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QCS Quality Compliance Systems

Effective risk control measures

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The details of a recent, high profile, Health & Safety Executive (HSE) prosecution serve to remind all providers in the care sector of the importance of effectively implementing the measures detailed in their policies and the importance of assuring that risk control measures are robust, effective, and clearly communicated to all upon whom they rely.

A care provider in Scotland has been fined, having been found guilty of health and safety breaches, under Section 3 of the Health & Safety at Work Act 1974, following the drowning of a vulnerable adult in its care. As well as the lessons which can be learned from the details of this incident and subsequent trial, the case also serves as a reminder that an employer's duties in health and safety law go beyond protecting themselves and their own employees.

Section 3 of the Health & Safety at Work Act requires that employers, in this case the care provider, conduct their activities in such a way that ensures, as far as it's reasonable, that other persons (non-employees) who may be affected by their activities are not exposed to risks to their health and safety.

In this particular scenario, the HSE report that a vulnerable adult with learning difficulties drowned in a bath within her flat in the early hours of the morning. Measures identified by the care provider to mitigate risks to this individual were either ineffective - a baby monitor provided to alert support staff that she was out of her bed was inadequate as it wouldn't have detected the sound of her movement – or they weren't implemented at all – the individual was able to run a bath when the water to her flat should have been isolated, it wasn't as neither of the staff on duty were aware of this requirement.

The immediate causes of the incident appear to be symptomatic of broader underlying failures to implement suitable and sufficient health and safety arrangements to protect service users. Staff shortages appear to have been the reason that two staff, unfamiliar with the critical risks of those they were supporting were present on the night of the incident.

The HSE investigation highlights no formal induction arrangements for staff, who had to find time to read through care plans after their shifts commenced, there were no clear shift plans to alert support workers to the critical needs of those they were supporting, and no instructions on how any necessary checks should be undertaken.

A failure to act on previously reported incidents and highlighted risks was also identified, with staff having reported finding this individual out of bed on a number of previous occasions. These concerns did not prompt review of the control measures necessary to protect this individual and no further controls were introduced. The HSE identified that more appropriate control measures such as pressure sensitive mats or door sensors had not been considered.

Despite pleading not guilty to the offences, the care provider was handed a £450,000 fine after a two-week trial and the HSE commented;

"The service user should have been safe at the care provider's premises but a failure by the care provider to identify and put in place simple and reasonably practicable safety measures resulted in two support workers being given insufficient information to protect this vulnerable lady in their care."

It's vital that all organisations regularly review not just their documentation, in terms of risk assessments and care plans, but that they also proactively review the effectiveness of the implementation of the assessments and documents. Regular checks that control measures are in place, are working and are understood by the staff responsible for their maintenance are vital.