TOWER HAMLETS GP CARE GROUP (THGPCG) CIC
HEALTH & SAFETY POLICY

HEALTH & SAFETY POLICY	
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Health and Safety Policy

Section 1

Policy Statement

THGPCG accepts the responsibilities and duties placed on them by the Health and Safety at Work Act 1974 and will ensure, as far as reasonably practicable, the health, safety and welfare of its staff while at work. This reflects our policy of a quality provider of care to our patients and employer to our people.

The Organisation is responsible for providing places and systems of work which ensure that the work can be carried out safely and with minimum foreseeable risk, in line with current legislation and best practice, and for providing instruction, training and supervision to its staff in safe work systems. Employees are kept regularly informed of health and safety requirements and the Service Area will ensure that they are competent to carry out their work to good safety standards.

All employees have a legal duty under section 7 of the Health and Safety at Work Act to work safely, to look after their own safety and those they work with, including visitors and contractors, and to co-operate with the organisation in its endeavours to create safe working conditions. In doing so, they must be aware of not only their own safety but that of others who may be affected by their actions or omissions. They also have a duty to inform the Organisation of any work situation, which represents a serious danger or a shortcoming in the Organisation's safety precautions.

The Organisation recognises its obligation to be informed of the legal requirements placed on it by other current legislation and regulations, and will endeavour to discharge these duties, as far as is reasonably practicable

The policy is reviewed annually as part of the Organisation's ongoing review of its methods of operating. An outline of key safety information is provided to all staff and the discharge of these duties forms a part of the contractual relationship between employees and the Organisation. Due consultation will take place prior to the introduction of, or change to Health and Safety policy or procedure.

Overall responsibility is that of THGPCG. The Chief Executive Officer is the appointed officer responsible to THGPCG for implementation of the Organisation Safety Policy

Health and Safety Policy

Section 2

General Arrangements

General

The THGPCG undertakes to guard against foreseeable hazards, as far as is reasonably practicable, in order to ensure the health, safety and welfare of its employees and other persons. It accepts the responsibilities defined in the Management of Health and Safety at Work Regulations 1992 and to this end, potential hazards and likelihood of risk to individuals will be regularly assessed, reviewed and recorded and appropriate control measures introduced where feasible. These will be brought to the attention of all employees.

THGPCG requires its employees to co-operate with Safety measures and not to interfere with or misuse anything provided to promote their health, safety and welfare at work. Breach of Safety rules or procedures will constitute a disciplinary offence and may be deemed as Gross Misconduct in line with the THGPCGs' Disciplinary procedures.

The policy must also be observed by self-employed persons, contractors, visiting specialists or locums working on the THGPCG's behalf. They will be provided with a copy of the policy which they will be expected to observe.

Training

All employees are briefed on the contents of this policy, which is retained by the Manager and issued to all members of staff. Further guidance on Health and Safety issues can be obtained from the Manager.

Specific training is given where relevant during Service Area meetings

Premises

The THGPCG aims to ensure that its premises meet the requirements of the Workplace (Health, Safety and Welfare) Regulations 1992 so far as is reasonably practicable.

- Relevant adaptations to facilities will be reviewed in the event of major changes.
- Cleaning will be undertaken regularly.
- Adequate washing and toilet facilities will be provided for staff and patients
- Lighting, heating and ventilation will be adequate for work
- Entrances, exits, passages and staircases must at all times be free from obstruction

Accidents

Any injury sustained during the course of working duties must be reported to the manager or the senior receptionist at the earliest opportunity, who will make the relevant entry in the Accident Report File. The THGPCG is responsible for notifying the Environmental Health Authorities if the accident results in absence from work for more than 3 days or in major injury e.g. broken bones, amputations, electric shock etc. Any accident which does not result in actual injury but which represents a potential risk in the future must be notified to the manager.
The First Aid box is located in the xxxx.

Fire Precautions

The appointed Fire Marshall's are on various walls in Reception and in the staff room, they will be responsible for testing of the fire alarm. Fire drills are carried out on an annual basis. Emergency procedures are displayed in the corridors and in the main administration room.

Staff will be shown the main principles of fire prevention by the Fire Marshalls. All employees must make themselves familiar with evacuation procedures in the event that their assistance is required.

Patients and Visitors

All patients must be recorded on arrival at the reception desk. Other visitors should sign the Visitors Book. Visitors will be detained at reception until being greeted by a member of staff or they will be directed to the appropriate meeting room, in which case they are the responsibility of the person organising the meeting. Visitors should be accompanied at all times on the premises and their hosts are required to be aware of their responsibility for the safety and welfare of their guests. In the event of an emergency, patients and visitors must be escorted from the building and assembled outside at the designated fire assembly point until reception records are checked and verified.

Health and Safety Policy

Section 3

Specific Hazards

VDUs

The THGPCG is aware of the Health and Safety (Display Screen Equipment) Regulations 1992 and will endeavour to comply with them as far as reasonably practicable

- Computer workstations are assessed and maintained in good working condition. User audits are conducted to identify job holders who may be classed as "high- users", for whom specific training and guidance is given.
- Adequate space and ancillary equipment is provided to ensure the welfare of all computer users.
- Working patterns are arranged so as not to give undue strain through repetitive or intensive work.
- User must ensure that they adopt a comfortably and appropriate posture for work and do not eat or drink in the immediate vicinity of the work station.
- Any user who experiences undue discomfort, pain or stress which they believe to be connected with the use of the workstation must report this to the manager, who will arrange further assessment and referral to experts as appropriate e.g. optician.
- The THGPCG will contribute towards the cost of the eye test on proof on valid receipt from a qualified optometrist

Electricity at Work

Potential hazards and risks in the use of all office equipment are given particular attention by the Organisation and all electrical installations and supply points in the Organisation's own premises are checked by a competent person and recorded.

All employees must follow agreed standards relating to methods and systems of work with electrical equipment. Particular attention must be given to children on the premises; all sockets exposed to children are protected by socket covers.

Lifting

The Organisation is responsible under the Manual Handling Operations Regulations 1992 for ensuring, as far as is reasonably practicable, that employees do not place the health and safety of themselves or others at risk through the lifting and moving of heavy objects. Whilst this is not a significant activity in the Organisation, nevertheless:

- Employees are not required to lift heavy loads where potential risk of injury has been identified.
- Relevant assistance must be requested where there is no alternative method.
- Employees must personally consider the risk of lifting a load, giving consideration to the shape, size and weight of the load.
- Where lifting may prove hazardous to the individual, employees should find an alternative method, or seek assistance, where necessary
- Employees must adopt a suitable posture for lifting to ensure a balanced distribution

Hazardous Substances

The Organisation observes the requirements of the Control of Substances Hazardous to Health Regulations 1988/1994 in assessing potential risk arising from exposure to substances which may be toxic or in any way harmful to employees. Whilst current assessments indicate that such substances are limited, particular care should be given to the storage, handling and use of:

- Drugs and Vaccines
- Clinical Waste
- Disinfectants, Sterilising Fluids and Cleaning Agents

Each individual is responsible for ensuring that toxic substances are stored and used appropriately in their own area of work. Any concerns about these substances should be reported to the Manager.

Sharps

It is the duty of the clinical members of the Service Areas to ensure that sharps bins are kept high up on a shelf and that sharps waste is put into them immediately after use. Sharps bins are sealed and removed regularly by a contracted waste disposal company.

Clinical Waste

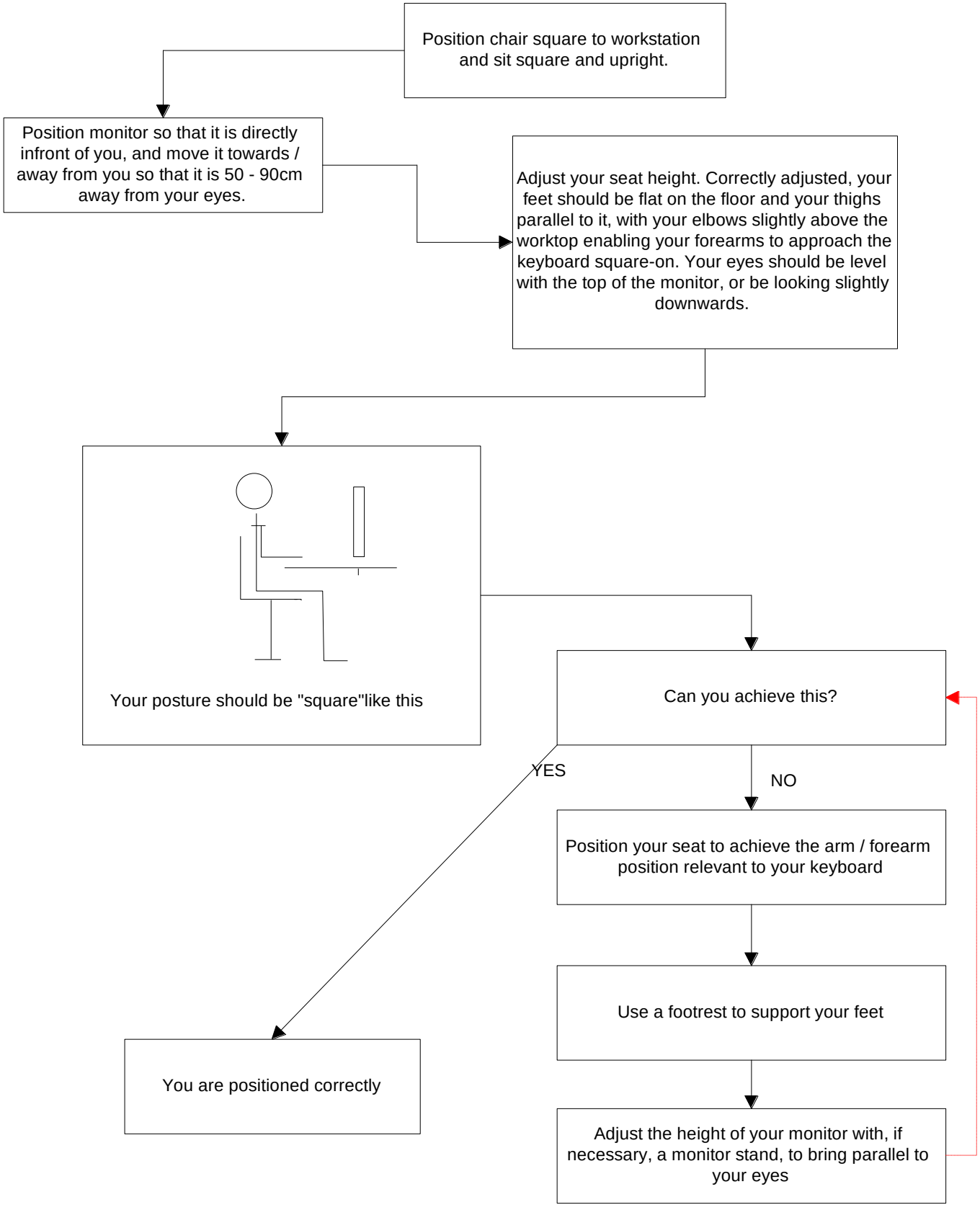
Bins, specifically for the disposal or clinical waste, are provided and should be used for all clinical waste. A contracted waste disposal company removes the contents regularly.

DISPLAY SCREEN EQUIPMENT (WORKSTATION POSTURE GUIDE) – DESK AID

INTRODUCTION

The flowchart on the following page may be used as an aid for staff to adjust their posture at their workstations in order to comply with display screen equipment recommendations.

It may be suitable for laminating and being made available at each workstation for reference purposes.



BOMB SCARES/THREATS – DEALING WITH

Bomb threats may hardly ever occur, but if they do occur the vast majority will be made by malicious hoaxers. However, all such threats should be taken seriously. Each incident is likely to require a different approach depending on the individual circumstances, and the

following notes are intended as a general guide.

The specific response may also be subject to premises and grounds layout in relation to safe exit routes

The majority of bomb threats are made by telephone. If the Organisation receives a call, the person who answers the call should:

- Not hang up
- Try to gather as much information as possible, and write down these details
- Try to establish the location of the bomb. In particular, whether it is inside or outside the building, front or back, downstairs or upstairs, etc.
- If the threat is a real one, by making the call the caller is probably trying to avoid casualties, and the more information which can be obtained, the more likely it is that patients and staff can be moved to safety
- Try to ascertain how much time there is before the device explodes
- Ensure that the Service Manager is informed immediately

If the bomb is said to be **inside** the building:

1. Notify the police straight away and act on whatever advice they give
2. Subject to any alternative advice from the police, evacuate and seal off the immediate area. If it is known where the bomb is located, ensure that patients and staff are not moved towards or past the bomb's location. This includes the need to avoid an external route which passes the vicinity of the suspected internal location of the device. Do not sound the fire alarm. Evacuate by word of mouth.
3. Do not use electronic transmitting devices such as mobile phones, as these may trigger the bomb
4. Once immediate safety needs of patients and staff are attended to, inform the Primary Care Organisation

If the bomb is said to be **outside** the building:

1. Notify the police straight away and act on whatever advice they give
2. Subject to any alternative advice from the police, keep patients and staff inside the building but move everyone away from the side of the building where the bomb is located (if known)
3. Draw curtains or blinds if it is safe to do so and then keep everyone away from windows
4. Sit on the floor so as to be below the level of windows and wait for further advice from the emergency services
5. If patients or staff are outside the building at the time of the emergency, ensure they are moved to a safe area well away from the building. They should not re-enter the building
6. Once immediate safety needs of patients and staff are attended to, inform the Primary Care Organisation

After the event, record the details as a significant event.

CLINICAL WASTE MANAGEMENT PROTOCOL

INTRODUCTION

The THGPCG has a general duty to ensure, so far as is reasonably practicable, the health and safety of employees and other persons who may be affected by the storage, handling or disposal of waste products. It is essential that waste is disposed of in a proper manner and that the method of disposal, and the standard of record keeping, complies with both legislation and best practice.

The policy will be reviewed annually to ensure that it remains effective and complies with both best practice guidelines and current legislation.

The aim of this protocol is to increase awareness among staff who may be involved in the handling of clinical waste to ensure that safe procedures are maintained. Waste handling risk assessments should be carried out for all employees handling clinical waste.

The colour-coding arrangements for waste containers contained in this protocol are best practice compliant however it should be noted that they are not mandatory. The principle resource in this respect is the DoH Technical Memorandum accessed from the Resources section below and Service Areas are recommended to be familiar with the relevant principles.

The regulations regarding the categorisation, packaging, storage and disposal of waste are complex and Service Areas should ensure that they accurately identify the types of waste produced on the premises and discuss their requirements for disposal with their licensed waste contractor.

Clinical Waste

Any waste which consists wholly or partly of human tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with it. This includes other waste arising from the provision of treatment such as disposable clothing, towels, or any other waste which may cause infection to any person coming into contact with it.

Clinical waste is classed as hazardous, as it has properties which may be harmful to persons or the environment.

Segregation

Waste will be segregated into appropriate colour-coded containers at the point of use, which will determine the storage, transportation, and disposal methods. Clinical staff will have appropriate receptacles available and will be responsible for the most suitable choice of receptacle for the material being disposed of, with due regard to the type of receptacle (bin, bag etc) and the colour coding requirements. The disposal method will then become the responsibility of the authorised and licensed contractor who will dispose of the containers according to their colour-coded, and correctly segregated contents.

Appendix 1 details the colour-coding in place at this Service Areas.

Appendix 2 details examples of contents of colour-coded containers

Key Colour-Codes

Yellow

- Requires disposal via incineration
- Includes anatomical waste
- Classified as Hazardous Waste

Orange

- May be treated to render it safe prior to disposal in a licensed facility
- May contain pathogens
- Classified as Hazardous Waste

Purple

- Requires disposal via incineration
- Contaminated or consisting of cytotoxic or cytostatic products
- Service Areas should ensure proper colour-coded receptacles are available for this waste stream, including bags, sharps bins, and rigid containers.
- Classified as Hazardous Waste

Yellow / Black

- Offensive / hygiene waste. May be landfilled in a licensed facility
- Not considered to be infectious.

General Procedures for handling waste

All staff handling waste must wear appropriate and suitable protection (gloves, aprons) and be trained in Infection Control and Control of Substances Hazardous to Health (COSHH) risk mitigation procedures at least on an annual basis. All bags of waste must not be more than three-quarters full.

All waste must be placed into an “appropriate” container, which must clearly indicate the nature of its contents, and must be secure in relation to its nature. As a minimum, externally stored containers must be lockable and preferably stored in a secure and dedicated area. There may be a need to segregate waste, especially chemical waste which may interact.

All waste is to be handled and disposed of by an authorised contractor who will provide certified waste transfer notices and who will be responsible for disposal of the waste using registered disposal sites. Casual disposal of waste or the use of casual contractors is not permissible. Waste must be collected at intervals not exceeding 1 week.

Liquid waste or solidified liquid waste must be in a leak-proof container and placed in a properly colour-coded receptacle. Liquid waste cannot be sent for disposal to landfill. Guidance should be obtained from the licensed contractor.

All transfer of waste from the Service Areas to an authorised contractor must be supported by a Waste Transfer Note (WTN). This may be a note issued for the purpose of one transfer of waste only, or it may be in the form of a certificate (perhaps annual) which states the nature of the waste and its collection arrangements. These must be retained for at least 2 years, or, for Hazardous Waste, a three year period.

The contractors may require a declaration from the Service Areas stating the composite nature of the waste in advance of a contract year, and require the Service Areas to limit the waste to the previous stated items, or advise them of any extra waste types which may be included from time to time. Contractors may also offer a special disposal collection for certain waste types.

Waste, including unused medicines and sharps are not accepted from patients or members of the public as the Service Areas is not a licensed waste contractor. Patients are to be directed to community pharmacies.

Sharps

Sharps are any items which may cause a puncture, including needles, syringes with attached needles, broken glass, ampoules, scalpel blades etc.

Syringes containing residual products should not be intentionally discharged fully in order to dispose of them in a "fully discharged" sharps bin (i.e. the orange – lidded bin). If the syringe is only partially discharged and contaminated it must be disposed of in the yellow-lidded sharps bin.

Sharps waste excludes syringe bodies where no needle is attached.

Training

All staff required to handle clinical waste must be given adequate instruction about the risks associated with, and the procedures to be used, in order to ensure the safe handling, segregation and storage of clinical waste.

In addition to this all staff must be made aware of the procedures to be used following a spillage (see Infection control - biological substances protocol [*]), and receive COSHH training at least annually, or as relevant to their role.

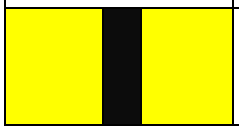
Staff handling cytotoxic drugs must be specifically authorised to do so. Staff at any stage of pregnancy are not permitted to handle or dispose of these drugs or products. Personal Protective Equipment (PPE) must be worn at all times to include PVC disposable apron, Latex gloves or similar, eye protection, as appropriate.

Training will include:

- Risk assessment
- Use of PPE
- First aid on exposure
- Waste handling and segregation
- Spillage
- Needlestick injury
- Personal and equipment hygiene

APPENDIX 1

Colour coding may apply to the container and / or container lids or tags

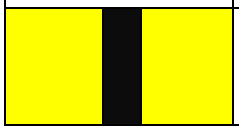
	Waste for incineration in a licensed facility
	Waste which may be treated to render safe in a licensed facility or by incineration
	Cytotoxic waste for incineration in a licensed facility
	Domestic waste suitable for landfill
	Offensive / hygiene waste suitable for landfill in a licensed facility

APPENDIX 2

EXAMPLES OF CONTENTS

Colour coding may apply to containers and bags of all types, including sharps bins, bin tops, and tags. The correct container type must be selected for the item being disposed of e.g. sharps must be placed in a sharps bin not a bag.

	• Infectious and other waste for incineration. • Standard clinical waste / healthcare waste not specifically mentioned below. • Anatomical waste, specimens, reagents and tests • Partially discharged sharps may be placed in a yellow-topped sharps bin if not contaminated with cyto products • Syringe body with residual medicinal product.
	• Infectious waste, soiled dressings • Sharps in an orange-topped sharps bin which are not contaminated with medicinal products • Phlebotomy sharps (orange-topped sharps bin) • Fully discharged sharps contaminated with medicinal products other than cytotoxic and cytostatic products
	• Infectious waste with cytotoxic and / or cytostatic materials • Soiled dressings, tubings etc. • Sharps will be placed in a purple topped sharps bin when contaminated with cytotoxic products e.g. methotrexate, and cytostatic medicine products.
	• General Service Areas refuse and domestic items

	• Human hygiene waste • non-infectious waste such as bedding, sheets and miscellaneous disposables. • Classed as non-hazardous

FIRE RISK ASSESSMENT CHECKLIST

Below is a checklist to assist with the preparation of a **Fire Risk Assessment**. Use the **Risk Assessment Table** which is included in the Risk Assessment toolkit [*] to record the findings of the Risk Assessment.

IDENTIFY HAZARDS

Sources of ignition

1. Are all heaters fitted with suitable guards and fixed in position away from combustible materials?

2. Are all items of portable electrical equipment inspected regularly and fitted with correctly rated fuses?

3. Is the wiring of the electrical installation inspected periodically by a competent person?

4. Is the use of electrical extension leads and multipoint adaptors kept to a minimum?

5. Are flexes run in safe places where they will not be damaged?

6. Is the building smoke-free and are the statutory warning signs in place at each entry / exit?

7. Are there any potential sources of ignition from outside the building? (Adjoining buildings, storage or other activities carried on near to building)

Sources of fuel

8. Is the upholstery of furniture in good condition? Note: old and dilapidated furniture can contribute to the spread of fire and torn upholstery exposes combustible filling material that may be used as kindling material by a potential arsonist. All new upholstered furniture for non-domestic use should comply with the requirements of British Standards 7176, 1995 and BS 7177, 1995.

9. Is the workplace free of rubbish and combustible waste materials?

10. Have measures been taken to ensure that smoke and flames cannot spread from one compartment/area within the building to another e.g. are there automatically closing internal fire doors?

11. Is there a system for controlling the amounts of combustible materials and flammable liquids and gases that are kept in the building?

12. Are any combustible materials and flammable liquids and gases stored safely? Are flammable items stored in suitable vessels / cupboards designed for that purpose and are they suitably labelled?

13. Do procedures and Service Areass avoid the use of combustible materials or processes that use heat?

14. Is any heating equipment or electrical equipment left on for longer than is needed?

Sources of oxygen

15. Is an air conditioning system present?

16. Is there a supply of medicinal / emergency oxygen on the premises?

IDENTIFY PEOPLE AT RISK

Staff

17. Do any staff members work alone at any time?

18. Do any staff members work near to sources of ignition / combustible materials

19. Do any staff members work in areas which are difficult to exit from?

***Patients* – especially any who are:**

20. Infirm or disabled

21. Elderly

22. Very young

CHECK FIRE DETECTION AND WARNING

23. Is there an automatic fire detection system and alarm system?

24. Is the fire alarm system in good working order?

25. Is the fire alarm tested weekly? (See Checklist below)

26. Can the fire alarm be raised without placing anyone in danger?

27. Are the fire alarm call points clearly visible and unobstructed?

28. Is the fire alarm system connected to a monitoring centre which calls the fire brigade?

29. Is the fire alarm system, and all its components, continuously monitored?

30. Are staff aware of the method of contacting the monitoring centre?

CHECK FIRE FIGHTING EQUIPMENT

31. Is an adequate number of suitable fire extinguishers provided?

32. Are the fire extinguishers and/or fire blankets located suitably and ready for use?

33. Are the fire extinguishers serviced annually by a competent contractor?

34. Is any fixed fire-fighting installation or automatic fire detection system in working order?

35. Are fire extinguishers sited in positions which are accessible in the event of a fire (e.g. close to room doors, in corridors etc)

CHECK SAFE ROUTES FOR EXIT

36. Is there a sufficient number of exits of suitable width (e.g. to allow for wheelchairs) for the people likely to be present in the building?

37. Do the exits lead to a place of safety?

38. Are all gangways and escape routes free from obstructions?

39. Are the escape routes free from tripping and slipping hazards?

40. Are steps and stairs in a good state of repair?

41. Are final exits always unlocked when the premises are in use, or are the devices securing final exits capable of being opened immediately and easily without the use of a key e.g. break-glass bolts which are released by breaking a glass tube?

42. Are internal fire doors labelled as such and normally kept closed?

43. Are the self-closers on fire doors operating correctly?

44. Do the doors on escape routes open in the direction of travel (i.e. towards the escape route)? Note: normally doors on escape routes should open in the direction of travel.

45. Are escape routes clearly signed?

46. Are escape routes adequately lit?

47. Where escape lighting is installed is it in working order and is it maintained regularly?

48. Are the escape routes suitable for wheelchair use, or are wheelchair facilities available in the event of evacuation?

CHECK PLANNING AND ADMINISTRATION

49. Are there reminders in place to turn off all heat producing equipment at the end of the working day?

50. Have plans been made and rehearsed regarding assisting disabled staff, patients and visitors to evacuate the premises?

51. Have suitable measures been taken to protect against the risk of arson? Note: arson is often an apparently motiveless crime, prompted merely by the availability of combustible materials, its presence will increase the likelihood of an arson attack. All rubbish and combustible waste should be kept away from the building

52. Have staff been trained in how to call the fire brigade, the use of the fire extinguishers and basic fire prevention?

53. Have you asked your insurers for advice regarding the fire protection of your premises (many insurers have free advice booklets for policyholders)?

54. If you employ five or more people, have you recorded the findings of the fire risk assessment?

55. Have you told your staff or their representatives about your findings?

56. If you have prepared a formal report, has it been shown to your staff or their representatives?

57. If you share the workplace with others, do they know about the risks that you have identified?

58. If you do not have direct control over the workplace have you made your findings known to owner or landlord?

59. Are fire action notices displayed prominently throughout the workplace?

60. Has an emergency plan been drawn up in case of a major fire?

61. Is a copy of the emergency plan kept other than at the workplace?

62. Has a procedure been established to review the fire risk assessment periodically?

Action: Record findings on the **Risk Assessment Table** which is included in the Risk Assessment toolkit [*]

FIRE SAFETY POLICY

INTRODUCTION

This policy applies to all Primary Health Care Staff, including Community Staff, working at St Paul's Way Medical Centre.

POLICY STATEMENT

A Fire Risk Assessment has been carried out in conformance with the Regulatory Reform (Fire Safety) Order 2005 (England & Wales)/ the Fire (Scotland) Act 2005 (Scotland)/ the Fire

Precautions (Workplace) Regulations (NI) 2001 (N. Ireland). The Risk Assessment is maintained and updated [*state the frequency of update, e.g. annually*] by the 'Responsible Person' [*name*].

All staff must ensure that they are familiar with the alternative means of escape in case of fire by walking the routes from the area in which they are employed. Staff should familiarise themselves with the designated assembly points and all fire exits.

When staff are required to evacuate the premises they will ensure that they:

- DO exit quickly and calmly by the nearest exit route
- DO go directly to open air
- DO close the door behind you
- DO NOT stop to collect personal belongings

PROCEDURE

All staff will be required to record all entries to and exits from, the premises. An "IN/OUT" record will be completed and will be sited in reception.

All members of staff who receive visitors will ensure that the visitors name is included on the record and that the "IN/OUT" boxes are ticked as appropriate. Staff responsible for meetings held on the premises will complete an attendance sheet containing the names of all "guest" attendees, BEFORE THE MEETING COMMENCES. In the event of an evacuation of the building, the responsible member of staff will present this sheet to one of the Fire Marshals on arrival at the assembly point.

ANY PERSON SUSPECTING OR DISCOVERING A FIRE SHOULD:

- Raise the alarm by breaking the glass of the nearest fire alarm call point
- Dial 999 – ask for the Fire Brigade
- If circumstances dictate or if ordered to do so leave the building by the nearest available exit route

ANY PERSON HEARING A CONTINUOUSLY SOUNDING FIRE ALARM MUST:

- Leave the building by the nearest available exit route
- Go directly to the assembly point
- Fire Marshals should ensure that all staff in their area have left the building
- Never re-enter the building until instructed to do by Senior Staff Member or Health & Safety Officer
- Instructions given by the nominated staff (Fire Marshals) must be followed
- Breaches of these procedures will be considered serious and may be dealt with under disciplinary measures
- Nominated Fire Officer or deputy, satisfied the emergency is being managed within the building, will go to the assembly point and liaise with Fire Marshals

When fire brigade arrive the Nominated Fire Officer or deputy will make him / herself known to the fire officer in charge and pass on relevant information.

EVACUATION PROCEDURES FOR DISABLED PERSON(S) WHEELCHAIR USERS

On hearing the fire alarm the Fire Marshal within that area will ensure that the wheelchair patients evacuate the building by the nearest available exit and proceed to the assembly point. Where a clinician is involved with the patient at the time of the alarm they will assist in the evacuation in normal circumstances.

DEAF/HEARING IMPAIRED PERSON/PATIENTS

Visual signs are situated throughout the building. Deaf or hearing impaired persons are encouraged to advise colleagues if they are likely to be working in an isolated/quiet area in order they may be notified in the event of a fire alarm being raised.

BLIND/VISUALLY IMPAIRED PERSON/PATIENTS

Blind and visually impaired persons should, with their nominated assistant, agree a procedure for evacuation in the event of a fire alarm being raised.

EVACUATION DRILLS

In accordance with fire safety legislation, [*Insert name of responsible person*] will carry out fire evacuation drills from time to time. These drills will monitor the effectiveness of local evacuation procedures.

TRAINING INSTRUCTION & INFORMATION

All new employees shall be given local fire safety induction training. This will include identification of escape routes, location of fire extinguishers, call points to show where assembly points are located as well as any local hazards they need to be made aware of.

A list of Fire Wardens is located in several areas around the building.

DUTIES OF THE NOMINATED FIRE OFFICER OR DEPUTY

The Nominated Fire Officer or deputy will confirm with switchboard operator that the fire brigade has been called. The Nominated Fire Officer or deputy will proceed to the assembly point. On meeting the Fire Marshals it will be determined if all staff have been accounted for. On the arrival of the fire brigade the Nominated Fire Officer or deputy will make him/herself known to the fire officer in charge, and pass on any relevant information such as if any staff are not accounted for.

DUTIES OF FIRE MARSHALL

Standard Duties:

- Ensure safe systems of work are in place with regard to fire safety
- Check that the fire fighting equipment is maintained and in position
- Monitor that the fire alarm is tested on a regular basis
- Report any defects that may compromise fire safety
- Report any obstructions to fire doors or fire escape routes

- Ensure that new members of staff are made aware of the fire procedures, means and direction of evacuation and location and operation of fire exit doors
- Report any defects to the Service Area Manager Manager

During an Emergency:

- Ensure that the alarm has been sounded
- If possible locate the person raising the alarm and determine the extent of the fire
- Ensure that all staff in your immediate area are aware of the emergency
- Ensure that all staff leave the building immediately and in an orderly fashion
- Ensure that the doors are closed as staff leave the building
- Ensure that no persons remain in the building
- Ensure that disabled persons or those with mobility / sensory problems are assisted to evacuate the building
- Collect "IN/OUT" tick lists on way out of building and at Assembly Point, receive attendance sheets detailing attendees at meetings, if appropriate
- Ensure that no persons enter the building during the emergency procedure
- At the assembly point to make a roll call using the "IN/OUT" lists and meeting attendance sheets to determine that all staff are accounted for
- When the Nominated Fire Officer or deputy arrives, pass on all relevant information

PROCEDURE FOR SWITCHBOARD OPERATOR

- Ring 999 to inform Fire Brigade.
- Contact Nominated Fire Officer or deputy pass on all relevant information, confirm that fire brigade has been called and leave the building.

HANDWASHING TECHNIQUES

INTRODUCTION

Effective hand washing techniques are the most important element in the prevention of the spread of infection. The requirements of the National Patient Safety Agency **clean hands** Alert dated 2nd September 2008 have been incorporated into this document version. This is no longer a current NPSA campaign however the resources are still available in this link.

Hands are a repository for infectious organisms and healthcare staff have the greatest opportunity to transfer these organisms both between patients and between different procedures for the same patient. This is most likely in:

- The transfer of the patient's own micro organisms into sterile areas of the patient's body during treatment
- The transfer of micro organisms from one patient to another
- The transfer of micro organisms from the environment and equipment to the patient
- The transfer of micro organisms to yourself and other healthcare staff as a result of patient contact and subsequent person to person contact.

PROCEDURES

The use of an alcohol gel (see below) is usually preceded by handwashing, but may be effective without.

Hands should always be washed:

- When starting work
- When leaving the workplace
- When dirty and also at intervals
- Before and after direct contact with a patient
- After removing gloves
- After visiting the toilet
- After handling soiled items
- Before handling food
- Prior to any clean or aseptic procedure

Other points:

- Always use paper towels (only)
- Never use “bar” soap
- Always ensure that soaps, scrubs, and alcohol gel containers are wall-mounted
- Where nail-brushes are provided these must be single-use sterile brushes, disposed of immediately

Alcohol Gel

The use of alcohol rub should be frequent and routine on non-soiled hands as it is quick, effective, well tolerated by the skin, and can easily be placed in areas where needed the most – for example at the point of patient care, such as treatment rooms, couches, patient chairs etc, as well as adjacent to each clinically–designated sink. It may be used following hand washing, but is also effective on otherwise clean hands where no hand washing facilities are available, and for this purpose a small container may easily be carried in a doctor’s bag.

It may (in addition to the instances above) be used:

- Prior to a patient contact – *protect the patient from germs on your hands*
- Prior to an aseptic task – *protect the patient from germs, including their own, entering the body*
- After a body fluid exposure risk – *protect yourself and the environment of the room*
- After a patient contact - *protect yourself and the environment of the room*
- After contact with a patient’s surroundings - *(e.g. a chair or door handle)*

Follow the handwashing technique 6 stage process as illustrated on the poster below where a subsequent sterilisation of hands is required using the gel. Sterilisation is not a substitution for handwashing as gel does not clean hands, however where hand-wash facilities are not available the use of a sterilising gel is appropriate before or after undertaking any of the above activities (e.g. on external visits etc).

Alcohol rub is ***not*** the preferred primary hand cleansing product where:

- Hands are visibly soiled
- Patient is experiencing vomiting and / or diarrhoea

- There is direct hand contact with body fluids
- There is an outbreak of norovirus, clostridium difficile or other diarrhoeal illness.

In this case hands should always be washed first with liquid soap and water.
It is recommended that small dispensers (e.g. 125ml) are carried in every doctor's bag specifically for use on home visits. Wall mounted dispensers should be available above every clinical sink.

Contents should comply with European CEN Standard EN1500.

The poster below should be displayed in the following locations:

- Above every treatment room hand-washing basin
- Above every examination room hand-washing basin
- Above the hand-washing basin in every toilet used by staff

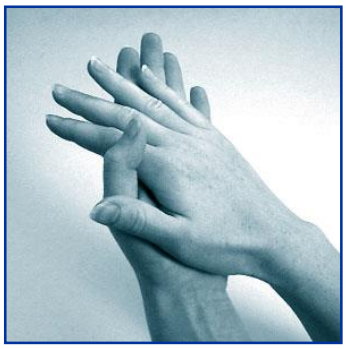
Consideration should also be given to the display of the poster in public toilets. Where possible, the poster should be laminated to facilitate wiping / cleaning.

Handwashing is the single most important activity for preventing cross infection

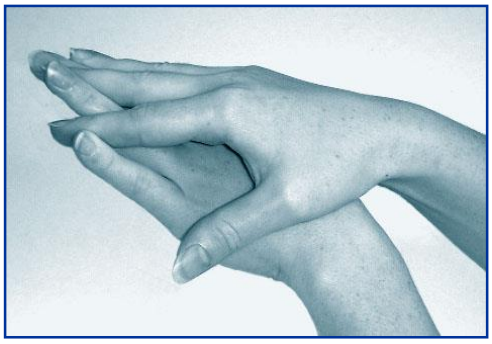
- Wet hands under running warm water
- Apply liquid soap
- Without applying more water, vigorously rub all parts of the hands using the technique below (10-15 seconds for routine handwashing)
- Rinse hands under running water
- Dry thoroughly using disposable paper towels

Six Step Handwashing Technique

1



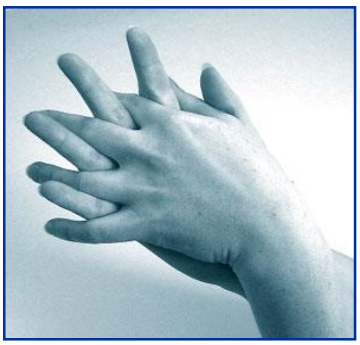
2



Right palm over back of left hand
then left palm over back of right hand

3

Palm to palm
fingers interlaced

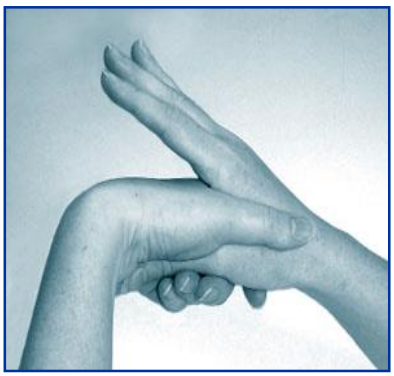


Palm to palm

4

Backs of fingers to opposing palms with fingers interlocked

5



Rotational rubbing of right thumb clasped in left palm and vice versa

6

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

Should supplies of liquid soap or paper towels be needed please contact Reception

Reviewed January 2014

PROTOCOL FOR NEEDLESTICK INJURIES

INTRODUCTION

The purpose of this protocol is to provide guidance for the urgent treatment and attention to injuries by sharps. It should be readily available in the event of an incident. Service Area s should research local arrangements and follow procedures in place as recommended by their own Health Protection unit.

PROCEDURE

The following action is recommended in the event of an inoculation injury.

1. IMMEDIATELY:

(a) Make the wound bleed, if possible.
(b) Clean well with copious amounts of soap and running water.
(c) Apply occlusive dressing.
(d) Identify the source of the sharp.

SEEK IMMEDIATE ADVICE FROM:
During working hours: 0830 – 1630 (Monday – Friday).

Needle stick Helpline
Health and Wellness Centre (Occupational Health)
Royal London Hospital
31- 43 Ashfield Street
E1 2AH
020 7377 7449

Out of working Hours (1630 – 0830) including Weekends and Bank Holidays

Attend Accident & Emergency at Newham University Hospital and contact Senior Registrar – Virology or the Virologist on Call on 020 7476 4000 via switchboard at Newham University Hospital who will be able to advise you.

Do not delay reporting this type of injury. Prophylactic treatment - if indicated - is most effective if started within 2 hours of the injury.

Recommended Action may then be:

3. Obtain sufficient information to identify the patient and the member of staff. Take a focused and impartial history to identify risk of HIV, HEP B (HBV) and HEP C (HCV).

4. If at high risk for HIV start Post Exposure Prophylaxis preferably within an hour, but worthwhile up to 36 hours post-exposure. Find HBV status of “recipient” and consider booster even if good immunity, consider HEP B immunoglobulins.

5. Note the type of injury, depth, gauge of needle, if used for injecting or aspiration, and if hollow bore or bloodstained.

6. Counsel and consent “donor” to take blood for immediate testing regardless of history.

7. Counsel and consent “recipient” for bloods to be taken and stored for HIV, HBV and HCV

Appropriate clotted blood specimens from the member of staff involved and the source patient may be requested immediately and in three months time, and should be sent with request forms and details of the accident. HIV testing is not routine and will not be undertaken without full counselling.

If immunoglobulin is required the member of staff will be contacted and treated by the Accident and Emergency Unit. Immunoglobulin must be given within 48 hours to be of most benefit.

6. **An accident report should be completed.** The Accident Report Book is held in the Service Area Managers office. The following should be recorded.

The source of the sharp and description of the accident. Include the place, date, time and any witnesses.

The name of the source patient.

The action taken.

Any persons who gave advice and the advice given.

The advice given to the patient and/or staff member concerned.

The action taken to prevent recurrence.

Sharps should be kept in the appropriate "Sharps" box, out of the reach of children and with the lid closed - except when disposing of the sharp.

Sharps should be disposed of by the person using them. **Never leave sharps to be disposed of by someone else.**

It is the responsibility of staff suffering injury to ensure that advice on first aid is sought and to ensure completion of the appropriate documentation in accordance with the Health and Safety Regulations.

HEPATITIS B STATUS

INTRODUCTION

This document sets out the outline of a Service Area policy for checking Hepatitis B status. Precise clinical requirements are outside the scope of this document. Service Area s should satisfy themselves of the correct method of dealing with these or other arising issues prior to taking action, in particular relating to staff members involved in EPP activities (See below) who decline to be immunised or tested for immunity.

There is various health service and other guidance which refers to the requirement to record and monitor the Hepatitis B status of all employees. The requirements of the Quality and Outcomes Framework (QOF) are basic and require that the status of all staff and partners is known and is updated on a regular basis. For the purposes of QOF it is sufficient for the Service Area to make enquiries of staff both on recruitment and on a follow-up basis thereafter to determine their status in relation to immunity and record this. Where it is deemed to be appropriate for a vaccination to be given this will be recommended to staff however staff will not be under an obligation to have this done.

In a similar way, staff who have had a part course of treatment, or have had a course of treatment but have not been tested for immunity are under no obligation to continue or complete the course or investigation, although this may be strongly recommended.

New Staff

Where a staff member is classed as a “New” staff member (see below) it is a condition of employment that they are checked and non-infectious for HIV, Hep B, and Hep C (this is subject to specific clinical requirements). The checks will be completed prior to appointment to an EPP post, as they will be ineligible for the role if infectious.

New workers are defined as new to NHS or the Service Area , returning to the NHS, new to performing exposure-prone procedures (EPPs) and a few other categories (See Resources links below).

The checks will be completed prior to an offer of employment and be a condition of it. This is not to stop these candidates working for the NHS, but may restrict infected people to working in “non-risk to patient” jobs. This policy is consistent with the policy working restrictions placed on persons *known* to be infected.

The workers themselves are considered to benefit from the screening requirement as earlier diagnosis could benefit them.

Existing Staff

Existing staff will normally be subject to the monitoring system above.

Refusals

Where a staff member is an existing staff member who is not changing roles or activities within the job and refuses testing procedures, as an employer we unable to force them to have a test, but guidance states that these staff "should" have their status checked, immunised and recorded.

Such a refusal conflicts with employer official guidance where the staff member is involved with EPP and does bring quite a few other very major issues and implications into play.

As an employer the organisation has a responsibility to staff and patients under the Health & Safety at Work Act where employers are responsible for both staff and members of the public, and under COSHH regulations employers are required to review every procedure carried out by their employees which involves a direct contact with a substance hazardous to health – this includes pathogenic micro-organisms such as Hepatitis – and the employer must ensure that no one, as far as reasonable practicable, is placed at avoidable risk.

This will make the employer potentially legally liable if a clinician who has refused to be tested is allowed to undertake exposure-prone procedures (EPPs).

This clinician involved in EPP may pass on an infection to a patient or other person. Even if guidance is only "guidance", an employer who ignores this would have a poor legal defence as the guidance is well-established.

The following extracts are relevant:

"Health care workers whose hepatitis B carrier status is unknown should not perform Exposure Prone Procedures".
Addendum to HSG (93) 40: Protecting Health Care Workers and Patients from Hepatitis B.

"Should a health care worker refuse to be tested for markers of HBV (Hep B Virus) infection their attention should be drawn to para 11 of annex A of HSG(93)40 which states;" if a health care worker whose work involves EPP refuses to comply with the guidance he or she should be considered as if e-antigen positive and managed accordingly"

This in effect may be interpreted that a refusal should be managed as a positive infectious result, and that if the employer does not stop them treating patients by EPP and discuss transferring them to other roles (among other options) then the employer is taking a very significant legal risk.

This risk (and any similar or arising) must be assessed and managed like any other, and the statutory duty to "identify and assess the risks to health of microbiological and chemical hazards, prevent and control exposure to the risks, inform and train employees, and monitor exposure…." come into play.
(Guidance for Clinical Health Care Workers)

Defence organisations should be consulted in the event of a refusal from workers involved in EPP, as allowing a non-tested person to continue to deal with EPPs may jeopardise the organisation's defence cover.

GMC and NMC are specific about positive result staff not undertaking EPPs, and the duty of members who know they are positive, and clinicians should refer to their own professional bodies (in confidence) for guidance.

Organisations should also take legal and professional advice before dealing with the refusal by a staff member, including possible consultation with the Occupational Health Department, and should take appropriate advice when a worker is found to have a positive result

RESOURCES

Exposure prone procedures (EPPs) – A Definition

Exposure prone procedures (EPPs) are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

In such circumstances there is a potential risk of transfer of a blood borne viral infection from an infected health care worker to the patient. Health care workers infected with a blood borne virus, Hepatitis B, Hepatitis C, or HIV are restricted from performing EPPs according to guidelines issued and updated by the UK Health Departments. Other situations, such as pre-hospital trauma care and care of patients where the risk of biting is regular and predictable, may involve similar risks to the invasive procedures described above and should be avoided by health care workers restricted from performing exposure prone procedures.

LONE WORKER POLICY

INTRODUCTION

Some staff may be required to work by themselves either within the surgery or out on home visits. The purpose of this policy document is to establish basic principles to ensure that any personal risks are properly assessed and controlled. Employers are responsible for health and safety of their workers whether in the surgery or on location, and, where necessary, should undertake a risk assessment sufficient to adequately assess the individual circumstances applicable to each member of staff.

Working within the Surgery

Ensure that:

- All external doors and accessible windows are locked where patient / public access is to be prevented.
- Lone workers should not admit anyone into the premises who is unknown to them.
- Ensure that you are familiar with the locations of telephones with direct access to outside lines, and that you know how to access these.
- Keep your keys secure and not accessible to visitors.

- Use the most secure door for access and exit, preferably one which has a security camera or a door-viewer available. Where the building has CCTV available to monitor the external area, use the system to check visible areas before exiting.
- Do not undertake high-risk physical activity such as lifting / carrying, working on ladders, or undertake manual work whilst alone in the building.
- Lock all doors and windows behind you when you leave an area.
- Ensure that when you are moving around the building that access to other areas is prevented or controlled to ensure that an intruder has not accessed another part of the building without your knowledge.
- Keep a mobile telephone on your person.
- Be aware of the number of the local police station and key Service Area contacts or keyholders who live locally.
- Be aware of the intruder alarm system, the procedure for calling the security control centre (where used) and the method by which a duress call may be activated.
- Ensure that a colleague or family member is aware of the time that you are expected home. Ring that person if you are delayed. Ring them to tell them that you are leaving the building and what time you expect to be home. Ensure that the person knows what to do should you fail to arrive in a reasonable time, and that they have the means to contact you both in person (mobile phone) and in the surgery after hours.

Home Visits

Patients who are unwell or suffering from stress may be unpredictable or act in an unusual way. The THGPCG will take all necessary steps to remove the risks associated with visits which have the potential to cause the staff member alarm. Home visits will not be made to patients who are known to be generally aggressive, or where other members of their household pose a similar threat.

Where a staff member perceives that a home visit may be inappropriate for personal safety reasons then an alert will be placed on the clinical system, and an alternative means of delivery of the health service will be investigated.

Staff may:

- Decline a visit where they feel uncomfortable.
- Decline a visit where the house or the area causes concern.

- Decline a visit where other aspects of the visit may cause concern, e.g. aggressive animals not fully controlled, aggressive or intimidating family members, threats to person or property.

In addition, where the house is occupied by persons smoking, or where the atmosphere in the house is affected by recent smoking or is otherwise smoke affected, the staff member may decline to enter or remain on the premises. In these circumstances the staff member may return to the base and make a report. The clinical system will normally be endorsed with an alert message to the effect that a visit has been declined due to smoking, and the patients will be written to with an explanation, which will include the future requirement to ensure a healthy atmosphere prior to a visit request.

Each Home Visit must be recorded in a recognised format and / or location, including the estimated time of arrival and departure. Where the Home Visit is one of a series of visits the records must have a clear indication of the order / sequence and the duration of each. The record should include:

Who you will see.
Their contact telephone number
Time of Appointment
Duration of visit
Reason for visit
Time of return to the surgery or arrival at next visit.
Time of arrival at home if not returning to the surgery

Where the visit is a first to a particular patient or house then the visit record will be endorsed prominently to that effect to emphasise a greater risk element. A sample record is provided at Appendix A.

- Each visitor should be provided with, or have access to, a mobile phone and / or a personal attack alarm.
- Each visitor should be trained in dealing with aggressive patients and in self-defence / avoidance techniques.
- Each person visiting and using a car should be a member of one of the driving recovery organisations.

- Arrange a distress code or phrase with the Service Area – its use via a mobile will alert the Service Area staff to a situation where the police may be called without alarming the patient / householder.
- The visitor should park as close as possible to the house, ensuring the area is well-lit.
- If the visitor is unhappy in visiting a particular home or a particular area then do not go. Alternative arrangements will be made, including, if appropriate, the need for two people to attend. This may include visits to high-crime areas or isolated rural locations.
- Visits during “unsocial” hours or finishing after dark should be avoided.
- Establish a procedure whereby the visitor contacts the surgery before and after each visit to confirm that each one has been safely completed. Where this confirmatory call is not received within a defined time after the estimated duration the surgery should contact the visitor on the mobile phone provided.
- When returning directly home after visits you should establish a system whereby you ring the surgery to confirm that you have safely completed your visits and have arrived home. In the event that this call is not received a system should be established within the Service Area to initiate follow-up action including contacting the visitor or relatives as appropriate.
- Reception staff to ensure the effective management of the above procedures and that there is an effective “handover” when Service Area staff change during the day.
- When undertaking a home visit there may be times when, on arrival, that you feel uncomfortable in either entering or remaining in the house. In these circumstances do not enter, and make a suitable excuse, leaving immediately. If necessary, make a mobile phone call to the surgery and pretend that an urgent call has arisen.
- It is the responsibility of [*Insert name of designated person*] to ensure that systems are in place whereby the whereabouts of the visitor(s) are known at all times, and to start enquiries where there is cause for concern.

APPENDIX A

VISIT RECORD

Date……Visitor……..

Patient Name		Clinical Number	
Date of Visit		Time of Visit	
Address		Phone Number	
Reason for Visit			

Security

Arrival Confirmed	Time	Confirmed By

Duration	Expected Departure Time

Departure Confirmed	Time	Confirmed By

Expected Time of next visit or confirmation (also see next visit record sheet)	Time	Confirmed By

Visit Record Complete……(Signature)

PROTOCOL FOR NEEDLESTICK INJURIES

INTRODUCTION

The purpose of this protocol is to provide guidance for the urgent treatment and attention to injuries by sharps. It should be readily available in the event of an incident. Service Areas should research local arrangements and follow procedures in place as recommended by their own Health Protection unit.

PROCEDURE

The following action is recommended in the event of an inoculation injury.

1. IMMEDIATELY:

(a) Make the wound bleed, if possible.
(b) Clean well with copious amounts of soap and running water.
(c) Apply occlusive dressing.
(d) Identify the source of the sharp.

2. Refer initially to one of the doctors in the Service Area, and refer to the Occuaptional Health IN Ashfiled St on 020 7377 7254 who can advise what further action is necessary.

Recommended Action may then be:

3. Obtain sufficient information to identify the patient and the member of staff. Take a focused and impartial history to identify risk of HIV, HEP B (HBV) and HEP C (HCV).

4. If at high risk for HIV start Post Exposure Prophylaxis preferably within an hour, but worthwhile up to 36 hours post-exposure. Find HBV status of "recipient" and consider booster even if good immunity, consider HEP B immunoglobulins.

5. Note the type of injury, depth, gauge of needle, if used for injecting or aspiration, and if hollow bore or bloodstained.

6. Counsel and consent "donor" to take blood for immediate testing regardless of history.

7. Counsel and consent "recipient" for bloods to be taken and stored for HIV, HBV and HCV

Appropriate clotted blood specimens from the member of staff involved and the source patient may be requested immediately and in three months time, and should be sent with request forms and details of the accident. HIV testing is not routine and will not be undertaken without full counselling.

If immunoglobulin is required the member of staff will be contacted and treated by the Accident and Emergency Unit. Immunoglobulin must be given within 48 hours to be of most benefit.

6. **An accident report should be completed.** The Accident Report Book is held in the Service Area Managers office.The following should be recorded.

The source of the sharp and description of the accident. Include the place, date, time and any witnesses.

The name of the source patient.

The action taken.

Any persons who gave advice and the advice given.

The advice given to the patient and/or staff member concerned.

The action taken to prevent recurrence.

Sharps should be kept in the appropriate "Sharps" box, out of the reach of children and with the lid closed - except when disposing of the sharp.

Sharps should be disposed of by the person using them. **Never leave sharps to be disposed of by someone else.**

It is the responsibility of staff suffering injury to ensure that advice on first aid is sought and to ensure completion of the appropriate documentation in accordance with the Health and Safety Regulations.

PANIC ALARMS PROCEDURE

INTRODUCTION

There are a number of differing alarm types now available in service Areas, from on-screen buttons which may be used to summon help, through to belt-worn portable units which activate at strategically located sounding points throughout the building, to the traditional wall-mounted panic buttons attached to wired intruder alarms systems, which may, or may not, activate an alert to a central monitoring control centre.

The purpose of this protocol is to cover the procedure to follow in the event of an activation, assumed to be where an individual is perceived to be at risk.

Use and Activation

Panic alarms are used to alert staff that assistance is required in aggressive situations. Panic alarms must not be used for emergency clinical situations – telephones must be used for all non-aggression events.

Use the alarm if you feel threatened by a situation:

- Verbal or physical disruption
- Verbal aggression
- Physical aggression or threat of physical violence or mental distress
- Physical violence

All staff should trust their instinct and activate the alarm if they feel a situation may develop.

Where a staff member decides to activate an alarm they should be aware that the standing instruction is that another attending staff member will enter the room after a knock, with only a very short response time, unless the room owner meets them at the door.

In the Event of Hearing an Activation

Two people should attend the site of the activation together, and where a third person is available they should stand at a discrete distance (e.g. further down the corridor) ready to:

- Activate the static alarm which will notify the control centre that there is a personal attack situation, which will generate a police presence, and

- Dial 999 for the Police, advising them of the alarm activation.

One of the two persons should knock and enter the room after a short pause for a response. They may quickly assess the situation and may say ask the Doctor / room owner to:

"Come quickly to help a patient"

This may give the room occupant time to leave the room before the aggressor has time to react.

It is recommended that keys remain in the lock on the inside of doors during the normal working day. This may help prevent unauthorised access to administration or other private (but not necessarily secure) areas by patients who turn out to be aggressive in this way.

Alarm Types in this Building (examples)

Alarm Types	Descriptions / Locations	Deactivation Instructions
Static – intruder system	Front Reception Desk	Turn deactivation key under desks

Little Green Button	All screens when logged onto windows	Administrator to reset
Computer Screen software (button)	All screens when logged onto Emis Web	Administrator to reset

SECURITY

All members of staff have responsibility for the daytime security of the surgery. Those members of staff who are responsible for opening and closing the surgery should also adhere to the procedures as follows:

1. Opening the surgery:

(a) Where possible, this should never be done on your own. The first person to arrive should wait at a discrete distance from the door. The second person to arrive should observe that the first person is not under duress or observation before approaching. A minimum of two persons should be present before the building is approached and entered. One person should remain at a distance outside until the first person has entered, and returns to indicate that it is all clear.

(b) Once you have entered the surgery, you will hear a series of short beeps from the alarm and you will need to turn off the alarm system following the prescribed protocol.

2. During the day:

(a) All records (computer and manual/hard copy files) must be kept safe and secure at all times: access must only be for authorised people.

(b) Access to consulting rooms, treatment rooms etc must be carefully monitored.

3. Last thing at night or on closing the surgery:

(a) A minimum of two persons should lock up together.

(b) Make a thorough check of all rooms both upstairs and down (including the toilets).

(c) Ensure nobody else is left in the building, all windows are shut and secure, all computers have been logged out and turned off, all lights have been turned off and all doors have been closed.

(d) Ensure front door has been locked.

(e) Turn off other machines e.g. photocopier.

(f) Check any unnecessary lights are not left on.

(g) Set the alarm following the prescribed protocol.

4. In the event of an emergency, if you are alone:

(a) If you feel physically threatened and there is no one else in the surgery, immediately telephone the police giving your location and saying you are on your own.

(b) If you are alone in reception or other parts of the surgery but there are others in the building, telephone through to the nearest internal telephone to make others aware you are in danger. **FAILING THIS SHOUT FOR HELP**.

(c) Activate the alarm Panic facility following the prescribed protocol.

SAMPLE HANDLING PROTOCOL

INTRODUCTION

This protocol sets out non-clinical safe handling procedures.

GENERAL

Reception staff accepting samples from patients should only do so where containers are correct and secure in accordance with the following guidelines. Where not, the sample should be refused and a correct container supplied or the patient should be referred back to the appropriate clinician.

Blood

All samples of blood are to be in the approved sample tubes provided, which are sealed by a top. Should leakage of blood occur to imperfections in the bottle or incorrect fitting of the top, the sample is not to be transported out of the Service Area in the container.

All sample tubes containing blood are to be inserted into an approved plastic bag, which should be sealed to minimise the risk of contamination of personnel should leakage occur.

If there is a leak or spill the action will depend on the extent of the leak. If the leak is contained within the plastic bag the bag should not be opened and should be inserted within another plastic bag, which should then be sealed. A suitable person (doctor/nurse) is to be informed if a leak occurs and will decide whether to dispose of the sample or to transfer the remains of the sample into another bottle. The transfer of blood should only be undertaken when the risk of contamination of personnel is minimal and when gloves are used. Otherwise the sample is to be disposed of as above in a plastic bag inserted into the sharps box.

If the leak is not contained within the bag and contaminates either the outside of the bag or external objects the following action is to be taken:

- Avoid any further contamination by containing the sample within another plastic bag - if possible without undoing the bag. Tighten the top of the tube as this may be loose.
- Dispose of the sample within an approved sharps box.
- Ensure that your hands are washed thoroughly with hot water and/or alcohol gel or soap. Any cut or open wound that comes into contact with the patient's blood should be thoroughly washed to ensure that none of the patient's blood remains in contact with the wound.
- Any contaminated objects should be cleaned and disinfected.
- All blood should be treated as high risk and universal precautions applied.

Urine

Urine, whether non-infected or infected, poses less of a risk than blood. However sensible precautions should still be taken to avoid contamination of personnel or their clothing. Gloves should be worn when handling urine containers as it is impossible to tell whether or not the container is contaminated with blood or faeces.

Samples in Sealed Containers

Samples of urine in sealed containers should pose no health risk provided that the bottle is adequately sealed and no urine contaminates the outside of the bottle.

Pregnancy tests and dipstick testing make necessary the opening of urine bottles and exposure of personnel to urine. Gloves should be worn whilst testing urine and hands must always be washed after handling urine and testing urine.

Disposal of Urine. Urine is to be disposed of down the sluice or toilet. Under no circumstances may it to be disposed of down a sink.

Disposal of Urine Containers. Urine containers are disposable and are to be used once only. Urine bottles are to be emptied when analysis is complete and the bottle resealed and disposed of in the sharps bin.

Faeces

Faeces pose a risk to medical personnel. Through faeces a number of diseases are transmitted that can be serious (though they are rarely as serious as blood diseases). It is important to handle specimens correctly to avoid the risk of disease.

Samples

Samples should be handed in inside a specimen pot. Other containers are not acceptable. The patient should label his specimen container before defecation with his name, date of birth and date and time of production. The specimen should then be placed inside a specimen bag and **sealed by the patient**. The patient should be advised to wash his hands thoroughly after defecation before touching the specimen pot and again after inserting the specimen pot into the bag.

Microbiological Swabs

Swabs are taken of many infected areas of the body to assess the cause of the infection. Thus a swab by definition contains an unknown hazard. Provided the swab is not removed from the transport medium, no risk of transmission of infection exists unless there has been contamination of the outside of the container. The following guidelines are to be followed:

The top of the bottle must be sealed adequately before insertion into a sealed plastic hazard bag. The form that accompanies the specimen is to be placed in the appropriate pocket of the bag and not in the same compartment as the specimen.

In the event of the top becoming loose and parting from the container whilst in the bag, the top is to be re-sealed either through the bag, or by opening the bag.

The transport medium is solid and unlikely to leak out of the bag, however, in the unlikely event of this occurrence it has to be assumed that microbiological material has also leaked. Therefore the specimen is to be disposed of and re-taken.

Clothes

Precautions should always be taken to avoid contamination of clothing whenever possible, by the use of protective clothing, e.g. plastic apron when the situation can be anticipated. However there will be occasions when it is difficult to anticipate the situation. Contamination of clothes with biological material necessitates the following measures:

- Remove as much surplus material as possible using gloves and a disposable wipe.
- Change into clean clothing if there exists any risk to either the operator or patients whom the operator will treat during that shift. If in doubt - change.
- Personnel should ensure that the clothing does not come into contact with any surface on which food is prepared.
- Blood stained clothing should be soaked in cold water prior to washing to facilitate removal of the stain.
- Soiled clothing should ideally be washed separately from other non-soiled clothing and the washer used at the maximum temperature that the clothing could tolerate without being damaged.
- There may be occasions when it is deemed fit for an item of clothing to be destroyed due to contamination with biological material. Under these circumstances the item is to be sealed in a hazard bag and disposed of in the clinical waste bin.

TRANSPORTATION OF BIOLOGICAL/CLINICAL WASTE

- Biological or clinical waste is to be placed in appropriate containers only. Sharps are to be placed only in sharps boxes. Only contaminated material that cannot penetrate the plastic is to be placed in hazard bags. Contaminated or non-contaminated material that may penetrate the hazard bags most be placed in a sharps box. This includes unbroken glass that may become broken if the bag is damaged in transit.

- Yellow hazard bags are to have no contamination of their outer surface. If there is contamination of the bags outer surface with biological material, the bag is to be placed inside another bag and sealed ready for transportation.

- Once boxed or bagged in hazard containers, waste is to be stored in the Clinical Waste bin outside at the rear of the surgery. The waste material is to remain inside these solid containers until collected by the clinical waste contractor.

SAFE USE AND DISPOSAL OF SHARPS

INTRODUCTION

The risk of injury or infection from accidents with sharps within general practice is significant. The purpose of this protocol is to provide some basic rules relating to the handling and disposal of sharps.

Sharps must not be passed directly from hand to hand, and handling should be kept to a minimum.

Needles must not be bent or broken prior to use.

Always dispose of sharps at the point of use in a suitable container.

Needles **must not** be re-sheathed by hand.

Syringes/cartridges and needles **should be disposed of intact.**

Ensure that the sharps containers comply with BS7320:1990 '*Specification for sharps containers*' and/or are type-approved in accordance with the *Carriage of Dangerous Goods(Classification, Packaging and Labelling)* and *Use of Transportable Pressure Receptacles Regulations 1996*

Do not fill sharps containers above the manufacturer's marked line.

Lock the used sharps container when ready for final disposal in accordance with the manufacturer's instructions.

Sharps containers should be disposed of when the manufacturer's marked line has been reached or at the intervals specified by local procedures.

Always carry used sharps containers by the handle.

Do not dispose of sharps with other clinical waste.

Do not place used sharps containers in yellow bags for disposal.

Place damaged used sharps containers into a large secure rigid container, which is properly labelled.

Dispose of sharps containers either by incineration or maceration followed by heat or chemical treatment.

HEPATITIS B STATUS

INTRODUCTION

This document sets out the outline of a Service Area policy for checking Hepatitis B status. Precise clinical requirements are outside the scope of this document. Service Areas should satisfy themselves of the correct method of dealing with these or other arising issues prior to taking action, in particular relating to staff members involved in EPP activities (See below) who decline to be immunised or tested for immunity.

There is various health service and other guidance which refers to the requirement to record and monitor the Hepatitis B status of all employees. The requirements of the Quality and Outcomes Framework (QOF) are basic and require that the status of all staff and partners is known and is updated on a regular basis. For the purposes of QOF it is sufficient for the Service Area to make enquiries of staff both on recruitment and on a follow-up basis thereafter to determine their status in relation to immunity and record this. Where it is deemed to be appropriate for a vaccination to be given this will be recommended to staff however staff will not be under an obligation to have this done.

In a similar way, staff who have had a part course of treatment, or have had a course of treatment but have not been tested for immunity are under no obligation to continue or complete the course or investigation, although this may be strongly recommended.

New Staff

Where a staff member is classed as a “New” staff member (see below) it is a condition of employment that they are checked and non-infectious for HIV, Hep B, and Hep C (this is subject to specific clinical requirements). The checks will be completed prior to appointment to an EPP post, as they will be ineligible for the role if infectious.

New workers are defined as new to NHS or the Service Area, returning to the NHS, new to performing exposure-prone procedures (EPPs) and a few other categories (See Resources links below).

The checks will be completed prior to an offer of employment and be a condition of it. This is not to stop these candidates working for the NHS, but may restrict infected people to working in “non-risk to patient” jobs. This policy is consistent with the policy working restrictions placed on persons *known* to be infected.

The workers themselves are considered to benefit from the screening requirement as earlier diagnosis could benefit them.

Existing Staff

Existing staff will normally be subject to the monitoring system above.

Refusals

Where a staff member is an existing staff member who is not changing roles or activities within the job and refuses testing procedures, as an employer we unable to force them to have a test, but guidance states that these staff “should” have their status checked, immunised and recorded.

Such a refusal conflicts with employer official guidance where the staff member is involved with EPP and does bring quite a few other very major issues and implications into play.

As an employer the THGPCG has a responsibility to staff and patients under the Health & Safety at Work Act where employers are responsible for both staff and members of the public, and under COSHH regulations employers are required to review every procedure carried out by their employees which involves a direct contact with a substance hazardous to health – this includes pathogenic micro-organisms such as Hepatitis – and the employer must ensure that no one, as far as reasonable practicable, is placed at avoidable risk.

This will make the employer potentially legally liable if a clinician who has refused to be tested is allowed to undertake exposure-prone procedures (EPPs).

This clinician involved in EPP may pass on an infection to a patient or other person. Even if guidance is only “guidance”, an employer who ignores this would have a poor legal defence as the guidance is well-established.

The following extracts are relevant:

“Health care workers whose hepatitis B carrier status is unknown should not perform Exposure Prone Procedures”.
Addendum to HSG (93) 40: Protecting Health Care Workers and Patients from Hepatitis B.

“Should a health care worker refuse to be tested for markers of HBV (Hep B Virus) infection their attention should be drawn to para 11 of annex A of HSG(93)40 which states;” if a health care worker whose work involves EPP refuses to comply with the guidance he or she should be considered as if e-antigen positive and managed accordingly”

This in effect may be interpreted that a refusal should be managed as a positive infectious result, and that if the employer does not stop them treating patients by EPP and discuss transferring them to other roles (among other options) then the employer is taking a very significant legal risk.

This risk (and any similar or arising) must be assessed and managed like any other, and the statutory duty to “identify and assess the risks to health of microbiological and chemical hazards, prevent and control exposure to the risks, inform and train employees, and monitor exposure….” come into play.
(Guidance for Clinical Health Care Workers)

Defence organisations should be consulted in the event of a refusal from workers involved in EPP, as allowing a non-tested person to continue to deal with EPPs may jeopardise the THGPCG’s defence cover.

GMC and NMC are specific about positive result staff not undertaking EPPs, and the duty of members who know they are positive, and clinicians should refer to their own professional bodies (in confidence) for guidance.

THGPCGs should also take legal and professional advice before dealing with the refusal by a staff member, including possible consultation with the Occupational Health Department, and should take appropriate advice when a worker is found to have a positive result

RESOURCES

Exposure prone procedures (EPPs) – A Definition

Exposure prone procedures (EPPs) are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

In such circumstances there is a potential risk of transfer of a blood borne viral infection from an infected health care worker to the patient. Health care workers infected with a blood borne virus, Hepatitis B, Hepatitis C, or HIV are restricted from performing EPPs according to guidelines issued and updated by the UK Health Departments. Other situations, such as pre-hospital trauma care and care of patients where the risk of biting is regular and predictable, may involve similar risks to the invasive procedures described above and should be avoided by health care workers restricted from performing exposure prone procedures.

Confidentiality Dos and Don'ts

The **NHS Confidentiality Code of Practice (2003)** outlines for main requirements that must be met in order to provide patients with a confidential service:
• Protect patient information.
• Inform patients of how their information is used.
• Allow patients to decide whether their information can be shared.

Dos

- Do safeguard the confidentiality of all person-identifiable or confidential information that you come into contact with. This is a statutory obligation on everyone working on or behalf of NHS England.
- Do clear your desk at the end of each day, keeping all portable records containing person-identifiable or confidential information in recognised filing and storage places that are locked at times when access is not directly controlled or supervised.
- Do switch off computers with access to person-identifiable or business confidential information, or put them into a password protected mode, if you leave your desk for any length of time.
- Do ensure that you cannot be overheard when discussing confidential matters.
- Do challenge and verify where necessary the identity of any person who is making a request for person-identifiable or confidential information and ensure they have a need to know.
- Do share only the minimum information necessary.
- Do transfer person-identifiable or confidential information securely when necessary i.e. use an nhs.net email account to send confidential information to another nhs.net email account or to a secure government domain e.g. gsi.gov.uk.
- Do seek advice if you need to share patient/person-identifiable information without the consent of the patient/identifiable person's consent, and record the decision and any action taken.
- Do report any actual or suspected breaches of confidentiality.
- Do participate in induction, training and awareness raising sessions
- on confidentiality issues.

Don'ts

- Don't share passwords or leave them lying around for others to see.
- Don't share information without the consent of the person to which the information relates, unless there are statutory grounds to do so.
- Don't use person-identifiable information unless absolutely necessary, anonymise the information where possible.
- Don't collect, hold or process more information than you need, and do not keep it for longer than necessary.

St Paul's Way Medical Centre

CONSENT PROTOCOL

INTRODUCTION

The purpose of this protocol is to set out the Service Areas's approach to consent and the way in which the principles of consent will be put into practise. It is not a detailed legal or procedural resource due to the complexity and nature of the issues surrounding consent.

Where possible, a clinician must be satisfied that a patient understands and consents to a proposed treatment, immunisation or investigation. This will include the nature, purpose, and risks of the procedure, if necessary, interpreters, to ensure that the patient understands, and has enough information to give 'Informed Consent'.

Implied Consent

Implied consent will be assumed for many routine physical contacts with patients. Where implied consent is to be assumed by the clinician, in all cases, the following will apply:

- An explanation will be given to the patient what he / she is about to do, and why.
- The explanation will be sufficient for the patient to understand the procedure.
- In all cases where the patient is under 18 years of age a verbal confirmation of consent will be obtained and briefly entered into the medical record/ template
- Where there is a significant risk to the patient an "Expressed Consent" will be obtained in all cases (see below).

Expressed Consent

Expressed consent (written or verbal) will be obtained for any procedure which carries a risk that the patient is likely to consider as being substantial. A note will be made in the medical record detailing the discussion about the consent and the risks.

Obtaining Consent

- Consent (Implied or Expressed) will be obtained prior to the procedure, and prior to any form of sedation.
- The clinician will ensure that the patient is competent to provide a consent (16 years or over) or has "Gillick Competence" if under 16 years. Further information about Gillick Competence and obtaining consent for children is set out below.
- Consent will include the provision of all information relevant to the treatment.

- Questions posed by the patient will be answered honestly, and information necessary for the informed decision will not be withheld unless there is a specific reason to withhold. In all cases where information is withheld then the decision will be recorded in the clinical record.
- The person who obtains the consent will be the person who carries out the procedure (i.e. a nurse carrying out a procedure will not rely on a consent obtained by a doctor unless the nurse was present at the time of the consent).
- The person obtaining consent will be fully qualified and will be knowledgeable about the procedure and the associated risks.
- The scope of the authority provided by the patient will not be exceeded unless in an emergency.
- The THGPCG acknowledges the right of the patient to refuse consent, delay the consent, seek further information, limit the consent, or ask for a chaperone.
- Clinicians will use a Consent Form [*] where procedures carry a degree of risk or where, for other reasons, they consider it appropriate to do so (e.g. malicious patients).
- No alterations will be made to a Consent Form once it has been signed by a patient.
- Clinicians will ensure that consents are freely given and not under duress (e.g. under pressure from other present family members etc.).
- If a patient is mentally competent to give consent but is physically unable to sign the Consent Form [*], the clinician should complete the Form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

Other aspects which may be explained by the clinician include:

- Details of the diagnosis, prognosis, and implications if the condition is left untreated
- Options for treatment, including the option not to treat.
- Details of any subsidiary treatments (e.g. pain relief)
- Patient experiences during and after the treatment, including common or potential side effects and the recovery process.
- Probability of success and the possibility of further treatments.
- The option of a second opinion

Immunisations

Informed consent must be obtained prior to giving an immunisation. There is no legal requirement for consent to immunisation to be in writing and a signature on a consent form is not conclusive proof that consent has been given, but serves to record the decision and discussions that have taken place with the patient, or the person giving consent on a child's behalf.

Phlebotomy

Patients must consent to having their blood taken and if they refuse this should be documented and the clinician in charge of the patient's care informed. It is a general legal and ethical principle that Practitioners/Phlebotomists obtain valid informed consent prior to this procedure. That consent is based upon giving accurate information which is confirmed as having being understood, either verbally, by gesture or in writing. Practitioners/Phlebotomists need to adhere to the principles and practices of the Mental Capacity Act 2005.

Consent for children

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then he/she will be competent to give consent for him/herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign a Consent Form [*] for themselves, but may like a parent to countersign as well.

For children under 16 (except for those who have Gillick Competence as noted above), someone with parental responsibility should give consent on the child's behalf by signing accordingly on the Consent Form [*].

PROTOCOL FOR NEEDLESTICK INJURIES

INTRODUCTION

The purpose of this protocol is to provide guidance for the urgent treatment and attention to injuries by sharps. It should be readily available in the event of an incident. Service Areas should research local arrangements and follow procedures in place as recommended by their own Health Protection unit.

PROCEDURE

The following action is recommended in the event of an inoculation injury.

1. IMMEDIATELY:

(a) Make the wound bleed, if possible.
(b) Clean well with copious amounts of soap and running water.
(c) Apply occlusive dressing.
(d) Identify the source of the sharp.

SEEK IMMEDIATE ADVICE FROM:
During working hours: 0830 – 1630 (Monday – Friday).

Needle stick Helpline
Health and Wellness Centre (Occupational Health)
Royal London Hospital
31- 43 Ashfield Street
E1 2AH
020 7377 7449

Out of working Hours (1630 – 0830) including Weekends and Bank Holidays

Attend Accident & Emergency at Newham University Hospital and contact Senior Registrar – Virology or the Virologist on Call on 020 7476 4000 via switchboard at Newham University Hospital who will be able to advise you.

Do not delay reporting this type of injury. Prophylactic treatment – if indicated - is most effective if started within 2 hours of the injury.

Recommended Action may then be:

2. Obtain sufficient information to identify the patient and the member of staff. Take a focused and impartial history to identify risk of HIV, HEP B (HBV) and HEP C (HCV).

3. If at high risk for HIV start Post Exposure Prophylaxis preferably within an hour, but worthwhile up to 36 hours post-exposure. Find HBV status of "recipient" and consider booster even if good immunity, consider HEP B immunoglobulins.

4. Note the type of injury, depth, gauge of needle, if used for injecting or aspiration, and if hollow bore or bloodstained.

5. Counsel and consent "donor" to take blood for immediate testing regardless of history.

6. Counsel and consent "recipient" for bloods to be taken and stored for HIV, HBV and HCV

Appropriate clotted blood specimens from the member of staff involved and the source patient may be requested immediately and in three months time, and should be sent with request forms and details of the accident. HIV testing is not routine and will not be undertaken without full counselling.

If immunoglobulin is required the member of staff will be contacted and treated by the Accident and Emergency Unit. Immunoglobulin must be given within 48 hours to be of most benefit.

7. **An accident report should be completed.** The Accident Report Book is held in the Service Managers office. The following should be recorded.

   The source of the sharp and description of the accident. Include the place, date, time and any witnesses.

   The name of the source patient.

   The action taken.

   Any persons who gave advice and the advice given.

   The advice given to the patient and/or staff member concerned.

   The action taken to prevent recurrence.

Sharps should be kept in the appropriate "Sharps" box, out of the reach of children and with the lid closed - except when disposing of the sharp.

Sharps should be disposed of by the person using them. **Never leave sharps to be disposed of by someone else.**

It is the responsibility of staff suffering injury to ensure that advice on first aid is sought and to ensure completion of the appropriate documentation in accordance with the Health and Safety Regulation

Name of Service Area

INCOMPLETE REFERAL FORM FOR PHLEBOTOMY

CHECKLIST

All phlebotomy request forms need to include the following before tests can be performed.

- Full Name
- Date of Birth – if patient does not know this we can also ask for address.
- Correct test has been requested
- If fasting or non- fasting blood test

IF ANY OF THE ABOVE INFORMATION IS INCORRECT

- Speak to an on call Doctor about any incorrect tests ordered.
- If patient has not been fasting and this has been requested – the patient would need to be re-booked.