identified by a code only, and a separate list kept of their usage
- additional copes of keys should be made only in exceptional circumstances, with the authorisation of the department manager concerned, and a record should be kept of any additional copies

In some community-based services, staff hold keys to the homes of their clients. This places special responsibility on these staff and exposes them to the risk of accusations if thefts or other incidents occur. Staff should hold keys only in exceptional circumstances, and this should be recorded formally in writing.

Although **digital locks** are frequently used in health care premises, their value is often compromised by extensive knowledge of the combination, or use of an obvious number, such as the telephone extension of the area concerned. It is also rare for the combination to be changed when a member of staff leaves.

■ **Action points:**

- **a key control system containing the elements outlined above should be introduced and enforced**

- **care should be taken in the coding of digital locks**

Professional security firms

There are a number of security firms which are interested in securing contracts with health care providers. The constant presence of a uniformed security guard can be a powerful deterrent to wrongdoers but does not in itself substitute for vigilance by staff. In areas where there is a particularly high risk of violent crimes against the person, such a presence may be warranted.

Health care providers entering into contracts with professional security firms should satisfy themselves that the personnel and the arrangements for cover are appropriate and that the contract is adequately monitored by a designated manager.

Where no security firm is employed to provide surveillance, security in hospitals is frequently seen to be the responsibility of the portering staff. These staff rarely, if ever, receive training. If staff are expected to carry out security related duties, they should receive appropriate training and support.

Surveillance and intruder alarms

It is possible to spend many thousands of pounds on elaborate surveillance and intruder alarm systems, only for them to be misused and circumvented by staff who find them an encumbrance.

Before alarm systems are installed, there should be discussion with the staff who use the areas concerned, including those who use an area for transit purposes, to ensure that the measures which are put into place do not unduly inconvenience people and are therefore more likely to be used properly.

Closed circuit television systems can provide extremely valuable information but this is only of use if the screens are observed at all times and, preferably, with video tape recordings made as a matter of course. There is some deterrent value in mounting security cameras in very visible places and displaying notices to that effect and there has been some success in using dummy cameras. However, any such deterrent effect will be short-lived and will not put off a determined criminal.

- **Action points:**

  - **staff should be involved as far as practicable in any decisions on the installation of security systems**

Many health care providers are establishing hospital watch schemes, and forging links with local beat police officers, who may have a base within the health care premises. Both of these initiatives are worthy of serious consideration. Acute hospitals in particular will find the NAHAT NHS Security Manual[(1)] useful.

[(1)] The NHS Security Manual - National Association of Health Authorities and Trusts, 1992

CHAPTER 12

IDENTIFICATION OF FIRE RISKS

Fire prevention has always warranted a high profile in hospitals, but with the lifting of Crown Immunity and the transfer of responsibility for inspection from the Home Office to local fire authorities, it is more important that ever that managers of health care premises obtain and act on the advice of fire professionals regarding the fire risks in their premises to ensure that an effective fire precautions programme is in place.

Different situations exist in nursing homes and in community homes for people with physical or mental disabilities. Although these establishments are not so attractive to an arsonist, there are many instances of fires occurring in such places, with loss of life in some cases.

This chapter highlights good practice and covers the action to be taken to implement an effective fire precautions programme:

- to minimise the probability of a fire starting
- to avoid, so far as possible, the likelihood of a fire causing death or injury to patients or clients, staff or visitors
- to minimise the likely damage to the buildings and equipment
- to minimise the effect of the fire on the provision of health care

Minimising the probability of a fire starting

There are five main causes if ignition:

- electrical faults
- carelessly discarded smokers' materials
- arson
- contractors' activities
- cooking

- ***electrical faults***

  Many hospital fires are caused by an electrical fault. The key to controlling this risk is regular maintenance and inspection. The surveys required under the Electricity at Work Regulations will identify problem areas and actin should be taken to rectify problems.

  In most health care premises, there is a high volume of portable electrical equipment in use in all departments and in residences. All such equipment should be checked by the electrical specialists in the organisation and an authorisation label attached to it. Systems must exist for this to be done promptly; if staff have to wait more than one or two days for equipment to be approved for use, they will tend not to ask for approval. Equipment brought in by patients or clients should be similarly checked. Staff should be encouraged to ensure that electrical appliances are switched off when not in use and at night, and the plugs removed from the sockets.

Particular problems may arise from unoccupied buildings; many premises for people with learning disabilities or psychiatric hospitals are on contracting sites, which have large numbers of disused buildings. Systems in unoccupied buildings deteriorate, insulation breaks down, overheating occurs and fire can take place. Regular safety checks should be carried out in disused buildings, and especially in unused areas of buildings which are occupied. Disused buildings may also be attractive to arsonists and others with malicious intentions.

■ **Action points:**

- **all portable electrical appliances brought onto the premises for use should be inspected and authorised. A system should be devised which will ensure that this happens promptly**

- **staff should be reminded to switch off electrical appliances when not in use and unplug them when out of use for long periods**

- **regular safety checks should be carried out in unused buildings or areas, and utilities disconnected if this is practicable.**

· ***carelessly discarded smokers' materials***

The increasing introduction of non-smoking policies in health premises is to be encouraged, but there is a danger that a total ban will drive smokers "underground" and induce them to smoke in secluded areas. There are obvious hazards in this, in that early detection of any fire is unlikely in such areas. From a fire safety point of view, it is preferable for there to be designated smoking areas, rather than a complete ban on smoking.

■ **Action points**

- **care should be taken to ensure that smokers do not resort to smoking in secluded areas**

- **where smoking is allowed, there should be metal receptacles for discarded smoking materials and appropriate detection systems so that any outbreak of fire is noticed quickly.**

· ***arson***

Malicious arson is always a possibility and it is, sadly, not unknown for hospital staff themselves to set fires. There are also particular risks in some psychiatric areas where patients or clients may set fires deliberately, although not always with malicious intent.

A significant contribution to reducing the risk of arson is made by improved security. Chapter 11 highlighted the importance of adequate security measures and recommended action. Guidance to the NHS on arson is to be issued shortly.

· ***contractors' activities***

Building contractors are not always as careful as they could be when carrying out work involving cutting, welding or using a blow torch.

All contractors used by health care providers should be approved, approval covering a number of areas such as technical competence, financial stability and insurance cover. Some health care establishments operate a "permit to work" system, which ensures that contractors are specifically authorised by a suitable manager on the staff of the provider unit to work in a particular place at a specific time. Although this is a worthwhile system, it is no substitute for regular inspection by professional staff and it is recommended that an estates management professional inspects areas where contractors have been active before leaving the site each night.

■ **Action points#**

- **all contractors should be selected from an approved list, or not allowed to start work until appropriate checks have been carried out**

- **consideration should be given to a "permit to work" system**

- **an inspection of areas where contractors have been working should be carried out at the end of each working day**

Avoiding death or injury

The foundation of the avoidance of personal injury and death in the event of a fire is an effective training programme for staff. Training inspires confidence to react without panic in an emergency situation. It allows planned procedures to function smoothly in the event of fire, and can result in the reduction of loss. Whilst emergency assistance is being summoned, containable fires can be dealt with by staff who have participated in training. It is recognised that the first few minutes of a fire are the most importance in its development. Correct training and education can result in savings both in terms of monetary value, and in the lives of staff and patients or clients.

Health care providers who do not employ a qualified fire officer should secure the services of a professionally qualified fire prevention specialist to undertake such training; this may be through a joint appointment with another unit, or through contracting for the services of a consultant or of the local Fire Brigade.

Large hospitals are required to employ a hospital fire officer. Health care providers should ensure that **all** staff receive training in fire control, fire fighting and evacuation techniques. Training sessions should be held frequently, and at different times of day and night to ensure that all staff have the opportunity to attend. Attendance on at least one such training session per annum should be compulsory for all staff, including medical staff and senior managers. An effective system should be in place to record staff attending training and to identify those who have not attended. Failure to attend should be a disciplinary matter.

Several health providers now have a disused ward or building set up as an evacuation training area, into which smoke can be introduced and staff can be trained in evacuation techniques under fire simulation conditions.

Fire exit doors and routes must be clearly marked and not obstructed. Managers should ensure that regular inspections of fire exits are carried out to make sure that they are not blocked.

At some hospitals, unauthorised car parking on hospital roads and surrounding areas would impede access for fire engines. Managers should act to ensure that adequate access is maintained.

■ **Action points**

- **providers should ensure that advice is available and sought from a suitably qualified professional. Purchasers will wish to satisfy themselves that such advice is available**

- **a compulsory training programme should be provided in each unit, with arrangements in place to ensure that all staff attend at least once a year**

- **fire exists should be inspected regularly to ensure that they are not blocked**

- **access for fire engines should be maintained at all times**

Minimising likely damage

The spread of a fire once it has started can be minimised by:

- use of fire resistant materials for construction
- combustible materials being kept to a minimum
- compartmentation
- detection
- fire fighting equipment

· ***fire resistant materials***

Before any alterations are carried out, the advice of the fire prevention specialist must be sought at the design stage, to ensure that the materials which are to be used are suitable and also to ensure that the integrity of compartmentation is not compromised. Many older hospital buildings are constructed from wood and other combustible materials, and there may be little which can be done to improve existing buildings.

■ **Action points**

- **the advice of the fire prevention specialist should be sought at an early stage in the design of new buildings or minor alterations**

■ ***combustible materials***

Textiles and furniture used in health care premises should be fire retardant to the appropriate standard. Particular care needs to be taken in the case of donated items of furniture and fabrics as these may not be of an acceptable standard of safety. The advice of the fire prevention specialist should be sought, since it may be possible to make the items safe at a relatively low cost.

Old furniture and defunct equipment should not be hoarded in hospitals. In many cases, staff are loath to part with old, but serviceable, furniture when it is replaced and there are often disused wards or other buildings full of displaced furniture "which might be useful one day". It is often preferable to arrange the sale of such items, and to put the proceeds back into the furniture budget for the area concerned.

■ **Action points**

- **care should be taken to ensure that all furniture and textiles being brought into use reached approved standards of fire retardancy**

- **the possibility of fire in stores of old furniture should be considered, stocks reduced to the minimum level and stored in a designated area.**

· ***compartmentation***

compartmentation is used to limit the spread of fire and it should include ceiling and floor voids. It may also be used to contain the spread of oil from tanks if a leak should occur, and bunding of large storage tanks is desirable.

Where compartmentation relies on fire doors, it is important that they are not wedged open and that they can operate efficiently. When planning the location and type of fire doors, designers and managers should take into account the type of movement which takes place in each area and provide equipment which is compatible with its use. For example, in areas where there are a large number of patients in wheelchairs or with walking frames, staff will tend to prop open fire doors which have strong closers to allow patients to move about more easily. In such areas, doors fitted with magnetic catches linked to the fire alarm system may offer a realistic alternative. For their part, staff must be instructed by their managers in the importance of ensuring that fire doors are able to do their job in the event of a fire, which they cannot do if they are wedged open or obstructed by items such as cabinets and wheelchairs.

Fire doors should be inspected regularly to ensure that they are still effective, and door closers should be adjusted where necessary.

■ **Action points**

- **the type of fire precautions to be used should be decided in the light of the use to which each area is put, so as to avoid inconveniencing staff and patients and thereby tempting them to override systems**

- **fire doors and closers should be inspected regularly to ensure that they are still effective**

· ***detection***

Raising the alarm is dependent on discovery of a fire. Automatic detection systems are now widespread in health premises and are very effective in early detection of smoke or heat. They are, however, susceptible to false alarms if they are not sited in the best positions or are of the wrong type; heat and smoke detectors sited in ward kitchens are particularly sensitive to, for example, toast. False alarms can in time give rise to false sense of security and a reduce response to alarms sounding. Detection and alarm systems should be regularly maintained by an approved contractor.

Detection alone will not extinguish a fire. It is important that the alarm is raised either by a person on the premises or automatically by use of a direct link to a permanently staffed control point. In the latter case, the control point may be the hospital switchboard or an external specialist alarm service.

■ **Action points**

- **automatic detection systems must be of appropriate design and sited in the optimum position to ensure coverage but to avoid false alarms.**

· ***fire fighting equipment***

Appropriate fire fighting equipment should be installed in every area of health premises. The equipment which is supplied must be regularly maintained and records kept of the maintenance. People who undertake the servicing of equipment must be properly trained to do so.

In the case of community homes, there has been much debate about the type of detection and fire fighting equipment which should be installed. There is a potential conflict between the "ordinary life" concept, which calls for equipment of a domestic nature, and the need for the managing provider unit to be satisfied that the equipment is of a standard suitable for use in premises housing vulnerable people, and for which it may be held liable in the event of an incident occurring. With tolerance and understanding on both sides of the debate, it is possible to arrive at a satisfactory compromise which does not give an institutional flavour to a home but nevertheless provides acceptable protection against loss of life or property.

■ **Action points**

- **fire fighting equipment must be suitable to the area in which it is to be used and acceptable to staff**

- **fire fighting equipment should be serviced regularly by a qualified person and records kept of inspections**

Minimising the effect on services

A major fire would have a disruptive effect on the provision of health care, and areas which are geographically centralised are particularly vulnerable, for example operating theatres, or trust-wide catering facilities.

It is important to consider the problems which would exist if a major fire occurred, and every health provider should have contingency plans to ensure minimum disruption in the event of fire damage. Chapter 31 gives further guidance on this subject.

■ **Action points**

- **contingency plans should be developed to ensure minimum disruption to services in the event of a fire or explosion**

Sources of information

The Department of Health, through NHS Estates, has produced a series of guidance documents relating to the fire safety of health care buildings. They are advisory, but are recognised as representing adequate standards of fire safety and are regarded as normative.

■ **Action point**

- **reference should be made to Firecode, Engineering HTMs and Building Components HTMs when considering fire safety in buildings**

CHAPTER 13

RISKS ARISING FROM BUILDINGS, PLANT AND EQUIPMENT

Hospitals and other health service providers are dependent upon buildings, plant and equipment to maintain safe operation, so it is important that they are well maintained and suitable for their purpose.

This chapter is divided into four section:

- buildings
- plant
- equipment
- contingency planning

Buildings

The two pilot studies which were carried out identified a number of issues which are common to the majority of health service buildings, together with some which are particular to certain types of facility.

At both pilot sites, there was a substantial backlog of building maintenance. There is a variety of reasons for this situation, but a common reason is the tendency in the 1970s and 1980s to reduce expenditure on buildings maintenance at times of financial stringency. The large bills now arising are a legacy of those decisions.

Plans to close or consolidate buildings can reduce this considerable "debt" but in many cases it will take several years of significant investment to rectify the neglect of past years.

Some hospitals, particularly some old city centre hospitals and psychiatric hospitals, include listed buildings. These present particular problems, since any repairs to them may need specialist and expensive materials. They cannot be removed and this may have the effect also of reducing the value of any land and buildings released for sale.

Areas which have commonly been passed over for funding in favour of patient areas are staff residences. Neglect of these properties can result in a loss of income if they become unfit for habitation and loss of reputation if a staff member is injured or attacked in an unsafe building, particularly in the case of junior staff in training. The Department of Health's initiative to improve the working conditions for junior medical staff has placed new emphasis on the conditions in which junior doctors are expected to live and work.

Managers of health service organisations should give careful consideration to the cost of **not** maintaining buildings; planned preventive maintenance can be a very cost-effective investment if extensive and expensive repairs are to be avoided at a later date.

All health service buildings should have a register of areas where asbestos is known to be present. Such a register should include the type, condition and extent of asbestos material

and should be kept up to date in order to minimise any risk arising from work being carried out in areas where asbestos is present.

- **Action points**

  - **a review should be carried out of planned preventive maintenance requirements at each site, and a programme drawn up for funding these requirements**

  - **up-to-date registers of asbestos should be maintained for each site**

Plant

Up-to-date drawings and plans of all services should be readily available so as to avoid inadvertent disruption of supplies while work is being carried out. Aside from disruption to work, this is important for the safety of operatives.

There should be at each site a schedule of plant such as pressure vessels, lifts, lifting equipment and other plant for which regular statutory inspections are made.

Standby **electricity generators** should be tested regularly, at various times to assess their capacity to cope with differing loads. The increase in electrical equipment in hospitals and other health care buildings during recent years often means that the standby generators which were installed some years ago may no longer be adequate to cope with all essential supplies. Equipment connected to an emergency supply should be identified.

Cupboards containing electrical circuitry should always be locked and warning notices posted. Nothing should be stored in cupboards where electrical circuitry is present.

Residual current devices should be fitted to all electrical equipment where an operator is likely to come into contact with liquid. This applies to equipment such as dental chairs, which are cleaned using liquid, as well as to items such as bath hoists.

Heating boilers should be checked regularly to ensure that they are in good working order. They should be fitted with an alarm system linked to a point which is manned 24 hours a day and a call-out maintenance service should be available. Further information relating to heating boilers can be found in HSE Guidance Note PM5.

Water supplies may cause particular problems. In order to ensure adequate control of Legionella, one named individual should have responsibility for the necessary precautions. Water tanks and calorifiers should be cleaned regularly, water temperatures maintained to recommended levels and checked daily, and "dead legs" removed from pipe runs. NHS Estates and the HSE have both published detailed guidance on control of legionella, notably EPL March 1993, WIMS and HTM 2040.

At the same time, the temperature of hot water at outlets to sinks and baths should be regulated, particularly where vulnerable people such as children, elderly people and people with mental impairment are concerned. There have been several incidents of people sustaining scalds, sometimes with fatal results. Again, NHS Estates have produced guidance on water temperature control.

- **Action points**

  - **up to date records of services and plant should be maintained for each site**

  - **standby generators should be tested regularly to ensure that they operate effectively**

  - **a named individual should have responsibility for precautions against Legionella**

  - **the temperature of hot water should be regulated to a safe level**

Equipment

Hospitals and other health care providers have vast amounts of different equipment in use and it is impossible to mention each type and the action which should be taken to minimise risk. Some particular issues are mentioned here.

Preventive maintenance of equipment is important to avoid breakdown of essential equipment when it is needed.

It can often be the case that more attention is paid to repairing equipment after it breaks down than to prevention of any breakdowns in the first place. Failure of any equipment can be an annoyance and a drain on resources, but in the case of some electrobiomedical equipment failure may result in injury. Procedures issued regarding the decontamination of equipment to control infection risks should be adhered to when equipment is to be maintained or repaired.

The introduction of asset registers as a result of capital charging in the National Health Service has recorded explicitly the age and likely life of all items of equipment valued at over £1,000 (to be increased to £5,000). The information derived from these registers should be acted on to ensure that breakdowns are minimised and replacements planned for obsolete equipment. There should be a rolling programme for equipment replacement, to ensure that no equipment is retained in use beyond its useful life. It is important to remember to include the value of property not included on asset registers when calculating sums insured for insurance purposes.

Managers should bear in mind that the breakdown of an item of equipment may result in injury and a claim. This can apply equally to staff and to patient or client claims. Failure to maintain important equipment will not assist the health provider's case if he has to defend a claim for negligence or to justify his actions to the Health and Safety Executive or other agencies. Any statutory requirements relating to inspection, maintenance and repair of equipment should be adhered to.

Some equipment used in hospitals and other facilities has an inherent risk; examples are cooking equipment in training areas and community homes, and industrial equipment such as power saws and machinery in training or therapy workshops. It will never be possible or cost effective to eliminate all risk, but the level of risk present must be assessed and prioritised decisions taken about any action which needs to result from the assessment.

Any equipment which is condemned should be clearly marked that it is unsafe for use and should be disposed of at the earliest opportunity. "Graveyards" of old equipment are dangerous and should not be allowed to accumulate, particularly in areas to which the public has access.

- **Action points**

  - **asset registers should be maintained and the information contained in them used to plan equipment replacements**

  - **equipment should be maintained so that it is effective at all times**

  - **unused and condemned equipment should be disposed of as soon as possible and securely stored in the interim period**

Contingency planning

Failure in buildings, plant or equipment can lead to major disruption of the business of a hospital or other health care provider. Contingency plans should be in existence to deal with any major failure, including that of telephone systems, patient call systems, laundry equipment (where relevant) and cooking equipment, as well as vital medical and associated clinical equipment. Chapter 31 gives more detail on contingency planning.

Estates departments are best placed to take the lead in defining systems which may fail, and it is advisable for them to do so. Managers should then ensure that appropriate plans are in place to deal with breakdowns and other failures.

- **Action points**

  - **estates department staff should take the lead in developing contingency plans to deal with failure of buildings, plant, equipment or utilities in conjunction with user departments**

CHAPTER 14

RISKS ARISING FROM WASTE

All health care organisations have a legal responsibility to dispose of all waste so that no harm is caused either to people, or to the environment.

This chapter covers the following:

- key points from the legislation
- segregation, collection and storage of waste
- disposal of waste

The legislation

European Community directives have been incorporated into UK law by adoption into Acts of Parliament and subordinate Regulations including the Control of Pollution Act 1974, the Health and Safety at Work etc Act 1974 (HASAWA), the Control of Substances Hazardous to Health Regulations 1988 (COSHH) and the Environmental Protection Act 1990 (EPA). There is separate legislation for Scotland and Northern Ireland. COSHH is dealt with in detail in chapter 18.

Although it is not legally binding, the Environmental Protection Act 1990: Waste Management - The Duty of Care, A Code of Practice (1991 HMSO), should be used as the benchmark of good practice. This requires the producer of waste to:

- prevent unauthorised or harmful action
- prevent escape of waste from control
- secure transfer of waste to an authorised person
- provide a written description of what waste is transferred

The responsibility begins with the creation of the waste and continues until its disposal, even where properly authorised agents are used. The EPA imposes duties on individuals named as being responsible for waste management. Failure to comply is a criminal offence and may also lead to civil action if damage or injury arises.

Section 3(1) of the HASAWA states that "it shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety".

The Health and Safety Executive has brought successful prosecutions under Section 3(1) of the HASAWA, including at least one against a health authority. This was because a hospital failed to segregate clinical and domestic waste due to inadequate communication and monitoring, which led to refuse collection vehicles being contaminated with blood.

■ **Action points**

- **managers should be informed about the legislation under which waste disposal activities are carried out, and should ensure that their staff are also aware of the legal framework and their responsibilities.**

Segregation, collection and storage of waste

All health care providers should have clear written policies and procedures for dealing with waste, and these should be known to all staff. There should be specific procedures for clinical waste, drawn up with input from control of infection staff, and all staff involved in handling clinical waste should receive training. The policy should include the type of protective clothing to be available to staff handling such waste.

There are three different categories of waste, as follows:

· domestic - for example from offices, kitchens and residential accommodation

· clinical - for example soiled dressings, swabs, contaminated waste, human tissue, used blood bags and used sharps

· special - Statutory Instrument 1980 No 1709 gives a list of 31 substances. The Regulations also apply to other substances dangerous to health (as detailed in Schedule 2), substances with a flash point of 21° Celsius or less, medicinal products available only in accordance with a prescription, and certain radioactive waste.

Because different disposal procedures apply to each category of waste, it is important to **segregate** correctly at the point the waste is created. Failure to do this may mean that domestic waste is incinerated, resulting in unnecessary costs, or clinical waste wrongly bagged may be disposed of inappropriately, causing risk of injury or infection.

Health care providers should ensure that all departments producing waste have at their disposal sufficient containers to allow segregation at the point of production.

All clinical waste bags should be labelled, with the label displaying the place and date of origin. This allows the source to be traced in the event of any problems arising during storage and disposal.

Staff responsible for the **collection** of waste need protection, which should include:

· training in lifting and handling
· procedures to follow when there is a spillage or injury
· provision and use of protective clothing
· immunisation against tetanus and hepatitis B.

Receptacles for wastes should be appropriate to the type of waste, for example bins for clinical waste should be of the pedal type, and labelled. Once filled, receptacles should be stored in a suitable environment whilst waiting for collection, as recommended in the paragraphs below on storage. Containers for discarded sharps should not be overfilled, and should be stored out of the reach of children.

Vehicles used to transport all types of waste should be thoroughly cleaned at least once a week, and should not be used to carry items such as clean laundry or food.

If clinical waste is produced by a patient in the home environment it is the responsibility of the householder to make special arrangements with the local authority. Staff should ensure that the resident is aware of this responsibility, as there may be instances in which health care providers are asked to dispose of clinical waste by clients. Where a clinical practitioner provides health care within the community, he or she is the producer of waste and is therefore responsible for its safe disposal.

The **storage** of waste, which should be for the shortest possible time, is important. A high proportion of fires are started (maliciously or accidentally) in rubbish, so all waste should be removed from corridors and doorways to a safe place. Waste in general, but clinical waste in particular, should be kept in secure containers or compounds to reduce the risk of tampering and the level of security should take into account people attempting to obtain syringes or needles.

Bags of clinical waste should not be stored with nursing supplies, or powdered milk for babies, or in corridors or lying loose in the grounds. Clinical waste should be stored separately, for the minimum possible time and in areas which are secure and not open to view by the public or patients.

Community nurses may carry containers for used sharps in their cars and the containers may be too large to be carried unobtrusively. Managers should be aware of the risk of cars being broken into and arrangements should be made for appropriate containers to be provided. A Safety Information Bulletin "Use and Management of Sharps Containers" is to be issued.

- **Action points**

  - **managers should ensure that suitable and adequate containers are provided to wards and departments so that waste can be segregated correctly**

  - **all clinical waste bags should be labelled with the place and date of origin**

  - **vehicles used to transport waste should be thoroughly cleaned at least weekly and should not be used to transport items such as food or clean laundry**

  - **storage of waste should be kept to a minimum and should be in secure areas**

Disposal of waste

The disposal of waste is carried out in various ways. In some cases, large hospitals have incinerators on site for clinical waste and in other cases it is transported elsewhere. The loss of Crown immunity has caused concern, since the current regulations relating to the operation of incinerators are much more strict than previously and there are very few hospitals which comply fully with current regulations. Wherever the waste is disposed of, it is the responsibility of the producer of the waste to ensure that the incinerator operator has a valid licence and that the incinerator operates in accordance with the regulations.

An area which receives little attention is the discharge of waste into sewers. The disposal of anything other than domestic sewage requires the consent of the relevant sewage undertaker, which will lay down conditions setting out the permitted limits of concentration, solid particle content, pH and temperature. Discharge may be restricted to stated days and times, and breach of this consent is a criminal offence. Any consequent damage or injury may lead to compensation. In health care premises, great care must be taken with materials such as mercury and bedpan liners, as well as chemicals used in departments such as radiology and pathology.

The National Audit Office Report No 5 (May 1993) "Untapped Savings: Water Services in the NHS" states that hospitals should:

- audit the discharge of substances to the drain
- test the effluent discharge according to the criteria used by the water and sewerage companies
- manage the discharge to the drain based on the information gained by applying the previous two points.

Staff responsible for community homes and those treating patients or clients in the community should be made aware of the requirements of SI 1980 Re 1709 and the advice in the National Audit Office Report.

There should be clear procedures for the disposal of waste of a special nature, for example radioactive waste and drugs, in line with current legislation, for example the Control of Pollution (Special Waste) Regulations 1980.

■ **Action points**

- **all staff, including those working in patients or clients; homes, should be made aware of the regulations governing disposal of waste into the sewage system**

Publications which may be of further assistance include:

Department of Health - Strategic Guide for Waste
Health and Safety Commission - Safe Disposal of Clinical Waste
Department of the Environment - Waste Management Paper No 25: Clinical Waste
British Medical Association - Code of Practice for the Safe Use and Disposal of Sharps
Department of Health - Safety Information Bulletin "Use and Management of Sharps Containers"

CHAPTER 15

CONTROL OF INFECTION RISKS

Effective infection control is vital to the successful operation of all health care premises. The temporary closure of wards due to infection is almost commonplace, and the temporary closure of whole hospitals is not unknown.

This chapter is divided into four sections:

- organisation, policies and information
- training and awareness
- food
- separation of clean and dirty matter

Organisation, policies and information

It is vital that the control of infection in health premises is practised effectively and that the organisation, policies and procedures are well documented and available, and that all relevant staff are aware of them.

Health care providers should have a Control of Infection Committee, involving input from a microbiologist, control of infection nursing staff and other appropriate professionals. The committee should co-ordinate the preparation of policy documents and should be responsible for monitoring the control of infection in the hospital and recommending actin to prevent infection in the future. It is vital that staff are aware of whom to approach for guidance on infection control issues, particularly where an organisation occupies several sites.

Policy documents should be distributed to relevant areas, and the distribution recorded. Further guidance on the control of policy documents is given in chapter 27.

At one of the pilot sites, a database of infection "occurrences" is kept. This is sound practice and should help to establish any patterns of infection outbreaks.

Information on control of infection should be disseminated at regular intervals, so as to remind staff of the need to practise efficient control techniques at all times.

- **Action points**
  - **policies and procedures for infection control must be know to all staff**
  - **staff should be aware of whom to approach for advice on infection control issues**

Training and awareness

All staff should receive training in infection control at a level appropriate to their job. Basic infection control information should be contained in induction programmes, and staff working in particularly vulnerable areas should receive a regular updating.

Where contractors are used for support services such as cleaning and catering, managers should satisfy themselves that the contractor has adequate training arrangements for staff and that staff are encouraged to consider infection control risks in their day to day work.

Cleanliness and good hand hygiene are the most important weapons against cross infection. In the pilot studies it was observed that, while cleanliness was generally acceptable, there were particular problems in traditionally vulnerable areas such as washing areas including sluices, in kitchens and in sanitary areas. In some handwashing areas, only domestic soap bars, some of which were cracked and dirty, were available. In some clinical areas, elbow taps were not provided. Community staff may experience problems in that suitable handwashing facilities may not be available in premises visited in the course of their employment. There was food debris in some kitchens which would attract pests and some toilet facilities had unacceptable degrees of scaling.

Another common area of concern is the use of domestic style refrigerators to store items such as vaccines, expressed breast milk and other products. All refrigerators should be fitted with temperature gauges, and it should be the responsibility of a named person in each department to check whether acceptable temperatures are being maintained. These refrigerators should be dedicated in use, and foodstuffs should not be stored with clinical items.

Staff often take home their uniforms to wash rather than having them processed by a hospital laundry. This may be because of poor laundry standards or lack of changing facilities. To deal with this contingency, employers should provide guidelines on laundering uniform and other clothing worn at work.

- **Action points**

  - **all staff should receive appropriate training in infection control**

Food

All members of staff involved in handling or preparing food, including porters, domestic staff, nurses and volunteers, should receive training in food hygiene. The Food Safety Act 1990 brought in a new framework for food safety legislation and new enforcement measures which cover all staff handling food. Guidance can also be found in HSG(92)34 - Food Hygiene, and HSG(92)35 - Pest Control Management for the Health Service. Health service managers need to work closely with their local environmental health departments on matters concerning food safety and other safety issues. Reference should also be made to the NHS "Health Service Catering: Hygiene" manual.

The standards required in main kitchens are very detailed and specialised and need not be summarised here, but it is important to remember that food hygiene rules should cover all areas where food and drink is prepared, including staff rest rooms and training kitchens. At one of the pilot sites, food was seen stored in the sluice with cleaning materials and other

possible source of contamination. Food and drink should be kept separate from other items and in appropriate containers, labelled and dated.

- **Action points**

  - **all staff should be made aware of the importance of good hygiene in the handling and storage of food**

Separating clean and dirty

The separation of clean from dirty matter is a basic principle of infection control. It should be remembered that not all staff will automatically understand what is classified as "dirty" and this should be explained clearly. In the case of laundry, the separation is between dirty and foul items. It is important that staff are fully aware of the procedure and reason for segregating different categories.

Segregation applies at all stages of processes, not just at the end storage stage. At the pilot sites, it was observed that there was no compartmentation in a sterilisation and disinfection unit, so that clean and dirty instruments went through the same doors and were processed in the same areas. Some children's games and equipment were stored in a "dirty" utility room which could give rise to infection.

- **Action points**

  - **there should be clear guidance for all staff on the separation of clean and dirty materials and adequate facilities to practise this**

CHAPTER 16

HEALTH AND SAFETY OBLIGATIONS

The chapters which follow deal with health, safety and organisational liabilities. This chapter gives the statutory background to activities at work.

It covers the following areas:

- the statutory framework
- legal implications
- health and safety strategies

The statutory framework

This area of risk management is concerned mainly with the health, safety and well-being of staff, although there are areas in which the same concerns apply to patients or clients, residents and visitors.

The major piece of legislation which applies to this area is the Health and Safety at Work etc Act 1974 (HASAWA), Section 2(1) of which states that "it shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees".

In 1987 the Single European Act added a new Article 118a to the Treaty of Rome, specifically relating to health and safety at work. As a result of this, several European Directives were issued, being translated to Regulations in the United Kingdom on 1 January 1993.

The Management of Health and Safety at Work Regulations 1992 set out broad general duties which apply to almost all work activities in Great Britain and offshore, and can be seen as making more explicit what is expected of employers under HASAWA. It also requires the systematic assessment of workplace risks. An additional requirement is that, when there are more than five employees, the significant findings of the assessment are recorded, along with the names of any employees being identified by it as being especially at risk (regulation 3(4)). Additionally, the employer must provide his employees with comprehensible and relevant information on the risks to their health and safety identified by the assessment, the preventive and protective measures, the procedures to be followed in the event of serious and imminent danger to his employees, the identity of those people responsible for those procedures and to take all reasonable steps to inform other employers whose employees may be put at risk (Regulation 8).

Other, more specific, regulations which came into effect on 1 January 1993 include:

the Provision and Use of Work Equipment Regulations 1992
The Manual Handling Operations Regulations 1992
The Workplace (Health, Safety and Welfare) Regulations 1992
The Personal Protective Equipment at Work (PPE) Regulations 1992
The Health and Safety (Display Screen Equipment) Regulations 1992.

EL(93)66 issued to NHS employers on 29 July 1993 highlighted these becoming effective from 1 January 1993 and stressed the importance of effective health and safety management.

New EC directives are issued from time to time, and managers should keep up with new legislation. Early planning and foresight often reduce the cost of implementation simply by phasing the replacement of out of date equipment with items which comply with future requirements.

■ **Action point**

- **managers should ensure that copies of the six new health and safety regulations, and any further new EC directives, and approved guidelines are obtained, and that staff become familiar with the requirements**

Legal implications

Most legal claims by staff against their employer are "double action", claiming breach of statutory duty coupled with a claim for negligence.

For a negligence claim against any employer to be successful, it must be established that:

· a duty of care exists
· there was a breach of that duty and
· there was a causal link between the negligent act or omission and the injury sustained by the member of staff.

If the employee fails to establish that the employer has been negligent, then the claim for negligence will fail. However, the benefit of the "double Action" to the employee is that, whether there is negligence or not, if it can be shown that there has been a breach of a statutory duty then he merely has to establish that the breach was the main cause of the damage suggested.

It is possible to claim contributory negligence on the part of the member of staff, but this can be difficult to prove. For example, the existence of a training programme which staff of that genre attend is not proof that the individual has attended, nor that he/she received appropriate training. It is important that training and instructions given to staff are recorded and, where practicable, signed by the member of staff to confirm his/her knowledge. This is dealt with in more detail in chapter 19.

The HASAWA creates a broad base of duties, for breach of which an employer may be criminally prosecuted. The Act is framed in general terms, which mean that it is becoming increasingly difficult for an employer to prove that there has **not** been a breach of the Act if there has in fact been an accident at work.

The HASAWA also imposes a duty on individual staff to take care of their own health and safety and that of their fellow staff, but in practice there is a much heavier onus on the employer to ensure compliance with the Act. If individual staff have a duty to take care of their own health and safety, any member of staff who feels at risk of injury through not having been adequately trained or not having adequate assistance in lifting may refuse to carry out any task which involves a risk of injury. This could bring almost any health care premises to a standstill. If the organisation insists on perpetuating the existing situation,

there would be virtually no defence against claims brought by injured staff arising out of injuries caused by lifting.

It should be borne in mind that employers have a duty to inform, instruct, train and supervise staff so far as is reasonably practicable. Not only the employer but individual managers may also be prosecuted for breaches of their duty. Individual employees should be made aware that flagrant breach of prohibited action may lead to personal prosecution.

- **Action points**

  - **training and instructions given to staff should be recorded and signed by those involved**

  - **managers should be made fully aware of their potential liability to prosecution for a breach of HASAWA duties**

  - **staff should be made fully aware of their responsibility for the health and safety of themselves and others**

Health and safety strategy

All employers, including health care providers, should have an up to date health and safety policy which should be accessible to all staff and drawn specifically to their attention. Some departments may have their own policies in addition to the unit-wide policy. The Health and Safety Executive have produced a five step action plan entitled "Successful Health and Safety Management", which gives helpful guidance.

Health and safety strategies should be drawn up by a multi-disciplinary team, with the involvement of infection control staff and representatives of relevant groups of staff.

Safety action bulletins and hazard notices should be distributed in a co-ordinated way within units and an individual, probably in the estates department, should be given the responsibility to ensure that they are distributed appropriately and that any necessary follow-up action is taken and recorded.

Care should be taken to ensure that incident and accident forms are completed and processed properly in the event of an untoward incident occurring. Statements should also be obtained from any witnesses. Detailed guidance on reporting arrangements is in chapter 27 of this manual, and those organisations who have purchased insurance cover will have discussed incident notification requirements with their insurers.

Manager should be aware of the obligations to notify the relevant enforcing authority of injuries, diseases and occurrences in specified categories. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1985 (RIDDOR) may often be overlooked, particularly in respect of absences from work in excess of three days.

- **Action points**

  - **health providers should have a health and safety policy which is known to staff, up to date and regularly reviewed**

- **a named individual should have the responsibility to ensure that information on hazards and other safety matters is distributed and acted upon**

- **an action policy for compliance with RIDDOR should be created and put into effect**

CHAPTER 17

UNSAFE SYSTEMS OF WORK

Employers have a particular duty under the Health and Safety at Work etc Act 1974 to provide and maintain safe systems of work. A breach of this duty would support an action in negligence against the employer.

This chapter covers the following areas:

- definitions of safe systems of work
- lifting and handling
- protective clothing
- personal safety
- confined spaces and heights
- monitoring contractors

Safe systems of work

The employer's duty under Section 2 (2)(a) of the Health and Safety at Work etc Act 1974 is to ensure "**the provision and maintenance of plant and systems of work that are, so far as is reasonably practicable, safe and without risks to health".**

In addition, Regulations arising from EC Directives must be adhered to. If the HASAWA or Regulations relating to health and safety are breached and an injury or loss occurs, the health care provider is open to a claim for negligence and the payment of compensation. The need to conduct workplace risk assessments is referred to in chapter 16.

Lifting and handling

Lifting and handling of loads can result in back injury and the loss of staff time. Back i injuries are a significant reason for staff sickness in health care. The Manual Handling Operations Regulations 1992 cover the lifting, lowering, pushing, pulling, carrying or moving of loads, whether by hand or other bodily force. It is often difficult to prove that a member of staff received training in lifting and handling procedures, since records often rely on the fact that lifting training is part of induction which all staff undergo and detailed records are not kept of the attendance of individual staff members at each induction session.

The Regulations require employers to take four key steps:

- avoid hazardous manual handling operations where reasonably practicable
- assess adequately any hazardous operations that cannot be avoided; unless the assessment is very simple, a written record of it is needed

- reduce the risk of injury as far as is reasonably practicable: for example, if the load is bulky or heavy it may be possible to use mechanical handling aids or break down the load, or reorganise the task

- take appropriate steps to provide general indications and, where reasonably practicable, precise information on the weight of the load and the heaviest side of any load whose centre of gravity is not positioned centrally.

The Regulations are supported by general guidance which includes some numerical guidelines which help to identify the more serious risks which deserve a more detailed assessment.

Unless adequate training, aids and assistance are available to staff when required to lift or handle, it could be considered that the HASAWA and the Regulations had been breached.

In the pilot studies, analysis of the questionnaire sent to staff revealed that **45% had not been trained by their current employer to lift** in a manner which avoids injury to themselves and **over 60% stated that lifting equipment was not readily available in their work area.**

Training in lifting and handling should cover not only the lifting of patients or clients by nursing staff but also the manual handling of loads by any member of staff. Portering staff should be particularly targeted, but there are examples of members of staff of all disciplines carrying heavy loads up stairs and from one area to another, for example, health records clerks.

Community nursing staff are also at high risk during their work in patients or clients' homes, not only from helping patients or clients to move but also from lifting supplies into and out of their cars.

The Health Services Advisory Committee of the Health and Safety Commission has produced "Guidance on the Manual Handling of Loads in the Health Service".

■ **Action points**

- **manual handling should be avoided as far as is reasonably practicable**

- **assessments should be carried out in accordance with the regulations**

- **training in lifting and handling and risk assessment should be given to staff as necessary**

- **appropriate lifting equipment should be provided for use by staff**

Protective clothing and equipment

Under the Personal Protective Equipment at Work (PPE) Regulations 1992, employers have a duty to provide suitable PPE free of charge to employees exposed to risks which cannot be adequately controlled by other means; such equipment should not be seen as a first line of defence.

Employers have duties to:

- assess the risks and PPE they intend to ensure that it is suitable
- maintain, clean and replace PPE
- provide storage for PPE when it is not being used
- ensure that PPE is properly used
- give training, information and instruction to employees on its use, purpose and how to look after it.

The wearing of suitable clothing, footwear and other equipment such as ear protectors contributes to a safe system of work and staff should be encouraged to wear appropriate clothing.

It is well known that some protective clothing is cumbersome, uncomfortable or just unflattering, and staff dislike wearing it. Managers should ensure that staff do wear the clothing which is provided. The onus in defending an action for negligence is on the manager to ensure that staff wear the clothing, not simply that it is available for use.

■ **Action points**

- **managers should ensure that protective clothing is available for staff and that it is in fact worn**

Personal safety

Issues concerning personal safety are also dealt with in chapter 11. The questionnaire surveys revealed that a high proportion of staff are concerned about their personal safety, particularly at night.

Community-based staff are particularly vulnerable, since they often leave no record at their base of their planned movements for the day ahead. Furthermore, there is often no requirement for them to report into base during the day to alert others to any problems. Peripatetic staff are vulnerable not purely to the risk of attack, but being unable to make contact in the event of illness, accident or breakdown, particularly in more rural areas. Some staff may have use of mobile telephones or carry bleeps. In instances where community staff are visiting a known problem location or client, they may work in a pair.

In many buildings used by health care providers, there are often panic buttons available for staff in sensitive areas, but it is important that these buttons do in fact work and that someone comes to their assistance if the button is used. It was reported that in one of the pilot sites response is either poor or non-existent.

It is an unfortunate fact of modern life that health staff may be exposed to aggression or more immediate personal threat, and managers should take steps to ensure that staff are protected as far as possible, and that they have the means to attract and receive support if in difficulty. Some health care providers arrange training in dealing with aggression, and consideration should be given to all staff involved with patients or clients and the public

receiving such training. A control strategy is included in guidance issued by the Health Services Advisory Committee of the Health and Safety Commission, entitled "Violence to Staff in the Health Services".

- **Action points**

  - **consideration should be given to communications technology to ensure that staff are able to summon assistance if required and to report their whereabouts**

  - **records of "mobile" staff movements should be maintained at a central location, as well as carried by the professional**

  - **consideration should be given to "Check-in" systems for mobile staff at the end of shifts**

  - **panic buttons should be in good order and clear instructions must be given to switchboard and other staff about the action to be taken if a panic button is activated**

  - **consideration should be given to training staff in techniques for coping with aggression and violence**

Confined spaces and heights

Working in confined spaces can give rise to risk in a number of different ways. When handling items in cramped surroundings, it is often difficult to manoeuvre and this can cause strains and other injuries. Where staff are working in confined spaces, there should be adequate ventilation, particularly if they are required to remain in these areas for long periods of time. Pressure on space in hospitals and other health care premises often means that offices are created from rooms which were intended for storage purposes or even from sanitary accommodation. These rooms may be windowless, and it is important to ensure that there is sufficient ventilation and that the lighting is appropriate to the type of work being carried out in the room. The Workplace (Health, Safety and Welfare) Regulations 1992 set out general requirements in respect of the working environment, and should be consulted.

In some buildings where there are no lifts, large items have to be carried up and down stairs. Staircases are often narrow and risks may arise when staff are carrying large or awkward items.

Frequently cramped storage conditions result in poor stacking of items, which may cause injury if they topple over, or items are stored on high shelving, with inadequate steps or stools provided for staff to access them, giving rise to injuries from over-reaching.

Staff working at high levels and using ladders should be trained in the safe use of equipment and care should be taken to ensure that there are always sufficient staff available to foot ladders and to enable work to be undertaken safely. Safety equipment such as harnesses and protective headgear should be worn at all times.

- **Action points**

  - **appropriate ventilation and lighting should be provided in rooms to which staff need to have access or in which they work**

  - **staff working in hazardous areas at high level should receive appropriate training and support**

Monitoring contractors

The activities of contractors should be controlled by a permit to work system which incorporates safety standards and the need for the use of personal protective equipment.

measures to control contractors and to monitor their work are dealt with in detail in chapter 12 of this manual; it should always be clear whose responsibility it is to ensure that contractors are working safely, without endangering themselves or others. The Management of Health and Safety at Work Regulations 1992 deal with the requirements for employers in relation to the activities of contractors.

CHAPTER 18

CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH

The Control of Substances Hazardous to Health Regulations 1988 (COSHH) came into effect in 1989. They were designed to control activities where exposure to substances over a period of time could lead to disease or ill health.

As well as considering the COSHH regulations, organisations must also consider specific regulations dealing with asbestos (Control of Asbestos at Work Regulations 1980 and 1987), lead (Control of Lead at Work Regulations 1980) and the Ionising Radiations Regulations 1985.

This chapter explains the actions which health care organisations should be taking to ensure compliance and minimise risk. It is divided into the following sections:

- employers' duties
- organisation
- assessments
- use, storage and disposal
- information and instruction
- gases and liquids

Employer's duties

Employers have a particular duty under Section 2 (2)(b) of the Health and Safety at Work etc Act 1974 to make "arrangements for ensuring, so far as is reasonably practicable, safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances". The COSHH regulations apply to substances which have already been classified as being very toxic, toxic, harmful, corrosive or irritant[1] and those which have maximum exposure limits or occupational exposure standards. COSHH also covers substances which have chronic or delayed effects (for example, carcinogenic, mutagenic or teratogenic). A substance hazardous to health is not just a single chemical or compound, but also includes mixtures of compounds, micro-organisms, allergens, and nuisance dusts.

Protective clothing must be provided for staff involved with handling contaminated articles or substances; masks and gloves should be provided and staff should be given instruction in the correct use of them.

The COSHH regulations place specific duties on employers:

- assessments (Regulation 6)
- prevention or control of exposure (Regulation 7)

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[1] Chemicals (Hazard Information and Packaging) Regulations 1993

- use of control measures and maintenance, examination and test of control measures (Regulations 8 and 9)
- information and training (Regulation 12)

In addition, **monitoring exposure** at the work place (Regulation 10) is a duty "where requisite" and **health surveillance** (Regulation 11) is a duty "where appropriate".

These duties do not apply only to staff, they apply "in respect of employees and, other than health surveillance, to all people in the premises so far as reasonably practicable". Assessments, prevention/control of exposure and use of control measures (Regulations 6 to 9) apply to other people likely to be affected by work "so far as reasonably practicable".

Organisation

It is important that it is clear who is responsible for initiating and co-ordinating the action required by the COSHH regulations and one person should be designated in this role. Each department should have a nominated COSHH assessor, who should be trained. In the pilot studies, assessors had been nominated and had received some training, but several assessments had not been completed, or had been incorrectly completed.

The COSHH regulations are legally binding, and it is important that they are taken seriously.

■ **Action points**

- **a named individual in each organisation should be responsible for co-ordinating the action required by COSHH regulations**

- **each department should have a nominated and trained COSHH assessor**

Assessments

The purpose of a COSHH assessment is to enable a valid decision to be made about measures necessary to control exposure to substances hazardous to health arising from any work, both routine and non-standard. It also enables the employer to demonstrate both to themselves and others, that all the facts pertinent to the work have been considered. A suitable assessment should include an **assessment of the risks** to health, the **steps which need to be taken** to achieve adequate control of exposure and **identification of other action necessary** to comply with Regulations 8 to 12.

After initial assessments have been completed, reviews should be carried out at least every five years to ensure that they are valid and that there has been no significant change in the work to which the initial assessment relates.

Of the staff responding to the questionnaires in the pilot sites, over 60% said that no COSHH assessment had been carried out in their place of work. The work at the pilot sites also revealed a number of different assessment forms in use. Assessments forms should be standardised. In general, those initial assessments which had been completed had not been reviewed and there was no programme for doing so.

COSHH assessments should be easily accessible in the appropriate work place and staff should be familiar with COSHH and its implications.

Time should be allowed for the completion of COSHH assessments and the people undertaking them should be suitably trained. In the pilot sites, several common shortcomings were noted:

- assessment forms not describing in detail the nature of the task being undertaken or the hazards associated with the substances
- failure to provide information on the monitoring of exposure levels in the workplace
- failure to detail the maximum exposure limit or occupational exposure standards of substances being used
- failure to provide information on maintenance checks required for equipment and the location of maintenance records
- failure to identify the type of ventilation required, specific types of protective equipment and whether health surveillance was appropriate
- failure to include all the hazardous substances used in the department.

Assessment forms should be properly completed, by people trained to do so.

■ **Action points**

- **assessment forms should be standardised throughout each organisation**
- **if initial assessments have not yet been carried out, this should be undertaken immediately**
- **assessments should be reviewed regularly**
- **assessments should be available and accessible in each workplace**

Use, storage and disposal

Some substances which are covered by the COSHH regulations are widely used, and often no attempt is made to reduce or eliminate their use. Wherever there is an acceptable alternative, positive steps should be taken to reduce or eliminate the use of the hazardous substance.

One of the major hazards arising from the use of these substances is the lack of adequate ventilation. Many substances give off vapours which can cause ill effects, but the project teams observed several areas on the pilot sites where there was no, or inadequate ventilation. This was particularly evidence in dental suites, both in hospital and community, where methyl methacrylate is used. There was inadequate protective clothing for staff using this substance and there was no extraction chamber. Another substance known to be a sensitiser of skin or respiratory tracts is glutaraldehyde, the use of which should be carefully controlled.

Lack of ventilation was a problem also in areas where plaster of paris is used, and in chiropody suites.

Hazardous substances should be stored in appropriate containers and areas. Although strictly speaking not subject to COSHH, it should be mentioned that flammable liquids should be stored in flame-proof cupboards which should be kept locked and closed. At the pilot sites, chemical solutions were often found stored on the floor under sinks, or on high shelves, with risk of unauthorised access or tamper. Care should also be taken not to store incompatible substances in close proximity to each other, for example acids and oxidising agents.

- **Action points**

  - **wherever possible, hazardous substances should be phased out and eliminated**

  - **adequate ventilation should be in situ where hazardous substances are used**

  - **substances should be stored in appropriate containers in a secure environment**

  - **temperatures in refrigerators should be checked and recorded regularly**

Information and instruction

Employers have a responsibility to provide staff who may be exposed to substances hazardous to health with such information and instruction as is suitable and sufficient (Regulation 12). This should include making available information regarding the risks to health created by exposure, and instructions on procedures to be undertaken when using and disposing of substances, how to deal with spillages and what to do in an emergency.

Questionnaires completed by staff at the pilot sites revealed that one third of them have not received information about COSHH regulations.

- **Action points**

  - **managers should ensure that staff have available to them suitable information on risks and procedures relevant to hazardous substances in each work area**

Gases and liquids

Gas cylinders, whether full, partially full or empty are a significant hazard. Incorrect storage of cylinders can result in injury from falls and an increased risk of fire or explosion. It is important that cylinders are correctly secured, in most cases chained upright, although some, including Entonox, should be supported horizontally.

Examples of incorrect storage are stacking cylinders unsecured in porches outside buildings. Storage in cages outside may make them vulnerable to damage from vehicles if the location is not carefully chosen.

Liquid nitrogen is commonly used, but it should be stored securely and locked.

Scavenging systems in operating theatres should be regularly monitored to ensure that waste anaesthetic gases are being effectively removed. Occupational exposure limits for anaesthetic gases are due to come into effect during 1994.

- **Action points**

  - **gas cylinders should be stored where they cannot be damaged or pose a threat to people or property**

Managers may find COSHH - Guidance for the Initial Assessment in Hospitals (HMSO) useful.

CHAPTER 19

RISKS ARISING FROM FAILURE TO PROVIDE INFORMATION, INSTRUCTION, TRAINING AND SUPERVISION

If staff are to be expected to act in an appropriate way, they must receive the information and training necessary for them to be able to understand their obligations.

This chapter deals with training and information, with special emphasis on:

- induction training
- lifting and handling training
- food and hygiene
- other training
- policies and procedures

General training issues

The duty of the employer under Section 2 (2)(c) of the Health and Safety at Work etc Act 1974 is to provide "such information, instruction, training and supervision as is necessary to ensure, so far as is practicable, the health and safety at work of his employees". This obligation is reinforced by the Management of Health and Safety at Work Regulations 1992.

In order to provide an adequate defence to an allegation that this duty had been breached, the employer would have to show not only that training was provided, but that courses had been held, the contents of the course, and verification of an employee having attended. It is good practice to include a statement from the trainee confirming that he or she feels competent and confident to perform as trained, and to give the opportunity to state additional training required.

There is evidence that some training departments do not keep details of courses and attenders in the form of a signed register, and it is advisable for it to be clear whose responsibility it is to record attendances at training courses.

- **Action points**

  - **attendance at training courses should be recorded, staff attending should sign a register and a statement of understanding and competence**

Induction training

The type of induction training varies from site to site, and certain types of staff, particularly medical staff, may not receive induction training. Policies vary, with some preferring to hold induction courses some weeks after employment starts and others putting the new recruit into the classroom straight away. Another variation is immediate local induction training from the line manager, in conjunction with an organisation-wide orientation course.

There is no clear consensus of opinion as to the best form of induction training, but what is important is that there should be a policy which is observed by all managers. Induction training should contain, at the minimum, detailed information on fire, health and safety and security. Some health care providers supply new staff with a handbook, which sets out policies and procedures in use and may include health and safety information. This can prove invaluable for later reference as the sheer volume of information delivered on induction days cannot easily be retained by staff. Such handbooks should be regularly revised to take account of changes. Induction training should be given to all staff working within a unit, including staff of contractors such as domestic or catering. If induction training for contractors' staff is not delivered by the health care organisation, it is advisable to check the content of such training.

- **Action points**

  - **all staff should receive induction training at the earliest opportunity**

  - **consideration should be given to supplying all staff with a regularly updated handbook**

Lifting and handling

The importance of training **all** staff in lifting and handling has been mentioned earlier in this manual. The training should be carried out by qualified staff and managers should ensure that all their staff receive training and updating from time to time.

Staff working in the community are at high risk of sustaining injury from lifting and handling patients or clients, since they often work alone and in less than ideal environments. Particular attention should be paid to their training needs.

Other people working within health care organisations are involved in patient or client care. Consideration should be given to providing lifting training for volunteers, if they are involved in any manual handling activities.

- **Action points**

  - **training in lifting and handling should be given to all staff**

Food and hygiene

Hospital patients are particularly vulnerable to the effects of food poisoning and it is essential that all health care providers have policies and procedures to minimise the danger and meet the requirements of legislation[(1)].

As stated in chapter 15, all members of staff involved in food handling, including porters, domestic staff, nurses and volunteers, should receive training in food hygiene and this should be updated regularly. Staff preparing breakfasts and snacks in ward kitchens are now covered by the Food Safety Act 1990 and should be suitably trained in food hygiene. In

(1) Food Hygiene (General) Regulations 1970, Food Safety Act 1990, Food Hygiene (Amendment) Regulations 1990 and 1991

some units, staff have been encouraged to train for and seek hygiene certificates; this is good practice and should be used more widely.

■ **Action points**

- **managers should be aware of the scope of the food hygiene regulations and ensure that staff are trained**

Other training

Training in numerous other subjects should be provided, but special mention should be made of training staff to cope with aggression or violence, whether verbal or physical (see also chapter 17).

Many staff will find themselves faced with angry patients, visitors and others and it is important that they are able to react in an appropriate and confident way. Dealing appropriately with aggression will often defuse the situation and will prevent complaints or, at worst, violence.

Training in communication/negotiation skills will help staff in the first line of customer contact, for example receptionists, and staff who may have to restrain or control patients or clients should also be suitably trained in the techniques to be used.

■ **Action points**

- **consideration should be given to providing appropriate levels of training for staff in techniques of dealing with physical and verbal aggression**

Policies and procedures

Chapter 29 gives guidance on policies and procedures. It some departments, appropriate policies may be displayed on notice boards, or left in accessible positions so that staff may refer to them.

In some subjects, it may be preferable for summary leaflets to be produced for each member of staff.

In summary, policies should be:

- clear
- up to date
- accessible
- understood
- monitored
- reviewed

- **Action points**

  - **the recommendations in chapter 29 on policies and procedures should be implemented**

CHAPTER 20

RISKS ARISING FROM FAILURE TO PROVIDE A SAFE PLACE OF WORK

Employers have a duty to provide a safe place of work. This chapter highlights:

- the statutory duty
- some common hazards which could be avoided.

The duty of employers

Section 2 (2)(d)i of the Health and Safety at Work etc Act 1974 gives employers the duty to ensure **"so far as is reasonably practicable as regards any place of work under the employers control, the maintenance of it in a condition that is safe and without risks to health and the provision and maintenance of means of access to and egress from it that are safe and without such risks"**. A breach of this duty could support an action for negligence. Again, the Management of Health and Safety at Work Regulations 1992 have embraced this principle and set out broad general duties.

It is important to remember that hospitals and other health care premises are not only places of work, they are visited by very many people, some of whom may be particularly vulnerable by reason of age or infirmity. Particular care should be taken to ensure that visitors are not endangered.

Some common hazards

Some common hazards which are likely to cause injury and give rise to claims are:

- **wet or slippery floors**

  Many accidents are caused by people slipping on wet floors. Care should be taken to wipe up spills of liquid immediately and to put out warning signs where floors are wet. It is common practice for cleaners to have warning signs available for their use, but this is not always the case in, for example, ward areas, in the event of spillages.

  Staff who work in areas which are frequently damp underfoot should be provided with non-slip footwear.

  Care should also be taken where elderly or otherwise less mobile people are concerned since shiny floors, even when dry, present a visual obstacle which causes anxiety and may limit mobility.

- **trailing cables**

  With the large amount of electrical equipment in use in health care premises, there are a considerable number of cables which can trip the unwary. Cables for static equipment should be secured away from areas where people may trip over them or pull them, causing accidents. Children are particularly vulnerable to trailing leads. Cables on mobile equipment such as cleaning machines should be kept free from knots and

kinks and the operators should take care to ensure that they do not endanger people; warning signs can be useful.

It is not uncommon to find covers fitted to electrical plug sockets to prevent children inserting their fingers, or other objects, with a risk of electrical shock. This simple precaution is worthy of serious consideration.

- **poor lighting**

  Unsuitable lighting may contribute to eyestrain, other health problems and accidents both inside and outside buildings, and compound a security risk.

- **obstructions**

  Corridors are often seen to be obstructed with cardboard boxes, chairs or bulky equipment. This is hazardous in the context of fire precautions as well as general safety, and circulation areas should not be obstructed in this way.

- **faulty floor coverings**

  Frayed or uneven carpets or other floor coverings present a hazard to both staff and patients or clients. A reporting system should be introduced for such faults, and action taken rapidly to correct them.

  Minor hazards such as these can cause major injury, and a system should be devised, with the maintenance department, to ensure that they are repaired rapidly, promoting prompt reporting of future defects.

- **furniture and equipment**

  It is not uncommon to find furniture or equipment in a poor state of repair, either still in use, or removed from use, and inadequate precautions taken to ensure that it is not utilised again until it is repaired or disposed of. As with faulty floor surfaces, an effective system for the reporting and repair of such defects is required to prevent subsequent injury.

- **decorative features**

  Managers should bear in mind that attractive architectural or landscaping features such as open stairwells or ponds can present a serious hazard, particularly to children. Precautions should be taken to ensure that the risk is minimised.

- **exterior hazards**

  Potholes and other faults in roads and footpaths can give rise to a number of accidents, often resulting in personal injury and a claim for compensation. While road and footpath maintenance can be expensive, the cost should be weighed against the cost of claims for personal injury. It is also possible that regular documented inspections of the grounds are not made, weakening any defence to such claims.

In icy weather, footpaths and steps should be gritted and it should be clear whose responsibility it is to do this. When there is snow on the ground, the snow should be cleared first and the surface then gritted. It is important that the staff carrying out these duties are properly trained in the techniques to be used; a haphazard attempt to clear a path may lead to the health care provider being held liable for any injury which may occur.

- **disused buildings and building sites**

  These often are to be found in units undergoing a period of contraction, before vacating the site entirely, or in new developments. Both present a considerable attraction, not only for vandals but also for child trespassers, who may view them as adventure playgrounds. It is also not unknown for dens to be set up in underground service ducting systems. Care should be taken that such areas are adequately secured.

■ **Action points**

- **warning signs should be available and displayed advising of hazards such as wet floors**

- **electrical cables should be secured so that they do not present a trip hazard**

- **electrical plug sockets covers should be fitted in areas where there are likely to be children present**

- **corridors and circulation areas should be kept clear of obstruction**

- **simple and effective reporting systems should be in place to report all potential hazards**

- **furniture and equipment in need of repair should be removed from use and stored appropriately**

- **staff clearing paths and roads should be trained in appropriate effective techniques**

- **all building sites, disused buildings and underground ducting systems should be adequately secured against child trespassers**

CHAPTER 21

IDENTIFYING RISKS TO HEALTH

This chapter outlines the duty of employers to provide an environment without risk to health, and identifies the following main areas to which attention should be given:

- visual display units (VDUs)
- ventilation and extraction
- noise
- immunisation
- occupational health and first aid

Employers' duty

Employers have a duty under the Health and Safety at Work etc Act 1974 for the "**provision and maintenance of a working environment for his employees that is, as far as is reasonably practicable, safe, without risks to health and adequate as regards facilities and arrangements for their welfare at work".**

In addition to the Act, there are not a number of Regulations which have a bearing on the health of employees, and managers should ensure that they become aware of new regulations issued from time to time.

Visual display units (VDUs)

The increasing computerisation of activities in health care organisations has resulted in large numbers of staff now operating from VDU terminals. The Health and Safety (Display Screen Equipment) Regulations 1992 on VDUs and the ergonomics of work stations came into effect from January 1993, but up to four years is allowed for the upgrading of existing work stations. Within the regulations are set out the employer's duties to:

- assess display screen equipment work stations and reduce risks which are discovered
- ensure that work stations satisfy minimum requirements which are set for the display screen itself, keyboard, desk and chair, working environment and task design and software
- plan display screen equipment work so that there are breaks or changes of activity
- provide information and training for display screen equipment users.

Display screen equipment users are also entitled to appropriate eye and eyesight tests by a suitably qualified optician or doctor, and to special spectacles if they are needed and normal ones cannot be used. It is the employer's responsibility to provide tests, and special spectacles if needed.

Managers should ensure that assessments are carried out of all work stations by staff who are trained to carry out such assessments.

When purchasing or replacing workstation equipment, care should be taken to ensure that the equipment which is obtained complies with the requirements of the Regulations.

Ventilation and extraction

Adequate hearing and ventilation are necessary in any building providing health care, both for the provision of pleasant working conditions and the prevention of the spread of infection. In some treatment areas, sterilisers and electrical equipment are used, which lead to a build-up of heat. Security considerations can often make it difficult to provide natural ventilation so it is important to consider mechanical ventilation in order to provide adequate working conditions.

It is well known that overheating and poor ventilation can produce symptoms of fatigue and tiredness, together with minor ailments which prevent staff from performing at their optimum level.

Many procedures in hospitals and health centres lead to the production of chemical fumes and dust which can lead to health problems unless they are removed effectively from the air. Care should be taken to ensure that scavenging systems in operating theatres are adequate and that monitoring of air changes is performed regularly. Similar considerations apply in other departments such as radiology where chemical fumes are produced by developing of films and in pathology laboratories where the efficacy of fume cupboards should be monitored regularly.

Noise

The 1989 Noise at Work Regulations include a general requirement to reduce the risk of hearing damage to the lowest level reasonably practicable. To establish the level of exposure to noise, employers should arrange for noise assessments to be conducted by a competent person, and adequate records kept.

The importance of staff wearing protective clothing and equipment was emphasised in chapter 17. This should include ear protectors.

Immunisation

Health workers are particularly at risk of contracting infectious diseases through their work and there is in turn a risk that they will pass on infections to patients or clients.

The immunisation status of all staff should be checked when they are first employed, and appropriate immunisation should be offered.

The high profile of hepatitis B in recent years has led to employers offering protection to workers whose job brings them into contact with potentially infectious situations. The coverage of staff should be monitored and consideration given to offering protection to workers such as porters and domestic staff who may be required to carry clinical waste. Guidance is available in HSG(93)40, which underlines the importance of immunising all staff exposed to blood and body fluids, particularly those involved in "exposure prone procedures".

Occupational health and first aid

Staff in the health services account for some 75-80% of all expenditure, and it is advisable to provide the services necessary to protect this investment and reduce the amount of days lost due to sickness. Pre employment health checks and screening may give advance warning of potential problems, and avoid selection of staff who are not fit for the position applied for .

Most health care providers have access to occupational health services for their staff, but the amount and quality of cover is variable. It is important that occupational health physicians and nurses are suitably qualified and experienced.

Occupational health departments should be located where staff can easily use them, and should be manned at all times during the working day, with special arrangements to cater for the needs of shift workers. Departments can offer a range of services from pre-employment health screening through to full management of staff health, including eye tests, dental checks, holiday immunisation and healthy lifestyle promotions. Departments may also take a lead in health and safety issues highlighted in this and preceding chapters if their workload permits.

The availability of first aiders is variable. Some health care providers fund first aid training for staff and this is to be encouraged. Health premises should, ideally, have a trained nominated first aider in each department and the first aider should take responsibility for maintaining first aid boxes within their area of work. Minimum requirements are set out in the Health and Safety (First Aid) Regulations 1981.

Consideration should also be given to providing classes in resuscitation techniques for all staff who wish to take part. This, and first aid training for other than designated first aiders, can be an income generating or at least self-financing activity.

Much attention is given to the place of stress in the modern lifestyle. Staff providing health care can be under stress for a variety of different reasons and the level of stress can become damaging. Some health care providers have a confidential counselling service available to staff and also run stress management courses and workshops. This is to be commended.

- **Actin points**

  - **assessments of computer work stations should be carried out by appropriately qualified staff and action taken to correct deficiencies**

  - **staff working at VDUs should be offered vision tests**

  - **steps should be taken to ensure that there is adequate ventilation, extraction and temperature control in working areas**

- **in areas where there is felt to be a high level of noise, noise assessments should be carried out by competent people; and staff should be advised or encouraged to wear ear protectors as appropriate, if it is not possible to achieve a sufficient noise reduction at source**

- **the immunisation status of all staff should be established, and reviewed regularly**

- **initiatives to improve the general and specific health of staff should be encouraged**

CHAPTER 22

RISKS OF AN ORGANISATIONAL NATURE

The last few chapters have highlighted specific areas of risk identification. This chapter refers to a variety of risks which can be classified as organisational:

- communication
- liability from the provision of goods and services
- cross liabilities in respect of shared premises, staff or services
- information systems

Communication

Breakdowns in communication can often be an underlying, or even primary, cause of clinical negligence. The lack of communication or the passing of inadequate or incorrect information by one member of the clinical team to another can lead to a fundamental systems failure, as can insufficient explanation of the options for treatment and likely outcomes by a clinician to a patient. It is important to ensure that a good communications system is in place within the clinical departments and that clinicians communicate well with patients or clients and with their colleagues in other departments.

The way in which managers communicate with their staff has an effect on the efficiency of the organisation and therefore on the risks to patients or clients, staff and others. Organisations are held together by their communications structure; it follows that any weak link in the chain reduces the strength of the whole.

Prompt communication of adverse incidents is vital if there is to be maximum opportunity to investigate the cause of incidents and reduce the cost of any consequent action and prevent their recurrence. Incident reporting is dealt with in detail in chapters 25 and 27.

Provision of goods and services

The Consumer Protection Act 1987 places strict liability for injury resulting from a defective product on the ultimate suppliers, but if he cannot be identified liability rests with the nearest source to the supplier which can be identified. In many cases this will be the producer, which includes those who manufacture an item using components or ingredients supplied to them by others.

Many health care providers supply services to other organisations, from laundry to sterile supplies, and managers should take into account their liability exposure; for example hospitals and other health organisations which manufacture drug compounds or food products should be aware of their potential liability. Similarly, indemnities should be sought from other contractors operating on the site.

Cross liabilities in respect of shared premises, staff or services

In some health centres, general practitioners lease rooms for use as surgeries. Some hospitals and other health care premises hire rooms to other organisations for their use. Similarly, health care providers may operate from premises owned by other organisations such as local authorities. It is not always the case that such usage has been formally documented, explicitly setting out the terms and conditions of the lease or licence.

Care should be taken to ensure that proper agreements are drawn up for the use of premises and kept up to date, with rents reviewed at regular intervals.

Difficulties can arise where other users, for example GPs, bring into use equipment and substances without reference to the owner or to other occupiers. many managers are unaware of the terms of the leases and are unsure of their duties and responsibilities, such as who arranges for any repairs needed to the property.

It should be clear as part of the lease agreement that the policies and procedures of the owner of the premises will be adhered to.

This situation can be complicated further in the case of community homes which are staffed jointly by health and social services staff, and the issues of control and responsibilities may be unclear, and should be resolved by establishing clear written agreements.

It is of particular importance to note that under Section 4 of the National Health Service and Community Care Act 1990 normal contractual relationships are altered. Essentially, in any contract for the "provision of goods or services which it reasonably requires for the purposes of its function" between two Health Service bodies, no contractual rights and duties will be enforceable through the courts. Instead, any disputes must be settled by referral to the Secretary of State for determination.

Finance and insurance

It is common in health care premises for there to be no up to date inventory of equipment and other items with a value less than £1,000. In many cases, there are no central records of losses from theft or vandalism. If health care providers wish to seek insurance, insurers will want to know the historic frequency and cost of claims, so it is important to keep records of all property loss or damage, however small.

The subject of insurance was dealt with in more detail in chapter 2.

Information systems

Health care providers use a wide variety of information systems, many of which are computerised. Care should be taken to ensure that all data is safeguarded and access restricted to authorised persons only. Backups of information should be made at regular intervals and securely stored.

There have been successful prosecutions of public bodies for the illegal use of computer software, and managers should ensure that all software has the appropriate licences, and that the requirements of the Data Protection Act are complied with.

- **Action points**

  - **attention should be given to the communication mechanisms within each health care organisation, between professionals, between professionals and patients or clients and between management and workforce**

  - **hospitals and other health care providers who supply goods or services to other organisations or individuals should be aware of their potential liability under the Consumer Protection Act 1987 and take suitable precautions to safeguard their position**

  - **leases and other agreements for the use of premises should be drawn up with professional legal advice and managers of relevant departments should be fully conversant with the terms of leases and understand their powers and responsibilities**

  - **care should be taken to ensure that information systems are secure and that computer software has the appropriate licences.**

CHAPTER 23

METHODOLOGY USED FOR IMPLEMENTING A RISK MANAGEMENT PROCESS IN PILOT PROJECTS

Following analysis of the risk situation in the two pilot projects, the project teams assisted with the evolution of a risk management process in the two units. This chapter details the methodology used:

- team selection
- training the team
- decision making process by pilot project teams

These principles are explained more fully in following chapters of this manual, with guidance on how a comprehensive risk management process can be introduced into any health care organisation. However, it must be understood that risk management must be a fundamental responsibility of every line manager, who must understand and own the concept. a risk management team is vital in advising and supporting the line managers.

Team selection

There is no blueprint for the membership of a risk management team which will be appropriate for every health care organisation. The two pilot projects differed considerably.

Establishing a risk management team provides a focus on risk and brings together with relevant expertise which already exists within health care providers. While continuing to work in their existing roles, the individuals who make up the risk management team will pool information and expertise to provide a cohesive, organisation-wide strategy.

On the pilot sites, there were a variety of people whose experience, position within the organisation and personal qualities made them suitable to form the focus of the risk management approach. There is no "magic number" or critical mass for such a team, and the right configuration will depend on the management arrangements of the unit concerned and the qualifications and interests of people in post.

Training the team

The risk management team should receive specialist training in risk management techniques, which are outlined in chapters 2, 3 and 4 of this manual and given in more detail in chapter 27.

In the pilot projects, one risk management team received three weeks of development, planning, tuition and support to enable them to implement risk management. The three one-week modules were not run consecutively, but over a three month period. The other team undertook the two periods of theoretical training described below.

During **Phase I, Introduction and planning,** risk management professionals provided an introduction for the risk management team leaders to the breadth and depth of the subject of risk management. Eight study areas were introduced and explored (see below). Plans were

made for the programme for implementing risk management, including the raising of staff awareness, adopting an incident report process and refining/developing systems for claims handling. Proposals were then submitted to the chief executive for approval.

In **Phase II, Development**, intensive technical sessions were held with the risk management team, transferring specific information and instruction on the eight study areas to enable a pool of expertise to develop.

Phase III, Practical Implementation, consisted of practical sessions to apply the theoretical skills learned in phase II. This included conducting risk awareness training, risk audits and practical contingency disaster planning.

The eight key study areas were:

risk management structure
reporting and communication
tracking, trending, monitoring and projection
investigations and administration of untoward incidents
education programme
standards, policies and procedures
risk control objectives
contingency/disaster plans

These key elements are explained in detail in chapters 24 to 31.

Decision making process

The widely differing nature of trusts and directly managed units in itself reflects the fact that no single approach will be appropriate in all organisations.

Team leaders within the organisation are best placed to tailor the assimilation of risk management activity, and the responsibilities of the group, individual officers and each and every member of staff within the organisation. The result should be to produce a risk management strategy setting out aims, objectives and responsibilities, to be distributed to all staff following ratification by the chief executive.

CHAPTER 24

IMPLEMENTING RISK MANAGEMENT

This chapter sets out the organisational structure for the most effective implementation of risk management. It deals with:

- the role of the chief executive
- designation of a risk manager
- integration of risk management with line management and special interest groups and departments
- training, reporting lines and scope of influence of the risk management team
- changing the culture

Role of the Chief Executive and designation of a risk manager

The overall responsibility for the management of risk rests firmly with the chief executive of the organisation concerned. To be effective, risk management requires the commitment of the chief executive and this must be communicated throughout the entire organisation by a structured approach.

To make risk management effective, it is advisable to have one member of staff designated as the risk manager for the organisation. The professional background of the individual is less important than their personal qualities, particularly effective communication, attention to detail and commitment to risk management principles.

Integration of risk management with line management and special interest groups and departments

Establishing a risk management team provides a focus on risk and brings together the relevant expertise which already exists within health care providers. While continuing to work in their existing roles, the individuals who make up the risk management team will pool information and expertise to provide a cohesive, organisation-wide strategy.

Membership of the risk management team will depend on the management arrangements of the unit concerned, but it should include at a minimum the manager with prime responsibility for risk management, together with clinical staff representation and estates management. It could be beneficial to have a representative of the finance discipline so that early warning can be given of potential cost of risk. The breadth of experience of administrators should not be overlooked, as many have gained a variety of skills.

Special relationships should also be established with certain other relevant disciplines; these relationships should be with departments whose primary activity may or may not be obviously related to risk management but whose expertise can be usefully employed in the design of a risk management programme. The other disciplines will also benefit from the information collection and analysis undertaken by the risk management team.

Special relationships might be formed with, for example:

- complaints and legal claims staff
- information services manager
- contracts manager
- fire prevention manager
- occupational health
- security
- pharmacy
- infection control

This is by no means an exhaustive list.

It is imperative that the establishment of a central risk management team is not seen as an opportunity for individuals to abdicate their own responsibility for risk management. The aims of the risk management programme, and the roles and responsibilities of all the individuals in an organisation, should be clearly defined in a risk management statement.

Training the team

The risk management team should receive specialist training in the eight key elements of risk management which were mentioned in preceding chapters. Chapter 25 to 31 deal with the key elements in more detail, but a brief resume is as follows:

- **risk management structure**

  successful implementation of risk management requires the absorption of the principles of risk management into the corporate structure. Reporting lines, implementation and support issues must be identified, refined and submitted to the management team for approval;

- **reporting and communication**

  reporting and communication must be addressed in depth to ensure that effective transfer of risk related information occurs. There are different models available commercially which can be used (see chapter 25);

- **tracking, trending, monitoring and projection**

  training should be available to provide tuition to several members of the risk management team in specific areas of risk analysis. This will include various risk identification methods, including multi-disciplinary audit and historical incident analysis (see chapters 3 and 26);

- **investigations and administration of untoward incidents**

  training can be given which is designed to provide a claims protocol and an incident investigation protocol. This would include examination of several issues, including the gathering of witness statements and appropriate post incident activity (see chapter 27);

- **education programme**

  education needs will become apparent during the earlier phases of implementation; emphasis may be placed on health and safety or fire prevention training, or imply on risk awareness education (see chapter 28);

- **standards, policies and procedures**

  standards, policies and procedures are the basis for good risk management and they create an opportunity for potential liability to be defined. This subject is dealt with in detail in Chapter 29;

- **risk control objectives**

  this category covers the aims of risk management, risk control methods,cost benefit analysis and prioritisation (chapter 30);

- **contingency/disaster plans**

  it is important to consider the internal and external vulnerabilities which may give rise to a major incident and to prepare the procedures which will enable the health care provider to deal effectively with such circumstances. This area is dealt with in more detail in chapter 31.

Changing the culture

Moving to effective risk management needs a change in the culture of most health organisations. The new culture must be one of openness and willingness to admit mistakes, without any fear of punitive measures. The culture of the organisation must not allow staff to feel that they are "telling tales" about their colleagues and the procedure must not be seen as punitive.

The chief executive should set the example for a change in culture to one of openness and willingness to admit mistakes.

The key features needed for the successful implementation of risk management were identified by the risk management teams themselves: a change in attitudes and culture throughout the organisation, and commitment from all staff.

■ **Action points**

- **the chief executive should actively promote positive risk management initiatives**

- **a risk manager should be designated**

- **a risk management team should be established and receive suitable training**

- **a risk management strategy outlining aims, objectives and responsibilities should be devised and implemented**

CHAPTER 25

REPORTING AND COMMUNICATION

It is fundamental to an effective risk management programme that potential risks and actual incidents are reported to management and that appropriate follow-up action is taken.

The chapter identifies steps to ensure effective reporting, under the following headings:

- immediate action
- the scope of and need for reporting
- forms
- routes for communication
- collation and analysis of information
- action
- feedback

Immediate action

The action taken by staff and managers immediately after an untoward incident can significantly affect the outcome. If the injured party receives sympathy, counselling and support, the risk of a legal claim ensuing is much reduced. However, this must be done sensitively and without admission of guilt in circumstances where there may, legally, be no negligence. Clear procedures, supported by training of managers, will facilitate good practice and minimise the incidence of legal claims.

The scope of and need for reporting

Incident reporting should cover **all areas, including fire, theft, assault, employee accident and patient or client injury, together with adverse patient or client incidents**. Statistical evidence demonstrates that it is the clinical areas from which health care providers suffer their greatest individual financial losses. Additionally, accidents to staff can result in expensive claims; investigating potential claims at the incident stage could facilitate the defence of future claims and thus reduce costs.

The first notification of a claim is often in the form of a solicitor's letter, sometimes a year or more after the date of the occurrence. Prior notice is not commonly provided by a hospital's traditional incident reporting system, and as a result the health care provider is at a great disadvantage in defending a claim. It is extremely difficult to reconstruct details of the occurrence several years later: health records may be unavailable, witnesses or staff move on, individuals relocate and memory fades. These factors make the development of a successful defence much more difficult. Although in many areas complaints procedures have facilitated earlier investigation, the centralised reporting of adverse clinical events is comparatively rare.

It is essential not only that all incidents which may give rise to a liability claim are reported, but that they should be reported promptly and in a manner which allows for the appropriate information to be gathered and preserved against the possibility of future legal action. Reporting of near misses where there has been no actual injury or loss may enable appropriate action to be taken to prevent future incidents.

Early identification of potential liabilities will not only affect the outcome and cost of liability claims, but will also lead to early identification of systems, practices or equipment which are not contributing to the highest standard of patient or client care.

Forms

Busy staff often resent the additional workload imposed by reporting incidents, some of which may appear to be trivial, so it is important to ensure that methods for reporting are as simple as possible and take minimal time to complete.

Conventional reporting systems require the incident reporter to send forms in a variety of different directions. A standardised reporting system using no more than two forms, one for actual or potential personal injury and one for property, is recommended. Incident forms should be completed promptly at the management or supervisory level and sent to a designated person who will take the necessary actin. Wherever possible, staff who may be involved in completing incident report forms should receive training in the purpose for which the forms will be used and in how to fill them in. Written guidelines may be useful.

Routes for communication

Chapter 24 highlighted the importance of having one person designated as the risk manager for each health care organisation. All incident reports should be routed through a designated individual, whose responsibility it will be to ensure that appropriate people are informed and witness statements obtained where necessary. Staff completing incident forms should not be expected to decide which managers and departments need to receive the information; that is for the risk manager to decide, in the light of the risk management procedure which operates within the organisation.

Collation and analysis

The designated person will scan the forms and analyse the details. A computerised database is a good method to use for recording details of incidents, since it allows easy preparation of summary information and facilitates trending and tracking (see chapter 26). Untoward incident reporting systems are available commercially, together with supporting computer software.

Regular reports on actual or potential incidents should be prepared by the risk manager and submitted to the chief executive. It may be useful to distribute a regular bulletin throughout the health care organisation to promote awareness of risk management and thereby increase reporting of incidents.

Action

The incident form manager will scan the forms and will refer action to the appropriate individuals. He or she will operate a system which allows action to be followed up and logged. Asking people to take action without ensuring that it has taken place will not be enough to convince a Court that the health care provider has taken adequate steps to deal with a hazard.

Feedback

In order to promote confidence in the reporting system, it is important that the reporters of incidents are advised of the action which is taken as a result of their report.

- **Action points**

  - **a procedure should be devised and implemented, covering the actin to be taken by line managers in the event of an incident involving actual or potential injury, loss or damage**

  - **all incidents involving actual or potential injury, loss or damage should be reported immediately**

  - **a simple reporting procedure using no more than two forms should be introduced**

  - **a designated individual should be responsible for initiating further communication or enquiries and ensuring that appropriate action is taken**

CHAPTER 26

IMPLEMENTING RISK MANAGEMENT - TRACKING, TRENDING, MONITORING AND PROJECTION

This chapter outlines the techniques which can be used in controlling risk management activities. It covers:

- tracking
- trending
- monitoring
- projection

Tracking

Tracking is the recording of data, and assimilation of information, enabling patterns to be observed. There are two main methods of tracking: through manual systems or through computerised systems, used to establish the frequency of one or more criteria.

The foundation of a good tracking system is a comprehensive incident reporting system and this has been covered in the last chapter. Comprehensive systems are no use, however, if the information gained is not used; for information to be used, it must be recorded in a way which allows it to be accessed easily and manipulated against different criteria.

Although it is possible to have such a system operated manually, it is much more flexible if computerised. This can be done relatively inexpensively on a personal computer with an appropriate software package.

Trending

Trending is the comparison of information produced in tracking reports over a period of time.

When a normal pattern has been established, a rise in incidents in a given areas, or at a particular time of day should become apparent, and can be investigated.

Identifying trends and reporting back to relevant departments alerts them to the fact that there is an area which is worth analysing and exploring in more detail and which may result in a reduction of problems.

Monitoring

Monitoring of any given criteria recorded on incident forms gives a useful early warning system of a downturn in standards and an increase in incidents which may result in a legal claim.

The raising of staff awareness which may be generated by the introduction of a new reporting system, and training in its use, is likely to result in an increase in the number of reported

incidents. Managers should be wary of inferring that this indicates a downturn in standards; it is likely that the level of incidents in the past has been underestimated due to a failure to report untoward incidents.

As monitoring continues and information is fed back to departments, they are able to see the effect if risk control measures introduced.

Projection

The ability to project trends and costs is particularly important for financial planning. Once norms have been established, it becomes possible to anticipate the number of incidents of a given type which are likely to occur in following years.

These projections can take into account increased volume of work, improved equipment and so on, and can then be measured against actual results. The reasons for differences can be assessed and action taken to reduce risk. They are also of value when considering the level of insurance deductible to be assumed by trusts, giving a guide to previous loss patterns.

- **Action points**

  - **steps should be taken to implement a tracking, trending and monitoring system for untoward incidents, and reports produced regularly.**

CHAPTER 27

IMPLEMENTING RISK MANAGEMENT - INVESTIGATION OF UNTOWARD INCIDENTS AND CLAIMS MANAGEMENT

This chapter deals with the reporting and investigation of untoward incidents and the management of claims.

An essential element of risk management system is a procedure for identifying and reporting incidents and taking the action necessary to prevent a recurrence. Any system should be able to identify trends or patterns, pointing to areas for further investigation.

Systems exist in all health care providers for the reporting of accidents to patients or clients and staff and the same form is usually meant to cover "untoward incidents". There is seldom any definition of what constitutes an untoward incident, and there is often no mechanism for reporting damage to property with the exception of fire damage.

The chapter is divided into six main sections:

- definition of an incident
- reporting incidents
- investigating incidents
- financial implications
- risk management implications
- claims management

Definition of an incident

An incident for the purposes of risk management is:

> **any event which has given or may give rise to actual or possible personal injury, to patient dissatisfaction or to property loss or damage**

This definition covers all areas including patient or client injury, fire, theft, assault and employee accident.

Reporting incidents

As stated in chapter 25, busy staff often resent the additional workload imposed by reporting incidents, some of which may appear to be trivial. It is important that all staff realise that the purpose of reporting an incident is not to apportion blame to any individual. or group of people but to identify potential problems or, where a problem has already arisen, to expedite a remedy. The culture of the organisation must n ow allow staff to feel that they are "telling tales" about their colleagues and the procedure must not be seen as punitive. Many staff will quote occasions where the defective electricity socket, the missing light bulb or the hole in the carpet has been reported time after time, without any action being taken. So it is

important that remedial action is taken promptly to ensure that the reporting system is not discredited. Conversely, the taking of action demonstrates a positive approach to the management of risk and helps to change the culture of the organisation.

- **Action points:**

  - **there should be a standardised incident reporting system**

  - **staff who may be involved in completing incident report forms should receive appropriate training**

  - **a clear message should be given to staff that the reporting of untoward incidents will not result in punitive action against that staff member**

Investigating incidents

When the designated staff member receives incident forms and scans them, he or she will decide what further information is needed and what action needs to be taken. Witness reports may be needed, photographs may need to be taken, defective equipment may need to be removed from use and steps taken to prevent a recurrence. It is important that any allegedly defective equipment or other item is preserved, together with its maintenance records, evidence of purchase, packaging and batch numbers for smaller items, since it may have to be produced in subsequent actions, either to prove that it was not defective or to engage another party, such as the supplier, in the action. Equipment which may deteriorate with age while in storage (such as rubber bath mats implicated in a fall or back injury) should be photographed.

There should be clearly agreed arrangements for prompt photographic support to be provided to the member of staff investigating incidents. This may be through a Medical Photography Department, or through the provision of a camera to the Risk Management Team.

Managers should be sympathetic to the fact that many staff who are asked to provide witness statements will never have written such a statement before; such staff will be very worried about putting comments in writing and may, in some cases, have genuine difficulties in writing without their colleagues and mangers realising the fact. Witnesses should be offered help and support by the Risk Management Team in preparing their statements, but they should confine themselves to what they actually saw, rather than speculating on what happened. It is far better simply to state the facts, for example "Mr J was found on the floor", unless the witness actually saw her fall.

In addition to individual witness statements, it is useful to record the names of all staff on duty at the time of the incident, perhaps in the form of the staff rota. It may also be useful to record where staff were positioned when the incident took place. It can sometimes be several years before a claim is made and it is often difficult to track which staff were involved.

■ **Action points**

- **the member of staff receiving incident reports should take prompt and thorough action to ensure that steps are taken to provide or preserve evidence which may be needed in any future claim**

- **any allegedly defective equipment or other item should be withdrawn from use immediately and preserved as far as practicable**

Financial implications

An untoward incident results in many obvious, and hidden, costs; paying claims, replacing staff temporarily or permanently and replacing buildings or equipment. There can also be further consequential losses, for example the loss of a kitchen due to fire requires finance for the rebuilding, for the provision of alternative catering services during the rebuilding work and, if the kitchen has an income generation function, the loss of income and business. There are also costs to the organisation in the time taken to investigate incidents, and the effect of any adverse publicity.

Risk management does involve expenditure, but this can be offset by reduced losses and payments for damages, improved staff morale, less working days lost through staff injury and improvements in the quality of care given to patients or clients.

Risk management implications

Thorough investigation of an incident should reveal a number of elements which should be considered for further action, out side of dealing with the consequences of the specific incident:

- was the incident preventable?

- what measures are in place to prevent a recurrence?

- what other measures are recommended to prevent a recurrence?

The member of staff designated to act on incident forms should take responsibility for investigating these matters, with the appropriate departments, and reporting to senior management on the actions which have been or need to be taken.

The views of independent professional observers, who may be involved in the event of litigation, can give useful pointers to ways in which an organisation can minimise risk in future. Managers should read experts' reports and transcripts of any judgements given against their organisation in order to be more fully informed about the presence of risk.

In the past, many remedial actions have been shelved because they have financial implications and because other projects are seen to have a higher priority. But as we have seen earlier in this manual, expenditure on reducing risk is often money well spent.

In the event of a claim being pursued, evidence of a similar occurrence or prior knowledge of a hazard without any remedial action having been taken will immediately place the health

care provider at a disadvantage when deciding whether to defend the case or negotiate a settlement.

- **Action points**

  - **the cause of incidents should be thoroughly investigated and any measures which could prevent a recurrence should be defined**

  - **managers should examine reports produced by experts in the course of litigation, together with the transcript of any judgement made against their organisation**

  - **if a decision is reached that no further action is to be taken, this should be explicitly documented, giving reasons for that decision.**

Claims management

This section includes advice on:

- designating a claims manager
- involving legal and insurance professionals
- administration of documents

There is much evidence that the British are becoming more litigation-minded and there are now a number of firms of solicitors who specialise only in personal injury claims. As a result, health care providers should also adopt a professional approach to claims management which will lead to speedy conclusion of personal injury cases and to minimising the cost to the provider in both compensation and legal fees.

Damages awarded in personal injury claims are now considerably higher than used to be the case, and judges are increasingly awarding structured settlements, which help to safeguard the interests of the claimant rather than his associates.

The emphasis in this section is on health providers, but there is merit in named individuals being designated by purchasing health authorities to take an interest in these matters.

Health circular HC(89)34 stated that one identified individual with an appropriate level of understanding of legal processes, who is responsible for liaison with the legal professionals, insurance companies and the like should be designated as the **claims manager** for each health provider. This should be a named individual employed by the health care provider within its line management framework who is the named point of contact with these professionals, in order to maintain control of the process and to avoid conflicting messages.

There are a variety of ways of **involving specialists** with the knowledge required to take professional action on claims; providers may choose to employ a suitably qualified individual direct (either on their own or in association with other providers), to contract with a company which specialises in claims management, to retain a firm of solicitors or to rely on a service provided by other agencies, for example former regional health authority legal departments.

Whichever option is adopted, the claims manager should retain control of the process. He or she should take care to select an appropriate legal specialist.

It is particularly important that the claims manager co-ordinates access by the legal/insurance professionals to the staff of the health care provider. Uncontrolled access will lead to the claims manager not being aware of the exact progress of a case at a given time. He will also need to ensure that the legal professionals give regular updates on the progress of cases; it is not unknown for a hospital to discover almost by chance that a sensitive case is going to court in a few days time after several years of apparent inactivity, although relevant staff have been asked to attend as witnesses! The staff will assume that the managers of the hospital or other provider know the situation direct from the solicitors.

The claims manager should ensure that all staff involved in a case are regularly updated on its progress.

It should also be the role of the claims manager to **administer the documents** for claims. The master files should not be removed from the claims manager's office. Each claim should be referenced and all documents relating to it similarly referenced. There should be a record sheet at the beginning of the file which is regularly updated with brief details of correspondence, telephone calls, movement of documents such as case notes etc; and a summary sheet should be prepared at regular intervals giving brief details of the claim and its progress so that there is snapshot of the current situation. The chief executive and the Board should receive regular reports on the progress of claims and the summary sheets can be used for that purpose, anonymously if appropriate.

- **Action points**

  - **one individual should be designated as the claims manager, with responsibility for co-ordinating contact between the provider unit and the legal professionals**

  - **the claims manager should ensure that legal professionals provide regular updates on progress for each claim**

  - **claims documentation should be controlled by the claims manager**

  - **the chief executive and the Board should receive regular reports on the progress of claims**

Settlement

The claims manager should recommend that cases be settled where there is advantage in so doing. This may be in order to minimise the legal costs involved in a protracted defence, or following advice on liability and the defensibility or otherwise of the claim. The chief executive should ensure that there is a clear procedure for decision making on the settlement of claims. It must be clear who has the authority to decide on settlement and quantum and the limits to that authority.

It is often difficult for staff who have been involved in a claim to accept that settlement out of court is the most sensible course of action. They may see this as the hospital or Authority admitting that the staff failed or were otherwise "guilty". The claims manager should ensure that staff receive a clear explanation of the reasons for settling and, where appropriate, an explicit assurance that this does not mean that they have done anything wrong. In some circumstances, it may be appropriate to offer counselling.

- **Action points**

  - **there should be clear guidelines on the authority to agree settlements of claims**

  - **staff should receive an explanation of the reasons for settling a claim out of court, and offered counselling where appropriate**

CHAPTER 28

ESTABLISHING AN EDUCATION PROGRAMME

An effective risk management programme depends upon staff being educated in the reasons for risk management, how they can contribute, and what the benefits will be to themselves, the patients or clients and the organisation as a whole.

This chapter covers:

- the contribution of an education programme to a risk management programme
- the type and timing of training
- who should train and be trained
- the mechanics and recording of training

Contribution of an education programme

The human element is a powerful influence in the development of risk. Although it is conceivable that risk may arise without human input, it is more likely that people contribute significantly to its development.

People contribute to risk by being unaware of the nature of risk and the contribution which they make to it. An education programme will raise awareness and should help to reduce risk.

Staff who are aware of risk **will not** leave a handbag unattended in full view on a desk, or smoke where there are gases or flammable liquids, or leave a bag of clinical waste in a place where others might come to harm if it splits. They **will** report spillages in corridors so that they can be cleaned promptly and they will identify potential problems with evacuation from a particularly area in the event of fire.

Type and timing of training

All staff should be made aware of how they can reduce or increase risks to themselves and others. This can be incorporated into existing training schemes but could also include the development of new education modules. Training should be a combination of theoretical and practical training, some of which will already be in place such as fire prevention training.

Induction training, whether through organised courses or provided within departments, should include an explicit module on the management of risk. Policies and procedures should cover the steps to be taken to minimise risk, including the reporting of actual or potential incidents.

Staff in areas where there are particular risks should receive refresher training at regular intervals. Reference is made to this earlier in this manual, particularly where it relates to health and safety issues.

Who should train and be trained

Training in the management of risk can be provided by a number of different individuals and organisations. There are benefits in the risk management team receiving training from risk management professionals, which they can relay to the remainder of the organisation.

Managers should always be aware of the specialists at their fingertips. In any organisation, there will be people who have particular skills and expertise, not always relating specifically to their job, which they can pass on to others. It may be beneficial to compile a register of staff's interests and qualifications, so that their knowledge can be shared.

There are some aspects in which every member of staff should be trained, notably basic fire prevention and response training, security, health and safety and incident reporting.

Documentation of training

A training record should be kept on each individual's personal file, specifying the training for which the person has been nominated and recording their attendance. Staff should be asked to sign their training record to confirm that they have received training and feel competent in the areas in which they have been trained. Risk management training should be included on this record.

Mangers should take the responsibility for ensuring that their staff are nominated for, and do attend, training courses.

- **Action points**

  - **all staff should receive training in elements of risk management**

  - **the risk management team should receive specialist professional training and then relay that training to their staff**

  - **all training should be documented on staff personal files**

CHAPTER 29

IMPLEMENTING RISK MANAGEMENT - STANDARDS, POLICIES AND PROCEDURES

Risk management and quality systems are complementary activities. A quality systems programme will define standards and the means of achieving and monitoring them. This chapter gives guidance on good practice in creating, implementing and monitoring standards, policies and procedures.

This chapter is in three main sections:

- characteristics of good standards, policies and procedures
- managing the production of approved documents
- control, monitoring and maintenance of documents

Characteristics of good standards, policies and procedures

The purpose of a standard is to provide a record of the level of service which people are entitled to experience. Chambers 20th Century Dictionary defines a standard as: **a definite level of excellence or adequacy required, aimed at, or possible.** In some circumstances, particularly in the field of Health and Safety at Work, the standard is set by statute. In other cases, standards may be set by a profession's regulatory body. In yet other cases, standards are laid down by Ministerial requirements, such as the Patient's Charter. Standards can also be set locally. They should be specific, measurable and achievable.

A policy is **a course or general plan of action adopted by a party**, and is often a formal document issued by the managing board of an organisation which sets out its overall aims and objectives in a particular area. In the event of a claim for personal injury, the Court will want to know the organisation's policy on, for example, the frequency of inspection and maintenance of buildings and equipment or the selection of employees.

A procedure is **a method of conducting business or performing a task** and in this context is the setting out of a series of actions to be taken in a particular area. A health care provider may need to demonstrate that it has an adequate lifting and handling procedure designed to minimise risk to staff and patients or clients.

- **Action points**

  - **all standards, policy and procedure documents must be clear and unambiguous, practical and achievable, consistent and effective.**

managing the production of standards, policies and procedures

If standards and other documents are to be accepted and acted upon by staff, they should be involved in the drawing up of such documents. These should be ratified at the highest level of the organisation; the chief executive should present them to the board and should receive regular reports on the monitoring of standards and compliance with procedures.

- **Action points**

  - **the involvement of a representative selection of staff who will be operating procedures and who are bound by standards and policies, should be sought in their preparation at any early stage**

Control, monitoring and maintenance of documents

There are large numbers of documents in circulation in health care organisations, many of which may not be dated. Consequently, staff will be unsure as to whether they are still current. Conversely, staff will not always know of the existence of a standard, policy or procedure.

Standards, policies and procedures should be co-ordinated by a central point in the organisation and a record kept of the destination and date of each copy issued. This will ensure that there is a record of the distribution of each document which will allow updating information to be sent to the right departments in the right quantity. It will also ensure that conflicting instructions are not given in procedures. Should an incident occur, this can be checked against the relevant standard or policy, thus providing the first indication of whether or not liability exists.

An alpha-numeric reference system for these documents is recommended. Every document issued should have a reference, the edition/revision number, the date of issue or revision and should identify the originating department or individual. This procedure should be applied to all guidance documents, including those produced outside the organisation.

There should be a forwarding system for both the updating of document and for the issue periodically of a list of current documents. Consideration could be given to including an expiry date on each document, beyond which it is not current. Documents which are no longer current should be cancelled in writing to those who have received them.

The department which issues such documents should keep one copy of each in a master reference file for use as a library.

All new staff joining a health care organisation should receive a list of current documents relevant to them both personally and in their professional capacity, and be required to sign to state that they have rad and understood them; for example, all managers should receive an individual copy of Standing Financial Instructions and procedures, employment policies and so on.

In summary, it is necessary to ensure that the standards, policies and procedures are:

- up to date
- sent to and received by all who nee them
- read and understood by all who need to
- acted upon
- reviewed and revised periodically

- **Action points**

  - **the issue and updating of standards, policies and procedures should be controlled from one point in the organisation**

  - **arrangements should be made for new staff to receive a list of current documents**

  - **departmental managers should draw to the attention of new staff those procedures which have a significant bearing on their day to day work**

CHAPTER 30

RISK CONTROL OBJECTIVES

The principal aim of risk control is to reduce the risk to the lowest possible level. This chapter identifies:

- the aims of risk control
- risk control methods
- cost benefit analysis
- prioritisation

The first three topics were dealt with in detail in chapter 2 but are summarised here for ease of reference. The main emphasis of this chapter is prioritisation.

Aims of risk control

When looking at eliminating or reducing risk, must can be done with very little expenditure. The major aims of risk control are to identify ways in which risk can be **eliminated, avoided, made less likely** and **made less costly.**

Many risks can never be eliminated, but this manual has shown that it is often possible to reduce the likelihood of incidents occurring and to reduce the cost of them if they do occur, provided that the risk is managed and controlled.

Risk control methods

There are many ways in which risk can be controlled, some of which will require little or not financial outlay. These may be physical controls, or system controls.

In order to determine the best means of controlling identified risk it is necessary to have a systematic method of approaching and analysing a risk, and deciding the preferred risk control method for each one.

Cost/benefit analysis

The relationship between the cost of controlling risk and the benefits which will result must be considered. When establishing priorities, these criteria should be born in mind:

- **how much will the control action cost?**

  if the first choice is outside the available budget it may be better to think laterally and find an alternative solution rather than partially implementing the original idea at a reduced cost which may not be proportionally effective;

- **how quickly will it be effective?**

action taken to address a problem such as incidence of back injury to staff may take several years to show any effect on the incidence of legal claims, so it should be viewed as a long-term project rather than a single quick scheme. However, the effect on time lost due to such injuries should show an immediate improvement in the risk profile;

- **is it practical?**

  risk control measures must be practical and as simple as possible if people are to use them. The consequences of non-compliance (for example, failure to wear personal protective equipment) must also be clearly stated and enforced as appropriate. An elaborate procedure which no-one follows is of no use;

- **is the remedy more costly than the consequences of the risk?**

  beware of taking a sledgehammer to crack a nut, spending more on physical protections than you are likely to lose, for example from theft;

- **are there any associated benefits?**

  if more than one issue can be resolved as a consequence of tackling one, then the scheme will have a high priority. Improved incident reporting and analysis may, for example, highlight changes in a patient's behaviour resulting from an adverse reaction to change in their drug regime;

- **are there means of self-financing it?**

  charges for car parking might finance a 24-hour security presence;

- **can the organisation afford not to tackle the risk?**

  when claims arise, insurers may be prepared to pay damages but they will not pay fines imposed by the Health and Safety Executive. This risk, and the possibility of individuals being imprisoned cannot be transferred to insurers. Neither can loss of reputation be protected.

Prioritisation techniques can help to decide what action should be taken to control risk.

Principles of prioritisation

It is essential to have a system of prioritising risk control measures required, as there will always be only a limited budget to address these issues. No system or technique is perfectly objective and external influences cannot be ignored. The chosen priorities will always be a compromise.

a multi-disciplinary risk management team should address risks so as to avoid subjectivity; this is particularly important when prioritising because different people will have different ideas on the relative priority of risk being considered. There will be individual views that top priority should be given to those which score highest on the risk index, the most expensive, the least expensive, the most frequent, the most disruptive, the least disruptive, the one which most worries staff, or the one which is breaking the law.

When prioritising, it is important to **distinguish between the cause of a problem and its effect.** Very often there is a chain of causation which needs to be tracked back to the root cause. For example, in the case of back injuries to nurses, the **effect of the problem** is that the nurse cannot work; the **cause** is back pain, resulting from by injury, which may have been caused, for example, by attempting a lift in the wrong manner. The underlying causes might be: choice of inappropriate technique, lifting alone due to unavailability of assistance, absence of lifting aids or inadequate training and supervision. Going through this process will make it easier to identify where in the chain an intervention would be most effective.

A similar approach should be taken to **clarify the definition of objectives**. Competing areas might be:

- compliance with legislation
- compliance with codes of practice
- avoidance of legal claims
- prevention of death and injury

When considering the "cost" of a risk, it is important that one does not simply consider the direct financial impact of loss of, or damage to, property, or personal injury. There may be other expenses involved, such as hiring temporary staff, or the effect of the untoward incident on staffing levels if replacement cannot be hired. Neither should the consequences of the event on activity throughout the rest of the organisation be overlooked: a fire in the kitchen not only affects provision of meals to patients and staff, but may impact on any catering income generation activity.

Prioritisation techniques

However priorities are assessed, there are likely to be constraints on the level of expenditure which can be incurred within any given time scale. As stated previously, each organisation will have its own objectives, and will make different decisions about priority of actions. It may be that a risk which can be reduced by quick and inexpensive means and raise staff morale, may be given priority over what may appear to be a greater problem for which there is no immediate, or affordable, solution. It is also possible that having given due consideration to the potential probability and severity of an event, managers may decide to assume the risk and take no further action.

Ranking systems

Techniques range from the simplistic to the sophisticated, but many are based on the same underlying principle. That is:

frequency x severity = risk exposure

A common starting point is to categorise each exposure into low, medium or high in terms of both frequency and severity. An example could be:

Frequency	Low	-	rare and unpredictable
	Medium	-	occasional, but too often to ignore
	High	-	often and expected
Severity	Low	-	inconvenient; cost within operating budget
	Medium	-	major disruption; activity/income reduced
	High	-	catastrophic/financial ruin

It is advisable for every organisation to fix its own objective benchmarks for each category.

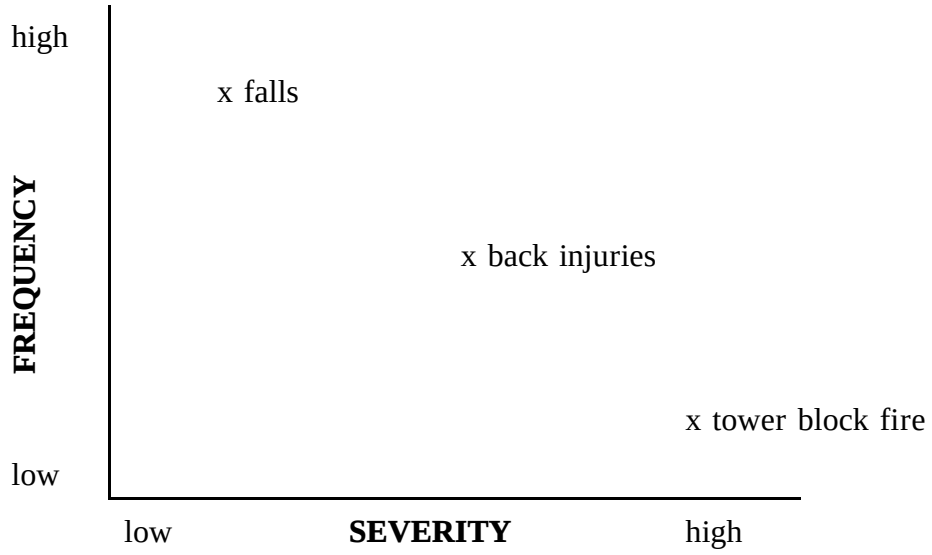
Probability

It is never easy to predict accurately the likelihood of an event. It is possible to draw up a very simple grid based on the frequency and severity of an event, rating it as either low, medium or high for each and marking it on the grid; for example, a fire in a tower block could be low frequency but high severity, lifting and handling incidents may be considered medium frequency and severity, or falls may be thought to be high frequency and generally low severity.

A line may be imposed on the grid showing what is considered to be "acceptable" and action taken on the items above it. The disadvantage is that definitions of low/medium/high may be subjective and the grid is not sufficiently accurate to be used in prioritisation analysis.

Figure 4

Probability grid



It is the relationship between the two elements, frequency and severity, that is important. A simple numerical matrix can be constructed using as a base 1 = Low, 3 = Medium, 5 = High as follows:

Frequency	Severity	Risk Exposure
Low	Low	1x1 = **1**
Low	Medium	1x3 = **3**
Low	High	1x5 = **5**
Medium	Low	3x1 = **3**
Medium	Medium	3x3 = **3**
Medium	High	3x5 = **15**
High	Low	5x1-**5**
High	Medium	5x3 = **15**
High	High	5x5 = **25**

This technique permits comparison of totally unlike risks, such as a fire in a tower block, or patient slips and falls. Its sophistication could be developed to embrace a series of benchmarks for integers from 1 to 10, or by breaking down "severity" into contributory factors, and allocating points to each, to be added up before multiplying by the frequency index number. Factors contributing to the severity of a risk include:

- direct financial loss
- staff downtime
- property downtime
- claims/legal costs
- level of personal injury
- loss of reputation

There are criteria other than frequency and severity which must enter into consideration when establishing priorities for action. These are:

- **implementation** - easy, difficult, extremely difficult
- **cost** - inexpensive, costly, very costly
- **time frame** - short, medium or long term
- **action** - eliminate/avoid/reduce, accept, transfer

CHAPTER 31

CONTINGENCY AND DISASTER PLANNING

In the NHS context, disaster planning has historically been considered to be the planning of the acute hospital's response to a major accident occurring outside hospital premises.

With the development of a more business-like approach to financial and operational planning, NHS organisations should now move to considering potential disasters which may befall them, and develop contingency plans to deal with them.

This chapter highlights the need to:

- define and accept the need for contingency planning
- identify internal and external vulnerabilities
- define the resources in place and to be considered
- plan the response to a problem

The need for contingency planning

Planning for disaster is a specific management task and should be treated systematically. If a disaster happens, vital decisions have to be made quickly on how to deal with it. Obviously it is better if these are made calmly and logically before the disaster happens and then, during the emergency itself, decisions need be limited only to implementing the pre-arranged and organised plan.

In general terms, a contingency plan consists of arrangements, procedures and documents for reference that are completed and held in readiness for use, in the event that a serious interruption occurs. The purpose of any contingency plan is to minimise disruption of essential activities and the consequent financial impact.

Vulnerabilities

It is common practice in business to assess a company's vulnerability to internal and external influences which may prejudice its ability to function normally. It is equally advisable to address these issues in the health care business.

Management will need to determine where there is the potential for major or minor:

- **environmental** emergency such as fire, explosion, release of hazardous materials or outbreak of infectious disease
- **accidental** systems failure, such as computer systems or power failure
- **deliberate** acts such as strikes, fraud or arson

Whatever the category of the potential threat, for an incident to qualify as a major emergency it must cause significant disruption to the business of the organisation. Disaster planning,

like other tasks, has to meet budgetary limits and it is necessary to evaluate which potential emergencies will be more serious than others.

■ **Action points**

- **managers should assess potential categories of disaster for which contingency plans should be drawn up**

Resources

A worthwhile and robust contingency plan requires a substantial investment in time and money and it is important before embarking upon the exercise to establish the resources which are already available and those which will be required in addition. A "stock take" of existing plans and resources may reduce the cost of the exercise.

As with all risk management activities, the cost of the action to be taken must be weighed against the potential loss which may occur. In a number of instances, advantage could be taken of existing major medical disaster plans which could be adapted to meet the needs of other emergencies. It will not always be necessary to start from scratch.

■ **Action points**

- **a stock-take of existing resources and disaster plans should be made before a decision is taken to invest additional resources**

Planning the response

This section deals with the method of planning a response to an emergency. It:

- recommends the formation of a planning team and
- gives the elements of a contingency plan.

The best means of preparing a co-ordinated response to contingency planning is to form a **small team** of senior management and professional members, under the leadership of a single manager who has overall responsibility for the preparation of the plan and overall control when an emergency occurs. The leader should have a deputy who will take charge in his absence. This core team will need to call in other expertise as and when applicable. It is important to remember that, although there are common elements to contingency plans, there will need to be more than one plan for any health care site. The number of plans will depend upon the number of vulnerabilities which are selected and the number of discrete departments which will be affected.

The **elements of the contingency plan** will include a list of addresses and telephone numbers of key staff, clear definition of the duties of each team members, actions to be taken during the disaster, actions in the short term after the disaster and those to be taken in the longer term.

The first action of the team should be to arrange a **list of home addresses and telephone numbers** of key personnel and other essential workers to be compiled. This list should include where possible provision of alternatives to cover for unavailability. The list should always be available and kept at strategic points such as telephone switchboards. Each team member should have a copy of the list, as should the external emergency services and police.

The next step is to **define the responsibilities** of each member so that it is quite clear who is responsible for specific actions such as reporting the incident, isolating power supplies, evacuation, liaison with emergency services or informing specific managers.

During the disaster, it is important that all staff are aware of the existence of a contingency plan and their part in it. Everyone on a site should know how to raise an alarm, whether it be a fire alarm or how to report a suspected fraud. This has the advantage of allowing the earliest possible action to be taken to control the situation which may avoid the development of a full scale emergency. In the event of an incident which requires access by external services such as fire brigade or other emergency services, it is important that they have full and up to date plans of buildings and details of the processes undertaken in various areas, particularly if hazardous chemicals or other dangerous materials are in use. Salvage work should begin as quickly as possible, particularly where vital records are concerned, but must always be at the discretion of the officer in charge at the time.

In the immediate short term after the disaster has been identified, after the welfare of patients or clients and other people has been assured, the two major considerations are the protection of the remaining property and the public relations aspect. The contingency plan should contain details of urgent action to be taken, whether this is recovering property or bringing into use manual systems to replace damaged computer systems. In the health sector, there will always be a large amount of media and public interest in any disaster and systems must be in place to deal with it. It must be clear who is authorised to deal with publicity and this information officer must have access to top management and be authorised to speak on its behalf. Contingency plans for incidents where there is likely to be loss of life, personal injury or at least disruption for people, particularly patients, will include the setting up of an incident room and arrangements for dealing with the media.

Longer term action will vary considerably with the type if incident which has occurred but may include rapid restoration of utility services such as electricity, gas and water and contacting suppliers of temporary equipment or buildings so that services can be resumed as soon as practicable. Arrangements may be made in advance with other computer users to buy computer time, and there may need to be arrangements with staff organisations to cover shift working, overtime and temporary transfer to other duties.

Once contingency plans have been prepared, they should be **tested** from time to time with mock exercises to ensure that they work and that they are kept updated, particularly as far as contact names and addresses are concerned.

- **Action points**

  - **a contingency planning team should be established under the leadership of a named manager**

- **contingency plans should be developed which include the major elements listed above**

- **contingency plans should be tested from time to time and reviewed at regular intervals**

- **the existence of plans should be known to all staff**

It is important that one does not overlook the potential for seemingly minor problems to be compounded into a major incident if concurrent, such as the Kings Cross fire. The resolution of small issues can avert a catastrophe.

CHAPTER 32

ENSURING EFFECTIVE RISK MANAGEMENT - THE PROVIDER UNIT

Risk issues are present throughout any organisation and the management of risk is a key responsibility of every line manager and the concern of every employee.

This manual recommends practical ways of improving the management of risk and gives advice on action to be taken. This chapter identifies the cultural environment needed in provider units if risk management is to be effective:

- commitment and involvement of all managers
- the relationship between risk management and clinical audit
- ensuring a culture where risk management is everyone's business

Commitment and involvement of managers

As stated in chapter 24, the overall responsibility for the management of risk rests firmly with the chief executive of the organisation. To be effective, risk management needs the commitment of that chief executive and this must be communicated throughout the entire organisation in a structured manner. What is needed is a more co-ordinated and focused approach, through a risk management team, which will support and advise the departmental and other managers to fulfil their responsibilities.

Risk management and clinical audit

There is a clear and close link between risk management, clinical audit and quality systems. It could be said that medical audit and risk management are both a part of progress towards total quality, alongside clinical audit, efficient administration and financial probity.

Clinical audit is widely recognised as the systematic critical analysis of the quality of clinical care, including the procedures used for diagnosis, treatment and care, and associated use of resources, and the resulting outcome and quality of life for the patient or client.

Medical audit has traditionally been a unidisciplinary peer group process, in which managers have had and sought no role. Recently there has been an increased understanding of the role which clinical audit can have in identifying potential risk and there has been a shift towards more sharing of data (with appropriate confidentiality safeguards) with managers and between professionals in the context of integrated risk management activity.

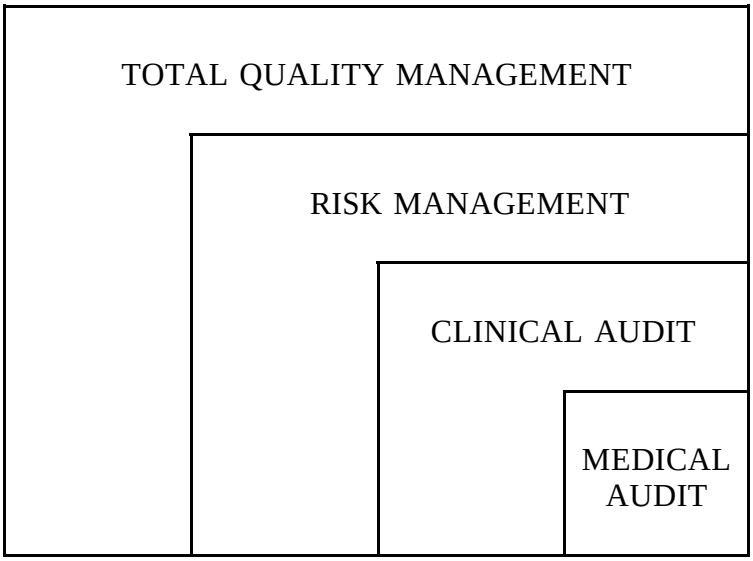
The development of clinical directorates with managerial responsibility for managing their own financial and human resources requires that the relationship between activity/workload, costs and quality becomes part of the core task of the clinical director and the team. Inevitably, this leads to consideration of the quality of care given by all professionals, and not just doctors.

Audit in other disciplines has traditionally been less exclusive, partly because nurses and paramedical professionals have viewed themselves as within the management family.

The risk management team must engage all managers and act as a central pool of expertise to supplement and support their own risk management work, and encourage a holistic and systematic approach to the management of risk. The team will carry out risk audits with managers and submit reports to them on the areas of risk within their sphere and action which could and should be taken.

Figure 5

A total quality approach



Information will flow into and out of the risk management team. Action will manifest itself in in-depth investigations, training for staff, regular risk management information bulletins, co-ordinated analysis of incident statistics, recommendations for amendment of working practices, poster campaigns and other communication methods designed to raise risk awareness. Manager and staff are expected to make significant changes in the way they manage untoward incidents and to devote time to improve reporting and investigations. In return, information and analysis should be communicated to all managers on a regular basis.

Much of the action which is needed to eliminate risk can be taken with very little expenditure. Some risks, however, incur considerable expenditure and it is important that managers understand the cost equation and have available sufficient information to make valid risk management decisions.

The cost of a particular risk improvement activity should be weighed against the savings which will be made subsequently, not only in obvious costs but also in hidden costs, for example equipment down-time and penalty costs such as fines.

Reports on the outcome of risk management activity should be shared regularly with all managers and with the chief executive.

- **Action points**

  - **the close relationship between risk management, clinical audit and quality systems teams should be recognised and information shared routinely, subject to confidentiality safeguards**

  - **the chief executive should set the example for a change in culture to one of openness and willingness to admit mistakes**

CHAPTER 33

ENSURING EFFECTIVE RISK MANAGEMENT - THE PURCHASER

This chapter addresses the benefits of risk management for purchasers of health care.

It addresses:

- the role of the purchaser
- the risks faced by purchasers
- collaboration between purchasers and providers

The role of the purchaser

The role of the purchaser is to secure high quality, cost effective and appropriate care for its population, working with those providers who are to deliver the services. Purchasers are increasingly seeking to raise quality standards and reduce costs. Risk management is important to purchasers since it plays an important part in their management of contracts and purchasing strategies.

Risks faced by purchasers

Purchasers must consider a number of potential risks in placing contracts for health services. These may include the effects of poor financial management by providers which lead to overheating of contracts and increased costs, the need to balance provision across the primary, community and secondary care settings, as well as the implications of reductions in patient services locally and costs incurred by providers which are reflected in higher provider unit prices.

Collaboration between purchasers and providers

The relationship between purchasers and providers is maturing into one in which the expectations of both parties are being made increasingly more explicit and specific. contract specifications are increasingly detailing requirements in quality, cost, activity levels and accessibility.

Ministers and the NHS Management Executive have stressed to purchasers the need to consider possible risks and to work closely with providers to minimise them. Guidance includes Priorities and Planning Guidance (EL(93)54), Review of Contracting - guidance for the 1993/94 contracting cycle (EL(92)79), Managing Activity and Change through Contracting (EL(93)10) and Contracting for Specialised Services (EL(93)98).

Key considerations for purchasers in working with providers to manage risk include:

- concentrating on strategy rather than day to day management, and the future pattern of health care provision. Looking longer term and involving providers and other purchasers in discussions should give providers time to respond appropriately to potential change;

- establishing long-term aims about the use of resources and likely pace of change and sharing these with providers;

- establishing open relationships with providers, to strengthen joint working and improve the exchange of information, so that all parties are aware of potential consequences which can be managed jointly;

- encouraging providers to undertake risk assessment and sharing the outcomes of risk analysis so that risks can be identified and appropriate plans made;

- developing close working relationships with other purchasers, including DHAs, FHSAs and GP fundholders to build a fuller picture of likely future changes and to agree strategies for dealing with mutual concerns.

■ **Action points**

- **the management of risk is important to both purchasers and providers and can best be achieved by close collaboration and a spirit of openness between the parties;**

- **purchasers should work closely with other purchasers to ensure a co-ordinated approach to providers**

CHAPTER 34

THE VALUE OF RISK MANAGEMENT TO THE NATIONAL HEALTH SERVICE

Risk management is about **choice:**

BE PROACTIVE:	LOSE:
Identify	quality
Analyse	reputation
Prevent	income
Control	
Reserve	PAY:
Monitor	claims
	fines
	staff costs
	patient costs

Be implementing a risk management programme, health care organisations will:

- **KNOW their risks**
- **CHOOSE how to spend their budgets**
- **MONITOR untoward incidents**
- **RESERVE for claims against them**
- **EDUCATE their staff**
- **PLAN for disasters**

Risk management is an essential component of **quality systems** and is a fundamental part of a total approach to quality improvement. It brings quality benefits to the whole range of health services, from acute hospital services to community services to general practitioners.

It is also a **financial system** which protects the assets and earnings of the organisation, reducing unnecessary costs, minimising losses from material damage, professional negligence and injuries to staff and visitors, and ensuring that income is not reduced through lost facilities.

Risk management is not something which is done by one department or manager, it is an essential **part of line management** which enables line managers to manage their services more effectively and to a higher standard.

An effective system of risk management will encourage increased **compliance with legislation,** thus reducing the cost of fines, improvement notices and loss of income through facilities being taken out of use. This in turn gives better working environments for staff, better care for patients or clients, and better value for money.

Explicitly addressing risk management allows all risks to be analysed and ensures that there is **not a piecemeal approach** within an organisation. It allows decisions to be taken on investment in an explicit and open way and, with the use of prioritisation techniques, it can define the criteria by which risks are assessed can be seen and managed.

ACKNOWLEDGEMENTS

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