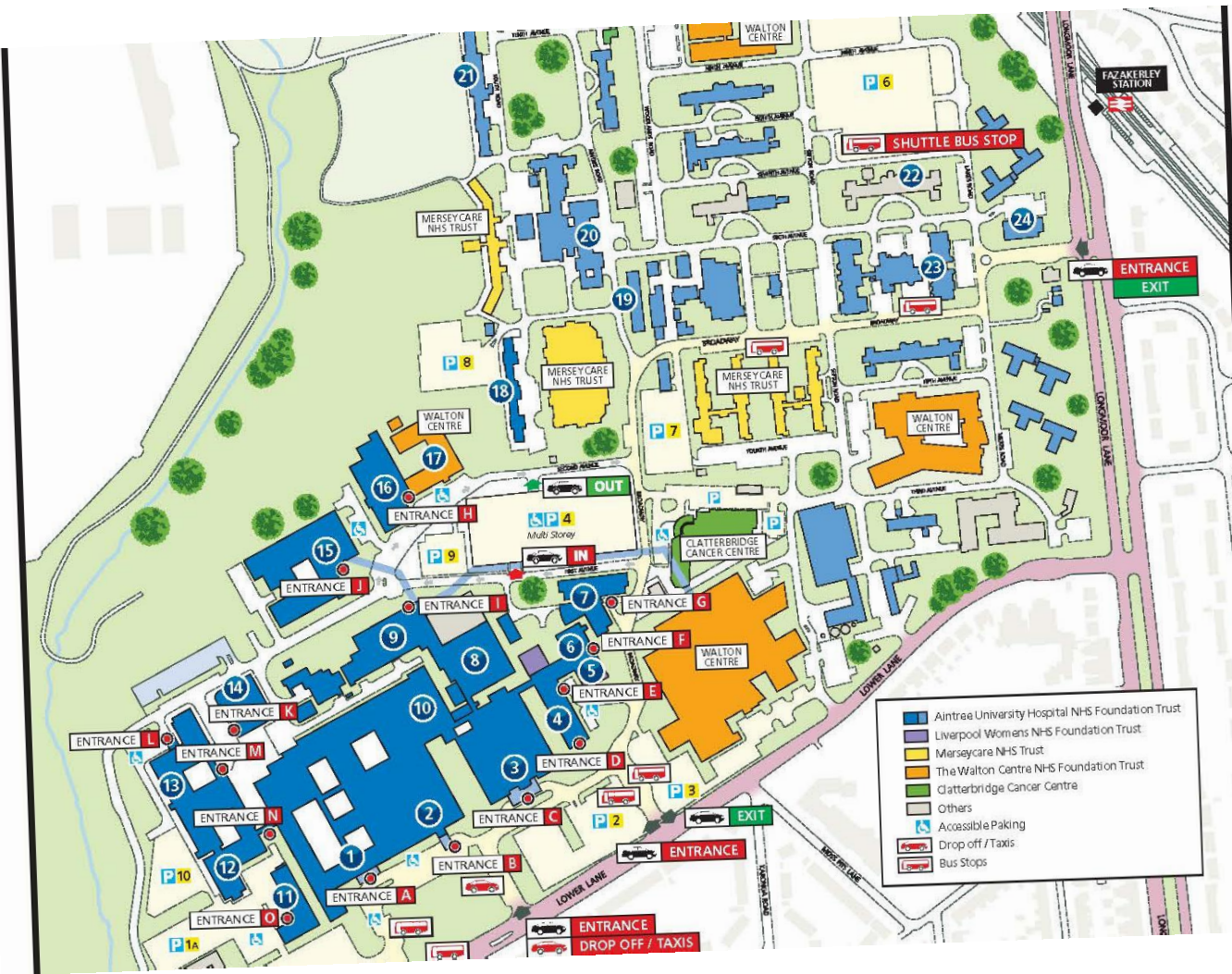


A PDCA Central Line for fire risk management

Dr Kathryn Woolham O'Brien
University of Central Lancashire



road car park.
 • A shuttle bus service is available from the Lakes Road car park.

BUILDING DETAILS

- 1 Entrance A Main Foyer to Critical Care Unit / Wards 8 to 25
- 2 Entrance B to Outpatients / Radiology / Fracture Clinic
- 3 Entrance C to Accident & Emergency
- 4 Entrance D to Centre for Women's Health, Entrance E to Wards 1 to 4 / Marina Dalglish Unit
- 5 Colposcopy (Liverpool Women's NHS Foundation Trust)
- 6 Entrance F to Diabetes Centre
- 7 Entrance G to Clinical Sciences Centre
- 8 Medical Assessment Unit (MAU), Wards 28 and 29, Main 'B' Theatres and Anaesthetics Directorate
- 9 Entrance I to Patient Hotel / Restaurant
- 10 Clinical Laboratories
- 11 Entrance O to Clinic G
- 12 Entrance N to Wards 30 and 31
- 13 Entrance L & M to Aintree Stroke Unit, Assessment & Rehabilitation Day Unit (ARDU), Prosthetics & Wheelchair Centre, Wards 32 to 35
- 14 Entrance K to Bluebell House & Bereavement Suite
- 15 Entrance J to Elective Care Centre
- 16 Entrance H to Therapies
- 17 Transitional Care Unit
- 18 Clinical Offices
- 19 Maintenance Offices
- 20 Aintree Hall
- 21 Learning & Development

Copyright. All rights reserved. Licence Number PU100020016

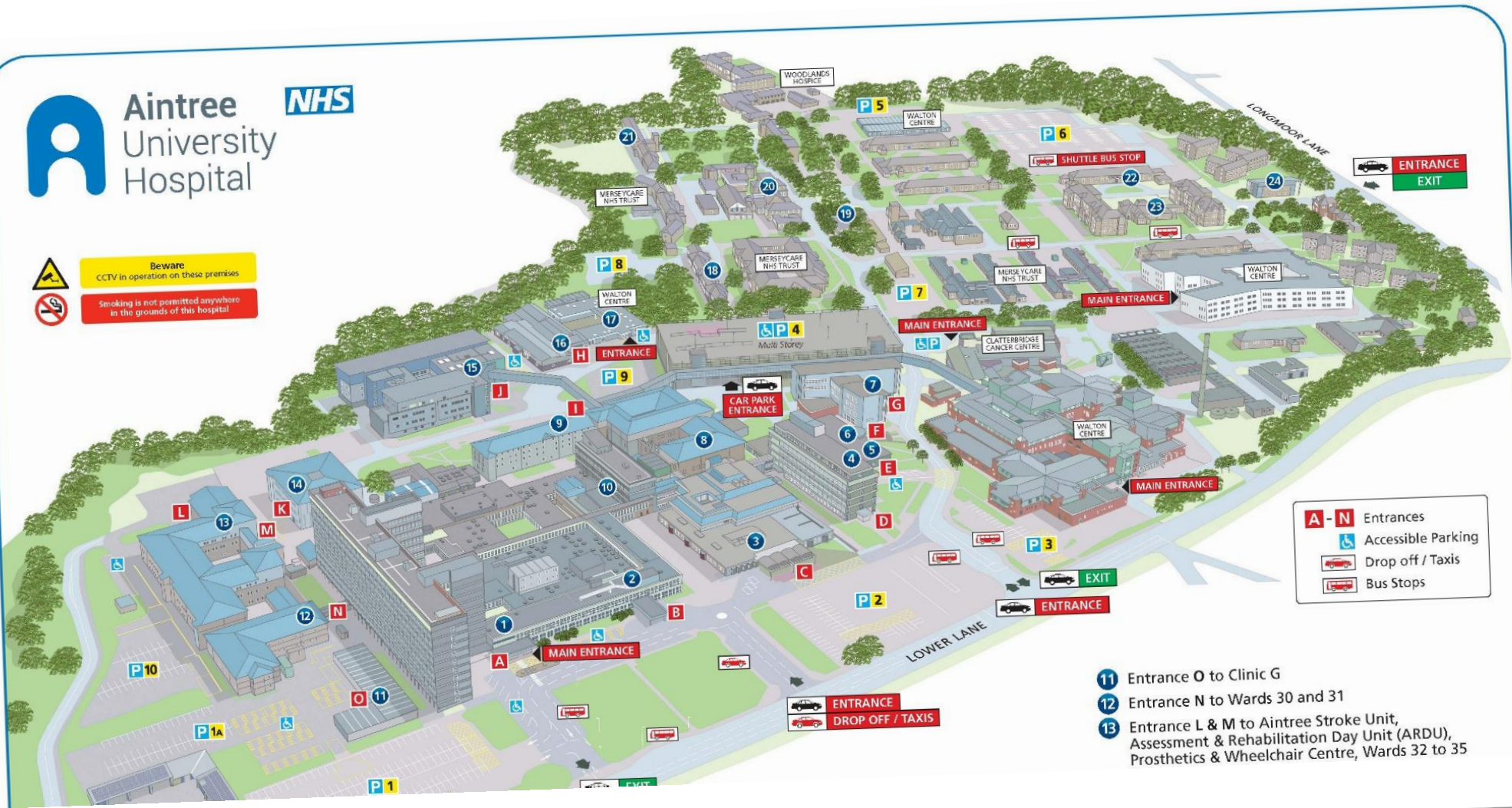
Aintree University Hospital



Beware
CCTV in operation on these premises



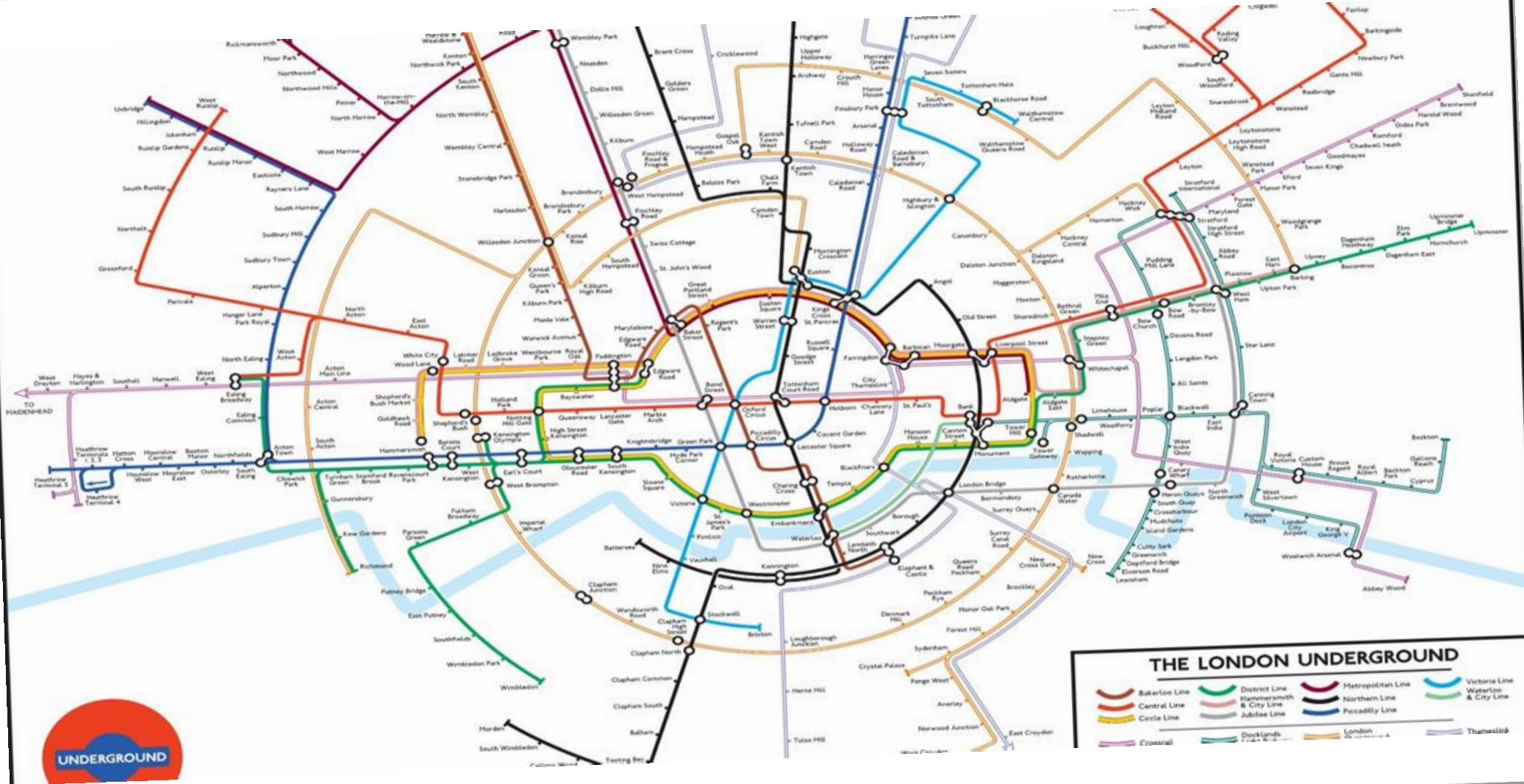
Smoking is not permitted anywhere
in the grounds of this hospital



A - N	Entrances
	Accessible Parking
	Drop off / Taxis
	Bus Stops

- 11** Entrance O to Clinic G
- 12** Entrance N to Wards 30 and 31
- 13** Entrance L & M to Aintree Stroke Unit, Assessment & Rehabilitation Day Unit (ARDU), Prosthetics & Wheelchair Centre, Wards 32 to 35





THE LONDON UNDERGROUND



Service Information

Date 19 June 2019

Time 11:30

Welcome to Modernity

Wicked Problems here now

Black Swans in xxx mins

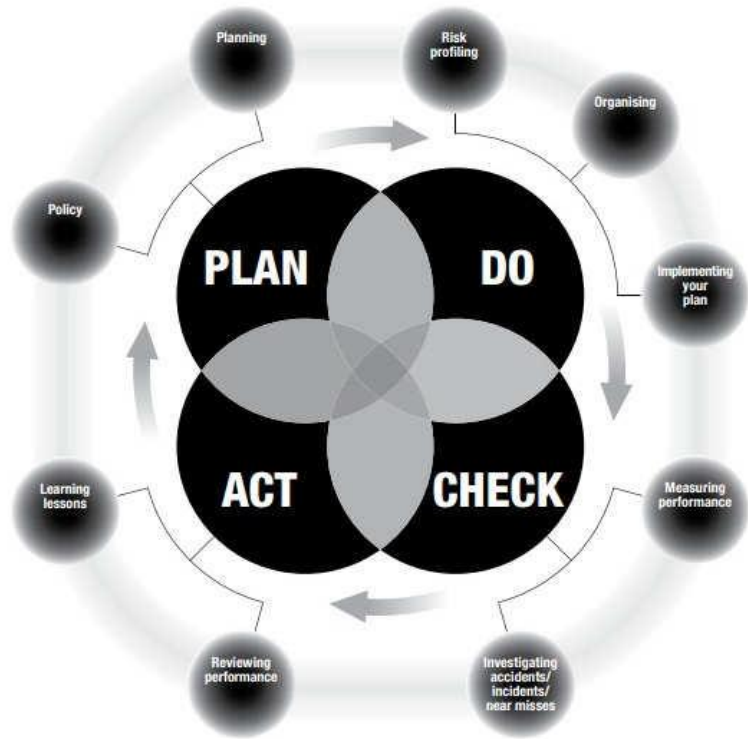
Disruption to system order

Deviance is normal

Do too much with too little

We forget to be afraid

Figure 3 The Plan, Do, Check, Act approach



Managing for health and safety (HSG65)



Date of publication: 2013

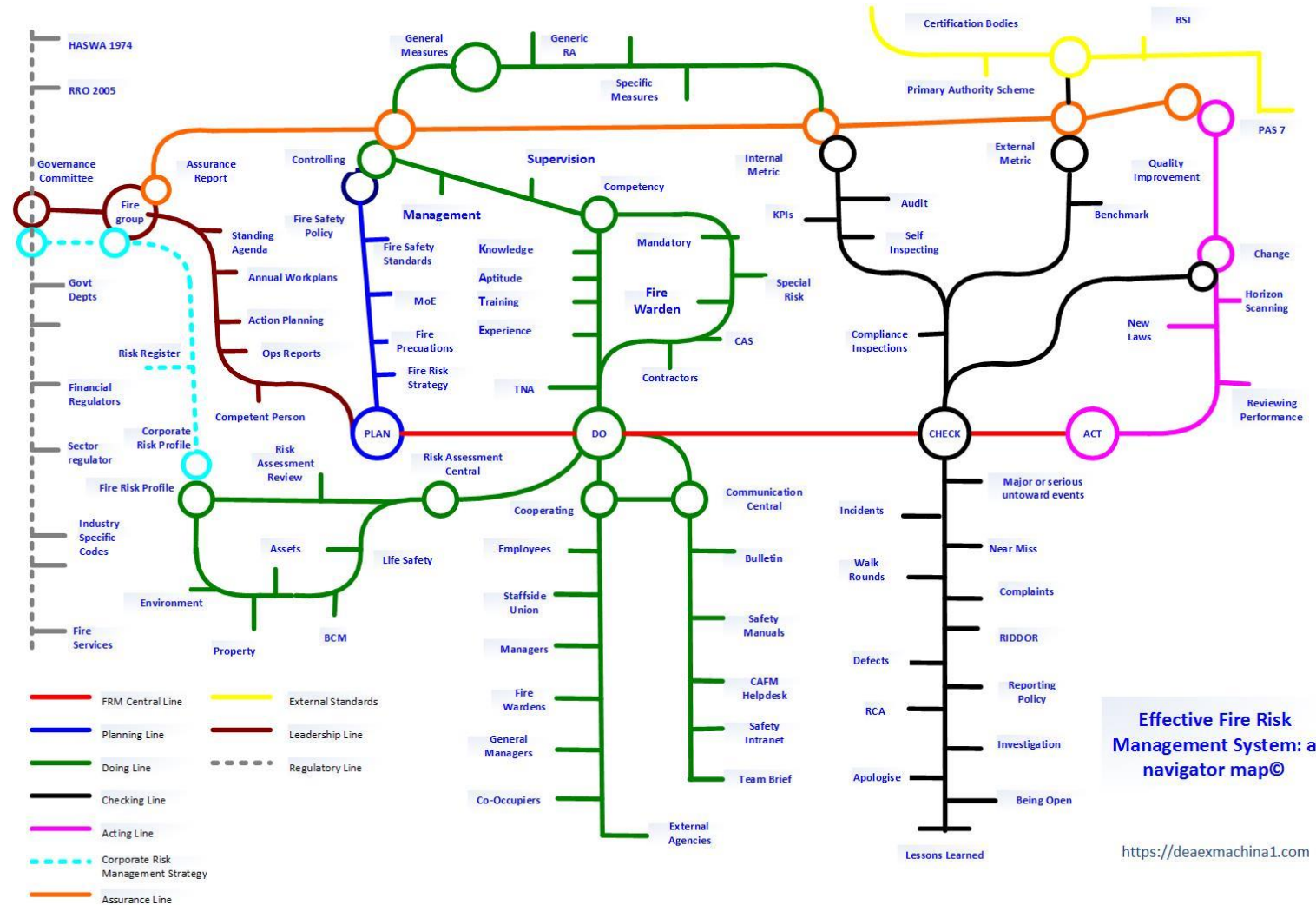
Series code: HSG65

[View the site](#)

[Download a free copy](#)

Using a PDCA Risk Management Cycle to “make arrangements”

The PDCA Navigator Map for Fire Risk Management



Effective Fire Risk Management System: a navigator map©

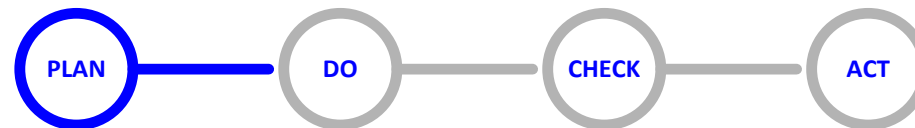
<https://deaexmachina1.com>

The Planning Line

Leadership



Policy development and planning



The Doing Line

Risk Profiling

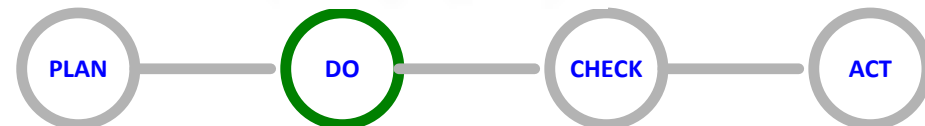


Controlling

Communicate

Cooperate

Competent



The Checking Line



Measuring

Investigating



Information is the lifeblood of an open transparent and candid culture. All professionals, individually and collectively, should be obliged to take part in the development, use and publication of more sophisticated measurements of the effectiveness of what they do, and of their compliance with fundamental standards.

Robert Francis, 2013.

WHY DO WE NEED DATA?

- Regulatory Compliance
- Position in the national /local fire risk space
- Knowing how we are doing
- Continual improvement



MEASURING

Information is compared or held up against a recognised standard or indicator



DATA

simply raw unorganised
facts and figures

INFORMATION

Small data that have been
processed, interpreted,
organised, structured or
presented so as to make
them meaningful or useful





DATA: each students' exam mark is one piece of data

INFORMATION: the average exam mark of the class is information that can be derived from the given data





DATA: 100 years of
temperature readings

INFORMATION: data
organised and analysed to
find that global temperature
is rising





DATA: each PTW request submitted

INFORMATION: all your PTW requests organised and analysed to find the % signed off in accordance with your stated procedure



But are we measuring the right things?

Baker Report into **BP Texas City Refinery Explosion 2005** – recommended that BP should improve its SPIs through considering proactive measures and monitoring its PROCESS (rather than PERSONAL) hazards and BP senior management were criticised for **placing too much emphasis on its low LTI rate.**

See Houston Chronicle for review of all incidents at refinery in 2004

See HSE sheet for recommendations following Baker (and also note similar fault in Deepwater Horizon 2010)

<https://www.youtube.com/watch?v=VCcN4SQkb9A>

Texas City Refinery 2005



Deepwater Horizon 2010



Deepwater Horizon: Pre-explosion problems and warnings

There had been previous spills and fires on the *Deepwater Horizon*; the [US Coast Guard](#) had issued pollution citations 18 times between 2000 and 2010, and had investigated 16 fires and other incidents. The previous fires, spills, and incidents were not considered unusual for a Gulf platform and have not been connected to the April 2010 explosion and spill. The *Deepwater Horizon* did, however, have other serious incidents, including one in 2008 in which 77 people were evacuated from the platform when it listed and began to sink after a section of pipe was accidentally removed from the platform's [ballast](#) system. By April 20, 2010 the *Deepwater Horizon* well operation was already running five weeks late. Internal BP documents show that BP engineers had concerns as early as 2009 that the metal casing BP wanted to use might collapse under high pressure. In March 2010, the rig experienced problems that included [drilling mud](#) falling into the undersea oil formation, sudden gas releases, a pipe falling into the well, and at least three occasions of the blowout preventer leaking fluid. The rig's mechanic stated that the well had problems for months and that the drill repeatedly kicked due to high gas pressure providing resistance. A confidential survey commissioned by Transocean weeks before the explosion states that workers were concerned about safety practices and feared reprisals if they reported mistakes or other problems. On the day the rig exploded, 79 of the 126 people on the rig were Transocean employees. BP Vice President of drilling, Patrick O'Bryan was on the platform two hours prior to the explosion. He had arrived to celebrate seven years without a "lost-time incident" with the rig's crew.

**This is a
Velociraptor-free
workplace.**



It has proudly been

12

**days since the last
Velociraptor incident.**

NHS

Answers on a postcard...

...or text, email, internet. We'll be asking you this simple question to make improvements to the local services you receive

"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

For more information about the Friends and Family Test programme -

email:
msc.nationalfriendsandfamilytest@nhs.net

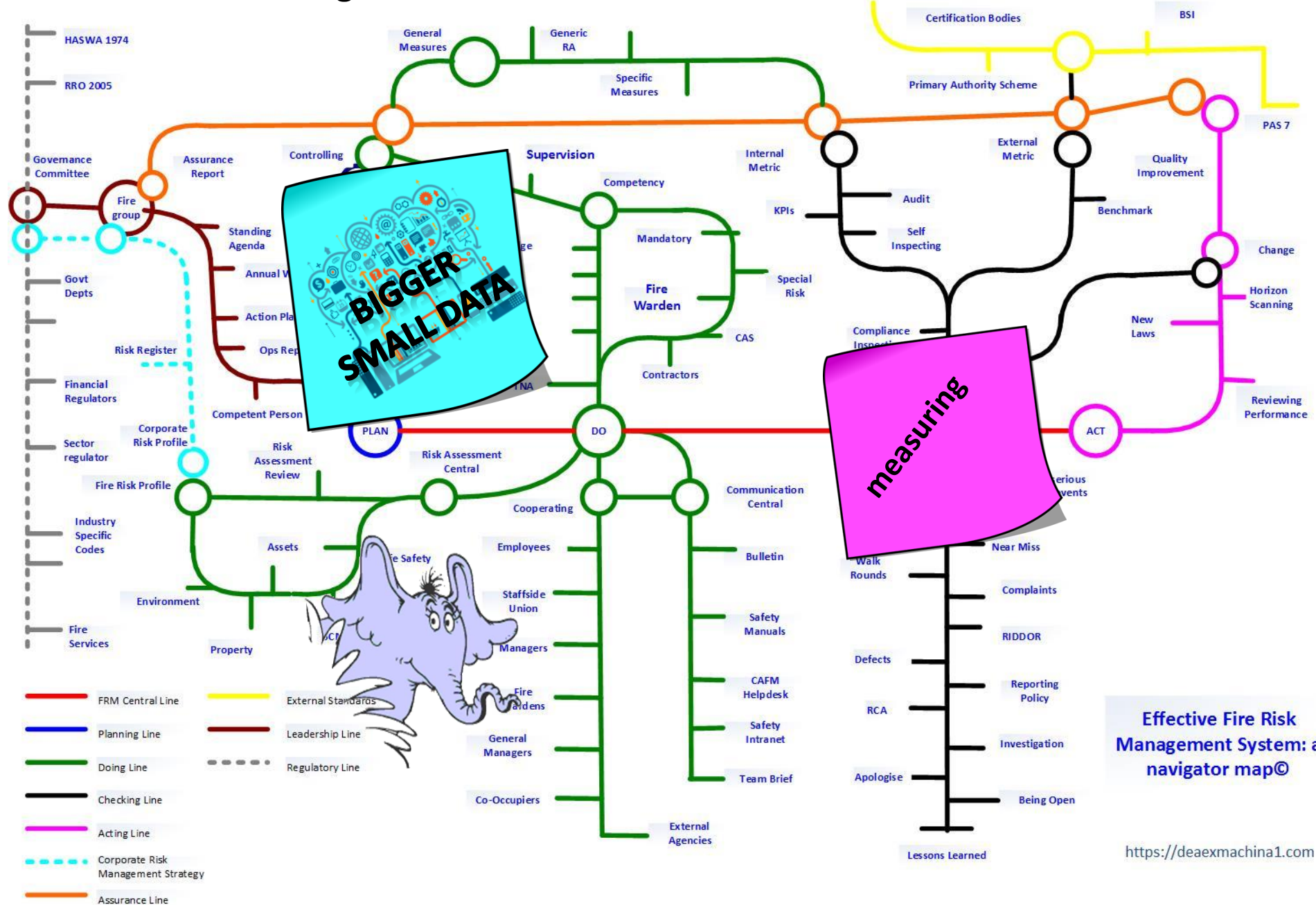
or visit:
www.eoe.nhs.uk/strategicprojects



The Friends & Family Test
Part of the NHS Patient Revolution

Produced by The Strategic Projects Team Ref: ADMPT/0163091112

The PDCA Management Central Line: "EVEN BETTER" looks like this

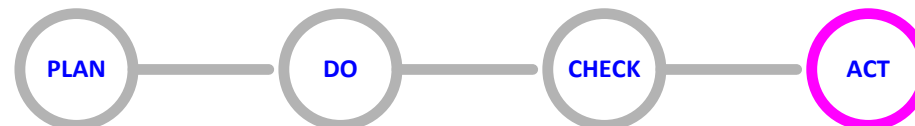


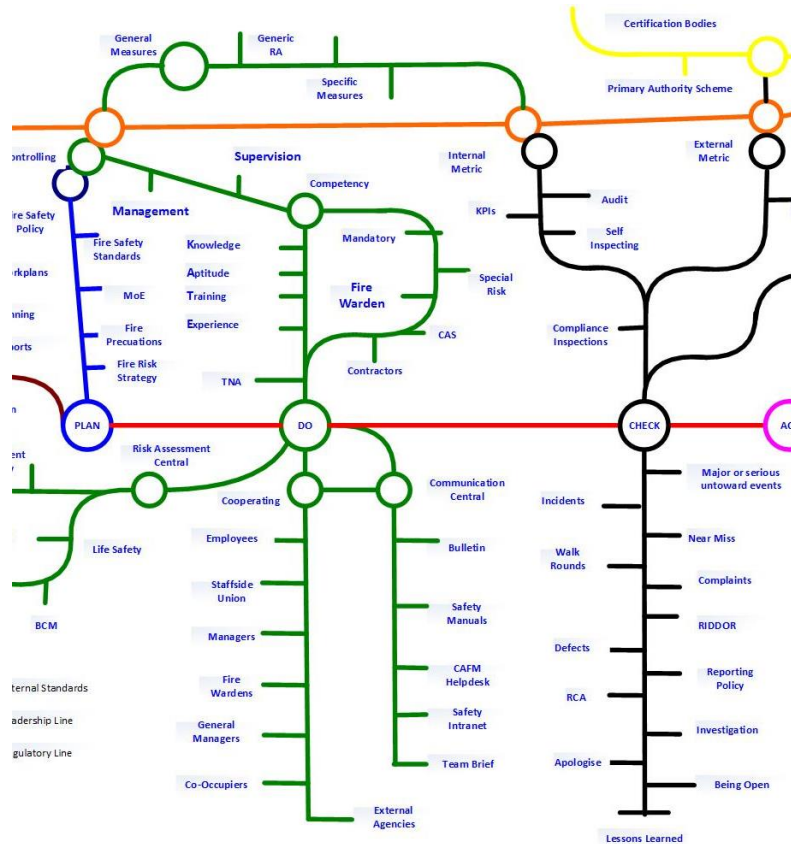
The Acting Line

Reviewing Performance



Acting on Learning





What's your pledge to effective fire risk management?