HaS VSS

THE SIGNIFICANT SEVEN

The Richmond Fellowship Scotland

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Presented by Tony Priest – CMIOSH - MIFSM

Significant 7

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This presentation gives an insight to:

- What is the Significant 7
- How do we do it
- Why we have the Significant 7
- The results
- Recommendation to others

What is it?

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What is it?

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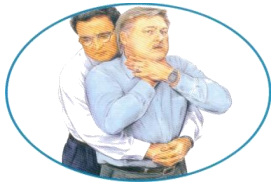
We identified the 7 Most significant risks to the people using Social Care services.

1. Falls From Height *(windows)*
2. Hoists
3. Hot Water/Drowning
4. Medication *(administering errors)*
5. Risk of Choking
6. Travelling in Vehicles
7. Use of Bed Rails



How do we do it?

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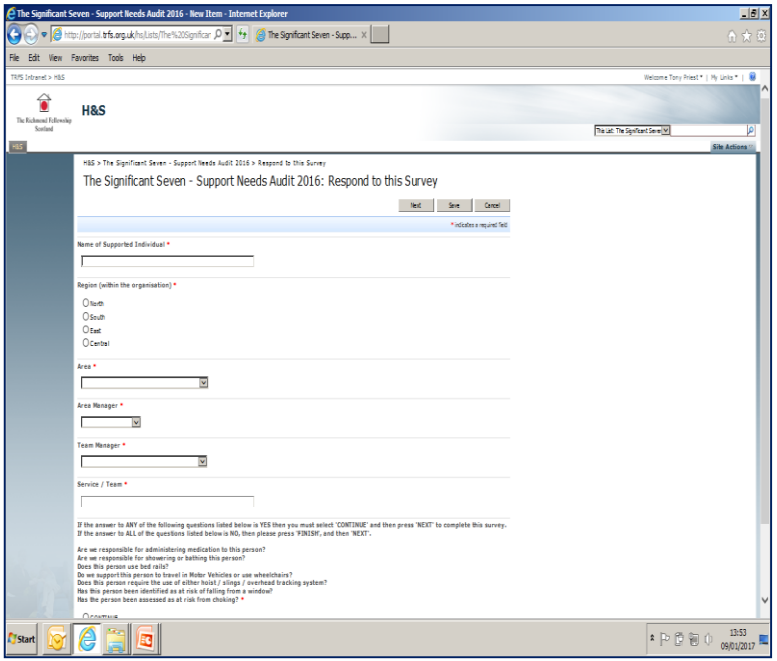
The Significant 7 is a survey *(questions)* that is carried out on an annual basis addressing the risks to all of our supported people.

1. Falls From Height
2. Hoists
3. Hot Water/Drowning
4. Medication
5. Risk of Choking
6. Travelling in Vehicles
7. Use of Bed Rails



6th Year Running

Why do we do it?

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Health and Safety at Work etc Act 1974

Section 2/3

General duties of employers to persons other than their employees

- Legal
- Moral *(we may all be vulnerable at some point in our lives)*
- Financial
  - Reputation

Recent Scalding Events

- Margaret Blackwood – Death - 56^{O}C – previously advised to fit anti scald valves
- Four Seasons Health Care – burns to legs
- Arc Housing – Death - slipped into the bath water – testing the water with a pinkie finger – No RA – No TMV's
- Real Life Options – TMV fitted - Amputated 10 toes
- Enable – Left unattended
- Premier Inn – On Holiday - Death in a Shower

HSE Health & Safety Executive

Currently Investigating 3 Incidents

Scalding events are preventable

Medication Events

- Missed medication*: 70 occasions*
- NHS contacted for advice: *57 occasions*
- GP contacted for advice: *33 occasions*
- Over medicated: *18 occasions*
- Medication given at the wrong time: *17 occasions*
- Medication dropped/spilled: *5 occasions*
- Medication given to the wrong person: *3 occasions*
- 154 errors were with regularly prescribed medication of which 85 were from a packet or a bottle and 69 were from Monitored Dosing System (MDS).
- 16 errors were associated with ‘as required’ medication.
- 69 errors were made whilst administering from a Monitored Dosing System (MDS) and 101 were made from a packet bottle.

Medication Events

Researchers from the Universities of York, Manchester and Sheffield report that an estimated 712 deaths result from avoidable medication errors (ADR's).

They say, however, that ADRs could be a contributory factor to between 1,700 and 22,303 deaths a year

ADR – Adverse Drug Reaction

Results?

The Significant 7 survey results are analysed and action plans produced for the Area Managers;

- An average of 1983 people surveyed annually,
- 50% presented one or more significant risks.

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We administer medication to **582** people *(58%)*

We administer ***'as required'*** medication to **362** people *(36%)*

We bath/shower **398** people *(40%)*

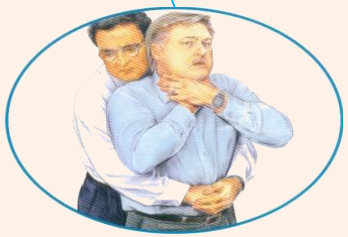
We support **778** people who travel in motor vehicles *(58%)*

35 people have been identified as being at risk of falling at height *(4%)*

We use hoists whilst supporting **76** people *(8%)*

Bed rails are used for **89** people *(9%)*

167 people we support present a choking risk *(17%)*



Results are represented from 999 (56%) people at risk out of 1783 surveyed.

What next?

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More work is needed

Research is needed to investigate the prevalence and cause of medication errors in the Social Care environment in Scotland to reduce/minimise harm to the most vulnerable members of our society that receives medication from care organisations.

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What next?

The Health and Safety in the Voluntary Sector Scotland (HASiVSS) group are committed to the safety of the people that use care services.

We can offer support and guidance in partnership with the regulatory bodies to ensure that vulnerable people are cared for safely.

Any Questions

Thank You

Presented by Tony Priest