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Shared Services Partnership
Legal and Risk Services

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Legal and Risk Services
Personal Injury Department
Lessons Learnt
1 October 2018 to 31 March 2019

At Legal & Risk Services we endeavour to provide generic risk advice to clients to reduce risk of future incidents. We have chosen a selection of cases and suggested lessons to be learnt in each

1. Timely repairs cost less than injuries

The Claimant in this matter was pulling a food trolley through double doors, when the mechanism on the door failed causing it to shut too quickly, injuring the Claimant's hand as it did. It was later found that the door had been reported as being defective; however the repairs were not carried out until later.

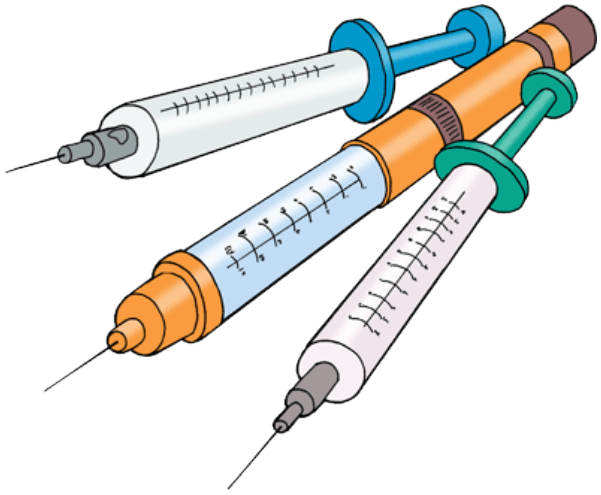
Lessons which ought to be learnt from this incident, are that as equipment is used daily, when a defect is notified, the repairs should be carried out as soon as possible in order to avoid such accidents and any staff member or visitor from being injured. Under the Occupier's liability Act, reasonable inspections of equipment should be carried out to avoid such incidents, doors are used frequently and daily, therefore such mechanisms need to be monitored as they are prone to wear and tear.

2. Double jeopardy

In this matter, the Claimant had been preparing lunch for a patient when she slipped on water leaking from the dishwasher, when her feet became tangled in tea towels which had been left on the floor to absorb the water from the dishwater.

Lessons to be learnt from such an incident arise when the dishwasher had been leaking, a member of staff should have reported it immediately so that it could have been cleaned and the dishwater's defect could have been raised for repairs. The fact that towels had been left created a tripping hazard on top of a slipping hazard. Safe system of work and reporting methods need to be reinforced to all staff so that such incidents can be avoided.

3. Think sharp



The Claimant was walking through the hospital car park whilst assisting her sister who was in a wheelchair when she stood on a needle. The Claimant went to A&E for immediate treatment and was advised by a member of staff that the needles in the car park had been reported the previous day.

Lessons learnt: Ensure needles are disposed of correctly. If there is a report of needles found in an unsafe place immediately carry out the necessary steps to remove the needles so that any risk of injury is avoided. Investigate where the needle may have come from and respond appropriately.

4. Slippery business

The Claimant was walking through the public entrance area of the hospital when she slipped in the corridor on water.

Lessons learnt: Ensure that staff members are compliant with cleaning procedures so that they do not use excessive amounts of water and foam. If the floor is found to be particularly slippery treat it immediately and make staff aware of the danger.

5. Inspections shouldn't be draining!

The Claimant slipped on a footpath due to food waste that had flowed out from a drain. Estates confirmed that there was a recurring issue with the particular drain as the drain gulley was not fit for purpose – it was a storm water gulley and not meant for food waste. There were no regular inspections of the drain.

In order to avoid future incidents, the following measures were suggested:

- Inspection of the drain for a permanent solution
- Advise staff not to dispose of food waste down the particular drain
- Routine fortnightly inspections of the incident location

6. Airing the dirty laundry

The Claimant sent a dirty laundry bag up the laundry line when it became jammed. The Claimant attempted to pull the bag out which resulted in the metal runners trapping her fingers. The Provision and Use Work Equipment Regulations 1998 state that every employer shall ensure that work equipment is maintained in an efficient state, in efficient working order and in good repair. The machine had been defective for some time and steps had not been taken to rectify it. There was also no system of inspection in place.

To avoid future incidents, the following measures were suggested:

- A risk assessment should be put in place for the use of the machine
- A system of inspection should be implemented to allow recording of issues with the machine
- Further detailed training for staff to cover situations like this

7. Ejector seat

The Claimant was attending the Hospital for a scan. Her husband was unable to drop her off outside the entrance due to ongoing building works. He parked the car in the main car park and walked into the hospital to fetch a wheelchair. As he was pushing the Claimant into the hospital, along the walkway through the car park, the front wheels of the wheelchair caught in a gully and she was thrown out of the wheelchair and landed heavily on the ground.

To avoid future incidents, the following measures were suggested:

- A risk assessment following the incident was conducted and it was also agreed that a metal sheet be put over the drain to make the walkway more accessible.
- There have been significant changes to the layout of the car park and the access route.
- It was suggested that a risk assessment be conducted in relation to the outside use of the wheelchairs.
- There have been new safety signs placed on the wheelchairs.
- There have been significant measures taken to retrain and warn porters of the risk of using the wheelchairs.

8. Safety in numbers

The Claimant was assisting an agency worker who was being attacked by a patient. The patient punched and hit the Claimant. It transpired that there had been a previous incident but this had not prompted a review of the patient's risk assessments.

We suggest any change in aggressive behaviour should trigger an immediate review of their care needs and staff safety. A revision of the risk assessment is essential.

9. Be smart with your sharps

The Claimant was cleaning a patient's table and whilst removing items was pricked by a needle. There was no sharps box available. The needle came from a self-administering diabetic patient who had not disposed of it correctly.

We suggest the following steps be taken to reduce the risk of injuries to staff:

- Ensure that self-administering patients are provided with sharps bins or informed of the location of sharps bins.
- Ensure that self-administering patients are compliant with the Health Board's disposal rules.
- Ensure that self-administering patients understand the consequences of not disposing of their used needles safely.
- We have provided a poster aimed at persuading patients that they need to be aware of the effects of the needle stick injury and therefore take more care in disposal. This poster is currently being trialled at our Health Board and we will feedback the perceived response and effectiveness of it.

10. Hit by LIGHTING

The Claimant was in the cleaning cupboard when the casing for the strip lighting fell down knocking the Claimant sideways into the wall. The light had previously been reported as broken and then slotted back into place with a broken edge.

We suggest the following steps be taken to reduce the risk of injuries to staff:

- All workplace equipment and fixtures should be inspected routinely and record of inspections should be retained.
- All noted minor defects should be noted and Risk Assessments carried out to determine whether a repair is needed.
- Defective equipment should be condemned or if that is not possible a warning sign should be placed on the equipment whilst repair is pending.

11. Clear the way

The Claimant was exiting the linen room of the Royal Gwent Hospital when she tripped over the prongs of a pallet truck that had been left there. The pallet truck was being brought through the linen room in order to access a loading bay. The normal route to the loading bay had been obstructed by beds.

The lesson to be learnt is to always ensure that routes and walkways are clear of obstructions, especially when staff are required to bring equipment through them.