Managing
Occupational Health and Safety
in General Practice
Managing Occupational Health and Safety in General Practice
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Acknowledgements

The author is thankful to all who gave their advice and assistance in production of this document, including:

Administrative and secretarial staff of the ICGP especially Ms Angela Byrne, Website Content Manager, Mr Dermot Folan, Assistant CEO and Director ICGP Management in Practice Programme & Mr Fionán O’Cuinneagáin, CEO ICGP
Dr John Cox, Co. Wexford
Dr Pauline Bowe, Co. Wexford
Dr Tony O’Brien, Co. Wicklow
Drs Michael and Deirdre Kennedy, Co. Cork
Dr Eamonn and Mrs Margaret Shanahan, Co. Kerry

About the Author

Dr Andrée Rochfort, the author, is a GP in practice in Co. Wexford and is married with four children. She has a special interest in the occupational health and safety of healthcare workers, and in the health of doctors particularly. This developed when she was one of four principal partners in a busy GP training practice in Cardiff, Wales.

She holds a Higher Diploma in Occupational Medicine from UCD and the Licentiate of the Faculty of Occupational Medicine, of the Royal College of Physicians in Ireland.

Andrée is Director of the Irish College of General Practitioners ‘Health in Practice’ programme, a system of confidential healthcare for general practitioners and their families. Her role involves co-ordination of networks of independent healthcare professionals to provide personal and occupational healthcare to general practitioners. Health in Practice also supplies health information and provides educational workshops and presentations related to the topic of managing occupational hazards and exposures to general practitioners and other medical groups.

June 2006
Managing Occupational Health and Safety in General Practice

Dr Andrée Rochfort

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January 2007
The aim of this publication is to:

• Improve and maintain high standards of the profession of general practice

• To assist in delivering a quality service from safe premises by healthy happy staff who follow safe work practices

• To provide comprehensive information and advice for the purpose of preparing or amending your safety statement but it is not a substitute for your own individual approach to safety policies

• To encourage you to nurture a safety culture within your practice

• To advise you of your obligations under the law

• To advise you where to look for further information on relevant topics and to seek out examples of good practice

Every occupation has its associated risks, but it is often erroneously believed that those of us who work in general practice have little or no risk. Have you considered the health hazards and risks of working in general practice? ‘Managing Health and Safety in General practice’ was produced because the ICGP identified a need for focussed information on the health and safety aspects of general practice in order to assist practices implement their legal and professional obligations. This information may be useful for all those who are involved in General Practice, including individual GPs, GPs direct employees and associated staff. It could also be useful to GP Units, CME Tutors, GP Trainers and GP Registrars.

Legislation dictates that GPs (both as self-employed persons and as employers) have obligations to provide a safe working environment. GPs employees also have legal obligations to co-operate with practice health and safety policies and to prevent others being hurt by their actions or omissions.

Duties of an Employer

The 2005 Act General duties of employees

It is vital that GPs are supported in their important position within the health service, and so the ICGP have produced this publication as part of its ongoing support to its members.
Consider the circumstances and working environment of general practice:

- General practice has the important role of being the first point of contact for most members of the public who access the health service.

- As part of the health service, we are deemed to be ‘in the know’ and that we should have innate immunity to illnesses and accidents.

- We are generally regarded, and in some instances by the policy makers themselves, as low-tech, low-key small enterprises compared to hospital services.

- With approximately 2,500 GPs providing services across the country, general practice has a greater throughput of patients than hospital services. A larger proportion of our patients are less acutely ill than hospital in-patients, but not necessarily less ill than many casualty department or outpatient department attendees. There is a greater volume of literature on the hazards of hospital based healthcare work despite the fact that GPs are exposed to the same medical emergencies as hospital doctors, and we have risks from much the same range of hazards as hospital based healthcare workers. Nursing and administrative staff in general practice have much the same level of exposure to occupational hazards as community based and hospital based nursing and administrative staff.

- General practice personnel, medical and non-medical, deliver a variety of healthcare services from a variety of premises with a variety of skills and variety of working styles.

- Many of us work alone (approx. 50% of GPs in Ireland are single-handed, i.e. not in partnership with another GP).

- Some of the premises we work from are owner-occupied, privately rented or health-board owned premises (or a combination of these) which in turn has repercussions for the extent of control of some elements of safety. Many of us are responsible for day-to-day running of the premises we work in, e.g. responsible for attending burst pipes, changing light bulbs, repairing broken door handles.

- Most GPs are employers, with the associated responsibilities of provision of accommodation and facilities, paying a salary and provision of training. Some of us employ family members.

- All GPs work in ‘relative isolation’ from other sectors of the health service, perhaps many miles from laboratory services and physically separate from supportive colleagues. There is often no opportunity for breaks or for lunch as GPs remain singularly responsible for attending to the days demands and addressing the administrative work.

- There is an enormous investment of family time and resources in our practices as there is in other family businesses.

- The HSA document below lists the major hazards in the healthcare sector and outlines the associated appropriate control measures.

>>[Report of the Advisory Committee on Health Services]
Executive Summary

- The ultimate goal of a safety policy for general practice must be the prevention of accidents, or the reduction of the extent of injury and harm from those that occur.

- It would be impossible to design and deliver safe working conditions in general practice without incorporating aspects of good practice management and practice organisation. Core areas that need to be assessed from the point of reducing health hazards and promoting health include time management, stress management, communication and information technology, and arrangements for working after normal working hours.

- Staff information and training has a pivotal role to play in the safe delivery of healthcare in general practice. Employees are the most valuable assets of general practice, and it makes common sense to provide staff with information and training to safeguard their health at work.

- By law, both GPs and GP employees have obligations to prevent themselves or others being hurt by their actions or omissions while they carry out work-related duties. Assessment of all the potential hazards encountered in your practice, and recording them with your safety policy, i.e. your plans to control the hazards, will assist you in fulfilling these obligations.

- Many of us in general practice are already appropriately addressing workplace health hazards and have knowingly or unknowingly put satisfactory controls in place. However, the safety aspects of general practice are dynamic, and change with new staff, new equipment, and with the introduction of new work practices. All changes require a review of the relevant section(s) of the practice safety statement in order to assess the impact of such change on health and safety.

- It is important for individual practices to adapt the advice given here, to their own particular working environments and conditions, and so it is not acceptable to simply copy a safety statement from another practice or from this publication. It may be necessary for practices to create more extensive risk management plans for the procedures undertaken by certain practice personnel or for other procedures not listed here.

- It is hoped that this publication will play its part by providing an overview of the impetus required in general practice to foster high standards of working conditions for the profession and their employees and, consequently, high standards of care for patients.

This publication is available on the ICGP website at [www.icgp.ie](http://www.icgp.ie). The Health and Safety Authority website at [www.hsa.ie](http://www.hsa.ie) is a valuable resource. Your regional Health and Safety Authority Office can be contacted for information and guidance also. Other sources of further information are given throughout and at the end of this publication.
2 Samples of practice health and safety documentation

2.1 Guidelines on risk assessments and safety statements

2.2 Sample Safety Statement

Health & Safety Statement
for the practice of
Dr Gall Stone and Dr Biliary Colic

Part 1. Practice Policy on Health and Safety Matters

This practice recognises its duties under the Safety, Health and Welfare at Work Act 2005 and the Safety, Health and welfare at Work (General Applications) Regulations 1993. The practice is committed to provide and maintain healthy and safe working conditions. It is the policy of this Practice to ensure, so far as is reasonably practicable, the health and safety of all employees while at work and of others entering the precincts of the Practice. In pursuing these objectives, the GP employers and the employees will take all reasonable steps to fulfil their responsibilities in Health and Safety.

Part 2. Organisational Arrangements

Terms used in the Safety Statement.

- A hazard is something with the potential to cause harm, and could be a substance, a piece of equipment or situation.

- A risk is the likelihood that the harm will occur and its possible severity.

- Risk assessment is the evaluation of risks. It involves identifying actual hazards and their associated risks, and quantifying the risks into high, medium or low risk.

- Risk Management involves risk assessment, and looking at existing controls and considering if further action should be taken to control the risk. Risks will need to be reassessed when there are accidents or near-accidents, changes in staff members, chemicals in use, procedures or equipment.
2 Samples of practice health and safety documentation

Employers duties are to:
1. Provide and maintain safe premises, equipment and methods of work
2. Prevent injuries by ensuring that all equipment is used in a safe manner
3. Ensure that safety aspects are fully considered in the planning, design and modification of premises; the purchase and maintenance of safe equipment and of tidy, clean premises including branch surgery, and liaising as necessary with others who control the premises or the activities in it.
4. Provide adequate information, instruction, training and supervision to all staff in order to develop safe methods of work including work outside normal hours, working alone, and use of new equipment, processes and substances
5. Take all measures to prevent fires and explosions including:
   - Information and training for staff on fire prevention, containment and fire drills
   - Provide and maintain adequate fire prevention equipment
   - Provide and maintain safe means of escape from the practice premises
6. Provide First Aid arrangements
7. Provide adequate toilet and refreshment facilities
8. Provide and ensure use of such protective clothing as is necessary for the tasks to be undertaken.
9. Keep up to date records of all accidents whether persons are injured or not. Review this record and take action to reduce unfavourable trends.
10. Review policies in the light of any guidelines set out by responsible and recognised national bodies and ensure any necessary changes are made.
11. Complying with procedures for the reporting and investigation of accidents and potentially dangerous occurrences by notifying the HSA in line with 2005 Act

This practice has appointed Nurse Swift as Safety Officer and Mrs Smiles as Deputy Safety Officer to act in the absence of the Safety Officer. The role of Safety officer and Deputy Safety Officer involves co-ordination of relevant health and safety information and implementation of safety policies in consultation with the employer. Tasks include:
1. Giving advice on how to access further safety information and publications;
2. Establishment and maintenance of procedures and plans for dealing with emergencies e.g. fire drill, needle stick injuries, violent disorder;
3. Sourcing appropriate personal protective clothing and equipment for employees with assurances and checks to ensure that they are used as required e.g. gloves and safety glasses;
4. Agreeing appropriate arrangements for the safe transport, handling and storage of hazardous materials, specimens and substances and safe disposal of hazardous wastes;
5. Indication of potential hazards by the use of notices, signs and labels, e.g. wet floor;
6. Appropriate arrangements with regard to the safety of the activities of maintenance staff and contractors working on Practice premises

The above list is not exhaustive and from time to time further advice may be issued describing the Practice’s arrangements and procedures for dealing with particular matters

Employees duties are to:
1. Take reasonable care of their own safety, health and welfare at work, and that of any other person who might be affected by their acts or omissions while at work.
2. Co-operate with the practice rules on Health and Safety and follow Practice guidelines, so as to enable the employer to comply with relevant statutory legislation.
3. Use all equipment properly and in such a way as not to endanger themselves or others.
4. Report to the Safety Officer or Deputy Safety officer immediately they detect anything that could compromise Health and Safety.
5. Report without unreasonable delay, all accidents and near-accidents to the Safety Officer or Deputy Safety Officer, whether persons are injured or not. All accidents and incidents are recorded in the Accident Book.
6. Wear appropriate protective clothing and safety equipment when required.
Consultation
All employees have a right under the Safety, Health and Welfare at Work Act 2005, to consult their employer on matters of safety, health and welfare at work. Where there are more than two employees, they may elect a safety representative to perform this function on their behalf.

Responsibilities assigned to staff members
Dr Gall Stone: has overall responsibility for Health and Safety.
Dr Gall Stone: is responsible for day-to-day administration including overseeing the updating of the Health and Safety Statement.
Dr Gallstone: is responsible for investigation of all entries in the Accident Book. Some accidents may need to be reported to the Health and Safety Authority.
Nurse Swift: is responsible for Health and Safety training of staff
Nurse Swift: is responsible for systems of the safe disposal of waste
Mrs Smiles (Secretary): is responsible for the maintenance arrangements for practice equipment.
Nurse Swift: is responsible for updating information and any changes in chemicals being used on the premises.

Safety Officer: Dr Gall Stone
Position: GP
Date: dd/mm/yyyy

Deputy Safety Officer: Nurse Swift
Position: Practice Nurse
Date: dd/mm/yyyy

Date set for annual review of the Accident Book: dd/mm/yyyy
Date set for annual review of this Safety Statement: dd/mm/yyyy
Staff will be notified of all changes.

Health and Safety Training
Training is provided for employees of the practice on matters of Health and Safety. All new members of staff will receive a copy of this Safety Statement as part of their induction training.

In-house training includes training in the safe use of equipment, use of personal protective equipment, and fire drill. Arrangements will be made for staff to obtain training in Occupational First Aid or manual handling skills where appropriate. Staff may be required to demonstrate their immunity to Hepatitis B virus where appropriate. All staff will be instructed in the immediate management of needlestick/sharps injury.

Bullying, harassment and dignity at work
This practice has an Anti-Bullying Policy based on HSA Code of Practice on Workplace bullying and HSA guidance on prevention and management of workplace bullying. Employers and employees are required to comply with the policies and procedures as detailed in the policy.

This policy document is kept with this safety statement and all staff should read it be familiar with its contents. It may be necessary to bring it to the attention of non-staff, patients and other visitors who interface with practice staff.
Interference with the goal of safe working environment
No person shall intentionally or recklessly interfere with or misuse any appliance, protective clothing, equipment or other items provided for securing the safety health or welfare of persons in connection with the practice.

Breaches of employment contract
The successful implementation of this policy requires the full support and active co-operation of all employees of the Practice. It may be a disciplinary matter (as per employee contract) for an employee not to conform to their duties as described in this Safety Statement.

Access to Safety Statement
This Statement will be kept available in reception for the use of practice staff and contractors. It may be required for inspection by an Inspector of the Health and Safety Authority.

Accident reporting:
The following accidents need to be reported to the Health and Safety Authority on Form IR1:
• When the accident causes loss of life
• When the accident/incident causes an employee to be absent from work for three consecutive days (excluding the day of accident)
• When the accident/incident occurs in connection with work activity but not on the premises and requires medical attention or results in loss of life.

In pursuance of the above general statement of safety policy the practice endeavours to provide for the maintenance of a safe entrance and exit.

The practice risk assessment was updated and completed on dd/mm/yyyy

Sample format for Practice H&S Risk Assessment

Sample practice risk assessment

Sample Safety Policy
2.6 Sample accident book / incident book entry

Date and time: 4/8/10, 8.30 am.

Place: Downstairs staff toilet

Persons involved: Mary Murphy, Receptionist

Person's account: Mary slipped on wet floor in toilet. Floor had just been washed with different cleaning fluid than usual, by new (temporary) cleaning lady. Lino on floor became extremely slippery and no sign on floor warning that floor was wet. Mary is seven months pregnant and fell backwards, hitting hip off toilet bowl. No direct abdominal injury but patient shaken by fall.

Outcome: Dr Byrne examined Mary. Baby movements felt and baby heart heard. Mary's hip bruised. Limping. Arranged for own GP to review Mary in afternoon.

2.7 Sample incident investigation

GPs and staff discussed the above incident. It was felt that the cleaner came at an awkward time in mornings when staff are busy preparing notes for morning surgery. Cleaner's working hours were changed to evening hours, after evening surgery. Part-time cleaner was advised to leave details of her routine and cleansers used in writing for temporary cleaners. All above changes occurred with full discussion and co-operation of cleaners. The cleaners contract was revised accordingly.

>> Advice on notification of accidents to the Health and Safety Authority
2.8 Sample Anti-Bullying Policy

Anti-Bullying Policy

Definition:
Workplace Bullying is repeated inappropriate behaviour, direct or indirect, whether verbal, physical or otherwise, conducted by one or more persons against another or others, at the place of work and/or in the course of employment, which could reasonably be regarded as undermining the individual’s right to dignity at work. An isolated incident of the behaviour described in this definition may be an affront to dignity at work but as a once off incident is not considered to be bullying.

(HSA Task Force on Bullying at Work, 2001)

Bullying includes aggression (physical and verbal), harassment, intimidation, shouting, and ignoring. Bullying may occur between any of the staff categories in the workplace and between all levels and involve groups or individuals, including patients and other visitors to the practice.

The employers and management of this practice will not tolerate bullying behaviour and will take appropriate steps to resolve existing bullying problems.

Consultation, participation and representation
Staff or staff representatives may participate in the production and updating of the Anti-Bullying policy through consultation with GP employer and practice management, in the same manner as producing a safety statement. Participation improves compliance by introducing a sense of ‘ownership’ and by clarifying acceptable and unacceptable behaviour at work.

Staff will be provided with information and training, where necessary for the implementation of the anti-bullying policy.

Informal Procedure
While in no way diminishing the issue or its effects on individuals, an informal approach can often resolve matters. An attempt should be made to address bullying as informally as possible by means of an agreed informal procedure.

(a) any employee who believes that he or she is being bullied should explain clearly to the alleged perpetrator(s) that the behaviour in question is unacceptable. Where a complainant finds it difficult to approach alleged perpetrator(s) directly they should seek the help of a contact person, who may be a GP, practice manager or practice nurse. The contact person should listen and be supportive and discuss the various options open to the complainant.

(b) The complainant may request the assistance of the contact person in raising the issue with the alleged perpetrator(s) the contact persons approach should be by way of a confidential non-confrontational discussion with a view to resolving the issue in an informal low-key manner.

(c) A complainant may decide to bypass the informal procedure.
Formal procedure
If the informal procedure is inappropriate or if bullying persists after the informal stage, the following formal procedures should be invoked.

(a) the complainant should make a formal complaint in writing to their GP employer(s). the complaint should confine itself to precise details of actual incidents.
(b) The alleged perpetrator(s) should be notified in writing that an allegation of bullying has been made against him / her. He or she should be given a copy of the complainants statement and advised that they will be given a fair opportunity to respond to the allegation.
(c) It may still be possible to resolve the allegation informally or through mediation at this stage. If not, or if unsuccessful then a formal investigation should proceed beginning with a determination of the facts and credibility of the allegation.

Investigation
(a) The investigation should be led by a GP or practice manager or, if deemed appropriate, an agreed third party. The investigation should be conducted thoroughly, sensitively and objectively with regard to confidentiality and with due respect for the rights of both the complainant and the alleged perpetrator(s)
(b) The investigation should be governed by terms of reference, preferably agreed between the parties in advance
(c) The investigator(s) should meet with the complainant, the perpetrator(s) and any witnesses or other relevant persons on an individual confidential basis with a view to establishing the facts of the allegation. Both the complainant and the perpetrator(s) may be accompanied by a work colleague if so desired.
(d) Every effort should be made to carry out and complete the investigation within an agreed timeframe. On completion of the investigation, the investigator should submit a written report to management / employers containing the findings of the investigation.
(e) Both parties should be given the opportunity to comment on the findings before any action is decided upon by management.
(f) The complainant and the perpetrator(s) should be informed in writing of the findings of the investigation

Outcome
(a) Should management conclude that the complaint is well founded the perpetrator should be given an formal interview to determine an appropriate course of action. Such action might include counselling, and/or monitoring the situation or progressing the issue through the disciplinary or grievance procedure of the employment.
(b) If either party is unhappy with the outcome of the investigation, the matter can be processed through the normal industrial relations mechanisms.
### Sample Format for Practice H&S Risk Assessment

#### Physical Hazards

<table>
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<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who might be at risk?</th>
<th>Categorise the risk, H, M, L</th>
<th>Action</th>
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Sample Format
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**Biological Hazards**

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Sample Format
for Practice H&S Risk Assessment

Chemical Hazards

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</table>
Sample Format for Practice H&S Risk Assessment

Psychosocial Hazards

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who might be at risk?</th>
<th>Categorise the risk, H, M, L</th>
<th>Action</th>
</tr>
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<tbody>
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</tbody>
</table>
# Sample Practice Risk Assessment

## Physical Hazards

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who is at risk?</th>
<th>Categorise the risk</th>
<th>Action</th>
</tr>
</thead>
</table>
| Access / Exit: Step, ramp, so close to busy road. | Slip, trip, falls  
Collision with vehicles | Visitors, staff | M | Mark step, sign, handrail |
| Mat (torn, curled up edge, loose) | Trip, falls | Visitors, staff | M | Remove / change / repair |
| Wet floor | Slip, trip, falls | Visitors, staff | H | Mat for floor. Warning Sign. Inspect loo floor regularly each day |
| Drawer edge, roller, unstable | Lacerations, crush | Staff | L | replace |
| Drawer contents, scissors, staples | Injury | Staff, visitors NB children | L | Lock, transfer contents |
| Over / reaching | Fall, strain, sprain | Staff | H | Staff training, rearrange access to commonly used items |
| Toys (broken) | Cuts, laceration | Visitors | M | Remove, repair |
| Glass door | Cuts, laceration | Visitors | M | Replace, |
| Exam couch lever | Cuts, crush | Visitors, staff | H | Replace, repair |
| Electrical equipment | Electrocution, trip, burns, death.  
Loss of computer information if a surge occurs. | Visitors, staff | H | Take kettles etc off floor, keep hot bulbs inaccessible, protect plugs / sockets. Surge protectors. |
| Car park | Collision, pedestrian injury | Visitors, staff | L | Signage, rules |
| Exterior surface uneven, wet leaves | Slips, trips, falls | Visitors, staff | M | Keep clear, check |
# Sample Practice Risk Assessment

## Biological Hazards

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who is at risk</th>
<th>Categorise the risk</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soiled dressings</td>
<td>Transmission of infection</td>
<td>staff</td>
<td>M</td>
<td>Handling, storage, gloves</td>
</tr>
<tr>
<td>Toys</td>
<td>Transmission of infection</td>
<td>Child patients to other children and staff</td>
<td>M</td>
<td>Wash regularly</td>
</tr>
<tr>
<td>Sharps</td>
<td>Infection, injury</td>
<td>Visitors, staff</td>
<td>H</td>
<td>Correct use of and storage of sharps bin</td>
</tr>
<tr>
<td>Samples / specimens</td>
<td>Contamination, spillage</td>
<td>Staff, visitors, couriers, licensed handlers</td>
<td>M</td>
<td>Packaging, labelling, storage, no-touch transfer,</td>
</tr>
<tr>
<td>Clinical waste</td>
<td>Infection, Spreading by dogs / rodents, Fire hazard</td>
<td>Staff, others</td>
<td>H</td>
<td>Segregation from general refuse. Keep records of its movements for liability purposes. Safe storage.</td>
</tr>
<tr>
<td>Food storage</td>
<td>contamination</td>
<td>staff</td>
<td>L</td>
<td>Keep separate from vaccinations &amp; stored specimens</td>
</tr>
<tr>
<td>Hep B &amp; other blood borne viruses</td>
<td>infection</td>
<td>staff</td>
<td>H</td>
<td>Vaccination, staff training, contract conditions, who should administer it, certificate of immunity</td>
</tr>
<tr>
<td>House calls</td>
<td>Infection, injury</td>
<td>Staff who do domiciliary or emergency visits</td>
<td>M</td>
<td>Portable sharps box, dressings. Disposal of diabetic needles and lancets</td>
</tr>
<tr>
<td>Patients infections</td>
<td>Transmission of infection</td>
<td>Staff, visitors</td>
<td>H</td>
<td>Hand washing, ventilation, good housekeeping</td>
</tr>
</tbody>
</table>
## Chemical Hazards

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who</th>
<th>Categorise the risk</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>oxygen</td>
<td>explosion</td>
<td>Staff, visitors</td>
<td>H</td>
<td>Correct storage, protect from flame</td>
</tr>
<tr>
<td>Detergents, bleach, disinfectants</td>
<td>Ingestion, inhalation, splashes to skin and eyes</td>
<td>Children, Splashes to staff</td>
<td>M</td>
<td>Storage, ?locked or combination lock to cupboard. Material safety data sheets to be assembled for information on first aid procedures for ingestion or splashes.</td>
</tr>
<tr>
<td>Liquid nitrogen</td>
<td>Burns, scars</td>
<td>staff</td>
<td>M</td>
<td>Correct storage and transport</td>
</tr>
<tr>
<td>Drug samples</td>
<td></td>
<td>Staff, children</td>
<td></td>
<td>Accept small amounts or none if particular product is not going to be used. Stock taking. Records for all especially for controlled drugs. Checking expiry dates (delegated)</td>
</tr>
</tbody>
</table>
# Sample Practice Risk Assessment

## Psychosocial Hazards

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who</th>
<th>Categorise the risk</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td>Guilt, lower self esteem, upset, poor retention of staff</td>
<td>All Staff</td>
<td>H</td>
<td>People management / communication skills/ training</td>
</tr>
<tr>
<td>Onerous rotas</td>
<td>Exhaustion, stress, depression</td>
<td>doctors</td>
<td>M</td>
<td>Co-op needed</td>
</tr>
<tr>
<td>Body odour of patients</td>
<td>Frustration, annoyance</td>
<td>Patients, staff</td>
<td>M</td>
<td>People management / communication skills</td>
</tr>
<tr>
<td>Skipping lunch and other breaks</td>
<td>Exhaustion, poor concentration, mistakes</td>
<td>Doctors mainly</td>
<td>H</td>
<td>Factor-in to days appointments and demands. Ask staff to support this</td>
</tr>
</tbody>
</table>
3. The Safety Statement

3.1 What is a safety statement?

A safety statement is a printed systematic list of hazards and risks that apply to a particular workplace, along with the details of the arrangements in place to control these hazards and risks. All workplaces must have a safety statement. The safety statement is based on the principle that safety can be managed, because most work-related ill health and workplace accidents are foreseeable and therefore they can often be prevented. Your statement sets out how health and safety is managed in your practice in order to protect the safety, health and welfare of people in the workplace.

3.2 Why should your practice have a safety statement?

3.2.1 A safety statement is a legal requirement

Once you commence in any business, including general practice, the law insists you assess your contribution to workplace safety. This is as mandatory as having a driving licence when you drive a car on a road and so it should be an integral part of your provision of services in general practice.

The 2005 Safety, Health and Welfare at Work Act, requires every employer and every self-employed person, so far as is practicable, to identify the hazards and assess the risks at their place of work, and to prepare a written safety statement. This safety statement should specify the manner in which the safety, health and welfare of those using the premises will be secured. Every person who controls a workplace premises has a duty to consider the safety of others, including non-employees.

3.2.2 There are penalties for non-compliance with legislation

Compliance with legislation is very important as non-compliance could result in legal action being taken by the Health and Safety Authority (HSA). Inspectors of the Health and Safety Authority have the power to enter, inspect, examine and search any place of work. Non-compliance with Health and Safety Law is a criminal offence.

3.2.3 A safety statement increases safety awareness and promotes safer working conditions.

It would be impossible to eliminate all health risks at work. One of the aims of the safety statement is to reduce the workplace risks to a minimum level for the GP, the practice staff and anyone in contact with the practice. Given the broad range of hazards in General Practice, it is appropriate for everyone to look at risks that might apply to them and to consider how they might be addressed. The safety statement highlights practice safety in...
a common sense manner and helps everyone in the practice consider how they perform their various work activities and tasks.

Regular safety audits can be carried out to determine how well the aims of the safety statement are achieved. Appropriate corrective action can then be taken to fulfil responsibilities. Having a safety statement will not prevent all workplace injuries or illness, but it does show that workplace risks and standards of health and safety have been given consideration. In fact, one could question the ethics of NOT performing a workplace risk assessment for a practice.

3.2.4 A safety statement makes good business sense

Addressing the safety aspects of working in general practice should be part of the overall management of the business of general practice. By helping to prevent accidents, reduce accidents or minimise the harmful physical and emotional effects of accidents, the safety statement can reduce consequential loss of time, loss of money, and loss of efficiency as well as reduce the amount of workplace trauma and distress. Safer working conditions boost staff morale and add to the feel-good factor of working in a team that works healthily together.

Both the GP employer and the employees have responsibilities for the safety of visitors to the premises, e.g. patients, maintenance personnel, pharmaceutical representatives.

The standard of presentation of practice premises influences the way staff, visitors and patients view us. Consider how you personally feel when you visit other workplace premises, for example those of your accountant or dentist. A practice with an image of order, tidiness and a calm welcoming atmosphere is far more conducive to trust and confidence than a practice which gives an impression of disorder and poor standards. Complaints and potential legal action by the public for injury or distress is a real threat for all businesses.

3.2.5 Cost-benefit of addressing practice health and safety issues

Cost-benefit analysis of health interventions has historically been difficult to quantify. Costs can be measured relatively easily but financial benefits of controlling workplace health risks are often intangible. How can we calculate the value of any benefit to human health and well-being? How can we measure the cost against the benefit of improving productivity and manpower retention within general practice?

Fall-out from workplace accidents and work-related ill-health includes the ‘costs’ of

- sick pay
- temporary staff pay
- training of temporary staff
- time spent in dealing with new arrangements
- worry over long term outcome including litigation
- strained work relationships
- the burden of pain and distress borne by the affected individual(s).
3. The Safety Statement

The first safety statement will involve a significant time commitment, but subsequent reviews and amendments should be relatively brief. Addressing practice health and safety issues is not simply a matter of upholding your legal responsibility – it can have many positive spin-off effects.

“There is now considerable evidence, borne out by businesses’ practical experiences, that effective workplace health and safety management actually contributes to business success, whereas accidents and ill health have costs, often hidden and underestimated…”

Transcript from HSA ‘Guidelines on safety statement & risk assessment’.

3.2.6 How the practice can profit from creating and using the safety statement

The safety statement is the key element of addressing health and safety for all those who work within general practice. Overall working conditions can be improved.

Table - Positive spin-off effects of having a safety statement

- Addressing your own health & safety needs
- Addressing your staff health & safety needs
- Improving morale
- Improving performance
- Improving productivity
- Improving teamwork
- Improving motivation
- Improving the quality of patient care
- By helping staff adapt to change, it can be used as a medium to make change in the practice more acceptable

The following points highlight positive spin-off effects in more detail:

- The safety statement can assist with compliance with legal requirements for workplace health and safety
- It can help to provide a safeguard should any legal action, insurance claims or compensation claims be made.
- Breaches of safety policies may lead to disciplinary actions. The safety statement can help the practice manage these within a positive framework.
- It is a practical tool for helping to reduce accidents and ill health at work
- It can reduce financial costs – accidents cost money
- It can improve efficiency – accidents cost time. Related absenteeism may result in upheaval.
- It can improve morale – accidents can cause worry, pain and distress
- It illustrates that all practice staff have considered possible hazards and that controls were put in place where appropriate
- All members of staff should be encouraged to consider ways to protect the health and safety of:
  - other staff and anyone else working on practice premises
  - patients and anyone else who may visit the practice
- GPs can improve their awareness of their own health and safety, an aspect of work that is easily overlooked
- Producing your safety statement will increase your awareness of:
  - What you do on day-to-day basis
  - How you do it
  - The equipment you use
  - The work practices you use
  - The procedures in place to deal with potential crises
- The safety statement can be incorporated into staff induction, staff training, and staff appraisal topics.
- Safety issues may be listed on the agenda for practice meetings.
- Safety statements should be reviewed before staff return from work after accidents, serious or prolonged illness.
3.3 What should your practice safety statement contain?

The areas that should be covered by the Safety Statement are quite specific and are covered by the 2005 Act and the 1993 General Application Regulations (Regulation 10).

>> Frequently Asked Questions on Safety Statements
http://www.hsa.ie/publisher/index.jsp?&1nID=93&nID=97&aID=1532

The following is an overview:

The Safety Statement should:

• Begin with a health and safety policy declaration which should indicate your commitment to ensuring the practice is as safe and healthy as reasonably practicable and that relevant statutory requirements will be complied with. This declaration is signed by the GPs and if possible, by an employee at ‘representative’ or ‘management’ level.
• Be based on an identification of the hazards and an assessment of the risks to everyone involved in the practice.
• Give details of how you are going to control the hazards and risks in your practice i.e. how you plan to manage your own and your employees’ health and safety.
• Contain the consultation arrangements with employees on health and safety matters.
• Specify the co-operation required from your employees on health and safety matters.
• Include the names and job titles of people designated to be responsible for specific health and safety tasks in your practice.
• List the internal resources provided by the practice and details of external sources of information available to employees on health and safety

>> 6 steps to drawing up your safety statement

1. Draw up a Health and Safety Policy
2. Identify the Hazards
3. Do a risk assessment
4. Decide what controls are needed
5. Record your findings – as a written risk assessment and safety statement
6. Review your findings and update as necessary

>> Sample safety statement

3.4 The importance of consultation on health and safety matters

Practice-based health and safety activities are one area where there is no hierarchy of roles or responsibilities among staff, employers or employees. EVERYONE’S opinion matters and everyone’s ideas may be incorporated into controlling hazards and risks at work.

Consultation between employers and employees on health and safety matters ensures that all practice personnel understand and take ‘ownership’ of the health and safety measures proposed. Co-operating effectively in developing and promoting health and safety is a legal duty of everyone at work in the practice. It also gives everyone an understanding
3.4 The importance of consultation on health and safety matters

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Consultation between employers and employees on health and safety matters ensures that all practice personnel understand and take ‘ownership’ of the health and safety measures proposed. Co-operating effectively in developing and promoting health and safety is a legal duty of everyone at work in the practice. It also gives everyone an understanding that the workplace and the people working in it can benefit from good health and safety performance. Pooling knowledge and experience through employee consultation and participation means that health and safety becomes ‘everybody’s’ business. Successful implementation of health and safety in the practice is also more likely if consultation has taken place.

Under the 2005 Act, GP employers must consult their employees in establishing arrangements for co-operation in safety issues in the workplace. Equally, employees have a right to consult the GP employer on safety issues. In larger practices, the staff may appoint one from among themselves to act as a safety representative.

Your Safety Statement must specify the arrangements you are going to use for consultation with your employees on health and safety matters. This would include the procedures you will use for facilitating effective co-operation and two-way communication on health and safety matters between you and your employees and might include some or all of the communication procedures listed in the box below.

Essentially, all relevant practice personnel should be involved in the creation and/or review of the safety statement, but legal responsibility for health and safety ultimately lies with the GP (or GPs) as the employer.

>> Information on consultation and representation

Examples of practice based consultation and communication on health and safety issues:
• Display new or important information on a staff notice board
• Safety issues to be tabled for discussion on agenda of practice meetings
• Draw attention to safety matters in practice memos
• Opportunistic discussion of the Safety Statement
• Reference to or inclusion of the Safety Statement in employees’ contract, handbook or manual
• Discussion during in-house staff training
• Display details of the name(s) and functions of any safety representatives in the practice
• Give details of the health and safety information available to employees in-house
• Specify where this information is located in the practice
• Introduce a safety handbook to provide a framework for the organisation of safety within the practice i.e. how you plan to manage your own and your employees’ health and safety

3.5 Who should write the practice safety statement?

All employers, those who control workplaces to any extent, those who provide workplaces for others and those who are self-employed are all required by law to prepare a risk assessment and a safety statement. General practices are small enterprises and in common with other small businesses, the preparation of a Safety Statement should be a relatively straightforward matter. If you are confident you understand what is required, the hazard identification and risk assessment
can be performed within the practice. General practice is well placed to create a safety statement in-house, with the assistance of this guidance document and information from the HSA.

>> Information on competencies of a person who creates a safety statement

>> Information on who is a competent person

NB Excerpt from above link:

For the purposes of the relevant statutory provisions, a person shall be deemed to be competent where, having regard to the task he or she is required to perform, and taking account of the size or hazards (or either of them) of the undertaking or establishment in which he or she undertakes work, he or she possesses sufficient training, experience and knowledge appropriate to the nature of the work to be undertaken."

Legislation does not specify the position of the person(s) who writes the safety statement: it could be a GP or a practice manager, a practice nurse or practice secretary. Delegation of particular tasks involved in writing a safety statement is of course acceptable, provided staff involved are given a defined reporting structure. The person(s) carrying out the risk assessment will consult with other GPs and other members of staff to help identify hazards that might be applicable to their area of the practice. Assigning duties to assist in drawing up a statement does not detract from the GP employers overall responsibility.

For example, one doctor or the practice manager might take on the role of ‘safety officer’, keep up to date with legislative developments, needs and changes in the practice, and keep all doctors and staff informed through practice meetings or in memos. A second example could be where two practices would amalgamate their resources and help each other by doing a diplomatic ‘walk-around-survey’ of each other’s practices and advise each other. Have you seen inside your GP colleagues’ practices or neighbouring practices? Would your practice premises and your staff awareness compare favourably?

>> Information on health and safety resources for the practice

3.6 Who should have access to a safety statement?

All directly employed staff, including staff who are temporary staff and locums should be made aware of and understand the terms of the safety statement, and should know where it is kept.

Where relevant, these staff may include receptionist, secretary, nurse, manager, counsellor, cleaner and all doctors. Each new appointment should be shown the safety statement, ideally before they commence employment in the practice. It can be useful as an aid to orientation, induction and training.

Where relevant, the contents of the Safety Statement must also be brought to the attention of any other people in your workplace who may be affected by health and safety risks and who therefore need to be aware of the necessary safety precautions they may need to take. This includes all contracted staff and other people carrying out their work while on practice premises, e.g. builder, maintenance worker, contract cleaner, gardener, dietician, physiotherapist, chiropodist, window cleaner, pharmaceutical representative, delivery personnel who come into contact with practice activities and any self-employed people who provide a service for the employer.
4. Workplace Health and Safety Legislation

4.1 Introduction to legislation

Under current Health and Safety legislation, the Safety, Health and Welfare at Work Act 2005, each workplace is required to ensure ‘as far as is reasonably practicable’ the health and safety of all people who work there.

The 2005 Act stipulates that once GPs commence seeing patients, i.e. operating a business, they are obliged by law to have a written risk assessment and a safety statement, and to keep them together. This requirement applies whether the GP is single-handed with no other employed persons or a GP employer in partnership and employing a full complement of staff.

>> Short Guide to the 2005 Act

>> 2005 Act FAQ’s

Full texts of the Acts and Regulations are available in printed form or on CD-ROM from Government Publications Office, Molesworth Street, Dublin 2.

>> Full text online via HSA

>> Full text online via the Irish Statute Book

>> Act, Bills and amendments via Oireachtas website

In essence the GP has a duty of care to themselves and to all who work in and use their premises. This duty is comparable to the legal duty to have a driving licence if you drive a car. Doing a risk assessment and having a safety statement is like examining patients and making clinical notes; it means you have written proof that you have considered possibilities, issues or options. The associated documentation may help to reduce your exposure to legal claims.

Every GP and staff member should be alert to the safety aspects of general practice. Consideration of the safety of others while at work should be just as important as the avoidance of personal injury. This requirement should be emphasised in all staff job descriptions. The job description could state that failure to observe safety policies or to adhere to practice guidelines may result in disciplinary action by GP employer(s). The current legislation is in fact the minimum standard acceptable for health and safety, and ideally, general practice as a profession should strive for higher standards than the minimum.
4.2 Which Acts and Regulations apply to general practice?

General practice falls under the umbrella of various acts and regulations. Non-compliance with these laws could form the basis of criminal action. These laws are separate to the laws of medical negligence and ethical codes of conduct. It would be appropriate for the individual(s) in the practice who are responsible for safety to be broadly familiar with the legislation pertaining to general practice.

The following pieces of legislation apply to all workplaces generally:
- Safety, Health and Welfare at Work Act 2005

A non-exhaustive list of some of the legislation relevant to general practice is contained in the Table below.

Table - Legislation relevant to general practice

- Safety, Health and Welfare at Work Act 2005 (referred to as ‘2005 Act’ in this document for the sake of brevity)
- FAQ’s on 2005 Act
- Full text of 2005 Act
- Short Guide to the 2005 Act
- NISO interpretation of the 2005 Act
  For the sake of brevity, these will be referred to as the ‘1993 Regulations’.
  These include:
  - General Safety and Health Provisions
  - Use of equipment
  - First Aid Regulations
  - Electricity Regulations
  - Visual Display Unit or VDU Regulations
  - Manual Handling of Loads Regulations
  - Personal Protective Equipment Regulations
  - Notification of Accidents and Dangerous Occurrences Regulations
- Text of 1993 Regulations
- Fire Services Act 1981
- Safety, Health and Welfare at Work (Biological agents) Regulations 1994 S.I. 146
- Safety and Health Signs at Work 1995
  - warnings/info to non-employees
- Pregnancy at Work Regulations 1994, and 2000
- Waste Management Act 1996
4. Workplace Health and Safety Legislation

4.3 To what extent are GPs and GP employees responsible for safety and health?

Legislation dictates that the prevention of accidents and illness in general practice is the duty of every individual in the practice. This applies to all the various areas and tasks being carried out in them: reception area, office area, library area, clinical areas, storeroom, waiting room, kitchen and other areas of work including branch surgeries. Safety outside the premises is equally important e.g. on the front doorstep, in the back yard, delivering specimens to the hospital or performing house calls.
4.4 Legal responsibilities of the GP as an employer

Self-Employed persons are treated as if they were employers under the 2005 Act (so they are both employers and employees).

Irrespective of the nature of business, all employers have specific responsibilities as defined by law. The 2005 Act states: “It shall be the duty of every employer to ensure, so far as is reasonably practicable, the safety, health and welfare at work of all his employees.”

**Duties of an Employer**

The employer must ensure…

The Safety, Health and Welfare at Work Act 2005 states that as an employer the GP must ensure, so far as is reasonably practicable:

- A safe place of work
- Safe means of access and egress
- Safe plant, equipment and machinery
- Safe systems of work e.g. procedures
- Provision of appropriate information, instruction, training and supervision to employees
- That staff are aware of the safety statement, its contents and where it is stored.
- That staff are consulted on matters of safety.
- Provision of suitable protective clothing and equipment where hazards cannot be eliminated
- Preparation and revision of emergency plans
- Designation of staff having safety related and emergency duties
- Provision and maintenance of welfare facilities, e.g. hygienic eating facility, clean toilet facility
- Provision, where necessary, of a competent person to advise and assist in securing the safety, health and welfare of employees.

**Information on workplace premises and conditions**

4.5 What does ‘so far as is reasonably practicable’ mean?

‘So far as is reasonably practicable’ appears in the 2005 Act in order to explain the extent of individual employers’ responsibilities. It has been accepted by the courts as the acceptable level to which risks should be reduced.

The definition of reasonably practicable is as follows:

“For the purposes of the relevant statutory provisions, “reasonably practicable”, in relation to the duties of an employer, means that an employer has exercised all due care by putting in place the necessary protective and preventive measures, having identified the hazards and assessed the risks to safety and health likely to result in accidents or injury to health at the place of work concerned and where the putting in place of any further measures is grossly disproportionate having regard to the unusual, unforeseeable and exceptional nature of any circumstance or occurrence that may result in an accident at work or injury to health at that place of work”.

This then links into the offences section, which reads:
“In any proceedings for an offence under any of the relevant statutory provisions consisting of a failure to comply with a
duty or requirement to do something so far as is practicable or so far as is reasonably practicable, or to use the best
practicable means to do something, it shall be for the accused to prove that it was not practicable or not reasonably
practicable to do more than was in fact done to satisfy the duty or requirement, or that there was no better practicable
means than was in fact used to satisfy the duty or requirement”.

In essence, this clause in the Act balances cost outlay against risk occurrence. Some costly measures might not result in
an overall benefit to those at risk, and eliminating one risk completely might simply result in it being replaced with
another. The phrase allows the courts to interpret an individual practices’ risk management as either ‘reasonable’ or
‘unreasonable’.

>> NISO interpretation of the 2005 Act

4.6 Legal responsibilities of a practice employee

Every employed person is now deemed to be an employee - people on work experience, temporary or fixed term
contracts etc. When conducting a risk assessment for your safety statement, ask yourself “who works here?” and “in what
capacity do they work?”.

Consider all possible categories of employee, e.g. new employees, young employees, permanent, temporary, full time,
part time, receptionist, secretary, nurse, phlebotomist, cleaner, maintenance worker, contracted worker, spouse, relative,
and locum.

Employers must ensure that employees have access to appropriate information, instruction, training and supervision in
relation to their work. This is not only common sense, good practice management and practice organisation but it is
enshrined in law.

Ideally, all new employees should be given a copy of the practice safety statement to read before starting their first day.
This should be part of the induction training the staff member receives. It is an ideal opportunity to inform the new
employee of their duties in the practice under health and safety legislation, and should not be missed.

>> The 2005 Act General duties of employees.

4.7 How is the legislation enforced?

The cornerstone of legislation affecting general practice is the Safety, Health and Welfare at Work Act 2005, which is
supplemented by various other Acts and Regulations some of which are listed above.

The statutory body charged with the enforcement of health and safety legislation in Ireland is >> The Health and Safety
Authority

>> The principle functions of the HSA are

>> The structure of the HSA organisation
4.7.1 Inspections of your Practice by HSA Inspectors

- General practice premises are subject to random inspections by the Health and Safety Authority. Comments and recommendations arising from these visits are received in the form of a letter sent to the Practice after the visit.

- The HSA Inspector has a statutory right to inspect premises, take photographs, recordings, equipment and samples of substances. The inspector may request the assistance of the Gardai if he has problems gaining access to a workplace. The particular hazards that are likely to interest him/her in general practice are electrical, biological and chemical hazards, but all matters which relate to health and safety can be reviewed e.g. storage of medication samples, compliance with VDU screen regulations.

- The Law requires every employer and self-employed person to have a Safety Statement, which is appropriate for the work they do and for where they work. You could be prosecuted for not having one. When an inspector from the Health and Safety Authority inspects your workplace s/he will place great emphasis on ensuring that you have prepared and implemented your safety statement. If s/he finds that the statement is inadequate they can ask you to amend or revise it.

- There is a system of improvement and prohibition notices that may be served on the Practice by the HSA. These can be used to curtail or to terminate an activity, which is deemed to be dangerous. The notices can come into immediate effect if necessary. Essentially, the practice itself, or an area within the practice, could be closed down.
  - The HSA could demand submission of an improvement plan within a specified time period, e.g. if welfare facilities are not adequate or if the workplace is particularly untidy; or
  - The HSA may serve an improvement notice, e.g. passageways not kept clean or failure to submit or implement an improvement plan.
  - In some situations of serious risk to individuals, the HSA can apply to the High Court for a prohibition notice to immediately restrict or prohibit the use of a place of work (or part of the place of work) so, in effect; the practice could be closed down until the problem is remedied.

- There is a possibility that an Inspector from the Health and Safety Authority can bring criminal proceedings against the Practice, or any individual, for a breach of any duty under the Safety, Health and Welfare at Work Act, 2005 or the other legislation applicable to the General Practice workplace. If all practice staff and doctors have assisted in the creation of the safety statement, then everyone will be familiar with its contents on the occasion of an inspector visiting your practice when you are absent. (you will have no prior warning of an inspection!)

4.8 Recording and investigating accidents

4.8.1 The practice ‘accident and incident book’.

All staff must ensure that all fires, breakages, accidents and dangerous occurrences within the practice are reported to the Practice Safety Administrator or GP. All injuries or accidents or illnesses that occur in connection with an individual’s work or workplace must be recorded (see SHAWAWA and regulations). All practice staff should know where the accident book is kept.

Details which should be recorded after each incident include date and time of incident, name of person(s) involved, circumstances of incident, and outcome, e.g. full recovery, laceration, bruising, referral to casualty etc. (see Sample Forms section). Someone should be assigned responsibility for checking the book periodically as part of audit cycle. Audit of accidents is a very valuable tool in safety training of all practice staff and thereby creating a more comfortable ‘safety culture’ at work.

4.8.2 Investigation of accidents, incidents and dangerous occurrences

The incident/accident book will assist in auditing dangerous occurrences in the practice and check on implementation of safety measures, protective equipment, safe disposal of contaminated items etc. Audit of safety policies should occur after any significant incident in case precautions or procedures need to be altered.

4.9 Legal notification of accidents to the HSA

The law requires that accidents at work must be notified to the Health and Safety Authority on the approved forms. These forms are available from the HSA website and HSA Publications Department and may be photocopied and used where appropriate.

Information on notification of accidents to HSA

The Authority must be notified using Form IR1 about:
• a work accident causing the death of any employed or self-employed person
• a work accident that prevents an employed or self-employed person from working for more than three days
• an accident caused by a work activity which causes the death of, or requires medical treatment to, a person not at work, e.g. a passer-by.

Form IR 1

4.9.1 Notification of dangerous occurrences to HSA

The Authority must be informed using Form IR3 about:
• any dangerous occurrence involving lifting machinery, pressure vessels or electrical short-circuit
• explosion or fire
• escape of substances
• collapse of scaffolding, building or structure or any incident involving overhead lines carrying 200 volts or more.

Access Form IR3
Further details from HSA. Any of the above examples could occur in general practice under normal circumstances or during renovations.

4.9.2 Who is responsible for notifying the HSA?

- In the case of the death or injury of a person receiving training for employment, the persons providing the training
- In the case of the death or injury of persons not at work which is caused by a work activity, the person in control of the place of work
- In the case of the death of a self employed person, the person in control of the place of work where the death occurred
- In the case of the death of a self employed person at a place of work under their own control, their next of kin
- Self-employed persons in relation to accidents to themselves

Records containing full details of all accidents or dangerous occurrences notified to the Health and Safety Authority must be kept for 10 years.

4.10 Liability insurance

The Safety, Health and Welfare at Work Act, 2005 does not in any way, alter the general position regarding civil liability.

Employers Liability Insurance covers the practice for any successful action in civil law arising out of the negligence by its employees at work. This policy protects individual practice employees against any successful action in civil law arising from a neglectful act whilst carrying out their normal duties as employees.

Public Liability Insurance covers the practice for any successful action in civil law brought by a member of the public against the practice for negligence.

>> Further information from the Irish Insurance Federation

4.11 Occupational Injury Benefit

Injury benefit is a weekly payment made to an individual if they are unfit for work due to an accident at work or because they have contracted a disease due to the type of work they do. Generally, people who pay PRSI at Classes A, D, J and M qualify for this type of benefit (self-employed persons pay PRSI at Class S). The illness or effects of the accident must last for at least four days (excluding Sundays). Injury benefit is normally paid from the fourth day of incapacity until 26 weeks. If the individual is still unable to work after 26 weeks they may qualify for Disablement Benefit.

>> Occupational Injuries benefits and entitlements
4. Workplace Health and Safety Legislation

4.12 Case law

Health and safety cases which have come before the courts of relevance to general practice:

- An example illustrated in one of the medical indemnity insurance agencies’ publications, involved a GP employee who was scalded by boiling water when a kettle overturned in the surgery. The events which followed were complicated by the fact the employee was also a patient of her GP employer. The claim that arose only came under the scope of the ‘medical indemnity insurance agency’ because the injured party was a patient of the GP. A settlement was negotiated and the ‘medical indemnity insurance agency’ contributed 50%. The GP did not have insurance cover for his liability as an employer, and so he was personally responsible for the other 50% of the settlement.

- A child was poisoned and sustained internal burns after gaining access to the contents of a cupboard in a vacant consulting room in a general practice surgery. The GP was found to have breached Health and Safety Law and was fined.
5. Health and Safety Risk Assessment in your practice

5.1 Introduction to occupational health hazards in general practice

Everyone assumes that working in the healthcare sector must be a very healthy and safe place to work and that we reap the benefits of ‘insider information’. Ironically, this is not often the case.

The following definitions are important.

**A hazard** is something that has the potential to cause harm to health, e.g. a wet floor, a syringe, excessively long working hours, or latex gloves.

**A risk** is the likelihood of the hazard to cause harm, e.g. low risk, medium risk, or high risk of slipping on a wet floor, or being injured with a blood filled syringe, fatigue while on duty, or occupational dermatitis.

A significant source of danger is the inherent familiarity that healthcare workers have with certain hazards, e.g.

- cleaning up blood splashes without wearing gloves;
- leaving urine or stool samples on the same surface you have your tea and biscuits;
- failing to wash hands after touching infected skin;
- being too embarrassed to ask the patient to ‘look the other way’ before giving you a cough or deep breaths during a chest examination;
- handling your telephone after handling urine sample.

Four categories of workplace hazard

- Biological hazards
- Chemical hazards
- Physical (including ergonomic) hazards
- Psychosocial (human factor) hazards

Five Steps to H&S risk assessment (see below)

1. Identify the health hazards in your practice
2. Categorise the hazard
3. Identify the risk posed by the hazard
4. Prioritise the risk
5. Example of risk assessment
5. Health and Safety Risk Assessment in your practice

5.2 Identify the health hazards in your practice

Take a copy of each of the four risk assessment template forms which come with this document.
>> Template Risk Assessment Forms

Walk around survey to check for work hazards
Make a list of hazards relevant to your practice by, literally, doing a ‘walk-around survey’ of the premises to find potential causes of harm. Other members of staff should also do this exercise at the same time or at different times and ideas or concerns could be pooled. Categorise each hazard by inserting each hazard onto the appropriate form for the category of hazard e.g. a trailing cable should go into the physical hazards form. Checking for hazards is a common sense exercise and a necessary element of writing a workplace safety statement.

The following process may help you to focus on identifying hazards and assessing risks in your place of work. Remember to think outside the box. Once this exercise is completed you will have gone a long way to create your safety statement.

• Consider the general risks of operating a small business on premises with many people involved in various ways.

• Consider the particular risks in your practice.
  When you identify hazards, it is helpful to view them in the contexts as outlined below.
  - Where?
  - Who?
  - What?
  - When?
  - How?
  - Why?

• Where?
  Where are the people when on the premises? Could the layout of each room or passageway be better arranged for staff security? Is there an adequate communication line between reception and the room(s) distant from it? Where is cash stored?

Consider entrances and exits

Consider outside the building:
  - steps
  - pathways
  - gradient
  - poor lighting
  - slippery surfaces, e.g. wet leaves
  - hazardous litter, e.g. broken glass.

Consider inside the building:
Room by room, including reception, toilet, passageways, and the attic, if it is used for storage in connection with work.

• Who is at risk?
  Who works here and in what capacity? Who visits here? Do you have people on work experience? Who transports specimens? Have new staff been adequately briefed with information and training?
Don’t forget who you and your staff interact with:
– contractors, sub-contractors and attached staff
– locums, temporary staff, part-time staff
– patients (and the range of their ages and abilities)
– Other visitors, e.g. delivery personnel, pharmaceutical reps, maintenance people).
Think about anyone who is involved in practice procedures, e.g. collecting supplies, delivering specimens

• What?
  What might people might be doing on the premises? Look at practice activities, e.g. phlebotomy may result in needle stick injuries. Try to standardise work practices to a high standard e.g. no re-sheathing of needles; phlebotomy tasks to occur close to a well positioned sharps bin. Think about the services provided by each member of staff, and the various tasks they perform. Consider extra responsibilities they may have, such as those associated with providing care for local employers or local sports clubs, being summoned by the Gardai, visiting nursing homes, working with acupuncture equipment, and performing minor operations.

• When?
  When are people working? Who is on the premises early in the morning and late in the evening? Might the receptionist be alone? Does s/he have a protocol to follow for the initial management of a collapsed patient, a bleeding patient, and an aggressive patient when a GP is not present?

• How?
  How is cash taken to the bank? How are specimens packaged and transported? How might a practice activity be improved, e.g. phlebotomy, giving test results to patients, interruptions?

• Why?
  Why is it so much busier at some times of the day? Could pressure on reception be reduced by staggering the doctors’ surgery times? Could a specific time be allocated for giving out test results over the telephone?

5.3 Categorise the hazard

List the hazards you have identified under the generally accepted categories to assist with your risk assessment. This will make it easier to see patterns and common ways of addressing similar hazards.

>> Categories of hazards at work

These various groups of hazard are considered in more detail in chapter 5.

5.4 Identify the risk posed by the hazard

List all the risks associated with each hazard.
What is the hazard? A trailing cable should be listed on the physical hazards form
What is the risk? e.g. trip and fall.
5. Health and Safety Risk Assessment in your practice

5.5 Prioritise the risk

Make an assessment of the risk posed by individual workplace hazards. Is the risk of harm high, medium or low? Prioritise the risk according to potential danger. Risk assessment characterises the magnitude of a specific risk, e.g. high, medium or low risk.

The scale of risk depends on
(a) the likelihood of the exposure to the occurrence e.g. is it a rare or frequent occurrence?
(b) the severity of the consequences e.g. might it be a scald or an electrocution.
(c) the number of people who might potentially be affected if the risk occurred.

In this way decision makers, (ultimately the GP), may decide if the risk needs to be addressed.

The key to avoiding accidents is to be aware of all possible risks, including that of human involvement or human error. Consider who might be involved. Who might be at risk?
Is action required? E.g. if the hazard is a trailing cable, you could move the printer, or change plug to a different socket or tape down the trailing cable. Decide which is best for you in the context of the hazard and its risk.

>> Information on risk assessment in the practice

5.6 Example of risk assessment

<table>
<thead>
<tr>
<th>Hazard</th>
<th>Risk</th>
<th>Who is at risk?</th>
<th>Categorise the risk</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access / Exit: Step, ramp, close to busy path and road.</td>
<td>Slip, trip, falls Collision with vehicles</td>
<td>Visitors, staff</td>
<td>M</td>
<td>Mark step, sign, handrail</td>
</tr>
</tbody>
</table>

>> Sample Risk Assessment Forms
6. Control of health hazards and health risks in your practice

6.1 Introduction

All self-employed persons and all employers in Ireland are legally required to carry out a risk assessment in order to control health and safety hazards at work. General practice is no exception.

Managing health and safety in the practice means being able to assess the real risks and put the appropriate health and safety control measures in place. GPs must do all that is reasonably practicable to ensure a work hazard will not injure anyone. Workers in the healthcare sector have no greater immunity to illness or injury than the patients they meet. Logic tells us that life is not risk-free. The majority of accidents and injuries are foreseeable to some degree. For this reason, we are obliged by law to look at and address the hazards of working in general practice in order to prevent accidents or to minimise the effects of accidents. Healthcare workers in general practice have potential exposure to certain hazard in the course of their work activities.

Information on Managing health and safety in the workplace

Drawing up a health and safety policy

European Agency for Safety and Health at Work

A Guide to safe working practices (HSA document)

The safety measures should be proportional to the real risks involved and should be adequate to eliminate, control or minimise the risk of injury. It is important to note that eliminating one risk completely might result in it being replaced with another type of risk, e.g., substitution of old equipment with new.

If you share a workplace, tell the other employers and self-employed people there about any risks your work could cause them, and what precautions you are taking. Also, think about the risks to your work-force from those who share your workplace.

What level of risk management is acceptable?
6.2 Methods of control for health and safety risk

We must begin the process of making our practices as safe as possible by considering possible hazards and potential risks. Hazard identification and risk assessments should be followed up by assessing existing control measures and deciding whether further safety measures are required.

**Hierarchy of control of risks** (see page 6 of publication)

**Options you may consider for controlling practice hazards:**
An example of how the hierarchy of control should work as regards the use of a hazard is as follows:
1st try to eliminate it, eliminating the hazard to avoid the risk completely
2nd try to substitute it with a safer or ‘less hazardous’ hazard. Could the activity be adapted?
3rd try to contain it, isolate the hazard to minimize risk or minimize the number of people exposed
4th protect yourself

**Examples of control measures in the practice:**
Elimination e.g. throwing out a torn mat
Substitution, e.g. use a disposable speculum instead of an autoclave;
Containment of the hazard at source, e.g. sharps bin elevated to safe working height out of reach of children who are attracted by bright colours
Ventilation e.g. waiting room droplet spread in winter
Isolation of the process, e.g. phlebotomy in separate area to where food or drink is ingested
Reduced time exposure (job rotation, change of work practice, e.g. typing then reception duties)
Safeguarding of equipment, e.g. keeping door of autoclave room closed during surgery times
Ensuring a clean and tidy workplace
Emergency planning procedures
Adequate health surveillance programme including vaccination for hepatitis and follow-up of needlestick injuries
Accident and ill health reporting and investigation
Adequate facilities for lunch breaks and coffee breaks, e.g. separate to clinical area, clean and hygienic, separate fridge for milk and food;
Housekeeping (personal & environmental hygiene)
Information, education, training and supervision, e.g. cleaning up spillages of blood and body fluids, First aid training.
Personal protective equipment. This is equipment designed to be worn or held by an employee for protection against one or more hazards likely to endanger the employees’ safety and health at work, and any accessory designed to meet this objective, e.g. gloves, eye goggles. Collective protection for wider benefit is preferable to individual protective measures (PPE). The use of PPE would involve arranging appropriate training and instruction to the employees concerned.

**Remember:**
If it is impossible to eliminate a hazard, then the unavoidable risks must be evaluated to determine the appropriate control measures.
The control measures selected must be capable of dealing with changing circumstances at the place of work.
6.2.2 Information and training

It is essential for staff to have information about hazards and safe work habits in order to prevent occupational injury and illness. Each practice needs to develop policies that ensure workers are familiar with potential hazards.

All staff should receive ongoing training, beginning with induction training. Most training for the needs of general practice may take place in-house with the assistance of external resources like this document.

> [links to further health and Safety resources](#)

> Health and safety training courses provided by HSA

> Information on safety signs at work

Sometimes new, young or inexperienced workers are more vulnerable to accidents and may need particular attention. The GP (or the practice administrator or manager in larger practices) needs to identify appropriate safety-related induction training needs and in-service training for practice employees. Doctors ongoing needs also need attention. Log the time spent on your staff education and training.

It is important to keep up to date with developments in the area of health and safety. This online links of this document should assist with this through its link to the HSA website.

> Application form for free HSA newsletter

> "What's New?"

> European health and Safety News

GPs and other staff need intermittent encouragement and reminders to follow safe work practices and to avoid taking shortcuts. If you have a disciplinary procedure for failure to comply with safety requirements where appropriate, these should be specified.

6.3 Assess whether existing controls are adequate

If existing control techniques are not sufficient then you must review your policies and procedures. Past incidents, accidents and exposure to practice hazards should be taken into account when drawing up new or amended plans of action. This information should be available in your ‘accident and incident book’.

> 'accident and incident book'

For completeness, consider exposures to hazards under different conditions or unusual circumstances. How would your practice handle obvious ‘foreseeable’ incidents e.g. if a particular floor was wet; if a patient was violent; if a child wandered into the empty consultation room, needle-stick injuries, spillage’s like vomit or blood, or working alone?

6.4 Assign responsibilities to named staff members

This does not abdicate responsibility from the GP, but should ensure involvement of all staff members to some degree. It gives everyone a stake in the success of the safety measures adopted.
6.5 Audit of safety in the practice

It is vital to monitor your control of workplace hazards and risks by periodical review of your risk assessment. Pick times that you would be likely to consult the safety statement, e.g. every six months, after an accident, or when a member of staff is appointed with new tasks, or when new equipment or new procedures are introduced. State the review intervals or cues in your safety statement insert.

6.5.1 Examine your ‘accident/incident book’.

Reviewing the accident and incident book is also a sensible place to begin an audit cycle. How effective is your control of hazards? Look at the accidents or incidents which have occurred. How many days have been lost? How might things be done differently or better? What do you need to do to change things? Make the changes. Review the situation when it comes to your regular review. Have the changes been successful in reducing or eliminating the risk? Are there any further changes needed? Is it necessary to start again? Over time, check if the changes impact on the safety record of the practice.

The practice accident/ incident book may:

- Assist in the assessment of dangerous occurrences in the practice
- Illustrate trends
- Illustrate recurrent problems
- Check on implementation of safety measures
- Check on appropriate use of protective equipment
- Check on safe disposal of contaminated items etc
- Highlight appropriate corrective actions.
6.5.2 Safety Audit

- You need:
  - your current accident book
  - your records of incident investigations
  - records of staff absences from work
  - details of manufacturers recommended service intervals for practice equipment
- Review in the light of changes in practice staff, alterations in staff roles, new equipment, new chemicals, new working procedures.
- Walk around survey may be valuable
- Note discrepancies in what the practice states it is doing to minimise risks and what actually happens in reality
- Note any additional actions required
- Record findings
- Discuss with relevant staff members, delegate or assign responsibilities
- Sign and date review
- List planned next date of review

“Access HSA publication: Auditing a Safety and Health Management System

6.6 Risk Management Summary

- Draw up a list of hazards
- Categorise the hazard, e.g. the physical
- Identify the risk of the hazard, e.g. electrocution
- Prioritise the risk (high, medium, or low)
- Check existing control of the risk
  - If it is adequate then state this in your records
  - If inadequate, state the actions required
- Record findings in safety statement
- Designate responsibilities for particular tasks to named individuals
- Set date for review of risk management
Introduction

Some of the more important elements of health and safety intervention and monitoring in general practice are given more detailed consideration in this section, along with examples of good practice. This list is non-exhaustive and needs to be tailored to the specific working environment of your individual practice.

7.1 Biological hazards in general practice

Biological agent hazards include viruses and bacteria that can cause infection as well as more rare infections such as protozoan, mycoplasma and transmission of prions. There is increased awareness of the prevalence of organisms in the community that are more resistant to treatment, e.g. MRSA which can be transferred between patients and staff.

As a consequence of the variety of work of general practice, and contact with so many people, some of whom may be infectious patients, we may be exposed to a variety of biological hazards. We also perform tasks such as sterilising instruments, cleaning up spillages, and managing clinical waste, which put us at risk. Blood is not the only high risk body fluid; others include amniotic fluid, vaginal secretions, semen, breast milk, respiratory secretions and stool.

7.1.1 Examples of Biological hazards in general practice

- **Blood borne pathogens** include hepatitis B, hepatitis C and HIV from handling of infected body fluids or clinical waste. Percutaneous transmission, which includes via uncovered cuts and grazes as well as sharps injuries, may also result in transmission of other diseases such as gonorrhoea, malaria, staphylococcal disease, streptococcal disease, syphilis, toxoplasmosis and Creutzfeldt-Jacob disease. It is documented that Hepatitis B was transmitted via dried blood.

- **Airborne pathogens** include tuberculosis transmitted from infectious patients, varicella, adenovirus infection, influenza, meningococcus, pertussis, measles, mumps, rubella, and legionella.

- **Skin to skin pathogens** include ringworm, warts, and herpes simplex virus and staphylococcal infections, e.g. impetigo.

- **Ingested pathogens** passed on via the faecal–oral route, i.e. as a result of poor hygiene, include hepatitis A, polio, salmonella, and campylobacter in addition to other causes of gastroenteritis.

>> Further information on biological hazards

7. Management of some common health and safety risks in your practice

**TB (tuberculosis)**

It is uncommon for healthcare staff to acquire tuberculosis infection from patients. Nevertheless, it would be prudent to ensure you and your staff have been screened for BCG scars or symptoms in order to minimise transmission of infection and to protect staff who handle specimens. Pre-employment questionnaire type screening is most effective and is where staff protection should begin. If no scar is present a Mantoux tuberculin test should be arranged. Where there is an inadequate response, staff will need referral for BCG.
Varicella Zoster infection
Employers in the healthcare sector need to include pregnancy or potential pregnancy in their overall workplace risk assessment. This may involve certification of rubella immunity in those workers at risk of contracting rubella in the course of their work in the early stages of pregnancy i.e. before employers are notified by an employee that they are pregnant. MMR may be considered for non-immune healthcare workers who care for obstetric or paediatric patients. Workers who are not immune to rubella are those with no definite history of chickenpox or vaccination and who test negative when screened for Varicella Zoster antibody.

>> Information on Varicella Zoster (see chapter 17 of publication)

7.1.2 Controlling Biological Hazards in the Practice

Staff information and training, vaccination, and use of protective clothing are important in the effective prevention of biological risks.

- **Staff information and training**
  Many staff admit they fear contracting an infection from specimens or practice toilet facilities as they may handle items touched by patients.
  The importance of regular staff hand washing cannot be over-emphasised. Adequate hand washing and drying facilities, and clean toilet facilities should be provided for patients, visitors and staff in order to minimise transmission of organisms. There should always be adequate supplies of soap, hand towels (or dryers) and toilet paper. How many people do you shake hands with on a daily basis? It is good practice to be seen by your patient washing your hands as they enter your room, as they leave your room or where indicated during the consultation. Hand-to-mouth and hand-to-eye contact should be avoided.
  Good general hygiene and tidy housekeeping in the practice should be the norm for everyone in the practice. Standard precautions should be taken with all patients in all health-care facilities at all times by all staff.
  Limit the areas where staff may have exposure to blood and body fluids and specimens. Staff should not come into direct contact with specimen containers that might have splashes or infectious residues, e.g. blood, stool or urine specimens. All specimens should be bagged as soon as they leave the area they are produced. Hazard warning labels could be used where appropriate, but every specimen should be regarded as potentially hazardous. Bags containing specimens should not be reopened as this involves a risk of spillage and breakage.
  How are specimens stored as they wait for processing? Specimens should be carried and stored in a collection box so as to minimise handling and to minimise specimens falling or leaking onto other surfaces. The collection box itself will need to be regularly disinfected. All practice staff should be familiar with the correct management of clinical waste.
  Disinfect and decontaminate work surfaces regularly with disposable cloth or wipes.
  Be sure to cover paper cuts and grazes on hands while at work.
  One-way-valve masks should be available for mouth to mouth resuscitation. Infections can be transmitted via body fluids; there has been documented transmission of meningitis from patient to doctor in cases where CPR was performed.
  Practice infection control policies should be agreed and implemented. Standard precautions should be taken with all patients in all health-care facilities at all times by all staff.
  Appropriate post-exposure evaluation and medical management policies should be in place, in conjunction with the policies of the relevant area microbiology department and hospital service. This applies to incidents of known exposure to, e.g. patients infected with TB, blood borne viruses.

>> Further information on MRSA and hand hygiene

>> Further information on Infection Control in general practice
7. Management of some common health and safety risks in your practice

Further information on Pregnancy at Work Regulations

• Vaccination
  Vaccination should be recommended for staff at risk.

Information on vaccination for healthcare workers (see chapter 18 of publication)

• Personal protective equipment
  Personal protective equipment: The ‘familiarity’ of general practice staff with their patients and extended families over many years should never be a reason for not wearing gloves when appropriate.

7.1.3 Needlestick injury or ‘sharps’ injury

Needlestick injuries and injuries involving other ‘sharps’ which are contaminated with body fluids may occur in general practice. ‘Sharps’ include scissors, razors, lancets, scalpels, broken glassware, glass smear slides, surgical clips, as well as needles and syringes. Beware of bone fragments if assessing an accident victim who may have a fracture.

2006 Department of Health Guidelines on transmission of blood borne diseases

NB Recommendations page xiii-xvii

NB Standard precautions should be taken with all patients in all health-care facilities at all times by all staff. See Table 1 Page 16 for Standard Precautions

Diseases transmitted via ‘sharps’ injury include:
• Hepatitis B virus
• Hepatitis C
• HIV.

Hepatitis B can be effectively vaccinated against; at present we have no vaccine for hepatitis C or HIV. HIV infection has been reported after occupational exposure via splashes of infected blood to the eyes, nose and mouth. The risk of transmission of HIV via needlestick injury from an infected source has been quoted as 0.3%, i.e. 1 in 300. The amount of hepatitis B infected blood required to transmit infection via needlestick injury is quoted as 0.0004ml. Unfortunately, we do not have statistics for general practice on the incidence of the three occupationally acquired infections as mentioned above. Treatment: GPs need to have a plan of action in place to manage needlestick injuries in the practice (see Table (2) treatment)

Table- Management of needlestick injury – (1) Prevention

• Taking blood specimens is always potentially risky as healthcare workers deal with people of unknown infectivity, no matter how well we think we know our patients. There is no excuse for not wearing gloves. Carefully searching for suitable veins will balance any reduction in tactile ability. Ideally a separate room or a separate area within a room should be available for phlebotomy.
• Immunisation is recommended in individuals who are at increased risk of hepatitis B because of their occupation. It is important that immunisation against hepatitis B does not substitute for good infection control procedures e.g. cuts and grazes must always be covered
• Food or drink must not be consumed in any clinical area.
• When gloves have been in direct contact with blood or body fluids, gloves should be replaced when possible and hands should be washed.
• Protect the eyes and mouth (with goggles or a mask) when splashing is a possibility e.g. when scrubbing instruments prior to autoclaving.
• Clinical waste should be segregated into yellow sacks for appropriate disposal so as to avoid being disposed of in household rubbish bags.
• Whoever uses sharps should be the one to dispose of them.
• Sharps containers should be convenient to the user to avoid having to walk past people while holding contaminated needles and in case of tripping while walking to the bin.
• Do not put needles in your pocket or handbag.
• Sharps containers should be kept out of children’s reach when in use e.g. at a height on a wall hook, or on a trolley surface, never on the floor.
• Do not re-sheath needles under any circumstance.
• Carry sharps containers by their handle and never by the body of the container.
• Sharps containers may leak fluid and this fluid can cause infection.
• Never overfill sharps containers, or force more sharps into them above the fill-line mark or according to manufacturers’ instructions. Fingers must not go beyond the lid margin.
• Close sharps containers when not in use, lock securely when full and store carefully while awaiting collection for incineration.
• Avoid short cuts and taking risks.
• Do not handle suture needles, use a needle holder.
• Report incorrectly disposed sharps as dangerous occurrences in your accident book as a medium of ongoing training.

Management of needlestick injury – (2) Treatment
• Bleeding from a wound should be encouraged, although no ‘scientific’ evidence exists to show this reduces transmission rates of HIV.
• Wash the area with soap and water.
• Splashes to the nose or mouth should be flushed with water.
• Splashes to the eyes should be irrigated with (preferably sterile) water.
• Record the details in the accident book including the date and time, source of the sharp instrument, the source patient’s name and address, whether the source patient is known to be in a high risk group for Hepatitis or HIV infection, whether the staff member is immune to hepatitis B.
• The GP on duty should be contacted with these details as soon as possible and appropriate actions taken.
• Regional Microbiology departments, Hospital Infection Control teams and all Casualty Departments have policies in place for management of needlestick injuries in the health care setting. All GPs should be aware of local policies including management during out-of-hours. It may be necessary to discuss immediate management with a Clinical Microbiologist, who can advise whether specific immunoglobulin or post-exposure prophylaxis is recommended, i.e. whenever there has been a significant exposure to body fluid known to be or strongly suspected to be infected with HIV or hepatitis virus. If a high-risk exposure has occurred, specific treatment should be commenced within one or two hours of the inoculation injury for best results, or at least within 10 days if deemed necessary. Post- exposure treatment does not guarantee to prevent all cases of transmission of occupationally acquired infection and side-effects are common. An individual may wish to start the treatment for a few days until a clearer picture of the risk arises, and they can assess their level of risk.
• The recommended follow-up procedures for serology testing should be adhered to including counselling for blood tests at the time of incident, and at three months and six months after the incident (and further tests if indicated). During the follow-up and testing period it may be necessary to follow advice on preventing further transmission of infection.
• Permission and consent of the source patient is required for any hepatitis B, C or HIV testing on their blood.
7. Management of some common health and safety risks in your practice

7.1.4 Spillage of blood or body fluid

Body fluids spills or accidental breakages of containers of body fluids should be reported, and the area cleaned and decontaminated by a trained staff member who is using personal protective clothing. Blood spills should be dealt with promptly. The blood should be immediately covered with either:
- with disposable towels, which are then soaked with sodium hypochlorite solution (at 10,000 ppm); a 1:10 dilution of household bleach should provide 10,000 ppm of sodium hypochlorite solution, but labels should be checked.

After a few minutes the residue and towels are removed and disposed of as clinical waste by a worker wearing protective clothing including gloves or apron and if an extensive spill has occurred, protective footwear to avoid contamination, goggles to prevent splashes into the eye, and face mask to protect the face and mucus membranes.

NB the chemical substances referred to above also have their risks. Please ensure you are familiar with instructions and cautions on their use. Consideration should be given to choosing floor surfaces which are amenable to efficient cleaning of spillages.

7.1.5 Sterilising Reusable Medical Devices

All medical devices must be used, cleaned, sterilised and maintained according to the manufacturers’ instructions. This includes vaginal speculae and minor surgical instruments used in primary care. If using autoclaves, moist heat autoclaves are the best option for sterilising equipment used in general practice. Some GPs have decided to use only disposable speculae and instruments following recent recommendations and information (2003 onwards) on managing the risk of prion transmission from use of reusable medical devices (including vaginal speculae and surgical instruments). See below.

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> Guidelines on minimising the risk of transmission of transmissible spongiform encephalopathies in the healthcare setting in Ireland.

Key points:
1) Cleaning surgical instruments & speculae is an essential part of an effective disinfection and/or sterilisation process
2) Automated washing methods are preferred over manual washing
3) Instruments should be reprocessed in a central sterilising processing unit (CSSD) where possible
4) NOTE Chapter 4 on specific guidance for washing reusable medical instruments include: protective goggles, two dedicated sinks (one for washing and one for rinsing IN ADDITION to normal hand wash basin),
5) NOTE Table 4.2, ineffective and partially ineffective methods for inactivation of prions
6) NOTE Chapter 6 recommends tracking system for decontaminated reusable instruments

For further information on reusable medical devices, go to www.nice.org.uk, www.dh.gov.uk or www.hhra.gov.uk.
7.1.6 Clinical waste

According to the Waste Management Act (1996), Category 1, generic type of Hazardous Waste includes:

- Anatomical substances, hospital or other clinical waste
- Pharmaceutical or medicinal compounds.

Properties of waste which may render it hazardous: Explosive; oxidising; highly flammable; flammable; irritant; harmful (substances or preparations which, if they are inhaled or ingested or if they penetrate the skin, may involve limited health risks); toxic; carcinogenic; corrosive; infectious (substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in humans or other living organisms); teratogenic; mutagenic; ecotoxic.

Management of clinical waste

Clinical waste should be properly segregated, bagged and stored so that it is safely contained. Clinical rooms could have automatic spring closing door features to minimise the possibility of children wandering into dangerous areas. Materials stained with body fluids, e.g. dressings, swabs, gloves, couch paper tissue rolls, should be disposed of as clinical waste and not normal household type refuse. Ensure licensed clinical waste management contractors transport your clinical waste, or HSE appointed contractors. Also, be alert to the possibility of stored waste becoming a fire hazard.

7.2 Physical hazards

Some potential causes of accidents in general practices resulting from physical hazards are:

- Manual handling, e.g. heavy, awkward or hard to reach loads, files at the back of a heavy top drawer in a filing cabinet, stiff and heavy drawers, handling patients
- Equipment, e.g. poorly maintained electrical appliances, splintered furniture, sharp corners
- Slipping/tripping hazards*, e.g. poorly maintained floors or stairs, trailing cables, loose or torn mats
- Fire, e.g. from unguarded heaters, combustible materials, refuse
- Electricity, e.g. poor wiring, poor maintenance
- Hazards of the workplace premises itself, e.g. stiff windows latches, baring doors can crush fingers
- Hot substances or surfaces, e.g. excessively hot tap water; sterilising instruments;
- Hand-held appliances, e.g. electrocautery and cryoacutery equipment; scissors
- Poor housekeeping, e.g. lack of hygiene, obstacles on floors and hallways, clutter.
- Assaults

*Slips, trips, falls and manual handling accidents are common in workplaces with similar activities to general practice.

Management

Legislation details the attention which must be given to areas such as standards of work equipment, the premises and facilities to be provided for staff.

Good housekeeping and sensible workplace design will help to address risks of slips trips and falls.

Overall, any deficiencies or dangers should be reported to the person responsible for safety as soon as is reasonable.

>> Text of safety health and Welfare at Work General Application Regulations 1993 for detailed information on physical hazards listed below 7.2.1-7.2.7
7. Management of some common health and safety risks in your practice

7.2.1 Premises

The arrangements for maintenance of the premises both inside and outside should be documented. List the intervals for a general ‘spring clean’ of floors, upholstery, windows, doors, skirting boards etc. Some hazards, e.g. loose handles, hinges and latches for example will need to be dealt with as they arise. Outside your building, list your arrangements for addressing, e.g. broken or uneven paths, wet slippery leaves etc.

7.2.2 Practice equipment

Check that practice equipment is kept in good working condition, and is maintained and serviced as per manufacturers’ instruction. Is your oxygen cylinder refilled and stored as recommended?

7.2.3 Fire

General practice premises are at additional risk of fire due to large amounts of paper, flammable substances including oxygen and smear fixatives, multiple operators of electrical appliances, in addition to a large throughput of people.

Management

Assess your practice hazards from the viewpoint of the layout of your premises. Are alterations necessary? Are there safe exits, with emergency lighting for illuminating access in the dark? Consider how an elderly or disabled person would be able to exit quickly. What fire prevention and fire control measures do you have? Are staff trained to use fire extinguishers? Fire blankets? Do you have regular fire drills? Consider the position of fire extinguishers and fire alarms. Are your fire extinguishers within their use-by-date? It is crucial for all staff to be familiar with practice evacuation procedures. Everyone should know the external assembly point, so that nobody’s life is put at risk re-entering the building in search of missing staff.

Further information on fire prevention in your practice premises can be obtained from the Chief Fire Officers Department in each County Council and Local Authority, and from the Fire Act 1981

7.2.4 Electricity

Hazard and risk

Electricity and electrical equipment have the potential to cause electrocution, burns, serious injury and death.

Management

The employer has a duty to provide safe equipment; this includes computer equipment but also kettles, microwaves, toasters, electrocautery equipment, and vacuum cleaners. Employees also have a duty to bring unsafe equipment to the attention of the employers, e.g. frayed flexes, broken plugs or sockets. Equipment should be serviced at intervals in line with manufacturer recommendations. Empty sockets may need safety blank plugs if they are accessible to small children.

7.2.5 Ergonomic hazards

Ergonomics is the study of how people relate and adapt to their working environment with a view to enhancing their safety, health, productivity and quality of life.

Ergonomics encompasses:
- Human factors, e.g. posture, movement, motivation
- The design of workspaces, e.g. relative positioning of chair, desk
- Its surrounding equipment, e.g. VDU (visual display unit), printer, telephone
- The work organisation, e.g. roles and responsibilities, monotonous tasks, training
• The physical environment, e.g. noise, lighting, odours, ventilation, and temperature).

The importance of ergonomics is confirmed by specific legislation on VDU usage, manual handling, workplace conditions and standards of work equipment as in the 1993 Regulations.

### 7.2.6 VDU hazards

VDU hazards can arise in the office, reception area, or any consulting room with a VDU workstation. Associated hazards can be categorised into poor workstation design and layout, poor workstation environment, lack of training and lack of consultation with the VDU user. Upper limb discomfort and visual fatigue are the main problems that may arise. To date, there is no medical evidence to support any association between VDU use and any permanent damage to eyes or eyesight, but it may give rise to temporary visual fatigue. It may also make existing visual defects more obvious.

A VDU user is not strictly defined by the 1993 Regulations. However, it has been accepted that a VDU user is someone who uses a VDU screen for one continuous hour in each working day (HSA guidance).

>> Information on Display Screen Equipment (VDUs)

**Management**

Correct management of ergonomic hazards relies heavily on appropriate layout of the workstation area and on each individual adopting technique of good posture and movement. Consider the parallels between a driver having a comfortable driving position, handling a car and muscular aches and pains after a long drive. This may appear to be self-evident but in reality requires a risk assessment of workstations and work-practices, and may require simple action such as the repositioning of a chair. Information should be provided to VDU users so that they may arrange their workstations so as to avoid problems of screen glare and reflections, awkward postures and movements, and the resulting fatigue and stress. Training and information should be provided with regard to the proper use of software also.

Correction of visual defects can result in better worker performance and worker comfort. Employers have a duty to ensure that VDU users have an eye-sight check before commencing VDU work and at ‘regular intervals’ thereafter, or if an employee experiences difficulties which may be related to VDU work.

>> Information on eye tests for VDU users

VDU information could be provided in handouts or displayed on notice boards for reference. There should be adequate breaks from VDUs for those who use them for long continuous periods, and these intervals may be used for other staff functions such as filing, handling the telephone or reception work. Most general practice staff are familiar with multi-tasking and so would be unlikely to spend continuous hours using a keyboard and screen without alternative movements and tasks.

Further, extensive, detailed information on VDU use is available from HSA for more complex problems, and the specific regulations that apply can be read from the ICGP and HSA websites.

### 7.2.7 Manual handling

Manual handling includes any movements or actions that require lifting, carrying, pulling, pushing, or stretching, which involves risk, particularly of back injury, to employees, (e.g. lifting patients, moving furniture, lifting boxes, reaching into the back of filing cabinets).
Management

Detailed specific legislation applies to the prevention of manual handling problems in the workplace in the 1993 Regulations. The employer is required to carry out a risk assessment in order to eliminate, avoid or minimise risks, and to provide information and training where appropriate as part of a practice policy on manual handling. Practice personnel should be made aware that they should never attempt to lift anything beyond their capability and to seek help when possible. This also applies to GPs and nurses who may be alone with patients when patients need to get on or off examination couches etc. Instead, patients should be encouraged to move themselves or to assist the person helping them, and the GP or employee should request assistance. Lifting awkwardly, e.g. boxes from an attic, or in restricted areas e.g. narrow aisle, is as potentially dangerous as lifting beyond ones capability.

Manual handling can be complicated by slips, trips, falls, striking against objects or trapping of fingers or limbs, so good housekeeping and adequate lighting is important.

7.3 Chemical hazards

Chemicals that are commonly used in the home like bleach or drain treatments have to be regarded and assessed differently if they are present in the workplace, as when they are present in a workplace they are governed by Health and safety Legislation.

General practice staff may be exposed to a wide variety of potentially toxic chemicals during normal working conditions or during accidents. They range from common everyday products like correction fluids and printer ink to disinfectants, oxygen and liquid nitrogen.

7.3.1 Effects of chemicals

The range of effects may vary from minor skin irritation to chronic disease (e.g. occupational asthma) or adverse reproductive outcomes.

The following are possible effects of chemicals:

- Immediate effects (e.g. acute toxic effects or flammability)
- Long-term effects of exposure (e.g. asthma, cancer)
- Potential of explosion (e.g. oxygen)
- Potential skin problems, (e.g. skin irritation or sensitisation, e.g. latex)
- Potential chest problems (e.g. respiratory irritation or sensitisation, e.g. airborne powder from latex gloves).

Chemical substances of some sort are used every day. In most cases the hazards are well documented and it is possible to access further information if necessary. Regulations require certain chemicals to be labelled according to their hazards. These take the form of codes which are displayed on the container, e.g. smear fixative ‘flame’ label.

In general practice, be vigilant about how you store toxic chemicals; it only takes a few seconds for one curious child with access to a cupboard for a disaster to occur.

Management

The employer is responsible for providing information and training to their employees or to any...
self-employed person who may be affected by chemical exposure arising out of their work undertakings. Information could be communicated through in-house labelling, formal training, written manual or memo. Under the Safety Health and Welfare at Work

>> Chemical Agents Regulations 2001

Packaging, labelling and safe storage of chemicals in the practice needs to be addressed, as well as actions required in the event of skin contamination or ingestion or inhalation.

>> Information on material safety data sheet (SDS) for chemicals.

These sheets are often supplied with the product, but are always available from the manufacturers who are legally required to provide them. The MSDS detail the known toxic effects of substances under various possible exposure routes, be it via inhalation, skin contact, or ingestion. The MSDS also give advice regarding precautions and initial management of any hazardous effects. All practice staff should have access to the appropriate MSDS for each toxic chemical they might use in the practice. One member of staff could be assigned this role allowing for all staff to be kept up to date on changing chemicals or brands in the practice.

Staff information and training

Staff training should encompass:

- How to access available chemical hazard information. Labels and MSDS information should be compiled. A good example could be where a practice log book displaying MSDS leaflets from products purchased for use in the practice. This would help to keep track of changes of brands or constituents over time.
- How to identify chemical hazards present in the practice (this would be covered during the drawing up or the review of the safety statement)
- Training regarding the use of personal protective equipment and safe work practices

7.3.2 Latex sensitivity or allergy

The protein in natural rubber latex can cause allergic reactions in the occupational setting. It is a rapidly growing problem for health care workers as its effects are cumulative. Development of a natural rubber latex allergy, and the morbidity that may ensue, can be devastating for staff physically, emotionally, and financially.

Skin rashes, cracked skin and hives may result. Other chemicals incorporated into latex gloves include chlorine, and antioxidants (consider how gloves become brittle when left exposed to air after time), and these chemicals may also cause dermatitis.

The dermatitis could be

- contact irritant (non-immune) dermatitis,
- allergic contact (type IV hypersensitivity) dermatitis, or
- Immediate (type I hypersensitivity) reaction which may culminate in anaphylactic shock.

Powdered gloves contain cornstarch powder, which the latex protein particles may adhere to. An aerosol of latex protein can be created by the powder becoming airborne during putting on and taking off powdered gloves. This can cause coughing, sneezing, watery itchy eyes and occupational asthma.

Any individual could develop this sensitisation and allergic response to latex, which may progress unpredictably after minimal symptoms to cause life-threatening anaphylactic shock.

Management

Avoidance of latex is the key. Gloves should only be worn when a barrier to infection is required during a procedure, and should not be worn continuously for long periods when unnecessary.
7. Management of some common health and safety risks in your practice

Preventing sensitisation and exposure for those who are susceptible may be complex and involve costs to the employer and employee. Gloves and other articles that contain latex in the person’s environment e.g. rubber bands, tourniquets, and some dressings, may be substituted with non-latex materials, as once sensitised to latex a person becomes allergic to all latex.

Diagnosis is generally made on the basis of the history, but it may be necessary to arrange blood tests or skin tests under controlled conditions. Practice staff with suspected latex allergy should attend either their own GP or seek advice from ICGP Health in Practice Occupational Physicians.

Policies are needed to identify employees at risk at an early stage, e.g. specific latex questionnaire, and to implement appropriate employee education and controls in order to prevent deterioration in skin condition.

7.4 Psychosocial /Human Factor Hazards

In general practice we are lucky to have enormous scope for job satisfaction. We have the option of developing special skills and special knowledge at any stage of our career as family doctors.

However, we are human, and we may be affected by stressors at work. All jobs have potential stressors. We are also naturally prone to stress from outside the working environment, e.g. bereavement, relationship problems and financial difficulties. So it is clear that anyone may become susceptible to their job stressors

7.4.1 Stress

Stress and stress-related conditions combined are the greatest cause of absenteeism in Europe. Apart from the individual experiencing it, their stress may impact on the many people they come in contact with and may have many knock-on effects. Everyone needs to consider ways of managing stress in the practice.

The general duties of the employer in the 2005 Act include to:
1. Ensure, as far as is reasonably practicable, safety, health and welfare of employees
2. Manage and conduct their work activities to ensure the safety, health and welfare of their employees.
3. Manage and conduct work activities to prevent improper conduct likely to put employees at risk.

The HSA therefore expects that management of stress and bullying be part of the health and safety management of a workplace.

If you consider the working environment of general practice, a small number of people work closely together in ‘relative isolation’ from other sections of the health care system, often under pressure from each other and from other people (e.g. patients and relatives). Patients’ demands and expectations added to the constraints of time available for each individual, with the additional pressure to provide a service after normal working hours (directly or indirectly) can cumulatively take their toll. General practice staff, not just doctors, have experienced being contacted by patients outside normal working hours for advice or requests! There are increasing pressures on all who work in general practice to be personally competent, flexible, tolerant, and to resolve queries and problems promptly.

Working in general practice, we tend to live close to or among the people we meet in the working environment, so there may be no defined barrier between work and home.
Common sources of stress in general practice

- Managing time in a demand-led environment
- Financial issues connected with controlling a business, being self-employed
- Being an employer of staff
- Role conflict generated by being a staff members’ GP and their employer. (ICGP Health in Practice programme recommends that you avoid this situation by encouraging staff to register with a GP outside their place of work)
- Living in or near to practice area – concern about reputation, being all things to all people, threat of criticism from patients and relatives (for generations!), inability to switch-off, being seen as ‘available’.
- Patients demands and expectations
- Litigation, complaints, and the threat of them
- Violence and aggression or the threat of it
- Interruptions to the work-family-personal interface, this may apply to all staff but especially doctors
- Excessive working hours i.e. evenings, nights and weekends in addition to the normal working day
- Administrative burden
- Role conflict of being a professional healthcare worker with moral and ethical issues
- Communication problems: GP-staff, patient-GP and patient-staff. Also, consider telephone calls that you and your staff find ‘difficult’ or ‘time-consuming’ (e.g. patients, relatives, hospital services)
- Dealing with distress and death
- Excessive feeling of responsibility for outcome
- Inability to cope with treatment failures or uncertainty
- Rapid pace of change in medical knowledge and technology
- Anxiety about dealing with crises when alone at work
- Isolation, inability to confer with medical colleagues
- Introduction of new equipment or work systems (unfamiliarity)

>> European Safety Agency on workplace stress

>> European Safety Agency Practical advice on workplace stress

>> European Safety Agency Practical advice on further information
7.4.2 Managing stress in general practice

Some type of ‘change’ becomes necessary when circumstances at work are unsatisfactory, otherwise the status quo will persist.

**Manage stress by:**
- Prevention – removes stress at source
- Develop your coping strategies to improve your resilience.
- Seek treatment and/or counselling if you are experiencing stress-related problems.

**Management of occupational stress in your practice**
- Identify situations that cause you stress. Why sometimes and not other times? Recognise how you respond to pressure. Is stress a threat or a challenge? Consider repetitive and foreseeable issues and plan in advance
- The workplace, the organisation of work and specific job tasks should be assessed and adjusted so as to avoid sustained stress. Look at how patients gain access to practice services and consultations. How is the telephone system used? Could it be upgraded? Who gives out test results? Consider the appointment system in use. Is it really in the patients’ interests to have un-booked demand led surgeries? Who is resisting change?
- Provide staff training in practice procedures for dealing with emergencies, including immediate management of a medical emergency. Train staff to handle intimidating situations. All appropriate staff should know the practice security precautions and arrangements.
- Good time management can be an invaluable tool. Stop interruptions; do something a different, quicker way
- Communication and consultation among staff should be facilitated and encouraged at appropriate times on a daily basis and also during structured practice meetings. This gives GPs and staff the opportunity to discuss problems and make suggestions they would otherwise have found difficult to bring up. If staff have been treated discourteously by a member of the public then it should be brought to the attention of the GP. Listen to what practice staff have to say, listen to each other.
- Utilise fax and email communications for convenience where possible. Information or queries can be transmitted instantly, avoiding spending precious time on telephone. Information can also be received promptly, when it is convenient for the recipient. Lengthy telephone interruptions are avoided. Clinical and reference information is readily accessible also on the internet.
- Physical surroundings (the working environment) could be taken into account when identifying stress hazards, i.e. room layout, décor, temperature, ventilation, lighting, and general cleanliness. ‘Nice’ places can help people feel more comfortable.
- Reduce the potential for litigation. Record all patient contacts (train staff to automatically give you notes of patients who telephone you), have a chaperone present in the room (but on the other side of the screen) during intimate examinations. Behave professionally; don’t give opportunity to being misinterpreted.
- Involve staff in safety audit, accident reporting and recording. Accidents cause stress.
- Monitor staff health and rates of absenteeism (e.g. Monday morning absenteeism, or frequent short absences) in order to identify problems at an early stage.
- Consider the needs of particular staff, e.g. recently bereaved staff, disabled staff using stairs, staff with ongoing health problems.
- Produce an employee handbook or manual and include the safety statement in it.
Coping skills for managing stress

- Prioritise, set realistic goals, and learn to say no appropriately.
- Think positively.
- Delegate. If you have nobody to delegate tasks to either recruit someone new or retrain existing staff. Practice staff can do many of the same tasks we do on a daily basis. This frees up GP time for GP tasks and adds to job satisfaction. We cannot be all things to all people.
- Change how you perceive demands on you or change how you respond to demands. Are the demands placed on you impositions or requests?
- Promote staff health and performance with information, education, regular appraisal & training.
- The role of exercise, rest and relaxation should not be underestimated. Spend time with family and friends.
- Look for help – e.g. The ICGP Health in Practice Programme.

7.4.3 Burnout

Burnout, or complete physical and mental exhaustion has been recognised as an end-stage consequence of chronic stress in the caring professions. General practice is no exception.

>> ICGP Health in Practice article on Burnout

7.4.4 Violence and Aggression

International research and an Irish research have confirmed that a significant percentage of those who work in general practice experience violence or the threat of violence in their work. Management of problems such as verbal or physical violence needs addressing from both the prevention aspect and from the point of coping with the aftermath of an incident. The risks to staff of violence at work must be assessed in the same way as any other hazard is assessed. Any act of violence, whether carried out outside of work, or within, is outlawed and should be reported to the Gardai. The laws of the State apply at all times and so violence at work is not treated differently to any other violent act. The HSA recommend that you report any such event to the Gardai and also to your employer. Your employer should also have procedures in place for dealing with violent incidences.

>> Prevention of workplace violence information

>> European Agency for Safety and Health at Work Fact Sheet on Violence at Work

>> ICGP Health in Practice Programme Information on managing the aftermath of a violent incident
7. Management of some common health and safety risks in your practice

7.4.5 Bullying and Harassment

Bullying includes aggression (physical and verbal), harassment, intimidation, shouting, and ignoring.

>> Information on bullying at work

>> Information on bullying from an employees perspective

>> Information on bullying from an employers perspective

To assist both parties in fulfilling their responsibilities, the HSA have produced a very useful document.

>> HSA Code of Practice in the Prevention of Bullying in the Workplace

>> Sample Practice Anti-Bullying Policy

Other useful information

>> European Agency for Safety and Health at Work Fact Sheet on Bullying at Work

7.4.6 Working alone

The GP employer must be aware if practice staff are alone on the premises during the early morning, late evening or at weekends. Staff who have experienced emergencies on the premises while the GP was not present, recall their experiences as traumatic and a lot of practice staff voice their concerns about how they would cope with emergencies when the doctor is not on the premises. Some practice staff have said they feel patients expect them to know what to do in emergencies, at least initially. Information and training on this topic can support you and it assists staff to feel competent. ICGP has a specific course in occupational First Aid for Staff.

>> Information on lone workers in general practice

7.6 Dealing with emergencies in general practice

Categories of emergencies

- Emergency evacuation, e.g. how often do you perform a fire drill? Do you check the safety and clearance of entrance(s) and exit(s)?
- Consider incidents that may occur in the practice area including a road traffic accident; fire; agricultural accident; chemical leak; explosion; poisoning; act of violence; drowning; public disorder where large crowds gather etc;
- Electricity power cut; water supply cut, gas leak, flooding.

7.6.1 Strategies for dealing with emergencies

Your safety statement should describe the procedures in place in the event of emergencies. Time is of the essence. Think…who should do what?

- Train all staff in good telephone techniques. What information is required from telephone caller or injured party? Do you have a procedure in place for calling emergency services? Do all staff know how and when to call Gardai, ambulance, fire, priest? Are relevant contact telephone numbers on speed-dial or on prominent display?
- Are there adequate supplies of emergency medications, e.g. anaphylaxis kit, O2, mobile communications, dressings
7.6.2 What are the advantages of addressing possible emergencies?

In general practice, as in the hospital setting, there are incidences of collapse and sudden deaths on surgery premises. Staff without first aid training have said they felt particularly helpless and distressed when events such as these occur in the practice, particularly if it is before the doctor arrives. Irrespective of how rarely these events might occur or how the eventual outcome might be unchanged, addressing possible emergencies with practice policies helps prevent or minimise stress and distress after anyone is faced with sudden crises.

7.7 First Aid

An Occupational First-aider is someone who has trained and been examined and holds a first-aid certificate from a person who is registered as a First Aid Instructor. A qualified first-aider is in a position to provide immediate assistance to somebody injured or suddenly taken ill before medical help arrives. They can also provide assistance to medical personnel at the scene of an emergency.

Common sense dictates that the doctors’ administrative staff should not be expected to know how to deal with certain medical emergencies in the same way as the GP would. However, a lot of practice staff are left alone at some time during a working day, especially those in single-handed practices. Many practice staff admit they fear they would not be able to deal with an emergency if they were alone in the surgery and feel they would benefit from a course in first-aid. There maybe a conflict of perception between the staff and GPs perceived need for staff training in this area. Practice staff are ideally placed on the front line for the practice to benefit from their knowledge of first aid. Staff also need training on avoidance of biological hazards while carrying out first-aid. The ICGP has provided Practice Staff Training Courses in First-Aid for a number of years.

People with heart attacks, choking, haemorrhage, poisoning, burns, scalds and severe injuries could present to doctors’ surgeries when the doctor is not on the premises. Seriously injured patients have died on practice premises. First aid may be unlikely to save these patients lives, but relatives of such patients and also practice personnel would feel more reassured about eventual outcomes if optimum first aid procedures are used and if no actions are omitted that might save a patient.
7. Management of some common health and safety risks in your practice

7.7.1 First-aid box
It is easy to make up your own practice first aid kit, and ideally there should also be one kept in the car boot of the GP on-call. It is also possible to purchase ready-made kits from chemists. If you do not have a first-aid kit you may need to improvise with scarves, tea towels and adhesive tape when you least expect to! A member of practice staff should be assigned the task of checking that the stock of the first aid box is sufficient and up to date.

Further information from ICGP which runs an Occupational First Aid course for medical secretaries, receptionists, administrators and nurses.

Recommended contents of the practice first-aid box
- Sterile dressings in assorted sizes (small, medium, large)
- Triangular bandages x2
- Crepe bandage x 2
- Adhesive tape x 1
- Sticky plasters, and strip of sticky plaster
- Cotton wool
- Antiseptic wipes
- Scissors, safety pins, disposable gloves
- Pen light/torch
- Sterile eye pads x 2
- Disposable containers of sterile normal saline for eye irrigation

7.8 Health promotion
The Centre for Health Promotion studies, UCG carried out a review of workplace health promotion activities and confirmed that the level of health promotion activity in Ireland even among medium to large companies is low. The study recommended that small businesses (i.e. those employing less than 50 people, i.e. general practice) should be given special consideration with regard to their level of health promotion activities.

Staff lifestyle interventions such as increasing exercise levels, healthy nutrition awareness, giving up smoking and reducing alcohol consumption could be encouraged, irrespective of how small the practice is. Discussion with the ICGP Health in Practice Programme could be one way of planning to introduce such initiatives or of disseminating information on successful practice based health promotion activities.

GP Staff should not register with their employer as their family doctor. GPs should discourage this “tradition” as it leaves the GP in a situation of potential conflicts of interest. Instead, practice policy should openly encourage practice staff to register with a GP away from their place of work.
References*

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31. Prevention and Control of Hepatitis B in the Community. WHO regional office for Europe (Denmark) and Viral Hepatitis prevention Board (Belgium). 1996.
33. Report of the Advisory Committee on Health Services Sector to the Health and Safety Authority. HSA. 1992
38. Tuberculosis in Health Care Staff. Faculty of Occupational Medicine, Royal College of Physicians of Ireland. Nov 1998.
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*All online references are included in the text*
Further Reading

- A short guide to Health and Safety law. HSA.
- ABC of Work Related Disorders. BMJ 1996.
- Computerising your practice. ICGP 1996
- Health and Safety Authority Annual Report 1998
- Counselling in Practice-A guide for general practitioners. ICGP 1996. Dr Austin O’Carroll, Dr Margaret O’Riordan.
- European Agency for Occupational Health www.osha.eu.int/
- European Foundation for Living and Working Conditions www.eurofound.ie
- Health and Safety Authority of Ireland www.hsa.ie/
- Institute of Occupational Safety and Health www.iosh.co.uk/
- Irish College of General Practitioners. www.icgp.ie
- Occupational Asthma. An employers guide. HSA.
- Officewise. Health and Safety Executive. UK.
- Pregnant at work. HSA.
- The misuse of alcohol and other drugs by doctors. BMA 1998.
- VDU Regulations. An easy guide for employees. HSA.
- Who cares for the carers? HSA information leaflet.