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MANAGING HEALTH
AT WORK

guideline



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MANAGING HEALTH AT WORK



Ministerial Foreword

This PIN Guideline sets important standards designed to improve the health at work of all staff in NHSScotland.

Our National Health established a Staff Governance Standard for NHSScotland staff for the first time. This placed the fair and effective management of staff on the same footing as the management of clinical standards and finance within the national Performance and Accountability Framework. Performance against the Staff Governance Standard and the implementation of this and other guidelines will be assessed in partnership using the Self Assessment Audit Tool and will form an integral part of the Performance and Accountability Framework against which NHS Boards and their constituent parts will be reviewed.

Staff across Scotland have a clear entitlement to be "provided with an improved and safe working environment" monitored through the commitment in the Staff Governance Standard. I am looking for NHSScotland employers to work in partnership with staff to develop a health and safety management framework needed to help make NHSScotland an exemplar on health at work. The Managing Health at Work PIN Guideline provides a sound framework for taking forward this partnership approach, allowing further policy and guidance to be developed over time.

The model policies are intended to be adapted to suit local needs and to reflect local structures and resources, but the best practice in the Guideline is the minimum that will be provided by employers in NHSScotland.

A handwritten signature in black ink that reads "Malcolm Chisholm". The signature is written in a cursive style.

Minister for Health and Community Care

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INTRODUCTION

“Managing Health at Work” is a short title for a very large topic. NHSScotland is committed to protecting and promoting the health, safety and wellbeing of its staff*. The aim of this guideline is to help deliver that commitment.

Given the breadth of the subject, this Guideline makes no claim to cover everything in detail. However, its opening chapters (2 – 4) set out the general principles which apply across NHSScotland. Following these sections, the Guideline includes a range of topic-specific guidelines in a standard format. They can either form part of an overall approach or be taken out and used, where appropriate, as stand-alone guidelines. Where users need a guideline on a topic not included, it will be relatively straightforward to develop one using the general principles (Chapters 2 – 4) and the standard format.

As a PIN Guideline, it is one of a range of guidelines produced to help managers, staff and their representatives. There is inevitable overlap with, and cross-reference to, other PIN Guidelines. For example, the Guideline on Family Friendly Policies is relevant to health and wellbeing, and the Dignity at Work Guideline provides an approach to deal with issues of bullying and harassment. There is also both general and specific guidance, for example, around Radiation Protection or Visual Display Units, which applies to the NHS as to other bodies. The Guideline does not attempt to repeat that material: instead users should follow through cross-references etc as necessary.

The many individuals who contributed to the development of this Guideline will be using it in their own work. They believe it will be of key importance across NHSScotland.

* This Guideline uses the word “staff” to include direct employees of NHSScotland, those working in and for the contractor professions, volunteers and those working for voluntary and statutory agencies in partnership with NHSScotland.

1. PROMOTING EMPLOYEE HEALTH AND WELLBEING

1.1 Introduction

A healthy organisation is one that successfully balances the needs of individuals with the needs of the organisation as a whole. Within NHSScotland, it is well recognised that staff face a demanding working environment and are continually facing new challenges. Both of these factors have an effect on the physical and mental wellbeing of staff. NHSScotland depends upon a healthy, motivated workforce to deliver the service which the country needs and expects.

The importance of a healthy workplace is based upon the principle of co-operating and linking all the relevant initiatives, policies and opportunities together. Health at work is not only about health and safety, occupational health and promoting healthier lifestyles: the way in which work is organised also plays a major role.

There are four major components underpinning a healthy organisation:

- health and safety;
- promoting access to competent occupational health services;
- promoting staff health and wellbeing; and
- organisation of work.

The importance of co-operating and linking all the relevant initiatives, policies and opportunities cannot be over-emphasised. The Staff Governance Standard aims to make sure that organisations are committed to providing an improved and safe working environment for staff, and an annual self-assessment will monitor the organisation's delivery of this commitment. PIN guidelines such as Dignity at Work, Dealing with Employee Concerns and Family Friendly Policies also have a major contribution to make to health at work. The Partnership Forum is the mechanism by which health at work can be co-ordinated and duplication avoided. It must be stressed that the Forum's role is to co-ordinate and support the organisation in its efforts to manage health at work, without replicating the efforts or assuming the responsibilities of others in the organisation.

1.2 Promoting access to competent Occupational Health Services

It is crucially important that staff have access to competent occupational health services. Ill health can be caused by work, however ill health which manifests itself in the workplace can be caused by a problem in a staff

member's home life. The Scottish Occupational Health Strategy – 'Towards a Safer, Healthier Scotland' recognises that the key to success of the strategy is based upon partnership, involving all of those with an interest in treatment, rehabilitation and prevention of disease. This strategy and the ten-year occupational health strategy for the United Kingdom 'Securing Health Together' outline the action necessary to achieve the competent occupational health provision for health at work.

1.3 Organisation of work

The way in which work is organised can have a major impact on the health of staff. It is clear from a number of surveys that staff feel better and perform better in a workplace where:

- there is an open and flexible culture with good communication;
- there is a genuine commitment to reducing stress;
- merit is recognised and achievement rewarded; and
- staff are properly trained and equipped to do their job with a realistic workload.

Stress has been reported as a major health factor in staff surveys across Scotland and Guideline 1 outlines the ways in which an organisation can take action to tackle stress and improve health.

1.4 Developing policy and structures

There is a number of health and safety related policies which by law have to be developed and implemented. These, however, should not be seen as the limit to an organisation's development of policies. A number of issues can benefit from having a stated organisational policy on how each issued will be addressed. The benefit of a written policy is that it provides a legitimate basis for action. Very importantly, it provides a clear point of reference. Such policies send clear signals to staff, patients, visitors and the outside world about the behaviour that is expected within the workplace, and about its ethos and 'health culture'. Policies are not just about the "do's and don'ts". They also support staff who want to make positive health changes (for example, to eat healthier food or give up smoking). Policies must be developed in partnership, and to be effective must apply to, and be seen to apply to, all levels within the organisation.

1.5 Nutrition

Diet and eating patterns are very clearly linked to health. In Scotland too many people have a nutritionally poor diet.

The consequences of a poor diet are obvious in oral as well as general health, with large numbers of people developing coronary heart disease, and certain cancers being typical. Obesity and eating disorders are also increasing.

Action to consider

For many staff working within NHSScotland, the circumstances of their work (for example, shift work, and/or long and unpredictable hours) mean that eating a well-balanced diet, and having regular meals, is not always possible. Nevertheless, a number of measures can be taken to help them:

- • Actively promote the workplace nutrition policy to make sure that dining rooms and other areas provide a wide choice of foods and that the choice of ingredients, preparation and cooking methods are based on sound nutritional guidelines.
- • Make sure that vending machines and snack bars sell healthier alternatives to traditional chocolate, sweets etc, such as fruit juices, wholemeal bread and sandwiches, fresh fruit, and cereal bars.
- • If there is no dining room in the workplace, provide and maintain an eating area with access to a fridge so staff can store healthy foods brought in from outside.
- • Encourage special events such as healthy-eating weeks or 'taste and try' days, to introduce new healthier food options in canteens.
- • Help staff returning to work after maternity leave to get the next generation off to a good start by helping them to continue to breastfeed their babies.
- • Provide food at times and in ways that suit shift workers or staff working irregular hours.
- • All caterers in NHSScotland should aim to achieve the commended standard of the Scottish Healthy Choices Award. The co-ordinator can be contacted at the Scottish Consumer Council (0141 226 5261).
- • Monitor, review and evaluate the nutrition policy.

1.6 Physical activity

Lack of exercise has a negative effect on health, and contributes to illness. Taking regular exercise helps to reduce the risk of heart disease and helps prevent obesity. A physically fit person is generally healthier and better able to cope with the demands of a stressful job. However, busy staff with little free time during the day may find it difficult to make time to exercise.

A physical activity policy demonstrates a commitment to provide both information and, if possible, facilities and other measures to encourage staff to exercise and to keep fit. It also encourages greater links between NHSScotland workplaces and other health-promoting settings in the local community.

Action to consider

- • Encourage staff to walk whenever possible, for example, support the stair-walking campaign.

- • Discuss public transport access with the local authority (and if possible improve it) and encourage the development and use of cycle paths.
- • Provide exercise areas and fitness equipment.
- • Provide lockers, changing and shower facilities for those taking exercise.
- • Provide bicycle racks to encourage people to cycle to work.
- • Provide information about local sports and leisure centres, classes and clubs.
- • Provide subsidies for staff membership or entrance fees to local health or sports clubs, swimming pools or fitness centres. Discounted rates can often be negotiated with local authorities.
- • Publicise sporting or other fitness events such as fun runs or walks, and support workplace sports and activity clubs such as aerobics, football, badminton, squash, etc.
- • Offer health and fitness assessments to staff.

APPENDIX 1.1

References

- Health and Safety Commission *Securing Health Together, A long-term occupational health strategy for England, Scotland and Wales, HSE Books, London, 2000*
- National Audit Office *Health and Safety in NHS Acute Trusts in England – A Report by the Comptroller and Auditor General, HC 82, 1996/97, 22 November 1996, ISBN: 0102626979*

2. HEALTH AND SAFETY FRAMEWORK

2.1 Introduction

Organisations that successfully manage health and safety recognise that the relationship between controlling risks and general health is at the very centre of the business itself. Their approach rests on the principles in the Health and Safety Executive's guidance document 'Successful Health and Safety Management' HS(G) 65. The document clearly states that managing health and safety successfully is founded on effective systems which:

- set and develop policy;
- organise for health and safety;
- plan and put in place systems;
- monitor performance; and
- review.

NHSScotland has demonstrated through the staff governance agenda its commitment to be both a model employer and provider of occupational health and safety. The documents 'Securing Health Together' and 'Towards a Safer, Healthier Workplace' clearly set out the strategy in relation to this. It is essential therefore for each NHSScotland employer, in partnership with staff, to develop a health and safety management framework which will not only comply with legislation but will lead to NHSScotland becoming an exemplar employer. The main elements of such a framework are set out in Box 1.

Box 1 Structure for an occupational health and safety framework

1 Statement of commitment.

2 What the policy will cover.

3 Responsibilities.

4 Consultation arrangements.

5 Arrangements (systems and procedures).

This section should link to, or include, the systems and procedures that are in place to reduce risk and provide a safe and healthy working environment. This will include ways of carrying out assessment to feed through to the planning process and then putting the plans in place.

6 Instruction and training, in particular:

- management training;
- risk-assessment training;
- induction training; and
- specialist training.

7 Sources of information.

8 Monitoring, including:

- inspections;
- reporting incidents;
- complaints; and
- claims.

9 Reviews

- audit.

2.2 Responsibilities of managers and staff

2.2.1 Senior managers are responsible for:

- making sure that there is a written policy which is regularly updated;
- assessing health and safety risks to staff and others – to identify measures needed under health and safety law;
- making arrangements for putting these measures into practice – including planning, organisation, control, monitoring and review;
- in conjunction with the Occupational Health Service, identifying and providing appropriate health surveillance;
- identifying and appointing competent people who are trained to carry out specific health and safety tasks;
- establishing the systems for communicating procedures to deal with serious and imminent danger;
- giving staff understandable information;
- giving staff adequate and appropriate training and instruction on health and safety issues;
- co-operating with other employers where premises are shared;
- consulting with safety representatives; and
- contributing to and developing appropriate organisational policies and standards.

2.2.2 Departmental and ward managers are responsible for making sure that:

- there is an up-to-date and clear written local policy which sets out the organisation's structure (the people responsible) and arrangements (the procedures to be followed) for identifying hazards, assessing risks and preventing or controlling them;
- staff know about the policy and making sure they understand it;
- the policy is compatible with the overall organisational policy;
- the policy is up-to-date and has a review procedure built in; and
- the policy identifies the need to scrutinise and review performance and that the policy is effective.

These managers must also check that personnel for whom they have responsibility are organised, so it is important to make sure that:

- responsibility for health and safety is given to specific people;

- there is a means for consulting and involving staff and safety representatives effectively at departmental or ward level;
- staff have enough information about the risks they face and the preventative measures to be taken;
- overall within the department or ward there is the right level of expertise and staff are properly trained; and
- access to specialist advice is taken as necessary, either from within or outside the organisation.

2.2.3 All **staff** are responsible for:

- taking care of their own safety and the safety of all others who may be affected by their acts;
- following all organisational rules, regulations and instructions to protect the health, safety and welfare of everyone affected by the organisation's services;
- knowing organisational policy and departmental, ward, or local health and safety working practices;
- not deliberately or recklessly interfering with or misusing any equipment provided for the protection of health and safety;
- knowing all emergency procedures including evacuation and fire precaution procedures relating to their place of work;
- attending health and safety training sessions and refresher courses provided by the organisation;
- following safe working practices and using safety equipment provided; and
- taking part in risk assessments and identifying safe working practices.

2.2.4 **The Occupational Health and Safety Service (OHS)** is responsible for:

- advising on legal responsibilities; and
- providing advice and support in tackling problems relating to health, safety and welfare at work.

2.2.5 **Trade Unions/Professional Organisations and safety representatives** are responsible for:

- participating in consultation mechanisms relating to health and safety issues at work;
- helping to develop local policy; and
- taking part in risk assessments and identifying safe working practices.

2.3 Ways of carrying out consultation and communication

The statutory Health and Safety Committee consults about and communicates health and safety plans. The members of this committee should reflect the characteristics of the employer and make sure that staff and managers have appropriate representation on the committee, which can include:

- safety representatives;
- line managers;
- a fire prevention officer;
- control of infection advisers;
- director responsible for health and safety;
- health and safety advisers;
- occupational health staff; and
- specialist advisers, for example, on issues such as manual handling, violence and aggression.

There may be a need for departmental committees to support the corporate committee if this is necessary, and departmental and staff meetings should have health and safety as a standing item on their agendas.

Other ways of spreading information on health and safety are:

- attaching information to:
 - payslips;
 - staff handbooks;
 - departmental safety manuals; and
 - notice boards;
- holding:
 - departmental and ward meetings;
 - corporate induction programmes;
 - safety audits;
 - training events and workshops on health and safety; and
 - departmental training activities;
- through partnership forums;
- sending out newsletters;
- producing safety inspection reports; and
- through intranets.

The agenda for a health and safety committee should include, as a minimum:

- the Occupational Health minimum dataset;
- statistics on accidents and incidents and a review of any trends;
- a review of critical incidents;

- health and safety policies;
- risk assessment trends;
- reports from safety audit teams; and
- work-related sickness absence.

The systems an organisation has in place for health and safety need to involve everyone, with the Health and Safety Committee playing a central role. Responsibility for leading the health and safety agenda lies with Chief Executives of organisations. An Executive Director of the organisation will have responsibility and should be named in the organisation's health and safety policy. This person will report at least once a year to the organisation's Board on health and safety issues and will put forward (for approval) the coming year's health and safety agenda. The health and safety roles of senior and operational managers and staff must be clearly set out in the health and safety policy, and each operational manager must have a clear understanding of the area or site responsibility they have for health and safety. This will include responsibility for shared facilities such as meeting rooms.

Specialist advisers (for example, occupational health, fire safety, etc.) will support operational managers. We suggest that the nominated director convenes and chairs the Health and Safety Committee. This committee will monitor how policies are put in place by arranging regular audits and reports from committee members. The committee will communicate all health and safety issues to the organisation. The Health and Safety Committee will be linked to occupational health services, risk management structures and the Control of Infection Manager and other specialist advisers. Each health organisation needs to promote a positive health and safety culture, which features the following.

- **Communication** – either written or oral – to show that management are committed to a safe and healthy working environment.
- **Competence** – making sure that all staff are competent and that health and safety advice is readily available.
- **Co-operation** – to encourage people to get involved in risk assessments to achieve better results.
- **Control** – where representatives are clearly identified and resources secured.

This approach must be followed consistently across all parts of the organisation. It should also be 'interactive' and should constantly refresh the safety agenda.

2.4 Access to information

Safety representatives have the right to ask for documents relating to the workplace or individual staff (except for identifiable health records). An

employer must provide relevant health and safety information unless this would:

- go against any acts of Parliament;
- be against the interests of national security;
- involve personal information about an individual without gaining that person's permission;
- cause harm to the organisation; or
- relate to legal proceedings.

NHSScotland employers should also use the principles of partnership in order to involve safety representatives at an early stage and include them in identifying safety issues. Sharing information with safety representatives, line managers and specialist advisers promotes an open way of working.

3. RISK ASSESSMENT





3 Risk Assessment

Assessing risk means carefully examining what, in our work, could cause harm to people. It involves weighing up whether we have taken sufficient precautions or should do more, both for work that is in progress and for work that is planned. So, it is about understanding what might happen and judging what to do as a result. An important step in this process is providing the information needed to allow managers to plan improvements in the health and safety standards within the organisation and then put them in place. A general risk-assessment framework, as necessary under the Management of Health and Safety at Work Regulations 1999, should follow the process set down in Box 2.

Employers need to carry out risk assessments for all hazards that arise from current activities, and, equally importantly, consider the measures that are needed to control the risks from new activities before they start.

The main principles of a risk assessment are to:

- eliminate risks altogether;
- tackle any risks at source;
- adapt work to the individual wherever possible;
- take advantage of technology wherever possible;
- give priority to measures which protect the whole workforce;
- make sure staff know what to do;
- review measures regularly; and
- train and involve all staff in risk assessment.

Box 2 The risk-assessment process	
<p>Step 1 Identify hazards</p> 	<p>Look for hazards that you could reasonably expect to result in significant harm under the conditions in your workplace. For example:</p> <ul style="list-style-type: none"> • slipping or tripping hazards (such as poorly-maintained floors or stairs); • manual handling (such as handling patients or goods deliveries); and • work at heights (such as from mezzanine floors).
<p>Step 2 Who might be harmed?</p> 	<p>You do not need to list individuals by name – just think about groups of people doing similar work or who may enter the work area, for example:</p> <ul style="list-style-type: none"> • people sharing your workplace; • cleaners; and • members of the public. <p>Pay particular attention to:</p> <ul style="list-style-type: none"> • people working alone.
<p>Step 3 Is the risk well enough controlled?</p> 	<p>Have you taken precautions against the risks from the dangers you have listed? For example, have you provided:</p> <ul style="list-style-type: none"> • enough information, instruction or training? • adequate systems?
<p>Step 4 What further action is needed, if necessary, to control the risk?</p> 	<p>What more could you reasonably do for those risks which you found were not well enough controlled? Give priority to those risks which affect large numbers of people or could result in serious harm. Use the principles below when taking further action, if possible in the following order.</p> <ul style="list-style-type: none"> • Remove the risk completely. • Tackle the risk at source (for example, prevent access to the danger by guarding the area). • Organise work to reduce exposure to the danger.
<p>Step 5 Review</p>	

4. PRIMARY LEGISLATION

4 Primary legislation

The Health and Safety at Work Act 1974 is the primary piece of legislation within the UK. The act is an 'enabling' act, often referred to as an umbrella act. (This means that Regulations can be introduced without the need for additional primary legislation.) This Act is supported by many other regulations and pieces of legislation, the most significant of which is the Management of Health and Safety at Work Regulations 1999. The crucial elements of these regulations lie in the requirement to have systems in place to manage health and safety. Using the technique of risk assessment to evaluate risk, to support planning and putting effective controls in place, helps to support such systems.

The Health and Safety at Work Act 1974 says that employers must, so far as is reasonably practicable, provide:

- a safe place of work;
- a safe working environment;
- safe equipment;
- safe systems of work; and
- sufficient information, instructions and training.

The Health and Safety at Work Act 1974 says that employers should have a written safety policy (see Appendix 4.A). The health and safety policy may form the document which provides the framework for a health and safety management system.

APPENDIX 4.A

Health and Safety Policy Statement

[Name of organisation] exists to provide healthcare services of high quality to the people of [Name of area]. We recognise that we cannot provide these services unless we ensure, as far as possible, freedom from risk to the health, safety and welfare of staff, and others affected by our work activities. This is a primary objective of [Name of organisation], and we prioritise it equally alongside other business and operating objectives.

The minimum acceptable standards of health and safety are those contained in legislation. It is our objective to improve on these standards.

We recognise that the prime responsibility for health and safety rests with our managers. This principle extends from the Chief Executive to first line supervisors. Managers and supervisors are directly accountable for the prevention of accidents, injuries and occupational illness, as well as damage to our property, within their area of responsibility.

This policy statement is supplemented by additional policies giving detailed arrangements for health, safety, welfare and related issues. Managers are responsible for bringing these policies to the attention of their staff.

All staff within [Name of organisation] are responsible for making safety at work a priority to protect themselves, their colleagues, patients, visitors and the interests of [Name of organisation].

The Occupational Health and Safety Service is responsible for advising managers and staff about their legal obligations and for advice and support in tackling problems relating to health, safety or welfare. [Name of organisation] has appointed a specialist advisor whose role is to help us meet our health and safety obligations.

As Chief Executive, I have overall responsibility for health and safety in [Name of organisation]. I have appointed the [Director of ...] as the Director with particular responsibility to oversee the implementation of this policy throughout [Name of organisation]. I will review the implementation of this policy annually and welcome suggestions for improvement.

Signed by

.....
[name]

Chief Executive

[date]

APPENDIX 4.B

References

- | | |
|-----------------------------|--|
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| Health and Safety Executive | <i>Successful Health and Safety Management, HSE Books, London, 1997, ISBN 0717612767</i> |
| National Audit Office | <i>Health and Safety in NHS Acute Trusts in England – A Report by the Comptroller and Auditor General, HC 82, 1996/97, 22 November 1996, ISBN 0102626979</i> |
| The Scottish Executive | <i>Towards a Safer Healthier Work Place – an Occupational Health Strategy for NHSScotland, HMSO, Edinburgh, 1999</i> |

Dealing positively with stress at work

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1. DEALING POSITIVELY WITH STRESS AT WORK

1.1 Introduction

The organisation of work, communication and leadership styles have a significant effect on the physical, social and mental wellbeing of staff, and consequently on their performance. The characteristics of an 'unhealthy' workplace could include staff:

- frequently showing signs of stress;
- experiencing depression;
- with low confidence;
- behaving aggressively;
- suffering 'burn-out' or breakdown; and
- being absent a lot.

1.2 Promoting attendance by dealing positively with stress at work

Work-related stress has been defined by the Health and Safety Executive as 'the adverse reaction people have to excessive pressures or other types of demand placed on them' (HSE 1995). Stress exists where people see that they cannot cope with what is being asked of them at work or if they are not certain of their job or role. In principle, everyone can experience work-related stress, and no one is immune. However, there is an important difference between work-related stress, and the beneficial effects of reasonable pressure and challenge.

Work-related stress is not an illness, but if it goes on a long time, it can contribute to ill health.

The physical effects include:

- raised blood pressure;
- heart disease;
- back pain;
- stomach problems; and
- minor illnesses.

The psychological effects include:

- anxiety and depression; and/or
- displaying other behaviour which can be bad for health such as skipping meals, drinking too much caffeine or alcohol and smoking cigarettes.

Work-related stress also has consequences for organisations. It can lead to:

- increased levels of sickness absence, together with the associated effects on other members of staff;
- reduced staff morale;
- reduced staff performance; and
- staff looking for other employment.

The scale of the problem

- The Confederation of British Industry (CBI) has estimated that the direct cost of stress-related sickness absence is estimated to be £7 billion a year. This represents a cost of £310 for each employee each year (Parker, 1999). According to the CBI / PPP Healthcare report, stress was the second most significant cause of sickness absence, behind minor illness. The cost for each employee is £426 and a total annual cost of sickness absence cost (for everything) of over £10 billion.
- The Industrial Society (now known as The Work Foundation) stated that bullying accounts for nearly £2.3 billion in lost productivity due to stress-related problems (News item, 1999).
- The Chartered Institute of Personnel and Development said that the annual cost of job stress is around £224 million and the price paid by UK business, in terms of inefficiencies arising from stress, is as much as 10% of the gross domestic product (1998).
- A TUC survey said that five million people have been bullied at work, one in 10 employees claimed intimidation by managers and more than a quarter said they know of colleagues who had been similarly treated (1998).

As a result of these factors it is estimated that stress and stress-related problems account for over one third of every GP's caseload in Scotland (The Scottish Office, 1992). While workplace policies and regulations can do much to improve the working environment and to change unhealthy lifestyle practices among staff, other approaches are needed to tackle stress-related issues and to understand and respond to staff's concerns and needs.

This is especially true in NHSScotland where much of the work is inherently stressful, and where staff are under constant pressure to perform against a background of continuous change and uncertainty. One of the consequences of this pressure is that more and more NHSScotland staff are experiencing stress at work. As a result of this, their physical and

mental health is being put at risk while the efficiency and quality of the service is also under threat.

In 1995, the HSE published a landmark document entitled 'Stress at Work: A Guide to Employers'. This clearly told employers about their duty of care for the mental as well as physical health of their employees. Included in the guide was the following warning.

"Ill health resulting from stress caused at work has to be treated the same as ill health due to other, physical causes present in the workplace. This means that employers do have a legal duty to take reasonable care to ensure that health is not placed at risk through excessive and sustained levels of stress arising from the way work is organised, the way people deal with each other at their work or from the day-to-day demands placed on their workforce."

In 1999, the HSE produced a discussion document, 'Managing Stress at Work', and carried out a major consultation exercise. In response to the results of the consultation process the HSE published two guidance documents in June 2001:

- • *Tackling work-related stress – A manager's guide to improving and maintaining employee health and wellbeing*
- • *Tackling work-related stress – A guide for employees*

1.3 Developing a stress policy which tackles organisational and individual issues (or including stress in a general health policy)

The parts of this type of policy might include the following.

- • Making a commitment to a healthy workforce by placing a high value on the physical and mental health of staff.
- • Acknowledging that stress problems have many causes – including in the workplace and the outside world.
- • Identifying and listing the factors that may contribute to increased levels of stress in the organisation. (This should be based on the risk assessments for the organisation.)
- • Recognising that domestic factors (housing, family problems and bereavement for example) may add to levels of stress experienced by staff.
- • Stating that the organisation is committed to a course of action that may include:
 - ◦ increasing knowledge of the causes of stress in the organisation;
 - ◦ dealing with the causes of stress and helping staff to manage stress; and

- managing health problems associated with stress through:
 - recognising symptoms early;
 - managing stress appropriately;
 - providing access to counselling;
 - providing advice and sources of help; and
 - managing the return to work of those who have suffered stress-related mental or physical health problems to make sure that their skills are not lost.

1.4 The benefits of an organisational stress policy

An organisational stress policy can lead to a number of benefits. These include:

- improved staff efficiency and effectiveness;
- improved morale;
- better working relationships;
- a reduction in the waste of trained staff; and
- a better image for NHSScotland.

1.5 The aims of the organisational stress policy

The policy should:

- encourage staff wellbeing within NHSScotland and discourage the stigma attached to stress;
- raise awareness of ill health associated with stress, its causes and associated factors;
- train managers to identify the causes of potential stress and the symptoms of stress;
- change those aspects of the workplace that have been identified (through risk assessment) as increasing the risk of stress;
- improve factors within the organisation that reduce the risk of stress;
- educate staff in techniques for coping with pressure and stress;
- provide staff with help if they have mental or physical health problems associated with stress;
- through information and education, encourage everyone to recognise stress-related problems;
- provide systems of support and make sure they are well publicised;
- encourage staff to get help at an early stage;
- offer easy access to counselling and other professional help;

- • make sure there is confidentiality for those who want help (from whatever source);
- • as far as possible, guarantee job security, sick leave, the retention of status and make sure that there is no blame attached to those using the support mechanisms;
- • set up procedures for return to work, and rehabilitation in work; and
- • make sure that these procedures are flexible enough to meet varying needs.

1.6 Putting the policy into practice

To help successfully put the policy into practice it is important to make sure that the policy:

- • is part of the health and safety policy and structure within the organisation;
- • is linked to other elements of health promotion within the organisation such as Scotland's Health at Work Award;
- • is developed to suit the particular structure, organisation and ethos of the organisation;
- • is developed by a working group that represents staff of all grades and from all sections of the organisation;
- • applies to all staff no matter what their age, sex, ethnic origin or grade; and
- • makes clear statements on the roles and responsibilities of each group of staff within the organisation including the following:
 - ◦ senior managers;
 - ◦ line managers;
 - ◦ HR;
 - ◦ Occupational Health Services;
 - ◦ Trade Unions/Professional Organisations; and
 - ◦ all staff.

1.7 Education and training needs

Due to the complex nature of stress, there is no simple education and training programme available to meet all the needs of an organisation. The organisation has to prioritise what action is needed. The type of issues which may need to be addressed include:

- • general awareness-raising for all staff; and

- training managers to identify the potential causes of stress and the symptoms of stress.

1.8 Evaluation, audit and review

The activities stemming from the introduction of the policy and all its constituent parts should be constantly monitored and examined with regular revisions of the policy when appropriate. The risk assessment process should also be reviewed in the light of any changes to work activities. Regular monitoring and reviewing staff turnover, sickness absence and accidents may also help to evaluate the effectiveness of the policy.

1.9 The risk assessment process

- Managing risk involves controlling hazards at source rather than treating the effects of a hazard. This philosophy is also suitable for organisational stress.
- A stress audit can be viewed as a precursor to a risk assessment, which in turn enables intervention decisions to be made. This is consistent with an assessment of stress as a hazard along with the likelihood of an attendant risk of harm. Adoption of interventions driven by risk assessment is likely to bring maximum benefit to all by focusing on the key issues. Furthermore, a joint focus of data-gathering, interpretation, discussion and action is likely to be more meaningful for everyone involved (Baker and Saunder OHR 2000).
- Cox and others (2000) in an HSE-funded report ('Organisational Intervention for Work Stress, A Risk Management Approach') made the case for a new approach to assessing and managing stressful work situations. Previous studies have looked at links between what causes stress and health in terms of risks to the individual. This reflects a bias towards dealing with stress at a personal rather than organisational level. The authors argue that what is needed is an approach that looks at problems faced by groups of staff. In other respects the strategy they describe is firmly based on techniques for managing risk used for other hazards including:
 - identifying the hazard leading to characterising risks;
 - an audit of existing risk management systems; and
 - recommendations for new measures that tackle the risks that are still present.
- Risk assessments are used with most other occupational health and safety hazards.

1.10 The organisational stress audit (OSHA)

In order to begin to identify and assess stressors within an organisation it is necessary to look at the organisational structure and culture. A number of stress audit tools are available to help with this process. The main function of a stress audit tool is to investigate current situations within the organisation and will include gathering information on the following:

- • organisational culture;
- • management and social environment;
- • communication;
- • task environment;
- • problem-solving environment; and
- • staff development environment.

The audit will provide the organisation with information on the relevant issues. This should be followed by the introduction of a process of developing interventions to address the identified areas of risk.

One example of an audit tool was developed in 1996 by the Institute of Occupational Medicine (IOM) who adopted this risk-assessment framework and developed the Organisational Stress Audit (OSHA). This identified and categorised the known causes of workplace stress. The categories form a semi-structured interview that acts as the risk-assessment tool.

The OSHA is a three-staged approach that is similar to the methodology used for physical dangers, namely that the first line of enquiry is not targeted at the individual but rather focuses on the nature of the hazard and what procedures are in place for controlling risks. As a result, the specific investigations carried out (for example, the conventional monitoring and control actions) can focus on areas where hazards are thought to be presenting the highest risk.

Stage one identifies the hazards by carrying out semi-structured interviews with a representative sample of staff at all levels and functions in the organisation. This stage identifies and prioritises the risks and recommends an action plan.

Stage two involves detailed investigation of the priority areas in order to develop more wide-ranging strategies for reducing risk.

Stage three aims to evaluate the effectiveness of interventions.

More detail on this model is included at Appendix 1.C.

Other tools available include *Work Positive – prioritising organisational stress*. This resource was developed by the Health Education Board for Scotland and the Health and Safety Authority, Ireland.

APPENDIX 1.A

Model policy on stress at work

1 Introduction

- 1.1 [Name of organisation] is committed to a healthy workforce by placing value on both physical and mental health. We acknowledge that stress problems have many causes, including in the workplace and the outside world. In [Name of organisation], our risk assessments show that factors which may lead to increased stress in our organisation include [...]. We also recognise that domestic factors (housing, family problems and bereavement) may also add to levels of stress experienced by our staff.
- 1.2 [Name of organisation] is committed to a plan of action which includes:
- action to manage the return to work of those who have suffered mental or physical health problems associated with stress to make sure their skills are not lost;
 - increasing knowledge of the causes of stress in the organisation;
 - action to tackle stress and helping staff to manage stress; and
 - managing health problems associated with stress by:
 - recognising stress early;
 - managing stress appropriately;
 - providing access to counselling; and
 - providing advice and sources of help.
- 1.3 This policy and its procedures have been developed and agreed through our Partnership Forum.

2 Scope

This policy applies to all staff in [Name of organisation] no matter what their age, sex, ethnic origin or grade.

3 Policy aims

Our policy aims to:

- encourage staff wellbeing within [Name of organisation] and discourage the stigma attached to stress;
- raise awareness of ill health associated with stress, its causes and associated factors;
- change aspects of the workplace which have been identified (through risk assessment) as increasing the stress risk;
- enhance the factors within [Name of organisation] that reduce the risk of stress;
- educate staff in techniques for coping with pressure and stress;
- provide staff with help if they have mental or physical health problems associated with stress;
- through information and education, encourage everyone to recognise problems;
- provide systems of support and make sure they are well publicised;
- encourage staff to get help at an early stage;
- offer easy access to counselling and other professional help;
- make sure there is confidentiality for those who want help (from whatever source);
- as far as possible, guarantee job security, sick leave, the retention of status and make sure that there is no blame attached to those using the support mechanisms;
- set up procedures for return to, and rehabilitation in work; and
- make sure that these procedures are flexible enough to meet varying needs.

4 Responsibilities

4.1 **Senior managers** are responsible for making sure that:

- stress, which is likely to lead to ill health, is eliminated from the work environment as far as possible;
- an organisational culture is developed where stress is not seen as a sign of weakness or incompetence and where seeking help in managing negative stress is seen as a sign of strength and good practice;
- suitable training and guidance is provided to managers to equip them to undertake the necessary risk assessments in

relation to stress in the workplace, and effective control measures are implemented where appropriate;

- information is provided for staff on:
 - the effects of stress at work;
 - positive coping mechanisms; and
 - general health improving activities within the workplace;
- advice and information is provided for all staff on how to recognise symptoms of negative stress in themselves and others;
- advice and information is provided for managers on their duty of care to staff;
- a working environment is promoted where staff who feel they are at risk of suffering from the negative effects of stress can raise the issue in confidence, so that necessary support mechanisms can be put in place;
- suitable support mechanisms for staff suffering from the negative effects of stress are established; and
- good practice guidelines based on current evidence and knowledge are produced.

4.2 **Line managers** are responsible for:

- involving individual staff and staff teams in seeking solutions;
- encouraging a workplace culture where mental wellbeing and physical wellbeing are regarded as equally important;
- making sure, as far as is reasonably practicable, that the physical work environments for staff are safe and do not expose them to risks that may give rise to stress at work;
- considering the implications for staff of any changes to working practices, ways of working, work location, new policies or procedures, and the need for appropriate support and training;
- making sure that all new staff receive appropriate induction to and training for their job, including reference to support services other than at unit level, for example, OHS, HR, Staff Counselling Service;
- providing clear job descriptions (outlining lines of responsibility, accountability, and reporting), individual supervision and clear objectives with review;
- resolving work-related issues at individual level and at team level as appropriate, involving others outside the team as necessary;

- managing absence in accordance with the organisational policy, and linking to other policies as necessary, such as Dignity at Work;
- keeping in touch with any staff who are on prolonged absence and agree with the individual, OHS and HR how to support their return to work;
- reviewing regularly excess hours worked by staff, time back, monitoring absence monitoring and staff turnover, and carrying out exit interviews;
- making sure that staff teams take time to review and celebrate positive achievements and likewise less positive outcomes so that a sense of balance can be achieved; and
- agreeing with staff teams what can be actioned and how to improve things, promoting openness and discussion.

4.3 **HR** is responsible for:

- making sure that organisational policies and codes of conduct (professional and general) are adhered to;
- facilitating discussions within areas of conflict;
- monitoring staff conduct, attendance, turnover, etc.;
- advocating clarity of roles and responsibilities, advising on job descriptions and organisational structure; and
- promoting positive cultural change within the workforce.

4.4 **Trade Unions/Professional Organisations** are responsible for:

- encouraging members to speak up as soon as they feel that their working environment is beginning to affect their health;
- using the facilities laid out in the Safety Representatives and Safety Committees (SRSC) Regulations and Management of Health and Safety at Work Regulations to tackle work-related stress;
- investigating potential hazards and complaints from their members, receiving information they need from employers to protect members' health and safety;
- liaising with management to carry out risk assessments, including reviewing absence figures and linking these with other policies that may be available such as Dignity at Work; and
- encouraging members to keep a written record of any problems and to put things in writing to management, so that there is evidence of any problem and that management is aware of them.

4.5 **OHS** is responsible for:

- advising managers and staff on occupational stressors and the risk assessment process;
- delivering an education/training programme on stress risk assessment/awareness and management;
- providing support for staff at all levels who may be experiencing the negative effects of stress; and
- monitoring work-related stress in terms of sickness absence patterns and self/management referrals and providing appropriate feedback to the organisation.

4.6 **Staff counsellors** are responsible for:

- offering help to individuals in assessing the effectiveness of the coping strategies they currently use;
- offering help and ongoing support in identifying and maintaining any changes to current strategies;
- offering help in establishing a tailor-made programme of stress management which extends beyond work;
- being accessed by any individual experiencing problems which affect their ability to function; and
- offering an opportunity to talk in confidence about any problem or difficulty, whether work-related or not.

4.7 All **staff** are responsible for:

- talking to their manager if there is a problem, or accessing OHS, HR or their Trade Union/Professional Organisation;
- supporting their colleagues if they are experiencing work-related stress and encouraging them to talk to their manager, OHS, HR or Trade Union/Professional Organisation;
- seeking support or counselling from OHS and/or the staff counselling service;
- speaking to their GP if worried about health issues;
- discussing with their manager whether it is possible to alter the job if necessary, to make it less stressful, recognising all team members' needs;
- trying to channel their energy into solving the problem rather than just worrying about it, thinking about what may resolve any issues and discussing this with their manager;
- recognising that stress is not a weakness;
- regularly exercising their right to attend stress management courses; and
- being actively involved in the risk assessment process.

5 Education and training

To deal positively with stress at the workplace, [Name of organisation] recognises the importance of:

- the link between home and the workplace;
- identifying particularly vulnerable groups; and
- the effects of prescribed medication on work performance.

These key points will be highlighted in:

- health education for staff;
- induction programmes for new staff (as stress education);
- specific training for occupational health practitioners; and
- feedback (for sorting out any problems with the policy).

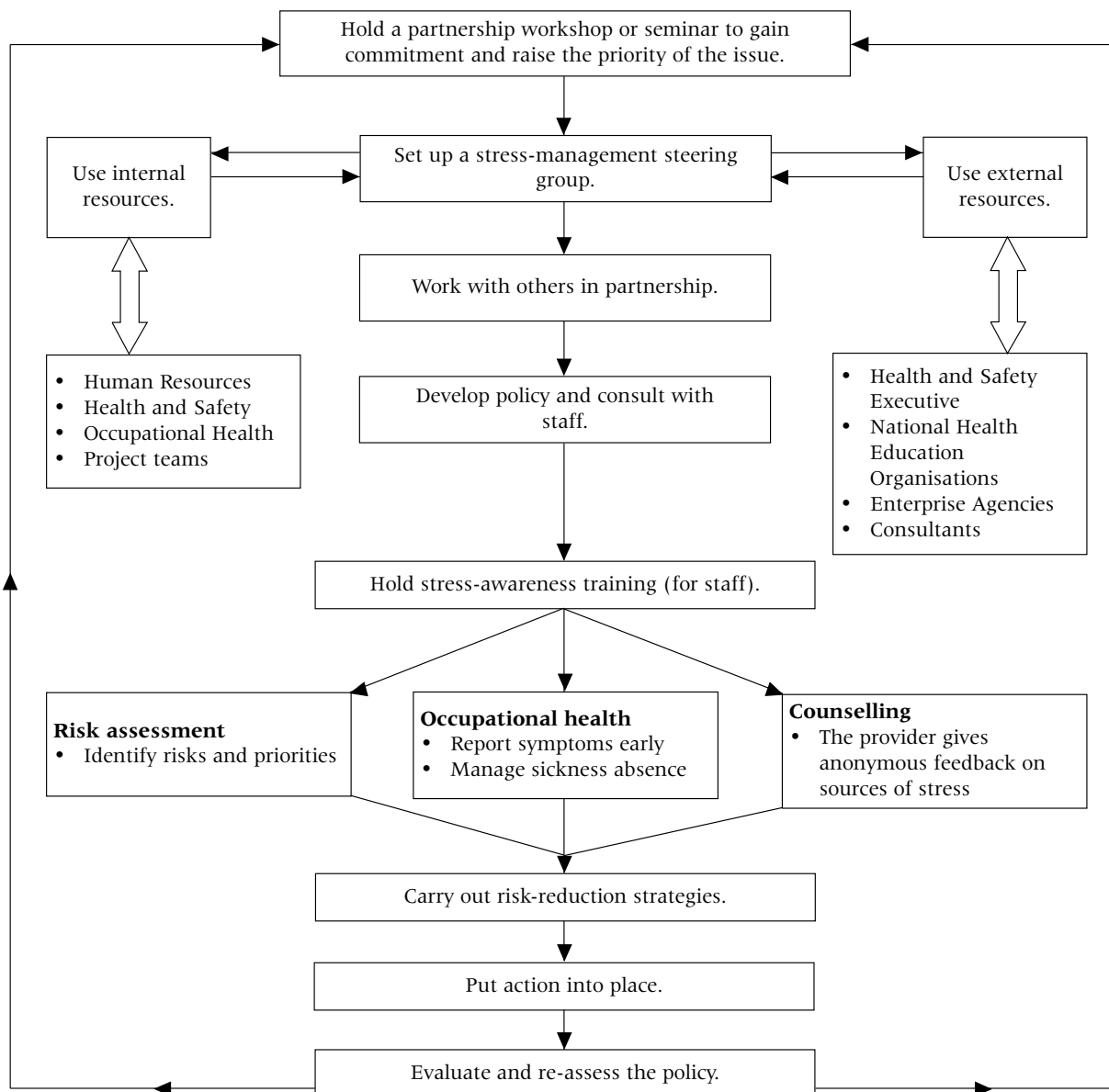
6 Monitoring and reviewing

- The activities which result from the introduction of this policy will be examined and the activities of each component part monitored. This review process will lead to a regular revision of the policy.
- As well as the policy itself, the risk-assessment process should be reviewed in light of any changes to work activities.

Regular evaluation of staff turnover, sickness absence and accidents will also contribute to the monitoring and reviewing of the policy.

APPENDIX 1.B

A risk-management approach to workplace stress



APPENDIX 1.C

Model Organisational Stress Audit (Developed by the Institute of Occupational Medicine)

Stage one

The aim of stage one is to identify:

- the presence or absence of recognised work-related stress factors within the organisation and provide recommendations for reducing risk; and
- areas considered as having the greatest effect on the health and wellbeing of individuals (and so the performance of the organisation) and to outline recommendations for detailed investigation.

Further investigations would use appropriate ways of carrying out testing chosen from published literature. The following are examples.

- 1 For psychosocial problems
 - The Work Environment Scale (Insel and Moosl 1994)
 - The Job Diagnostic Survey (Hackman and Oldham 1974)
- 2 For physical and environmental problems
 - The Body Comfort Questionnaire (Corbett and Bishop 1977)
 - or direct measurements, for example for heat or noise, may be needed.

Many of these instruments may be used in the assessment of an individual's circumstances, but by carrying out stage one of OSHA any action will be focused and guided by identified needs rather than stemming from a general 'trawling' operation.

In some circumstances the investigative tools may provide a quick response measure for evaluating the effect of change, giving an early indication of effect before more objective benefits such as reduced sickness absence become noticeable.

Using semi-structured interviews

It is important that the semi-structured interviews are tailored to the needs of the individual organisation but they should include questions related to recognised work-related stress such as:

- organisational structure;
- change;
- communication;
- management and supervisory skills;
- training;
- staff support facilities;
- policies;
- sickness absence;
- work characteristics; and
- contracts of employment.

The results of stage one should enable work-related stressors and measures for risk reduction to be recommended.

Stage two

The aim of stage two is to carry out a detailed investigation of the particular pressures being experienced by groups or individuals, or areas of organisational behaviour which, based on information from stage one, could have an effect on the wellbeing of several groups of staff. The method chosen must be appropriate for the organisation and must be specific to the causes of stress identified in stage one. Some of the survey tools that could be used include:

- the general health questionnaire;
- the anxiety stress questionnaire; and
- the work environment scale.

Other stage-two activities might include, for example, carrying out a needs assessment and training on stress awareness.

Stage three – Evaluation

This should revisit those involved in stages one and two to ask if they have noticed any change in levels or causes of stress at individual and organisational level.

Other measures might be changes in sickness absence and staff turnover.

APPENDIX 1.D

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- | | |
|--|---|
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Available from: http://www.cipd.co.uk |
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Recommended further reading

- | | |
|------------------------------------|--|
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| Hackman and Oldham | <i>The Job Diagnostic Survey,</i> 1974 |
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Promoting attendance

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2. PROMOTING ATTENDANCE

2.1 Introduction

The greatest resource of NHSScotland is its staff, because it is through them that services are delivered and improved. Staff salaries are the single greatest cost to the NHSScotland budget, and promoting attendance is crucial in the development of an efficient service which has, at its core, the wellbeing of its staff.

This document aims to give all those working in the service (managers or those being managed) clear guidance on the issues relating to promoting a healthy workplace and promoting staff health and attendance.

The PIN guidelines on 'Management of Employee Capability' and 'Management of Employee Conduct' should also be referred to for guidance on the management of health problems.

2.2 Principles and values

NHSScotland is seeking to create and build up a working culture in which regular attendance at work is normal. It will help if we can introduce:

- effective monitoring and management procedures to identify situations where a staff member's attendance is falling below agreed standards; and
- a way of dealing with the circumstances in a sympathetic and fair way, achieving the right balance between managing absence efficiently and providing support and help to a staff member who has health problems or is experiencing personal difficulties.

Attendance levels provide a picture of staff wellbeing, levels of morale and health and safety management performance. Monitoring attendance levels is an important tool in assessing these factors and in deciding where action is needed.

The importance of communication in creating such a working culture cannot be underestimated. Ensuring staff awareness of the importance of attendance is an essential prerequisite to everything that follows in this guideline.

The objectives of this policy will only be achieved if a proactive, consistent and effective approach is adopted throughout NHSScotland. This approach relies on:

- keeping to relevant legislation;
- involving important groups such as the occupational health service (OHS); and
- providing guidance and support to staff, managers and Trade Unions/Professional Organisations.

2.3 The need for this policy

The purpose of a Promoting Attendance policy is to improve and support the health and wellbeing of staff at work and to reduce the level of sickness absence. The policy will also encourage and enable the adoption and implementation of best practice in relation to the promotion of health and wellbeing at work.

The current sickness absence rate for NHSScotland is estimated to be between 4.8% (10.9 working days for each staff member each year) (CIPD, 2001) and 9.9% (Cabinet Office). Both these figures are above the national average for sickness absence, which for 1998 was 3.7% (CBI, 2001).

2.4 The policy aim

The aim of a Promoting Attendance policy is to help NHSScotland organisations make the most of attendance by reducing short- and long-term absence through promoting positive attitudes to work and trying to reduce staff ill health as far as possible. However, it is important to remember that “owing to the very nature of a ‘healthcare environment’, the issues surrounding sickness absence need to be set in their own particular context” (HEA).

Specifically, a Promoting Attendance policy aims to:

- enable the delivery of consistently high-quality services by achieving the best possible levels of staff attendance at work;
- provide procedures – communicated to and understood by all staff – which make sure that everyone is dealt with fairly and consistently;
- keep to the law, such as the Disability Discrimination Act (to make sure that reasonable adjustments to duties are made, or other suitable employment is offered through redeployment where necessary), and meet legal requirements relating to staff consent to the appropriate handling of sensitive personal data;
- make sure that managers communicate regularly and openly with staff, and where possible, offer appropriate support and help to get them back to work (see the “Carrying out the Return to Work discussion” checklist at Appendix 2.E);

- make resources and support available to staff with health problems through the OHS, staff support services and other specialist agencies;
- use other sources of support, for example, the Employment Service if retraining or redeployment is appropriate;
- make sure that the organisation's employment policies are based on good practice;
- improve staff retention and prevent discrimination;
- encourage staff to adopt a healthy lifestyle;
- help managers to monitor attendance levels effectively by setting up systems which provide relevant and up-to-date information; and
- give all staff the opportunity to be represented at all stages in the proceedings by a staff representative, colleague or friend.

2.5 Putting the policy into practice

The main principles:

- Each part of NHSScotland must examine its own values, in terms of organisational behaviour, culture and ethos.
- If there are obvious health problems of a physical or mental-health nature, the organisation should use an approach which is consistent, fair, sympathetic and caring.
- In order to make the procedures fair and consistent, managers must make sure that they collect enough information on the nature and extent of the health problem in order to make a reasonable decision in each case. This involves setting up an effective communication system with staff and getting professional advice from OHS if necessary.

At all stages in this process:

- there should be confidentiality;
- staff should have the opportunity to discuss the main issues and be able to contribute to possible solutions;
- managers should get advice and support from Human Resources (HR); and
- the staff member should have the opportunity to be accompanied by a colleague or representative from a Trade Union/Professional Organisation.

2.6 Definitions used within the policy

2.6.1 Sickness absence

This occurs when ill health, including disability, makes a person unfit to work. It also occurs when a doctor advises an individual to stay away from work due to illness, convalescence or the possibility

of being contagious. (This is also covered in the 'Management of Employee Capability' PIN Guideline.)

2.6.2 Short-term absence

Short-term absence is the period of time covered by a self-certificate (up to and including seven working days). This type of absence does not normally have a set pattern and is usually caused by minor, in most cases unconnected, ailments.

2.6.3 Frequent short-term absence

This is where an employee has a number of short-term absences, which may or may not be related, and may be certified or uncertified.

2.6.4 Long-term absence

Long-term absence is the period of time covered by a doctor's certificate (over seven working days).

The precise definition of long-term absence is best decided locally in discussion with partnership forums.

2.6.5 Unauthorised absence

This occurs when a staff member's absence:

- is not supported by medical evidence;
- has not previously been reported;
- has not been authorised by the appropriate level of management; or
- has not been communicated to the employer using the correct procedure (see Annex 2 of Appendix 2.D).

2.7 Procedures for putting the policy into practice

2.7.1 Promoting the policy

- All existing and new staff members should be made aware of the policy, and all staff must have access to the policy in their place of work. Organisational and departmental induction programmes are an effective way of doing this.
- Line managers must make sure that their staff know about any local reporting procedures.

2.7.2 Recording and monitoring

- NHSScotland organisations have a responsibility to set up proper systems for recording and monitoring attendance. A standard format for recording absences across the organisation is necessary to ensure consistency. The Minimum Dataset provides a framework for doing this.

- • Reasons for recording and monitoring attendance include:
 - ◦ meeting the requirements of the Statutory Sick Pay provision and Occupational Sickness Allowance;
 - ◦ identifying attendance patterns, and frequency and length of absences;
 - ◦ helping to detect problems early, so leading to speedier management or medical responses; and
 - ◦ helping to decide whether the absence is a 'capability' or 'disciplinary' matter.
- • Managers must make sure that a record is made of any meetings that they have with staff members to make clear the conversation that took place and the support that was offered.

2.7.3 'Trigger points'

It is important that managers have clear 'trigger points' in place for reviewing sickness absence. These 'triggers' may include:

- • frequent short-term sickness absence;
- • absence that is not satisfactorily explained;
- • absence linked to certain shift patterns; and
- • absence linked to certain days or times.

A suggestion for a 'trigger' would be four episodes, or more than eight days' short-term sickness absence within a 12-month period, which a manager will identify through the local absence recording mechanism. However, this standard is for local determination.

Absence patterns linked to the working environment may highlight a range of problems resulting in high or regular patterns of absence. A major factor in these circumstances is that of work-related stress (see separate guideline).

2.7.4 Reporting absence

On day one	Staff members must tell the appropriate manager or supervisor about their absence as early as possible. This may be varied within departments depending on local agreements.
More than three and up to and including seven working days	The staff member must fill in a sickness absence self-certificate form on their return to work.
More than seven calendar days	A medical certificate from a General Practitioner is required. If a staff member does not return to work when the certificate ends, then further consecutive certificates must be provided. A final medical certificate confirming fitness to resume duties must be sent in before or on the day s/he returns to work.

If a staff member becomes unwell during the working day they must speak to the appropriate manager before leaving work. However, if the person suffers a needlestick injury, s/he must go to the nearest Accident and Emergency Department or OHS as soon as possible.

2.7.5 What if there is no obvious health problem?

If there is no underlying medical reason for the absence, the manager must advise the staff member that the situation is unsatisfactory. Where there is any doubt about a person's fitness for work, help and advice should be sought from OHS. At the same time, s/he should stress the importance of regular attendance at work and reaffirm the organisational and departmental standards of attendance.

In cases where circumstances and investigation indicate a more serious situation, it may be necessary to formally set appropriate standards for attendance which are consistent with the organisational policy. The manager should meet with the staff member to let him or her know that:

- the level of attendance must improve;
- the level of attendance will be closely monitored;
- this monitoring will continue for an appropriate period of time according to individual circumstances; and
- if there has been no improvement in their level of attendance at the end of the monitoring period, the situation may be looked at under the 'Management of Employee Conduct' policy.

2.7.6 What if the absence is caused by a work-related or personal problem?

All staff have a responsibility to tell their manager if their absence is attributable to their work, to allow the organisation to comply with RIDDOR requirements. In these circumstances assistance should be offered to the staff member to help them overcome the problem. Help could include temporarily altering their shift pattern or granting compassionate leave if this is felt necessary. In these circumstances the staff member must continually update their manager, who will monitor and re-assess the support mechanisms as necessary. Throughout such situations, the manager should make the staff member aware of OHS and the staff counselling service, and explain how these services can be accessed.

2.7.7 The importance of maintaining contact

During any periods of extended sickness absence, contact between the manager and the staff member is particularly important. The purpose of the contact is to:

- reflect the genuine concern of a caring employer;
- find out the nature and progress of the illness and recovery;
- make sure the staff member knows they must supply medical certificates; and
- explain and try to provide any support that may improve the staff member's health.

It is important that managers apply a sensitive, consistent approach when reviewing individual circumstances in order to prevent anyone from feeling that particular members of staff are being singled out for special treatment.

The method and frequency of contact will depend on the circumstances surrounding the absence. Contact can be by phone, letter, and (especially important in cases of long-term sickness absence) meetings at the workplace or at the staff member's home.

If a meeting is to be held, the staff member should be asked if they wish to be accompanied. A representative from HR may also attend to give advice to the manager and the staff member. It is important that such meetings are handled sensitively and that the staff member is assured that the meeting does not represent any kind of disciplinary procedure.

2.8 Return to work

After any period of absence a staff member's return to work should be acknowledged. In many cases, this will be no more than a courteous enquiry as to whether the staff member is now well, and this may take place over the phone, or be delegated to another manager or supervisor as appropriate. In other cases, there may need to be an informal meeting, the purpose of which is to:

- discuss the reasons for absence;
- assess the individual's fitness for work;
- decide if the cause of the absence may recur; and
- arrange for a referral to OHS if necessary.

At this meeting the staff member should be given the opportunity to raise any issues they have about their absence and to get help from the organisation.

This discussion may cover some or all of the following, depending on the circumstances of each case (see the 'Carrying out the Return to Work discussion' checklist at Appendix 2.E.).

- Welcome the staff member back to work and provide a work update.
- Ask after their health.
- Make sure that the staff member fills in a self-certificate or provides a medical certificate.

- If attendance levels suggest that there may be an underlying health problem, discuss referring them to OHS.
- If the pattern or frequency of absence is causing concern, you should let the staff member know, explaining what the organisation considers to be a reasonable standard of attendance and what may happen if this is not met.
- Offer support, guidance and advice to help the staff member to attend more regularly, for example, a temporary change in hours or duties, training, etc.
- Set up a regular review process, set attendance standards and offer compassionate or unpaid leave if this is appropriate.
- Any cases involving alcohol, drug or substance misuse should be addressed under the procedure set out in the appropriate policy (see separate guideline).
- Encourage involvement and commitment to solutions.

If a discussion is necessary, this should not be confrontational in any way. It should rather be an investigation into any underlying problems – medical, work-based or domestic – which may be affecting attendance. The staff member has the opportunity to be accompanied by a staff colleague or representative. If the reasons for absence are personal or sensitive, the staff member may prefer to talk to someone outside the immediate situation, such as OHS or the staff counselling service.

These discussions should form part of local training on promoting attendance issues.

2.9 Referring staff to OHS

2.9.1 Self-referral

Staff should be made aware that they can self-refer to the OHS for any health-related matter, particularly if it relates to, or is affecting their work. No communication to any third party should result from a self-referral unless the member of staff concerned requests it.

2.9.2 Management referral

Managers can refer staff to the OHS in order to provide assistance to a staff member on a health-related matter, or to enable the OHS to provide the manager with advice about the staff member's health in relation to their work. Managers may need to use a template management referral form if this is provided by their local OHS.

Such referrals must be done with the **informed consent** of the staff member, and this must be sought on each occasion a referral is initiated. It is essential that such a referral is not portrayed as a punishment, and that the reasons for it are fully explained to the staff member. The reason for referral should be clearly set out in the

referral document along with any specific issues on which the manager wishes to receive advice. In general, the types of issues about which questions might be asked include:

- whether there is an underlying medical problem which could affect performance;
- the prognosis and likely effect on fitness for work;
- restrictions to, or adaptations needed for, work;
- the need for, and nature of, a programme of support;
- recommendations for rehabilitation into work; and
- ill-health retirement issues, if relevant.

2.10 Assessing risk

NHSScotland organisations must fully meet their responsibilities as laid down in health and safety law. This includes, where appropriate, carrying out a risk assessment before a staff member returns to work.

2.11 Phased return to work and adjustments

When a staff member is fit to return to work but cannot carry out their full range of duties (either in the short or longer term), every effort should be made to give them the opportunity for an earlier return to work. This might include reducing or amending their range of duties.

To comply with the Disability Discrimination Act 1995, the Disability Rights Commission recommends that organisations:

“take any steps which it is reasonable for it to have to take, to reduce or remove any substantial disadvantage which a physical feature of the premises or of the organisation’s employment arrangements causes a disabled member of staff compared to a non-disabled person”. In short, reasonable adjustments to a staff member’s job can include:

- changes to duties, shifts or hours;
- changing the place of work; and
- making adjustments to the features of a building or access to it, including its fixtures, fittings and design,

although this list is not definitive. Adjustments should only be made after:

- receiving the advice and recommendations of OHS;
- discussing the matter with the member of staff; and
- carrying out a review of their skills and abilities and the likely needs of the service.

A clear written programme, including timescales and review period, must be agreed with the manager and staff member before any return to work can take place. HR advice should be sought on any agreed variation to

contract and pay policy, to make sure that local policy is applied consistently. The use of flexible working arrangements and family friendly policies is encouraged.

Assistance is available from the Disability Employment Advisers based within job centres and other agencies. They can support the staff member and the workplace with respect to carrying out needs assessments, and they can advise on any equipment and modifications that might be required for the working environment.

2.12 Redeployment

If a staff member has been identified as unfit to return to their current post, the organisation must, within reason, offer other suitable employment (Disability Discrimination Act 1995), although a job does not have to be created. The line manager should fully discuss with the staff member and HR all the options for redeployment.

Redeployment may mean changing career direction and must include the assessment and identification of the person's training needs. This may include providing training opportunities from:

- within NHSScotland;
- the Employment Service Work Preparation Scheme;
- disability employment advisers; and
- other appropriate agencies.

2.13 Ending employment and retirement

The option to terminate employment on the grounds of incapacity due to ill health should only be considered when all options for reasonable adjustment or redeployment have been fully investigated and exhausted.

If a member is staff is superannuated, advice should be provided in relation to applying for premature retirement on the grounds of permanent ill health. Information on this is contained in the Scottish Public Pensions Agency "Guide to the Scheme for NHS Employees in Scotland". There are qualifying criteria and appropriate forms to complete, and assistance from HR should be offered to help staff fill in such application forms.

Information should also be given on 'Injury Benefits' payable where an accident (or disease) occurs in the course of work. Advice is available in the same SPPA Guide. These benefits apply even if an individual is not superannuated.

In considering termination of employment on the grounds of ill health, the employer must demonstrate that it has;

- taken account of written advice from OHS recommending this;
- consulted with the staff member and discussed the position with them;

- made a thorough investigation of the medical and other facts;
- balanced the staff member's likely future health against the organisation's needs;
- considered offering the staff member other employment; and
- fully explored other employment options and found these to be unavailable or not practical.

The decision to terminate employment on the grounds of ill health or capability must always be based on medical factors, and is not directly linked to the staff member's pay situation.

If termination of employment is the only available option, the staff member should be invited in writing to attend a meeting to discuss the termination of their employment on grounds of incapacity due to ill health. HR should support this process at the earliest possible opportunity. The staff member must be offered the opportunity to be accompanied by a representative (which can include a colleague or friend not acting in a legal capacity) at this meeting.

The meeting should be handled in a sympathetic and understanding way, making sure that the staff member is given time to discuss their point of view and that they have a clear understanding of the outcome. They should also be offered the opportunity to meet again if they would find it helpful to have some days thinking time to weigh up the options.

In accordance with local arrangements for delegated responsibility for dismissal and related procedures, HR will support the Head of Department to write to the staff member confirming the termination date, taking into account the relevant period of notice. The letter should also set out the staff member's right to appeal against the decision.

2.14 Responsibilities

In putting the Promoting Attendance policy into practice it is vital that all those involved are fully aware of their roles and responsibilities, as defined below.

2.14.1 All **staff** must:

- attend work regularly;
- keep to their local Absence Reporting procedure (see Annex 2 of Appendix 2.D) by letting their appropriate manager know as soon as possible about any absences, and to produce medical certificates (as necessary); and
- maintain regular contact with their manager and let them know about their absence, length of time off and return to work date.

Even if they are referred to OHS by their manager, a staff member cannot be forced to attend OHS appointments. However, it is in

their best interests to do so. Their manager will act on the information available to him/her, even if this is of a limited nature because the staff member has not kept their OHS appointment.

2.14.2 Line managers must:

- take responsibility for promoting attendance, using information on attendance in a way which will improve attendance levels, reduce absence costs and encourage staff to aim for high attendance levels;
- use the Promoting Attendance policy and its procedures fairly and consistently, taking account of individual circumstances and the staff member's right to confidentiality in relation to their absence;
- make sure that all staff know about the policy and local procedures for reporting absences;
- be available to staff who have problems, whether health, emotional or personal, and be receptive, sympathetic and flexible in dealing with these problems, always letting staff know about the availability of the staff support services;
- maintain open communication with staff, letting them know about the promoting attendance procedures and the implications for their personal situation at all stages;
- manage health and safety in the workplace, carrying out risk assessments of work activities to prevent and reduce health problems as far as possible;
- take part in training related to promoting attendance within the organisation and make sure that staff involved in promoting attendance also receive training;
- make sure all records and documents in relation to managing absence are kept in line with the Data Protection Act 1998; and
- get advice and help from HR, OHS, Health and Safety, the Employment Service and the Disability Employment Advisor when appropriate.

2.14.3 The Trade Unions/Professional Organisations must:

- act, at all times, in line with the role and responsibilities set out in the organisation's Partnership Agreement; and
- take part in training connected to promoting attendance within the organisation.

2.14.4 HR must:

- provide support and guidance to managers, staff members and Trade Unions/Professional Organisations when interpreting the Promoting Attendance policy and procedures;

- • train and develop the skills of managers and Trade Unions/Professional Organisations to allow the policy and procedures to be put into practice effectively;
- • provide support and expert and independent advice at attendance meetings; and
- • make sure that the Promoting Attendance policy and procedures are consistently followed throughout the organisation.

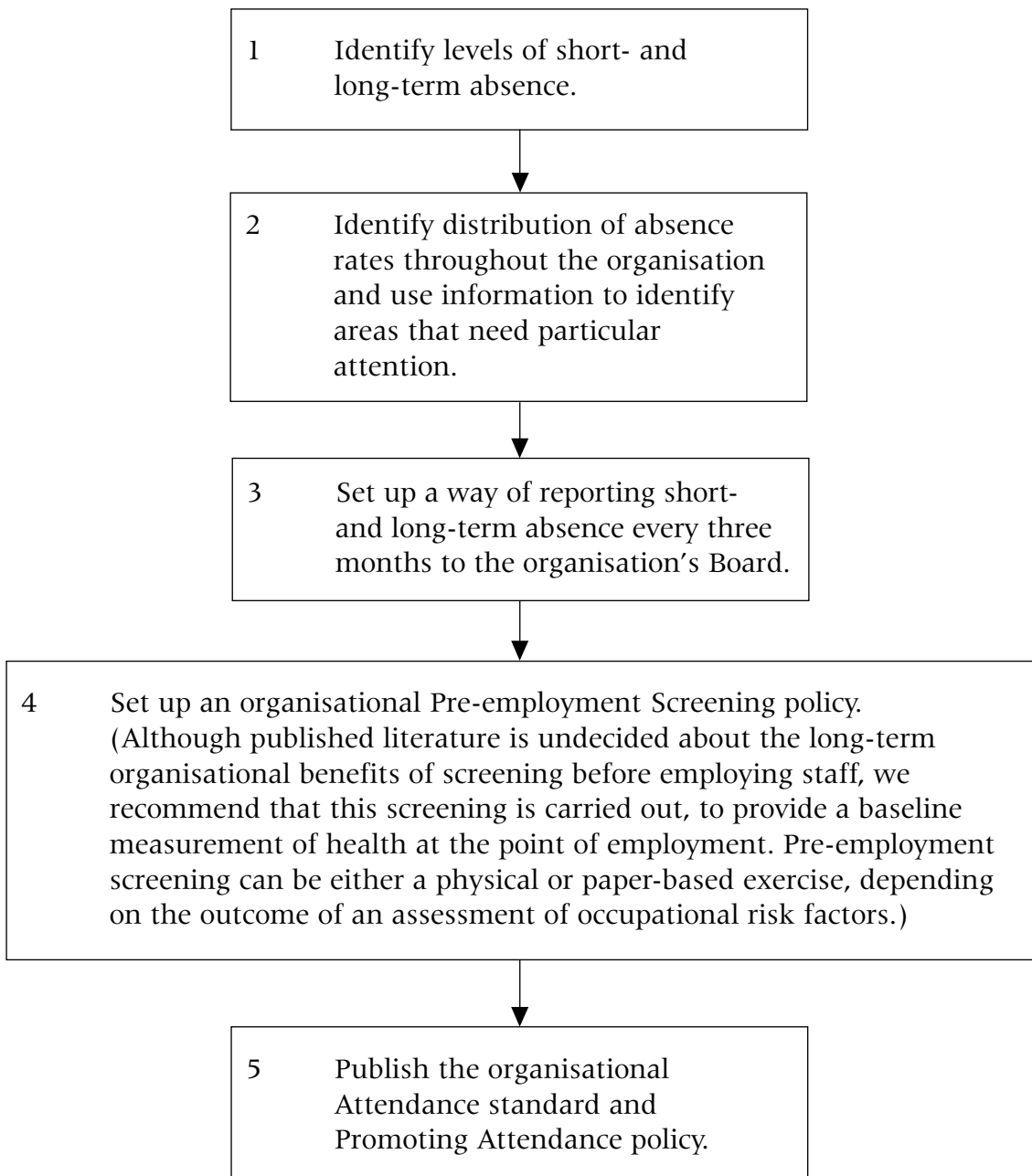
2.14.5 OHS must:

- • provide clear advice to line managers and staff on the effect health problems have on the working environment and the effects of work on health;
- • help manage the absence process by working with GPs and other agencies to make sure that all relevant and appropriate information is available concerning a staff member's health;
- • become involved in the earliest stages of staff absence to reduce the length of absence as far as possible and help the staff member return to work, acknowledging that this may depend on how soon a management- or self-referral is made; and
- • encourage and take part in discussions about health problems and their causes, and work with managers to identify and put appropriate solutions into place by:
 - ◦ telling managers about any ways in which a staff member's medical condition might limit their ability to perform their normal duties;
 - ◦ advising managers on the length of time the staff member's ability to perform their normal duties might be limited once they have returned to work;
 - ◦ advising managers on the employment implications of any continuing disability, including recommendations on adjustments to their work, redeployment and legislative obligations; and
 - ◦ advising on when and how the Employment Service, and in certain circumstances disability employment advisors, should be involved.

APPENDIX 2.A

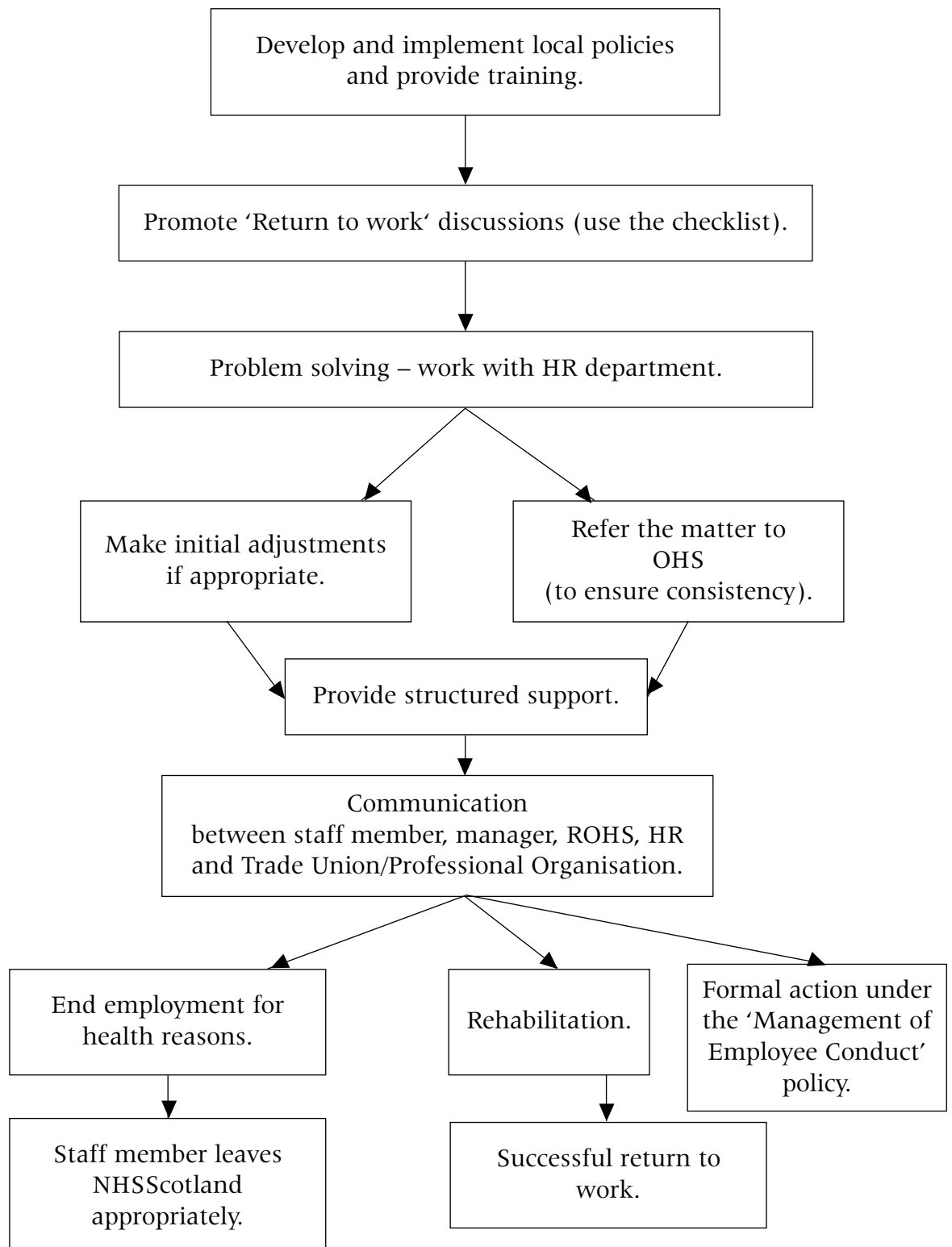
Putting the attendance policy into practice: Developing a strategy

The following template has been developed as a way of measuring the way attendance is managed across NHSScotland. It provides a step-by-step description of the actions necessary within each organisation to put the policy into practice fully.



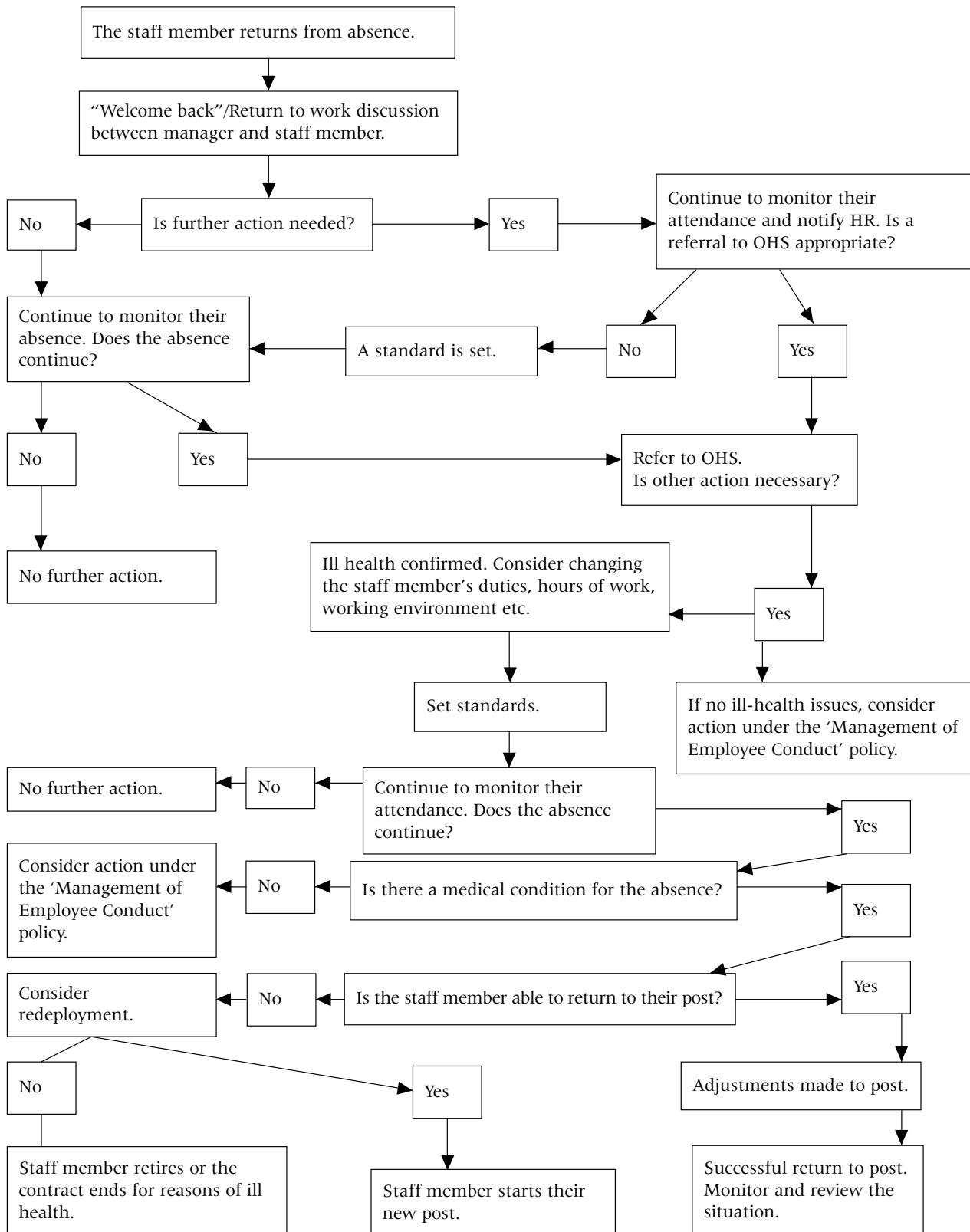
APPENDIX 2.B

Putting the attendance policy into practice: Developing a consistent approach



APPENDIX 2.C

Promoting Attendance Policy flowchart



APPENDIX 2.D

Model Promoting Attendance policy and procedures

1 Introduction

- 1.1 The aim of this policy is to make sure that managers throughout [Name of organisation] adopt a fair, consistent and supportive approach to staff with genuine health problems and to make sure that sickness absence levels are maintained within levels acceptable to [Name of organisation].
- 1.2 While [Name of organisation] aims to secure the attendance of all staff, we recognise that a certain level of absence due to sickness may occur and that the sensitive management of health problems and the promotion of good health contributes to the retention of staff. We also recognise that there will be occasions where, after consideration, staff who cannot attend work due to their health problems may not be able to continue working.
- 1.3 This policy and its procedures have been developed and agreed through the local Partnership Forum.

2 Scope

The policy and procedures apply to all managers and staff within [Name of organisation].

3 Policy

- 3.1 All staff have an entitlement to sick leave and pay in accordance with their terms and conditions of service. There will not normally be any extension of sick pay provisions.
- 3.2 Staff whose health problems give cause for concern may be dealt with under the the procedure for management of health problems (see Annex 1).

- 3.3 Failure to adhere to absence reporting procedures, poor attendance or abuse of the sick leave provisions may, however, be dealt with under our policy for the 'Management of Employee Conduct'.
- 3.4 Any cases involving alcohol, drug or substance abuse should be referred to our policy on dealing with alcohol, drug and substance problems.

4 Responsibility

4.1 Managers' responsibilities

- The responsibility for management of ill health ultimately lies with the manager for his or her own area. Managers will be aware of the importance of our commitment to deliver a high quality service, and clearly unacceptably high absence levels can hinder this by disrupting the department's work progress.
- Managers should make sure that staff have been issued with and understand instructions for how to report absence (see Annex 2). Managers should also make sure that the absence reporting procedure is fully explained to new staff during departmental induction.
- It is important that managers and staff keep in regular contact, particularly during long-term absence, to make sure that the manager is fully aware of progress and likely duration of absence. The manager should be sensitive to the staff member's circumstances and while it is important to demonstrate real and proper concern for the staff member, the level of contact should be at a level which is appropriate to the circumstances and avoids being intrusive.
- Managers are expected to record accurate individual absence information for all staff including the duration and reason for absence, and a note of all discussions relating to this. In addition they will maintain statistical information on absence rates within their department (see Annex 3).
- Managers are responsible for making sure that sickness absence levels are reviewed on a regular basis, to be able to address problem areas and maintain acceptable sickness absence levels within their own department. Target levels for [Name of organisation] are defined as [...].
- All managers should make sure that staff are seen whenever they return from a period of absence, to discuss their absence and sign the absence record form. It may be appropriate to use delegated responsibility for practical reasons (if the service is dispersed, for example).
- Where frequent absences, continuous absence or inability to perform duties due to ill health are causing problems in the

workplace, the manager will discuss this with the staff member, either at a return to work meeting or at another arranged meeting before any proposed action takes place.

- It is important that all managers discuss ill-health issues with Human Resources (HR) so that consistent standards are applied. Professional advice should be sought from the Occupational Health Service (OHS) before determining a course of action. Managers should always discuss the referral to OHS with the staff member before the referral takes place.
- In all cases the overriding criteria for deciding appropriate action is what is fair and reasonable given the individual circumstances of the case and taking into account age, length of service, frequency, length and pattern of absences, medical advice and service needs.
- Managers should make the staff member aware of the medical advice and should make sure at all stages that staff have the opportunity to discuss their health and point of view.

4.2 **Staff** responsibilities

- Staff must keep to our absence reporting procedures. This includes keeping their manager advised of progress and covering their absences by appropriate certificates submitted in time.
- If referred by their manager, it is in staff's best interests to attend OHS. Staff also have the right to self-refer to OHS.
- Staff are expected to see their manager on return from sick leave and complete an absence record form where appropriate.

4.3 **HR** responsibilities

- Management of ill-health problems are a line management function. However, HR staff will provide assistance, advice and support to managers and staff at all stages of managing ill-health problems, including analysing absence records and investigating particular cases to ensure fairness and consistency throughout [Name of organisation].
- The HR department will collect, analyse and publish, where appropriate, departmental and organisational absence statistics.

4.4 **OHS** responsibilities

- The OHS provides confidential advice and counselling to all staff. Although not a replacement for the family doctor, any staff member can arrange an appointment if they feel their work is affecting their health or vice versa. Referrals can be made directly by the staff member to OHS (a self referral), and can also be made at the request of the manager via HR.

5 Education and training

To promote attendance positively, [Name of organisation] will raise awareness of this policy and its standards as part of departmental and organisational induction for new staff. We will also provide training for staff, managers and Trade Unions/Professional Organisations which will include, as a minimum, the following issues:

- the benefits of good attendance at work;
- roles and responsibilities of staff, managers, HR, OHS and Trade Unions/Professional Organisations;
- the procedure for reporting absence;
- trigger points for reviewing absence in [Name of Organisation];
- return to work discussions;
- referrals to OHS; and
- recording and monitoring attendance levels.

6 Monitoring and reviewing

The activities which result from the introduction of this policy will be examined and the activities of each component part monitored. This review process will lead to a regular revision of the policy.

Regularly reviewing sickness absence rates, staff turnover, levels of redeployment and the number of terminated contracts and ill-health referrals will also contribute to the evaluation and audit of the policy.

Annex 1

Procedure for the Management of Health Problems

In some cases, the PIN Guidelines on **Management of Employee Capability** and **Management of Employee Conduct** should be referred to for guidance on the management of health problems. HR can advise on when this is appropriate.

Annex 2

Absence Reporting: Procedure for Staff

- 1 All staff are responsible for making every effort to communicate with their manager whilst on sick leave.
- 2 If you are unable to attend work or fall ill during a period of leave, you must tell your manager at the earliest opportunity before your starting time and no later than within one hour of your scheduled starting time.
- 3 It is your responsibility to make contact personally with your manager. Only in exceptional circumstances where you are unable to phone personally, a relative or friend may phone on your behalf, but the responsibility remains with you. Where the manager is not available, it is essential that contact is made with an alternative senior staff member who will be responsible for taking the information and passing it to the manager. Messages should not be left on voice mail, with the hospital switchboard or with other wards or departments.
- 4 Failure to make contact in time may lead to you being treated as absent, pay being stopped and may ultimately lead to action under the 'Management of Employee Conduct' policy.
- 5 It is important that you communicate all relevant details when making contact, including:
 - the reason for absence ("sick" or "unwell" is not an adequate description, although if the reason is too personal to discuss with your manager, you can ask to discuss the absence with OHS);
 - an indication of when you expect to be fit to return to work; and
 - details of any appointments with your GP.

Your information will be kept in line with the Data Protection Act 1998.

- 6 At this stage, your manager will tell you when you should get in touch again and when, if appropriate, a sick certificate must be submitted.

- 7 It is your responsibility to keep your manager informed of your progress and, in particular, should you be unable to return when you anticipated. If you are absent immediately before leave days or days off, you must tell your manager when you will be fit to come back to work.
- 8 If your sickness is more than seven calendar days, you must get a medical certificate from your doctor and send it to your manager immediately. Any subsequent certificates should be submitted as quickly as possible, ensuring all days in the absence period are covered. Failure to submit a medical certificate will result in pay being withheld.
- 9 If you fall ill at work or have to go home due to sickness or other reasons, you must discuss this with your manager before leaving unless you require urgent treatment, in which case you should tell your manager at the earliest opportunity.

Annex 3

Absence Monitoring Protocol

- 1 Managers are responsible for collecting accurate information on both individual staff members and for their departments.
- 2 The manager should record individual staff's absence on an absence record form as soon as the staff member tells them about their absence. This should occur even where a staff member has presented himself or herself for work and has had to go home.
- 3 Each staff member's absence (including annual, statutory, sick, maternity and other leave) should also be recorded on a staff record form to allow an illustration of the number, frequency and reasons for absence to make it easier to identify trends. Managers should monitor individual staff's absence regularly to allow the manager to identify, at an early stage, areas of concern. The earlier issues are identified and discussed with the staff member, the more effective the response and action will be for both staff member and manager.
- 4 Departmental absence is collated by the manager and submitted on a monthly basis in the form of a return to HR (unless a different system for doing so is already in place in the organisation).
- 5 The information collated is:
 - the number of available hours in the month;
 - number of hours lost through sickness by individual staff members; and
 - number of hours lost through other absence by individual staff members.
- 6 The 'available hours' figures should be based on the situation at the end of the month and should include temporary staff but not bank or casual staff. Vacant posts should not be included in the figures. The 'available hours' should be calculated using the following formula:

whole time equivalent x conditioned hours x 4.3

- 7 All sickness absence, certificated, uncertificated or self-certificated, long- or short-term, should be included in the sickness absence figures. Where a staff member has had to go home due to ill health, the part day should be included in the figures. Maternity leave should not be included in the figures for sickness absence.
- 8 Other absence figures should include: annual leave, public holidays, maternity leave, training/study leave, etc. and should be clearly identified on the return.
- 9 Absence rates are calculated using the following calculations:
- $$\frac{\text{Sickness Hours in Month}}{\text{Available hours}} \times 100 = \text{percentage figure}$$
- 10 This figure will provide a consistent, simple measure against which comparisons can be made.
- 11 HR will collect the absence information and present it to the organisation's Board regularly.
- 12 HR will produce the following documents on a monthly basis:
- a table showing the basic figures collated for the organisation;
 - a bar chart using the basic figures collated for the organisation; and
 - a line graph for each department showing the month by month position.
- 13 It is the manager's responsibility to investigate the figures for their department with support from HR.

APPENDIX 2.E

Carrying out the Return To Work Discussion

1 Preparation

- Get together OHS reports and copies of correspondence with the staff member.
- Get details of his or her length of service and previous record of absence.
- Look at the pattern of absence. Is it regular or unusual?
- If you need any more information or help, who can give you this?
- Arrange a time and private place for the meeting, and tell the member of staff about it.
- Prepare an introduction (see section 2).
- Look at your checklist for structuring the meeting (see section 3).

2 Introduction

- Explain the aims of the meeting.
- Highlight the absence record and pattern (if any).
- Agree the initial aim that his or her attendance must improve.
- Ask him or her for suggestions on how s/he could improve attendance.
- Agree an action plan, with timescales, for this improvement.
- Outline next steps if performance does not improve.
- Set a date for another review.

3 Structure

The following structure will help you to manage the interview sensitively and cover all the issues you need to look at. You should begin each item with an open-ended question to gain information and to open up the discussion.

Remember to use only those sections or questions which are relevant to the individual circumstances – this is simply a list of prompts. (For example, you may already know that the person may not have any domestic issues related to their absence, so do not use these questions.)

Introduction	<p>“You will be aware of our Promoting Attendance policy, and as your manager I need to meet with you to talk this through with you.</p> <p>So, how are you? Are you feeling better? What was wrong?”</p>	<input type="checkbox"/>
Health issues	<p>“What do you feel about this report?”</p> <p>“How do you feel about your health?”</p> <p>“How do you feel about your work in relation to your health?”</p>	<input type="checkbox"/>
Domestic issues	<p>“How do you feel your domestic situation may affect your work, in the future?”</p> <p>“What can we do to help?”</p>	<input type="checkbox"/>
Work issues	<p>“Is there anything worrying you about your work?”</p> <p>“Is there anything we could look at to change?”</p>	<input type="checkbox"/>
Summary	<p>“So you feel the problem has been ...”</p> <p>“You have also suggested ... could be a solution.”</p> <p>“If, together, we can find a way to achieve this do you agree we could sort this problem out?”</p>	<input type="checkbox"/>

Next steps	Agree action	<input type="checkbox"/>
	Agree attendance target	<input type="checkbox"/>
	Set a date and venue for a further review	<input type="checkbox"/>

These techniques should help you to promote attendance in a structured and fair way, and create a healthy and supportive working atmosphere. Showing a genuine concern for your staff will make them all the more willing to talk to you openly, before their problems keep them off work.

APPENDIX 2.F

References

- | | |
|--|---|
| The Chartered Institute of Personnel and Development | <i>Employee Absence: a survey of management policy and practice</i> , Survey Report, CIPD, London, 2001 |
| The Cabinet Office | <i>Managing Attendance in the public sector: 'Putting Best Practice into Work'</i> |
| The Confederation of British Industry | <i>Pulling Together: 2001 absence and labour turnover survey</i> , The CBI / PPP Healthcare, London, 2001 |
| The Health Education Authority | <i>Reviewing attendance in the NHS: Causes of absence and discussion of management strategies</i> |

Tobacco, alcohol and other substances

3.1	Tobacco	1
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3. TOBACCO, ALCOHOL AND OTHER SUBSTANCES

3.1 Tobacco

In Scotland, smoking is judged to be the single most important contributor to ill health, and the cost to NHSScotland of treating smoking-related illnesses is enormous. The cost of employee smoking is also significant. Parrot *et al* (2000) estimated that the annual cost of employee smoking in Scotland may be in the region of £450 million as a result of lost productivity, £40 million from higher rates of absenteeism among smokers, and £4 million as a result of fire damage.

One of the most important issues concerning tobacco use is the impact of environmental tobacco smoke (ETS) on non-smokers. The weight of evidence directly linking ETS to ill health in non-smokers has been building considerably. In 1988 (revised 1992) the HSE published guidance for employers, *Passive Smoking at Work*, which explains what should be done in order to comply with health, safety and welfare regulations as they apply to ETS.

The HSE is developing an Approved Code of Practice (ACoP) on passive smoking at work. When adopted, this will provide authoritative guidance on minimum standards employers will be expected to reach. There has also been a voluntary code of practice published by ASH Scotland and HEBS on *Smoking in Public Places*, which is relevant to staff caring for long-term patients. These codes should provide guidance for those who are exposed to ETS when visiting patients' homes, and those who care for long-term patients in hospitals and homes.

Action to consider

- Actively promote the workplace tobacco policy to make sure that non-smokers are protected from exposure to ETS at all times.
- Monitor, review and evaluate the policy regularly (at least once every two years).
- Provide advice, guidance and support services for staff who want to stop smoking, information, advice on nicotine replacement therapy (for example, patches, chewing gum, inhaler) and, if feasible, facilitate stopping smoking groups or encourage staff to visit stopping smoking services in the community.
- Promote the HEBS SMOKELINE service.

3.2 Alcohol, drug and other substance misuse

Alcohol misuse is a direct cause of ill health as well as a key factor in domestic violence, road, fire and other accidents. Drinking, even at modest levels, also affects behaviour at work, impairing judgement and co-ordination, may cause problems in relationships and even put lives in danger. Many working days are lost as a result of alcohol-related sickness, and the resulting cost and inconvenience is considerable. Drugs and other substance misuse can equally affect health, wellbeing and safety. Many organisations are now developing integrated substance misuse policies which take account the misuse of alcohol, drugs and other substances.

Action to consider

- Actively promote the workplace substance misuse policy to make sure that staff are not under the influence of alcohol or drugs while at work.
- Provide information, support and advisory services for staff who want to change their lifestyles.
- Have a clear disciplinary procedure for staff whose work and behaviour is affected.
- Monitor, review and evaluate the policy regularly.

3.3 Drug testing at work

Government statistics show that drinking alcohol and taking drugs are on the increase. NHSScotland organisations have a duty of care to patients and visitors to make sure they are not at risk. This has to be balanced with the employment issues related to drug testing. If the performance of a staff member is impaired by the use of drugs or alcohol then the duty of care to patients and visitors may be breached. Failure to comply with health and safety legislation is a criminal offence.

Consumption of drugs and/or alcohol can have an adverse effect on work performance but the relationship is ill-defined. There are legally safe driving limits for alcohol consumption but there are no such clear definitions for other substances. In addition there is also an accepted test for alcohol consumption. This is not the case for many other substances.

Employers have no right to conduct alcohol or drugs tests without the consent of the staff member. It would be unwise to introduce alcohol and drug testing where there is no existing provision in the contract of employment, so proposed changes must be negotiated with staff representatives or with individual staff. Securing the agreement of the workforce to testing is essential except in the cases of pre-employment screening.

There are other general issues to consider in implementing testing including:

- choosing the right laboratory;
- deciding which drugs will be tested for;
- making sure the samples are safe, to make sure samples tested are those provided;
- confidentiality; and
- what action will be taken after a positive result.

Testing may be carried out (with prior consent):

- when staff are promoted or transferred;
- before employment begins;
- on a random or unannounced basis; or
- following an incident or accident.

Testing for drugs and alcohol is controversial and needs careful consideration. An effective policy for controlling drug and alcohol use in the workplace will put an emphasis on promoting a safe culture.

APPENDIX 3.A

Model Tobacco policy

1 Introduction

1.1 Tobacco smoking is an addictive habit, which causes disability, disease and death, and represents the single largest preventable cause of ill health and mortality in Scotland. Tobacco smoke in the environment is also a health hazard to both smokers and non-smokers.

1.2 In [Name of Organisation], we are responsible under employment law to:

- maintain a safe and healthy working environment;
- protect the health of patients and staff, and not subject them to hazardous environments and materials; and
- make sure that staff understand their responsibilities to take reasonable care of the health and safety of others.

1.3 In [Name of Organisation], we have a responsibility to set a good example in health promotion and to work towards national targets set to reduce smoking and the incidence of diseases caused by tobacco smoke.

We are also committed to promoting healthy living and non-smoking as the norm. We will do this by establishing a smoke-free environment for all who wish it, while being sensitive to the needs of those who smoke and offering support to those who wish to give up.

1.4 [Name of Organisation] should not profit from direct investment in the tobacco industry, or from the receipt of sponsorship, research grants or donations from tobacco interests.

1.5 This policy and its procedures have been developed and agreed through the local Partnership Forum.

2 Scope

This policy covers all health service premises in [Name of Organisation]. It applies to

- all staff;

- patients, including out-patients, day cases, in-patients and long-stay patients;
- visitors; and
- the wider NHS family (that is, contractors, students, voluntary staff and anyone whose work, study or personal circumstances brings them into contact with the [Name of Organisation]).

3 Principles

- 3.1 This policy is designed to improve the health of the population of [AREA] by providing a smoke-free environment for all, while offering support to those who smoke and would like to stop.
- 3.2 No patient, visitor or staff member should be exposed to tobacco smoke against their will. To achieve this, smoking is prohibited within health service premises in [Name of Organisation].
- 3.3 However, we recognise that it is tobacco smoke, and its effect on those who use it and who are exposed to it, that is the problem, rather than the users themselves. Where it is not practical for staff or patients to access alternative areas to smoke outwith health service premises, limited designated smoking areas may be provided.
- 3.4 The Smoking Advice Service offers a range of support and advice to anyone who wishes to stop smoking, and this will be promoted across [Name of Organisation].

4 Commitment to a smoke-free environment

- 4.1 Except in designated smoking areas (see 5.1), smoking is not permitted

- within the buildings of [Name of Organisation];
- on its grounds, including:
 - at doorways;
 - in any vehicle on health service premises; and
 - in the vicinity of entrances to hospitals.

The term “entrance” refers to any entrance to an NHS site or building.

- 4.2 Staff who smoke while in uniform should be aware that this compromises the health promotion message which is fundamental to the role of all NHS staff and that other people, including patients, may find the smell of smoke offensive.
- 4.3 Visitors are not permitted to smoke, even in designated areas. This does not preclude staff using discretion in situations of extreme distress or grief.

- 4.4 In [Name of Organisation], we wish to discourage all patients who smoke from doing so while on health service premises. Patients who choose to smoke in a smoking area will be made aware that routine medical care cannot be provided within such an area, though, as in other public areas of the hospital, emergency help may be called. In-patients must inform ward staff if at any time they leave their ward to go to a smoking area.

5 Exceptional circumstances

- 5.1 In most health service premises, there will be no need for designated smoking areas. However, if practicable on large sites, limited basic, well-ventilated facilities may be made available for smokers (including patients, staff but not visitors), where they may smoke without exposing non-smokers to smoke. On large sites, there may be a need for more than one such facility, the sole purpose of which is to provide an area for smoking other than entrances and/or public areas.

Staff using designated smoking facilities will be required to keep to a code of conduct governing the use of the facility, which should be kept tidy and any rubbish disposed of appropriately. The condition of the facilities will be monitored and withdrawn if continually found to be below an acceptable standard of cleanliness.

Any healthcare premises within [AREA] may agree in partnership not to provide smoking areas.

If it is not possible to provide a designated area, the right of non-smokers to a smoke-free environment will take precedence. Ultimately it is hoped that such areas may not be needed.

- 5.2 Staff using designated areas will only be permitted to do so during official tea- and meal-breaks. Smokers will not be allowed longer or more frequent breaks than non-smoking colleagues.
- 5.3 Where hospital accommodation is the patient's home, or where there are acute psychiatric in-patients, local management has the discretion to implement the policy sensitively and to protect the health and welfare of both smoking and non-smoking patients.
- 5.4 Communal areas are strictly non-smoking. In the interests of fire safety, staff residents are requested not to smoke in their bedrooms.

6 Support to stop smoking

- 6.1 All smokers who wish to stop smoking shall be given advice and support to help them do so. This support is free of charge and is available from a "menu" of options including one-to-one advice and support groups.

This support is available via the Smoking Advice Service and the Occupational Health Service, and will be widely advertised throughout all health service premises. We may also consider offering therapies such as Nicotine Replacement Therapy at no or reduced cost.

- 6.2 Managers and staff will be offered training in implementing the policy and providing smoking cessation advice. Staff will be trained in the necessary skills to approach smokers politely but firmly, and will be supported by their managers at all levels should the need arise.

7 Policy implementation

- 7.1 This policy will be communicated throughout the premises of [Name of Organisation]. We will inform patients and visitors of the policy through admission booklets and we will offer advice through staff who have been trained in this.

This policy is part of each staff member's employment documentation and prospective staff must be informed of the policy at interview. The policy will be confirmed to successful candidates in their letter of appointment, at induction and in their contract of employment.

- 7.2 We will train staff and managers in implementation of this policy. (See 6.2)
- 7.3 Managers, staff and Trade Unions/Professional Organisations are jointly responsible for making sure that:
- individual staff know, understand and comply with this policy;
 - contractors or non-NHS staff know, understand and comply with this policy;
 - action is taken against anyone contravening this policy; and
 - application of the policy is monitored in their own area.
- 7.4 Staff are personally responsible for complying with this policy and also for making sure that patients and visitors are aware of and comply with the policy. Any breaches of policy should be communicated to the local monitoring group.
- 7.5 Staff smoking in areas other than designated areas will be regarded as misconduct, and repeated breaches of this policy will be dealt with under the 'Management of Employee Conduct' policy.
- 7.6 Visitors who smoke on the premises will be asked not to smoke and will be reminded of this policy.

8 Monitoring and reviewing

- 8.1 Outcomes and indicators which may be used to evaluate this policy include:
- Is the policy effectively and widely communicated?
 - Is appropriate information available for staff, patients and visitors?
 - Are staff aware of the policy and its implications?
 - Is the policy addressed in local and organisational induction programmes?
- 8.2 At each site a local monitoring group will assess progress and compliance with the policy at regular intervals, reporting achievements and difficulties to the Tobacco Policy Review Group, who will collate the reports for review by [Name of Organisation]'s Board at least annually.
- 8.3 This policy will be reviewed one year from its effective date, and annually thereafter by the Tobacco Policy Review Group, reporting to the [Name of Organisation] Board.

APPENDIX 3.B

Model policy for alcohol issues within the workplace

1 Introduction

- 1.1 [Name of Organisation] recognises the need for a policy using a constructive and preventative strategy designed to encourage early identification of alcohol-related problems among our staff. Alcohol abuse frequently affects personal health and social functioning and can impair work capability. The latter can lead to absenteeism, lost time on the job, accidents, loss of training investment, waste, poor judgement and wrong decisions.
- 1.2 A policy on alcohol-related problems is necessary to:
- prevent and reduce the prevalence of alcohol-related work impairment;
 - reduce the personal suffering of staff with drinking problems; and
 - create a climate which removes the tendency to conceal, deny, and cover up the problem while providing management, staff and Trade Unions/Professional Organisations with confidence when confronting alcohol-induced loss of capacity.
- 1.3 The aims of the policy are fourfold:
- To alert staff to the risks associated with drinking and to promote an awareness of sensible drinking.
 - To encourage staff who suspect or know that they have an alcohol-related problem (or who are suspected or known by colleagues to have such a problem) to seek help directly.
 - Where, if using the 'Management of Employee Conduct' policy, it is suspected or known that the problem is alcohol-related, to offer to refer the staff member to an appropriate agency for assessment, counselling and, as necessary, other forms of help.
 - To restore effectiveness of any staff member who may need to use this policy.

- 1.4 This policy and its procedures have been developed and agreed through the local Partnership Forum.

2 Scope

- 2.1 This policy and procedure applies to measures to be taken to respond to situations involving alcohol or drugs impacting on the workplace.
- 2.2 Nothing in this policy and procedure is intended to override statutory or national arrangements applying to particular categories of staff.
- 2.3 The policy and procedure below is drafted in terms of alcohol and alcohol-related problems. It applies equally to other drugs and any drug-related problems.
- 2.4 [Name of Organisation] regards staff as our most important asset. We wish to help any staff member with an alcohol- or drug-related problem to recover their effectiveness on an agreed timescale.
- 2.5 The application of the policy and procedure is limited to those instances of alcohol-related problems which affect the capability or conduct of the staff member in relation to their work. The policy does not apply to staff who, because of excessive indulgence of alcohol on random occasions, contravene our standards of safety and conduct. Such cases will be dealt with according to our 'Management of Employee Conduct' policy.
- 2.6 Whilst this policy is limited to instances which affect the work capability or conduct of our staff, [Name of Organisation] also prohibits the consumption of alcohol during meal-breaks.

3 General principles

- 3.1 In [Name of Organisation], we recognise that alcohol-related problems are areas of health and social concern, and we want to offer staff with such problems access to help.
- 3.2 Alcohol-related problems are defined as any drinking, either intermittent or continual, which definitely and repeatedly interferes with a person's health, social functioning and work capability or conduct.
- 3.3 Staff who suspect or know that they have an alcohol-related problem are encouraged to seek help and treatment voluntarily either through our procedures, or through resources of the staff member's own choosing. This self-referral facility is a key part of the policy.
- 3.4 The possibility of a staff member having an alcohol-related problem may be brought to light because of problems with health or with

work performance or behaviour, or other signs which may lead to action under our 'Management of Employee Conduct' policy. Where a manager identifies a possible problem, and if the staff member agrees, the opportunity for assessment and counselling can be given.

- 3.5 We recognise that managers and Trade Union/Professional Organisation representatives are not qualified to come to conclusions about whether an alcohol-related problem exists. Our OHS will undertake the critical role in determining whether a problem exists and what help is appropriate. The Director of the Service will ensure that OHS staff have the necessary knowledge and skills to do this, and where necessary will seek assistance from outside agencies.
- 3.6 In all instances within paragraphs 3.3 to 3.5 above, the encouragement, or offer of an opportunity, to seek and accept help and treatment are made on the clear understanding that:
- If necessary, the staff member will be granted leave to undergo treatment and such leave will be treated as sick leave within the terms of the appropriate sick pay scheme.
 - Where appropriate, formal action in relation to the 'Management of Employee Conduct' policy will be suspended.
 - On resumption of duties, or on return to work following a period of treatment, the staff member will be able to return to the same job, unless the effects of the alcohol problem makes him or her unfit or unsuitable to resume the same job, or where resuming the same job would be inconsistent with the long-term resolution of the staff member's alcohol problem. When the same job cannot be resumed, every consideration will be given to finding suitable alternative employment. The staff member will be encouraged to seek Trade Union/Professional Organisation representation in discussions regarding alternative employment.
 - Having accepted help or treatment and resolved the alcohol-related problem, the employee's normal promotional prospects will not be impaired.
- 3.7 A staff member whose problems are suspected to be alcohol-related and who refuses the offer of referral for diagnosis and/or help and treatment or who discontinues a course of treatment before its satisfactory completion, and who continues to show unsatisfactory levels of work performance, may be subject to action under our 'Management of Employee Conduct' policy.
- 3.8 Following return to employment, should work performance suffer as a result of alcohol-related problems, each case will be considered individually. If appropriate, a further opportunity to accept and co-operate with help and treatment may be offered.

- 3.9 The confidential nature of any records of staff with alcohol-related problems will be strictly observed.
- 3.10 We recognise that there may be occasions when colleagues/workmates will be placed under stress during the course of treatment and rehabilitation of a fellow staff member with an alcohol-related problem. We will be sensitive to this and are prepared to take appropriate measures to safeguard the interest and welfare of such staff.
- 3.11 We will apply any national arrangements to particular categories of staff.
- 3.12 Staff will be advised of the policy and procedures, in particular the arrangements for self-referral.
- 3.13 Training and guidance will be given to managers and staff organisation representatives to operate the policy and procedure effectively.

4 Procedure

- 4.1 Identifying problems of abuse can come through a self-referral by a staff member (see 4.2 and 4.4) or through a referral by the organisation, normally in light of problems of conduct or capability of a staff member (see 4.6).
- 4.2 Staff may, at any time, approach the OHS if they are concerned about their consumption of alcohol. As with other contacts with the OHS, all consultations will be treated in the strictest medical confidence.
- 4.3 Colleagues, managers and Trade Union/Professional Organisation representatives may seek advice informally from the OHS should they require help in dealing with a suspected alcohol problem. These discussions will also be treated in the strictest professional confidence.
- 4.4 Any staff member may seek help by either:
 - voluntarily seeking help directly from the OHS or other agency; or
 - contacting their line manager or HR, when the manager or HR manager will see the staff member as soon as possible and arrange an immediate appointment with OHS.
- 4.5 OHS will:
 - assess the nature and extent of the problem and arrange, if indicated, a programme of help;
 - tell the HR manager if absence from work will be necessary as part of a course of help and/or if the co-operation of the work department is required around the staff member's duties, working conditions or continuing support; and/or

- with the patient's consent, liaise with the family doctor and outside agencies (for example, Alcoholics Anonymous) to encourage recovery.

4.6 Referral by the organisation

The procedure for this is attached at Annex 1. The effective operation of this procedure depends upon communication and co-operation between the manager, the Trade Union/Professional Organisation representative (if wanted) and OHS. While the process described in Annex 1 uses the normal route of referral as through HR, there will be situations where there will be direct referral and subsequent communication between the manager and the OHS. The manager, HR and OHS should agree the most appropriate line of communication for particular cases. The importance of all parties being kept fully informed is emphasised.

5 Monitoring and reviewing

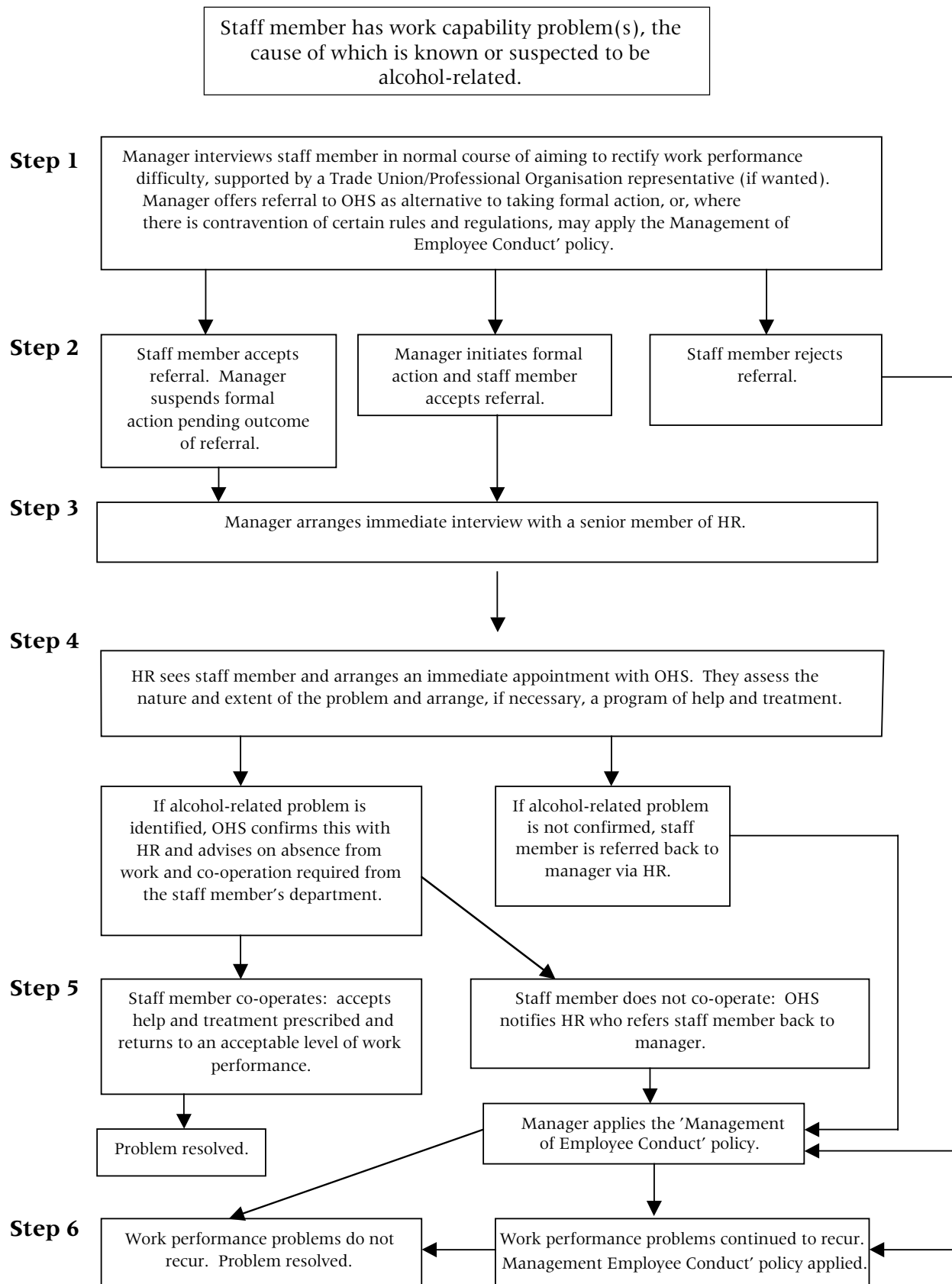
5.1 Outcome and indicators which may be used to evaluate this policy include:

- Is the policy effectively as of widely communicated?
- Are staff aware of the policy and its implications?
- Is the policy addressed in local and organisational induction programmes?

5.2 This policy will be reviewed one year from its effective date and annually thereafter by the steering group, reporting to [Name of Organisation] Board.

Annex 1

Referral by the organisation



APPENDIX 3.C

References

- Parrot S., Godfrey C., & Raw M. *Costs of employee smoking in the workplace in Scotland*, Tobacco Control, Vol 9, No. 2, pgs 187 – 192, 2000

Recommended further reading

- Income Data Services *Alcohol and Drug Policies*, Income Data Services Ltd, 1998
- Scotland's Health at Work and Scotland Against Drugs *Policies into Practice – Guidelines for Drugs Workplace Policies*, HEBS, Edinburgh, 2001
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Promoting safe manual handling

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4. PROMOTING SAFE MANUAL HANDLING

4.1 Introduction

Accidents and injuries cost an estimated £95 million a year in the NHS in the UK, including £12.5 million for back injuries and associated replacement staff (Nuffield Trust). Preventing back injuries can be cost-effective and programmes have shown, in some cases, an 84% reduction in hours lost from incidents involving manual handling.

4.2 Principles and values

It is acknowledged that working in the healthcare environment is unpredictable and unforeseen exposure to manual handling hazards will inevitably occur. However, through a programme of hazard identification, risk assessment, the implementation of control measures and constant monitoring, all reasonably practicable steps will be taken to minimise the risks to staff. The underlying principles for such an approach are found in the Health & Safety Commission (HSC) strategic document *Securing Health Together* (2000), which in summary aims to ensure that:

- work does not damage the health of workers or members of the public;
- people are not excluded from work because of ill health or disability; and
- individuals who have been ill are rehabilitated.

So, the main principle is to: 'Minimise the risk of injury to staff and patients from manual handling hazards in the working environment'.

The main injuries caused by manual-handling hazards are musculo-skeletal. Three types of measure can be adopted to reduce the risk of this type of injury occurring at the workplace, namely:

- good participative ergonomic practice;
- safe manual-handling practice; and
- appropriate rehabilitation following injury.

These measures are closely interlinked and need to be considered collectively rather than individually. They also need to be underpinned by effective senior management support and commitment.

4.2.1 Ergonomics

Ergonomics is the study of people and their working environment so that equipment or work systems can be designed to suit a person's

ability and make them as efficient as possible. Using ergonomics to assess risk involves considering a range of factors, such as:

- L load**
- I individual**
- T task**
- E environment.**

plus work organisation (Manual Handling Operations Regulations 1992).

An ergonomic risk assessment will enable the identification of hazards and provide a means of risk reduction that will make working life easier, safer, and healthier for staff and patients alike. This may be carried out, for example, by providing equipment, changing the task or altering the environment. This process should involve those staff likely to undertake the task.

The main principle is to 'fit the task or activity to the person, not the person to the task'. For example, this may mean re-positioning a computer screen (raising the height) to prevent neck strain from too much neck bending.

4.2.2 Manual handling

A manual-handling activity is described as any activity that involves transporting or supporting a load (including lifting, putting down, pushing, pulling, carrying or moving) by hand or bodily force (from Manual Handling Operations Regulations 1992).

A manual-handling hazard is an activity or system of work that could cause harm. A risk reflects the likelihood that harm will occur, together with how severe that harm may be. In order to reduce the risks associated with manual handling, a specific risk assessment can be undertaken. Such risk assessment involves the identification of manual-handling hazards and the associated level of risk.

4.2.3 Rehabilitation of staff following a musculo-skeletal injury

The aim of the rehabilitation process is to return to employment any individual whose ability to work has been affected by injury. This involves an ergonomic assessment of their work with the aim of eliminating or reducing any tasks that present a risk and then establishing a phased return to full activities (Working Backs Scotland 2000).

4.3 The legal framework

The following regulations and guidance apply to the process of reducing manual-handling hazards.

- Health & Safety at Work Act (1974)

- • Management of Health & Safety at Work Regulations (1999). Under these regulations all employers must:
 - assess and record all significant health and safety risks to staff;
 - re-assess those risks;
 - provide appropriate training; and
 - make sure all staff use equipment in accordance with training and instructions.
- • Manual Handling Operations Regulations [MHOR] (1992). These regulations further define an employer's responsibilities towards manual-handling tasks. They say that each employer must:
 - avoid any dangerous manual-handling tasks so far as is reasonably practicable and possible;
 - assess any tasks that cannot be avoided; and
 - reduce the risk as a result of this assessment.
- • Lifting Operations and Lifting Equipment Regulations [LOLER] (1998)
- • Health and Safety Executive [HSE] Manual Handling in the Health Services (Revised 1998)
- • Reporting of Injuries, Diseases and Dangerous Occurrence Regulations [RIDDOR] (1995)
- • HSE (1992) Work Equipment – Guidance on Regulations, Provision and Use of Work Equipment Regulations 1992 (PUWER).

The Guidance on Manual Handling of Loads in the Health Services (1992) says that:

- • all staff should be provided with appropriate training before carrying out any manual-handling tasks;
- • all staff should have refresher training each year; and
- • involving all staff, including medical staff, is vital.

4.4 The recommended approach to reducing musculo-skeletal injury

This section describes the seven key steps that need to be taken in order to reduce the risk of injury to staff resulting from manual-handling hazards in their working environment.

Step 1: Collecting information

Managers need to identify all potential manual-handling risks in the workplace.

Systems should be in place to allow access to, and the reporting and analysis of, relevant information. This information includes:

- • wide-ranging information on sickness absence including causes;

- details of manual-handling incidents;
- existing risk assessments;
- relevant policy documents;
- information relating to any legal claims (potential and actual);
- the number of new staff joining the organisation;
- the number of available training places;
- staff turnover; and
- incident reports (See step 7).

Step 2: Developing the manual-handling policy

The analysis of relevant information will allow the development of a Manual Handling policy, which will tackle the risks found in the organisation. The development of this policy should be a collaborative process involving health and safety advisors and committees, manual-handling advisors and co-ordinators, Occupational Health Service (OHS), and all managers and staff. Systems should be established to monitor and review the implementation of the policy and, most importantly, make sure that its requirements are met in full.

Step 3: Producing risk leave assessment reports

There is a legal obligation to carry out manual-handling risk assessments in areas and for activities that could cause an injury (MHOR 1992). These regulations also state that a risk assessment must be undertaken or reviewed annually if:

- there is reason to suspect that it is no longer valid; or
- there has been a significant change in the manual-handling operations.

The risk assessment process should include 'participatory ergonomics', in other words, staff, experts (ergonomists, occupational health physiotherapist, manual-handling advisors, occupational health advisors) and managers working together to:

- assess risks;
- identify problem areas; and
- jointly develop recommendations (the control measures) and action plans to reduce the risks.

All staff should undertake risk assessment on a needs basis. For example, a patient's level of dependence may alter over a period of days or even hours, and therefore their handling needs must be re-assessed accordingly.

Step 4: Prioritisation

From collecting information and carrying out risk assessments, an organisation should prioritise which control measures to put in place by first targeting areas and staff groups at highest risk.

Step 5: Putting control measures in place

Having completed the risk assessment process, it is vital to implement the control measures and action plans that have been developed in response.

The ultimate aim should always be to 'avoid or minimise the risk whenever possible'. For example, it is not necessary to lift or handle patients who can move themselves. If a risk cannot be eliminated or avoided, one or a combination of the following options should be considered. (This list is not exhaustive.)

- Change to another safer system of work

For example, a patient cannot move very well in bed, and asks for help from staff to move up the bed. However, the patient can walk with help. It may be possible for staff to tell the patient to get out of the bed, step up towards the head of the bed, and then get back in. This encourages the patient to be independent and reduces the need for staff to be involved in a potentially dangerous task.

- Providing equipment

Equipment must always be appropriate and suitable to the needs of the task (according to product evaluation) and specialist advice should be taken whenever necessary. Staff must also receive appropriate training and support. Organisations need to be aware of the law relating to maintaining equipment (for example, LOLER or PUWER).

- Managing caseload

For example, an acute stroke unit will have varying patient dependency levels. A large percentage of the patients may be very dependent needing intensive rehabilitation by physiotherapy staff.

The nature of therapy rehabilitation involves manual-handling techniques that might not be able to be replaced by equipment. In other words, "it is not always practicable to avoid manual handling in physiotherapy without abandoning the goal of the rehabilitation of patients" (CSP Guidelines on Manual Handling). To prevent injury to therapy staff, an increase in staffing or a reduction in the number of manual-handling activities may need to

happen. This will involve collaboration all round and ongoing risk assessment.

- Structural changes

Structural changes may need to take place, if the working environment has a risk of injury associated with it. Small spaces may be one of the identified hazards. For example, a patient needs help to go to the toilet but there is limited space within the toilet cubicle because:

- the door opens inwards into the cubicle;
- the toilet bowl is close to one wall, which would limit access of the assistant; or
- the basin in the cubicle limits space.

The control measure would be to alter these factors, so as to make best use of the space available. Interim measures should be used until structural changes have occurred, for example, using another toilet area.

- Training

The HSC 'Manual Handling in the Health Services' 2nd Edition (1998) recommends that:

- appropriate training should be provided before manual-handling tasks are carried out (maybe as part of induction);
- refresher training should be carried out, if training is to remain effective in the long term (the nature and delivery of the training will depend on the type of work being carried out); and
- records are kept of all training delivered to staff, including a description of the content of each course.

We recommend that you record the percentage of staff receiving induction training before taking up their duties (attendance rates and did-not-attend (DNAs) rates should be recorded. This information could be used as a measure against identified performance indicators.

The content of a course could include:

- legislation and local policy;
- ergonomics;
- risk assessment;
- back care;
- details of injuries;
- fitness;
- safe-handling principles;

- mechanical-handling equipment;
- using safe-handling principles when moving someone or something; and
- condemned manoeuvres.

Training should help to encourage staff to assess the risk of each situation. Staff should then be able to use the safe-handling principles and best work practices that they have been shown. Staff must recognise that they have responsibility for the actions they take. Ongoing monitoring of safe practice should occur in the workplace via key-workers.

Step 6: Rehabilitation of staff following musculo-skeletal injury

If a staff member suffers a musculo-skeletal injury which affects their ability to perform their job, there is a need to provide a rehabilitation programme. To help this process a number of people need to be involved, such as ergonomists, manual-handling advisors, OHS staff, health and safety advisors, physiotherapists and HR staff.

Staff should be able to receive rehabilitation in a prompt and convenient way.

Outlined below is the process which should be carried out to support staff suffering musculo-skeletal injury.

- Assess and diagnose the injury and cause.
- Identify associated functional problems.
- Recommend a management programme.
- Put the management programme into practice.

Elements of the management programme should include the following.

- Treating the injury

There are a number of different methods, for example, physiotherapy, counselling, osteopathy, referral to a consultant specialist.

- Support from HR

This can range from making sure that the staff member stays in contact with the organisation if they are on long-term sick leave or if their condition leads to ill-health retirement.

- Work-site assessment

Providing an ergonomic assessment based on a staff member's capability and their worksite can reduce the risk of the injury happening again by making adjustments to the working environment or the activities and tasks which are carried out.

- A planned return to work

Early return to work after injury or ill health can be achieved with the intervention of experts who understand the physical requirements of the job, human movement and the capability of the individual concerned. Facilitating a safe and timely return to work can be achieved through a multi-disciplinary approach, involving managers, the staff member, HR staff, the occupational health physiotherapist and OHS staff. (See also Appendix 4.C.)

Every effort should be made to think creatively and flexibly to facilitate return to work. Factors that might be addressed include:

- hours of work and, within this, start and finish times;
 - extra training;
 - job sharing;
 - restricted duties;
 - mentoring;
 - help with travelling; and
 - working from home.
- Review and follow-up
- Follow-up is essential in order to make sure that recommendations and actions have been implemented and, if necessary, modified. For example, a weekly review meeting between the staff member, their line manager and the clinical case manager would assist the process of a planned return to work. In cases where the process of planned return to work takes place over many weeks, a monthly review meeting, including HR staff, would be useful.

Step 7 Reporting incidents involving manual handling

In order to identify the causes of manual-handling incidents, and whether or not trends are developing, all incidents must be reported, fully investigated and analysed. This will also help to:

- check whether everyone is following the letter of the law;
- check the effectiveness of prevention measures; and
- identify any problem areas.

The depth of each investigation will vary depending on the nature of the incident. However, to be worthwhile any investigation must consider the underlying causes of the incident (HSC 1998).

Certain incidents must be reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. Organisations must follow established incident-reporting protocols. This will also give an organisational record of all accidents and incidents that cause musculo-skeletal injury and ill health.

4.5 Evaluation

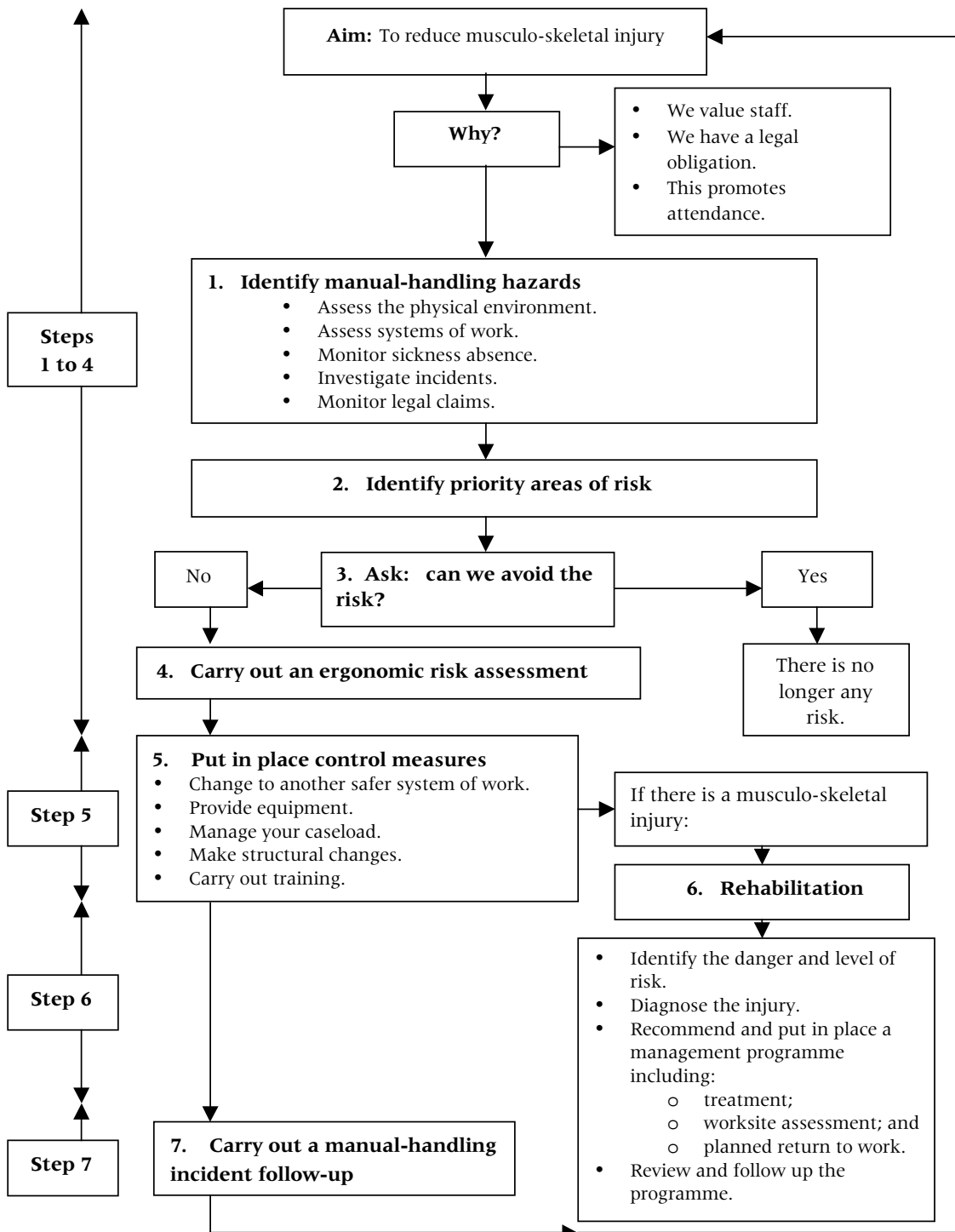
The following performance indicators can be used to ascertain whether or not the desired targets and outcomes have been achieved.

- • Working hours lost as a result of manual-handling incidents.
- • 20% reduction in the incidence of work-related ill health (Securing Health Together HSC 2000).
- • The number of training places offered compared to the number of new staff.
- • The percentage of staff receiving induction training before starting work (attendance rates and DNAs).
- • The level of appropriate and up-to-date training provided.
- • The percentage of staff receiving refresher training.
- • The level of injury-related compensation.
- • The level of injury-related early retirement costs.
- • Litigation claims and costs.
- • RIDDOR reports.

Systems and processes must be put in place to collect relevant data. However, having done this, it is possible that there will be a rise in the number of reported incidents in the short term. If this happens, it is because of the improvement in the reporting mechanisms, rather than an indication that the workplace is becoming less safe.

APPENDIX 4.A

The recommended approach to reducing musculo-skeletal injury



APPENDIX 4.B

Model manual handling policy

1 Introduction

- 1.1 In [Name of organisation], we recognise the risk of musculo-skeletal injury faced by staff from manual-handling operations. This policy has been developed in accordance with the relevant legislation, in particular:
 - Health and Safety at Work Act 1974;
 - Management of Health and Safety at Work Regulations (1992);
 - Manual Handling Operations Regulations (1992); and
 - Lifting Operations and Lifting Equipment Regulations (1998).
- 1.2 Although an organisation-wide approach has been established, detailed arrangements for controlling manual-handling risks remain the responsibility of Directors, Heads of Service and operational managers. All departmental health and safety policies should deal with the manual-handling risks arising in the course of the work of the department.
- 1.3 This policy and its procedures have been developed and agreed through the local Partnership Forum.

2 Principles

- 2.1 [Name of organisation] is committed to applying a safe system of work to all manual-handling situations as defined in the Manual Handling Operations Regulations (1992), that is: any lifting, putting down, pushing, pulling, carrying or moving of a load by hand or by bodily force.
- 2.2 We are committed to a policy of minimal lifting – in other words, promoting the elimination of all whole- or near whole-body when lifting patients.
- 2.3 We are committed to eliminating, so far as is reasonably practicable, manual-handling operations which incur a significant risk of injury, or otherwise reduce the level of risk to the lowest level reasonably practicable. To facilitate this we are committed to providing:

- risk assessment;
- adequate manual-handling training;
- manual-handling equipment; and
- guidance on site.

2.4 This policy will be reviewed annually, and registered holders of the Health and Safety Control Book / Health and Safety Manual will be notified of amendments.

3 Policy aims

This policy aims to:

- meet the general commitments to the health and safety of staff described in the Risk Management and Health and Safety policy;
- get rid of manual-handling operations which could cause injury, wherever this is reasonably practicable, and reduce risks to the lowest level reasonably possible;
- get rid of the manual lifting of patients in all but exceptional or life-threatening situations;
- reduce the risk of unnecessary manual handling by making sure that risk assessments are carried out and that equipment is used wherever appropriate;
- make arrangements for putting the policy into practice and make sure we make improvements in controlling the risks created by manual handling;
- contribute to helping staff who have musculo-skeletal symptoms;
- reinforce the responsibilities of general or directorate managers and heads of departments for manual-handling activities within their areas of responsibility; and
- keep to the Manual Handling Operations Regulations 1992 and all other legislative and professional guidance (see Annex 1).

4 General strategy

4.1 Our strategy for manual handling reflects the scale of the problems in this respect. Responsibility for risk assessments and implementing control measures rests with line managers with advisory input from the Manual Handling Co-ordinator, as appropriate.

4.2 The strategy for reducing manual handling risks is as follows.

- A multi-disciplinary Manual-Handling Group needs to work with the Risk Management and Health and Safety steering group to review and oversee how the policy is put into practice.

- A competent Manual-Handling Advisor or Co-ordinator needs to develop and oversee strategies, to provide staff training and expert advice on manual-handling issues.
- Wide-ranging risk assessments must be carried out by line managers, heads of department and identified key-workers of all manual-handling operations if there may be a significant risk of injury.
- There needs to be a plan for putting any action into place. The plan will aim to reduce the risk of injury within manual-handling operations by:
 - identifying priority risk areas;
 - helping staff use mechanical and patient-handling equipment correctly;
 - encouraging safe-handling practices;
 - adapting the working environment; or
 - reorganising work practices.
- Priority staff groups for training programmes must be established, and refresher training provided as appropriate.
- Manual-handling Key Workers need to be identified. Additional training should also be provided for these staff to increase their knowledge and practical skill base, in order to facilitate implementation of ongoing risk assessment, risk control measures and good handling practices, at a local level.
- Data which is collected should be used to monitor the policy's implementation.

5 Responsibilities

- 5.1 The **Chief Executive** will include a review of progress in controlling the risks from manual handling, and aims for the coming year, in the annual health and safety report for the organisation's Board.
- 5.2 The **Health and Safety Policy and Planning Committee and /or nominated Executive Director** will act on behalf of the Chief Executive in overseeing how the policy is put into practice and meeting the aims set.
- 5.3 The **Manual Handling Advisor** and Manual Handling Co-ordinators are our main source of expertise in manual handling.
- 5.3.1 The Manual Handling Advisor will lead, co-ordinate and develop the Manual Handling Department and the Staff Injuries Physiotherapy Service in line with this policy. S/he will advise on strategic developments necessary to reduce musculo-skeletal disorders to meet legislation and best practice.

5.3.2 The Manual Handling Co-ordinators are responsible for:

- delivering the Manual Handling Education Programme and maintaining a record of all staff who receive training;
- providing advice to the Manual Handling Key Workers and other staff on manual-handling risk assessment and risk control when necessary;
- carrying out on-site visits to reinforce the manual-handling education;
- providing advice on manual-handling issues and on new projects and buying equipment;
- developing systems to audit how effective the Manual Handling policy is and report to our Manual Handling Advisor (or other identified individual or committee) regularly; and
- investigating IR1 incident forms relating to manual-handling issues.

5.4 The **Patient Service Directors** and **operational managers** are responsible for:

- noting the initial risk assessments carried out and any amendments or additions made by Manual Handling Key Workers;
- putting the recommendations for eliminating or reducing risk into practice as far as is reasonably practicable, following the initial assessment or annual review;
- recording details in their departmental health and safety policies of their arrangements for manual-handling risks, outlining appropriate responsibilities, channels of communication and monitoring;
- making sure that appropriate measurements of fitness criteria are set for new staff and that these are used effectively by OHS when carrying out pre-employment screening;
- making sure that they have enough staff trained as Manual Handling Key Workers (as recommended by the Manual Handling Department), who will have refresher training each year with the Manual Handling Department;
- taking account of risks created by manual handling in the design of new facilities, buying of equipment or new work practices and take advice from the Manual Handling Department; and
- maintaining monthly statistics on all manual-handling incidents and the extent of any sickness absence which may be caused as a result.

5.5 **Line managers** are responsible for:

- identifying manual-handling risks within their department and, as appropriate, working with the Manual Handling Co-ordinator to identify measures to reduce risk;
- making sure that the incident forms are filled in for all injuries or near misses involving manual handling, and keep up-to-date details of all manual-handling incidents which occur in their area of responsibility, particularly during periods of absence;
- making sure that manual-handling risk assessments are carried out, updated as necessary, reviewed every year, and details kept;
- being fully aware of the issues highlighted within current manual-handling risk assessments carried out for their areas;
- putting into practice, as far as reasonably practicable, with the resources available, any control measures identified through risk assessments or required under this policy;
- recording details of action plans for reducing risk and passing information to general managers to make sure they prioritise risk control measures;
- taking account of the risks created by manual handling in the design of new facilities or work practices, and taking advice when necessary;
- appointing members of staff to receive further education as Manual Handling Key Workers;
- working with the Manual Handling Key Workers to make sure that all staff receive the relevant education before starting their jobs and that they are updated regularly;
- maintaining local records of staff who receive training, both at induction and for update sessions;
- recommending referral to the Staff Injuries Physiotherapist when appropriate, and taking advice on changing tasks or a phased return to work when necessary; and
- making sure that new members of staff in their ward or department have been passed by the Occupational Health Service (OHS) as fit for the job.

5.6 **Manual Handling Key Workers** are responsible for:

- encouraging people to use safe systems of work on a day-to-day basis;
- being responsible, with the Ward Manager or Head of Department, for making sure that the risk assessments are

completed, updated each year and that safe working practices are maintained in the ward or department;

- consulting with their Ward Manager or Head of Department and taking appropriate steps to make sure individual staff members who face increased risk because of existing injury, pregnancy or other factors get the advice of OHS, the Manual Handling Co-ordinators, or the Staff Injuries Physiotherapist where necessary;
- making sure that staff go on an appropriate manual-handling course at induction and that they receive regular updates;
- making sure, along with the Ward Manager or Head of Department, that staff keep a record of their attendance at these courses;
- encouraging staff to promptly report musculo-skeletal injuries which might be made worse in the course of work and adapting work patterns or tasks to prevent placing these individuals at further risk of injury;
- monitoring poor practice within the ward or department and referring any concerns to the Ward Manager or Head of Department or Manual Handling Department as appropriate;
- making sure that the staff have enough slings, sliding sheets and other manual-handling equipment, and make the Ward Manager and Head of Department and Manual Handling Department aware of any shortages; and
- going on regular refresher training provided by the Manual Handling Co-ordinator, to allow skills to develop.

5.8 All **staff** are responsible for:

- taking reasonable care for their own safety and that of colleagues and patients;
- making full and proper use of equipment provided;
- following safe systems of work shown in the risk assessments;
- following the precautions and procedures set up for avoiding or reducing the risk of musculo-skeletal injury created by manual-handling work and following the safe system of work, and in particular those carrying out patient handling will note the method of transfer shown in the care plan or mobility chart for identified patients;
- going on the manual-handling course provided by the Manual Handling Department at induction and further updates, following safe working practices for manual handling and asking for extra training if they feel that they need it;

- assessing the task before carrying out any manual-handling activity to make sure enough precautions are taken, and for ward staff, making sure that there is a mobility chart or an individual mobility assessment completed for every patient, which must be updated at appropriate intervals;
- following the large-patient or bariatric-patient procedure if involved in handling a patient who weighs more than 28 stone/175 kg (or other identified weight limit);
- reporting to their Key Worker or Head of Department any risks which they think have not been handled effectively;
- avoiding manually lifting patients in all but exceptional or life-threatening situations and report any injury or significant pain which may have been caused by manual work and any personal factor (such as musculo-skeletal injury, illness, or pregnancy), which might increase the risk;
- making sure that incident forms (IR1) are promptly reported and completed by following the procedure for all incidents involving manual handling; and
- reporting any problems or shortcomings in the risk assessment or safe system to their line manager.

5.9 **Health and Safety staff** are responsible for:

- reviewing and updating, as necessary, the guidance given in the Health and Safety Manual on assessing risk for manual handling;
- providing statistics on the incidence of manual-handling injuries within the organisation; and
- providing technical and organisational help to the Manual Handling Co-ordinator and other members of staff when necessary.

5.10 The **Staff Injuries Physiotherapist** is responsible for:

- providing a service to all staff within the organisation;
- providing assessment and treatment for staff with musculo-skeletal injuries;
- carrying out workplace assessments so staff can gradually return to work if they have been on sick leave;
- carrying out on-site assessments for those staff that are concerned about their workplace, or referring these staff onto the Manual Handling Department;
- giving advice to relevant line managers following a detailed workplace assessment, to prevent injuries becoming worse;

- advising on manual-handling issues and on buying equipment; and
- auditing the effectiveness of the Staff Injuries Physiotherapy Service and reporting to the Manual-Handling Policy Committee.

5.11 The **OHS** is responsible for carrying out pre-employment screening and making sure that new staff are fit for the duties involved in their post.

They will discuss with the Ward or Department Head, the Staff Injuries Physiotherapist, the Manual Handling Department or Health and Safety staff any manual-handling risk which they consider to be significant.

All staff can consult the service, confidentially, on any aspect of health and safety while at work.

6 Training

6.1 The best way of reducing the risk of musculo-skeletal injury is by putting measures in place which reduce:

- the amount of manual-handling work performed; and
- the risk factors in the manual-handling tasks that remain.

[Name of organisation] will provide training which:

- teaches the principles of:
 - legislation and local policy;
 - ergonomics;
 - risk assessment;
 - back care;
 - details of injuries;
 - fitness;
 - safe-handling principles;
 - safe manual-handling principles, manoeuvres and efficient movement;
 - using manual-handling equipment; and
 - the condemned manoeuvres;
- emphasises the practical application of these principles;
- gives guidance in the correct use of appropriate mechanical aids and patient transfer equipment; and
- teaches the principles of safe moving and handling (an ergonomic approach), to reduce the likelihood of injury from the manual work which cannot be avoided. Training is based on risk assessment.

6.2 All staff will receive initial training before working in the clinical area. The length of the training at induction will vary according to the tasks in which staff are involved.

6.3 All staff will also receive refresher training.

Manual Handling Key Workers will receive extended and refresher training so they can increase and develop their level of knowledge and practical skills. This will allow them to carry out their extended role.

Line managers will identify further training needs and appropriate training will be provided in consultation with the Manual Handling Co-ordinator.

7 Moving patients

7.1 Statistics show that most nurses experience musculo-skeletal injury in the course of their careers. This risk stems largely from the requirement to move patients who have difficulty moving themselves.

7.2 The provision of lifting aids in [Name of organisation] is now such that the following can be made formal organisational policy.

- Staff must use the manual-handling equipment available on the wards.
- Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) the following must not be carried out (see Annex 2):
 - drag lifts;
 - Australian or shoulder lifts;
 - orthodox or cradle lifts;
 - other manoeuvres involving the patient's hands around the handler's neck; or
 - any other procedure to lift most of or the entire body weight of a patient, without a mechanical lifting aid.
- Action may be taken under the 'Management of Employee Conduct' policy where there is evidence that staff are repeatedly carrying out the above manoeuvres without due cause.
- All staff should carry out a manual-handling risk assessment before handling a patient.

8 Rehabilitation and assessment

Managers, with the staff member's permission, will refer to the Staff Injuries Physiotherapist or OHS any staff who suffer musculo-skeletal injury and who may need temporary changes made to their normal duties.

The Staff Injuries Physiotherapist will assess the staff member's fitness in relation to the demands of their job and will make recommendations to the relevant head of department. They, in turn, will make all reasonable efforts to accommodate these recommendations.

If the relevant manager judges the recommendations to be impractical, they must discuss the recommendations with the next appropriate level of management.

9 Monitoring and reviewing

- 5.1 Outcome and indicators which may be used to evaluate this policy include:
- Is the policy effectively as of widely communicated?
 - Are staff aware of the policy and its implications?
 - Is the policy addressed in local and organisational induction programmes?
- 5.2 This policy will be reviewed one year from its effective date and annually thereafter by the steering group, reporting to [Name of Organisation] Board.

Annex 1

Legislative and Professional Guidance Documents

Health & Safety at Work etc Act (1974), Chapter 27, HMSO 1974 ISBN 0 10 543774 3

Management of Health & Safety at Work Regulations (1992) SI 1992 No2051 HMSO 1992 ISBN 0 11 025051 6

Manual Handling Operations Regulations (1992) HMSO ISBN 0717624153.
Guidance on the Regulations, HSE Books, updated 1998

Health Service Advisory Committee (1992), *Guidance on the Manual Handling of loads in the Health Service*

Lifting Operations and Lifting Equipment Regulations (1998), SI 1998, No2307 TSO 1998 ISBN 0 11 079598 9

NBPA & RCN (1997), *The guide to the handling of patients*, 4th edition, NBPA, Middlesex

RCN (1999), *Manual handling assessments in hospital and the community*, London

RCN (1999), *RCN Code of Practice for patient handling*, London

RCN (1999), *Introducing a safer patient handling policy*, London

Annex 2

Condemned Lifts

1 The drag lift

This was **condemned** by the RCN in 1981 (NBPA / RCN, 1997). It relies on the nurse placing a hand or arm under the patient's armpits. It has been used to:

- move a patient up the bed;
- sit a patient up from lying in bed;
- bring a patient to stand from sitting; and
- move a patient from one seated position to another.

2 Orthodox or cradle lift

This was **condemned** by the RCN in 1987 (NBPA / RCN, 1997). Any modification of this lift using handling slings is also banned. Using two blue plastic handling slings (one under the patient's back and one under the patient's thighs) is still an orthodox lift and must not be used. It was the original method used to lift a patient where a handler stood on either side, clasped their wrists under the patient's thighs and behind their back. It is very, very **dangerous**.

3 Bear hug, stroke lift or 'clinging ivy' lift

This lift involves moving or supporting a patient with their arms or hands around the handler's neck. This is particularly **dangerous** because if the patient does not stand, or collapses when his or her arms are around the handler's neck, all their weight is hung around the neck, obviously causing too much strain and probable injury. Also, if the patient falls backwards, their instinct will be to remain clamped around the handler's neck, so causing them to fall. This is obviously a high-risk manoeuvre with a high risk of injury. The site of injury ranges from upper neck to lower back.

Moving a patient with their hands on the handler's shoulders is also **not** a **safe** alternative for similar reasons.

4 Australian or shoulder lift

This was **condemned** by the RCN in 1996 (NBPA / RCN, 1997).

All manual lifts are dangerous, so even though the shoulder or Australian lift was considered one of the safer lifts, it still has risks (Scholey, 1982; Ergonomics Research Unit, 1986; Pheasant, Holmes, Stubbs, 1992).

4.1 Negative effects for the patient

- The force of the handler's shoulder against the chest wall can cause breathing problems.
- Certain conditions, for example hip replacements, prevent the amount of hip flexion required.
- Leaning forwards can be painful or uncomfortable.
- Lifts can be uncomfortable and dangerous for patients with shoulder problems or pain.
- These lifts are not suitable for most amputees.

4.2 Negative effects for staff

- Handlers are in a 'top-heavy' position.
- The handler lifts the load on one shoulder resulting in uneven loading and strain.
- The arm under the patient's thighs is twisted and at risk of injury.
- The handhold with the other handler is uncomfortable and means they need to grip.
- Communication between handlers is difficult.
- Handlers cannot see the patient's face.
- Tall handlers have difficulty getting into position.
- It is difficult to get the patient into position.

5 Any move where staff lift the whole or a large part of the weight of a patient, including:

- manually lifting patients up off the floor;
- manually lifting patients in and out of the bath;
- manually straight-lifting patients; and
- using canvas and poles.

APPENDIX 4.C

References

The Nuffield Trust	<i>Improving the Health of the NHS Workforce</i> , Sian Williams, Susan Michie, Shriti Pattani
Health & Safety at Work Act	HMSO, London, 1974, ISBN 0 10543774 3
Management of Health & Safety at Work Regulations (1992)	SI 1992 No2051, HMSO, London, 1992, ISBN 0 11 025051 6
Lifting Operations and Lifting Equipment Regulations (1998)	SI 1998, No2307, TSO 1998, ISBN 0 11 079598 9
Manual Handling Operations Regulations	HMSO London 1992, ISBN 0717624153

Recommended further reading

National Back Pain Association and Royal College of Nursing	<i>The guide to the handling of patients</i> , NBPA, Middlesex, 1998, 4th Edition
RCN	<i>Manual handling assessments in hospital and the community</i> , London, 1999
RCN	RCN Code of Practice for Patient Handling, London 1999
RCN	<i>Introducing a safer patient handling policy</i> , London 1999
RCM	<i>Midwifery Guidelines on Manual Handling</i> , 1998
Chartered Society of Physiotherapy	<i>Guidelines on Manual Handling</i> , CSP, 2002
Resuscitation Counsel	<i>Guidance on Manual Handling</i>
Association of Chartered Physiotherapists in Neurology	<i>Guidance on Manual Handling and Physiotherapy Treatments</i> , ACPIN
Scottish Healthcare Supplier Safety Action Notice System	
Medical Devices Agency	<i>Advice on the Use of Equipment</i> (MDA)

Protecting the health, safety and welfare of people working alone

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5. PROTECTING THE HEALTH, SAFETY AND WELFARE OF PEOPLE WORKING ALONE

5.1 Introduction

Lone workers are defined in the following ways.

‘Those employees who work by themselves without close or direct supervision.’ (Health and Safety Executive 1998) and

‘Employees whose activities involve a large percentage of their working time operating in situations without the benefit of interaction with other workers or without supervision.’ (Croners Health and Safety 2001)

Lone work is not the chance occurrence of finding oneself on one’s own, for example, when somebody arrives first in the office or leaves last, or where an individual has to go unaccompanied to another part of the workplace. Lone work is specifically intended to be unaccompanied work, or work without immediate access to another person for assistance.

5.2 Principles and values

Within NHSScotland there must be an integrated organisational approach to addressing the problems associated with lone working. The following principles and values should underpin the development of strategies and policies for addressing the issue of lone working at a local level.

- Organisations should develop and promote a culture where the personal safety of all staff is valued and protected and where increased risks resulting from working alone are seen as unacceptable.
- Senior managers within organisations need to communicate and show their commitment to reducing the dangers associated with lone working, make available the resources for putting policies into practice, and make sure that it is clear who is responsible for each function.
- All staff should expect that any risk to them or their colleagues will be reduced as far as possible by using effective risk management systems.

- Staff and their representatives should be fully involved in developing and putting in place local strategies and policies to reduce the risks associated with lone working.
- Effective support mechanisms should be in place for staff who need to work alone.

5.3 Identifying lone workers

Lone workers within NHSScotland organisations can be found in a wide range of situations. A simple categorisation system and examples of staff groups who may be required to work alone are given as follows:

- | | |
|--|---|
| 1 Staff working in fixed establishments: | <ul style="list-style-type: none"> • Reception staff. • Boiler-house staff. • Facilities and maintenance staff. • Radiographers. |
| 2 Staff working outwith normal work hours: | <ul style="list-style-type: none"> • Domestic staff. • Transport staff. • Nursing and medical staff. |
| 3 Mobile workers working away from their fixed base: | <ul style="list-style-type: none"> • Community nursing and midwifery staff. • Chiropody and podiatry staff. • Speech and language therapy staff. |

5.4 The dangers of working alone

The number of people working alone is increasing. People who work alone face the same dangers in their daily work as other workers. However, for lone workers, the risk of harm is often greater. The risks to lone workers will depend on the type of situation where lone working is being carried out.

Dangers which lone workers may face are as follows:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Accidents or emergencies. • Lack of first-aid provision. • Fire. • Problems with access/egress. • Night work or unsocial hours. • Working alone in buildings. • Poor or lack of communication. • Passive smoking risks. • Driving alone. | <ul style="list-style-type: none"> • Visiting high-risk locations. • Working in confined spaces. • Handling dangerous substances. • Not receiving enough rest. • Manual handling. • Potential violence. • Vulnerability of travelling alone. • Lack of peer support. |
|--|--|

5.5 The legislative framework

Establishing safe working arrangements for lone workers is no different from organising the safety of all other staff. NHSScotland organisations must know and apply the legislation and standards that pertain to their working practices. They must then assess whether or not the working practices of their lone workers meet the requirements.

There is no general legal restriction on working alone. However, the broad requirements of the Health and Safety at Work Act (1974) and the Management of Health and Safety Regulations (1999) still apply. These say that NHSScotland organisations should identify the dangers associated with lone working, assess the risk involved, and put in place measures to get rid of or control the risks.

If a risk assessment shows that it is not possible for the work to be done safely by a lone worker, then other arrangements must be put in place. Risk assessment should help to determine the level of supervision that is required. In certain high-risk activities there may be specific restrictions on working alone, for example, fumigation work, work in confined spaces, and electrical work near live conductors. In these situations, at least one other person may need to be present. It may also be necessary to have someone present who is dedicated to the rescue role, for example in working in confined spaces. The following are examples of legal requirements specifying work situations where more than one person is needed.

- • **Confined Spaces Regulations** (1997) – entry into confined spaces.
- • **Construction Health Safety and Welfare Regulations** (1996) – requirements for ladders.
- • **Control of Substances Hazardous to Health Regulations** (1994) – certain fumigation work and other work with substances which are dangerous to health (see separate Guideline).
- • **Electricity at Work Regulations** (1989) – electrical work near live conductors.

The above list is not exhaustive. General obligations in both statute and civil law may require the adoption of equivalent standards for similar work. What is essential is that lone workers should not be at more risk than other staff. This may require extra risk-control measures to be put in place. Risk assessment should take account of both normal work and foreseeable emergencies, such as fire, illness and accidents.

5.6 Risk assessment and control measures

In carrying out risk assessments on lone working, you should consider the following.

- Does the workplace present a special risk to the lone worker?
- Can one person adequately control the risks of the job?
- Is the person medically fit and suitable to work alone?
- What training is required to make sure the staff member is competent in safety matters?
- Have staff received the training which is necessary to allow them to work alone?
- How will the staff member be supervised?
- Is there a risk of violence?
- Are people of a particular gender especially at risk if they work alone?
- Are new or inexperienced staff especially at risk if they work alone?
- Are younger staff especially at risk if they work alone?
- What happens if a lone worker becomes ill, has an accident, or if there is an emergency?
- Are there systems in place for contacting and tracing those who work alone?

Control measures that can be put in place include:

- instruction;
- training;
- protective equipment;
- supervision; and
- back-up procedures.

NHSScotland organisations should take steps to make sure that control measures are used and that risk assessments are periodically reviewed to make sure that the control measures are adequate.

Procedures will also need to be put in place to monitor the activities of lone workers to make sure that they remain safe. These may include the following:

- regular contact between the lone worker and the supervisor, for example by telephone or radio;
- supervisors periodically visiting and observing people who work alone;
- automatic warning devices that operate if specific signals or communications are not received periodically from the lone worker;
- other devices designed to raise the alarm in the event of an emergency that operate manually or are activated automatically by the absence of activity if necessary; and

- • systems to check that a lone worker has returned to base or home after finishing their work activities.

5.7 Recommended approach

5.7.1 Developing policy

Measures for dealing with the risks associated with lone working are based on careful thought and good assessment of the risk. The risks of working alone must be taken seriously at all levels of the organisation. Policies, management arrangements and organisational culture must reflect this.

Policies on lone working should cover the following issues:

- • a commitment to making sure that those who work alone are safe;
- • defining and identifying lone workers;
- • a statement of the aims of the policy;
- • details of employers' legal responsibilities;
- • details of managers' responsibilities;
- • details of staff's responsibilities;
- • identifying the hazards of lone working;
- • information on risk assessment;
- • details of control or risk-reduction measures;
- • details on arrangements for monitoring and reviewing how policies are put into practice; and
- • manual handling policy and the risks of musculo-skeletal injury if lifting is done.

Policies need to be translated into effective action. They need to be supported by more detailed procedures, by effective organisation and by a positive health and safety culture. Policies need to recognise that staff may work in the situations described at 5.3 and in any location.

More specific policies or local guidelines may also be required to address specific areas of risk, for example in relation to:

- • staff working outside normal office hours;
- • staff travelling on their employer's business; and
- • staff involved in domiciliary or home visits.

Policies and guidance should set out clear procedures and set limits as to what can and cannot be done while working alone. There should also be agreement on circumstances in which it is correct to stop work and get advice. Appendix 5.A provides a flowchart relating to assessing risk and developing policy for making sure that lone workers are safe. Local managers only need to adopt policies to take account of specific local risks.

The principles of partnership should be adopted when developing and implementing policies and guidelines, as Trade Unions/Professional Organisations are a valuable source of information and advice. Their involvement will help to make sure that all relevant hazards have been identified and appropriate control measures are put in place. NHSScotland organisations will also find it useful to compare policies with partner agencies such as social services whose staff face similar issues.

5.7.2 Staff competence and training

Training is particularly important if there is only limited supervision to control, guide and help lone workers in uncertain situations. This training may be a very important factor in avoiding panic reactions in unusual situations. Lone workers need to have enough experience and be able to fully understand the risks associated with the tasks they carry out in their work, together with the precautions they must take to eliminate, or reduce, these risks.

Staff must be competent to carry out work unaccompanied and to deal with circumstances which are new, unusual or beyond the scope of training. This should include knowing when to stop and get advice from a supervisor. Part of the training given to lone workers must be to impress upon them the need to report any incidents which could affect their safety. This information is essential in any review of the adequacy of working arrangements. If training is necessary as part of the control strategy, this should be recorded as part of the risk assessment. An indication of how often refresher training should be given should also be noted.

5.8 Putting the policy into practice and reviewing it

5.8.1 Recording and collecting data

Lone workers must be actively encouraged to report and record any incidents that could affect their safety, in order to allow a proper review of the adequacy of the working arrangements. This should also extend to 'near miss' reporting.

5.8.2 Monitoring

Once safe working arrangements and strategies have been put into practice, they need to be regularly monitored and reviewed to make sure they are still effective. There should be support and commitment from senior management level and very clear management responsibilities linked to local arrangements.

The policy on lone working should include a timescale and mechanism for a review by the Partnership Forum and local Health

and Safety Committee. There should also be the opportunity for occasional reviews if this is required. All NHSScotland organisations:

- should identify local quality indicators in relation to the management and reduction of risk as a matter of good practice; and
- analyse information on reported incidents and use the results as the basis for future risk assessment and review.

5.8.3 Communication

All NHSScotland organisations must make sure that they set up clear communication systems, so they can pass on the organisation's policy on lone working to all relevant staff and to others working on a lone worker basis. This may include agency staff, students, volunteers and independent contractors.

In order to communicate the organisational policy on lone working:

- there needs to be obvious commitment and support from senior managers for the policy to be fully adopted within the organisation;
- briefing sessions should be held for managers on the launching of the new or amended policy;
- managers must make sure that staff are aware of their individual responsibility to keep to the policy; and
- new staff must be made aware of the policy and their responsibilities as part of their induction.

5.8.4 Measuring success

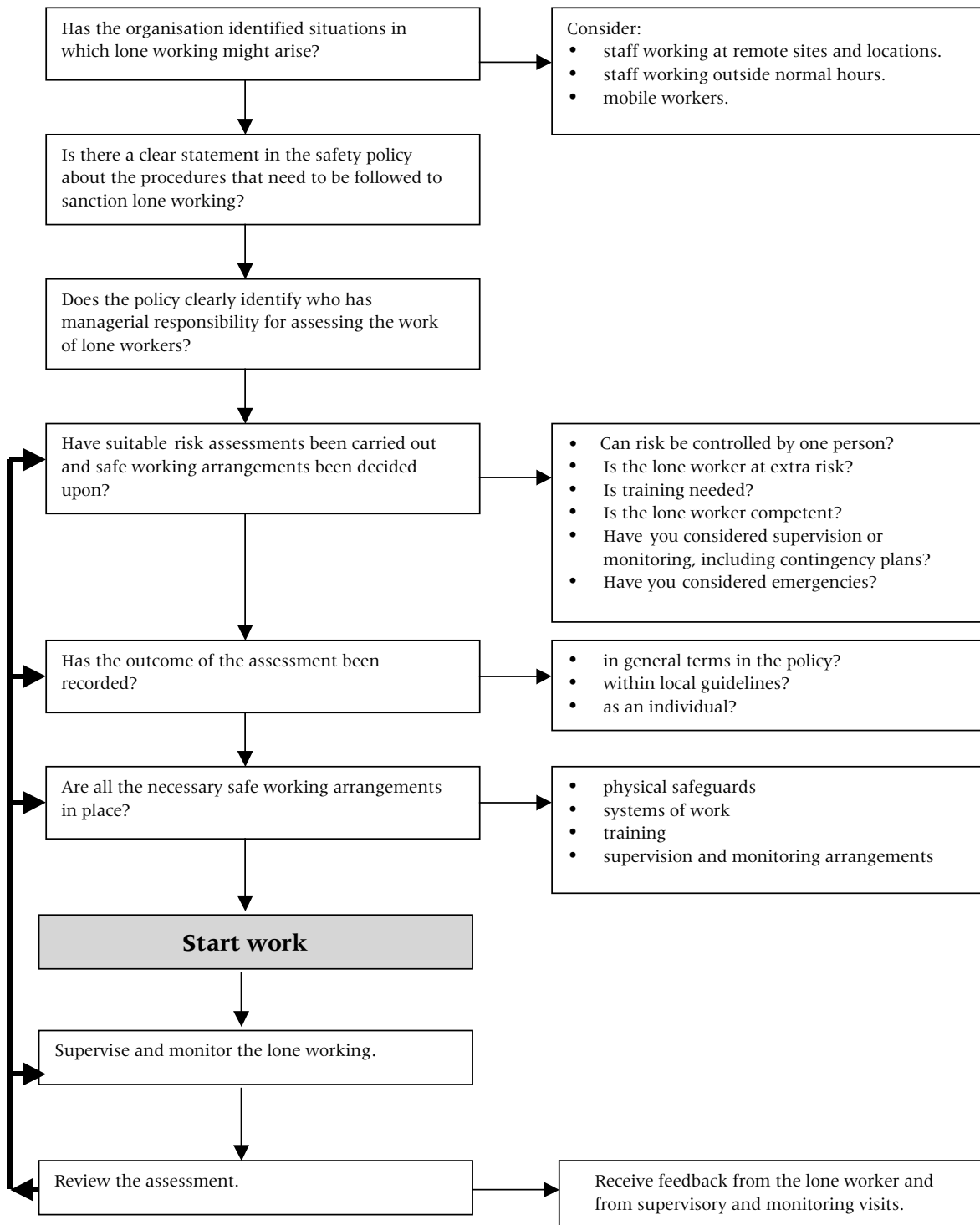
All NHSScotland organisations should have the following in place:

- a policy on lone working based on a full risk assessment which is reviewed each year within the Local or Area Partnership Forums and Health and Safety Committees;
- appropriate and thorough training programmes for relevant staff based on local risk assessment and including refresher training; and
- robust and effective reporting systems which encourage staff to record all incidents and near misses.

In summary, all NHSScotland organisations must be able to show that everything that is reasonably practicable is being done to eliminate or reduce, as far as possible, the risks associated with lone working. This will be achieved through a combination of risk assessment and increased awareness, having in place safe systems of work and making sure appropriate staff training is provided.

APPENDIX 5.A

Summary flowchart for making sure lone workers are safe



APPENDIX 5.B

Model policy on lone working

1 Policy statement

- 1.1 [Name of Organisation] takes extremely seriously the health, safety and welfare of all its staff. It recognises that some staff are required to work by themselves for significant periods of time without close or direct supervision in the community or in isolated work areas. The purpose of this policy is to enable [Name of Organisation] to meet its obligation to protect such staff so far as is reasonably practicable from the risks of lone working.
- 1.2 This policy and its procedures have been developed and agreed through the local Partnership Forum.

2 Scope

- 2.1 This policy applies to all staff including temporary and agency staff, contractors, volunteers, students and those on work experience. It forms an integral part of [Name of Organisation]'s Health and Safety policy and applies along with specific local guidance on lone working. The policy applies to all situations involving lone working arising in connection with the duties and activities of our staff.

3 Definition of lone workers

- 3.1 [Name of organisation] defines lone workers as:
'staff whose working activities involve in situations where they are without any kind of close or direct supervision.'

4 Policy aims

4.1 This policy aims to:

- increase staff awareness of safety issues relating to lone working;
- make sure that the risk of working alone is assessed in a systematic and ongoing way, and that safe systems and methods of work are put in place to reduce the risk so far as is reasonably practicable;
- make sure that appropriate training is available to staff in all areas, that equips them to recognise risk and provides practical advice on safety when working alone;
- make sure that appropriate support is available to staff who have to work alone;
- encourage full reporting and recording of all adverse incidents relating to lone working; and
- reduce the number of incidents and injuries to staff related to lone working.

5 Responsibilities

5.1 Lone working environments present a unique health and safety problem. Although there is no specific legal guidance on working alone, under the Health and Safety at Work Act 1974, and the Management of Health and Safety Regulations 1992, we must organise and control the health and safety of lone workers.

5.2 The **Chief Executive** is responsible for:

- making sure that there are arrangements for identifying, evaluating and managing risk associated with lone working;
- providing resources for putting the policy into practice; and
- making sure that there are arrangements for monitoring incidents linked to lone working and that the Board regularly reviews the effectiveness of the policy.

5.3 **Senior and line managers** are responsible for:

- making sure that all staff are aware of the policy;
- making sure that risk assessments are carried out and reviewed regularly;
- putting procedures and safe systems of work into practice which are designed to eliminate or reduce the risks associated with working alone;

- making sure that staff groups and individuals identified as being at risk are given appropriate information, instruction and training, including training at induction, updates and refresher training as necessary;
- making sure that appropriate support is given to staff involved in any incident; and
- managing the effectiveness of preventative measures through an effective system of reporting, investigating and recording incidents.

5.3 All **staff** are responsible for:

- taking reasonable care of themselves and other people who may be affected by their actions;
- co-operating by following rules and procedures designed for safe working;
- reporting all incidents that may affect the health and safety of themselves or others and asking for guidance as appropriate.
- taking part in training designed to meet the requirements of the policy; and
- reporting any dangers they identify or any concerns they might have in respect of working alone.

6 Identifying lone workers

6.1 Lone workers within the organisation are likely to be found in a wide range of situations. The categorisation system at Annex 1 identifies the main staff groups who may be at risk within the organisation, and lists example occupations for each category.

7 Assessing risk

7.1 Lone workers should not face any more risks than other staff within the organisation. Setting up safe working arrangements for lone workers is no different to organising the safety of other staff, so we must all follow the general principles of risk assessment. If a risk assessment shows that it is not possible for the work to be done safely by a lone worker, other arrangements must be put in place. Risk assessment should take account of both normal work and foreseeable emergencies such as fire, illness and accidents. The risk assessment process is summarised below, separated into five distinct stages and action points to support effective assessment of the risks involved in lone working.

	Process	Action point
1	Identifying lone workers	Establish and identify lone workers for each work area.
2	Identifying associated hazards	Isolate the range of dangers associated with whole work areas of work and/or work processes. Review a generic risk assessment to make sure you have included these issues.
3	Assessing the degree of risk for generic or individual situations	Review the generic risk assessments and complete individual or local risk assessments if necessary. Then prioritise the level of associated risk.
4	Putting control measures in place, and developing safe systems of work	Assess how effective the existing control measures are and update them if appropriate. Develop local procedures or action plans if necessary.
5	Evaluating and review	Evaluate and record how effective the control measures are. Review when the assessments or controls are no longer required.

7.2 Risk assessments must be carried out in all areas of work where working alone poses an actual or potential risk to staff. The risk assessment will involve identifying all potential dangers and the risks associated with specific work tasks or activities. It should identify who will be affected and how, and the control measures which are needed to get rid of or reduce the risk to the lowest level reasonably possible. Risk assessment should be carried out by competent people and should be recorded and shared with relevant others. Factors to consider when carrying out the risk assessment include the following:

- Does the workplace present a special risk to the lone worker?
- Can the risks of the job be adequately controlled by one person?
- Is the person medically fit and suitable to work alone?
- What training is needed to make sure the staff member is competent in safety matters?
- Have staff received the training which is necessary to allow them to work alone?
- How will the person be supervised?
- Is there a risk of violence?
- Are people of a particular gender especially at risk if they work alone?
- Are new or inexperienced staff especially at risk if they work alone?

- Are younger workers especially at risk if they work alone?
- What happens if a person becomes ill, has an accident, or if there is an emergency?
- Are there systems in place for contacting and tracing those who work alone?

7.3 Details of the risk assessment should be recorded and should include:

- the extent and nature of the risks;
- factors that contribute to the risk including job content and specific tasks and activities; and
- the safe systems of work to be followed to eliminate or reduce the risk.

Information from the risk assessment should be passed to staff. Risk assessments should be reviewed and updated each year (or sooner should circumstances change).

8 Managing risk

8.1 The risk which lone workers face should be reduced to the lowest level that is reasonably practicable. Using safe systems of work depends largely on local circumstances, and local procedures or protocols should be in place that provide specific guidance for staff in relation to lone working and the associated risk reduction. Issues to consider in developing safe systems of work include:

- joint working with others for high-risk activities;
- improvements to security arrangements in buildings;
- security lighting in parking areas;
- using checking-in and monitoring systems;
- communication systems for sharing information on risk with colleagues in other disciplines and agencies; and
- using personal protective equipment or mobile phones and personal alarms.

8.2 Annexes 2 and 3 provide two generic examples of risk assessment and measures to help control these general risks. However, each type of lone-working situation will need to be assessed and, where necessary, take account of local circumstances. Arrangements for managing risk should include:

- guidance for lone workers on assessing risk;
- details of when to stop and get advice; and
- the procedures to be followed in the event of an incident or emergency. All staff must be familiar with these local protocols

and procedures. There may also need to be detailed guidance to tackle specific areas of risk such as:

- lone workers travelling alone on work-related business;
- domiciliary and home visits;
- working outwith normal office hours;
- fumigation work and working with dangerous substances;
and
- electrical work near live conductors.

9 Staff training

9.1 [Name of organisation] will provide training where required to allow lone working. The training will be based on the needs identified through local risk assessment. Advice and guidance on training is available from the Training and Development Department.

10 Reporting and recording

10.1 Staff should report all incidents (including near misses) to their line manager at the earliest opportunity. These should be reported on an incident form and the line manager should investigate all reports. In order to monitor the implementation and effectiveness of this policy and associated local protocols, local statistics and incident reports should be reviewed regularly.

11 Monitoring and reviewing

11.1 We will monitor and review this policy in partnership to make sure that we are achieving the aims of the policy. We will do this with Trade Unions/Professional Organisations and safety representatives. The review processes will include:

- collecting and monitoring all reported incidents by our Health and Safety Adviser;
- every three months, reporting to local Health and Safety Committees and the Partnership Forum incident statistics and safety improvement measures which have been introduced;
- every year, reporting to our Health and Safety Committee and Risk Management Group on how we are following the policy, the outcomes of risk assessment, and details of training provided; and
- every year, reporting to the Board on progress in reducing risk and incidents and making recommendations for the forthcoming year.

Annex 1

Identifying lone workers

Staff group		Example occupations
1	Staff working alone in fixed establishments	<ul style="list-style-type: none"> • Reception staff • Boiler-house staff • Facilities and maintenance staff • Radiographers
2	Staff working outwith normal work hours	<ul style="list-style-type: none"> • Domestic staff • Transport staff • Nursing and medical staff
3	Mobile workers working away from their fixed base	<ul style="list-style-type: none"> • Community nursing and midwifery staff • Chiropody and podiatry staff • Speech and language therapy staff

Annex 2

Sample risk assessment for domiciliary visits

Description of work activity or danger: <i>Potential violence when carrying out community or home visits.</i>	People exposed to risk:
---	--------------------------------

Department:	Location:
--------------------	------------------

Risk assessment carried out by:	Date completed:	Review date:
--	------------------------	---------------------

Main risks and issues of concern	Tick if this applies	Assess whether the degree of risk is high, medium or low?
Do staff carry out visits in high-risk locations (for example, areas with high crime rates)?		
Do staff carry out visits in isolated rural areas?		
Do staff visit unfamiliar clients or relatives?		
Do staff visit a high-risk or unstable or unpredictable client group?		
Do staff carry out visits during unsocial hours?		
Do you use staff who are new or inexperienced in community work?		
Do you use staff easily identifiable as healthcare workers (for example, those who wear uniforms)?		
Do staff carry valuables or drugs?		
Others (please give details):		

Existing control measures - Tick if these are in place		
Do you assess new clients in a health centre or clinic?	Have you issued personal attack alarms?	
Do you provide accompanied visits when there are concerns about safety?	Do staff use mobile phones?	
Do you include potential or known risk factors in referral documents and care plans?	Do staff have information and training on basic personal safety?	
Do you share risk information with other professionals and agencies?	Are staff trained in strategies for preventing and managing violence?	
Are there systems for monitoring staff whereabouts and movements and for regularly reporting to base?	Do staff carry forms for reporting incidents or near misses and appreciate the need for this procedure?	
Others (please give details):	Others (please give details):	

Are the existing control measures adequate?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'no', what modifications or additional actions are necessary?	
1	
2	
3	
4	

Annex 3

Sample risk assessment for working alone in buildings

Description of the work activity or danger: <i>Working alone in buildings.</i>	People exposed to the risk:
--	------------------------------------

Department:	Location:
--------------------	------------------

Risk assessment carried out by:	Date completed:	Review date:
--	------------------------	---------------------

Main risk and issues of concern	Tick if this applies	Assess whether the degree of risk is high, medium or low?
Do staff work alone?		
Do staff work outwith normal office hours?		
Do staff meet with clients or patients in isolated locations?		
Is there enough security provision?		
Is there poor access to the building?		
Is there a lack of first aid if staff become ill or injured?		
Do staff activities involve working in confined spaces?		
Do staff activities involve handling dangerous substances?		
Others (please give details):		

Existing control measures – Tick if these are in place			
Do you provide joint working for high-risk activities (in other words, in confined spaces and with dangerous substances)?		Do you carry out regular supervisor or colleague checks during activities?	
Do you use closed-circuit television within or around the building?		Do you use two-way radios or other communication systems?	
Do you use entrance security systems (for example, digilocks or swipe cards)?		Do staff have information and training on basic personal safety?	
Is there security lighting around access points and parking areas?		Are staff trained in strategies for preventing and managing violence?	
Have you installed panic buttons linked to manned locations?		Do staff have access to forms for reporting incidents or near misses and appreciate the need for this procedure?	
Do you use reporting checking-in systems?		Others (please give details):	
Others (please give details):		Others (please give details):	

Are the existing control measures adequate?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'No' what modifications or additional actions are necessary?	
1	
2	
3	
4	

APPENDIX 5.C

References

- Croner *The A – Z Guide to Health and Safety*, Croner Group Ltd, Surrey, 2001, Product Code EHS
- Health and Safety Executive *Working alone in safety: Controlling the risks of solitary work*, HSE Books, London, 1998, ISBN 0717615073
Also available at:
<http://www.hse.gov.uk/pubns/indg73.pdf>

Recommended further reading

- Royal College of Nursing and the NHS Executive *Safer Working In The Community: A Guide for NHS Managers and Staff on Reducing the Risks from Violence and Aggression*, RCN, London, 1998, ISBN 187 385 2304
- The Suzy Lamplugh Trust *Personal Safety at Work: Guidance For All Employees*, The Suzy Lamplugh Trust, London 1998 (No ISBN)
- UNISON *Working Alone: A Health and Safety Guide On Lone Working for Safety Representatives*, UNISON, London, 2000, Product Code 1750
<http://www.unison.org.uk>

Protecting against violence and aggression at work

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6. PROTECTING AGAINST VIOLENCE AND AGGRESSION AT WORK

6.1 Introduction

This guideline reflects the view that violence and aggression towards NHS staff is unacceptable. Staff have the right to expect a safe and secure workplace, and NHS organisations have a legal and ethical duty to do their utmost to prevent staff from being assaulted or abused in the course of their work. NHSScotland is committed to promoting a safe and healthy workplace culture, and NHS organisations should take a positive approach towards tackling the problem of violence at work.

Work-related violence has been defined as:

‘Any incident in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment.’
(Health and Safety Executive 1997)

This definition reflects the fact that violence is not restricted to acts of aggression which result in physical harm. It also includes behaviour, such as gestures or language, that may cause staff to feel afraid, threatened or abused.

6.2 Principles and values

Within NHSScotland there must be a consistent organisational approach towards tackling the problem of violence at work. The following principles and values should form the backbone of developing strategies and policies for tackling the problem at a local level.

- Organisations should develop and promote a culture in which the personal safety of all staff is valued and protected and where violence towards staff is seen as unacceptable.
- Senior managers within organisations should show their commitment to reducing violence, make available the resources for putting policies into practice and make sure that it is clear who is responsible for each function.
- All staff should expect that any risk to them or their colleagues will be reduced as far as possible by using effective risk-management systems.

- Staff and their representatives should be fully involved in developing and putting in place local strategies and policies to reduce the problem of violence at work.
- Effective support systems should be in place to support staff who do become victims of violence.

6.3 The scale of the problem and why we need action

Violence at work is a serious problem for all people whose work brings them into contact with members of the public. A report by the Health and Safety Executive (1997) on 'Self-Reported Work-Related Illness' showed that one in five workers (20%) were physically or verbally attacked by a member of the public while at work in the previous year.

It is difficult to get hold of accurate figures on the incidence of violence in health settings. This problem is made worse by:

- differing definitions of what constitutes violence and aggression;
- wide variations in reporting and data-collection methods; and
- reluctance on the part of many NHS staff to report incidents.

There has been mounting evidence over the last ten years of a significant increase in violence within healthcare settings. Examples of such evidence include the following:

- A study by the Industrial Relations Society (1998) showed that, overall, NHS staff are four times more likely to be victims of work-related violence than other workers. The study reported that almost one in ten staff had been physically assaulted at work in the previous year. Of these, 5% were attacked with a weapon and 10% of attacks had resulted in major injury.
- Violence is now the third most common cause of injuries at work in the health service, after falls and needlestick injuries.
- A survey by the NHS Executive (1998) found that, on average, seven violent incidents were recorded each month for every 1000 staff. This is equivalent to about 65,000 violent incidents against NHS staff each year.
- The position appears to be more serious in community and mental-health Trusts where one in three staff reported having been attacked in the previous year, and 20% of victims suffered a major injury.
- Violence against healthcare workers can come from many sources including patients, visitors, family members, intruders, and co-workers.
- A broad range of health service staff are felt to be at risk. As a general guide, the risk of assault is felt to be directly related to the degree of face-to-face interaction between staff and the general public.

- Nurses are felt to be particularly at risk, with incidents of attacks on nurses from members of the public reported by the Health and Safety Executive (1997) to be five times the national average. A survey by the RCN (1998) found that 50% of nurses had been physically attacked at work in the previous year, while 85% reported having been verbally abused.

Some researchers have suggested that the increase in assault rates within the health service reflects the overall increase in violence in society. What is clear is that healthcare workers are now common targets of violent behaviour and healthcare settings in general are becoming more violent places in which to work. The problem appears throughout hospitals and other environments where healthcare is delivered. It affects a wide range of healthcare workers and is a major occupational danger.

Violence to healthcare staff is believed to be related to the nature of the work as it involves contact with a wide range of people in often difficult circumstances. Patients and their relatives may be anxious and worried. Some patients may be predisposed towards violence.

Factors which may increase the risk of violence include:

- working alone;
- working after normal hours;
- working and travelling in the community;
- handling valuables or medication;
- providing or withholding a service;
- using authority;
- working with people who are emotionally or mentally unstable;
- working with people who are under the influence of alcohol or drugs; and
- working with people under stress.

(Health and Safety Advisory Committee, 1997)

The cost (physical and mental) of violence against staff can be great. As well as the immediate physical effects of an assault, staff can experience psychological distress and confidence levels can be permanently damaged. Stress levels can rise, and the effects can undermine staff's overall effectiveness. The financial costs to the NHS resulting from violence at work can also be considerable and include:

- sick pay if the staff member has to take time off work;
- the extra costs of temporary or replacement staff;
- fees for taking legal action;
- treatment costs, including providing counselling and ongoing support for staff;

- loss of experience and the cost of training if the member of staff leaves the service; and
- the effect of negative publicity on morale, productivity and corporate image.

6.4 The legislative framework

The legislative framework within the UK obliges all employers to protect their employees from violence at work. The following legislation is relevant to incidents associated with violence at work.

- Health and Safety at Work Act (1974);
- Management of Health and Safety at Work Regulations (1999); and
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (1995).

Within this legislative framework all NHSScotland organisations have a duty to assess the risks associated with violence and must put in place measures to eliminate or reduce identified risks and protect staff from violence at work.

Control measures may include instruction, training, protective equipment, supervision and emergency procedures. NHSScotland organisations must take steps to check that control measures are actually in place and should review the risk assessment regularly to make sure that the control measures are adequate.

6.5 Recommended approach

6.5.1 Developing policy

Measures for dealing with violence need to be based on careful preparation and sound risk assessment. Unless the risk of violence is taken seriously at all levels within the organisation and the policy, management arrangements and culture are supportive, it is unlikely the problem will be reduced.

NHSScotland organisations can gain the confidence of their staff and show support and commitment to staff safety by developing local policies to tackle the problem of violence at work.

Organisations should use the basic principles of partnership when developing and putting into practice strategies and policies. Staff and Trade Unions/Professional Organisations must be involved in developing local policies. Not only do they have an interest, their direct involvement will encourage their support.

Local policies should tackle a range of issues and should include:

- a commitment to protect staff at work;
- a definition of violence;

- a statement of the aims of the policy;
- details of employers' legal responsibilities;
- details of managers' responsibilities;
- details of staff's responsibilities;
- information on risk assessment;
- details of local prevention and reduction plans;
- details of local emergency procedures;
- details of staff training;
- an explanation of local reporting procedures;
- information on support after incidents of violence;
- details on police involvement and organisational support for pursuing criminal charges;
- information on support for legal help or compensation claims for injury; and
- details of arrangements for monitoring and reviewing how policies are put into practice.

Policies must be translated into effective action. They should be supported by detailed procedures, by effective organisation and by a positive health and safety culture. More targeted policies may be required to tackle specific areas of risk, for example in relation to:

- lone and isolated working;
- escorting and transferring patients;
- staff working outwith normal office hours;
- staff travelling on their employer's business; and
- staff working in high-risk clinical areas.

To further demonstrate commitment to staff safety, NHSScotland organisations should give staff regular updates and progress reports. This will help reassure staff that positive actions are being taken to address the problem of violence at work.

6.5.2 Staff competence and training

Staff working in NHSScotland should know that their safety comes first. They should not be placed in situations that make them feel unsafe. However, if they are, they need to know how to deal with these situations in a competent way. As a result, appropriate staff training is crucial.

The training of staff is a complicated issue, not least because different staff groups and grades of staff face different degrees of risk. However, it is possible to identify the risks and provide training of graded intensity (in terms of content and length) to suit the needs of different groups.

NHSScotland organisations should assess the risks to staff and analyse their training needs. Assessing risks will make it possible to measure the nature and type of training which staff need and which will equip them for their roles. It is important to make sure that the training is appropriate to the degree of risk the staff face.

In general, training programmes should cover:

- **theory** (understanding aggression and violence in the workplace);
- **prevention** (assessing danger and taking precautions); and
- **interventions** (verbal and non-verbal strategies for dealing with aggressive people).

Training should be:

- up-to-date;
- relevant, and backed by evidence;
- provided by people with relevant expertise; and
- regularly reviewed and evaluated.

Staff training should not be seen as a 'one-off' exercise. The skills being taught are complicated and may involve psychological and physical techniques. Employers should therefore consider the need for updating and refreshing staff, and a time-limited certificate is recommended as a way of making sure their skills are up-to-date.

One of the main focuses of training should be preventative strategies. Training interventions might also be extended to incorporate programmes on customer care, assertiveness, and developing interpersonal skills. It is essential that training gives staff the ability to deal with the problems they might come across in the course of their work and makes sure that they develop the specific skills needed for their role.

Appropriate training and specialist support for managers on development of local procedures should also be provided (for example, training sessions on assessing risk and managing the difficulties experienced with regard to their local work areas).

The 'Good Practice Statement on the Prevention and Management of Violence' produced by CRAG (1996) provides detailed guidance on the recommended content of training programmes for staff facing different levels of risk.

Suggestions for a possible training programme are provided below.

- Definitions, theories and models of aggression and violence.
- Examples of aggression in healthcare settings.
- Self-awareness – tolerance and responses to aggression.
- Risk factors – relating to the attacker, staff, environment, and task.
- Risk assessment – including warning signs.
- Do's and don'ts of verbal and non-verbal interactions (theory and practice).
- General and specific safety precautions.
- Demonstration and practice of breakaway and physical-restraint techniques.

- Local policies and procedures.
- Reporting and debriefing after incidents.
- Legal issues – using reasonable force.
- Dealing with weapons.

6.5.3 Environmental considerations

The environment in which staff work, patients are treated and other members of the public visit can have a significant influence on behaviour. The environment and associated work practices can trigger or make worse a stressful situation and increase the risk of violence. Danger can be inadvertently built into the environment or work practices, for example by:

- making it difficult for people to use services or facilities;
- alienating people with a ‘them and us’ set-up, or restrictive notices;
- exposing people to noise, crowding, boredom or discomfort; or
- providing access to objects or equipment that could be used as weapons.

The aim should be to have an environment and work practices that create an atmosphere which is safe but not oppressive and which reduces the risk of violence as far as possible. Organisations need to assess the environment and work practices to see whether the layout, décor, or general routines could actually increase the risk of violence.

Factors to consider include cleanliness, light, temperature, space, control of access, signs, privacy, toilets and smoking areas. Areas that may need particular attention include reception and waiting areas, and interview rooms.

Modifications to the work environment that can help reduce the risks include:

- redesigning buildings or the layout of rooms;
- moving activities such as reception or treatment areas in order to make them more secure;
- installing door-entry systems;
- improving lighting (inside and outside);
- installing alarms and panic buttons;
- fixed seating and fittings;
- improved facilities (for example, access to snacks, smoking areas, phones, recreational materials, private space);
- improved signs; and
- installing CCTV.

As well as changing the environment staff may need personal protective equipment, mobile phones or personal attack alarms, if a risk assessment has shown this to be appropriate.

6.5.4 Staff support

Given the nature of its work activities, the NHS is unlikely to be able to prevent all violent and aggressive incidents. So, it is essential that all NHSScotland organisations have appropriate procedures to support affected staff in case of a violent incident occurring at work. NHS managers need to be aware that they are responsible for making sure that adequate levels of support are in place to help reduce the effects experienced by staff who have been involved in an incident.

Arrangements for supporting staff should include procedures for:

- rapid access to medical treatment if necessary;
- time off work to recover from the physical or psychological effects of an incident;
- debriefing to get details of the incident and provide emotional support;
- access to qualified psychological support such as that which may be available through occupational health departments, in-house or independent counsellors;
- support from management when dealing with the police and with any subsequent court proceedings; and
- providing information, support and practical help in making compensation claims through the Criminal Injuries Authority (CICA) or the NHS Injury Benefit scheme.

6.5.5 Withholding treatment

In some cases the threat of violence and intimidation from patients and visitors may be so serious that it becomes necessary to withhold treatment and bar visitors. The withholding of treatment from violent and abusive patients will always be a last resort, but it should be an option made clearly available to staff. It is also important that patients and those accompanying them are fully aware of the standards of conduct expected of them and of the sanctions that may follow unacceptable behaviour.

The need to protect staff must be properly balanced against the need to provide healthcare to individuals. If a decision is made to withhold treatment, it must be made in the context of a defensible local policy and procedure applied to the facts of the individual case.

6.5.5.1 In developing a policy on withholding treatment, NHS organisations should:

- seek the views of staff, their representatives and patient representatives on the introduction of the local policy;
- consider arrangements for notifying other local NHS service providers and as a matter of good practice other agencies of patients who may be subject to the effect of the withholding of NHS treatment; and

- clearly define behaviours which are unacceptable, the sanctions available to staff when faced with such behaviours and the point at which such sanctions will be triggered.

6.5.5.2 Local policies must recognise that withholding treatment will only be appropriate where violent or abusive behaviour is likely to:

- prejudice any benefit the patient might receive from the care or treatment; or
- prejudice the safety of those involved in giving the care or treatment; or
- lead the member of staff offering care to believe that s/he is no longer able to undertake his or her duties properly. This might include incidents of racial or sexual abuse; or
- result in damage to property inflicted by the patient or as a result of containing him/her; or
- prejudice the safety of other patients present at the time.

6.5.5.3 All local policies on withholding treatment should, as a minimum:

- state that each case will be looked at individually to ensure that the need to protect staff is properly balanced against the need to provide healthcare to individuals;
- describe the action staff should take in response to less serious or “one-off” incidents; for example, alerting hospital security or informing the police;
- include an explanation of the sanctions which will apply to violent or abusive patients. These should include the following:
 - a verbal explanation by a staff member of what is unacceptable behaviour and the possible consequences of any further repetition of unacceptable behaviour. A copy of the policy and/or explanatory leaflet with information on withholding treatment could be given at this stage;
 - a formal written warning with details of organisational policy and procedures on withholding treatment to be sent by a manager, Clinical Director or senior nurse and copied to the patient’s GP;

- as a last resort, a final written explanation of exclusion from the premises and the withholding of treatment. This letter, which should be sent by the Chief Executive, should notify the patient of the period of the ban and be copied to the patient's GP; and
- under exceptional circumstances, the immediate withholding of treatment.
- state that a decision to withhold treatment must be based on a proper clinical assessment and the advice of the patient's consultant or senior member of the medical team (on-call team for out-of-hours);
- make clear that withholding treatment is time-limited for a period of no more than 12 months;
- make clear the links to other relevant procedures and organisational policies, for example, consent procedures and clinical procedures for handling patients with learning disabilities and/or patients with mental health problems, such as the need for a secure area for treatment. Neither this guidance nor individual policies are intended to take the place of the legal requirement relating to consent;
- set out clear lines of accountability on instigating the withholding of treatment. A senior clinician should provide advice, following a clinical assessment, to the Chief Executive or his or her deputy to issue a formal letter withholding treatment;
- include details of the mechanism for seeking a review of a decision to withhold treatment; for example via local patient complaints procedures;
- include details of the procedure to be followed where treatment is withheld from a patient who is also on a waiting list for non-emergency treatment; and
- make clear that treatment will not be withheld from a patient as a result of the behaviour of a person accompanying or visiting a patient.

6.5.5.4 The following action should be taken after the decision has been reached to withhold treatment from a violent or abusive patient.

- The decision should be recorded in the patient's medical and nursing notes and the patient must be informed of this. Data Protection law must be complied with.
- Where appropriate, other local NHS service providers and, as a matter of good practice, other agencies

should be informed of the decision to withhold treatment from the patient.

6.5.5.5 There will be circumstances where it will not be appropriate to apply policies on withholding treatment. All local policies and procedures should provide for exceptions in the following cases:

- patients who, in the expert judgement of a relevant clinician, are not competent to take responsibility for their action, for example an individual who becomes violent and aggressive as a result of an illness or injury;
- patients who are mentally ill and/or may be under the influence of drugs or alcohol;
- patients who, in the expert judgement of a relevant clinician require urgent emergency treatment; and
- other than in exceptional circumstances, any patient under the age of 16.

6.5.5.6 Copies of local policies and procedures for withholding treatment should be made available to all managers and staff. Managers should also ensure that patients, relatives and other visitors are made aware of organisational policies and procedures, copies of which should be displayed in waiting rooms and other public areas.

6.5.5.7 NHSScotland organisations must make sure that where they do provide treatment or care to violent and aggressive patients, staff are aware of local procedures for doing so. These might include the use of medication, physical intervention or a requirement for organisational security staff to be present and/or the involvement of the police.

6.6 Putting the policy into practice and reviewing it

6.6.1 Recording and collecting data

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) place a duty on employers to record and report violent assaults against their staff. However, there is evidence that the problem of under-reporting runs throughout the health service.

'Towards a Safer Healthier Workplace' (Occupational Health & Safety Services, 1999) states that all NHS organisations

'must encourage, facilitate and require staff to record all accidents and incidents which lead to injury, with the aim of a 100% recording of accidents and incidents to staff, patient and visitors to NHS in Scotland premises'.

So, it is essential that all NHSScotland organisations take a positive approach in encouraging staff to report all incidents and near misses in relation to violence and aggression at work.

All NHSScotland organisations should set up robust and clear reporting procedures that are easy to use and do not take too much time. Improved reporting may lead to an initial increase (in the short term) in the number of incidents but it should be recognised that low incident rates do not always mean that good practice is being followed.

All NHSScotland organisations must also keep to the Minimum Dataset on reporting. Under this dataset, each year organisations must publish the number and rate of RIDDOR-reported incidences of violence and aggression by occupational group. It should cover all staff directly employed by the organisation and also those not directly employed such as contractors, self-employed, or students.

Reporting systems should also include appropriate ways of providing feedback. This will mean that staff know what action the organisation has taken to prevent a reported incident happening again in the future.

6.6.2 Monitoring

There must be effective monitoring in place to help control violence and aggression. Furthermore, there must be support and commitment from senior management and very clear local management responsibilities. The policy on violence and aggression should include a timescale and way of carrying out an annual review by the Local Partnership Forum and local Health and Safety Committee. There should also be the opportunity for other reviews if this is necessary. All NHSScotland organisations should

- • identify local quality indicators to reduce violent or aggressive incidents as a matter of good practice; and
- • analyse information on reported incidents and use the results as the basis for future reductions in the number of aggressive and violent incidents towards staff.

6.6.3 Communication

All NHSScotland organisations must make sure that they set clear systems to tell all staff and others working within the organisation (such as agency staff, students, volunteers, or independent contractors) about the organisation's policy on violence and aggression.

In order to communicate the organisational policy on violence and aggression:

- • there needs to be clear commitment and support from senior managers for the policy to be fully adopted within the organisation;

- briefing sessions should be held for managers when the new or amended policy is launched;
- managers must make sure that current staff realise their individual responsibility to keep to the policy; and
- new staff must be made aware of the policy and their responsibilities as part of their induction.

Details of the policy, or particular sections of the policy, could also be publicised throughout the organisation by using a range of communication channels. These could include:

- a letter from the Chief Executive;
- a poster campaign;
- booklets and wallet cards;
- regular staff newsletters;
- regular team briefings;
- attachments to payslips;
- policy manuals;
- focus groups;
- training and induction;
- management seminars; and
- e-mail (for example, an open network notice board).

NHSScotland organisations should also consider how to pass on their stance on violence towards staff to users of the service. Using 'zero tolerance' posters is one option. One example of a 'zero tolerance' poster campaign is:

'We will not tolerate violence, physical aggression or verbal abuse towards our staff. If this happens, we will take legal action.'

(Tameside & Glossop NHS Trust)

NHSScotland organisations should recognise that staff morale and confidence can be improved if staff see that their employers and other agencies are genuinely committed to prosecuting cases of assault. NHSScotland organisations should therefore publicly commit themselves to taking legal action against all those who assault a NHS staff member.

6.7 Measuring success

Real change takes time to achieve. However, NHSScotland organisations can effect change on an ongoing basis and should measure this change each year. Measures to see if an organisation is successful in preventing and managing violence towards its staff include:

- a Managing Violence and Aggression policy based on a full risk assessment, reviewed each year within the Local or Area Partnership Forums and Health and Safety Committees;

- appropriate and thorough training programmes for all staff based on local risk assessment and including refresher training;
- staff counselling and support systems for staff who have been the victims of aggression while at work; and
- robust and effective reporting systems that encourage staff to record all incidents of violence and aggression.

In summary, all NHSScotland organisations must be able to show that everything practical is being done to eliminate or reduce, as far as possible, violence and aggression towards NHSScotland staff. The major measure of success will be a reduction of at least 25% in the number of injuries, accidents and incidents resulting from violence and aggression by 2006 as compared to a base of 2000/01. This will be achieved by using best practice and a combination of training, increased awareness and improved audit in line with the requirements laid down in 'Towards A Safer Healthier Workplace'.

APPENDIX 6.A

Model policy on violence and aggression at work

1 Policy statement

[Name of organisation] takes extremely seriously the health, safety and welfare of all its staff. It recognises that violence towards staff is unacceptable and that staff have the right to be able to perform their duties without fear of abuse or violent acts. No staff member should consider violence or abuse to be an acceptable part of their employment. The purpose of this policy is to enable [Name of organisation] to meet its obligation to protect staff as far as is reasonably practicable.

2 Scope

This policy applies to all staff, including temporary and agency staff, contractors, volunteers, students and those on work experience. It forms an integrate part of [Name of organisation]'s Health and Safety policy and applies along with specific local guidance for managing violence and aggression in the workplace. The policy applies to all situations in which violence at work may occur arising in connection with the duties and activities of our staff.

3 Definition of violence and aggression

[Name of organisation] defines an incident of violence and aggression as: 'any incident in which a member of staff or person working in [Name of organisation] is verbally abused, threatened or physically assaulted by a patient or member of the public in circumstances relating to his or her employment'.

4 Policy aims

This policy aims to:

- increase staff awareness of issues relating to violence and aggression;

- make sure that the risk of violence and aggression is assessed in a systematic and ongoing way, and that safe systems and methods of work are put in place to reduce the risks as far as is reasonably practicable;
- make sure that appropriate training is available to staff in all areas, that equips them to recognise risk and provides practical advice on preventing and managing violence and aggression;
- make sure that appropriate support is available to staff involved in violent incidents;
- encourage full reporting and recording of all incidents of violence and aggression; and
- reduce the number of incidents and injuries to staff resulting from violence and aggression.

5 Responsibilities

5.1 The **Chief Executive** is responsible for:

- making sure that there are arrangements for identifying, evaluating and managing risk associated with violence and aggression at work;
- providing resources for putting the policy into practice; and
- making sure that there are arrangements for monitoring incidents of violence and aggression and that the Board regularly reviews the effectiveness of the policy.

5.2 **Senior and line managers** are responsible for:

- making sure that all staff are aware of the policy;
- making sure that risk assessments are carried out and reviewed regularly;
- putting procedures and safe systems of work into practice which are designed to eliminate or reduce the likelihood of violence and aggression;
- making sure that staff groups and individuals identified as being at risk are given appropriate information, instruction and training (including training at induction, updates and refresher training when necessary);
- making sure that appropriate support is given to staff involved in any incident of violence and aggression; and
- monitoring the effectiveness of preventative measures through an effective system of reporting, investigating and recording incidents.

- 5.3 All **staff** are responsible for:
- taking reasonable care of themselves and other people who may be affected by their actions;
 - co-operating by following rules and procedures designed for safe working;
 - reporting all incidents involving verbal abuse, threats and physical assault;
 - taking part in training designed to meet the requirements of the policy; and
 - reporting any dangers they identify or any concerns they may have about potentially violent situations or the environment in which they work.

6 Assessing risk

- 6.1 Risk in all work areas where violence and aggression pose an actual or potential risk to staff must be assessed. The assessment will involve identifying situations where acts of violence and aggression could occur. It should identify who will be affected and how, and what control measures are needed to eliminate or reduce the risk to the lowest level reasonably practicable. A competent person must carry out the risk assessment and it should be recorded and shared with relevant others. The following details should be recorded:
- the extent and nature of the risks;
 - the factors that contribute to the risk – including job content and work environment; and
 - the safe systems of work to be followed to eliminate or reduce the risks.
- 6.2 These details should be communicated to staff, and risk assessments reviewed and updated annually, or sooner if circumstances change.

7 Managing incidents

- 7.1 Departmental procedures must be in place which provide guidance for staff on managing violent or aggressive incidents. This should include details of emergency procedures. All staff must be familiar with these local procedures. In particular, staff must be aware of local procedures for raising the alarm and getting help if an incident occurs.
- 7.2 Practical guidance for staff in relation to preventing and managing violence and aggression is contained in our booklet *Personal Safety: Guidance For Managing Violence At Work*.

8 Staff training

- 8.1 We will provide training to give staff the skills needed to help prevent and manage violence and aggression. Different levels of training will be available and we will provide training which is based on the needs identified through local risk assessment. We will provide specialist training, such as training in control and restraint techniques, for staff working in identified high-risk areas. Staff working in these areas will have to attend the training as part of their job.
- 8.2 We have an obligation to provide training, and managers are responsible for making sure that staff receive appropriate training and have access to regular refresher training. All training will be provided by accredited instructors, and details are available from our Training and Development Department.

9 Staff support

We will make sure that all staff who are victims of violence or assault will have access to appropriate support. Managers are responsible for making sure that debriefing is carried out as soon as possible after the incident with all the staff involved. Staff may need time off to get medical attention, legal advice, or counselling support. An independent and confidential counselling service is also available through OHS. Managers can refer staff for counselling support or they can refer themselves.

10 Reporting and recording

Staff should report all incidents of violence and aggression (including near misses) to their line manager at the earliest opportunity. Managers should record this on an incident form and investigate the matter. In line with RIDDOR the manager must write to the Health and Safety Executive within ten days of an incident if any staff member is absent from work for more than three days in a row as a result of an act of violence and aggression. To monitor the effectiveness of this policy and associated local protocols, local statistics and incident reports should be reviewed regularly.

11 Involving the police and prosecution

- 11.1 [Name of organisation] is actively committed to protecting staff from violence and assault and will support criminal proceedings against those who carry out assault. All staff are encouraged to report violent incidents to the police and will be supported by the organisation throughout the process.
- 11.2 The Procurator Fiscal may decide to take legal action and line managers must make sure that staff have access to ongoing support throughout this process. Other support may also be available to staff through Trade Unions/Professional Organisations.

12 Withholding treatment

- 12.1 Where a patient's aggressive or violent behaviour impairs a staff member's ability to undertake his/her duties properly, or has become a threat to the safety of a staff member, another patient, or hospital property, [Name of organisation] reserves the right to withhold treatment from the patient.
- 12.2 If a patient, or someone accompanying a patient, is violent or aggressive, s/he will be told what is considered unacceptable behaviour and its possible consequences. If the behaviour continues, the patient or person accompanying a patient will receive a written warning with details of the policy on withholding treatment, signed by a site manager/Clinical Director or senior nurse, and copied to the patient's GP. The patient's consultant (or senior member of the medical team) will advise the Chief Executive on a decision to withhold treatment on the basis of a clinical assessment. As a last resort, the treatment will be withheld, and the patient will receive a written explanation from the Chief Executive giving the reasons for exclusion, and copied to the patient's GP. Exceptionally, treatment may be withheld immediately. The decision will be recorded in the patient's medical and nursing notes and the patient informed of this. Other local NHS service providers and agencies will be informed of the decision.
- 12.3 Each case will be considered individually and all staff will be given information specifying the action they should take in response to varying levels of incidents. Allowances will be made for patients who are under 16, mentally ill, who require emergency treatment, or who cannot be held responsible for their actions. The withholding of treatment is limited to a maximum period of 12 months. A patient may appeal against a decision to withhold treatment via the local patient complaints procedure.

13 Compensation

- 13.1 The Criminal Injuries Compensation Scheme provides a system of compensation for any victim of violent crime. Under this scheme staff can make a claim for personal injury resulting from an assault. Guidance on eligibility and advice on making a claim is available from Human Resources.
- 13.2 If a staff member loses earnings as a result of an incident they can make a claim to the NHS Injury Benefits Scheme. Information and advice on this scheme is available from Human Resources.
- 13.3 If a staff member suffers loss or damage to personal property as a result of an assault, they can make a claim for compensation through Human Resources.

14 Monitoring and reviewing

We will monitor and review this policy in partnership to make sure that we are achieving the aims of the policy. We will do this with Trade Unions/Professional Organisations and safety representatives. The review processes will include:

- • collecting and monitoring all reported incidents by our Health and Safety Advisor;
- • every three months reporting to local Health and Safety committees and the Local Partnership Forum on incident statistics and safety improvement measures which have been introduced;
- • every year, reporting to our Health and Safety committee and Risk Management Group on how we are following the policy, the outcomes of risk assessment, and details of training provided;
- • every year, reporting to the Board to highlight progress in reducing risk and incidents and making recommendations for the forthcoming year.

APPENDIX 6.B

Risk factors for workplace violence – a sample checklist

1 Workplace

Outside	Yes	No
Is there uncontrolled access to the site?		
Is there uncontrolled access to buildings and work areas?		
Are bus stops and car parks close to buildings?		
Are there appropriate footpaths?		
Are areas well lit with good all-round visibility?		
Are there areas where people can hide or move unnoticed (for example, trees, shrubbery, waste and storage areas)?		
Are signs clear, visible and appropriate?		
Is there a security patrol?		

Inside	Yes	No
Are there physical barriers to restricted areas?		
Are these areas suitably signed?		
Can staff make unobstructed 'swift' exits if necessary?		
Are existing security installations working and maintained?		
Are signs clear, visible and appropriate?		
Is the lighting sufficient or are there dark or shaded areas?		

1 Workplace (cont'd.)

Interactive areas – for example, waiting areas	Yes	No
Is there enough space to prevent overcrowding?		
Are there private rooms available to deal with sensitive issues?		
Are waiting areas separated from other activities?		
Do staff have a good view across the area?		
Is the layout confrontational?		
Is there physical separation for staff – is this confrontational or intimidating?		
Is seating comfortable and is there enough?		
Is the area noisy (for example, trolleys, banging doors)?		
Are there systems to keep patients informed (for example, of delays)?		
Are there ways to reduce anxiety or boredom?		

Lighting, decoration and furnishings	Yes	No
Is the lighting harsh or glaring?		
Are there any potential weapons or missiles (for example, unsecured chairs, pictures, pot plants, crockery)?		

2 Work place procedures and organisation

Outside	Yes	No
Are there enough competent staff to deal with any possible violence?		
Are there special arrangements for higher-risk staff (for example, young workers, pregnant workers, staff with any disability, new or inexperienced staff)?		
Are there procedures for bank staff?		
Are there any lone workers?		
Are there other precautions in place for lone workers?		
Is appropriate information available to staff on potentially violent or aggressive patients or family?		
Are emergency arrangements in place?		
Do staff have to travel alone?		
Do staff have a mobile workplace?		
Do staff work in a community-based setting?		
Do shift patterns involve working alone or in small numbers?		
Do shift patterns involve working late at night or during the early hours of the morning?		
Do staff work in a high-crime area?		
Do staff handle valuable property or possessions?		
Do staff handle materials, including drugs, which are often targets for theft?		
Do staff handle complaints?		

Communication	Yes	No
Can staff attract the attention of other staff if necessary?		
Can staff get immediate support?		
Can staff call for help if alone or working off site?		
Are systems in place to pass on information on incidents and patients to other affected staff, departments and agencies?		

2 Work place procedures and organisation (cont'd.)

Staff training	Yes	No
Are staff trained and competent to deal with potential violent and aggressive situations?		
Are staff facing unusual stress in their personal lives?		
Are staff aware of incident forms and how to fill them in?		
Are staff so busy that it may be difficult to display a caring attitude?		
Do staff have the opportunity to discuss concerns about violence and aggression?		

3 Patients, family and friends

Patients, family and friends	Yes	No
Is there the possibility of alcohol or drug abuse?		
Are there rowdy or over-anxious groups of people accompanying patients?		
Is there the possibility of psychiatric disorders or confused states or behavioural problems?		
Is there the possibility of situations which patients or relatives see as threatening?		
Are people likely to be unstable or volatile?		
Are people likely to be highly stressed or angry?		
Are long waiting times involved (for example, in receiving units or clinics)?		

APPENDIX 6.C

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Reducing work-related driving risks

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7. REDUCING WORK-RELATED DRIVING RISKS

7.1 Introduction

Work-related driving is defined as:

‘driving activities undertaken by staff in the course of their work’.

Out of a total of 3600 deaths from road accidents every year, it is estimated that between 800 and 1000 occur in accidents involving vehicles being driven for work purposes. A recent HSE survey shows that every year ‘work’-related road accidents account for 77,000 injuries to employees. (HSE 2001)

Staff have the right to expect safe working conditions in relation to all aspects of their work and employers have a legal and ethical duty to take an active approach to managing occupational road risks. NHSScotland organisations must do all that is reasonably practical to protect their staff who, as part of their job, have to do some work-related driving.

Besides taking action to protect staff and other road users, NHSScotland organisations need to manage risks in order to control the very significant losses which arise from ‘at-work’ road accidents. These include:

- direct accident costs;
- lost staff time;
- higher insurance premiums; and
- poor public image.

It is essential to make sure that occupational road risks are managed in exactly the same way as any other risk to the health and safety of staff.

7.2 Principles and values

Within NHSScotland there must be an integrated organisational approach to addressing the problems associated with work-related driving. The following principles and values should form the backbone of developing strategies and policies for tackling this issue at a local level.

- Organisations should develop and promote a culture in which the personal safety of all staff is valued and protected and where risks to staff resulting from work-related driving are seen as unacceptable.
- Senior managers within organisations need to show their commitment to reducing dangers associated with work-related driving, make available the resources for putting the policy into practice, and make sure that it is clear who is responsible for each function.
- All staff should expect that any risk to them or their colleagues will be reduced as far as possible, by using effective risk-management systems.
- Staff and their representatives should be fully involved in developing and putting in place local strategies and policies to reduce work-related driving risks.

7.3 The dangers of work-related driving

The number of people who need to drive as part of their work is increasing. The risks to these staff will depend on the nature of situations where driving is needed. Many staff who drive will carry out these activities alone and you should consider the risks associated with work-related driving along with the risks of lone working. Dangers include:

- driving in poor weather conditions;
- driving for long periods over long journeys;
- the vulnerability of travelling alone;
- driving in unfamiliar or isolated rural areas;
- driving in high-risk locations;
- isolated parking facilities;
- vehicle breakdowns; and
- driving unfamiliar vehicles.

7.4 The legislative framework

The main piece of legislation governing road safety is the Road Traffic Act, supported by the Highway Code. All drivers are legally responsible for their own actions on the road and for keeping to the requirements of the Road Traffic Act. The Health and Safety at Work Act (1974) also applies where staff have to use vehicles for work. This essentially means that all organisations have a duty of care and should have 'safe systems of work' in place which reduce related risks to staff and others as far as possible.

7.5 Risk assessment

The Management of Health and Safety at Work Regulations (1999) say that employers must make suitable assessments of the risks faced by their

staff on the road and introduce measures to eliminate or control any risks identified.

Factors to be considered in carrying out this type of risk assessment include:

- the competence of the driver;
- the driver's fitness and any medical conditions that could put them at risk;
- driving hours and the length of the journey;
- the reliability and suitability of the vehicle;
- driving in poor weather;
- handling and securing loads;
- road conditions and journey routes; and
- the associated risks of working alone.

Assessments of the risks associated with work-related driving should also take account of associated occupational health issues such as:

- ergonomic factors;
- musculo-skeletal disorders;
- eyestrain;
- noise;
- vibration; and
- strain.

Staff should also be aware of their responsibility to carry out a risk assessment before each journey. They should take account of:

- their own physical condition and fitness to drive;
- the condition of the vehicle;
- weather conditions; and
- planned routes of travel.

7.6 Developing policy

Measures for dealing with occupational road risks need careful thought and sound risk assessment as their basis. Policies, management arrangements and organisational culture need to be such that the risks of work-related driving are taken seriously at all levels.

Policies on work-related driving should cover the following issues.

- a commitment to making sure those who are involved in work-related driving are safe;
- a definition of work-related driving;
- a statement of the aims of the policy;
- details of employers' legal responsibilities;
- details of managers' responsibilities;
- details of staff's responsibilities;
- identification of the dangers of work-related driving;
- information on risk assessment;
- details of control and risk-reduction measures;

- emergency procedures and arrangements for unplanned events (for example, accidents and breakdowns); and
- details on arrangements for monitoring and reviewing policies.

Policies need to be translated into effective action. They need to be supported by more detailed procedures, effective monitoring and a positive health and safety culture. Specific local guidance may be required in relation to:

- driving in adverse weather conditions;
- carrying and transporting passengers (including patients) and equipment;
- handling and securing loads;
- transporting food; and
- transporting dangerous loads and dealing with spillages.

When developing and putting in place policies and local guidelines, organisations should work in partnership. Involving staff and Trade Unions/Professional Organisations is an important step, as they are a valuable source of information and advice. Their involvement will also help to make sure that all relevant dangers have been identified and appropriate control measures put in place. Consultation with staff and their representatives on health and safety matters is also a legal duty.

7.7 Strategies for managing work-related driving

There are a number of recommended strategies that should be used by organisations to reduce the risks associated with work-related driving.

These include:

- an inspection every year of driving licences and insurance certificates;
- providing regular information for staff on driving safely;
- restrictions on using hand-held phones and other distracting activities (for example, eating and drinking) while driving;
- referring to the organisation's alcohol and drug policies and assessing the general fitness of the driver;
- providing eye tests every two years through the Occupational Health Service;
- clear limits on maximum driving distances each day and maximum unbroken driving hours (no driver should drive continuously for more than 2½ hours without a break);
- providing guidance on planning a safe journey and procedures to be followed in the event of a breakdown or accident;
- providing guidance on carrying basic safety equipment (for example, a first-aid kit, fire extinguisher, warning triangle and torch); and
- formal procedures for reporting, recording and investigating all accidents, incidents and near misses.

Vehicles must be fit for their purpose and in a roadworthy condition. How vehicles are used may vary widely and it is essential that the correct type of vehicle is chosen. Staff who need to drive a vehicle as part of their work must have the most suitable vehicle for their needs and where necessary, vehicles should be fitted with any extra safety equipment needed (for example, a body-space safety partition, or luggage or goods-retention system).

7.7.1 Monitoring

Effective monitoring of the strategies in place to minimise and reduce the risks of work related driving is essential. All organisations should identify local quality indicators around risk reduction and management as good practice.

7.7.2 Communication

All organisations must make sure that they set up clear systems to communicate the organisation's policy on work related driving to all relevant staff within the organisation.

In order to communicate the organisational policy on work-related driving risks:

- • there needs to be clear commitment and support from senior management for the policy to be fully adopted within the organisation;
- • briefing sessions should be held for managers on launching the new or amended policy;
- • managers must make sure that current staff realise their individual responsibility to keep to the policy; and
- • new staff must be made aware of the policy and their responsibilities as part of their induction.

7.7.3 Measuring success

All organisations should have in place:

- • a policy on reducing work-related driving risks based on a full risk assessment which is reviewed each year within the Local or Area Partnership Forums and Health and Safety Committees;
- • appropriate and thorough training programmes for relevant staff based on local risk assessment and including refresher training; and
- • robust and effective reporting systems which encourage staff to record all incidents and near misses.

In summary, all organisations must be able to show that everything that is reasonably practicable is being done to eliminate or reduce the risks associated with work-related driving. A major measure of

success will be reducing the number of injuries, accidents and incidents resulting from these activities. This will be achieved by using best practice and a combination of safe systems of work and increased awareness of the risks involved.

APPENDIX 7.A

Model policy on work-related driving risks

1 Policy statement

[Name of organisation] takes extremely seriously the health, safety and welfare of all its staff. It recognises the risks to staff who need to carry out work-related driving and is committed to the prevention of injury, loss of life and damage to property from work-related driving incidents. The purpose of this policy is to enable [Name of organisation] to meet its obligation to protect staff so far as is reasonably practicable from all occupational road risks associated with work-related driving.

2 Scope

This policy applies to all staff involved in work-related driving activities, including drivers of organisational vehicles, and leased-car and owner-drivers. It forms an integral part of [Name of organisation]'s Health and Safety policy and applies along with specific local guidance on work-related driving and the management of occupational risks. The policy applies to all work-related driving arising in connection with the duties and activities of our staff.

3 Definition of work-related driving

[Name of organisation] defines work-related driving as:

‘any driving activities carried out by employees in the course of their work’.

4 Policy aims

This policy aims to:

- increase staff awareness of safety issues associated with work-related driving risks;

- make sure that risk in relation to work-related driving is assessed in a systematic and ongoing way, and that safe systems and methods of work are put in place to reduce the risk as far as is reasonably practicable;
- make sure that appropriate training is available to staff in all areas, that equips them to recognise risk and provides practical advice on preventing and managing occupational road risks;
- make sure that appropriate support is available to staff involved in work-related driving incidents;
- encourage full reporting and recording of all incidents arising in the course of work-related driving; and
- reduce the number of incidents and injuries to staff resulting from work-related driving.

5 Responsibilities

5.1 The **Chief Executive** is responsible for:

- making sure there are arrangements for identifying, evaluating and managing risk associated with work-related driving;
- providing resources for putting the policy into practice; and
- making sure that there are arrangements for monitoring incidents linked to work-related driving and that the Board regularly reviews the effectiveness of the policy.

5.2 **Senior and line managers** are responsible for:

- making sure that all relevant staff are aware of the policy;
- making sure that risk assessments are carried out and regularly reviewed;
- putting into place procedures and safe systems of work designed to eliminate or reduce the likelihood of work-related driving incidents;
- making sure that staff groups and individuals identified as being at risk are given appropriate information, instruction and training, including training at induction, updates and refresher training as necessary;
- making sure that appropriate support is provided to staff involved in any incident associated with work-related driving; and
- managing the effectiveness of preventative measures through an effective system of reporting, investigating and recording incidents.

- 5.3 All **staff** are responsible for:
- taking reasonable care of themselves and other people who may be affected by their actions;
 - co-operating by following rules and procedures designed for safe working;
 - reporting all incidents in relation to work-related driving;
 - taking part in training designed to meet the requirements of the policy; and
 - reporting any dangers they identify or any concerns they might have about work-related driving.

6 Assessing risk

- 6.1 Risk assessment must be carried out in all areas of work where work-related driving poses an actual or potential risk to staff. The risk assessment will involve identifying all potential dangers and the risks associated with specific work-related driving activities. It should identify who will be affected and how, and the control measures which are needed to eliminate or reduce the risk to the lowest level reasonably practicable. A competent person must carry out risk assessment and it should be recorded and shared with relevant others. The following details should be recorded:
- the extent and nature of the risks;
 - the factors that contribute to the risk – including job content and specific tasks and activities; and
 - the safe systems of work to be followed to eliminate or reduce the risk.
- 6.2 These details should be communicated to staff, and risk assessments reviewed and updated annually, or sooner if circumstances change.
- 6.3 All drivers should also carry out risk assessments before beginning any journey. This should include assessing the condition of the vehicle, weather conditions and route, and their own fitness to drive. The driver risk-assessment checklist included in Annex 1 of Appendix 7.A can help with this process.

7 Managing risk

Departmental procedures must be in place that provide specific guidance for staff on managing work-related driving risks. This should include guidance on driver risk assessment and details of procedures to follow in the event of a work-related driving incident. All staff must be familiar with

these local procedures. Specific measures to include in local procedures to help reduce risks include the following:

7.1 Driver checks and qualifications

Drivers may only drive vehicles for which they hold appropriate licences.

Car and **van** drivers must have a full and current driving licence. **Minibus** drivers (up to eight seats) must be over 25 years of age and have a full and current driving licence. Drivers who passed their ordinary driving test after 1 January 1997 (in other words, category B) may not drive any vehicle with more than eight seats, not including the driver. For **minibuses with over eight seats**, drivers must also have passed a further test allowing them to drive vehicles in category D1 (passenger vehicles with between nine and sixteen seats).

Line managers should undertake an annual audit of licence, and where appropriate insurance certificates, for all staff involved in work-related driving activities. The line manager must see the licence and insurance certificate, and the driver and the line manager should sign a driver declaration form. In cases where the licence or insurance details are not in line with requirements the staff member should not be allowed to continue to drive on behalf of the organisation. Staff must tell the organisation about any changes in the status of their licence or their health that could affect their continued driving.

The following people are specifically excluded from driving organisation vehicles.

- Anyone who does not hold a full, valid UK driving licence for the category of vehicle being driven (or who does not have a relevant foreign or international licence that allows them to drive in the UK).
- Anyone who suffers from a condition that would disqualify them from holding or getting a relevant current driving licence.
- Anyone who has a current conviction for a motoring offence in the following categories:
 - dangerous driving, causing death by dangerous driving, or manslaughter;
 - driving under the influence of drink or drugs;
 - failing to stop after an accident; and
 - any other offence (or combination of offences) which has or might result in disqualification.

If the organisation becomes aware of any pending prosecution it can exercise the right to suspend staff from driving duties whilst awaiting the trial outcome.

7.2 Driving standards

Under the Road Traffic Act drivers are legally responsible for their own actions on the road and for keeping to all traffic regulations. We consider all our staff to be ambassadors for the organisation. Their behaviour while driving is a reflection on our corporate image. As such, we expect drivers to be polite and to follow the Highway Code and other driving laws and regulations. This is particularly important for drivers of vehicles which bear our logo. We will make sure that our drivers of vehicles involved in careless or repeated incidents take part in an assessment and retraining programme. We may also use the 'Management of Employee Conduct' policy following serious violations or persistent unsafe driving behaviour.

7.3 Caring for vehicles

Under the Road Traffic Act it is the driver's responsibility for making sure any vehicle they drive on public roads is roadworthy. If there is any doubt about a vehicle's roadworthiness, it should not be driven on public roads or our sites until the problem has been sorted out. A staff member in each location will have responsibility for checking and maintaining the roadworthiness of our vehicles.

7.4 Wearing seatbelts

All drivers and anyone in a vehicle must, by law, wear a seatbelt. It is the responsibility of the driver, but also the duty of any staff member, to make sure that anyone in an organisational vehicle is wearing a seatbelt.

7.5 Alcohol, drug abuse, smoking

Driving on organisational business while under the influence of alcohol or illicit drugs is not allowed. We will use the 'Management of Employee Conduct' policy and may take formal action for any staff member this applies to. Staff should also tell their manager if, at any time, they have to take prescribed drugs that may affect their ability to drive. Smoking is not allowed in our vehicles.

7.6 Using mobile phones

Staff should not make calls from mobile phones while driving. Even with 'hands-free' phones, studies show that calls can be a distraction and, consequently, calls should only be made when the vehicle is stopped. If a staff member receives a call on a mobile phone while driving, s/he should pull over at the nearest point at

which it is safe to do so before answering the call. We suggest that staff use automated voice-mail facilities.

7.7 Drivers' hours and rest

Any specific legislation referring to drivers' hours (for example, tachograph regulations) applies. Tiredness, fatigue and stress (be it from work, domestic or social circumstances) can affect safe driving. Drivers should take account of this and not drive if they believe that they are unfit to do so. No staff member should drive for more than 2½ hours without taking a break for at least 15 minutes.

8 Staff training

8.1 We will provide basic driver safety training to give staff the knowledge and skills needed to help prevent and manage work-related driving risks. Different levels of training will be available and we will provide specialist training if necessary, based on the needs identified through local risk assessment. (For example, this could include training for staff involved in transporting patients or food, training in transporting dangerous loads, and training in loading and securing goods.)

8.2 We will also provide training in relation to driver risk assessment, and guidance on musculo-skeletal conditions associated with driving for long periods. The seat being in the correct position, position of the head rest and position of major controls are essential to reduce the risk of personal injury in an accident and to make sure the driver has a good posture to prevent back problems and tiredness. Line managers are responsible for making sure that staff receive appropriate training and have access to refresher training on a regular basis. Advice and guidance on basic and specialist driver training is available from the Training and Development Department.

9 Reporting and recording

Staff should report all incidents (including near misses) to their line manager at the earliest opportunity. These should be reported on an incident form and all reports should be investigated by the line manager. In accordance with RIDDOR, the Health and Safety Executive must be notified in writing within ten days of an incident if any staff member is absent from work for more than three consecutive days as a result of a work-related driving incident. To monitor the implementation and effectiveness of this policy and associated local protocols, managers should regularly review local statistics and incident reports.

10 Monitoring and reviewing

We will monitor and review this policy in partnership to make sure that we are achieving the aims of the policy. We will do this with Trade Unions/Professional Organisations and safety representatives. The review processes will include:

- • collecting and monitoring all reported incidents by our Health and Safety Adviser;
- • every three months, reporting to local Health and Safety Committees and the Partnership Forum on incident statistics and safety improvement measures;
- • every year, reporting to the Health and Safety Committee and Risk Management Group on how we are following the policy, the outcomes of risk assessment, and details of training provided; and
- • every year, reporting to the Board to highlight progress in reducing risk and incidents and making recommendations for the forthcoming year.

Annex 1

DRIVER RISK ASSESSMENT CHECKLIST

You should consider the following points before beginning any journey.

1 Journey planning

1.1 Has a safe journey plan been put together covering:

- start time?
- finish time?
- stops?
- adequate rest breaks?
- safest route?

1.2 Does it take account of:

- environmental conditions?
- enough time for breaks?
- restrictions on maximum distances and driving hours?
- times of day associated with fatigue?
- accident black spots?
- traffic conditions?
- number of pedestrians?
- business overruns and hold-ups?
- Other factors which might have an effect?

2 The vehicle

2.1 Is the vehicle fit for the purpose of the journey, including:

- distance to be travelled?
- load carrying?
- passengers?
- the road conditions?

2.2 Have pre-journey safety checks been carried out on:

- tyres?
- lights?
- windscreens and windows?
- washers and wipers?
- mirrors?
- oil, coolant and battery levels?
- signs of damage?

2.3 Is the vehicle one with which the driver is familiar, particularly in relation to:

- seating position?
- mirror settings?
- position of major and minor controls?

2.4 Does the vehicle have:

- ABS (an anti-lock braking system) or other desirable safety features (for example, driver and load partitions)?
- on-board emergency equipment such as a first-aid kit or fire extinguisher?

3 The driver

- Does the driver have the appropriate, valid licence for the vehicle being driven?
- Is the driver fit to drive?
- Is the driver in the right frame of mind?
- Has the driver received any driver training needed?
- Does the driver know what to do in the case of an emergency?

APPENDIX 7.B

References

- | | |
|---|---|
| Health and Safety Executive | Work Related Road Safety Task Group Discussion Document on "Preventing At-work Road Traffic Incidents", HSE Publications, 2001 Available at http://www.hse.gov.uk/road |
| Management of Health and Safety at Work Regulations | HMSO, 1999, ISBN 0 11 085625 2 |

Recommended further reading

- | | |
|---|---|
| Driver and Vehicle Licensing Agency | <i>At a glance guide to the current medical standards of fitness to drive</i> , Department of the Environment and Transport. Available at http://www.dvla.gov.uk |
| Royal Society for the Prevention Of Accidents | <i>Managing Occupational Road Risks - The RoSPA Guide</i>
Available from RoSPA, Edgbaston Park, 353 Bristol Rd, Birmingham B5 1ST.
Phone: 0121 248 2000 |
| The Road Traffic Act (1991) | |
| The Health and Safety at Work Act (1974) | |

Biological and chemical hazards

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8. BIOLOGICAL AND CHEMICAL HAZARDS

8.1 Introduction

It is acknowledged that in the healthcare environment unpredictable and unforeseen exposure to chemical and biological hazards will inevitably occur. However, through a programme of hazard identification, risk assessment, control implementation and monitoring all reasonably practicable steps will be taken to minimise the risks to healthcare staff.

8.2 The legislative framework

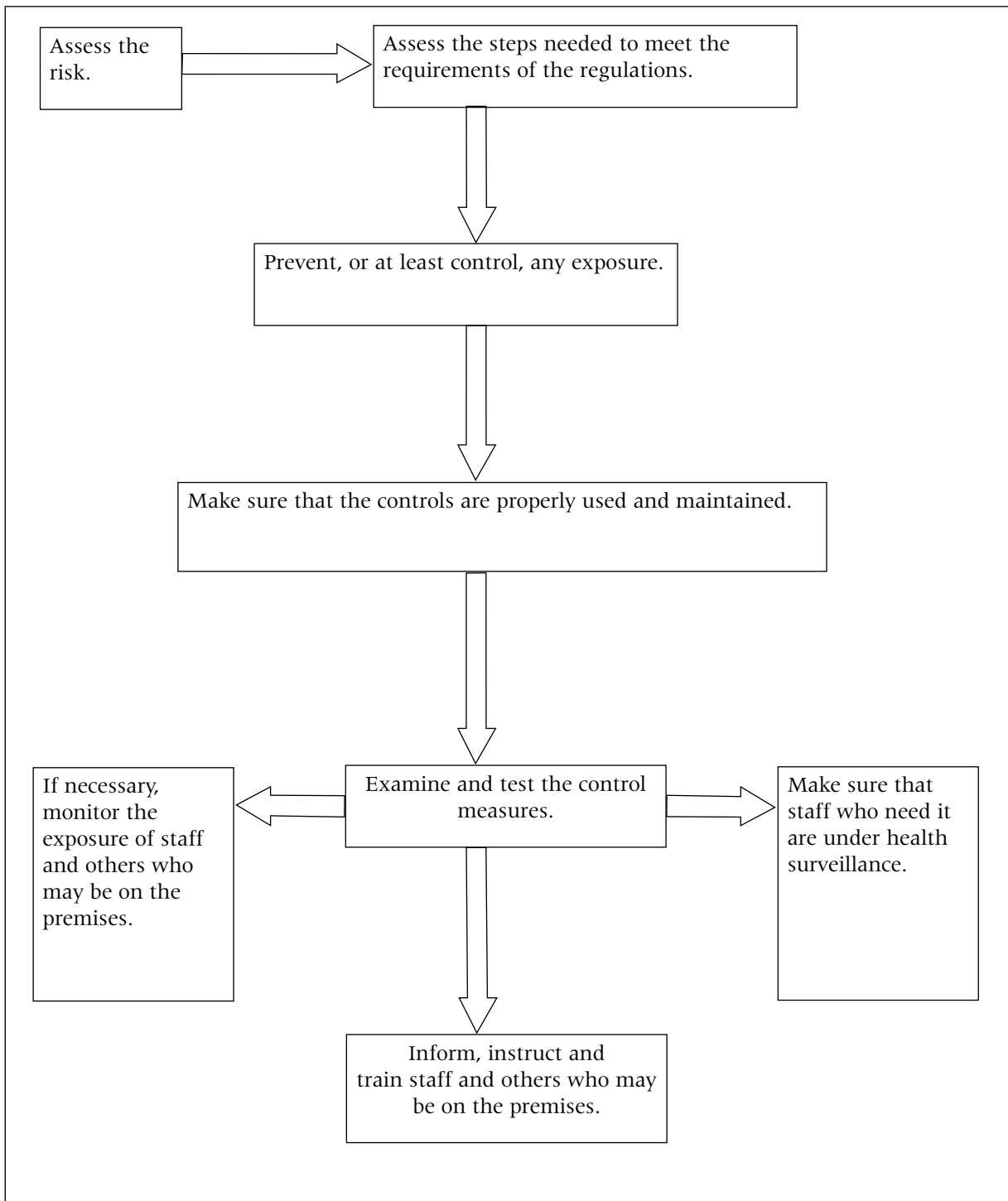
Legislation related to chemical and biological hazards includes:

- • Health and Safety at Work Act (1974)
- • Management of Health and Safety at Work Regulations (1999)
- • Control of Substances Hazardous to Health (COSHH) Regulations (1999)
- • Chemical (Hazard, Information & Packaging for Supply) Regulations (1994) – CHIP
- • Food Safety Act (1990)
- • Food Safety (General Food Hygiene) Regulations (1995)
- • Reporting of Injuries, Diseases & Dangerous Occurrence Regulations (RIDDOR) (1995)
- • Data Protection Act (1998)

Requirements of the regulations

- • Staff must not carry out any work which could involve being exposed to a hazardous substance unless a suitable assessment of the health risks has been carried out and the necessary steps taken to adequately control the risk.
- • An employer's first duty is to eliminate the use of a dangerous substance (see 8.4) or to substitute it with a less dangerous one. Only when this is not reasonably practical should employers consider other control measures.
- • Controls should, as far as reasonably practicable, involve protection other than providing personal protective equipment (PPE). Employers must keep to the specific legal standards relating to the control measures for carcinogenic substances and biological agents.

8.3 Employers' main duties



8.4 Recommended approach

The term 'substance hazardous to health' covers virtually all substances which can cause adverse health effects or diseases arising from work activities. However, lead and asbestos are covered by separate regulations. The COSHH regulations deal with chemical and biological hazards, although employers will need to consider all substances used in order to keep to these regulations in the healthcare setting. Some of the more common dangers (which may need their own policy) are shown below.

8.4.1 Legionella

Legionella bacteria have the potential to cause Legionnaire's Disease, a potentially fatal pneumonia. Breathing in small droplets of water contaminated by legionella bacteria causes infection. Outbreaks have been associated with cooling towers and hot- and cold-water services.

NHSScotland organisations should carry out risk assessments to identify potential sources and prepare a scheme for controlling the risks.

8.4.2 Respiratory sensitisers

Respiratory sensitisers can cause asthma. Some of the more common respiratory sensitisers in the healthcare setting include glutaraldehyde, formaldehyde, laboratory animals, latex proteins and certain drugs including penicillin, tetracycline and methyldopa.

Treating occupational asthma involves removing the sensitised subject. This may mean a change of job or even speciality or profession.

8.4.3 Skin sensitisers

Skin sensitisers can cause allergic contact dermatitis. In the healthcare setting many agents are used which can cause skin sensitisation. However, the commonest skin sensitisers include accelerators and antioxidants in latex products, formaldehyde, certain anti-microbial agents and some pharmaceutical products. Treating someone who has become sensitised may involve removing them from further exposure.

8.4.4 Controlling infection and communicable disease

Infections and communicable disease may not be obvious or diagnosed at the time of patient contact. As a result, staff must use standard (previously known as 'universal') precautions at all times to protect their patients and themselves.

Employers need to carefully assess waste generated from healthcare activities to make sure that items which could cause 'sharps' accidents or cross-infection are disposed of appropriately.

Biological dangers in healthcare extend beyond clinical and laboratory settings to other areas. For example, poor practices when handling food can lead to contamination, food-borne illness and food poisoning.

8.4.5 Mercury

Mercury is a poisonous substance and direct exposure to the vapour by inhalation, through the skin or orally or nasally is a health risk. Employers should have a policy to get rid of products containing mercury but, in the meantime, have a spillage policy and make sure that equipment and trained staff are available to deal with any mercury spills. Appropriate waste disposal procedures should also be in place.

8.4.6 Pharmacy products

This covers a wide range of items which can affect health. Employers should control the use of anaesthetic gases and monitor air to make sure that standards are being met. Where cytotoxic drugs are given and disposed of, there should be a policy that protects staff and visitors. Unused 'prescription only medicines' (POMs) must be disposed of as special waste through the pharmacy.

8.4.7 Immunisation and post exposure prophylaxis

Employers should offer staff immunisation against infectious diseases caught at work which are appropriate to their occupational risk. There is also a duty of care to patients in reducing the risk of transmitting infectious agents from staff to patients.

If a staff member suffers a needlestick or contamination incident, their manager must carry out an immediate assessment and take necessary follow-up action including providing HIV post-exposure prophylaxis if appropriate.

8.5 Responsibilities for putting policies and procedures into practice

It is important that the responsibilities both at a strategic and local level are clearly defined. Procedures must identify who is responsible for the following functions within the organisation.

8.5.1 Identifying hazards

In this context a hazard is a substance that could cause harm. A system should be in place to identify all dangerous substances used.

8.5.2 Risk assessment

A risk is the likelihood of a hazard occurring. Employers should keep documents for the procedures for carrying out assessments to meet the requirements of the regulations and keep these as simple as possible. The assessment process should take into account specific risks posed, for example, to new and expectant mothers and young people.

8.5.3 Putting control measures in place

Employers should identify suitable control measures which satisfactorily control the risk. In descending order of priority, control measures are:

- getting rid of the risk;
- substituting the agent causing the risk;
- working in a totally enclosed system;
- providing local exhaust ventilation;
- providing a safe system of work; and
- providing personal protective equipment.

Employers must use all control measures that are identified as necessary at all times. They must also maintain, examine, test and review control measures regularly to make sure that they stay fit for purpose.

8.5.4 Monitoring exposure

If necessary, health surveillance and environmental and personal exposure monitoring should be carried out at appropriate intervals. This should be agreed by consulting with the Occupational Health Service (OHS).

8.5.5 Keeping records

It is a good idea to have an agreed assessment form to support a consistent approach towards assessment. Employers and staff must make sure that all information is recorded in an accurate and timely way. All written records should be legible, signed and dated.

Under the regulations, employers must be able to produce the following records.

- The assessments of risks to health caused by exposure. This should include a list of hazardous substances, the control measures provided and the training provided for staff.
- The examination, testing and maintenance of control measures. Employers must keep these records for at least five years.
- Records of monitoring environmental exposure. Employers must keep these for at least five years.

- Employers should keep records of individual dosimetry monitoring and health surveillance for staff for at least 40 years from the date of last entry.

8.5.6 Monitoring and review

All procedures should give details of the method of the review and how often it is carried out. Employers must review assessments in particular when there is reason to think they are no longer valid or there has been a significant change in the work to which the assessment relates.

8.5.7 Communication

At induction and during employment all staff should know about the measures in place to protect them from chemical and biological hazards relevant to their roles. Employers should update this information regularly.

Staff should have access to copies of all COSHH risk assessments which are relevant to their area of work.

8.5.8 Training

Procedures should be in place to make sure that assessors are given enough training to carry out their roles. Employers should also provide information, instruction and training to staff on:

- the risks to health created by being exposed to the substances they are working with; and
- the measures in place to control the risk and their own responsibilities.

It is particularly important that employers provide this information at induction and regularly after this, and also when any change is made to working practice or the working environment.

8.5.9 Evaluation

Measurements used include the following.

- Reactive:
 - using the 'Reporting of Injuries, Diseases & Dangerous Occurrence Regulations (RIDDOR) 1995';
 - providing the minimum dataset needed under 'Towards a Safer Healthier Workplace';
 - recording incidents including needlestick injuries; and
 - uptake and DNA (did not attend) rates for immunisation programmes.

- • Proactive:
 - ◦ setting targets for reducing injuries and illness in line with national and NHS strategies;
 - ◦ carrying out a health and safety audit;
 - ◦ creating action plans for putting improvements in place to control risks;
 - ◦ evaluating staff awareness of policies and procedures;
 - ◦ sending regular summary reports to Executive Directors; and
 - ◦ producing an annual report for the organisational Board.

8.6 Blood-borne viruses

- 8.6.1 Blood-borne viruses include HIV, hepatitis B (HBV) and hepatitis C (HCV). There are many other blood-borne viral infections of which we know little about how infectious they are or the long-term outcomes. Infected people may show no signs or symptoms of blood-borne infections that may be acquired or transmitted at any age from birth to retirement.

As a result, it is essential that all healthcare workers take routine or 'standard precautions' every day to make sure that good practices become a way of life rather than an 'add-on'. See section 8.7 for more information about standard precautions.

Most precautions taken to prevent blood-borne infections are simple and do not need expensive equipment or major changes to existing advice. For example, covering any cuts and abrasions with a waterproof dressing before going to work should be routine practice.

- 8.6.2 A blood-borne viruses policy should also include and link with the following topics:

8.6.2.1 Preventing transmission at work

This includes:

- • immunisation before people start work;
- • safe working procedures including standard precautions;
- • reporting near misses;
- • a health and safety culture; and
- • providing enough staff.

There should be local procedures in each area to take account of the particular challenges of the client groups and workload.

Specialist areas such as laboratories, maternity units and surgical theatres will need routine and major incident and

emergency policies and plans. Paramedics, staff working in mental health services, accident and emergency staff and resuscitation teams face both predictable and unknown hazards. Plans and procedures should anticipate risks and prepare staff to protect themselves. Employers should encourage healthcare workers to get help if they are not sure that they can carry out an activity or treatment safely.

8.6.2.2 Preventing transmission

This includes:

- • pre-employment screening for staff who carry out 'exposure-prone procedures' (this includes those staff working in body cavities where fingers cannot be seen, for example, dentists, surgeons and midwives);
- • support and advice from OHS for staff with skin conditions which might expose them to risk;
- • non-invasive techniques;
- • redesigning procedures to reduce manual input as far as possible, for example in cleaning;
- • single-use-only equipment; and
- • retraining or support for staff to change career if they become infected and can no longer work in their previous role.

8.6.2.3 Treating needlestick injury

This includes:

- • providing appropriate first aid (all staff need training);
- • a fast-track risk assessment in Accident and Emergency or a designated unit;
- • providing appropriate antibiotic or anti-viral therapy if necessary;
- • storing baseline blood samples for any later testing; and
- • reviewing incidents with the staff member and management to assess if a similar incident could be prevented and making sure documents are correct and complete.

8.7 'Standard precautions'

To reduce the risk of transmitting blood-borne viruses from infected patients to healthcare workers, and vice versa, staff should do the following¹:

- • Use good basic hygiene with regular hand washing, before and after contact with each patient, and before putting on and removing gloves. Change gloves between patients.
- • For all clinical procedures, cover existing wounds and breaks in exposed skin with waterproof dressings, or with gloves if the hands are widely affected.
- • Healthcare workers with chronic skin disease such as eczema should avoid invasive procedures which involve sharp instruments or needles when there are extensive breaks in the skin surface. Broken skin provides a potential route for blood-borne virus transmission, and blood-skin contact is common through holes in gloves which may not be seen.
- • Use protective clothing as appropriate, including protecting the mucous membrane of eyes, mouth and nose from blood and body fluid splashes. Avoid wearing open footwear in situations where blood may be spilt or where sharp instruments or needles are handled.
- • Prevent puncture wounds, cuts and abrasions and if they are present, make sure that they are not exposed.
- • Avoid using sharps wherever possible and consider using other instruments, cutting diathermy and laser.
- • If sharps have to be used, be particularly careful handling them. Follow approved procedures and use approved sharps disposal containers.
- • Clear up spillages of blood and other body fluids promptly, and disinfect surfaces.
- • Follow approved procedures for sterilising and disinfecting instruments and equipment. Wear gloves when cleaning equipment before sterilisation or disinfection, when handling chemical disinfectant and when cleaning up spills.
- • Follow approved procedures to get rid of contaminated waste safely.

¹From UK Health Department's *Protecting Health Care Workers and Patients from Hepatitis B: Recommendations of the Advisory Group on Hepatitis 1993*, *'AIDS/HIV Infected Health Care Workers 1998* and *Guidance for Clinical Health Care Workers: Protection against Blood Borne Viruses 1998*.

APPENDIX 8.A

Model Policy for Controlling Substances Hazardous to Health (COSHH)

1 Introduction

The COSHH Regulations (1999) protect staff and others against risks to their health. They apply to hazardous substances which arise in connection with work under our control or carried out on our behalf. The substances can be solid, liquid, gas, fume, dust, vapour or even micro-organisms and can endanger health by being absorbed or injected through the skin or mucous membranes, inhaled or ingested.

2 Hazardous substances

These include:

- a substance which is listed in part 1 of the approved supply list as hazardous for supply within the meaning of the Chemicals (Hazard Information and Packaging) Regulations 1994. It has been specified as dangerous in part V of that list and is very toxic, harmful, corrosive or an irritant;
- a substance for which the Health and Safety Commission has approved a maximum exposure limit (MEL) or an occupational exposure standard (OES);
- biological agents;
- dust of any kind, when there is a high concentration in air; and
- a substance which creates a danger to the health of any person which is comparable with the hazards created by substances mentioned in those subparagraphs.

Not all substances which can be hazardous to health are covered by the COSHH regulations, either because they fall outside the definitions given above or are covered by other specific regulations. Among these are the Control of Asbestos at Work, the Control of Lead at Work, the Ionising Radiation Regulations and medicines given to patients.

3 The requirements of COSHH

Employers are responsible for:

- assessing the risk to health arising from work and what precautions are needed;
- introducing appropriate measures to prevent or control the risk;
- making sure that control measures are used and that equipment is properly maintained and procedures observed;
- monitoring the exposure of the workers and carrying out the appropriate form of surveillance of their health; and
- instructing and training staff about the risks and the precautions to be taken.

4 Prevention and control

Clinical Directors and heads of department must make sure that staff are not exposed to dangerous substances or, if that is not reasonably practicable, that they are reasonably controlled.

Adequate control is achieved if employers meet the following criteria.

- If the level of exposure of a substance which could be inhaled and has a MEL is reduced as far as is reasonably practicable (and in any case below the MEL).
- If the level of exposure of a substance which could be inhaled and has an OES is reduced to the OES. If the level of exposure is more than the OES, employers must identify the reason and take action to sort out the problem as soon as is reasonably practicable.
- A substance which could be inhaled and which does not have a MEL or an OES does not mean that it is safe. Employers should control the level of exposure to that which most of the population could be exposed to repeatedly without any effect on their health.
- Employers should control exposure to any substance which can be dangerous if swallowed, absorbed through the skin or mucous membranes or which comes into contact with the skin or mucous members (chemical burns, dermatitis and microbial infection) to a standard where most of the population could be exposed repeatedly to it without any effect on their health.

Employers should always prevent exposure to carcinogens if this is reasonably practicable, or must at least control it to as low a level as is reasonably practicable.

Preventing exposure is the main aim. Measures that employers can consider for controlling exposure include the following.

- 1 **Prevention** – eliminate the hazardous substance or substitute it for a less dangerous form of the substance.
- 2 **Control** – clean to remove solid or liquid contaminants which contain any dangerous substance.
- 3 **Dispose** – get rid of dangerous substances safely.
- 4 **Enclose** – place the substance in a suitable container.
- 5 **Exclude** – non-essential personnel from the contaminated area.
- 6 **Minimise** – create or use as little of the dangerous substance as possible.
- 7 **Provide:**
 - suitable personal protective equipment (PPE);
 - suitable respiratory protective equipment (RPE); and
 - adequate facilities for washing, resting, changing and storing clothing, food or drink.
- 8 **Prohibit** – do not allow eating or drinking in contaminated areas.
- 9 **Reduce** – reduce the number of staff exposed or the period they are exposed for.
- 10 **Store** – store dangerous substances safely.
- 11 **Remove** – eliminate contaminants carried in the air.
- 12 **Ventilate** – provide ventilation to remove contaminants carried in the air.

Employers should prevent exposure in ways other than just providing PPE except to a carcinogen or a biological agent. Employers should always introduce process, engineering, procedural and personal controls before PPE if this is reasonably practicable.

5 Assessment

It is the responsibility of the Clinical Director or head of department to make sure that an assessment is carried out for each process involving hazardous substances. Employers must also assess substances released or produced as part of the process.

Even if the assessment is simple and obvious and can be explained at any time, it must still be recorded on the organisational assessment form (see Annex 1). This must be signed by the assessor and by the manager or head of department. Managers should keep a copy of the assessment form in their department and send one to the Director of Facilities (or equivalent). The use of these forms will be audited.

Managers must review the assessment if there is reason to suspect it has become invalid or if there has been a significant change in the work

previously assessed. Before any new substance is introduced to a workplace within the organisation, the manager must carry out an assessment. The manager must contact the Director of Facilities (or equivalent) about all additions and deletions to a department's inventory of hazardous substances.

The steps to follow in making an assessment are:

- • identify any hazardous substances which staff and others may be exposed to;
- • identify the route by which the substances might enter the body;
- • identify the resulting effects;
- • examine the working processes, practices and procedures which involve hazardous substances;
- • estimate the current exposure levels and those which might result from a planned or an unplanned event, such as an increase in levels if work or an accidental release;
- • compare the estimate against a valid exposure limit to allow it to be controlled;
- • only use PPE when all other methods of control have proved inadequate; and
- • decide on other precautions to help control the substance and whether there is any need for monitoring the exposure.

In gathering information for an assessment, managers may need expert advice. More information is available from manufacturer's data sheets, from the substances database or the Health and Safety Adviser.

Adequate controls must include procedures for dealing with dangerous substances accidentally escaping.

PPE equipment must keep to the requirements of the International Standards Organisation, British or European Standards if these exist. Eye protection must follow the requirements of the Personal Protective Equipment at Work Regulations 1992 and with the current edition of BS2092. To keep to the COSHH Regulations, RPE must be suitable for the purpose and be of the type approved by the Health and Safety Executive or keep to their approved standard.

6 Examining and testing control measures

It is the responsibility of the Clinical Director or head of department to make sure that all control measures are kept in efficient working order and in good repair. Procedures may vary from weekly visual checks to thorough servicing schedules. Employers should examine local exhaust ventilation plant thoroughly and test it at least once every 14 months. Employers must also examine respirators and breathing apparatus frequently. A

record of each examination should be kept and this should be available for inspection for at least five years from the date on which it was made.

Employers should provide enough information, instruction and training to allow staff to know the risks to health created by being exposed to hazardous substances and the precautions to be used, including decontamination, PPE and RPE.

7 Monitoring and reviewing

For the purpose of the regulations, monitoring involves using valid and suitable techniques to estimate the airborne exposure of staff to hazardous substances. The Clinical Director or head of department is responsible for making sure that this is being carried out by a competent person and that these activities are recorded.

Employers must monitor the exposure of staff if:

- failure or deterioration of control could be a serious risk to health;
- MELs, OES or any self-imposed working standards should not be exceeded; and
- it is necessary to have an extra check of controls.

Employers must keep records of monitoring for 40 years if they record the personal exposure of identifiable staff. They should be kept for at least five years in all other cases. Records should provide enough information to decide:

- when, where and under what conditions it took place;
- what monitoring procedures were used and how long they took; and
- whose exposure was monitored and what the results were.

8 Health surveillance

Health surveillance is appropriate when staff are exposed to substances in circumstances where:

- an identifiable disease or negative health effect may be related to the exposure;
- there is a reasonable likelihood that the disease or negative effect may occur under the particular conditions of the work;
- valid techniques exist for detecting disease or effect.

This will involve the services of OHS who will be responsible for maintaining health records and carrying out the appropriate examinations, immunisations and investigation. Clinical Directors or heads of departments must act on any medical decision to restrict a staff member's work with a specific substance. Employers must keep staff health records for 40 years from the last date of entry. On receiving reasonable notice, any

staff member must be allowed access to any health record which relates to them.

9 Informing staff

The Clinical Director or head of department must tell staff about the dangers and risks arising from their work, any precaution to be taken and, if carried out, the results of monitoring and the results of health surveillance. They must also provide training in using controls and RPE and PPE correctly.

10 Health and Safety Department

The Director of Facilities (or equivalent) will maintain the central records of assessments, controls and monitoring.

Annex 1

COSHH REGULATIONS 1999 RISK ASSESSMENT FORM

1 Department, ward or location	2 Work activity
3 Substances used (trade and approved name)	4 Classification for example, toxic, risk phrase MEL or OES (see below) <input type="text" value="15 minutes"/> <input type="text" value="8 hours T.W.A."/>

Very toxic, corrosive, irritant, dust, carcinogen, micro-organism, allergen, substance with a maximum exposure limit (MEL), substance with an occupational exposure standard (OES), no official hazard classification (insert manufacturer's if any).

5 Exposure during routine work	
Is there a possibility of being exposed to the substances during normal use?	Yes <input type="checkbox"/> No <input type="checkbox"/> Contained <input type="checkbox"/>
If 'yes' are they from: an aerosol	<input type="checkbox"/> liquid <input type="checkbox"/> vapour <input type="checkbox"/> powder or dust <input type="checkbox"/> fumes <input type="checkbox"/> gas <input type="checkbox"/>
Other <input type="checkbox"/> Please give details	_____
Estimated exposure during routine work	Other comments
High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/>	
How often does the exposure take place?	
Constantly <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/>	
Number of staff exposed during the work activity	<input type="text"/>

6 Health risk

What is the route of entry?	Possible effects on the body
Inhalation <input type="checkbox"/> Skin <input type="checkbox"/> Swallowing <input type="checkbox"/>	
Accidental inoculation <input type="checkbox"/> Eyes <input type="checkbox"/>	

7 Existing control measures (for example, local exhaust ventilation, workplace air monitoring)

Are air control measures in place?
Yes <input type="checkbox"/> No <input type="checkbox"/>
Are control methods suitable to get rid of any risk to health?
Yes <input type="checkbox"/> No <input type="checkbox"/> Please give details of any control methods used.
<input type="text"/>
Is a technical or maintenance report available? Yes <input type="checkbox"/> No <input type="checkbox"/> (See section 11)
Is personal protective equipment (PPE) provided as a control measure? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is health surveillance needed? Yes <input type="checkbox"/> If 'Yes' give details in section 11. No <input type="checkbox"/>

8 Safe system of work

Is there a written procedure for the work activity showing health and safety precautions? Does this include disposing of water? Yes No Where is it located? _____

9 Information, instructions, supervision and training

Have staff received appropriate information, instruction, supervision, support and training to carry out the work safely including using any existing control measures?

Yes No

Please give details _____

10 Contingency arrangements

Is there a procedure to deal with the risk arising from an accidental release of dangerous substances?

Yes Please give details: Wall chart Data sheet (attached) Poster

Standing instructions, etc.

No (Refer to the action proposed)

Have staff received enough information, instruction, supervision, support and training in emergency procedures?

Yes No Please give details _____

Is suitable equipment available in the department to deal with an accidental release of hazardous substances (for example, PPE, and neutralisation chemicals)?

Yes No Please give details _____

11 Assessor's conclusions

Please tick appropriate box.

In the opinion of the assessor, taking into account the hazardous nature of substances used and the way in which they are used a controlled for example, technical or maintenance report attached:

does a risk occur? Yes No

If 'Yes', describe how, where and what improvements are needed to reduce the risk as far as possible and achieve satisfactory control, for example, control measures, local exhaust ventilation, PPE, air monitoring, health surveillance, training, etc.

Action proposed or taken (notes)

Name of assessor

Designation

Date

Signature of manager

Review Date

Review Date			
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APPENDIX 8.B

References

- Control Of Substances Hazardous to Health Regulations (COSHH), 1988
- Health & Safety Executive, HS(R)23, Guide to the Reporting of Injuries, Diseases & Dangerous Occurrences (RIDDOR) Regulations, 1985
- MDA DB2000(04) (August 2000): Single-use Medical Devices: Implications and Consequences of Reuse
- Microbiology Advisory Committee to the Department of Health (England) (July 1991): Decontamination of Equipment, Linen and Other Surfaces Contaminated with Hepatitis B and/or Human Immunodeficiency Viruses.
- NHS HDL(2000)3: Hepatitis B Infected Healthcare Workers.
- NHS HDL (2001)10: Decontamination of Medical Devices.
- NHS MEL (1993)7 and NHS MEL(1993)86: Hospital Laundry Arrangements for Used and Infected Linen.
- NHS MEL(1996)93: Addendum to Guidance on Protecting Healthcare Workers and Patients from Hepatitis B.
- NHS MEL(1997)70: High Isolation Provision for Actual or Suspected Cases of Viral Haemorrhagic Fever in Scotland. Advisory Committee on Dangerous Pathogens: Guidance on the Management and Control of Viral Haemorrhagic Fevers.
- NHS MEL (1998)47: Advisory Committee on Dangerous Pathogens (ACDP)/Spongiform Encephalopathy Advisory Committee (SEAC) Guidance (April 1998): Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection.
- NHS MEL (1999)29: AIDS/HIV Infected Healthcare Workers: Guidance of the Management to Infected Healthcare Workers and Patient Notification: Recommendations of the Expert Advisory Group on AIDS.
- NHS MEL(1999)65: Variant Creutzfeldt-Jakob Disease (vCJD): Minimising the Risk of Transmission.
- NHS MEL(1999)79: NHS in Scotland Infection Control: Decontamination of Medical Devices.
- SAN(SC)01/01: Safety Action Notice: Reporting of Adverse Incidents in NHS Scotland.
- Scottish Office NHS in Scotland Letter (Anderson GA & Kendell RE): Protecting Healthcare Workers and Patients From Hepatitis B(18 August 1993).
- SE\X\HD\CMO(2000)4: Guidelines on HIV Post-Exposure Prophylaxis, UK Chief Medical Officers' Expert Advisory Group on AIDS (July 2000).
- SEHD\CMO(98)12: Guidance for Clinical Healthcare Workers: Protection Against Infection with Blood-borne viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis.

The Scottish Office Department of Health Advisory Group on Infection (1998): Scottish Infection Manual: Guidance on Core Standards for the Control of Infection in Hospitals, Healthcare Premises and at the Community Interface.

Scottish Executive (2001) Report of the Short Life Working Group on Needlestick Injuries in NHSScotland, "Needlestick Injuries: Sharpen your awareness"

Scottish Executive (March 2001), HDL (2001) 22, Occupational Health Minimum Dataset

Recommended further reading

- Medical Series Guidance Notes, HSE (MSG's)
- Infection Risks To New And Expectant Mothers In The Workplace, HSE Books
- New And Expectant Mothers At Work, HSE HSG122
- Legionnaire Disease: The Control Of Legionella Bacteria In Water Systems: Approved Code Of Practice And Guidance, HSE L8
- Safe Working And The Prevention Of Infection In The Mortuary And Post-Mortem Room, HSC
- Monitoring Strategies For Toxic Substances, HSE HSG173
- Biological Monitoring In The Workplace, HSE HSG167
- Young People at Work, HSE HSG 165
- Safe Working And The Prevention Of Infection In Clinical Laboratories, HSC
- COSHH Essentials, HSE HSG193
- Health Surveillance Under COSHH, HSE 1995
- Surveillance of People Exposed to Health Risks at Work, HSE HSG61
- Occupational Exposure Limits, EH40
- Categorisation Of Biological Agents According To Hazard And Categories Of Containment 1995, ACDP
- Guidelines For The Use Of Cytotoxic Chemotherapy In The Clinical Environment, HDL (2001)13
- Towards a Safer Healthier Workplace, Scottish Executive, Dec. 1999
- Needlestick injuries: Sharpen Your Awareness, Scottish Executive May 2001
- Scottish Infection Manual, Scottish Office, July 1998
- Immunisation Against Infectious Disease, Scottish Office DoH 1996
- Clinical Standards Board Scotland: Standards on Infection Control, draft July 2001
- Food Handlers Fitness to Work - Guidelines for Food Business Managers, Expert Working Group convened by the Department of Health 1995
- The Management, Design and Operation of Microbiological Containment Laboratories; Advisory Committee on Dangerous Pathogens 2001, HSE

Incident Management Policy

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9. INCIDENT MANAGEMENT POLICY

9.1 Definition of an incident

“Any event or circumstance arising during NHSScotland care or service provision that could have or did lead to unintended or unexpected, harm loss or damage.”

In this policy, unless the context otherwise requires:

- • **the 1995 Regulations** means the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995;
- • **dangerous occurrence** and **major injury** are each defined in the 1995 Regulations. Further information is given in Appendix 9.A of this policy;
- • **incident** includes personal accident; clinical incident; violence/abuse/harassment; ill health; near miss; drug error/blood transfusion error;
- • **line manager** can be defined as the person responsible for the area or work activity within which the incident took place. This includes charge nurse, supervisor, head of department, nurse in charge, estates manager or other responsible person and should be interpreted in context of the incident.

9.2 Policy statement

[Name of organisation] is committed to complying with its statutory responsibilities to ensure, so far as is reasonably practicable, the health, safety and welfare of all its staff and other persons on the premises or using its services.

It is recognised that it is not possible to prevent all untoward events. This policy aims to make sure that [Name of organisation] can meet its statutory obligations under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

This policy also aims to make sure that all incidents are reported, investigated and analysed as appropriate and that the knowledge thus gained is regularly disseminated. This will encourage and strengthen a learning culture in which care will continuously be reviewed and improved.

In the majority of cases the causes of serious incidents go far beyond the actions of individuals immediately involved. In healthcare there are a number of factors at work at any one time that can affect the likelihood of incidences occurring. It is with this in mind that we are committed to advocating a 'Just Culture'. There will however, be instances where individuals must be held accountable for their actions, particularly if there is evidence of gross negligence, recklessness or criminal behaviour. A culture where errors or service failures can be reported and discussed, lessons learned and necessary changes put in place is essential.

This policy is not for the purpose of clinical performance monitoring. If anyone is concerned with the performance or professional standard of any individual staff member, this should be reported in confidence to the appropriate professional manager.

This policy will be monitored and reviewed regularly in partnership.

9.3 Incident management protocol (See Appendix 9.C)

9.3.1 Primary action after an incident

The priority is that the patient/staff member should receive appropriate first aid or medical treatment. The line manager must ensure that this is done, and that action is taken to prevent further danger to others. Equipment involved in the incident must be removed from use and retained for inspection. Where possible, the surrounding area of the event should be isolated, pending any necessary investigation.

If the event results in a fatality, the line manager must contact:

- the police; and
- the Health and Safety Executive (0845 300 9923).

If it is thought that a criminal act, including acts of violence, has been committed, immediate advice must be sought from the police. Call 999.

If the incident is a RIDDOR-reportable incident (i.e. a major injury; dangerous occurrence; over three-day injury; or occupational disease), then the necessary report should be made to the HSE via the incident report line (0845 300 9923).

In circumstances where a significant or serious incident arises where media interest may be generated, the organisation's media policy and procedures must be instigated. In all instances, staff and patients involved in the incident must be informed before releasing information to the media.

9.3.2 Secondary action after an incident

The line manager must make sure that an Incident Report form (See Appendix 9.D) is completed according to the instructions detailed in the procedure, and that any necessary reports are made to the HSE.

The line manager should also make sure that when a patient is involved, the patient is informed that the event has occurred and with their consent and where appropriate their relatives are contacted and told. Transport home should be arranged for casualties if this is required.

In the event of an incident where serious harm has occurred, the line manager should arrange a de-brief session for all staff affected by the incident. Depending on circumstances, this may be conducted as one-to-one sessions or in groups. Availability of a counselling service for staff should also be considered.

The line manager must also make sure that a detailed accurate account of the incident is documented in the patient's records. This will ensure full communication is guaranteed regarding incidents, especially in cases where the patients are moving around the organisation.

9.3.3 Completing the Incident Report form

All incidents, no matter how trivial, must be reported using an Incident Report form (see Appendix 9.D). If more than one person is directly affected by an event, a separate form must be completed for each.

As far as possible, an incident report form must be completed by the person(s) involved in the incident. The line manager may help with this if necessary. If it is not possible for the person(s) involved to complete their form, it should be completed by the line manager with help from witnesses where required. In any case, the form(s) should be completed and submitted before the personnel involved go off shift, and at the most within 48 hours of the event.

Local procedures must specify where and to whom copies of the report shall be sent. However, the following must be observed:

- In all cases, the form must be sent within 48 hours to the nominated person, for example, the Health and Safety Advisor.
- A copy should be kept in the department where the event occurred.
 - Staff report forms should be filed with departmental personnel records.
 - Patient report forms should normally be filed in the patient notes.
- If an event occurs in a communal area or off-site, a copy should go to the department with responsibility for the patient or staff member.
- If an event occurs to a visitor in a communal area, a copy should also be sent to the Health and Safety Advisor or other nominated person.

Managers should check specific local arrangements.

9.4 Data management

Upon receipt of a form, the nominated person will make or verify that a report has been made to the necessary agencies, specifically the Health and Safety Executive (HSE), using an approved system. Incident data will then be recorded in the organisation's risk management system.

Departments will be encouraged to use the collated information to monitor the effects of local risk controls and as part of their risk identification system. Incident trends and statistics will inform the development of future risk management strategies and the Organisation Risk Register.

Individual managers or departments may request data from the Health and Safety Advisor or Clinical Risk Manager where appropriate.

9.5 Incidents requiring investigation

All individuals involved directly or indirectly in patient care must report any event or circumstance arising during NHSScotland care that could have or did lead to unintended or unexpected harm, loss or damage.

To work out the degree to which the incident needs to be investigated, all incidents must be graded using an Incident Grading Matrix.

(An example of a grading matrix is set out at Appendix 9.E).

Two gradings should be documented on the Incident Report Form:

- Grading 1: Actual outcome of this incident
This should be identified in terms of harm etc and the appropriate grading documented.
(See Step 1 in Appendix 9.E.)
- Grading 2: Future potential risk if this incident happens again.
The likelihood of a similar incident recurring in your area is selected from Step 2 in Appendix 9.E. In practice, this is subjective and will depend on the knowledge and expertise of the line manager. Staff should take expert advice if they are unsure – incidents may well fall outside the immediate experience of those involved. Wherever practicable, a consensus view should be arrived at by two or more persons with some knowledge of the potential likelihood of a similar incident recurring. Then, the most likely consequence of the incident if it did happen again is selected from Step 3. The grading is then made to establish the risk category - high, moderate, low or very low. Grading 2 can now be documented in the Incident Report Form (Appendix 9.D).

The level of investigation for incidents is determined by the grading given for Future Potential Risk, regardless of whether the grading of the actual outcome was a near miss or serious adverse incident.

9.5.1 Very Low category incidents

All incidents should be reported. If incidents fall into the green category for potential future risk i.e. at step 3 of the matrix, a report form must still be completed and sent to the nominated person. No further action is required at department level at this time and the reports will be reviewed on an aggregate basis. Any trends that are subsequently identified can be discussed with appropriate staff and solutions determined and shared.

Each incident analysis/investigation contains a series of steps, which should be followed as a matter of routine.

9.5.2 Low to Moderate category incidents

Line managers will be required to instigate appropriate analysis and where necessary, appropriate specialists, for example, the Health and Safety Advisor or Clinical Risk Manager may be called for advice and support.

If the incident occurs as a result of a problem with, or failure of, medical equipment including infusion devices, the Technical Services manager (or equivalent person) must be informed immediately or at soon as possible if the incident occurs outwith normal working hours. This is to make sure that the equipment is withdrawn from use and that the incident is recorded in the relevant device register of Serious Adverse Incidents including subsequent action taken.

The Technical Services manager is responsible for reporting infusion device incidences to the manufacturer, the Organisational Equipment Advisory Group, the Management Executive and the Medical Devices Agency.

Incidents involving infusion devices include errors in:

- prescribing;
- dose calculation;
- rate of infusion;
- preparation of infusion solution;
- setting up of the infusion device;
- malfunctioning of the device; and
- tampering.

9.5.3 Major Category – Serious Incidents

All of these incidents will be investigated by the appropriate professional head who will take the lead. Guidance notes for significant event analysis are provided in Appendix 9.F.

The relevant professional head leading a serious incident investigation, can, where deemed appropriate, instigate procedures from local Major Emergency procedures.

If a serious incident occurs out of hours, the on-call manager should be contacted and they will inform the appropriate Senior Manager/Director as soon as possible.

9.6 Dealing with the media

Managers should expect media interest in any serious incident within the organisation, and prepare for it. NHSScotland is particularly at risk where a child or vulnerable elderly patient is involved, for example, if the wrong treatment is given, or where groups of people are at risk due to failures in a diagnostic reporting process, or if there has been an outbreak of food poisoning.

At all times patients and relatives must be notified before the media.

Communications with media will only be via the Chief Executive, other senior manager identified for the purpose or the Communications Manager. Contact can be achieved through a variety of means including a press conference, the releasing of press statements or being available for *ad hoc* press enquiries.

APPENDIX 9.A

Definitions of terms

1 Major injury

RIDDOR defines a major injury as any of the following:

- any fracture, other than to the fingers, thumbs or toes;
- any amputation;
- dislocation of the shoulder, hip, knee or spine;
- loss of sight (whether temporary or permanent);
- a chemical or hot metal burn to the eye or any penetrating injury to the eye;
- any injury resulting from an electric shock or electrical burn (including any electrical burn caused by arcing or arcing products) leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- any other injury -
 - leading to hypothermia, heat-induced illness or to unconsciousness, requiring resuscitation, or
 - requiring admittance to hospital for more than 24 hours;
- loss of consciousness caused by asphyxia or by exposure to a harmful substance or biological agent;
- either of the following conditions which result from the absorption of any substance by inhalation, ingestion or through the skin -
 - acute illness requiring medical treatment; or
 - loss of consciousness;
- acute illness which requires medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material.

2 Dangerous occurrences

According to RIDDOR a dangerous occurrence is any of the following incidents.

2.1 Lifting machinery, etc.

The collapse of, the overturning of, or the failure of any load-bearing part of any:

- lift or hoist;
- crane or derrick;
- mobile powered access platform;
- access cradle or window-cleaning cradle;
- excavator;
- pile-driving frame or rig having an overall height, when operating of more than seven metres; or
- fork-lift truck.

2.2 Pressure systems

The failure of any closed vessel (including a boiler or boiler tube) or of any associated pipework, in which the internal pressure was above or below atmospheric pressure, where the failure has the potential to cause the death of any person.

2.3 Overhead electric lines

Any unintentional incident in which plant or equipment either:

- comes into contact with an uninsulated overhead electric line in which the voltage exceeds 200 volts; or
- causes an electrical discharge from such an electric line by coming into close proximity to it.

2.4 Electrical short circuit

Electrical short circuit or overload attended by fire or explosion which results in the stoppage of the plant involved for more than 24 hours or which has the potential to cause the death of any person.

2.5 Biological agents

Any accident or incident which resulted or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness.

2.6 Breathing apparatus

Any incident in which breathing apparatus malfunctions:

- while in use; or
- during testing immediately before use, in such a way that it would have posed a risk had it malfunctioned while in use.

This paragraph shall not apply to breathing apparatus while it is being maintained or tested as part of a routine maintenance procedure.

2.7 Collapse of scaffolding

The complete or partial collapse of:

- any scaffold which is:
 - more than 5 metres in height which results in a substantial part of the scaffold falling or overturning; or
 - erected over or adjacent to water in circumstances such that there would be a risk of drowning to a person falling from the scaffold into the water; or
- the suspension arrangements (including any outrigger) of any slung or suspended scaffold which causes a working platform or cradle to fall.

2.8 Carriage of dangerous substances by road

Any incident involving a road tanker or tank container used for the carriage of a hazardous substance in which:

- the road tanker or tank container overturns (including turning onto its side);
- the tank carrying the hazardous substance is seriously damaged;
- there is an uncontrolled release or escape of the hazardous substance being carried; or
- there is a fire involving the hazardous substance being carried.

Any incident involving a vehicle used for the carriage of a hazardous substance, where there is:

- an uncontrolled release or escape of the hazardous substance being carried in such a quantity as to have the potential to cause the death of, or major injury to, any person; or
- a fire which involves the hazardous substance being carried.

2.9 Collapse of building or structure

Any unintended collapse or partial collapse of:

- any building or structure (whether above or below ground) under construction, reconstruction, alteration or demolition which involves a fall of more than five tonnes of material;
- any floor or wall of any building (whether above or below ground) used as a place of work; or
- any false-work.

2.10 Explosion or fire

An explosion or fire occurring in any plant or premises which results in the stoppage of that plant or the suspension of normal work in those premises for more than 24 hours, where the explosion or fire was due to the ignition of any material.

2.11 Escape of substances

The accidental release or escape of any substance in a quantity sufficient to cause the death, major injury or any other damage to the health of any person.

APPENDIX 9.B

Examples of reportable incidents

1 Personal accident

- slips
- trips and falls
- moving and handling equipment failure
- person trapped by something
- exposure and contact with harmful substance
- vehicle breakdown / road traffic accident e.g. on patient transfer
- electric shock

2 Clinical event

- fatality
- wrong operation performed
- misdiagnosis
- healthcare associated infection
- major outbreaks of infection
- needlestick injury
- infusion device failure (with/without drug incident)
- suspected foul play
- failure to follow procedure or protocol
- incorrect patient assessment
- communication problems between patient and healthcare professional
- health records not available during consultation
- delayed treatment or transfer
- unexpected peri/post-operative complication

3 Violence/abuse/harassment

- verbal aggression
- physical violence
- damage to property and/or personal belongings

4 Ill health

- work-related ill health
- failure to follow vaccination requirements
- failure to inform OHS of any health issue likely to lead to increased risk to staff, patients and relatives

5 Near miss

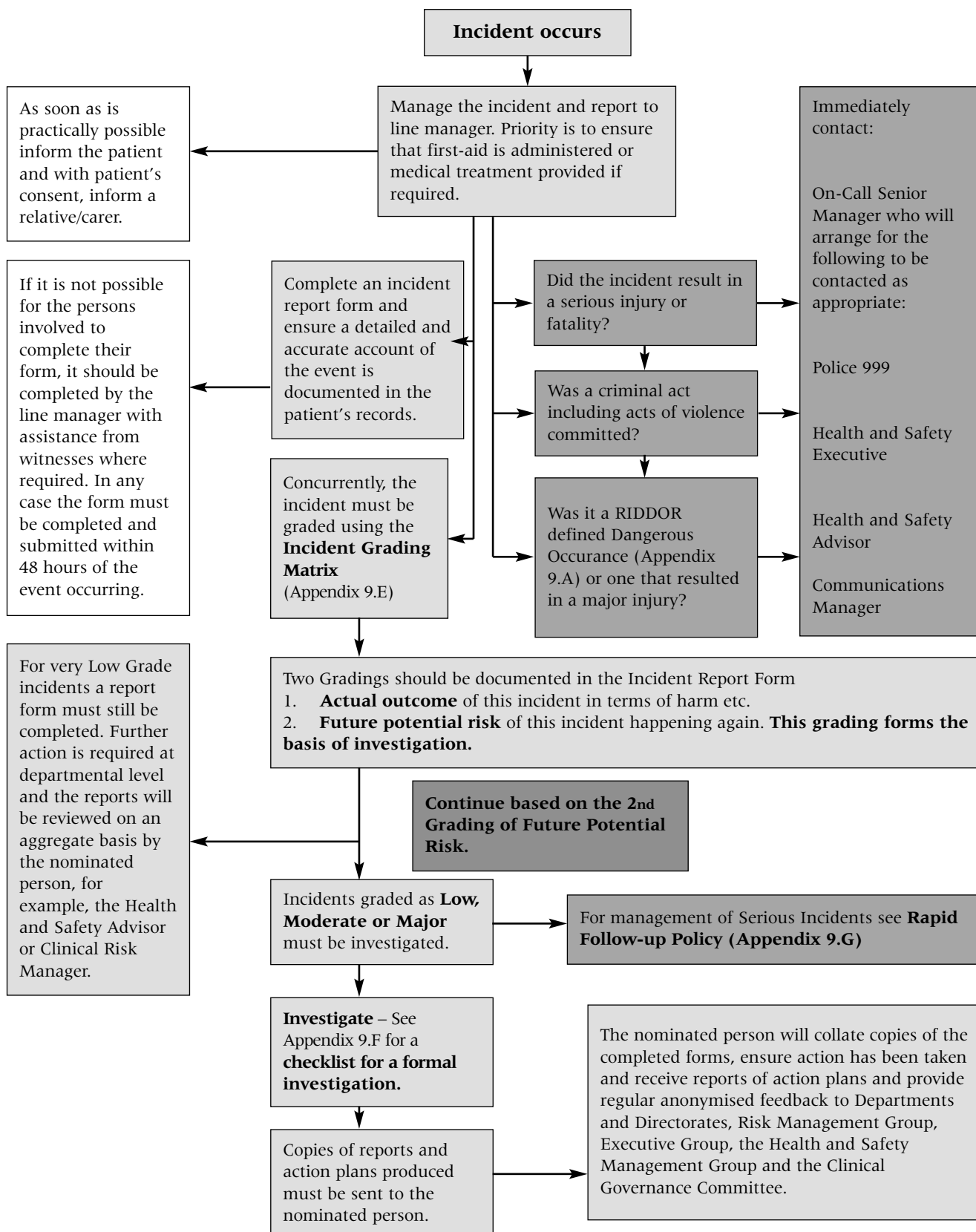
- any occasion where there is potential to lead to unintended or unexpected, harm, loss or damage to patient, carer or staff member

6 Medication/Blood Transfusion Incident

- any significant event involving drugs or blood products being prescribed or administered
- significant event involving infusion device (with drug incident)
- adverse drug reaction

APPENDIX 9.C

Incident management flowchart



APPENDIX 9.D

Incident report form

1st Copy (white): To Health and Safety Advisor
 2nd Copy (pink): To Head of Department
 3rd Copy (blue): To Directorate Manager

For Admin. Use Only
Reference:

A: The Incident: Personal Accident Clinical Incident Violence/Abuse/Harassment
 Near Miss Ill Health Drug/Blood Transfusion Error

B: (Potentially) Affected Person

Category (list 1):
 Name:
 Home Address:
 Post Code:
 Sex: F M Date of Birth
 Job Title: Employer:

C: Incident Effects

Part of Body (list 2): Left Right Both N/A
 Nature of Injury (list 3):
 Nature of Ill Health (list 4):
 Nature of Incident (list 5):
 Was/will staff member be absent from duties? Yes No Don't Know

C1: Additional Incident Details:

Patient Fall Incident: Fall witnessed Fall not witnessed
 Fall from: Bed Chair Wheelchair Trolley Commode Toilet
 Other (specify)
Sharps Incident: Clean needle/sharps Dirty needle/sharps
 Cause: Transporting Use Resheathing Disposal (sharps bin) Disposal
 Handling Waste Other (specify)
Violence/abuse/harassment: Weapon involved No weapon involved
 Nature of Incident:
 Threat of physical violence Actual physical violence Sexual Assault
 Verbal abuse Disorder or intimidation Racial harassment
 Sexual harassment Other (specify)

D: Incident Details (use Incident Management Policy Appendix 9.E)Actual Outcome (0-3): Potential Future Risk (0-3): Incident Grading: Category 0 Category 1 Category 2 Category 3 Hospital: Ward/Department: Speciality: Directorate: Exact Location:
Date (dd/mm/yy): Time(24 hr) **E: Incident Description (including contributory factors if known)**

Please give a brief description of the incident. For incidents of violence/abuse/harassment, please give name, sex and status (i.e. patient, visitor, etc.) of the assailant.

F: WitnessesName: Address: **G: Form Details**Form Completed by: Designation:

Date(dd/mm/yy)

Incident reported to: Designation:

Date(dd/mm/yy)

APPENDIX 9.E

Incident grading matrix (Example)

Immediate Impact of Incident

STEP 1 - Actual outcome in terms of harm, etc.				
None	Minor	Moderate	Major	Catastrophic
1	2	3	4	5

Description	Potential Future Risk STEP 2 Likelihood of recurrence	STEP 3 - Most likely consequences (if in doubt grade up not down)				
		None 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Will undoubtedly recur, possibly frequently	Almost certain 5	5	10	15	20	25
Will probably recur, but not a persistent issue	Likely 4	4	8	12	16	20
May recur occasionally	Possible 3	3	6	9	12	15
Not expected to happen again but is possible	Unlikely 2	2	4	6	8	10
Don't believe that this will ever happen again	Remote 1	1	2	3	4	5

Risk	Very Low	Low	Moderate	Major
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Examples of how to categorise and grade incidents

Score	Description	Consequences				
		Objectives	Cost	Clinical Impact	Schedule	Reputation
1	None	Minimal Impact No service disruption	Minimal financial loss, <£10k	No obvious harm/ injury	Minimal	No interest to the press Internal
2	Minor	Minor impact on service provision	Moderate financial loss £10-50k	First aid treatment Non-permanent harm up to 1 month	Increased level of care/length of stay 1-7 days	Some public embarrassment No damage to reputation or standing in the community
3	Moderate	Service objectives partially achievable	Significant financial loss £50-100k	Medical treatment required Semi-permanent harm up to 1 year	Increased level of care/length of stay 8-15 days Pressure on service provision	Local adverse public embarrassment leading to limited damage Local MP interest or SEHD Legal implications
4	Major	Significant impact on service provision	Major financial loss £100-1M	Extensive Injury Major permanent harm	Increased level of care/length of stay >15 days Temporary service closure	National adverse publicity Major loss of confidence in organisation
5	Catastrophic	Unable to function Inability to fulfil corporate obligations	Severe financial loss >£1M	Death	Extended service closure	Highly Damaging International adverse publicity Severe loss of public confidence Court Enforcement Public Accounts Committee Enquiry

APPENDIX 9.F

Checklist for a formal investigation

This process has been drawn up for clinical settings, but the same principles should be adapted for non-clinical settings.

Stage 1

An initial meeting should take place where possible within 72 hours of the incident, in order to:

- review the circumstances surrounding the incident;
- support those involved in the incident (staff, patients, relatives, visitors etc);
- discuss and agree if there is a need for a formal review; and
- set a date for the formal review.

This meeting should include the service manager and staff involved. In a clinical setting this meeting would also include the patient's GP or consultant.

Questions to be raised at stage 1:

- 1 Who will chair the formal review?
- 2 Who will make a record of the review?
- 3 What happened?
- 4 Was a staff member hurt? If so, what was the extent of the injury/ies?
- 5 What help was given to the staff members on duty during the incident?
- 6 Was a patient hurt? What was the extent of the injury/ies? What action was taken?
- 7 Have relatives been informed?
- 8 Were any visitors or non-Trust staff involved?
- 9 Was an incident form completed and a record made in the person's records?
- 10 Was the duty doctor and/or the person's consultant informed?
- 11 What is the person's care plan/safety care plan? Was it implemented? Did it work? Does it need to be reviewed?
- 12 Are there any service/resource/training implications?
- 13 Were other agencies involved? If yes, invite them to the stage 2 meeting.
- 14 Has the Lead Clinician/Nurse or Head of Clinical Services been alerted of any concerns about possible press response to the incident?

- 15 Is there a need for a stage 2 meeting? If yes, request Lead Clinician/Lead Nurse or Head of Clinical Services to nominate a Chairperson and inform the Organisation Audit Secretary.
- 16 Who should receive a copy of the record of the meeting?

At the end of the meeting, the convenor of the Stage 1 review is responsible for:

- notifying the General Manager, Lead Clinician/Nurse or Head of Clinical Services of any immediate actions that need to be taken because of the incident; and
- sending an initial report to the Clinical Risk Manager.

Stage 2

- 1 The stage 2 meeting should take place within 4–6 weeks of the incident.
- 2 A senior clinician or other appropriate person will chair the meeting, which will be recorded by the Clinical Office/Audit Secretary. It should involve the staff directly involved in the incident plus significant others who have responsibility for that part of the service or to the patient involved.
- 3 The minutes of the stage 1 meeting should be available and form the starting point for discussion which will expand to cover the following:
 - events leading up to the incident;
 - what happened during and after the incident;
 - person's care plan;
 - number of staff on duty;
 - level of staff on duty;
 - any shortages that may have contributed to the incident;
 - availability of staff at the time of incident;
 - environmental factors;
 - equipment failure;
 - needs of other patients present during the incident;
 - information and support needs of the family;
 - support needs of staff, including legal advice or representation, if appropriate;
 - any service/resource/training implications;
 - information to go to GP;
 - report to Clinical Risk Manager;
 - contacting the Central Legal Office if required; and
 - in the case of deaths, considering whether a Fatal Accident Inquiry is likely.
- 4 A record of the discussion and the outcomes of the review must be forwarded to:
 - the Clinical Board, where actions are identified; and
 - the Clinical Governance Group, to ensure a continuous audit of such incidents.

The Audit Secretary will retain a copy to maintain a central file of all serious incident reviews.

Stage 3

The minutes of the reviews will be audited annually to:

- identify any repeated issues;
- update the review process itself; and
- adapt standards as necessary.

APPENDIX 9.G

Rapid follow-up policy

1 Statement

Whilst the [Name of Organisation] is committed to reducing and eliminating risk, it acknowledges that there may be occasions when a significant incident has occurred that needs rapid action. The organisation will therefore:

- make sure that all necessary resources are made available to protect patients, staff and the organisation; and
- communicate verbally first with any patient or their relatives (if appropriate) and any member of staff involved before communicating with any external agencies.

2 Definition

A significant incident is a situation in which staff, or one or more patients are involved in an event which is likely to produce significant legal, media or other interest. If not managed effectively it may result in the loss of life or the loss of organisation's assets or reputation.

Examples of significant incidents include:

- death;
- death or injury where foul play is suspected;
- serious drug dispensing or administration errors;
- systematic screening errors or consistently poor diagnostic performance;
- nosocomial infection, especially legionella;
- major outbreaks of infection;
- major clinical errors;
- failures in engineering infrastructure putting patients at risk (for example, electricity, medical gases); and
- unauthorised interference with or malfunctioning of medical equipment or supplies.

3 Serious Incident Management Procedure

- Upon the occurrence of a serious incident the appropriate person in charge will take immediate measures to ensure that risk to patients, staff, equipment and property is minimised and must ensure the patient(s), and where appropriate, with their consent, their relative(s) are informed.
- Between 9am and 5pm or weekdays, the nurse in charge must inform their line manager, who will inform the appropriate Departmental/Directorate Manager, who will then inform the Clinical Director and Executive Director responsible for Risk Management.
- Between 5pm and 9am and at weekends, the line manager will inform the on-call senior manager.

The on-call senior manager will decide if the incident warrants informing immediately or the next day (if the next day – it must be by 9am): Chief Executive and appropriate Director(s).

If the event results in a fatality, the line manager must immediately contact the on-call senior manager and the Department/Directorate Manager, if between 5pm and 9am, who will then arrange for the following to be contacted as appropriate:

- the Police;
- the Health and Safety Executive (0131-247 2000);
- the Chief Executive; and
- the Health and Safety Advisor.

If it is thought that a criminal act, including acts of violence, has been committed immediate advice must be sought from the police. Call 999. Every time the police are informed or significant injury has occurred then the Departmental/Directorate Manager or on-call senior manager (if between 5pm and 9am) must be informed immediately.

If the incident is a RIDDOR-defined 'Dangerous Occurrence' or results in a major injury, the line manager must contact the Health and Safety Advisor. A message should be left if the Advisor is not available.

In the event of a serious incident where serious actual harm has occurred, the line manager should arrange a de-brief session for all staff affected by the incident. Depending on circumstances, this may be conducted as one-to-one sessions or in groups. At the debrief, the line manager should make personnel aware of the staff counselling service. An offer should be made by the line manager to arrange referrals for any staff that wish to use this service. Staff may also make direct contact with the counselling service if they prefer.

If there are multiple casualties the Senior Manager in charge will revert to arrangements within the Major Incident Procedure Manual (held in Accident and Emergency) to deal with relatives and multiple enquiries.

The Senior Manager in charge of the area where the incident has occurred will convene a Significant Incident Team which may vary according to the incident but should include:

- • Medical Director or representative;
- • Director of Nursing or representative;
- • Consultant responsible for the patient(s) if applicable;
- • Clinical Director;
- • Head of any supporting department as appropriate (for example, Pharmacy or Pathology);
- • Head of Communications or PR advisers for the organisation (if appropriate);
- • Central Legal Office (if appropriate);
- • Clinical Governance Co-ordinator; and
- • Clinical Risk Manager/Health and Safety Adviser (whichever is more appropriate).

This team will gather all the relevant information as soon as possible and decide a course of action.

4 Objectives of the Serious Incident Team

- • Make sure that all immediate necessary actions have been implemented to safeguard patients, staff and the organisation.
- • An interim report should be submitted within 14 days.
- • Make sure that the confidentiality of the patient or staff member is maintained in the context of the incident.
- • Identify an appropriate named person to be responsible for making sure there is adequate communication with the patient and their relatives.
- • Establish the accurate facts of the incident.
- • Make sure that all documentation, instruments and equipment relating to the incident are clearly identified and kept in a safe condition until the incident is deemed closed.
- • A final report of the incident, including action plan, for the Chair of the Clinical Governance Committee and the Executive Groups should be produced within 45 days.
- • Agree the content of any statement and the means of dissemination to other professionals.
- • Agree the content and timing of a press release (if appropriate) and make sure that any patient, their relatives and any staff involved have a copy beforehand.
- • Nominate an appropriate person to deal with the media.
- • Make sure that all other agencies and organisations are informed as necessary, for example, the Area Health Board, Health and Safety Executive; Scottish Executive; Medical Devices Agency; manufacturers and suppliers.

- • Produce an action plan to make sure changes are made to prevent recurrence of the incident. The action plan will include names of those responsible for implementing the actions with timescales attached.
- • Monitor the implementation of the action plan and resolve any problems encountered in doing so.
- • Decide when the incident is completed and the file closed and make sure this is communicated to all involved.

The report will set out in full:

- • the root cause of the incident, including identification of any relevant breach of policies and procedures;
- • the implications/consequences of the incident, including any disruption to services;
- • remedial action to minimise disruption to services; and
- • recommendations to prevent recurrence of the incident.

The lead for the Serious Incident Team will provide a report to the Clinical Governance Committee, Risk Management Group and the Clinical Governance Support Team who will arrange for the report to be discussed at their next formal meeting. The Director of Nursing and/or Medical Director will decide whether the report should be referred to the organisational Board for discussion. The recommendations from the incident investigation should be disseminated as widely as appropriate as part of the process of learning and continuous improvement.

5 Dealing with the Media

Managers should expect media interest in any serious incident within the organisation, and prepare for it. The NHS is particularly at risk where a child or vulnerable elderly patient is involved, for example, if wrong treatment is given or where groups of people are put at risk as a result of failures in a diagnostic reporting process or where there has been an outbreak of food poisoning.

At all times patients and relatives must be notified before the media.

We will continue to explore ways of establishing good working relationships with the media and will take every opportunity to encourage the establishment of mutual trust and understanding.

Communications with media will only be via the Chief Executive, other senior manager identified for the purpose or the Communications Manager. Contact can be achieved through a variety of means including a press conference, the releasing of press statements or being available for *ad hoc* press enquiries.