

**HEALTH AND SAFETY
MANAGEMENT**

CHAPTER EIGHT

Health Service Guidelines

HSG(97)6
13 June 1997

NHS HEALTH AND SAFETY ISSUES

Executive Summary

The National Audit Office (NAO) in their report on "Health and Safety in NHS Acute Hospital Trusts" found that standards of health and safety management were variable, with a number of Trusts failing to meet their statutory obligations. Reports from Health and Safety Executive (HSE) Principal Inspectors have confirmed this view. This guidance, suggesting good practice and identifying some specific hazards prevalent in the NHS, reflects in the main the conclusions of the NAO report. *The issues addressed are not exhaustive and do not intend to be comprehensive guidance on health and safety.*

The NAO concluded;

"To succeed in attaining the high standards expected, hospital trusts should aim to develop a more proactive, rather than a reactive, approach. This involves developing hospital-wide strategies to minimise the level of accidents. These strategies need to be supported by effective reporting arrangements to assess trends, and informed by comparisons of best practice in health and safety management from both within and outside the NHS. To achieve good progress, action should be led from the top by trust boards and chief executives, so that the health and safety of patients, visitors and employees is routinely accorded a high priority within and across all trusts". (para 24 Health and Safety in NHS Acute Hospital Trusts in England).

Health and Safety is managed most effectively by integrating health and safety management with mainstream business objectives. An essential component of general management is the management of risk. The integration of health and safety management into risk management and thus into general management, creates the foundation for achieving a high standard of health and safety performance. Failure to manage health and safety can result in heavy costs, whether in terms of staff absences, low staff morale, financial losses, higher insurance premiums, civil and criminal legal action resulting in fines and compensation payments, or damage to the public reputation of the employer.

Annexes

- Annex A Management of Health and Safety
- Annex B Health and Safety Problems in the NHS
- Annex C Health and Safety Checklist for Boards
- Annex D Useful Reference Documents
- Annex E Acknowledgements

Action

NHS Employers should;

- ensure that they are aware of and comply with their statutory health and safety obligations.
- consider the Health and Safety checklist (see Annex C) provided for NHS Boards.
- take steps to implement the recommendations of the NAO (these are listed in EL(96)104) and give a high priority to following best practice in the management of health and safety.
- have in place policies and procedures to investigate, record, monitor, review and assess the causes and costs of accidents, sickness absences, ill health retirement and occupational ill health.
- provide their employees with access to a confidential and effective occupational health service.

- remind staff that it is the duty of every employee while at work to take reasonable care for the health and safety of themselves and of other persons who may be affected by their acts or omissions at work.
- consider the inclusion of information on health and safety performance in their published reports.
- be aware of the principles in EL(96)104 & EL(96)44 "Health and Safety Management in the NHS", HSG (94)51 "Occupational Health Services for NHS Staff", "Risk Management in the NHS" (NHS Executive 1993) and the Health Services Advisory Committee's (HSAC) guidance "*Management of Health and Safety in the Health Services*".
- take account of these guidelines when negotiating contracts between purchasers and providers.

A significant source of good practice in managing health and safety in the NHS is the Health Services Advisory Committee of the Health and Safety Commission (HSAC). This committee which includes nominees of the representative organisations of NHS boards and of employee organisations, has published guidance both on the interpretation of legislation and on good practice in this field (See Annex D).

Background

(a) The NAO and District Audit Study into Health and Safety in NHS Acute Hospital Trusts

- (i) The NAO and District Audit studied 30 NHS acute hospital Trusts in England. They examined:-
- the number and nature of accidents to patients, visitors and NHS employees and the associated costs of these accidents to the NHS; and
 - the action hospital managers had taken to address their legal obligations on health and safety.
- (ii) From this study, the NAO concluded that Trusts could do more to reduce the level of accidents and to implement the requirements of legislation and good practice in health and safety management. In particular, failure to adequately investigate accidents meant that employers were unaware of the true costs of failing to follow best practice in health and

safety/occupational health. The NAO was concerned that the aggregated costs of; sickness absences as a result of accidents, compensation payments, increasing insurance premiums and possible premature retirement of valued employees would be considerable.

(b) Health and Safety Performance in the Contracting Process

Purchasers are responsible for ensuring the quality of services provided by their Trusts. The contracting process can be used by them and by the providers to show the importance they attach to quality and their commitment to following best practice. Health and Safety policy can be seen as an important element of the quality agenda and can be addressed directly in the contracting process. At the outset, the purchaser might ensure that a credible health and safety policy is in place. They might then ensure that the commitments in the policy are explicitly referred to in the contract. If the purchaser chooses this route, it will be important that the monitoring of the contract covers the effectiveness of the policy and the performance of the Trust against agreed criteria.

Addressees

For action:

NHS Trusts
 Health Authorities (Health Authorities may wish to disseminate this information to GPs' in their area)
 Special Health Authorities

For information:

Community Health Councils
NHS Executive Directors
NHS Executive Regional Offices

From:

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MANAGEMENT OF HEALTH AND SAFETY

The Management of Health and Safety at Work Regulations 1992 place duties on **employers to systematically assess all workplace risks, and to take all reasonably practicable action to minimise those risks**. Responsibility rests with the Chief Executive. The Chief Executive and Board must take the lead in setting the overall framework for effective and efficient management through a management strategy. Clinical directors, nurse managers and other staff managers must support the strategy and ensure that all staff observe the rules. Staff at all levels must also recognise their personal responsibilities. Issues to consider will include:

- (a) Managing Risk
- (b) The Health and Safety Policy
- (c) Staff Training
- (d) Health and Safety Advice
- (e) Consultation with Safety Representatives
- (f) The Health and Safety Plan
- (g) Accident and Incident Reporting Systems
- (h) Awareness of the Costs of Accidents
- (i) Provision of Occupational Health Services

(a) **Managing Risk**

- (i) The Chief Executive of the organisation has the overall statutory and operational responsibility for managing health and safety. A board member (ideally an Executive Director) should be allocated clear responsibility for health and safety risk management across the whole organisation. This will clearly signal the Boards' commitment to health and safety management.

The appointed member should be responsible for ensuring that appropriate risk management strategies/systems, as well as properly trained health and safety advisors are in place. Regular reports should be made to the Board giving details of information concerning health risks and health and safety performance, noting emerging trends and recommending action as necessary.

Good risk management starts off with hazard identification. When seeking to identify risks avoid the mistake of overlooking the obvious. The fact that some activities may have been undertaken for long periods without incident, does not mean they are risk free. Once hazards have been identified, risks should be assessed and appropriate action taken to remove, minimise and control them.

When deciding on preventative measures aim to eliminate risks altogether. This can be done by combating risks at the source, or adapting work to the individual where possible, bearing in mind any health risk factors. Give priority to measures which protect the whole workforce and advise employees of their responsibilities¹.

Audits of risk assessments should be undertaken to check that they are up to date and that appropriate measures have been taken as a result. Safety inspections of the premises can be an important measure of health and safety performance. They can be undertaken on a regular basis enabling quick feedback to be given on the state of safety in the ward or department.

- (ii) **Benchmarking** enables employers to identify performance indicators against which performance can be measured, both between different departments and with other employers. NHS employers need to monitor their performance and standards of good practice in health and safety management. To support Trusts and Health Authorities, along with other commercial systems that may become available, NHS Estates are developing a benchmarking service on health and safety. The target is to make it available commercially by July/August 1997.
- (iii) **Software Packages.** The SAFECODE software package was issued by the NHS Executive in September 1994, followed by SAFECODE PLUS in 1997, as a means of assisting employers in health and safety management. Other software packages are available which can be used and are useful in providing Trusts and Health Authorities with tools for monitoring, incident recording, information systems, priority identification, and databases of relevant legislation and guidance etc. Trusts and Health Authorities should note the wide variety available and should choose that package most suitable for their needs.

(b) **The Health and Safety Policy**

The Board should ensure that there is a clear, written health and safety policy which:

- is endorsed by the Board and fully supported by senior management.
- sets out the organisation (the people responsible) and the procedures to be followed for identifying hazards, assessing risks and preventing or controlling them.
- focuses the accountability for health and safety to discrete levels within the organisation.
- is accessible to all staff and is drawn particularly to their attention.
- expresses the employer's commitment to best practice in health and safety management.
- includes a built in review procedure which recognises the need to scrutinise and review performance regularly.

Individual departments or directorates may have local policies and/or procedures which address their own specific health and safety concerns. These must be compatible with the organisation's overall policy. Employers should survey their operations to identify hazards (including those mentioned in annex B) and formulate procedures which outline how and by whom these problems are to be addressed in the organisation.

(c) Staff Training

NHS employers must ensure that all staff are given appropriate health and safety training on recruitment and when exposed to new or increased risks, whether due to changing responsibilities or the introduction of new equipment. The training needs of staff will vary depending upon their particular duties. Training could include the following; general induction for all staff, manual handling, food hygiene, control of substances hazardous to health, first aid, violence, waste disposal, fire and security etc.

Training is an important way of achieving competence and helps to convert information into safe working practices. Training is needed at all levels including top management and medical staff. Risk assessment will help determine the level of training needed for particular tasks.

Refresher/update training is important because an employee's competence will decline if skills and knowledge are not used regularly. Training therefore needs to be repeated periodically to ensure continued competence. Information from personal performance monitoring, health and safety audits, accident investigations and near miss incidents can help to establish whether refresher training is required.

Managers should ensure that;

- induction programmes aim to make all staff aware of hazards and their responsibility for the health and safety of themselves as well as others.
- records enable staff to be recalled for refresher training when necessary.
- all training given to staff is recorded.
- audits are undertaken to check whether staff have had appropriate and effective safety training.

(d) Health and Safety Advice

Employers are required to appoint competent persons to assist them in complying with health and safety legislation. Competent here means someone with sufficient training, experience and knowledge to enable proper assistance to be given. They should ideally be employees or may be independent health and safety experts. While it is not necessary for the board member responsible to be an expert, it is important that those appointed to provide advice are not only technically competent, but also hold management positions where they are able to influence others in the organisation. Membership of appropriate professional institutions is recommended.

(e) Consultation with Safety Representatives

By law employers must consult with all their employees on health and safety matters. Consultation involves not only giving information to employees but also taking account of employees views before making decisions. A safety committee should be set up which meets regularly (minimum of twice yearly) - and which should be attended by a senior manager representing the Chief Executive. Trade Union safety representatives are a valuable asset to health and safety in the workplace. *Safety Representatives and Safety Committees* (HSE Books, 1996) provides further details. Safety representatives are protected in employment

law from dismissal or suffering any other detriment for exercising their functions. The Health and Safety (Consultation With Employees) Regulations, 1996, apply to employees who are not covered by Trade Union safety representatives.

(f) The Health and Safety Plan

Best practice in health and safety management requires that employers establish plans and set performance standards. Health and safety plans should have specific, measurable, achievable and prioritised objectives with realistic deadlines.

Without measuring performance against pre-determined plans, it will not be possible to identify areas where improvements have been made, or where areas may need further improvements.

(g) Accident/Incident Reporting Systems

An effective incident reporting system will have many benefits to the employer. It will identify problem areas on the premises where incidents are frequently arising. Without a good system it will be impossible to conduct effective risk assessment or cost-benefit analysis. It will also help in providing useful evidence when handling a claim of negligence.

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.

The use of separate systems to record accidents to patients and staff, can lead to a failure to identify common causes of accidents and so prevent appropriate remedial action.

The initial incident reporting form should be kept as simple as possible and take the minimal time to complete. Using such a form will encourage staff compliance and as a result improve data gathering. If it is not, potential problem areas may be ignored as staff fail to complete forms due to a perceived lack of time. The form should include sufficient information to allow for completion of the statutory "Reporting of Injuries, Diseases and Dangerous Occurrences Regulations", 1995 (RIDDOR) form F2508. Extra information may be collected later during incident investigation.

The primary purpose of incident reporting is not to apportion blame but to identify potential problems, or where actual problems have arisen, to enable prompt remedial action¹.

(i) A good incident reporting system will have the following characteristics:

- be simple to use (ideally based on a standard form for all incidents which can be used by all staff - one form should be used in all situations).
- be based on a standard definition of incidents to ensure comparability across the organisation.
- allow for the timely collation of data and investigation of incidents (near misses) and accidents.
- be able to record the people involved (eg names, ages or training), the cause(s) of both the accident and the injury (eg falls or chemicals), the location and time of the incident, treatment given, any resulting staff absence and most importantly, action taken by management to prevent a recurrence.

It is the line manager's responsibility to ensure that the system works. Staff 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.

NB: As an effective reporting system is introduced it is probable that the numbers of reported accidents/incidents will increase. This indicates that the reporting system is working. It is important that targets are not set too early in terms of reducing accidents and incidents.

(ii) Analysis of this data should be able to identify:

- individuals involved in a higher incidence of accidents than would normally be expected.
- low-loss accidents or incidents (ie near misses) with huge loss potential costs if not addressed, eg small fires.
- employee groups involved in a disproportionately large number of accidents.
- the linkage of one incident to another.
- common causes needing workplace improvements, eg condition of floors or new procedures eg sharps policy.
- seemingly minor problems which, when viewed on a organisation wide basis, are causing significant losses.
- health and safety management planning needs through the production of numerical and graphical analysis of incidents.

(iii) Statutory Requirements: "RIDDOR", 1995. Certain types of accidents must be reported to the Health and Safety Executive within defined timescales. All NHS employers should have systems which permit the timely reporting of incidents to the Health and Safety Executive, in compliance with RIDDOR.

(h) Awareness of the Costs of Accidents

All accidents have cost implications for the employer. To ensure that management action is effectively prioritised, NHS employers may find it helpful to be aware of the potential costs of accidents. These may include:

(i) Immediate costs:

- cost of reporting and investigating the accident.
- treatment and first aid costs including staff time.
- cost of cleaning up following an accident.
- decreased productivity.

(ii) Longer term costs:

- staff time lost due to absence, overtime cost or the cost of covering for an injured member of staff.
- costs of recruiting and training replacement staff.
- NHS injury benefit or pension costs paid to employees injured at work.
- compensation paid to injured parties.
- increase in the cost of insurance premiums.
- cost of increased length of stay of an injured patient (this may also include the loss of income as a bed cannot be used for another patient).
- fines for breaches of legislation and legal costs involved in defending court action.
- structural work or replacement/maintenance of equipment.

The Health and Safety Executive's "The Costs of Accidents at Work" HS(G)96, provides further information.

(i) Provision of Occupational Health Services (OHS)

HSG(94)51 asked employers to ensure the provision of good quality and confidential OHS to all their staff. NHS employers should ensure these guidelines are reviewed regularly.

Occupational health professionals contribute to reducing risks at work which lead to ill health, staff absences and accidents through:

- providing assistance in the risk assessment process.
- pre-employment health screening.
- health promotion and education in the workplace.
- health surveillance of employees - looking for signs of ill health caused by hazards at work.
- promotion of compliance with health and safety legislation, in liaison with health and safety managers and health promotion services.
- assessing the health requirements of particular jobs through knowledge of the workplace and health hazards/risks.
- analysing data on sickness absences to identify possible problems at an early stage (eg stress related illness).

- investigating cases of ill health and absence to enable action to be taken to prevent similar problems arising again.
- Management of the rehabilitation process.

ANNEX B:

HEALTH AND SAFETY PROBLEMS IN THE NHS

Common risks prevalent in the NHS include:

- (a) Manual Handling
- (b) Disposal of Waste
- (c) Needlesticks/Sharps
- (d) Substances Hazardous to Health
- (e) Violence to Staff
- (f) Slips, Trips and Falls
- (g) Stress at Work

The list of hazards addressed is not exhaustive and individual employers may have others.

(a) Manual Handling

Injuries caused by lifting and handling are the most frequently reported type of accident faced by nurses and other health staff at work. The correct aids to assist these processes are therefore important. Where aids are not used or are not in place, or where there has been inadequate training, injuries sustained from lifting and handling can result in increased costs through sickness absence and/or the loss of a highly trained employee from the service. It currently costs £33,600 to train a nurse and this represents part of the financial loss which can be incurred as a result of injury caused by the above factors¹.

Problems arise for many reasons, staff may be lifting patients instead of using available equipment, they might be lifting patients who do not require lifting, or an injury during the handling of loads.

Manual handling is a problem which can be reduced if simple steps are followed¹:

- manual handling should be avoided as far as is reasonably practicable.
- assessments of manual handling tasks should be carried out so as to prioritise action.
- appropriate training in lifting and handling techniques should be given. Unless adequate training, aids and assistance are available to staff when required to lift or handle, the employer may be in breach of regulations.

¹ Research at one hospital trust shows that the numbers of back injuries can be reduced cost-effectively. The research began in 1991 when the relevant district health authority estimated that they would be required to pay compensation costs of £700,000 in 1991-92, with a further £1.5 million payable in future years. As by far the largest cause of such costs was back injuries, the health authority decided to establish a programme of training for staff in manual handling to reduce the numbers of injuries. The training programme began in 1991 and has cost some £30,000 per year. In June 1994 the trust evaluated the effectiveness of their training programme and found that staff were twice as likely to be absent sick with back ailments before training than afterwards. Overall,

the total number of days lost due to back injuries reduced by 20% between April 1991 and March 1994, or six days per staff member per year. The trust considers that the action taken has also reduced the levels of compensation which they have had to pay to injured parties.(NAO Report-Health and Safety in NHS Acute Hospital Trusts)

- appropriate lifting equipment should be provided and used to replace or aid manual handling tasks, i.e. hoists, sliding sheets or boards.
- the use of team work - staff should seek the help of co-workers where possible
- all lifting and handling equipment must be regularly checked and maintained. Staff should also receive regular updating on lifting and handling techniques.

Statutory Requirements:

The Manual Handling Operations Regulations 1992 cover the lifting, lowering, pushing, pulling, carrying or moving of loads, whether by hand or bodily force.

(b) Disposal of Waste:

Health and safety policies and procedures should cover the safe handling and disposal of all types of waste, including domestic, clinical and special. The Chief Executive and Board must take the lead in setting the overall framework for the effective and efficient waste management through a waste management strategy. The strategy needs to be endorsed and supported by Clinical Directors, Nurse Managers and other Senior Managers plus Infection Control Staff and they must ensure that all staff at all levels are aware that they have a responsibility for implementing the strategy.

Clinical waste presents significant health and environmental risks if not disposed of properly. NHS trusts have a duty to ensure that they store and dispose of their waste safely and effectively. In particular, the Environmental Protection Act introduced a "duty of care" on all those producing waste which continues through

to the point of safe disposal (even when the service is being contracted out) and imposes criminal liability on the individual(s) responsible for waste management.

Clinical waste must be handled carefully; sharps items such as used needles are a particular hazard and therefore dealt with separately below. It is recommended that trusts establish a waste segregation policy, introduce single handling arrangements to increase safety and obtain written confirmation from their packaging suppliers that their product meets the required legislation. The policy will need monitoring and regular training programmes and/or waste awareness seminars should be held to ensure all staff are fully familiar with requirements and protocols. Further guidance and advice can be found in the recently published Audit Commission report; "Getting Sorted - The Safe and Economic Management of Hospital Waste, February 1997".

Weaknesses in the disposal of waste procedures point to a need for much tighter arrangements. These problems could be reduced if the following steps were followed:

- include handling arrangements within regular waste awareness seminars;
- ensure that clinical waste is disposed of in packaging ("yellow bags" or "bins") that is certified and marked as suitable for the purpose;

- provide lockable wheeled bins that allow 'single handling' of clinical waste;
- provide protective clothing for those handling waste;

1 Further guidance and information can be found in: "Guidance on Manual Handling of Loads in the Health Services", Health Services Advisory Committee, 1992 and "Manual Handling Operations Regulations", 1992

- carry out regular checks to ensure that bins and protective clothing are used properly; and
- record needle-stick injuries, and any other mishaps arising from the handling and transferring of clinical waste.

Statutory Requirements:

The main criteria for placing stricter controls and standards on waste management are: The Environmental Protection Act 1990; the Duty of Care Regulations 1992; the Health and Safety at Work etc Act 1974, and the New Special Waste Regulations 1996 (SI 972).

The Carriage of Dangerous Goods (Classification, Packaging and Labelling) and Use of Transportable Pressure Receptacles Regulation 1996 (SI 2092) has introduced a legally binding requirement that covers the transport of all dangerous goods on Public Highways. **From 1 January 1997** clinical waste can only be transported on public highways in UN approved containers. This places an **overall duty of care relating to the suitability for purpose on the consigner (ie the NHS trust)**. Trusts must therefore satisfy themselves that the products, such as clinical waste bags and sharp's containers, received from their packaging waste suppliers, comply with the legislation.

(c) Needlesticks/Sharps Injuries:

Injuries can arise before or during the use of a needle or sharp instrument; while the instrument is being prepared for disposal and during or after disposal. Many of these injuries can be prevented through training and adherence to good practice, based on usage and disposal methods. Guidance can be found in the BMA's "A Code of Practice for the Safe Use and Disposal of Sharps".

To reduce the number of sharps and needlestick injuries NHS Employers should ensure that:

- staff are trained in the safe use and disposal of sharps.
- needles are not resheathed or recapped after use.
- needles are disposed of into an impenetrable sharps container immediately after use.

(d) Substances Hazardous to Health

Due to the nature of their work, hospital employees encounter a wide range of substances which may be toxic, harmful, corrosive or irritant. The use of the disinfectant glutaraldehyde is a particular problem that can cause various types of allergic reaction and occupational illnesses (respiratory problems and dermatitis are a common complaint).

Statutory Requirements¹

Under the "Control Of Substances Hazardous to Health" Regulations (COSHH 1994), employers are required to prevent, or where this is not reasonably practicable, adequately control exposures to substances hazardous to health.

¹ Further guidance and information can be found in: "Control of Substances Hazardous to Health" Regulations 1994 and "Control of Asbestos at Work" Regulations 1987.

The "Control of Asbestos at Work" Regulations of 1987 state that precautions should also be taken to safeguard against accidental exposure to asbestos arising from building and maintenance work.

To comply with these regulations each organisation should carry out its own individual risk assessments to evaluate what risks are posed by the exposure to, and use of substances in the working environment.

NHS Employers:

- must assess the risks involved *before* they allow their staff to undertake any work which may expose them to hazardous substances.
- should use these assessments to identify means to prevent or control the exposure of substances to staff and others.
- must have access to specialist advice.
- must ensure that staff are trained in how to work safely with these substances and are aware of the dangers and any control measures needed, such as protective equipment.
- must implement procedures for dealing with spillages and train staff in how to safely carry out these procedures.
- should ensure that health surveillance is undertaken where appropriate.

(e) Violence to Staff

Violence is a health and safety risk which must be managed like any other. Physical assaults by patients on particular groups of staff such as nurses and doctors are becoming more common. Violence to staff can lead to low morale, stress and a poor image for the organisation, making it difficult to recruit and retain staff. It can also mean extra costs, absences, higher insurance premiums and compensation payments.

For staff, violence can cause pain, suffering and even disability or death. In addition, serious or persistent verbal abuse or threats can also damage health through anxiety or stress.

Community based staff are also vulnerable as it is often difficult to check on their daily movements¹.

This problem can be minimised if the following steps are taken:

- risk assessments should be undertaken.
- an action plan should be created to identify, analyze and rectify problems.
- incidents of violence and aggression should always be reported.
- training should be given to educate staff on how to avoid or defuse potentially violent situations and how to respond appropriately to incidents of violence.
- support and counselling should be provided for staff who are subjected to violence.
- technology and procedure should be effective so that staff can summon assistance if required (eg alarm systems).
- indicating in care plans precautions required for specific patients.

Relevant precautions for community staff might include log-in visit itineraries, checking in at intervals by phone or provision of mobile telephones and/or alarms.

(f) Slips, Trips and Falls

These are amongst the most common cause of injury to staff, visitors and patients. Patients may slip or trip when walking or falling from their beds during the night. Spillages or loose carpet may also result in slips or falls. Patients will be particularly susceptible to these types of accidents when they are elderly, infirm or receiving treatment by drugs which may disorient them. Most injuries will be minor bruises but more serious injuries such as cuts to the head or broken bones can occur.

Hospital managers can reduce this problem if the following steps are taken^{1,2}:

- training staff in how to work safely.
- assessing the risks to each patient to determine whether any special measures are needed to ensure their safety.
- analysing accident records to identify where these accidents are occurring.
- investigating their cause and taking appropriate remedial action to remedy persistent problems.

Specific checks/modifications which can be undertaken include:

- slip resistant flooring in heavily used areas.
- electrical leads secured and routed safely so that they do not present a trip hazard.
- spillages cleaned up quickly and warning signs put out where floors are wet.
- identifying the need to provide lower height beds for patients who may be at risk from falling out of bed.

- procedures for clearing snow and gritting ice which prioritise the areas to be actioned first.
- good grounds maintenance avoiding faults in roads or footpaths which cause accidents often resulting in personal injury and compensation claims.
- regular documented inspections of the grounds should also be made so as to identify potential problems and to strengthen defence against compensation claims.

(g) Stress at Work

Work induced stress is now widely recognised as a significant problem in the health service. The costs of stress can involve high levels of sickness absence, accidents, errors, low morale and poor performance.

Employers have a duty to ensure that their staff have a safe and healthy place to work. Health and Safety legislation is concerned with both the mental and physical wellbeing of employees. The risks of workplace stress should be assessed and measures taken to prevent them¹.

NHS employers should consider:

- taking steps to identify organisational causes of stress.
- introducing changes in structures and procedures which are identified as causing stress.
- introducing policies and procedures for handling stress.
- reviewing and developing support systems they have for staff needing guidance and help.

Human Resource Management and the OHS can assist employers to:

- identify organisational aspects of stress and, for example, assist in change management.
- identify and support stressed employees on a confidential basis.
- intervene at an early stage to prevent problems and where problems exist, to prevent them getting worse.
- establish stress awareness and stress management programmes.

¹ Further information is available in "Organisational stress" (Health at Work in the NHS\Health Education Authority 1996).

ANNEX C:

HEALTH AND SAFETY CHECKLIST FOR BOARDS:

Have you:

- a clear, written health and safety policy focusing accountability within the organisation which is signed by you and promulgated to all staff ?
- a board member who is responsible for health and safety risk management and who reports regularly to the Board ?
- set local targets enabling progress in health and safety performance to be measured ?
- a health and safety plan which has specific, measurable, achievable, and realistic objectives with given deadlines ?
- ensured that health and safety risks to employees and others, are assessed to identify preventative and protective measures required by health and safety law ?
- ensured that staff are provided with sufficient information about the risks they face and the preventative measures that are to be taken ?
- made arrangements for putting into practice the preventative measures - including planning, organisation control, monitoring and review ?
- plans to deal with the non-routine, new work and serious risks such as fires, spillages, exposure to ionising radiations, pathogens and genetically modified organisms ?
- allocated responsibility for health and safety to specific persons and gained access to competent advice, either from within or outside the organisation ?
- provided employees with adequate training and instruction on all health and safety issues as part of their induction and at further stages during their employment ?
- consulted staff and safety representatives effectively ?
- an incident/accident reporting system which provides reliable and timely information on all types of incidents and allows for the reporting of incidents/accidents to the Health and Safety Executive under RIDDOR ?
- provided your staff with access to confidential Occupational Health Services ?
- given a high priority to improving compliance with manual handling legislation ?
- a local policy and procedures in place to deal with work place and organisational stress ?

ANNEX D:

USEFUL REFERENCE DOCUMENTS:

Guidance issued by the NHS Executive:

Risk Management in the NHS, 1993

Effective Management of Security in A & E, May 1997

EL (93)47 - Preventing Crime in the NHS: the Management Challenge: July 1993

EL (93)66 - Health and Safety at work: July 1993

EL (93)111 - Risk Management in the NHS: December 1993

EPL (94)34 - Safecode - A Health and Safety Management Tool for the NHS - Imminent Issue to the NHS in England: September 1994

HSG (94)51 - Occupational Health Services for NHS Staff: December 1994

EL (95)89 - Health at Work in the NHS: August 1995

EL (96)13 - Security in the NHS

EL (96)44 - Health and Safety Management in the NHS: June 1996

NHS Security Manual, NAHAT, March 1992

Guidance Issued by NHS Estates:

ELM (91) M/1 - Strategic Guide for Waste Management: March 1991

EPL (96)3 - Firecode - Health Technical Memorandum 81 - Fire Precautions in new hospitals - Fire Practice Note 2 - The storage of flammable liquids directory of fire documents: April 1996, ISBN 0-11-322249-1

EPL (95)16 - Reporting defects and failures relating to non-medical equipment, engineering plant, installed services and building fabric: July 1995

HSG (94)50 - Clinical Waste Management: December 1994

EEL (94)1 - A Strategic Guide to Clinical Waste Management: January 1994

EPL (95)13 - Health Guidance Note: Safe Disposal of Clinical Waste Whole Hospital Policy: April 1995

NB; Copies of NHS Executive documents available by writing to: Department of Health Distributions, P.O.Box 410, Wetherby, LS23 7LN, or phoning: NHS Responseline 0541 555 455
NHS Estates documents are available from SO (formerly HMSO), 51 Nine Elms Lane, London, SW8 5DR. Fax: 0171 8311326. (All requests should be faxed where possible).

Health at Work in the NHS publications: (All free of charge to the NHS in England)

Available from: HEA Customer Services Dept. Tel. 01235 465565 Fax. 01235 465556

Measuring and Monitoring Sickness Absence in the NHS - A Practical Guide (1995) ISBN 0 7521 0559 9

NHS Staff Needs Assessments - A practical guide (1996) ISBN 0 7521 0643 0

Organisational Stress in the NHS: An intervention to address sources of work-related stress (1995) ISBN 0 7521 0646 4

Organisational Stress: Planning and implementing a programme to address organisational stress in the NHS (1996) ISBN 0 7521 0681 3

Resources Directory for Promoting Health at Work (1995) ISBN 0 7521 0572 8

Health at Work in the NHS - action pack (1995) ISBN 0 7521 0467 5

Health at Work in the NHS Research Study: Survey of Hospital Activity (1995) ISBN 0 7521 0642 2

Health of the Nation Strategy: Health Promoting Hospitals, 1994

Available from "Health at Work in the NHS", Health Education Authority, Hamilton House, Mabledon Place, London, WC1H 9TX Tel. 0171 413 1873 Fax. 0171 413 0341

Bloodborne Infections - Preventing the Transmission of Bloodborne Pathogens in Healthcare Settings (1996) - Teaching Pack

Working for Health - A practical guide to developing a healthy workplace in the NHS' (1995)

Health and Safety Executive Publications:

Management of Health and Safety at Work, Approved Code of Practice; Management of Health and Safety at Work Regulations 1992, ISBN 0 11 886330 4

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995

Good Health is Good Business: An Introduction to Managing Health Risks at Work, 1995

Health Risk Management: A practical guide for managers in small and medium-sized enterprises, 1995

Preventing Slips, Trips and Falls at Work, 1996

Violence at Work - A guide for employers, 1996

Violence to Staff in the Health Services, 1996

The Costs of Accidents at Work, HS(G)96, 1993, ISBN 0 7176 0439

Stress at Work: A Guide for Employers, 1995

Successful Health and Safety Management, HS(G)65, 1991, ISBN 0 11 885988 9

Five Steps to Successful Health and Safety Management "Special help for directors and managers", 1994

Management of Health and Safety in the Health Services, (Health Services Advisory Committee), 1994, ISBN 0 7176 0844 1

Guidance on Manual Handling of Loads in the Health Services, (Health Services Advisory Committee), 1992, ISBN 0717604306 [No longer available - new guidance to be published in mid 1997]

Anaesthetic agents: Controlling exposure under COSHH, (Health Services Advisory Committee), 1995

Getting to Grips With Handling Problems, Worked Examples of Assessment and Reduction of Risk in the Health Service, (Health and Safety Commission), 1994

The Management of Occupational Health Services for Healthcare Staff, (Health Services Advisory Committee), 1993 ISBN 0 11 882127 X

Safety Representatives and Safety Committees (Health and Safety Executive), 1996

All documents can be obtained from HSE Books, PO Box 1999, Sudbury, Suffolk, CO10 6FS. Tel: 01787 881165. Fax: 01787 313995

Others:

"Health Risks to the Health Care Professional" (Royal College of Physicians in London in association with the Faculty of Occupational Medicine), Ed. Paul Litchfield, 1995, ISBN 1 873240 95 3

Environmental and Occupational Risks of healthcare, (British Medical Association), June 1994, ISBN 0 7279 0887 1

A Code of Practice for the Implementation of the UK Hepatitis B Immunisation Guidelines for the Protection of Patients and Staff (British Medical Association), 1995, ISBN 0 7279 0923 1

Health and Employment, (ACAS), 1994, ISBN 0 906073 45 6

Violence and Community Nursing Staff, Advice for Managers (Royal College of Nursing), March 1994

Code of Practice for the Safe Use and Disposal of Sharps (British Medical Association Scientific Division), 1995

ABC of Mental Health in the Workplace - The Health of the Nation (Department of Health), 1994

SAFECODE software package is available from SAFECODE Ltd, Strathclyde University, 141 St James Road, Glasgow, G4 0LT. Tel: 0141 552 2466 Fax: 0141 522 2889

ANNEX E:

THE NHS EXECUTIVE WOULD LIKE TO THANK THE FOLLOWING FOR THEIR HELP AND ASSISTANCE IN PREPARING THIS GUIDANCE:

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MANAGING RECRUITMENT

CHAPTER NINE

MANAGING RECRUITMENT

Action required in light of the Disability Discrimination Act 1995

1. NHS employers should follow good practice in the employment of disabled people, as recommended in EL(95)143, "**Employing Disabled People in the NHS: a guide to good practice**". However, there is a need to consider the detailed implications of moving from voluntary good practice to statutory duties. In particular, personnel managers and line managers in taking decisions on advertising vacancies, interviewing and selecting staff, arranging for training, transfers, promotions, disciplinary action, appeals, dismissals etc will need to take account of the key legal requirements: (a) to avoid unjustifiably treating disabled people less favourably; and (b) to consider "reasonable adjustments" where necessary. [Taken from EL(96)70]

Induction/Probation periods

2. Employers should consider the benefits to the organisation and employee of an induction period. This would allow the new member of staff the opportunity to familiarise themselves with their new job and the organisation. Employers might also wish to consider a probationary period which would allow them to satisfy themselves that the employee was demonstrating their ability to achieve satisfactory standards of conduct and performance. (**Bullock Recommendation 1**)

References

3. Central to good recruitment and selection procedures is the need for the take up of references. Employers should consider the use of a standard form of reference for applicants. Such references should be factual and follow the guidelines set out by the IPD so that impressions conveyed are substantiated by evidence. (**Bullock Recommendation 2**)
4. As a term of good practice, referees should make applicants aware of what is said about them in their reference.
5. Every prospective employer should designate an officer to check that carers are registered with the UKCC, GMC, CPSM or other statutory bodies as appropriate. Current NHS guidance (EL(92)84) advises that employers should check registration before applicants take up a post and this was consolidated by the UKCC in 1997 when they wrote to employers reminding them of their duty to ensure that all nurses, midwives and health visitors in employment are appropriately qualified and registered. (**Bullock Recommendation 3**)
6. Responsibility for the taking up of references, including information about absence behaviour, rests with the engaging manager unless the organisation has arranged for this to be done centrally or through the Personnel section.
7. Special attention should be paid to the provenance of references to ensure that they are provided by a competent officer of the previous employer who should be required to give their own position in the organisation, status and formal line management relationship with the applicant. Should any doubts be felt about the references checks should be made with the originator. (**Bullock Recommendation 4**)

Interviews

8. Those staff involved in the recruitment and interviewing of new employees should have received appropriate training in recruitment and interviewing techniques. This is especially important in meeting the requirements of anti-discrimination legislation. Employers should ensure that if trained staff are unavailable, due to illness or some other emergency, to carry out an interview it is only taken forward by another trained member of staff. Failing this the interview should be postponed until trained staff are available. **(Bullock Recommendation 5)**
9. Employers should ensure that appropriate management training, including the development of strong communication and interpersonal skills, to equip managers with the relative and positive ability to deal with problems in the employment sphere, is provided for all relevant staff. **(Bullock Recommendation 6)**
10. It is good recruitment practice for interviews to cover discussion of career gaps, question previous criminal convictions, and where the applicant would be working with children, checking for a possible criminal background with the police. (Procedures for undertaking Police checks for NHS employers are outlined in the NHS Executive HSG(94)43).
11. Employers should consider informing applicants at the outset that, should they be considered for the post advertised, their health questionnaire may be passed to their GP for consideration. It has been found that this encourages applicants to be more careful about answering questions and thus saves time later in the process. **(Bullock Recommendation 17)**

Exit Interviews

12. Employers may wish to consider the use of exit interviews to allow departing staff the opportunity, in a face to face confidential meeting, to express any concerns they have about work, working practices or colleagues. Information gained from these interviews should be recorded and reviewed from time to time to ascertain whether a pattern of concerns is arising which may need to be addressed by managers. **(Bullock Recommendation 22)**