PRACTICE OBSERVED

Law and the General Practitioner

Health and Safety at Work Act 1974: enforcement

ANNE CULLINAN, NORMAN ELLIS

The Health and Safety at Work Act covers all "places of employment," and its inspectors therefore have the right to inspect general practitioner's premises. The Health and Safety Executive has divided the country into areas, and each has its own team of inspectors. One group of inspectors is responsible for the "health services," which includes general practice premises.

Powers of the inspectors

Each inspector has a warrant of appointment that states his extensive powers, and the general practitioner may ask to see this for identification. An inspector normally has the right to enter any premises to enforce the Act. He does not have to seek the GP's or any other person's permission, neither does he have to give notice of his visit. He may, however, only enter at a "reasonable time."

Inspectors normally give notice of their visits, and ring to make an appointment. Occasionally, however, some visits are "reactive" in response to a complaint from an employee or even a patient. Sometimes inspectors have made unannounced visits, not because they intend to cause offence or "catch" anybody off guard, but simply to slot the inspection of some small premises into a day's schedule of visits to larger premises. Although a surprise visit may be disconcerting, the GP should not assume that the inspector has an ulterior motive. Oddly enough, it is because inspections of surgeries are still a comparatively rare event that some upset has been caused to the few GPs so far affected.

British Medical Association, London WC1H 9JP
ANNE CULLINAN, LLB, industrial relations officer, Oxford region
NORMAN ELLIS, MA, PHD, under secretary

During his investigation the inspector can interview and take written statements from anyone who may have relevant information (and this could include patients as well as members of the ancillary staff). The inspector may want to obtain information to establish the facts about an accident or for evidence in legal proceedings. Any information provided will normally be treated as confidential. The information, however, may be subsequently disclosed if a prosecution is brought against the employer.

What will the inspector look for?

The inspector will wish to ensure that the GP, if he employs five or more persons, has issued a statement of general policy on health and safety and any relevant instruction on safety procedures. He will expect an accident book to be kept on the premises. He will want to assure that all electrical equipment is in safe working order and properly maintained. The normal standards applying to toilet and washing facilities in offices and shops should be met in the practice premises. He will undoubtedly expect to find a supply of hot and cold running water, and he may also recommend that wrist-operated taps should be fitted in rooms used for the examination and treatment of patients. Inspectors are also concerned about the condition of the heating plant, the arrangements for the storage of drugs, the condition of steam sterilisers, the standards of heating and lighting, and the procedure for the disposal of clinical waste. The *Statement of Fees and Allowances* provides for the direct reimbursement of any charges levied for the disposal of trade waste (see para 51.12(b)).

Improvement and prohibition notices

After completing his inspection the inspector will usually approach the person in administrative charge of the premises (often the practice manager) about any improvements to safety

procedures and standards that may be required. If these are minor he will simply ask for them to be put right. If there is something more serious the inspector may write formally, or may serve a written notice requiring matters to be remedied. This is known as an Improvement Notice; it will specify a time limit of not less than 21 days within which the improvement must be made. The inspector must inform staff as well as the GP of his intention to serve it. He may also bring a prosecution alleging a specific breach of a statutory provision.

If there is a serious risk to health or safety an inspector may issue a Prohibition Notice prohibiting the offending work activity. If the position is very grave the notice will take immediate effect, and work must stop at once; otherwise, a deferred Prohibition Notice may be issued stopping the work after a specified time.

The Improvement and Prohibition Notices are both served on the person carrying on or in control of the work in question, and this is normally done at the time of the inspection. The inspector should also advise of the procedure for appeal against the provisions of the notice. The GP would usually receive the Notice, unless control of the practice had been delegated to a practice manager. When complied with, the Notices cease.

Offences and penalties

Because the Health and Safety at Work Act is a criminal statute contravention of its provisions may lead to a fine or imprisonment. Both the employer and his staff (as well as any other person on the premises) may be liable to prosecution. Furthermore, failure to carry out *any* duty under the Act is an offence and could also lead to prosecution. Verbal or written warnings, however, such as Improvement Notices, always precede any legal action. It is also an offence to obstruct an inspector in the performance of his duties and to contravene an Improvement or Prohibition Notice.

The Health and Safety Executive, as the enforcing authority, has the discretion to decide whether or not to prosecute and this decision is taken after advice from the inspector. Alongside a criminal prosecution of an employer, an employee could sue his employer for damages on the basis of employer's liability law, or simply for negligence. In any prosecution by the Executive account will be taken of what was reasonably practicable in the circumstances. This offers little consolation to a large employer but some comfort to the smaller employer with limited resources.

Crown premises—health centres

Because a health authority is a Crown body it cannot be prosecuted under the Act. This, however, does not alter the liability of the GP if he is the controller of premises owned by the authority. Although Improvement or Prohibition Notices cannot be served on the health authority itself, Crown Notices can be served, and these will normally be complied with. If an authority does not comply, the Department of Health will intervene.

Fire precautions

Although the Fire Precautions Act 1971 is distinct from the Health and Safety at Work Act, GPs should be aware of its requirements. The GP and his employees, together with any other people working on the premises, must for their own safety and for the safety of others see that there are adequate means of escape (unlocked, unobstructed, and useable when people are in the building) and also adequate fire fighting equipment that is properly maintained and readily available.

In large buildings where more than 20 people work, or where more than 10 people work other than on the ground floor the owner of the premises is required to obtain a certificate from the local fire authority regulating the means of escape and markings of fire exits. If the premises are owned by a health authority they are deemed to be Crown property, and the fire authority would be the Home Office, Scottish Home and Health Department, or Welsh Office. These premises should be equipped with properly maintained alarms and the employees should be familiar with the means of escape and the routine to be followed in the event of a fire, and they should have emergency lighting if this is necessary. Local fire inspectors ensure that premises comply with these statutory requirements. If you are in any doubt whether your premises require certification you should contact the fire prevention office of your local fire brigade.

Points to act on

(1) An accident book—for example, Health and Safety Executive Book, F2509 (which can be purchased from HMSO at £1·70), and copies of form 2508, the Accident Report Form—should be kept in an easily accessible place.

(2) You should prepare a written safety policy for all employees. Although this is mandatory only for those with five or more employees it is advisable for all general practitioners to prepare such a statement, even if it is brief and simple. This may be included in the employee's contract of employment.

(3) Regularly check any obviously hazardous areas—for example, unfinished building work, electrical equipment, loose floor covering—to see if there is anything that needs immediate attention.

(4) Ensure that electrical equipment is regularly maintained and serviced.

(5) Consider appointing a "safety officer"—this could be the practice administrator.

(6) Look at your lease or licence agreement to see who is responsible for the upkeep and repair of the premises. Consult your practice solicitor or the BMA if there is any doubt.

(7) Warning notices should inform patients and visitors of any hazards.

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This is the third of a three-part article on the Health and Safety at Work Act.

Further reading

Free booklets available from the Health and Safety Executive

Health and Safety Commission. *Safety representatives and safety committees.* London: HMSO, 1977.
Health and Safety Commission. *The Act outlined.* London: HMSO, 1980.
Health and Safety Commission. *Advice to the self-employed.* London: HMSO, 1980.
Health and Safety Commission. *Advice to employers.* London: HMSO, 1975.
Health and Safety Commission. *Advice to employees.* London: HMSO, 1981.
Health and Safety Commission. *Some legal aspects and how they will affect you.* London: HMSO, 1975.
Health and Safety Commission. *Guidance notes on employers' policy statements for health and safety at work.* London: HMSO, 1980.
Health and Safety Executive. *Safety committees: guidance to employers whose employees are not members of recognised independent trade unions.* London: HMSO, 1979.
Health and Safety Executive. *Short guide to the Employers' Liability (Compulsory Insurance) Act 1969.* 1976.
Health and Safety Executive. *Reporting an accident.* 1980.

Free from the Home Office

Doctors and the Misuse of Drugs Act 1971. Home Office, 1978.
A guide to the Health and Safety at Work Act. London: HMSO. £2·75.
The notification of accidents and dangerous occurrences. London: HMSO. £2·75.
The safe disposal of clinical waste. London: HMSO. £1·50

Practice Research

Coronary care in a general practitioner hospital

ARWYN DAVIES

Home and hospital care for patients with acute myocardial infarction has received much attention over the past 10 years.[1, 2] Because of the high rate of initial mortality, which usually occurs before medical care has been started, mobile systems of care have been developed but are confined to centres of large populations.[3, 4] Little attention has been paid to systems of care that would be relevant to rural and isolated communities. In a retrospective survey in a general practitioner hospital I evaluated whether a system of a comparatively low input of medical care offered sufficient essential advantages of hospital care to offset the risks of removing patients from their homes.

Background

Brecon War Memorial Hospital is a general practitioner hospital with 40 beds, serving a winter population of 13 500, roughly half of whom live within a mile of the hospital. The rest of the population is scattered over 300 square miles. The nearest district general hospital is 20 miles away, along a busy route that is periodically obstructed by road traffic accidents, snow, and lately floods; it has no coronary care unit. Seven general practitioner principals and two GP trainees, who practice in a group in premises 500 yards from the hospital, are on the staff. As far as we can determine, all the patients in the catchment area of the hospital are patients of the group practice.

There is a physiotherapy department, an x-ray department that does contrast media examinations, and a casualty department where roughly 4500 new cases are seen every year. With the support of visiting consultants, the practice provides an acute service for selected cases in ear, nose, and throat and general surgery, operative obstetrics and gynaecology, traumatology, and uncomplicated orthopaedics; 400 general anaesthetics are given a year by members of the practice. Thus it is necessary to have a general resuscitation service, which has been extended to patients suffering from acute myocardial infarction, and I have experience and an interest in treating patients with coronary disease.

There are 34 beds in two wards, each of which is staffed by at least two trained nurses and three auxiliary nurses at all times. There is no coronary bed,[5] but patients who are in the early stages of illness are routinely nursed either in a side ward or in a bed close to the nursing centres. Using a Cambridge PCG monitor and oscilloscope type 01023, patients with acute myocardial infarction are monitored for about 48 hours, and rhythm strips routinely obtained every two hours. The practice holds regular sessions on resuscitation methods, and each trained nurse is taught the basics of defibrillation. No doctor is regularly resident in the hospital, but no principal may live more than five minutes' driving distance from the hospital—and this is enforced by a formal practice agreement. There are always two doctors "on call." There is no formal practice policy for caring for patients with acute myocardial infarction, but elderly patients whose condition is stable are generally cared for at home.

Brecon, Powys LD3 7AA
ARWYN DAVIES, BSC, MRCP, general practitioner

Method

Using the Hospital Activity Analysis records, case-notes of patients who had been diagnosed as suffering from acute myocardial infarction, or "coronary thrombosis," were obtained for the period from 1 June 1976 to 31 May 1981—the first five years after the hospital had acquired a cardiac monitor. Only patients with definite electrocardiographic (ECG) changes of acute myocardial infarction and raised concentrations of serum cardiac enzymes (serum aspartate aminotransferase and lactate dehydrogenase) were included in the survey. Patients who had symptoms suggestive of myocardial infarction but no ECG evidence or raised enzyme concentrations were excluded, even though they may have been monitored. Patients who were brought to the casualty department in cardiac arrest and in whom resuscitation failed were also excluded unless positive ECG evidence was obtained before cardiac arrest. No post-mortem evidence was included.

Results

Table I gives details of the patients admitted for myocardial infarction. Town dwellers lived within easily identifiable geographic limits, the furthest dwelling being roughly 1000 metres from the hospital. Eight patients were excluded from the survey because of mistaken diagnosis or lack of evidence. There were 118 admissions for 114 patients. The mean practice population during this time was 13 490; the mean death rate throughout Powys from acute myocardial

TABLE I—*Details of 118 admissions for acute myocardial infarction*

	No of admissions	Age (years) (mean ± SD)	No of town dwellers	No of country dwellers	Hospital stay (days) (mean ± SD)
Men	69	63·8 ± 9·6	64	54	14 ± 9·9
Total	118				

TABLE II—*Successfully treated patients who had had cardiac arrest*

Patient No	Age (years)	No of cardiac arrests	Nurse treated	Doctor treated	Town dweller	Country dweller	Survived to leave hospital	Survived (mth)
1	72	3	+	+		+	+	18
2	68	1		+			+	18*
3	48	1			+		+	3
4	70	1				+	+	15*
5	70	1					+	21*
6	65	1					+	30*
7	70	1					+	0

*Still alive

infarction, as derived from the Registrar General's figures, was 3·7 per 1000 population. Three patients who had complete heart block, who later died and are not included in these figures, were transferred to the nearest coronary care unit 40 miles away, which had pacing facilities.

Table II gives details of patients who were successfully treated, which demonstrates the value of familiarising the nursing staff with the principles and details of resuscitation. The duration of survival after resuscitation is satisfactory, but conforms to the predictions of other series.[6] Table III suggests that the mortality rate was similar for both men and women; five patients were not actively resuscitated, three having had cerebral vascular accidents, one terminal carcinoma of the lung, and one advanced hepatic cirrhosis. Living near to the hospital appears to confer no advantage. Table IV shows the correlation between age and mortality in acute myocardial infarction; the mortality rate for patients under 70 years of age is 11%.

TABLE III—*Details of patients who died*

Mean (±SD) age (years)	Men	Women	Town dwellers	Country dwellers	Acute myocardial infarction as terminal event
66·5 ± 8·49	15	4	10	9	5

TABLE IV—*Age distribution of patients who had acute myocardial infarction*

Age range	No of patients admitted	No of deaths	Resident population at risk
30–39	1	0	2063
40–49	8	0	1432
50–59	28	3	1855
60–69	39	5	1849
70–79	41	11	1041
80–89	5	2	339
90–99	0	0	48
Total	118	19	7926

Discussion

This study was confined to the group of patients who, by natural selection and doctors' selection, were cared for in the local GP hospital after suffering an acute myocardial infarction. The results cannot be compared precisely with other studies unless accurate information about home care, post-mortem findings in cases of sudden death, and outcome in patients with suspected but unproved myocardial infarction are included. The general admission policy of the hospital, however, is likely to exclude a bias towards analysing a hospital population with a relatively favourable outcome. Comparing Kyle's figures for the same hospital in 1971 suggests that there has been little change in admission policy over the past 10 years.[7]

The resuscitation rate is acceptable and compares with rates in larger series based on formal coronary care units or medical wards in district general hospitals.[8–10] In a hospital where no doctor is regularly resident resuscitation by nurses is essential (table II). The overall mortality rate and that for patients under 70 years of age are acceptable when compared to those of larger studies, though mortality rate is usually expressed for one month after admission.[6, 8]

The only other place to care for patients with acute myocardial infarction is at home or in the district general hospital 20 miles away. Home care is contraindicated for patients who live alone and for those whose illness is complicated; there are frequently practical difficulties with women patients and those whose relatives cannot or will not take any responsibility. Recent cuts in the community nursing service may also affect such care. Care in the district general hospital has the problems and dangers of an ambulance journey of 20 or more miles. There are also the small number of holidaymakers and self-referred patients who would attend a GP hospital casualty department.

There are several advantages of GP hospital care for patients with acute myocardial infarction who live in a small community. The medical and nursing staff, other patients, and the physical surroundings may contribute to reassure the patient when admitted. The implications of "successful resuscitation" may influence the expectations of the patient and relatives about hospital rather than home care; the attending doctor in each case may be similarly influenced. The social and financial advantages of visiting relatives and friends in hospital needs no mention, except that in general assessments of costs by professional health planners take account only of outgoings from the public purse and not those from individual pockets. Finally, nursing and medical staff become more and more practised at resuscitation, which contributes to the quality of care of patients whose collapse may be attributable to a cause other than acute myocardial infarction.

In view of the resurgence of interest in community hospitals at the Department of Health, and Cavenagh's estimation that 3%, of all acute hospital beds in England and Wales are located in GP hospitals, there is considerable scope for encouraging systems as described here, particularly in isolated, rural communities.[11] Much medical expertise will be available, since most new entrants to general practice will be familiar with the techniques of hospital care for acute myocardial infarction. The expense of training nursing staff and acquiring monitoring facilities should be negligible.

Conclusions

A system of caring for patients who have had an acute myocardial infarction has been set up in a general practitioner hospital that serves a rural, isolated population. Both the mortality rate (16%) and the resuscitation rate (4%) compare with those of series based on medical wards in district general hospitals and coronary care units. Such systems should be set up in community hospitals, particularly when these hospitals are in rural areas.

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