Hospital Topics

Guidance on preparing local rules to help implement the Health and Safety at Work etc Act

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Medical practitioners in the National Health Service should know that since 1975 all its staff have been both covered by, and liable under, the Health and Safety at Work Act (1974). Doctors may be concerned in safety as line managers, with responsibility for directing others, or as employees, with a duty to comply with directions given to them—often they are concerned in both ways at once. This entails more complexity than a first reading of the Act would suggest.

We have found that direct guidance from DHSS or NHS sources or from professional bodies on what is now required from NHS staff for safety at work has been slow to appear and inadequate in its coverage of the diversity of NHS activities; codes of practice are not yet available for much of our work. We therefore thought that the guidance notes on preparing local rules on safety that were devised by the Tower Hamlets District Safety Committee might be of some help to others. Central collation and distribution of such material in all NHS fields is desirable, but in the interim "self-help" may be useful.

We prepared a memo or check list to help heads of departments in our district in preparing written safety rules for their staff. There is a need for such written rules to be assessed, for their application to be monitored, and it is especially important for them to cover all work done by a department with specific details on hazards and on working arrangements.

Guidance notes for drawing up local rules for promoting health and safety at work

(1) (Name of department)

(2) INTRODUCTION

To state the Health and Safety at Work Act requirements (see District Policy) and that while the preparation of local rules is the responsibility of the head of department, familiarity and compliance with them, and keeping them up to date, is the responsibility of all staff.

(3) LOCATION

These rules apply to (give brief statement of areas/locations covered).

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(4) NATURE OF WORK

Give brief statement of nature of work in department with reference to section 14 (below) which lists activities and potential hazards, and facilities and arrangements for hazard avoidance and safe working.

(5) SAFETY OFFICERS

Head of department .....
Deputy (if appropriate) .....
Departmental safety officer .....
Special hazard
(eg radiation) officer .....

(6) HAZARD/INCIDENT REPORTING

All incidents
hazards
near misses
} must be reported immediately to:
(the DSO or head of department/deputy) who will complete an incident form.

Accident books must be kept for each department (arrangements to be made with unit administrator). All accidents to be entered by staff, or if they are unable to do so, by their head of department.

(7) EMERGENCY TELEPHONE NUMBERS

eg Fire
Toxic hazard team
Cardiac arrest
Works department
Duty administrator

(8) FIRST AID

Immediately available: eg location of first aid box; or state what is available, what for, how to use if special.

Emergency and accident department: where it is, how to use, when.

Staff clinic: where, when to use, times open.

(9) PREVENTIVE HEALTH PROVISION

(eg All staff working in this location are advised/must have immunisation against tetanus/TB, etc.)
Advice/testing and immunisation facilities are provided by.... ..... (or these facilities are available through your GP.)

(10) PROTECTIVE CLOTHING

For example, white coat, goggles, gloves, safety shoes—say why and when to use, and where to keep them.

(11) WARNING NOTICES

List site and contents:
(a) for visitors eg Radiation, Biohazard, No Smoking, Mind the Step
(b) for staff eg Report to..... on arrival,
eg warning lights to be used, fridge hazards.

(12) SECURITY

List types eg: drugs/chemicals/toxic substances/biohazards, valuables, personal goods, books, keys } and make reference to any *written* procedures to be complied with eg DHSS rules, departmental procedures, legislation
Closure of department out of hours: whose job
emergency access

(13) FIRE PRECAUTIONS

General: warn staff to learn sites of telephones, fire-fighting apparatus, local plans for escape.

Fire: give call numbers, sites of telephone.

Action: take no risks. Use appliances if possible. Close doors and windows. Turn off gas and electricity. Call emergency services,
int.....
ext.....
and state type of fire and site. Evacuate all personnel. Check staff and others accounted for. Collect at evacuation point. Care for patients. Keep others away.
Follow the orders of fire officer
police
site administrator
Evacuate from site procedures; detail these. (Seek advice from fire officer).
Lifts not to be used unless so ordered by incident officer.
Fire notices: should be displayed with relevant data written in (one format to apply for all wards, OPs, *x*-ray departments, kitchens, offices, lecture/seminar rooms, household, works department, residences, porters, and so on across the district).

(14) HAZARD AVOIDANCE

This section should include: outline of work done, plus
hazards generated eg *x*-rays in *x*-ray department and electric risks, wet floors, avoidance of excessive noise
source of further advice eg codes of practice, existing advice, legislation or DHSS guides relevant to the work done.

Specific activities

eg for radioactive work — dos and don'ts from relevant code of practice
for catering activity — dos and don'ts from DHSS Code and Training Advice
for laboratories — dos and don'ts from relevant code of practice
for animal work — dos and don'ts from biohazard advice
for workshop/factory areas (eg boilers, laundry, and works departments) — dos and don'ts from relevant Acts and regulations
for domestic work — dos and don'ts and local problems

General activities:

Common to many types of work.
eg Waste disposal: paper, food, sharps, chemical toxic, flammable, radioactive } Give a note on facilities provided for hazard avoidance
eg Floors, corridors: general need to keep slip free and open if a fire escape route
eg Spills: fat, water, chemicals, polishes, toxic, radiation, blood } procedures to follow
eg Electrical equipment: general checks (things to avoid eg in residences)
good housekeeping
to use works department for checks
specify the regular checks or servicing needed

Specific problems:

Collection of goods, transport of goods, delivery of goods } note special precautions and requirements for categories moved (consider: patients, radiation, flammables, food)
Lifting: general—use of back. To get help
specific—how to tackle jobs known to be problems
Reaching for goods: eg use of steps
eg storage arrangements
Storage of goods: avoidance of hazards and local arrangements
eg for flammables in metal storage cupboards and not in fridges
eg of food
of blood
of radiation
of sterile goods
of clean laundry
of dirty laundry
of bedding
of gas cylinders and the use of the supports provided
Office areas: care of floor (flex/'phone cables)
filing cabinet precautions (keep drawers closed)
turning off electric typewriters
Lockers: provision for personal effects,
for food
Washing and recreational facilities:
rest room, tea break,
food preparation, state where when precautions
Residencies: specific hazards
local fire drill, etc
no goods on window sills
electricity: not to overload plugs. To use the works dept for repairs
use of laundry or other facilities
use of kitchen area eg gas
Smoking arrangements: list non-smoking areas with reasons, and smoking areas for staff

Unexpected hazards:

List possibilities and give note on what to do or how to get help.
eg gas leaks
toxic spills
bomb scares
fire drills—to carry out local arrangements
disturbance of the peace
sudden illness

(15) TRAINING

List detailed hazard sources and training needed eg:
centrifuges, slicing machines, dish washers, ovens, mixers, fans, lifting patients, use of stretchers, use of high-power electrical appliances, use of fume cupboards, use of ultra-violet lights, use of radiation, use of drills, etc.
All precautions to be followed should be listed in section 14 (above).

MONITORING SAFETY ARRANGEMENTS
ADVICE TO HEADS OF DEPARTMENTS—HEALTH AND SAFETY AUDIT—CIRCULAR

Available from the hospital secretary or unit administrator, on request.
Abstracts of efficiency studies in the National Health Service (No 180); Health and Safety at Work Act, 1974; audit of the standards of health and safety practices.
This audit should help in establishing the standards of the health and safety practices in each health unit in the district and should be used with the help of unit administrators and local safety committees.

Site visits—Your local safety subcommittee should visit you to review safety arrangements. If you have trouble with these rules such a visit may help and can soon be arranged.
Union safety representatives appointed from October 1978 have the right to arrange random safety inspections with heads of departments at minimum intervals of three months, or earlier in emergency.
The inspectors of the Health and Safety Executive may arrange to inspect your department at any time, but can be expected to respect sensitive work areas.
The inspectors of the Health and Safety Executive can be asked to give guidance by you or by any member of your staff or others affected by your department independently if a hazard is causing concern.
Heads of departments are strongly advised to discuss their local safety arrangements with their staff at regular intervals, both to keep the rules up to date and as a vital part of safety training.

Comment

Much of industry was covered by safety legislation before the general enabling Act of 1974. Similarly the universities, much of whose work is covered by codes of practice, have largely structured their safety arrangements, while the NHS hospital and community systems are still emerging.

The NHS is at a disadvantage, since compliance with the Act is hampered whenever major funds are required because of its continued financial crisis. Discouraging though this is, it makes it especially important to ensure that awareness of safety requirements is increased, working arrangements are made as safe as possible, and NHS staff are actively concerned in implementing the requirements of the Act. The development, provision, use, and discussions of local safety rules are key areas in these respects and are useful also in increasing identification and notification of hazards. The NHS is a large and spread-out organisation. "I have promises to keep, and miles to go before I sleep." (Robert Frost.)

What is the latest treatment for and the role of vasodilators in treating senile dementia? Has encephabol any part to play?

Vascular disease does not cause the slowly progressive dementia of old age—primary senile dementia. Brains from patients with senile dementia show cerebral atrophy with senile plaques and neurofibrillary tangles as in Alzheimer's disease. In such patients cerebral blood flow is reduced, but this is probably a result of the cerebral atrophy rather than its cause. Dementia associated with cerebrovascular disease depends on the occurrence of cerebral infarct, usually multiple small ones. At least 50 ml of brain must be lost before the symptoms of dementia occur. Patients with multi-infarct dementia are generally rather younger than those with senile dementia. They are more often men, and there is often underlying hypertension. The illness is episodic, each episode representing a further infarct. Clinically, weakness, slowness, dysarthria, dysphagia, march à petit pas, brisk reflexes, and extensor plantar responses are well established by the time the patient is obviously demented. A distinguishing feature is emotional incontinence with pathological laughter and crying, which is unusual in senile dementia.[1 2]

There is thus no a priori reason to expect that vasodilators will improve cerebral function in primary senile dementia, and there has been a move away from the promotion of drugs as cerebral vasodilators. But the same substances and some newer ones are now promoted as agents to modify the physical characteristics of the blood itself, allowing it to flow more readily through narrowed vessels or as metabolic improvers. More than 20 drugs are currently being promoted in Britain for the brain failure of old age, and some of them do increase the cerebral blood flow. Unfortunately, there is no correlation in the published results between enhanced cerebral blood flow and clinical improvement. Some double-blind controlled trials with metabolic improvers report improvement in memory, intellect, and behaviour, but the degree of improvement has seldom proved of great practical importance, and the evidence is still probably insufficient to support the routine or frequent use of any of them.[3]

Although there has been no break-through in drug treatment, an important advance has been the wider recognition that dementia is a serious problem meriting high priority in medical research. Moreover, old people with dementia retain their individuality and often continue to be lively. It is important to regard them always as people and not as cabbages. They can readily become unhappy and they respond to kindness, interest, and emotional support. If they become agitated or over-active they may well need tranquillisers, though in quite small doses. Overactive patients often do best on haloperidol (Haldol, Serenace), 2 mg twice daily, but it is important to watch for Parkinsonism. An alternative is thioridazine (Melleril), 10-25 mg thrice daily. Sometimes an antidepressant may help, and if the patient is apathetic and withdrawn some improvement has been reported with stimulants such as methylphenidate (Ritalin) fencamfamin (Reactivan), and pemoline (Kethamed). Attendance at a day hospital is an important method of support both for the patient and his family. Pyritinol hydrochloride (Encephabol) is not available in Britain, and I have no experience of it. It is reported to promote the uptake of glucose by the brain.[4] It has been used in confusional states, apoplexy, and encephalitis. Reported side effects are headaches, nausea, and dizziness. It is on sale in Japan, Australia, Germany, South Africa, and France. The last reference mentioned in *Martindale* is a paper published in 1969, which suggests it is not of great clinical value. It is not mentioned by Hyams.[3]

[1] Hachinski, V C, *et al*, *Lancet*, 1974, **2**, 207.
[2] Hachinski, V C, *et al*, *Archives of Neurology*, 1975, **32**, 632.
[3] Hyams, D E, in *Textbook of Geriatric Medicine and Gerontology*, ed J C Brocklehurst, 2nd edn, p 670. Edinburgh, Churchill Livingstone, 1978.
[4] Martindale's *Extra Pharmacopoeia*, 27th edn, p 1805. London, Pharmaceutical Press, 1977.

What is the best advice to a woman in her 50s who is troubled with long-standing facial hirsutism? Electrolysis is effective for a period of about 10 days.

This is difficult to answer without a more detailed description of the type of hirsutes on the face and elsewhere and what recent change there has been—particularly how generalised it is and how coarse or fine. If it is coarse electrolysis is satisfactory but only if the hirsutes is not too extensive (I am puzzled about its effect lasting for 10 days: if that is true the electrolysis is not being done properly because its effect is permanent, it is just that it is a long and painful process). The alternatives are physical removal with wax, depilatory, or razor (razor is psychologically unsatisfactory) and bleaching what is left because the hairs are usually dark and show up more. It is important to emphasise that none of these procedures increase hair growth, density, toughness, or colour. The only new procedure is cyproterone acetate. This will control hirsutes if it is of the usual androgen-primed type and despite her age is worth serious consideration if the condition is severe.