



REPORT of the ADVISORY COMMITTEE
ON
HEALTH SERVICES SECTOR
TO THE
HEALTH AND SAFETY AUTHORITY
(including Guidelines on Occupational Health and Safety Training)



Published by
The National Authority for Occupational Safety and Health
An tUdaras Naisiunta Um Shabhailteacht agus Slainte Ceirde

Price £2

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INTRODUCTION

The Health Services sector was one of those groups which came within the scope of statutory occupational health and safety legislation for the first time under the Safety, Health and Welfare at Work Act, 1989.

Though this sector is dedicated to the well-being of all the population it is a workplace and in common with all other workplaces can impact on the health and safety of the staff who work there. This sector has both its own specific hazards and those in common with all other workplaces. Based on the work of its Advisory Committee, the Health and Safety Authority in publishing this report

- is identifying the major areas for concern in the health services sector
- is prioritising areas for attention
- is recommending the actions to be taken by all those responsible for occupational health and safety within this sector.

The 1989 Act is based on the principle of prevention; a principle which if applied throughout the sector would not alone reduce personal suffering but would yield economic benefit through savings in costs, lost time, reduced insurance premiums etc.

The Authority wishes to acknowledge the valuable work undertaken by the Advisory Committee on the Health Services Sector and wishes to thank the various organisations who contributed to the Report and made representatives available to undertake the task.

SUMMARY AND RECOMMENDATIONS

The Health and Safety Authority (HSA) has overall responsibility for the administration and enforcement of the occupational safety and health system under the Safety, Health and Welfare at Work Act, 1989. The Act makes provision for the setting up of Advisory Committees to assist the Authority in its work.

The HSA decided, as a matter of priority, to establish an Advisory Committee on the Health Services Sector as this is one of the significant areas, in terms of the number of persons affected and the range of risks involved, which came within the scope of statutory legislation for the first time under the Safety, Health and Welfare at Work Act, 1989. The membership of the Advisory Committee is set out in Appendix 1.

1. TERMS OF REFERENCE OF THE ADVISORY COMMITTEE

- (a) To prioritise and advise on the principal safety and health problems in the sector;
- (b) To assess and advise on a balanced approach to enforcement in the sector having regard to information, advisory, inspection and legal possibilities;
- (c) To advise on the development of appropriate guidance notes on the application of the "general duties" in the sector and in relation to particular identified problems;

- (d) To advise on the potential for co-operation and support between the Health and Safety Authority, Government Departments, State Agencies and representative sectoral bodies in raising safety awareness within the sector; and
- (e) To report to the Board of the Health and Safety Authority.

2. APPROACH ADOPTED BY THE ADVISORY COMMITTEE

The Advisory Committee met eight times during its term of office. In its approach the Advisory Committee concentrated on three broad areas which were examined by Sub-Groups on:—

- (i) *Statistics* — on occupational accidents and illnesses in the sector in order to prioritise problems and identify solutions;
- (ii) *Safety Statements and Consultation* — the cornerstone of the preventive system in the 1989 Act;
- (iii) *Information, Education and Training* — essential elements in ensuring that an effective preventive strategy is implemented and maintained.

3. STATISTICAL BACKGROUND TO THE HEALTH SERVICES SECTOR

In all, upwards of 60,000 persons are employed in the sector. There are no comprehensive occupational accident/ ill health statistics available for this sector. Chapter 1

includes data mainly on physical accidents gleaned from several sources which confirm that, in addition to injuries from assaults and from "sharps" (needles, scalpels etc), which are particular to the employment, the sector suffers from causation factors which are common to many other employments such as persons falling, handling and lifting and machinery and equipment. Occupational ill-health in the health services sector arising from blood borne and other infections needs constant attention. Unquantified as yet, but nevertheless an area which will need examination, is the effect of work-related stress among health-care workers caused by the pressures and demands which exist in the sector.

4. SUMMARY OF MAJOR RECOMMENDATIONS

4.1 Prioritising for attention the areas of highest risk of accident and ill-health

Based on the information made available to the Committee, the principal cause factors identified, accounting for almost 60% of accidents, were:—

- **handling and lifting**

Management must ensure that heavy lifting should be avoided where possible; that lifting equipment be provided where appropriate and in the case of every employee at risk that good ergonomic principles are applied in providing training and instruction in proper lifting techniques before

being assigned duties involving lifting of any kind and that such training and instruction is repeated on a regular basis. Annual refresher courses should be provided and a record maintained of attendance at such courses.

- **persons slipping and falling**

It is recommended that hospitals use emulsion polishes intermittently on the advice of the polish suppliers.

- **assaults**

It is essential that appropriate measures be applied including training, organisational measures and the maintenance of staffing levels necessary to ensure protection of employees.

- **sharps and blood borne infections**

All staff at risk from Hepatitis B be offered vaccination at the employer's expense.

In addition, the risk for staff, in both the community and hospitals, who are in direct contact with infectious patients and material of becoming infected themselves should be faced, and hospital staff with responsibility for infection control will need to work closely with those responsible for the health and safety of staff.

4.2 Developing an approach to Enforcement of current Legislation

Except for incidents involving sharps and assault, the principal causes of accidents were similar to 0.8 those in other sectors,

including the manufacturing industry. The Advisory Committee does not consider that at this stage any specific additional legislative measures over and above the 1989 Act are called for as regards effecting improvements in health and safety in this sector of employment. The Advisory Committee took note that certain EC Directives, such as those on the workplace (89/654/EEC) and on the manual handling of loads (90/269/EEC) will, when implemented by the end of 1992, be applicable to the sector and will have direct relevance to reducing accidents such as those arising from persons slipping and falling and from handling and lifting.

The Committee believes that much can be achieved if the system of Safety Statements and Safety Consultation required under the 1989 Act is put in place quickly and effectively and if these are supported by:—

- (i) special emphasis by management on raising safety and health awareness in both management and staff throughout the sector;
- (ii) adequate attention to health and safety training within the sector;
- (iii) a level of enforcement and advice to be provided by the Authority's Inspectorate and other services;

The Advisory Committee recommends an initial target of one inspection per workplace per annum in this sector,

requiring up to four Inspectors to accomplish.

- (iv) a compulsory accident and ill health notification system, which will be required under the proposed Accident Reporting Regulations.

4.3 Guidance Literature

The Advisory Committee recommends the production of a series of guidelines on:

- patient handling and lifting;
- goods handling and lifting;
- management of Sharps Injuries and prevention of blood borne infections including Hepatitis B and HIV;
- the maintenance of floors;
- the prevention of assault.

4.4 Publication and Dissemination of the Information Identifying the Hazard

The following valuable information is included in this Report, which should be disseminated throughout the sector with the objective of increasing safety consciousness and providing information which will encourage preventive action for the future:

- Chapter 1 *Statistics — The nature of the problem;*
- Chapter 2 *The Hazards* and
- Chapter 3 *Safety Statement and Safety Consultation.*

4.5 Development of Specialised Occupational Health and Safety Services

The Committee recommends that the Health and Safety Authority should encourage and support the further development and provision of a co-ordinated Occupational Health and Safety Service within the sector.

4.6 Developing Co-Ordination Between the Various Bodies (State and others) in the Sector

The Advisory Committee noted the positive links which have already been established between the Health and Safety Authority and various representative and other bodies in the Health Services Sector. The further development of such links will be essential if a sustained impetus for preventive action is to be maintained. The objective should not only be the prevention of occupational injury and illness but in so far as possible the all round promotion of health and well-being.

The resourcing of the health services sector takes up a considerable proportion of national and other expenditure. While many of the causes of accidents and ill-health can be dealt with or eliminated at no real cost, commitment will be required in several directions from the interests involved if effective policies are to be put in place. In particular:—

- employers will need to put in place Safety Statements and Safety Consultation arrangements;

- professional bodies will need to review training requirements and employers will need to adjust training programmes;
- Government Departments and Health Boards must accept the need to have these measures taken;
- Trade Unions will need to work together to ensure effective consultation mechanisms;
- the training of Safety Representatives will need attention;
- safety and health prevention measures can be achieved in the sector through the co-operation of the employers, trade unions, insurance interests and the Authority;
- data collection can be improved through co-operation by employers, the insurance industry and others;
- the Health and Safety Authority can help to maintain the momentum towards improvements by providing a forum for review of progress on the recommendations in this report.

In making its Report to the Board of the Authority, the Advisory Committee was appreciative of the opportunity given to it to examine and comment on the principal safety and health problems and issues in the Health Services Sector. The Committee was confident that significant progress could be made through the

implementation of its unanimous recommendations.

The Advisory Committee placed on record its appreciation of the effort and assistance of Ms. Clare Eager, Secretary to the Committee, and of other staff members of the Authority who assisted in the work of producing this Report.

Mary Mulkerrin
Chairman of the Advisory
Committee
Vice Chairman of HSA
October, 1992

STATISTICS — THE NATURE OF THE PROBLEM

CHAPTER 1

Occupational Accidents and Illness in the Health Services Sector

1. BACKGROUND

The HSA Advisory Committee on the Health Services Sector, in attempting to quantify the current level and priority of occupational safety and health problems in the sector, was constrained by a lack of safety and health data. No system for the collection and analysis of data on occupational accidents and illnesses exists as yet in this and other new entrants under the Safety, Health and Welfare at Work Act, 1989.

Some data had already been collected by the Interim Board for Occupational Safety and Health for the period 1983 to 1987 with the assistance of Irish Public Bodies Mutual Insurances Ltd. (IPBMI). IPBMI also kindly assisted the Advisory Committee by the provision of overall data on a sample of over 2,000 claims or potential claims by employees against Health Boards during the period January, 1984 to December, 1990. (Appendix 4)

In order to supplement the data available and to allow for comparison and the detection of possible trends the Advisory Committee circularised 50 organisations / institutions including the eight Health Boards and 32 hospitals of various categories and geographic locations as well as various representative and professional bodies and trade unions.

The questionnaire issued (Appendix 2) was designed to allow for responses, in so far as possible, for any of the calendar years 1988, 1989 or 1990 or any available combination.

Data was sought on (a) the numbers of occupational accidents resulting in absences from normal duties for three days or more (i.e. the criteria used for the statutory notification of accidents in manufacturing industry), (b) other recorded accidents, (c) the number of occupational illnesses resulting in absence from normal duties for three days or more and (d) the total number of working days lost as a result of (a) and (c).

Data was also sought in relation to 18 specified accident causation classifications including machinery/equipment, persons falling, handling/lifting, sharps, assaults, chemical spillage etc. compared with 14 personnel categories including medical, paramedical, nursing, kitchen, domestic, laundry, maintenance, ambulance personnel and non-employees.

In respect of occupational illnesses, data was sought in relation to occupational asthma, dermatitis, hospital infections e.g. hepatitis and T.B., back injury, anxiety, stress, coronary, occupational cancer, eyes, ears and chest illnesses.

2. RESPONSES

At the time of drafting the Report, data returns had been received

from five Health Boards and nine hospitals. These had all provided information to the extent possible ranging from complete data for the full period under review, to complete data for individual years in the period, to partial data. A number of organisations indicated that while the information sought was not available in the form requested they were examining improvements in their information bases in relation to occupational accidents, illnesses and absences.

For the purposes of analysis, taking account of variations in responses received, the data was examined in the following format as detailed in the relevant Tables set out in Appendix 3:—

3. PRINCIPAL FINDINGS

(i) Accidents and Absences

Two Health Boards combined had 265 recorded accidents in 1990. Of those, 58 resulted in absences of three days or more amounting to a total of 1,729 days or an average of 30 days per accident. The total recorded accident rate per 100 employees was 2.80.

Four hospitals combined had 181 recorded accidents in 1990. Of those, 35 resulted in absences of three days or more amounting to a total of 1,279 days or an average of 37 days per accident. The total recorded accident rate per 100 employees was 6.50.

Health Board "A" had 447 recorded accidents in the three

year period 1988–1990 giving an annual average of 149 or an annual average accident rate per 100 employees of 3.46. Data on working days lost was unavailable.

In the same three year period two hospitals combined had 357 recorded accidents giving an annual average of 119 or an annual average accident rate per 100 employees of 4.40. Hospital "A" had 429 recorded accidents giving an annual average of 143 or an annual average accident rate per 100 employees of 7.90. Again full data was not available on working days lost.

Overall, on the returns received, less than 20% of recorded

occupational accidents resulted in absences of three or more days in normal duties. However, of those that did, the average absence per person was over one month.

(ii) Accident Causation

Tables 1A to 2B in Appendix 3 set out the accident causations identified in the analysed returns. Each Table comprises three parts — (a) **accident causation numbers and % of total** — (b) **principal causations and** (c) **principal causation combined with principal personnel categories affected.**

From the returns analysed the overall order of accident causations recorded was as follows:

	Causation	% of Total	Range %
1	Persons Falling	19	12–30
2	Handling and Lifting	18	13–25
3	Unclassified	13	3–30
4	Assault	11	7–16
5	Sharps	10	6–22
6	Machinery & Equipment	6	5–29
7	Hot Substances	5	8–10
8	Striking Against Objects	4	6–13
9	Falling Objects	3	5– 6
10	Miscellaneous	11	7–23

(iii) Principal Accident Causation and Principal Personnel Categories Affected

1. PERSONS FALLING		2. HANDLING AND LIFTING	
Nurses	26%	Nurses	50%
Ward Attendants	24%	Ward Attendants	20%
Kitchen Staff	11%	Ambulance Staff	8%
Domestic Staff	11%	Domestic Staff	6%
Administrative/Clerical Staff	9%		
3. ASSAULT		4. SHARPS	
Nurses	71%	Nurses	41%
Ward Attendants	17%	Domestic Staff	18%
		Porters	18%
		Ward Attendants	11%
5. HOT SUBSTANCES		6. STRIKING AGAINST OBJECTS	
Domestic Staff	37%	Domestic Staff	22%
Nurses	20%	Nurses	19%
Kitchen Staff	13%	Ward Attendants	19%
Ward Attendants	9%	Maintenance Staff	12%
Porters	6%	Kitchen Staff	6%

(iv) Comparison

The following Table sets out in comparative form the % levels of principal accident causations based on (a) the HSA Questionnaire, (b) Interim Board data from 1988 covering a sample of insurance

claims or potential claims in the period 1983 to 1987 in all Health Boards and three voluntary hospitals and (c) insurance claims data for the period 1984 to 1990 covering all Health Boards.

	CAUSATION	(A)	(B)	(C)
		HSA QUESTIONNAIRE	INTERIM BOARD	IPBMI
		% OF TOTAL	% OF TOTAL	% OF TOTAL
1	Persons Falling	19	32 (slips)	26 (slips & falls)
2	Handling & Lifting	18	31	22
3	Unclassified	13	—	—
4	Assault	11	8	13
5	Sharps	10	—	—
6	Machinery & Equipment	6	1	23
7	Hot Substances	5	5 (Burns)	—
8	Striking Against Objects	4	—	—
9	Falling Objects	3	—	—
10	Miscellaneous	11	22 (incl. falls)	16

(v) Occupational Illnesses

The returns received in relation to occupational illnesses were much less detailed than those relating to occupational accidents. Some respondents indicated that their method of recording absences from work would not facilitate differentiation between occupational illness absences and non-occupational illness absences. Back injury was the principal cause shown with a total of 199 cases recorded by all respondents. In one case 50 working days were lost. One respondent indicated that some staff members had significant absences due to dermatitis and back injuries. While none had claimed that their illness was occupational it was accepted that their occupations could have aggravated the problems.

4. GENERAL CONCLUSIONS

In examining the data collected a number of caveats need to be entered. Firstly, in the absence of a prescribed system for the recording and reporting of occupational accidents and illnesses it is likely that different criteria may apply between different Health Boards and between different hospitals. Secondly, it is also likely that different criteria may apply in relation to the type of data required by insurers for the processing of claims and the type of data which would be required by the HSA in the investigation of accidents or dangerous occurrences. Thirdly, the absence of a prescribed system would also

mitigate against the establishment of comprehensive data on the overall incidence of occupational accidents and illnesses throughout the sector. Nonetheless, the data which was obtained, taken in conjunction with the data already collected by the Interim Board and that supplied by IPBMI, was sufficient to indicate general trends and to allow for general comparisons.

The principal causation factors identified in the response to the questionnaire — persons falling; handling and lifting; assault; sharps; hot substances (burns); machinery and equipment — were generally consistent with the returns from other sources. While there were some differences under the various headings in the levels of particular causes recorded in different hospitals and Health Boards, the overall trend was reasonably consistent. As far as could be ascertained from the three sources examined the personnel categories affected were also reasonably consistent.

The principal accident causations identified were also largely similar to those which arise in the case of other sectors including manufacturing industry. Notable exceptions peculiar to the health services sector were injuries from sharps and assaults on personnel.

Many of the causations recorded, such as persons falling; handling and lifting; hot substances; striking against objects and falling objects should be preventable under a properly developed Safety

Statement coupled with appropriate and adequate safety training and information.

Such programmes can best be developed at local level to suit the needs and characteristics of the particular workplace. The Health and Safety Authority also has an important role in developing appropriate advisory and information material whether in the form of general guidelines, codes of practice or regulations. These need not necessarily be confined to any one sector but could be designed to have application across as wide a range of sectors and activities as possible. Appropriate training and information on general safety consciousness, principles of safe housekeeping and appropriate handling and lifting techniques are also essential.

While very few returns out of a total of 2,059 accidents reported under the questionnaire were caused by electricity, inhalation, radiation, explosion or biological hazards, etc., the potential consequences of exposure to hazards in such areas need to be borne in mind. Preventive standards in those areas need to be regularly reviewed and updated.

5. ACTION

The Advisory Committee was strongly of the view that a comprehensive occupational accident and ill-health data recording and reporting system is essential if effective preventive policies and programmes are to be developed and applied at national

and workplace levels. The Committee accordingly noted with approval the preparatory work which is under way within the Authority towards the establishment of such a system based on the Authority's own needs and or EC requirements.

The Authority's intention to conduct pilot studies *alia* in the health services sector, was also noted with approval.

Finally, the Advisory Committee wishes to express its gratitude to all who participated in the survey.

THE HAZARDS

CHAPTER 2

Hazard Identification, Risk Assessment and Hazard Control

A variety of occupational accidents and diseases occur among health care workers, some of which are common to many sectors of activity and others which are more likely to arise specifically in the health care sector. However, with proper organisation and management of safety and health all can be prevented or, at least, minimised.

1. PREVENTIVE MEANS

- (1) The Identification of Hazards;
- (2) The Assessment of the risks they pose in any given situation; and
- (3) The control measures.

2. THE SAFETY STATEMENT

In order to write a Safety Statement (see Chapter 3) setting out the arrangements to be deployed to secure the safety, health and welfare of the workforce it is necessary to identify the hazards and assess the risks at the place of work.

3. HAZARD IDENTIFICATION

A hazard may be described as any substance, article, material or practice which has the potential to cause harm. The first step in safeguarding safety, health and welfare is to identify all hazards associated with the workplace in a systematic manner. In addition, records of accidents, ill-health and

insurance claims can provide an indication as to the types of hazards existing in the workplace.

To identify hazards it is necessary to carefully examine the workplace, work equipment and the work practices used.

Hazards identified can be written up in the form of a Hazard Identification and Control Sheet (see example in Appendix 6)

As a working approach to identification, hazards can be loosely placed in four groups:—

- Physical Hazards
- Chemical Hazards
- Biological Hazards
- Human Factor Hazards

Physical Hazards

Examples:

machinery, falling objects, electricity, faulty equipment, poorly maintained flooring, handling tools, poor house-keeping, fire, internal transport, handling of loads, hot substances, noise, ultra violet light, sharps and radiation.

Chemical Hazards

Examples:

allergens (sensitisers), solvents, detergents, dyes, acids, carcinogens, reproductive toxins, ethylene oxide, chemotherapeutic agents, anaesthetic gases etc.

(Chemicals which are placed in the market are required to be labelled according to their hazards.

Manufacturers and suppliers are legally required to provide information on the safety and health hazards of chemical substances).

Biological Hazards

Examples:

tuberculosis, hepatitis B, HIV, rubella, other viruses and bacteria, infected body fluids etc.

Human Factor Hazards

Examples:

young workers, new or inexperienced workers, pregnant workers, disabled workers, stress inducing situations, assault, inadequate training, long hours, poorly designed shift systems, inadequate staffing levels, poorly designed work organisation etc.

Hazard identification techniques range from comprehensive systematic surveys through to a simple checklist method. The technique to be used will depend on the scale and nature of the risks in the undertaking. Where personnel in the undertaking have the competence to do so they may carry out the exercise. If the expertise does not exist in the undertaking it will be necessary to use the services of external competent persons.

However, regardless of their competence, outside consultants will not have the detailed "hands-on" experience possessed by those actually working in the area. Therefore it is essential that the

outside consultants work closely with the employees so that they can contribute to the safety process. Without this involvement the whole process (and ultimately the Safety Statement, itself) may be regarded by the employees as lacking relevance and credibility.

4. RISK ASSESSMENT

Risk Assessment is an attempt to estimate the probable happening of an event arising from any hazard and the probable consequences.

The procedures to be used in making the assessment may range from simple methods appropriate to small operations to more sophisticated methods appropriate to large institutions with a number of different types and levels of hazards.

5. SPECIFIC EXAMPLES

It is proposed here to look in more detail at some of the principal hazards facing workers in the health care sector. Many of the main hazards are going to pose a risk in a number of departments and for various health care workers. For example back injury due to patient handling may occur in the wards, in casualty or in radiology and it could affect different personnel including porters, nurses and doctors. Appendix 5 contains a non-exhaustive check list which can be used when looking for hazards in all hospital departments.

5.1 Slip and Fall Accidents

As shown earlier, slips and falls are among the main concerns involving accidents to persons in the health sector. It is intended here to show how management can act to reduce floor slip hazards as far as is practicable.

5.1.1 Polishes

Because of their nature, hospitals must maintain a high standard of floor hygiene to prevent the accumulation of bacteria. Formerly, cleaning staff used the traditional method of washing followed by polish application and buffing. There have been cases where slips were caused by over application (layer upon layer) of polish. This only applies to a wax polish. It has been shown scientifically by means of practical tests using the Tortus floor friction tester that build up of wax polish can cause slipping accidents. This is because the polish constituents contain a high level of wax which "gives" under horizontal forces exerted by a person's foot. The same experiments were carried out on emulsion polish and the results showed that conditions underfoot were enhanced when polish was applied in excess. This is because emulsions contain resins and polymers which can withstand the horizontal forces described above. Emulsions are manufactured to provide different levels of gloss ranging from fully-buffable to dry-bright.

Manufacturers are now recommending more widespread

use of emulsions even to increase the slip resistance of the traditionally smooth and dangerous marble and terrazzo floors. It has been found that some hospital cleaners wash only with disinfectant and water followed by intermittent buffing without polish. This procedure may not be good for linoleum and vinyl floors because the wearing surface is not replaced. It is recommended therefore that hospitals use emulsion polishes intermittently on the advice of the polish supplier.

5.1.2 Floor Types

Smooth hard surfaces such as marble, terrazzo, non-glazed ceramic, linoleum and vinyl provide satisfactory resistance in dry conditions because their coefficients of friction are generally above 0.4. These surfaces however are not satisfactory when wet because the coefficient of friction decreases to 0.2–0.35. Most slipping accidents occur during initial contact of the heel with the floor. In wet conditions the heel is separated from the floor by a film of water and “aquaplaning” results. Textured and profiled floor surface types are more suitable in areas likely to become wet because the projections penetrate the film and grip the foot thus preventing a slip. Wet areas in hospitals include bathrooms, sluice rooms and kitchens. Most hospitals in this country use non-glazed ceramic tiles in these areas. In most cases they will be unsatisfactory and might require attention. It is not suggested that existing tiled floors

in wet areas should be removed and replaced. The cost would probably be prohibitive. Alternative measures are:—

- Use mats in the immediate vicinity of the wet area.
- Chemically treat ceramic tiles to produce a rough texture.
- Cover the floor with proprietary non-slip PVC membrane.

The latter would be less costly than tile replacement and more efficient than mat placement. Floor specialists will advise on the choice.

5.1.3 Floor Washing

Most hospitals undertake daily floor washing between 09.00 and 12.00 hours outside visiting hours. This prevents visitors from walking on wet floors but mobile patients and staff may be exposed. It is good standard cleaning practice to erect “wet floor” cones and signs in corridors and wards as the work progresses. Corridors should be divided in half, longitudinally wherever possible, allowing pedestrians to use the dry half. Special warning is needed outside doorways and corridors because those working inside may not know that the corridor floor is wet until it is too late. A single cone positioned outside each doorway in the middle of the corridor will provide sufficient warning.

5.1.4 Footwear

Ward staff should wear rubber soled shoes with broad heels for good grip and balance. Shoes

should have high front and laced sides for support. Slip-on and clog-type footwear should not be permitted.

5.2 LIFTING ACCIDENTS

5.2.1 Patient Lifting

Lifting of patients in hospitals is a cause of concern due to the high number of recorded accidents. The problem not only prevails in this country but also in Britain. Twenty per cent of industrial injury claims in the NHS arise directly from the handling of patients. At the Royal College of Nursing Annual Congress in Britain, in 1985, it was reported that an increasing number of nurses and attendants went to Industrial Tribunals following back injuries. However, in many hospitals, little attention was paid to training to prevent such injuries and the availability and use of mechanical aids was also limited.

The drive for safer and more efficient handling techniques can best be served by the proper application of ergonomics and safety training.

5.2.2 Ergonomics

Ergonomics is a study of the relationship between workers and their working environment and is based on a broad spectrum of the human and engineering sciences. Lifting aids and hoists are designed to allocate the lifting functions to machines and must be designed so that they are comfortable to use.

Hospital beds are designed with tilting headrests to minimise the

moving of patients. The beds must be low enough so that the nurse or attendant can kneel on it during a lift thus relieving the back of unnecessary stress. The need for ergonomics and its successful application will be readily appreciated by nurses and attendants and there is every justification for management asking trained nurses for suggestions.

5.2.3 Training in Lifting Techniques

There are yet no official guidelines in this country on how training for safe handling should be conducted. In the past, training in lifting techniques has been mainly confined to the training college and recruits in hospitals. Many nurses consider that techniques learned in the training college are now out of date. In addition, the skills taught by the lecturers are not reinforced in the place of work and the learners are not supervised by competent observers. The training is thus wasted. Training in lifting techniques requires skilled instructors who are competent and keen observers.

Experience also indicates that training in handling techniques is not given to non-nursing employees, such as attendants, domestics, maintenance employees, etc., who are involved in lifting operations on a daily basis.

A Safety Management programme will ensure that each and every employee is trained and instructed in the proper techniques of lifting within twenty-four hours of their

appointment at the hospital and that such training and instruction is repeated on a regular basis. An annual refresher course should be implemented. A record of attendance at such courses should be kept.

Clearly illustrated lifting techniques are shown in "The Handling of Patients" issued by the Royal College of Nursing. There is little scientific analysis of the handling techniques described but they are the most modern teaching principles and may be summarised as follows:—

- (a) Always consider the aim and overall objective to be served by every handling task. Never lift a patient unless you have to.
- (b) Do not move a patient on your own unless you are absolutely confident this is safe — otherwise wait for help.
- (c) Assess the patient and the medical and therapeutic factors which may affect the handling method.
- (d) Always explain what you are doing to patients and get them to co-operate and help as much as their condition allows.
- (e) Always use the appropriate lifting aid or hoist.
- (f) Prepare the handling area and watch out for all hazards.
- (g) Know your own lifting capacity and the lifting capacities of all with whom you work.
- (h) The position of the feet during a lift and type of footwear worn are also critical factors.

- (i) Make sure of the hand grip.
- (j) The handler should hold the patient as close as possible — avoid over-reach.
- (k) Keep the back straight.
- (l) Use the body weight.
- (m) Rhythm and timing between handlers and patient are essential.

5.3 OTHER AREAS OF CONCERN

5.3.1 Burns and Scalds

These mostly occur in the kitchen when lifting cumbersome containers of boiling liquids. Staff should not be required to lift any objects outside their lifting capacity.

Other points worth noting include:—

- Long sleeves and rubber gloves should be encouraged.
- Identify hot surfaces (e.g. piping) and guard where practicable.
- Mop up spillages immediately.
- Boiler and steam containers must have tight fitting lids.
- Open-toed footwear should not be permitted.

5.3.2 Illumination

Illumination of stairways, ramps and single steps at all entrances, exits and other doors is important because of the high incidence of accidents in these areas. Defective switches and bulbs should be reported as soon as they are detected and should be replaced immediately. It is standard practice

to dim lights in wards and corridors in the evening for the comfort of patients. This is acceptable as long as tripping hazards are not placed in shadow.

5.3.3 Stairways, Steps and Ramps

Nosing strips on stairway steps should be firmly secured in place and level with the step tread. A continuous firmly fixed handrail is adequate on one side only up to a stairway width of 1.0m. A second handrail on the opposite side is required for widths greater than this.

Single steps are common causes of accidents and must be clearly distinguishable by a different colour from the surrounding floor; white nosing strip and proper illumination are essential.

Exterior ramps are common features in hospitals for the mobility of stretchers and wheelchairs. Those with a slope greater than eight degrees should be fitted with handrails. Snow removal and de-icing is essential in winter. Textured or profiled surfaces should be installed where possible.

5.3.4 Machinery and Equipment

A programme of inspection must be implemented to regularly examine all machinery and equipment in use in hospitals and other health care premises, including for example, trolleys, wheelchairs, stretchers, lifting aids, autoclaves and so forth. Account must be taken of equipment in use in all areas including those which may not be immediately apparent

such as maintenance workshops and agricultural operations. The objective is to ensure that machinery and equipment is fit for and only used for the jobs for which it is intended. Remedial action or replacement must take place as appropriate as soon as possible after defects are discovered.

5.3.5 Maintenance

Hospital maintenance can involve access to heights greater than the normal height because ceiling heights in hospitals are sometimes greater than in other workplaces. Particular areas of concern are window cleaning, decorating, light replacement and roof access. These activities are governed by the Construction (Safety, Health and Welfare) Regulations, 1975. The following should be highlighted:

- Straight ladders greater than 10 ft. should either be secured at the top or footed at the base. They should be inclined at an angle of 4 vertical :1 horizontal.
- The apex of painters' wooden trestles should not be "straddled" because there is no handhold.
- Scaffolds assembled with steel trestles with planks spanning between them should not be used to a height greater than 6 ft 6 in. Heights greater than this can only be safely reached by using a mobile "instant" scaffold tower.

5.3.6 Lifts, Doors and Windows

Accidents involving lifts usually occur during automatic closing of the lift landing/car doors. Safety

devices to limit the door-closing-forces require periodical maintenance by the lift maintenance contractor. Improper car sill levelling may cause trips and should be promptly reported to the contractor. Some hospitals still operate the older type "folding picket" car doors which can cause pinching accidents. The more serious limb entrapment accidents can be eliminated by installing filler bars to reduce the access openings. These type doors are being gradually replaced by solid doors.

Bearing in mind the security and safety of patients it is good practice to install window stops to restrict the opening but still permit fresh air circulation. Oversized sliding windows have been known to fall from their tracks. Back injuries can result in awkward latch positioning, stiff hinges and poorly maintained sash.

The older corridor doors in hospitals were constructed with the pivot remote from the heel with the result that a gap opens up between the door and frame as the door opens. A child's hand can be inserted in this opening and the leverage crushing force exerted by the door closing can be considerable. Techniques are available for reducing the pivot-heel distance or installing a finger guard.

5.3.7 Laundry

Amongst the most common problems encountered in laundries is dermatitis caused by handling of detergents. Some preventive measures are:—

- Provision of scoops to transfer the powder from the container to the washing machine receptacle.
- Provision of suitable rubber gloves in all size ranges. Lined gloves are most suitable because they are more comfortable and prevent sweating (a promoter of dermatitis).
- Wearing of long sleeves.
- Provision of suitable washing facilities including soap, barrier creams, hot water and towels.
- Erection of warning posters to instruct staff on the tell-tale symptoms.

Scalds in laundries are common if the washing machine equipment is defective:

- Washing powder receptacles should be spring loaded so that hot water is not ejected during the washing cycle.
- Doors should be fitted with safety latches that prevent opening during the washing cycle.
- Machines fitted with manual steam inlet valves should have a temperature gauge in order to prevent "boiling" and ejection.

5.3.8 Sharps

Broken glass and used syringes should not be disposed of in plastic sacks. These "sharps" should be disposed of in specially labelled sharps disposal containers. Those containers should be available at all sites where sharps are used or likely to be encountered. The container and its contents

should be incinerated or otherwise disposed of in an approved manner to protect waste handlers from cuts and infection. It is the personal responsibility of the person using a sharp to dispose of it carefully. Suitable information and training must be given to staff at risk.

5.3.9 Hepatitis B, HIV and Other Blood Borne Infections

Investigations indicate that the vaccine now available for Hepatitis B is suitable and safe. It is recommended therefore that all staff at risk from Hepatitis B be offered the facility of vaccination at the employer's expense.

There is also considerable discussion in relation to the risk to health sector employees from the HIV virus. If the proper precautions are taken then this risk is minimal.

The precautions include the use of suitable gloves and protective clothing when handling body fluids and excreta from patients with HIV or AIDS. Masks are required if there is a danger of splashing.

Observance of the guidelines issued by the American Centre for Disease Control (CDC) on AIDS and Hepatitis and the World Health Organisation Guidelines should go a long way to eradicating the risk from these sources.

5.3.10 Infection Control

Hospitals should have an infection control officer who should preferably be a fully qualified member of the nursing staff. In

addition, it is recommended that an infection control committee be set up in each hospital on which a member of the nursing staff and members of the surgical and medical staff should sit, together with a microbiologist if one is employed.

5.3.11 Assault

Incidents under this heading are particularly prevalent as can be seen from the statistics. They occur more frequently in accident and emergency and psychiatric facilities. It is essential that appropriate measures be applied including the maintenance of proper staffing levels in these areas in order to minimise the risks involved.

5.3.12 Children

Children's wards require particular care. The type of items that should be checked are:—

- Glass* — is it shatter proof in partitions and doors? If not, it should be replaced or a film should be placed on same to render it safer.
- Door mechanisms and jambs* — are they working properly, do they present a hazard to fingers?
- Toys* — are the toys available examined on a regular basis to ensure that they do not present a risk to the young patients?
- Are cots examined on a regular basis to ensure that they do not constitute a threat to fingers in their opening and closing mechanism?

5.3.13 The General Public

Persons coming onto the premises or grounds of a hospital or other health care centres are entitled to do so in the belief that they may do so safely. Under the 1989 Act hospitals etc. owe a duty of care to those persons to the same extent that they owe a duty of care to their patients.

5.3.14 Floors

The causes of accidents already dealt with in relation to employees refer also to visitors coming into the hospital. Floor washing should not take place during a period when visitors are expected on the premises.

5.3.15 Car Parks

Car parks must be properly maintained and pot-holes regularly filled. Car park kerbing presents a danger particularly at night and it should be painted so that it is clearly visible to people using the car park.

5.3.16 Lighting

Adequate lighting must be provided in car parks and at the entrance to the hospital. Regular inspection of lighting to ensure that it is working is essential.

5.3.17 Transportation

There are basic requirements in relation to the proper management of the motor fleet:—

- (a) Particular attention should be paid to drivers' driving licences to ensure that they are licensed to drive the vehicles they are expected to drive.

- (b) All vehicles must be regularly serviced. It is essential that a full service record is kept in relation to each vehicle. This is particularly important where outside garages carry out servicing.

- (c) The provision of proper restraints in all vehicles is essential. Special attention may need to be given to the safe transport of persons such as the young, the elderly or handicapped persons. Particular attention must be paid to this risk when vehicles are being replaced.

- (d) The suitability of vehicles in the fleet for certain tasks should be examined. Any vehicle which gives rise to the risk of a back injury to employees using it, where for example there is insufficient headroom, should be replaced.

- (e) Door locking mechanisms and steps on vehicles used for the conveyance of patients must be checked regularly for faults and any defects must be repaired immediately.

- (f) Drivers must be constantly advised to remove keys and lock vehicles when left unattended so as to prevent unauthorised use.

- (g) Drivers must be advised of the provisions of the Road Traffic Acts in respect of their driving in emergency situations. They have no immunity from prosecution and must exercise reasonable caution at all times.

5.4. PROPERTY RISKS

5.4.1 Loss or Damage by Fire

The first step in the process of risk reduction is to establish a planning programme. Fire safety planning involves:

- (a) identification of fire risks in the fullest possible sense;
- (b) establishment of a fire precautions system by laying down rules in a formalised way;
- (c) maintenance of that system by means of a regular checking procedure.

5.4.2 Identify the Risk Areas

The objective is to identify any particularly vulnerable areas, (e.g. laundry, kitchen, stores etc.) the destruction of which would cause serious interruption, and to produce an inventory of danger areas. By marking on a plan of the building all possible sources of ignition and areas or materials specially at risk, a picture will exist as to how the danger spots threaten vulnerable areas either because they are in close proximity to each other or because a fire could spread unchecked from one to another.

5.4.3 Establishment of a Fire Precautions System

This process can be tackled from five primary aspects as follows:—

- *Buildings:*
How easily could a fire spread?
- *Plant and Equipment:*
What is the fire risk involved in each item or presented by it?

- *Materials used:*
How easily can they be ignited?
- *Employees:*
How can they be trained to recognise the risk and act correctly?
- *Fire Protection:*
Is the right equipment provided in the right place?

system, once established, is maintained on a permanent basis.

5.4.5 Fire Services Act, 1981

Local Fire Authorities, as the competent authorities in respect of fire prevention, should be consulted in relation to fire hazards and precautions.

Hospitals should issue staff with a Fire Precautions Manual in concise and easily understood terms which gives advice on fire prevention and the action to be taken in the event of fire. This should cover:

- legal requirements
- basic training for fire safety
- organisation of fire protection :
persons responsible and duties
means of escape and
evacuation
- hospital floor plan showing
protected areas, escape routes
and fire exits
- structural precautions to
prevent fire spread
- fire protection equipment
- smoking rules
- maintenance for plant and
equipment
- storage arrangements
- waste collection and disposal
- security against intruders
- rules for outside contractors

5.4.4 Maintaining the System

A vital part of the planning programme is routine checking to ensure that the fire prevention

SAFETY STATEMENT AND SAFETY CONSULTATION

CHAPTER 3

Introduction

A Safety Statement is management's programme in writing, setting out how it ensures the safety, health and welfare of its employees. It is based on:—

- an identification of the hazards that exist in the workplace, and
- an assessment of the risks associated with them.

The prevention of occupational safety and health problems depends on the identification of the hazards, the assessment of the risks and the application of control measures and these must be reflected in the Safety Statement. Objectives and targets must first be set and the appropriate resources in terms of existing management expertise or new expertise must be identified and applied.

Sections 6, 7, 9, 10, 12 and 13 are the core of the Safety, Health and Welfare at Work Act, 1989. These sections are inter-linked and inter-dependent and their objective is to achieve a safe and healthy environment at the work place.

The Safety Statement will consist of a number of parts:—

- (1) A declaration confirming that the management has initiated a safety plan or programme which details the organisation's/ employer's commitment to the primary objective of ensuring the safety, health and welfare of the employees.
- (2) Details of the arrangements and resources provided at all

levels for securing safety and health in the particular employment e.g. floor cleaning arrangements, machine maintenance, fire prevention, waste disposal, etc.

- (3) The names and job titles of people responsible for safety and health in the organisation.
- (4) The Statement must also specify the co-operation required from employees in safety and health matters and must contain arrangements for consultation with employees on those matters.

While there is no definitive manner in which the Safety Statement should be set out these Guidelines attempt to show how the task of preparing a Safety Statement may be carried out in a health service employment. They supplement the general advice on Safety Statements and Safety Consultation given in the HSA publications "Guidelines on Safety Statements" and "Guidelines on Safety Consultation and Safety Representatives" first published in May, 1990.

The Safety Statement

- must be clear and succinct and use language which is readily understood by all, and
- the wording of hazard remedies and controls should be in the past or present tense e.g. "..... the hazard has been remedied" or "..... a plan (with stated time limits) is in place to remedy these hazards".

Employers such as health boards, hospitals and other institutions with

diverse activities and various categories of staff may choose to draw up a Safety Statement which is made up of a number of sections, for example a general section which contains the arrangements and resources applying to the organisation as a whole and separate sub-sections or chapters setting out the specific arrangements and resources for each work area. Each work area could have the Safety Statement with its appropriate chapter located in a prominent place. This would ensure that all employees when entering an unfamiliar work place would have ready access to the relevant safety information.

A "Master Copy" containing all parts of the Safety Statement should be kept in the organisation's headquarters.

1. COMMENCING THE EXERCISE

The following procedures reflect how the exercise may be carried out in medium to large enterprises. Smaller organisations should adapt their approach to suit the size and nature of their undertaking and the hazards arising.

The Chief Executive Officer may set up a safety management team in order to co-ordinate the preparation and writing of the Safety Statement. The composition of the team will depend on the complexity and size of the organisation. It would be essential that a senior member of management would be included on such a team to provide a co-ordinating role and

to act as a liaison between the various departments and work areas in the institution.

It is recommended that the project commence with the preparation of the general section of the Safety Statement and then move on to have the chapters for specific work areas prepared.

Steps

1. Set up safety management team to co-ordinate preparation.
2. Divide board or hospital into natural departments, on which specific chapters of the Safety Statement will be prepared e.g. Radiology, Accident and Emergency, Wards, Kitchen, etc.
3. Nominate person(s) responsible for preparation of each individual chapter.

Appendix 7 sets out in summary format and in a flow chart the principal stages in the methodical preparation of a Safety Statement.

2. GENERAL SECTION

This section will set out the safety arrangements which apply on a universal basis throughout the organisation. Each employer will have to determine the methodology which best meets the specific needs of each organisation but hereunder is guidance on possible headings for writing the Statement:—

(i) Contents

There should be a list of contents for easy reference.

(ii) Policy or Objective

A declaration, signed by the Chief Executive, confirming the employer's commitment to all the measures outlined in the written programme for ensuring the safety, health and welfare of employees should be included.

(iii) Organisation and Responsibilities of Management

Set down the names and duties of the persons nominated as responsible for performing tasks specified in the Safety Statement. Prepare an organisation chart showing the reporting routines. The chart should be easy to check and easy to revise if someone leaves or is replaced in the organisation.

(iv) Duties of Employees

These duties are clearly set out in the Act. This section might also outline the co-operation which is required from employees and where disciplinary procedures for failure to comply with safety requirements are in place, these should be specified. The system for reporting safety problems should be indicated here.

(v) Hazard Identification

Explain in this section how the organisation will identify hazards and state who will be required to carry out the identification e.g. administrator, matron, department head etc.

(vi) Maintenance

Set down the general arrangements for maintenance of the workplace, plant and equipment.

(vii) Accidents & Emergencies

Set down the procedures to be followed in the event of accidents or emergencies.

(viii) Fire Safety

Give details of the arrangements for fire prevention, fire control, fire-fighting equipment, fire alarms, fire drills and evacuation procedures.

(ix) Training and Instruction

Outline the training schedules that are in place or planned. Safety training is needed for all employees, including managers, supervisors and safety representatives. (See Report of the HSA Advisory Committee on Occupational Safety and Health Training dated February, 1992).

(x) Consultation and Information

The Statement should specify the arrangements for consultation with employees and safety representatives on all safety and health matters. Outline how the Safety Statement will be explained and brought to the attention of employees. Explain where technical information on safety standards and hazard data etc. is located.

(xi) Contractors

The terms of the organisation's Safety Statement must be brought to the attention of contractors in so far as it affects them. Conversely, if contractors are carrying out work which may affect the safety of employees, arrangements should be laid down

stating who is responsible for obtaining and examining the contractor's Safety Statement.

(xii) Welfare

Set down the arrangements which are in existence for employees' meals and other break arrangements, washing/toilet facilities, first aid arrangements etc.

(xiii) Resources

The Statement must give details of the resources provided in terms of time, people and finance to secure safety, health and welfare.

(xiv) Monitor and Review

Give details of how representations made by employees will be considered and how and when the Safety Statement will be revised and up-dated.

3. SAFETY ARRANGEMENTS FOR SPECIFIC WORK AREAS

On completion of the first draft of the general section of the Safety Statement the safety management team should present a copy to each of the heads of departments or other persons responsible for the preparation of the individual chapters. The first task in the preparation of the chapters will be hazard identification. The heads of each department or each work area should be provided with adequate training and guidelines as to how hazard identification is to be tackled, as it is necessary to ensure consistency in the carrying out of the exercise.

The headings of the individual chapters could follow the same

sequence as that of the general section.

When the written documentation and arrangements for each department have been completed, they should be returned for examination to the safety management team.

4. HAZARD IDENTIFICATION AND CONTROL SHEETS

Those safety arrangements which are adequate can be incorporated into the relevant heading of the main text. Hazards identified can be written up in the form of the Hazard Identification and Control sheets (Appendix 6). The action plan of corrective measures contained in the Hazard Control Sheets will be drawn up by management with input from appropriate employees.

5. SAFE WORK PRACTICE SHEETS

The use of Safe Work Practice Sheets has been found to be an effective way of contributing to the arrangements required for safeguarding the safety, health and welfare of persons at work (see samples in Appendix 8)

6. AN EVOLVING DOCUMENT

It is acknowledged that the initial Safety Statement will not necessarily contain the optimum safety arrangements. Both in terms of resources and expertise it will take time before appropriate safety arrangements or controls can be put in place. Thus the Safety Statement is an evolving document, and as adequate safety

arrangements come on stream the Safety Statement will be amended. Equally, as the safety audits identify new hazards and risks, corrective measures will have to be put in place and set out in the Hazard Identification and Control Sheet.

7. EMPLOYEE PARTICIPATION

While the responsibility for the preparation of the Safety Statement rests with the employer, it is necessary to ensure that employees are regularly consulted. If the Safety Statement is to have real significance and a genuine impact on the workplace, employees must be committed to implementing its terms; such commitment can be enhanced if employees have had an active role in its preparation.

TRAINING AND INFORMATION

CHAPTER 4

Introduction

The objective of training and information, apart from increasing safety consciousness is to provide relevant and comprehensive assistance in translating such awareness into positive preventive action at all levels throughout the sector.

1. TRAINING

In the area of training and information, the Committee was conscious that the HSA Advisory Committee on OSH Training was concurrently examining the issue in relation to all levels in various employments. It therefore confined its brief to a number of central points as follows:

- (i) the basic training of all health care professionals whether technical, administrative or other should include a module on health and safety;
- (ii) in-house training for all employees should include a safety element and should encompass induction, transfer and refresher training as well as training in relation to specific hazards;
- (iii) trainers within the sector should themselves have suitable training in safety and health;
- (iv) safety and health training in the sector should be co-ordinated with a named individual assigned overall responsibility within the organisation.

Training is the transmission of the knowledge, skills and attitudes

necessary to protect the health and safety of workers.

Training should complement and support the safety statement by equipping staff to cope with identified occupational hazards e.g. manual handling.

Health and safety should be an integral part of routine training so that these issues are presented as an essential component of skills acquisition and health promotion.

Safety and health training of employees in the Health Services Sector must be tackled at two levels. Firstly, to ensure specialists in safety and health, and secondly, to impart basic information on safety, health and welfare to all employees about how best to protect themselves.

Under Section 6(2)(j) of the Safety, Health and Welfare at Work Act, 1989, specialist skills in health and safety will either have to be contracted in or be available at health board or other sub-board level (i.e. larger hospitals). In the case of large employments it would be beneficial either to employ persons with the National Diploma in Occupational Safety and Health or equivalent qualifications, to advise on safety and health or to place existing employee(s) on the Diploma course.

Occupational Health and Safety Services

The Advisory Committee noted the role of Occupational Health and Safety Services and other specialist services within the Health Services

Sector in the promotion of health and the prevention of occupational injury and illness. The solutions to managing safety and health may well then point to the need for occupational physicians, occupational health nurses, occupational hygienists, occupational physiotherapists and trained occupational safety and health officers. Occupational health and safety personnel, where they are employed, must have had suitable training. They will deal with many different job categories of health care employees who may encounter problems despite the existence of a good system of safety and health at work. Because of the relationship between these employees and their working environment the occupational physician and occupational health nurse will, where they are employed, take a leading role in advising management on drawing up and implementing the safety and health system.

Occupational physicians and occupational health nurses will deal with individual cases where employees are faced with hazards including, for example, those who are under stress or who have developed allergies. They will have a special role with regard to infectious diseases and vaccination programmes. They will also have particular expertise in advising management on the fitness of health care workers for their jobs and on appropriate modifications to their duties where required. The normal rules of medical confidentiality must apply when dealing with staff.

Occupational Health Services must have sufficient independence of management at all levels to discharge their functions and this must be recognisable in the reporting arrangements in place. Occupational Health Services should not be regarded as a general medical practitioner service by employees. The confidentiality of employees' personal occupational health records must be maintained. Management, whether administrative, medical or nursing, have no right of access to such records.

While not discharging a G.P. function, Occupational Health Services should nonetheless be alert to all factors which may impinge on safety, health and welfare at the workplace. For example, stress is recognised as an important workplace issue in various sectors including the health care sector. Not only should the Occupational Health Service deal with the issue by promoting stress management techniques and by the provision of counselling assistance but it should also be addressed as a hazard in the context of the Safety Statement. This could involve the making of appropriate changes in the organisation, in the working environment, in specific tasks and in the training provided when stress factors are present.

The Occupational Health Service would also have an important contribution to make in any Safety Committee or similar consultation mechanism that exists.

Special Training Needs

The Committee recommends that the basic training of health care professionals, engineers, administrators, fire/safety and other specialist groups should include a module in health and safety.

Managers, maintenance engineers, senior nursing officers, senior administrators and equivalent staff should have basic training in health and safety, such as a Foundation Course or similar level courses. Health Service safety representatives will require appropriate training in order to carry out their duties as detailed in Section 13 of the Safety, Health and Welfare at Work Act, 1989. The H.S.A. Advisory Committee's Report on O.S.H. Training includes a recommended course content for Safety Representative training.

It is essential that Safety Representatives have the knowledge and skills necessary to perform their functions effectively. They should be knowledgeable enough about safety and health matters to make a responsible and practical contribution to safety and health at work.

The Barrington Commission observed that Safety Representatives (and others involved in safety consultation such as Safety Committee members) would have two distinct training needs. The Commission suggested that trade unions would provide training on Safety Representatives' functions in general. The employer would have responsibility for training Safety Representatives on

the specific hazards and safe systems of work in their own place of work. Other State and private training organisations are also likely to develop courses for the training of Safety Representatives.

A properly trained Safety Representative can make a significant contribution to improving safety and health standards. The whole organisation will benefit, from a reduction in accidents and ill-health, less time lost, cost of remedial action, etc.

Some Examples of Existing Courses in Health and Safety

(1) The National Diploma Course in Occupational Safety and Health.

This third level multidisciplinary course is for Occupational Health Nurses, Occupational Health Physicians, Occupational Safety Managers and Occupational Hygienists and others who are interested in acquiring a professional knowledge of health and safety standards and techniques.

(2) The Foundation Course and the Certificate Course in Occupational Safety and Health.

These are courses on general principles for managers, employees and others in organisations who hold responsibility for safety and health.

(3) Courses for Safety Representatives.

These are specialised courses for Safety Representatives provided by trade unions and other organisations.

(4) Other Courses:

Various bodies with specialist interests in Safety, Health and Welfare run seminars and skills training courses for managers, employees and others.

2. INFORMATION

1. Information is the key component of any safety, health and welfare programme. Information allows health care workers to:

- identify hazards and assess the risks,
- develop the skills and procedures necessary to minimise risk.

2. Each health sector employer is responsible for ensuring that sufficient information is accessible to staff to achieve these ends.

3. The Health and Safety Authority will provide a developing national databank in respect of health and safety in the health sector.

4. Each employer should access, supplement and complement this data source to provide in an accessible format the information to identify and address potential hazards.

5. Training programmes should be supplemented by specific information activities e.g.

- poster campaigns.
- inserts with pay slips.
- incentive schemes.

3. GUIDELINES/CODES OF PRACTICE.

In the light of its examination of the health and safety issues in the sector, the Advisory Committee strongly recommends that as a matter of urgency the HSA, drawing as necessary on material already available from other sources, develop and issue Guidelines on the following problems:—

- (i) Patient Handling and Lifting for Health Care Workers;
- (ii) Goods Handling and Lifting for Health Care Workers;
- (iii) Blood Borne Infections including Hepatitis B, HIV and the prevention and management of sharps injuries;
- (iv) The Maintenance of Floors in the Health Sector;
- (v) The Prevention of Assault in the Health Sector.

The Advisory Committee also strongly recommends that the HSA on a longer term basis draw up and issue Guidelines on the following:—

- (vi) The Prevention of TB in the Health Sector;
- (vii) The Prevention of Rubella;
- (viii) Waste Anaesthetic Gases;
- (ix) Disposal of Infectious Hospital Waste;
- (x) Accident Recording and Audit Techniques.

The Advisory Committee felt strongly that the issue of appropriate

Guidelines in each of the above ten areas would be the most expedient and effective initial approach. However, in the longer term, consideration would need to be given to the further development of the Guidelines as appropriate and necessary for adoption as Regulations and/or Codes of Practice under the 1989 Act. It was envisaged that the assistance of appropriate "technical" Working Groups would be essential in such a process. The Advisory Committee also recommends that a similar approach be adopted, for example, as regards such matters as the existing **Guidelines on the Safe Handling and Administration of Cytotoxic Drugs**, issued by the Irish Association for Nurses In Oncology, and the UK **Code of Practice for the Prevention of Infection in Clinical Laboratories and Post-Mortem Rooms** (based on the "Howie Report") which is currently under review.

4. RESPONSIBILITY

Under the Chief Executive, an individual named in the Safety Statement should be assigned specific overall responsibility for health and safety training in individual Health Service employments. Those who carry out the training should themselves have had suitable training in health and safety. For control and co-ordination purposes, the provision of information, training and education in health and safety is generally a component of the management/training function.

ENFORCEMENT OF HEALTH AND SAFETY

CHAPTER 5

The Advisory Committee noted the vital role that enforcement in its broadest definition plays in ensuring that appropriate safety and health standards are attained and secured. It noted in particular the Authority's efforts since its establishment, in conjunction with other bodies, to increase awareness amongst those who work in the health services at all levels. The continued development of that aspect has already been referred to. In addition, however, the Committee was strongly of the view that advice, exhortation and information programmes in themselves will not be effective unless an appropriate enforcement service is also provided by the Authority. The Committee noted with concern that up to the date of its Report a significant proportion of inspection visits to workplaces in the sector were reactive to complaints and/or incidents.

Having regard to the range and nature of activities in the sector and the range and nature of hazards and risks, the Advisory Committee was convinced that an initial broadly based inspection programme across the sector is essential. It was also of the view that the appropriate inspection target in the sector would be one inspection visit per workplace per annum. To give effect to this objective the Advisory Committee recommends that at a minimum an initial staffing complement of four full time Inspectors would be required by the Authority if it is to make any recognisable enforcement impact in the sector.

In addition to the advisory and information elements such enforcement should encompass as necessary the various "notice" and other procedures provided for in the Safety, Health and Welfare at Work Act, 1989 up to and including the initiation of prosecutions. The principal notice procedures are as follows:—

(i) *Improvement Directions and Plans (Section 35).*

Where there is or is likely to be risk to safety and health of persons an Inspector under the Act may serve an improvement direction. This directs the employer to submit a plan setting out the proposed remedial action.

(ii) *Improvement Notice (Section 36).*

Where there is contravention of any statutory provisions an Inspector may issue an improvement notice. This notice includes the specific provisions being contravened and a timescale in which to remedy matters.

(iii) *Prohibition Notice (Section 37).*

Where there is or is likely to be a risk of serious personal injury to persons at any place of work an Inspector may issue a prohibition notice.

The prohibition notice includes: details of the matters which give rise to the risk and prohibits the carrying on of the activities covered in the notice. A prohibition notice may take effect immediately if it so states.

(iv) *Court Order (Section 39).*

Where the risk to the safety and health of persons is so serious that the use of a place of work should be prohibited immediately the Authority may apply to the High Court for a prohibition order.

IMPLEMENTATION

The Advisory Committee was concerned that there should be a clear understanding of the different roles of enforcement and implementation of safety and health standards. In line with the Robens Committee in the UK and the Barrington Commission in Ireland, the Advisory Committee stresses that the responsibility for dealing with safety and health problems at the workplace rests with those who create and manage the risks. Safety and health must be an integral part of the management process. Responsibility must rest with those who have power to make decisions and to see that they are applied.

Workers also have an interest in and responsibilities in relation to their safety and health and that of others affected by their work. They are entitled to adequate and appropriate training and information on the hazards they face and they are entitled to be consulted and to make representations on such issues. While the law and its enforcement has an important role to play it is no substitute for commitment based on clear responsibilities and powers at the workplace.

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Mr. Nicholas Keogh, I.M.P.A.C.T. (I.C.T.U.)
Fire Prevention and Safety Officer, Midland Health Board

Ms. Joan Douglas, Irish Nurses Organisation (I.C.T.U.)
Occupational Health Nurse, Bank of Ireland

Mr. Michael Layde, (Department of Health)
Assistant Principal Officer, Personnel Unit

Dr. Emily Twomey, (Faculty of Occupational Medicine)
Regional Hospital, Wilton, Cork.

Mr. Eugene Donoghue, (An Bord Altranais)
Chief Executive Officer

Mr. Alan Connolly, Development Services Manager
Irish Public Bodies Mutual Insurances Ltd,
(Irish Insurance Federation)

Mr. Tom Moloney, Chief Technologist,
(Medical Laboratory Technologists' Association)
Pathology Department, Mater Hospital

Dr. Dan Murphy, (Health and Safety Authority)
Director of Occupational Medical Services

Mr. Vincent Wall, (Health and Safety Authority)
Health and Safety Inspector

Secretary: Ms. Clare Eager

APPENDIX 1

HSA OCCUPATIONAL ACCIDENTS AND ILLNESSES

APPENDIX 2

Questionnaire for the Health Services Sector

1. Period(s) Covered

Please tick appropriate box(es)

1st January, 1988 to 31st December, 1988

☐

1st January, 1989 to 31st December, 1989

☐

1st January, 1990 to 31st December, 1990

☐

Other — please specify

☐

2. Name of Organisation

**3. Average Total Number of Employees
in Period(s) Covered**

☐

**4. Occupational Sickness Absences Recorded
as follows**

4.1 Total number of Occupational Accidents resulting
in absence from normal duties for three days or
more

☐

4.2 Total number of working days lost due to
4.1 above

☐

4.3 Total number of Occupational Illnesses resulting
in absence from normal duties for three days
or more

☐

4.4 Total number of working days lost due to
4.3 above

☐

4.5 Total number of incidents resulting in absences
of less than three days or no absences.

☐

5. Occupational Illnesses

5.1 Occupational Asthma

☐

5.2 Dermatitis

☐

5.3 Hospital Infections e.g. Hepatitis, T.B.

☐

5.4 Back Injury

☐

5.5 Anxiety/Stress/Coronary

☐

5.6 Occupational Cancer

☐

5.7 Eyes/Ears/Chest

☐

5.8 Other

☐

ACCIDENT AND ILLNESS ANALYSIS CAUSATION 12

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	TOTAL
PERSONNEL CATEGORY	Machinery/ Equipment	Hot Substances	Hand Tools	Falling Objects	Persons Falling	Handling/ Lifting	Striking Against Objects	Electricity	Transport/ Trolleys	Sharps	Fire	Noise	Inhalation	Assault	Radiation	Explosion	Chemical Spillage	Biological Hazards	Others	
1. Medical																				
2. Paramedical i.e. X-Ray Pathology Laboratory Physiotherapy Others																				
3. Nursing																				
4. Kitchen Staff																				
5. Domestic Staff																				
6. Laundry Staff																				
7. Ward Attendants																				
8. Porters																				
9. Maintenance																				
10. Ground Staff & Agricultural Work																				
11. Ambulance Services																				
12. External Community Workers (Nurses and Social Workers)																				
13. Administrative and Clerical Workers																				
14. Non Employees																				
15. Others--please specify																				
TOTAL																				

ANALYSIS OF ACCIDENT CAUSATION AND PERSONNEL CATEGORY AFFECTED

APPENDIX 3

Table 1A

Returns from five Health Boards (1988 - 1990)

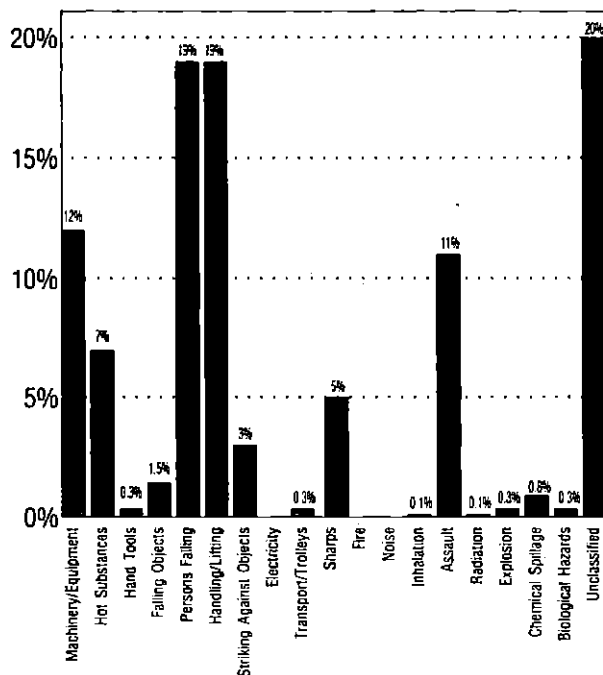


Table 2A

Returns from seven Hospitals (1988 - 1990)

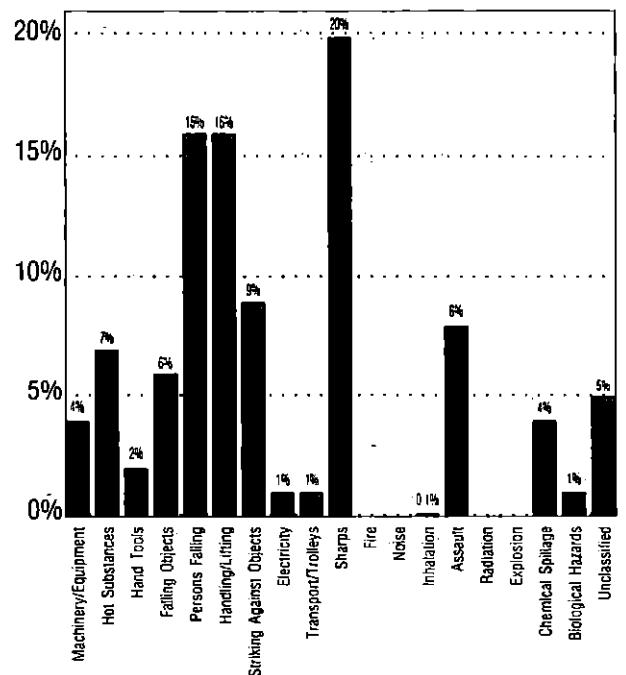


Table 1B

Health Boards: Percentage Accident
Causation by Occupation

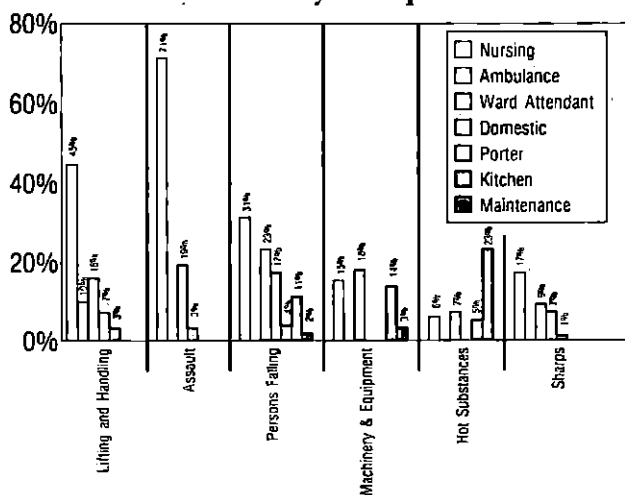
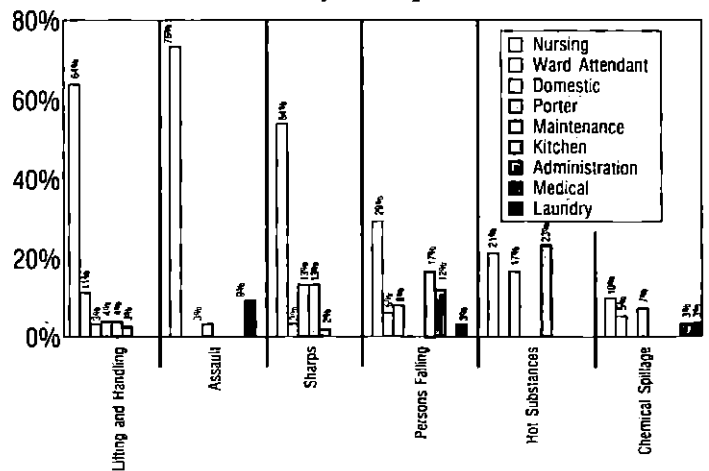


Table 2B

Hospitals: Percentage Accident
Causation by Occupation



All Health Boards

A sample of 2,341 claims or potential claims by employees against Health Boards during period January, 1984 to December, 1990 Sorted by Cause

SLIP/TRIP		615	26%
MACHINERY	(Equipment/Domestic 338 Equipment/Industrial 197)	535	23%
LIFTING	(Attendant 200 Nurse 164 Ambulance 47 Other 99)	510	22%
ASSAULT		312	13%
MISCELLANEOUS		369	16%

All Health Boards

A sample of 2,341 Claims or Potential Claims by Employees Against Health Boards During Period January, 1984 to December, 1990 Sorted by Occupation

ATTENDANT/ DOMESTIC	(Domestic 180 Catering 204 Porter 77)	Attendant 472 Cleaner 13 Laundry 47)	983	42%
NURSE			607	26%
UNKNOWN			187	8%
GENERAL OPERATIVE			96	4%
TRADESMAN	(Carpenter 25 Fitter 23 Plumber 18 Painter 7)	Electrician 14 Bricklayer 2 Plasterer 12)	101	4%
COOK/CHEF			66	3%
AMBULANCE MAN/DRIVER			47	2%
CLERICAL			32	1%
DRIVER—GENERAL			28	1%
HOME HELP			24	1%
GROUNDSMAN			18	1%
DOCTOR/SURGEON			14	0.5%
RADIOGRAPHER			12	0.5%
FARM LABOURER			19	0.8%
MISCELLANEOUS			108	5%

**INSURANCE
INDUSTRY
RETURNS**

APPENDIX 4

All Health Boards

*A sample of 1,232 Claims or Potential Claims by
Employees Against Health Boards During Period January,
1984 to December, 1990 Sorted by Department*

WARDS	(Ward 456, Corridor 68, Hall 19, Sluice 13, Stairs 35, Bedroom 5)	596	48%
CATERING	(Kitchen 242, Dining Room/Canteen 39, Washup Area 7)	288	23%
GROUNDS		72	6%
PREMISES OTHER THAN HEALTH BOARD		38	3%
OFFICES	(Offices 9, Records 4, Pharmacy 5, Stores 18)	36	3%
BOILER HOUSE		32	3%
WORKSHOP		29	2%
TOILETS/BATHROOM		24	2%
THEATRE		17	1%
AMBULANCE		14	1%
X-RAY DEPT		13	1%
CASUALTY		10	1%
DENTAL CLINIC		7	1%
NURSES HOME		6	0.5%
PEST CONTROL		5	0.5%
MISCELLANEOUS		45	3.6%

Check list for Identifying some of the Hazards associated with work in the HEALTH SERVICE SECTOR.

The following is a non-exhaustive check list identifying some of the Hazards associated with work in the Health Service Sector under four main headings. This list must only be used as a guide.

1. PHYSICAL HAZARDS
2. CHEMICAL HAZARDS
3. BIOLOGICAL HAZARDS
4. HUMAN FACTORS (PSYCHOSOCIAL) HAZARDS

PHYSICAL HAZARDS

ERGONOMIC

- LIFTING ● STRETCHING ● STRAINING
- PUSHING/PULLING

GENERAL

- UNGUARDED HEIGHTS ● SLIPPY FLOORS ● BAD HOUSEKEEPING ● DANGEROUS STAIRS ● FALLING OBJECTS ● ACCESS ● OVERCROWDING ● SLURRY TANKS (ON FARMS)

ELECTRICAL

- WIRING ● PORTABLE MACHINES ● SOCKETS
- PLUGS ● FUSE BOXES ● SWITCHES ● TRAILING CABLES ● BARE WIRING ● LIGHT FITTINGS ● HIGH AND LOW VOLTAGE EQUIPMENT ● TEST EQUIPMENT

RADIATIONS

- IONISING RADIATIONS* ● RADIONUCLIDE USE*
- RADIONUCLIDE DISPOSAL* ● ULTRASOUND ● NOISE
- ULTRAVIOLET ● MICROWAVE ● NUCLEAR MAGNETIC RESONANCE ● LASER EQUIPMENT

*ENFORCEMENT AND TECHNICAL ADVICE IN THE AREA OF IONISING RADIATIONS IS THE RESPONSIBILITY OF THE RADIOLOGICAL PROTECTION INSTITUTE OF IRELAND (R.P.I.I.) CLONSKEAGH SQUARE, DUBLIN 14.

HEAT

- AUTOCLAVES ● STERILISERS ● WASHING MACHINES
- COOKING EQUIPMENT ● STEAM PLANT AND COOKERS

FIRE

- RUBBISH ● IGNITION SOURCES ● OXYGEN ● FLAMMABLE GASES ● OTHER CHEMICALS ● STATIC SOURCES (IN THEATRE)

NON EXHAUSTIVE HAZARD IDENTIFICATION CHECKLIST

APPENDIX 5

MACHINERY

- MACHINE TOOLS ● DRILLS ● HAND HELD TOOLS
- MILLING MACHINES ● ABRASIVE WHEELS ● METAL SAWS ● WOOD-WORKING MACHINERY ● SLICING MACHINES ● DOUGH MIXERS ● MINCING MACHINES

MEDICAL EQUIPMENT

(NOTE: ELECTRICAL, BIOLOGICAL AND MACHINERY HAZARDS).

- SUCTION APPARATUS ● POSITIVE PRESSURE VENTILATION EQUIPMENT ● ANAESTHETIC EQUIPMENT
- HEART/LUNG MACHINES ● SURGICAL EQUIPMENT
- BONE BORING MACHINE ● HYPERBARIC CHAMBERS
- DEFIBRILLATION EQUIPMENT ● RENAL DIALYSIS EQUIPMENT ● ELECTROCARDIOGRAPHS
- ELECTROENCEPHALOGRAPHS

VENTILATION

- FAULTY VENTILATION/AIR CONDITIONING ● DIRTY FANS, BAFFLES, DUCTWORK, GRILLS ● FAULTY LOCAL EXHAUST VENTILATION ● FAULTY FUME CUPBOARDS
- POOR DUST CONTROL

CHEMICAL HAZARDS

- CHEMICAL DISINFECTANTS ● ISOPROPYL ALCOHOL
- SODIUM HYPOCHLORITE (CHLORINE) ● IODINE
- PHENOLICS ● QUATERNARY AMMONIUM COMPOUNDS
- GLUTARALDEHYDE ● CYTOTOXIC DRUGS
- ETHYLENE OXIDE ● FORMALDEHYDE ● FREON
- MERCURY ● METHYL METHACRYLATE ● ACIDS; PERACETIC, HYDROCHLORIC, NITRIC, SULPHURIC etc.
- IMMUNOSUPPRESSIVE DRUGS ● BENZENE ● RESIN (SKIN SENSITISERS) ● SOLVENTS ● WASTE ANAESTHETIC GASES

BIOLOGICAL HAZARDS

- AEROSOLS (COUGHING, BOILING) ● SURFACES
- BODY FLUIDS ● TISSUES ● PATIENTS
- LABORATORY CULTURES ● T.B. ● HEPATITIS
- RUBELLA ● H.I.V. ● COOLING TOWERS (LEGIONELLA)
- FAULTY BIOSAFETY CABINETS ● INFECTIOUS DISEASE UNITS ● INFECTED WASTE ● SHARPS

HUMAN FACTORS (PSYCHOSOCIAL) HAZARDS

- INADEQUATE TRAINING ● BADLY PLANNED SHIFT SYSTEMS ● POOR COMMUNICATIONS ● ASSAULT
- MANAGEMENT STYLES ● DEATHS ● MUTILATION
- ORGANISATIONAL CHANGES ● CHANGING TECHNOLOGY ● LACK OF JOB SECURITY

APPENDIX 6

RESPONSIBLE PERSON:

AUTHORISED DEPUTY

ASSESSOR:

SHEET

RISK EVALUATION: H-High, M-Medium, L-Low

SAFETY STATEMENT PREPARATION

APPENDIX 7

Summary and Flow Chart

"A Safety Statement is management's programme, in writing, for safeguarding safety and health in the workplace".

Programme Flow-Chart

The flow chart shows how the programme can be developed in an organised orderly manner. There are 5 separate parallel flow paths on which development work can proceed simultaneously. It is not absolutely necessary to stick rigidly to each step in the order in which they appear. There are distinct stages of development in each flow path, culminating in the sixth stage, namely the preparation of the Safety Statement. The flow chart can be expanded to accommodate target dates, persons responsible for development work etc.

Stage 1

Set up a safety management committee (SMC) which should, at the initial stages, include the Chief Executive Officer or his/her deputy, together with other senior management officers, for example personnel, finance, technical etc.

Stage 2

First meeting of SMC. Divide and list hospital/board into individual sections, e.g. radiography, catering, maintenance etc. Prepare organisation tree to explain safety functions and assign responsibilities. Employees select safety representative.

Stage 3

SMC nominates responsible persons (and authorised deputies) in each section. The assessor and department heads assess work place risks and training needs. Commence collation of library and information on health, safety and welfare matters. Source videos, seminars etc.

Stage 4

SMC defines responsibilities of responsible persons. Decides on risk control measures and training modules. Clarifies employee co-operation. Sources safety publications, posters, computer data bases etc.

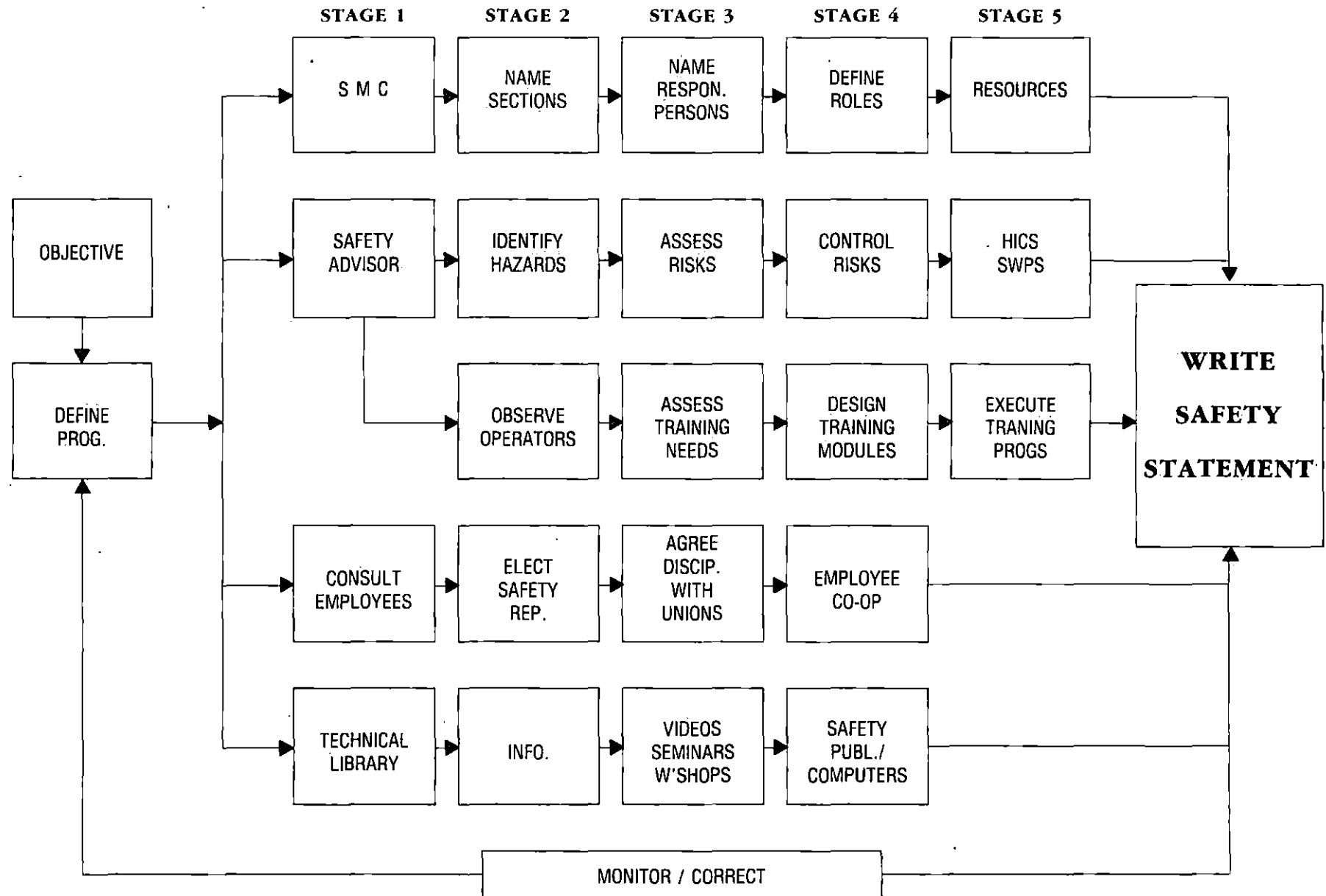
Stage 5

Assigns resources and prepares budgets. Prepares hazard control sheet, safe work practice sheets. Executes training programme.

Stage 6

Writes Safety Statement, monitors and agrees date for revision.

FLOW CHART FOR SAFETY MANAGEMENT PROGRAMME



SAMPLE SAFE WORK PRACTICE SHEETS

APPENDIX 8

Example 1

EMPLOYER: Name

DATE:

ACTIVITY: Radiology

SHEET No. 5

REVISION 0

Fume inhalation and splashes from chemicals used in the developer and fixer are major hazards in radiography. Fumes arise from mixing of chemicals e.g. formaldehyde, acetaldehyde and sulphur dioxide, ammonia or hydrogen sulphate from the processor, formaldehyde from the developer.

- Maintain room temperature below 25°C to reduce levels of formaldehyde. Fit tight covers on containers.
- Check autoprocessors and bottom of replenishment tanks daily for leaks.
- Install ducted extract system to draw fumes and heat from the processors and dryers.
- The dark room should have ventilation rates of 12-15 air changes per min.
- The processing room should be at a slight negative pressure to prevent leakages of acetic acid and sulphur dioxide smells. Air must be supplied to the room to make up for extracted air.
- Wear goggles, apron, neoprene or PVC gloves when handling concentrated chemicals or cleaning processors. Keep full face mask and canister filter available to deal with spillages or mixing of chemicals.
- Never expose parts of body to the unattenuated primary beam in the X-ray room. Stand away from the patient and use mechanical devices to support children or weak or anaesthetised patients when possible. Otherwise ensure that the same member of the staff is not used to support patients on every occasion.

Example 2

EMPLOYER: Name

DATE:

ACTIVITY: Domestic Cleaners 1

SHEET No. 34

REVISION 0

Historical data on accidents in hospitals shows that slipping on wet floors is common. Most of these accidents occur during daily floor washing exercises by domestic cleaners.

- When floor washing, erect warning signs and cones. Place one cone outside each corridor door for the extent of the affected area to alert those leaving wards, offices and ancillary rooms. When possible, wash floor in two separate longitudinal halves leaving one half dry for pedestrians.

- Tidy up trailing buffer/vacuum machine leads. Erect warning cones. Run cables along walls.
- Wear gloves when handling detergents, cleaning agents and if wringing out wet mops by hand. Rinse before taking gloves off. Dry hands well. Many skin problems occur after wet hands are replaced inside rubber gloves.
- Do not mix cleaning materials unless permitted by instructions.
- Bleaches (sodium hypochlorites) should never be mixed with lavatory cleaners, acids or other cleaning products because they can give rise to chlorine fumes which are toxic.
- Do not touch laboratory equipment, electrical apparatus or fume cupboards.
- Do not mop up laboratory spillages. Report them to your supervisor.
- Do not pick up broken glass in sinks. This should be done by laboratory technicians.

Example 3

EMPLOYER: Name

DATE:

ACTIVITY: Domestic Cleaners 2 SHEET No. 35

REVISION 0

- Exercise care when emptying waste bins — glass, sharps, contaminated towels/papers may have accidentally been left in them.
- Wear goggles when scrubbing wall tiles with cleansers.
- When spray cleaning, avoid even distant food. Aim low and never work closer than arm's length.
- Mop up spills on floors immediately. Protect the mopped area until it is dry.
- Report damaged plugs, sockets and wiring.
- Report defective equipment e.g. buffing machines must have automatic cut out when handle positioned vertically.
- Never place broken glass in a plastic sack.
- Refer to Safe Work Practice Sheet No ... on Manual Handling.
- Refer to Safe Work Practice Sheet No ... on Dermatitis.
- Refer to Safe Work Practice Sheet No ... on Aerosol Waste.
- Refer to Safe Work Practice Sheets Nos on Fire Safety.

BIBLIOGRAPHY

APPENDIX 9

List of Publications which may assist in the drawing up of Safety Statements

This list of publications is presented for illustrative purposes only, and does not purport to be exhaustive recommendations of good practice. Wherever the Term "Code of Practice" appears this does not mean that this is a Code of Practice issued or approved by the Health and Safety Authority under the provisions of Section 30 of the Safety, Health and Welfare at Work Act, 1989.

GENERAL

Ireland

TITLE: *Guidelines on Safety Statements.*

AVAILABLE FROM: The Health and Safety Authority,
Hogan Place, Dublin 2.

PHONE: (01) 6620400

TITLE: *Guidelines on Safety Consultation and Safety Representatives*

AVAILABLE FROM: The Health and Safety Authority,
Hogan Place, Dublin 2.

PHONE: (01) 6620400

TITLE: *Safety and Health in the Operating Theatre.*

AVAILABLE FROM: The Irish Nurses Organisation &
National Council of Nurses of
Ireland,
11 Fitzwilliam Place, Dublin 2.

PHONE: (01) 760137/760138

United Kingdom

TITLE: *A List of Guidance on Health, Safety and Welfare in The Health Service.*

AVAILABLE FROM: Health and Safety Executive, Library
Information Services, Broad Lane,
Sheffield S3 7HQ.

TITLE: *Care And Maintenance of Floor Surfaces. BS6263, 1982.*

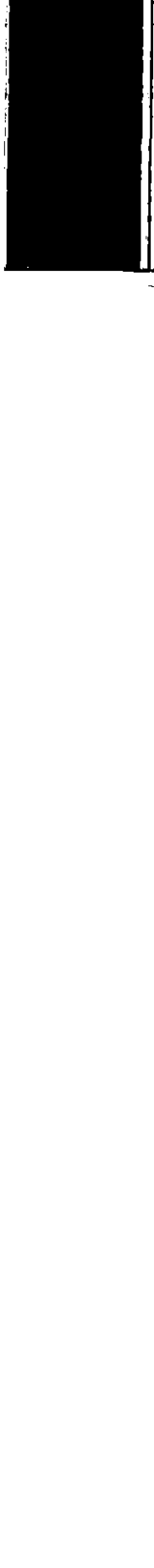
AVAILABLE FROM: Standards Sales Office, National
Standards Authority of Ireland,
EOLAS, Glasnevin, Dublin 9.

PHONE: (01) 370101.

TITLE: *Installation of Sheet And Tile Flooring. BS8203, 1987.*

AVAILABLE FROM: Standards Sales Office, National
Standards Authority of Ireland,
EOLAS, Glasnevin, Dublin 9.

PHONE: (01) 370101.



PHYSICAL

United Kingdom

Title: *Steam Sterilizers—BS3970, 1988.*
Available from: Standards Sales Office, National Standards
Authority of Ireland, EOLAS, Glasnevin,
Dublin 9.

Title: *Guidance Note, PM5: Automatically
controlled steam and hot water boilers.*
Available from: HMSO Publications Centre, P.O. Box 276,
London SW8 5DT

BIOLOGICAL

Ireland

Title: *Safe Practice Guidelines for Nurses
regarding Sharps Injury, Eye Exposure and
General Preventive measures when dealing
with Blood and Body Fluids.*

Available from: The Irish Nurses Organisation & National
Council of Nurses of Ireland, 11 Fitzwilliam
Place, Dublin 2.

Phone: (01) 760137/760138.

Title: *Special Collection of Fact Sheets on HIV,
AIDS and HEPATITIS. How to prevent
cross-infection in your surgery. (Dental).*

Available from: Dental Council, 57 Merrion Square, Dublin 2.

Phone: (01) 762226/762069

Title: *A Guide to Preventing the Transmission of
Hepatitis B, AIDS and Herpes in Dentistry.*

Available from: The Dental Council, 57 Merrion Square,
Dublin 2.

Phone: (01) 762226/762069.

United Kingdom

Title: *Code of Practice for the Prevention of
Infection in Clinical Laboratories and Post-
Mortem Rooms.*

Available from: HMSO Publications Centre, P.O. Box 276,
London SW8 5DT

Phone: (071) 8730011/8739090

Title: *Categorisation of Pathogens according to
Hazard and Categories of Containment.*

Available from: HMSO Publications Centre, P.O. Box 276,
London SW8 5DT.

Phone: (071) 8730011/8739900

Title: *Vaccination of Laboratory Workers handling
Vaccinia and related Poxviruses Infectious
for humans.*

Available from: HMSO Publications Centre, P.O. Box 276,
London SW8 5DT.

Phone: (071) 8730011/8739090

Title: *Soiled Linen Trolleys—BS2854, 1984.*

Available from: Standards Sales Office, National Standards
Authority of Ireland, EOLAS, Glasnevin,
Dublin 9.

Phone: (01) 370101.

Title: *Laboratory Furniture and Fittings—BS3202,
1959.*

Available from: Standards Sales Office, National Standards
Authority of Ireland, EOLAS, Glasnevin,
Dublin 9.

Phone: (01) 370101.

Title: *Laboratory Centrifuges — Safety
Requirements BS4402, 1982.*

Available from: Standards Sales Office, National Standards
Authority of Ireland, EOLAS, Glasnevin,
Dublin 9.

Phone: (01) 370101

Title: *Microbiological Safety Cabinets—BS5726,
1979.*

Available from: Standards Sales Office, National Standards
Authority of Ireland, EOLAS, Glasnevin,
Dublin 9.

Phone: (01) 370101

Title: *The Safe Disposal of Clinical Waste.*

Available from: HMSO Publications Centre, P.O. Box 276,
London SW8 5DT

Phone: (071) 8730011/8739090

U.S.A.

Title: *Biosafety in Microbiological and Biomedical
Laboratories.*

Available from: U.S. Department of Health and Human
Services, Public Health Service, National
Institute of Health, Bethesda, Maryland
20893.

ELECTRICAL

United Kingdom

Title: *Medical Electrical Equipment—BS5724.*
Available from: Standards Sales Office, National Standards Authority of Ireland, EOLAS, Glasnevin, Dublin 9.
Phone: (01) 370101.

Title: *Guidance Note, GS27: Protection Against Electric Shock.*
Available from: HMSO Publications Centre, P.O. Box 276, London SW8 5DT.
Phone: (071) 8730011/8739090

Title: *Guidance Note, GS37: Flexible Leads, Plugs & Sockets.*
Available from: HMSO Publications Centre, P.O. Box 276, London SW8 5DT
Phone: (071) 8730011/8739090

FIRE

Ireland

Title: *Fire Manual.*
Available from: North Western Health Board & Sligo County Fire Service, Manorhamilton/Sligo.
Phone: (072) 55123.

United Kingdom

Title: *Fire Precautions in the design & Construction of Buildings.—BS5588, 1988.*
Available from: Standards Sales Office, National Standards Authority of Ireland, EOLAS, Glasnevin, Dublin 9.
Phone: (01) 370101

RADIATION

Ireland

Title: *Safety and Health in The Operating Theatre.*
Available from: The Irish Nurses Organisation & National Council of Nurses of Ireland, 11 Fitzwilliam Place, Dublin 2.
Phone: (01) 760137/760138.

OCUPATIONAL DERMATITIS

Ireland

Title: *Guidance Notes on Prevention of Dermatitis.*
Available from: Health and Safety Authority, Hogan Place, Dublin 2.
Phone: (01) 6620400

ERGONOMIC

Ireland

Title: *Guidelines on the Safe Operation of Visual Display Units.*
Available from: The Health and Safety Authority, Hogan Place, Dublin 2
Phone: (01) 6620400

Title: *Code of Practice on Safe Lifting Techniques.*
Available from: The Irish Nurses Organisation & National Council of Nurses of Ireland, 11 Fitzwilliam Place, Dublin 2..
Phone: (01) 760137/760138

United Kingdom

Title: *The Lifting of Patients in The Health Services.*
Available from: HMSO Publications Centre, P.O. Box 276, London SW8 5DT
Phone: (071) 8730011/8739090

Title: *Office Furniture—BS5940, 1980.*
Available from: National Standards Authority of Ireland, EOLAS, Glasnevin, Dublin 9.
Phone: (01) 370101.

Title: *Mobile, Manually Operated Patient Lifting Devices. BS5827.*
Available from: National Standards Authority of Ireland, EOLAS, Glasnevin, Dublin 9.
Phone: (01) 370101.

Title: *Avoiding Low Back Injury Among Nurses, 1979.*
Available from: Royal College of Nursing, 20 Cavendish Square, London W1M 0AB.
Phone: (071) 4093333.

HUMAN FACTORS (Psychological)

United Kingdom

Title: *Violence to Staff in the Health Services*
Available from: Health and Safety Executive, Library and Information Services, Broad Lane, Sheffield S3 7HQ
Phone: (0742) 752539