PRACTICE OBSERVED

Practice Organisation

How safe is your surgery?

ANNE PAINE

The Health and Safety at Work Act 1974 is a fact of our working lives, and there is a great deal for the doctor or the practice manager to consider. Though all the help and information is there if you look for it, it takes time and effort to evaluate and decide what applies to you. This paper brings together the relevant information and offers some guidelines to help to make a safe and healthy surgery.

Crime prevention

The police say that breaking and entering is on the increase and is likely to remain so. What can we do to ensure that we have taken all practical steps to prevent a break in? Your local crime prevention officer will visit your premises and provide a written report and measures that are considered advisable to take to make the building more secure. He or she will also provide literature on various alarms and crime prevention aids and a list of local companies that produce them.

In the first instance the police favour physical security—that is, double doors and window locks, grilles, bars, and strengthened doors; and special glazing. Drags, hypodermic needles, pens, pencils, and petty cash should always be kept in a strong store area when not in use. The police recommend that several numbers of electrical equipment and key numbers should be recorded. Key security is important. Losses of keys should be reported and locks changed. Decide how many people actually need keys and who will be the key holder responsible for answering the alarm calls. All keys should be signed for by the holders. Internal doors should not be locked except for the strong store area; a frustrated thief will break down a door, thus incurring more expense for the practice in replacing the damage. Curtains should be left open at night and night lights on to deter anyone moving about at night. A final lock up drill should be devised, which is logged nightly, and the log inspected regularly. The police also suggest checking the identity of visitors before allowing them access to office or strong store areas.

Should you decide on an electrical alarm system you are faced with two choices, one based on detecting movement in the building and the other

activated by the opening of a door or window. Often a mixture of both types produces the best result. Literature and a list of approved installers is available from: The National Supervisory Council for Intruder Alarms, St Ives House, St Ives Road, Maidenhead, Berks. Contact your local family practitioner committee, or the "Red Book" improvement grants have been extended to include fitting security systems. You need three estimates, and provided the cost is above £500 they will pay one third of the total cost. They may also be able to give useful advice about measures that other practices have adopted. Remember that an alarm only warns that an intruder is inside the building; it does not stop one from breaking in. Prevention is better than cure.

Fire precautions

Under the Fire Precautions Act (1971) premises that are used as a place of work require a fire certificate unless: (a) not more than 20 persons are employed to work on the premises at any one time; or (b) not more than 10 people are so employed to work there on the ground floor. These exclusions do not apply in multi-occupancy buildings, where it is the total number of staff employed in the building that counts, not the numbers in each of the premises.

If you think you require a fire certificate apply to the local fire authority, who will then require you to provide information concerning the premises and the use to which they are put. They will then inspect the building and issue a certificate provided that the premises are reasonably equipped with the means of escape, of fighting fire, and for giving warning of fire. Should you not require a certificate certain precautions must still be observed under the Fire Precautions (Non-Certified Factory, Office, Shop and Railway Premises) Regulations 1976.

1) The doors through which a worker might have to pass to get out must not be locked or fastened so that they cannot be easily and immediately opened on the way out.

2) The contents of any workroom shall be so arranged as to afford free passage to a means of escape in case of fire.

3) There shall be provided and maintained appropriate means of fighting fire fitted readily available for use.

Fire exit doors should be clearly marked, and staff trained in the use of any fire-fighting equipment. Staff should be instructed concerning their duties in case of fire—with particular regard to patients in all parts of the building, including the lavatories. Fire drills should be held every six months. It is a good idea to have printed instructions for fire drill on important doors.

The Surgery, Crowthorne, Berks RG11 4JL

ANNE PAINE, practice manager

- (3) Heating
 - (a) Suitable temperature: no extremes
 - (b) Thermostats available
 - (c) Portable heaters or fans are safe and in working order
- (4) Lighting
 - (a) Lighting is adequate in all rooms and passageways
 - (b) The artificial light does not cause glare or eye strain
 - (c) Ladders are correctly positioned
 - (d) Check for defective lighting and see that repairs and replacements are done as soon as possible
- (5) Furniture
 - (a) There is sufficient furniture for the use of all staff
 - (b) The furniture is in a good state of repair
 - (c) Furniture or fittings are not causing an obstruction
 - (d) All furniture is suitable for the use to which it is put
- (6) Equipment
 - (a) All equipment is regularly maintained
 - (b) Service installations are regularly checked
 - (c) Where necessary, written instructions and safe codes of practice are displayed for the use of the equipment
- (7) Services (water, electricity, etc)
 - (a) Services installations are regularly checked
 - (b) There are sufficient installations in the workplace to prevent overloading of services
 - (c) Installations correctly positioned
 - (d) Services clearly marked
- (8) First aid
 - (a) First aid box well equipped
 - (b) Accident book available
 - (c) Supplier of accident report form F2508
- (9) Structure
 - (a) Doors and windows regularly maintained
 - (b) Features secure
 - (c) Everywhere in good state of repair and redecoration
 - (d) External pathways safe, in good state of repair, and adequately lit
 - (e) Moulds and drains covered
 - (f) Guttering and drains clear
- (10) Fire
 - (a) Fire exits clearly marked
 - (b) Alarm correctly positioned and in working order
 - (c) Fire fighting equipment correctly placed and maintained
 - (d) All staff aware of location of fire fighting equipment and alarms and of procedure in case of fire
 - (e) Fire procedure notices drawn to attention of visitors to workplace
 - (f) Access for fire engines adequate and hydrants marked
- (11) Security
 - (a) Check door and window locks
 - (b) Security alarms are in working order
 - (c) Review security procedures
 - (d) Staff informed of security procedures

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Practice Research

Respiratory consultations in asthmatic compared with non-asthmatic children in general practice

MARK LEVY, MOHINI PARMAR, DAVID COETZEE, STEPHEN W DUFFY

Abstract

In a retrospective study we found that before a diagnosis of asthma had been made children with asthma had consulted their general practitioner more often with respiratory symptoms than children who were non-asthmatic under the age of four. In the second, third, and fourth years the number of consultations differed significantly between the two groups. Asthma should be suspected in any child who presents often with respiratory symptoms. This should lead to earlier diagnosis in most cases.

Introduction

A recent audit of respiratory consultations in children with asthma before asthma had been diagnosed showed that these children had

had an average of 16 respiratory consultations before their doctor diagnosed asthma. Although all these children had consulted their doctor with respiratory symptoms before their fifth birthday, only half had been diagnosed by then.

The aim of this study was to compare the consultation rate for respiratory symptoms in children with asthma with that of non-asthmatic children in our general practice.

Patients and methods

Our practice is an urban, National Health Service, group practice of mainly middle class Caucasian patients. From 470 children aged between 18 months and 11 years two groups of patients were identified: Group 1, the group with asthma, was described in an earlier paper where asthma was defined as: (a) variable airway obstruction as shown by a history of recurrent wheeze, shortness of breath, or cough and a subsequent response to anti-asthma treatment; or (b) variation in peak expiratory flow rates of 20% or more, or both (a) and (b). Fifty two children (prevalence of 11%) were diagnosed as having asthma. 31 objectively (criterion a) and 21 according to the subjective criterion (a). Group 2, the group without asthma, was obtained by sampling at random the records of the remaining 47 children who had not previously been diagnosed as having asthma. In this group the information was extracted by two independent observers. Complete records only—that is, starting from birth—that were unambiguous were included. Sixty nine patient records met these criteria and these children were included in group 2. Some children with mild, undiagnosed asthma may have inadvertently been included in group 2. We think that this is unlikely in view of the results and the 11% prevalence of children with asthma in this

Northolt, Middlesex

MARK LEVY, MB, BSc, general practitioner and trainer

MOHINI PARMAR, MB, BSc, trainee in general practice

DAVID COETZEE, medical student on attachment

Division of Computing and Statistics, Clinical Research Centre, Harrow, Middlesex

STEPHEN W DUFFY, MB, BSc

Correspondence to: Dr Mark Levy, 173 Castle Road, Northolt, Middlesex UB8 4SQ

In the event of a major fire one of the most serious losses could be your medical records. The only way to protect them is to put them into fire safe or fire resistant cabinets. Some would say that this is very expensive and highly impractical. A fireproof cover might be a worthy alternative. It is a simple putting appointment books, ledgers for private patients, and practice accounts into metal cabinets at night.

As a preventive measure periodically check all external electrical wiring, plugs, and appliances. Make sure that where possible all electrical appliances are switched off at night. It is a simple rule, which is often overlooked.

Fire prevention officers are helpful, and it is advisable to consult them if you are moving into new premises or having an extension to existing buildings built. Finally, should you consider installing an electrical fire alarm, and moving you can get written authority from the fire officer that a system is required by them, the family practitioner committee will consider the application for an improvement grant in the same way as for intruder alarms.

Health and safety

Under the Occupiers Liability Act of 1957 doctors owe a common duty of care to all visitors to their premises; this duty requires only reasonable precautions to be taken for their well being. The Health and Safety at Work Act 1974, however, requires doctors to provide and maintain a safe place of work and states that "it shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety, and welfare of all his employees." Doctors' services should be supervised by the Health and Safety Executive, whose address and telephone number are in the local telephone directory. Any proceedings that may be taken under the Act are criminal.

There are many publications on this subject to choose from, but a very useful booklet may be obtained from the BMA: Health and Safety at Work Act 1974 by Anne Cullinan and Norman Ellis. It will tell you how to maintain your building, about the hazards when the building is in use, the duties to the staff, and the duties of the staff themselves. It will also advise you of the things the health and safety officer will look for.

It is essential that all practitioners with more than five ancillary staff prepare and display a written statement of their general policy "with respect to health and safety" of their employees and the organisation and arrangements for carrying out this policy. It is important to review this statement regularly in the light of changing requirements to keep it up to date. The statement must relate specifically to the needs of the practice for which it is written (it is not sufficient to copy someone else's statement). The policy must make clear that there is a continuing review, and it must be dated and signed. It must have objectives and should state how these should be achieved. Finally, it must be monitored regularly for effective implementation.

Though it may seem superfluous in a doctor's surgery, first aid is important under health and safety regulations. The Health and Safety Executive will provide you with a leaflet on "First aid in small work places," which will tell you most of what you need to know, including how to keep records. The accident book is the most important item and must record the date of an injury, accident, or dangerous occurrence, the place, circumstances, and name, sex, age, and occupation of the injured person and the nature of the injury. The Health and Safety Executive like to be informed when there has been a major injury, accident, or dangerous occurrence. Their definitions of a major injury are: fracture of skull, spine, or pelvis; fracture of arm, leg, but not foot, ankle, or hand; amputation of hand or foot; loss of sight in an eye; any other injury requiring admission to hospital for more than 24 hours (except for observation). A dangerous occurrence could be a piece of electrical equipment blowing up, whether it is a typewriter or electrocardiograph. All such incidents must be reported to the Health and Safety Executive, a written report on F2508 submitted within seven days, the accident book completed, and records kept for three years.

All of the foregoing deals with employers' duties, but employers also have duties under this Act. The Act states that "it shall be the duty of every employer while at work to take reasonable care for the health and safety of themselves and other persons who may be affected by their acts or omissions at work. It also states that: No person shall intentionally or recklessly interfere with or misuse anything provided in the interests of health and safety or in pursuance of the relevant statutory provisions.

It is essential that all employees see and understand the policy statement and that they know of the various hazards and correct methods of procedure. Their own responsibilities should be pointed out to them, and the best way to do this is to include health and safety in the employees' training programme. HM Stationery Office has helpful leaflets such as "Reporting an accident" and "Advice to employers, safety representatives and committee members," and these, together with the booklet mentioned above, will provide most of the information you should need. Your local Health and Safety Executive office will be happy to advise you if you have any problems.

Emergencies

Do all receptionists know exactly what to do in an emergency? There is a strong case for training receptionists to recognise a real emergency, giving them access to emergency telephone numbers, and teaching what information to obtain in the case of poisoning, when to send for an ambulance, and how to give appropriate first aid. Many doctors would disagree with the last point, fearing that they may be held responsible for any repercussions originating from the actions of the staff. Might they not be considered negligent, however, if none of their staff can provide first aid and should a patient collapse in the surgery?

Violence and vandalism are on the increase, and who has not had to deal with a belligerent patient? A violent incident might occur at any time, and staff should be trained to deal with this in a calm, unemotional, and quiet way—above all with patience and the ability to listen to what the patient is saying, while further help is summoned. Each practice should have instructions or guidelines, or both, to safeguard everyone.

Discussion

Many people find health and safety a boring subject, but, after all, it might be a matter of life and death and few of us are bored by that. A coordinated approach to the matter is needed. Start by writing things down under four subject headings. Firstly, the statement of policy. Remember that it must be tailor-made for your surgery and that it applies to all staff, including nurses, who of course handle potentially more hazardous equipment than clerical staff. Consult your staff and encourage them to help to formulate the statement and to bring to your notice (or that of the health and safety officer if you have one) any changes that need to be made. Finally, remember to date, sign, and distribute the statement.

Secondly, write out a list of the security procedures that need to be followed at your surgery. Ensure that each room is visited at night in case any unauthorised persons are still on the premises. Check window and door locks, and place important items such as scripts in a secure store area. These checks should be logged and the log inspected at intervals.

Thirdly, write out your instructions in case of fire. These should have details of routes to be followed and of where to assemble. Each member of staff should be aware of any designated tasks that they should perform before leaving the surgery to ensure that evacuation is completed—for example, the receptionist checks the patients' lavatories. As everyone is unlikely to be in their designated position at all times ensure that the staff read and understand all the instructions so that they may cover any gaps caused by absences.

Lastly, the Health and Safety Act requires you to ensure that the premises and services are kept in good repair and are suitable for the purposes to which they are put. To do this I suggest that you carry out a regular health and safety audit, which means inspecting the building and its activities, following the guidelines at the end of this paper, writing down anything that needs attention. Try to walk round on a different day and at a different hour each time you carry out your check, and in that way you will cover all activities taking place in your surgery and appreciate their various needs. Instruction on what measures the staff should take in emergencies should be given by the doctors in each surgery and not by the practice manager. The situations that might arise should be examined, and the practice policy made clear to everyone. How safe your surgery is depends on how well you have prepared and trained your staff. Careful thought can make your surgery a safer, healthier place in which to work.

Health and safety audit

- 1) Hygiene
 - (a) Everywhere cleaned to a good standard
 - (b) Washing facilities, etc., adequate
 - (c) Everywhere a tidy and uncluttered
 - (d) Check disposal of sharp objects and contaminated waste
- 2) Ventilation
 - (a) Everywhere is sufficiently ventilated
 - (b) Means of ventilation and any equipment used for that purpose regularly checked and maintained
 - (c) There is no pollution of this due to fumes from toxic substances

study, indicating that we have probably identified most of the children with asthma.

The following information was extracted from the records: name, age, date of birth, and records of consultations for both groups for the first four years of life and for respiratory symptoms—that is, cough, wheeze, shortness of breath, and sleepless difficulty owing to respiratory symptoms. In group 1 only those consultations before asthma was diagnosed were considered. To compare the two groups only completed years of life were studied so that data from incomplete years were excluded. This procedure applied to those children with asthma in whom the diagnosis of asthma was made before the age of 4, and to those in group 2 who were under 4 at the time of the study. Distribution free methods were used for analysis because the data were not normally distributed. Differences between the two groups were assessed by the Mann-Whitney U test: median and interquartile ranges are presented instead of means and standard deviations.

Results

The table shows medians and interquartile ranges of numbers of consultations categorised into sex, group, and year of life, along with Mann-Whitney U values. In the first year the number of consultations did not differ significantly between the children with asthma and those who were non-asthmatic for either boys or girls. In the second, third, and fourth years there was a significant difference between the two groups—in both sexes the children with asthma consulted more often.

Medians and interquartile ranges of numbers of consultations by group, sex, and year, with a table of differences between groups

	Year 1	Year 2	Year 3	Year 4
Asthma				
Median	2.0	2.0	3.0	3.5
Interquartile range	0.0-1.0	0.0-3.0	1.5-3.0	1.0-4.0
Non-asthma				
Median	1.0	1.0	0.0-1.0	0.0
Interquartile range	0.0-2.0	0.0-2.0	0.0-1.0	0.0-1.0
U Value	0.28	0.02	<0.001	<0.001

The results were confirmed by the median test, a more conservative test than the Mann-Whitney U test.² By censoring the data in the year of diagnosis we could conceivably have biased the comparison by attenuating the difference between the groups. Given the results, however, this does not seem to have occurred. If anything, the true difference may even be greater than that reported.

100 YEARS AGO

We learn that the idea of erecting a memorial to General Gordon in the shape of a hospital at Port Said, was unfavourably commented on by many of his admirers, European and Egyptian. In Egypt it is stated that Port Said is unsuited for a hospital which would do honour to the memory of General Gordon, or be a credit to its promoters. Port Said is a small town almost outside of Egypt, with a few English families in its population, where a British seaman or a rare passenger to or from India may occasionally be landed. If it is to be open to Arabs, they have no means of access to it as there is no railway nor proper highway to Port Said from any part of Egypt. An English hospital, such as a cottage-hospital on a small scale, would be simply an anachronism, and could be kept up at small expense, whereas the elements do not exist for a much larger hospital. One would hope that the memorial hospital will not be for the treatment of English only, but, like other hospitals in Egypt, will be open to Egyptians and others, and be Anglo-Egyptian in character, as Gordon lived much of his life for, and died for, the Egyptian people. If so, its usefulness at Port Said would be very limited, and a large institution thrown away. The Egyptians do not repair to Port Said, but gravitate towards two centres, Cairo and Alexandria. At Alexandria, the

Discussion

Previous studies have estimated consultation rates for respiratory illness in children. The second (UK) national morbidity study for respiratory illnesses found a rate of 1.26 respiratory consultations a year in the one to four age group.³ The overall consultation rate for this age group was 3.01 a year. In Livingston New Town a rate of 0.94 respiratory consultations per child a year was reported in 1970; another study in Aberdeen noted 1.3 episodes of respiratory illness per child a year.⁴

In our practice we find that children with asthma consult more often than children who are non-asthmatic during their first four years. Although it has been stated that "asthmatic children are exposed to the same range of respiratory pathogens as other children,"⁵ we believe that the "tricky" or hyperreactive nature of their airways leads to increased and persisting respiratory symptoms. Asthma is underdiagnosed and therefore underreported in the community.⁶ It has been argued that it may be impossible to identify children with asthma clinically until overt symptoms and signs of asthma develop.⁷ The findings of this study and the evidence that most children with asthma have consulted their doctors with respiratory symptoms by their fourth birthday indicate the potential for an early diagnosis of asthma.⁸ The results of this study therefore challenge doctors to consider the diagnosis of asthma in all children who consult frequently for "respiratory" symptoms.

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References

- 1 Levy ML, Bell LC. General practice study of asthma in childhood. *Br Med J* 1984;289:1115-6.
- 2 Gower WJ. Practical epidemiology. London: New York: Wiley, 1980:17.7.
- 3 Anonymous. Morbidity statistics from general practice: second national study 1970-1. Studies on medical and population subjects No 26. London: HMSO, 1974.
- 4 Duncan AH. The Livingston project—five years' Scottish Health Service. *Br J* 1978;296:1623.
- 5 Howe JCH, Bagg AR. Family trends in psychosocial and asthmatic prescribing in general practice. *Br Med J* 1982;285:136-9.
- 6 Underwood TJ, Butler JH. General practice study of asthma in childhood. *Br Med J* 1984;289:1623.
- 7 Spigelst AM, Lin DA, Hay EN. Underdiagnosis and underreporting of asthma in childhood. *Br Med J* 1979;288:1215-7.
- 8 Spigelst AM. Childhood asthma: being underdiagnosed and underreported. *Br Med J* 1979;288:1215-7.
- 9 Lin DA, Williams NB, Spigelst AM, Hay EN. Prevalence and spectrum of asthma in childhood. *Br Med J* 1981;283:1264.
- 10 Anderson HR, Butler JH, Cooper JS, Palmer RJ. Influence of morbidity, illness level and social, family, and health service factors on presentation of childhood asthma. *Lancet* 1981;i:1002.
- 11 Goldson S. Problems peculiar to the diagnosis and management of asthma in children. *RTJ* 1974;1:116.

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English population, rich and poor, is large; it is one of the chief of the world's great cities, and has a long and distinguished history. British ships congregated on all parts of England. Englishmen employed in the interior of the country, who have no proper home, nor means for proper medical and surgical treatment, repair to Alexandria to enter one of the foreign hospitals there. A large number of British seamen are there left yearly for treatment in a foreign hospital, which has also given hospital to many officers of the army and navy. There is no British hospital in Alexandria, and, of all places in Egypt, it has a strong claim for one, and for many reasons, it is the place the best suited for a memorial hospital. The hospitals already existing there would do credit to any city in Europe, but an English hospital is conspicuous amongst them by its absence, though other less wealthy nationalities have theirs. The town possesses a large body of medical men of high scientific acquirements. Egyptians and Bedouin Arabs repair (thither from all parts of the country, many of them attracted by the reputation there of English surgery. We hope the Committee will not be too hasty in deciding finally on the place for a hospital memorial, before they have made full inquiries. (*British Medical Journal* 1884;2:709)