Dermatitis inspection report 2008/09

Prevention and management of work-related contact dermatitis in the NHS acute sector

Executive summary

In 2008/09, a team of HSE specialist inspectors in occupational health undertook a project to inspect NHS organisations' management arrangements for implementing the requirements of the Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH). This was within acute trusts in England and Wales and special health boards in Scotland. Though organisations had implemented the Hygiene Code (DOH 2006), 90% (40 of them) felt that they had not fully considered the impact of resulting hygiene practices on staff health. Overall, the COSHH Regulations 2002 (as amended) were poorly implemented by the organisations inspected. There was also a lack of integration or involvement of occupational health functions in the risk management system. The occupational health service (OHS) had a variable contribution in the case management and diagnosis of individual cases of work-related dermatitis. A range of deficiencies or omissions regarding the organisations' policy, procedures and arrangements for reporting dermatitis under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) were also identified.

Purpose of this report

This report informs interested parties, both within and outside the Health and Safety Executive (HSE), of the findings from a project delivered by a national team of specialist inspectors in occupational health during 2008/09. The trigger of the project was a series of anecdotal reports to HSE indicating a rapid increase in the incidence of work-related contact dermatitis (WRCD) in some acute trusts in England. These anecdotal reports did not result from reports made under RIDDOR. Throughout the report, the term 'organisations' is used and includes the trusts in England and Wales and the boards in Scotland.

Summary of findings

- 44 organisations participated in the inspections, representing approximately one third of organisations in England, Scotland and Wales.
- Forty organisations (91%) were unable to identify actual (or approximate) incidence of dermatitis or skin problems.
- 70% of organisations had an incomplete or flawed system either for identifying cases of dermatitis or for reporting such cases under RIDDOR 1995.
- 46% of healthcare staff questioned had had problems with their skin. Symptoms ranged from dry skin to dermatitis.
- 91% of the organisations' risk assessments failed to differentiate between the generic risk situation, which could be assessed centrally, and those risks specific to job or location.
- Various glove types, sterile and non-sterile, including latex were found to be in use. Latex glove use ranged from between 3–5% to 95%. Glove use policies were found in 22 organisations, although these policies failed to inform staff of activities where gloves were not required.
- Only 10% of organisations had either considered the full impact on staff of hand washing policies, including use of alcohol gels, or had management systems in place to assess, monitor or review the effects.
- 34% of organisations provided employees with information, instruction and training regarding hand hygiene. However, instruction about the signs and symptoms, prevention and control of dermatitis was not included in this training despite the significant level of risk.

In addition:

- Organisations made limited use of the occupational health services (OHSs) to assist in the prevention or management of WRCD.
- Only 3 out of 44 organisations had integrated the functions of occupational health in the health and safety management system to prevent or manage WRCD.
- None of the occupational health services visited provided ill-health data on dermatitis (or other work-related health issues) to the organisations. Advice and guidance were produced to individuals and managers only if requested.

Aim of the inspection

The aim of the project was to gather both quantitative and qualitative data about an organisation's management and prevention of skin problems associated with health carers.

Data collection

Two methods were used:

- Examination of the organisation's documented health-related policies and procedures, subsequent interviews with key members in the management of health and safety (eg members of the health and safety department, occupational health department, procurement department, some unit managers and workers representatives). A site inspection then took place. Each occupational health inspector (OHI) completed a standard report based on the *Successful health and safety management*[1] model (see Appendix 1 for an example).
- During the site inspection, at random, OHIs asked healthcare workers to complete an anonymous questionnaire (see Appendix 2). The questionnaire covered: glove use; the individual's skin hygiene and skin care practices; reported skin problems; and information, instruction and training received about aspects of skin hygiene and prevention of dermatitis.

Data analysis

The organisation was rated in specific areas using a four-point system. The key risk control areas, identified by HSE, in the prevention and management of health issues are:

- effective organisational policy and arrangements, a clear control strategy in terms of risk assessment, implementation of the hierarchy of COSHH – eg elimination, substitution, reduction in numbers exposed etc;
- implementation of the policy;
- provision of health surveillance or skin checks where appropriate;
- provision of information, instruction, training and supervision for those at risk;
- robust arrangements for reporting under RIDDOR; and
- communication, co-operation and worker involvement in managing these issues.

The ratings categories were:

- full inclusion in the areas that matter;
- broad inclusion in the areas that matter;
- some inclusion in the areas that matter; and
- limited or no inclusion in the areas that matter.

Analysis of the individual questionnaires was undertaken by HSE's epidemiology and statistical branch.

Regulatory context

The specific regulatory framework applicable to this project is the:

- Health and Safety at Work etc Act 1974;
- Control of Substances Hazardous to Health Regulations 2002 (COSHH) (as amended);
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR); and
- Management of Health and Safety at Work Regulations 1992.

Findings and discussion

Policy and arrangements for prevention or control of dermatitis

Forty-four organisations in England, Scotland and Wales were inspected as part of this project. 18% of organisations (eight) did not have a specific COSHH policy. Such a policy should identify managers and individual roles and responsibilities to implement the requirements of COSHH and set out the arrangements for monitoring and reviewing COSHH.

In the remaining 36 organisations, specific COSHH policies were found, but 12 organisations did not define the roles and responsibilities of key players to implement the policy and 10 of them omitted to identify the role of the purchasing department in suitable product selection for staff protection.

Organisations can adopt a corporate approach to risk assessment where organisation-wide risks exist such as skin care product use, hand gel use or safety-related issues such as prevention of slips/trips. However, the organisation needs to be clear what issues will be dealt with corporately and what issues need to be assessed locally. In one organisation inspected, approximately 1000 COSHH risk assessments had been completed, an extreme example of unnecessary duplication of effort.

'Use of latex', 'infection control', 'glove use', 'hand hygiene policies' or similarly called policies were found. However, organisations did not have a policy to deal with the broader issue of dermatitis prevention. Arrangements were in place to co-operate when considering patient safety and acceptability to changes in care, yet there was a recurring failure across organisations to involve all relevant parties and consider whether there will be any staff health or safety issues as a result of changing care, working practices or product use. This includes the risks to staff skin health.

Glove use is an example of a corporate risk. Latex glove use comes under COSHH and the COSHH hierarchy should be applied. Organisations are required to identify, as part of this COSHH assessment process, those areas where it is reasonably practicable to provide alternatives to latex. Control measures need to be put in place to ensure management controls employee exposure and in those remaining areas where latex gloves may still be used, eg in theatres or during minor operations, appropriate and robust health surveillance should be introduced.

As can be seen in chart one below, the glove types used across the organisations varied; some of them using as little as 3–5% natural latex rubber (NRL) and others using as much as 95% NRL. Eleven organisations have found it reasonably practicable to source suitable alternatives to latex. The other principal glove types were nitrile and vinyl.

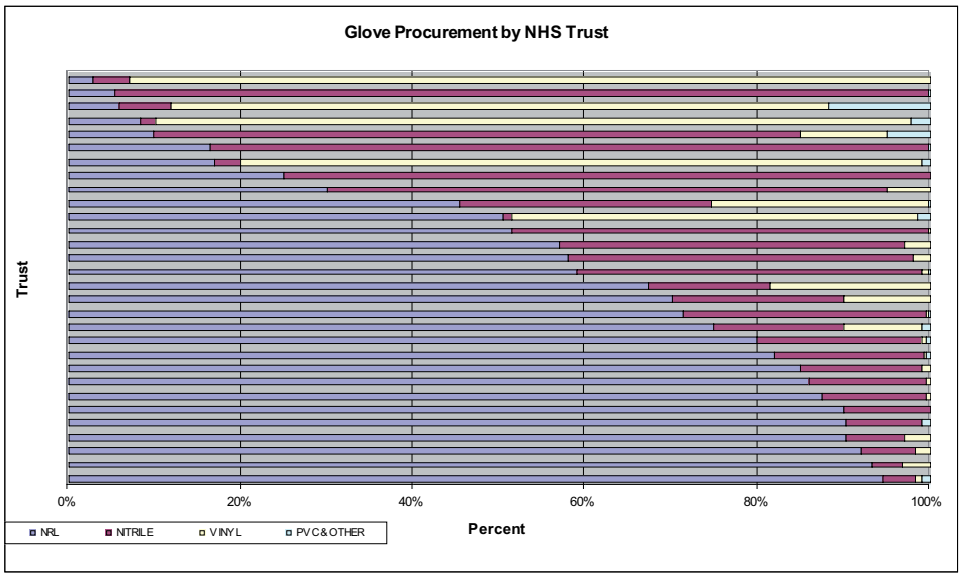

Chart 1 Glove procurement across organisations

Health surveillance is required where there is a risk of allergic dermatitis.[2] Though the exact delivery model is not specified by legislation or by current evidence, the primary aim of health surveillance is to identify early symptoms so that steps can be taken to reduce risk or exposure further. Only 4% of organisations (two) dealt with this issue proactively by undertaking regular skin inspections using 'link nurse' arrangements with referral to the OHS when required. The remainder of organisations operated a self-reporting system where employees were supposed to present at OHS when they got dermatitis. This latter example is not only inadequate as a health surveillance programme under COSHH, it also misses the opportunity to reduce the likelihood of sickness absence related to the dermatitis. According to comments by Johnson in Latex Allergies,[3] the NHS organisations' to have the choice of whether to use latex gloves or not. This being the case, organisations need to have robust systems in place to ensure its use is controlled, monitored and reviewed. The evidence indicates these activities do not take place within the organisations inspected.

Broad systems were in place for the co-operation, involvement and effective liaison between key players in the organisations' health and safety regarding health and safety matters in general (see Chart 2).

The management of COSHH issues in particular was omitted which is surprising as COSHH has been on statute books since 1988. Although the original regulations were revoked and replaced, the basic obligations of COSHH have remained the same. The specific reasons for the lack of robust implementation within organisations was not explored even though the benefits and contribution to business performance of integrating the occupational health in the safety management system have already been acknowledged and documented (*Integrating occupational health with safety management system*,[4] *Towards a safer healthier workplace standards for occupational health service*[5]).

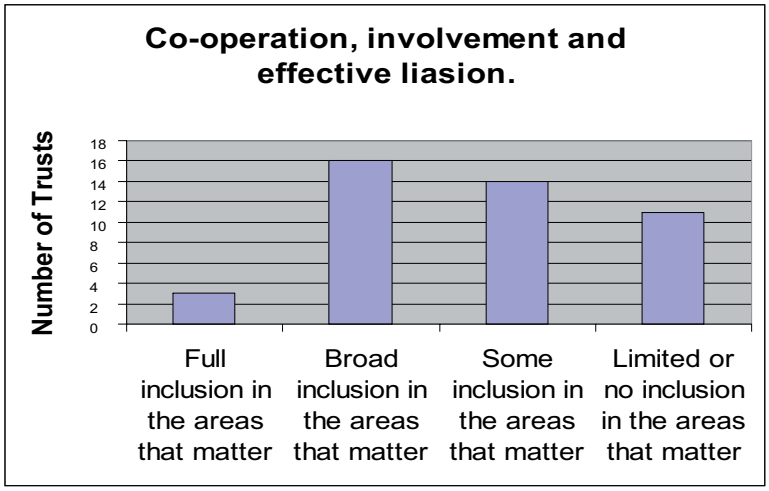

Chart 2 Co-operation, involvement and effective liaison

An organisation's management board needs to ensure that it is aware of the significant occupational health risks it faces, have ownership and understand the key issues involved. Furthermore, the board must ensure that its OHS:

- is adequately resourced;
- has systems in place to ensure the competency of the occupational health service; and
- has robust arrangements in place to ensure access to occupational health advice is sought particularly at any planning stage.

Where an organisation's health and safety management system failed to implement COSHH, it generally included one or more of the following issues:

- an absence of a COSHH policy (two organisations);
- where a written COSHH policy was present, specific roles, responsibilities or arrangements were not defined;
- the COSHH policy was not linked with the organisation's health and safety policy;
- failure to train assessors resulting in inconsistencies and errors (an example of which was the assessment of medical treatments such as suppositories);
- failure to monitor whether the policy was implemented;
- an absence of a formal mechanism to consider the hierarchy of control in the risk assessment;
- no mechanism to assess the risk to health of new products which staff were to use or to be exposed to;
- poor risk assessments which failed to include skin irritants, skin allergens or activities such as repeated hand washing.

All of these failures, either singly or in combination, represent flaws in the organisations' health and safety defensive layers, as described in *Managing the risks of organisational accidents*[6] when referring to the 'swiss cheese model of defences'. All of these defensive layers should be present and intact to prevent the potential losses associated with contact or allergic dermatitis.

Prolonged glove use, use of soaps and skin care products and repeated hand washing are risk factors of work-related dermatitis. Only two organisations had a system whereby line managers – or a responsible person – carried out proactive and regular skin checks on their staff. For the remaining organisations, an informal self-referral system was the norm, thereby relying on staff – once symptomatic of dermatitis – to attend OHS or their GP.

Many organisations have patient safety committees as part of the procurement

process. It is at this point that implications to staff health should be considered. However, unless the occupational health and safety implications of all procurement activities are included, the three aspects which will only be considered are patient safety, acceptability and costs – all important factors but not the complete picture. The role and contribution that procurement could make in controlling or monitoring product use was appreciated in only a few organisations. Good examples were where procurement 'greyed' out on their IT system certain products so they could not be ordered in error (eg latex gloves in areas where they were not required) or by providing reports of how many litres of skin care products were used and where, to ascertain whether adequate hand cleaning regimes were being followed.

Dermatitis was not recognised as a significant issue as there was a general belief of a 'low' incidence of cases where organisations had focused on the 'latex' issue as directed in NHS publications – *Dermatitis Occupational aspects of management*,[7] *Occupational health and safety standards*,[8] and *The management of health, safety and welfare issues for NHS staff (The Blue Book)*[9] – and not on the broader dermatitis issue. For these reasons, organisations did not believe there was a need to proactively undertake skin checks. From the evidence provided during these inspections alone, this judgement was erroneous.

Monitoring, auditing and reviewing COSHH implementation within the organisation

Monitoring and reporting are vital parts of a health and safety culture. The organisation's management system must ensure the board receives both specific (eg incident-led) and routine reports on the performance of aspects of its health and safety policy. Organisations generally did monitor their accident and incident rates, undertake trend analysis and investigate to determine root-cause problems for accident and incidents. This was not the same for work-related health issues. These aspects of management were generally poorly implemented (if at all) across all organisations, even in those four organisations which approached being exemplars. Two organisations had a negative occupational health-related performance indicator (related to latex allergies) and the remainder were deficient in the area of monitoring, auditing and reviewing any or all or particular aspects of the organisation's COSHH policy and its implementation. Tools are available to assist in the process within *Occupational health dealing with the issues: A TUC Education workbook for union reps*[10] which also promotes the involvement of key players such as the unions.

Clearly setting up and implementing auditing systems is possible within the organisation as regular auditing did take place under the care of the infection control teams regarding hand hygiene. The process of auditing within the OHS, whether auditing structure, process or outcome, can be a positive educational tool for OHS itself. However, intermediate outputs such as quality of advice given to managers should also be audited by the organisation, see *Clinical Governance in UK commercial occupational health providers*,[11] *The effective management of occupational health and safety services in the NHS*,[12] *The provision of occupational health services for general practitioners and their staff*[13] and *Practical occupational medicine*.[14]

It became evident that full implementation and integration of COSHH is not the job of a sole department or individual such as health and safety or the OHS, but requires action and co-operation by all of the key players identified in the organisation's health and safety management system. Specific duties and requirements can be placed on individuals, but this performance should be regularly monitored and reviewed.

This project inspected approximately one-third of organisations in England, Scotland and Wales so the findings are considered representative of the sector as a whole. No organisation fully reviewed the effectiveness of its COSHH policy and collected workplace health data to allow the board to monitor the organisation or its occupational health performance, regarding employee skin protection or dermatitis.

Only four organisations performed ahead of the others in terms of having a robust COSHH policy and arrangements which incorporated and made use of the OHS in prevention and management of the risk of dermatitis. For each of these four, some improvements were still required, principally in the monitoring, auditing or review of their policy and arrangements.

The lack of comprehensive and robust arrangements to implement and integrate COSHH into a health and safety management system is a fundamental flaw. Though there have been suspicions of this failing, by HSE specialist inspectors, it was not generally known to what extent the problem existed.

Benchmarking

Though benchmarking is not a legal requirement to comply with COSHH, health and safety benchmarking is a planned process by which an organisation can compare its health and safety processes and performance with others to learn how to reduce accidents and ill health, improve compliance with health and safety law; and/or cut compliance costs.[12,13] Though there are a range of professional groups, such as the health and safety groups, regional managers forums, regional procurement hubs, clinical supplies user groups, NHS occupational health management groups etc, which presented openings for benchmarking activities, there was no evidence of benchmarking between organisations regarding prevention or management of work-related dermatitis or related occupational health issues.

There are tools such as the *Corporate health and safety performance index tool* (CHaSPI)[15] which is a free online tool designed for use by all large organisations with 250 or more employees. It offers a reporting and benchmarking framework for occupational health and safety. Though some health and safety professionals indicated an awareness of the tool, no evidence was obtained regarding use of this or a similar tool and dissemination of findings throughout the organisation.

Identification of cases of dermatitis and implementation of RIDDOR

Eleven organisations had an explicit policy, with clear roles, responsibilities and arrangements for identifying work-related ill health and reporting under RIDDOR.

Where a policy was present but where there were flaws or omissions, examples were:

- Two organisations did not have an identified system for reporting occupational ill health under RIDDOR in their health and safety policy.
- 31 organisations had identified ‘occupational diseases’ as needing to be reported in their policy but did not specify whose role it was to (a) identify and (b) report them.
- 33 organisations had no clear route of what to do with the information when the diagnosis of dermatitis was made either by OHS or GP. There was a lack of clarity around who should make the report either internally, to HSE or both. During some interviews, health and safety have pointed to OHS to report and vice versa within the same organisation.

There was a lack of clarity of the role of OHS in diagnosing and reporting dermatitis to the organisation and within their own department. Also, the inspection team found a common misinterpretation of RIDDOR regarding dermatitis. Some OH departments believed there was a need to identify causation (eg identify the substance causing the allergic or contact dermatitis) before reporting it and so did not report the diagnosed

dermatitis with which the health carer originally presented. In addition, some OH departments began treatment for dermatitis, yet still did not report it.

The reason given by departmental managers with the delegated duties to report were either that they have not been provided with a 'medical report' by the OHS or the employee has not had sickness absence. Work-related dermatitis does not require sickness absence to be reported under RIDDOR.

Repeatedly, organisation policies stated the requirement for reporting diseases such as decompression sickness (related to diving), farmer's lung (related to farming) or pneumoconiosis (related to coal mining). This demonstrates a lack of understanding of the RIDDOR Regulations as these diagnoses do not relate to the organisation's work activities and so are not appropriate or necessary to be included in their policy.

It is imperative that organisations and their OH advisers review their policies to ensure they clarify (a) what diseases arise 'out of or in connection with their work' (b) who are the responsible person(s) for reporting and (c) what constitutes a written statement prepared by a medical practitioner diagnosing the disease when it is the OHS that has diagnosed the dermatitis. In one organisation, 14 cases had been seen by the Occupational Health Physician, diagnosed and reported under the voluntary Health and Occupation Reporting network known as 'THOR',[16] yet had not been reported under RIDDOR.

Detailed information about reasons for employee ill health enters the organisation in several ways: (a) direct to the payroll department, (b) to the line manager from the GP or (c) from OHS. The ill health may or may not have resulted in sickness absence. Organisation arrangements for capturing and recording this relevant data need to be robust enough to cover all these eventualities.

In every organisation inspected, workers complained of dermatitis. Yet a search of the HSE RIDDOR database indicated that only 8 of the 44 organisations had ever reported dermatitis under RIDDOR, which would indicate a significant under reporting. Only 23.5% of those workers questioned who had suffered from dermatitis had the diagnosis made by the OHS. Perhaps this, in combination with a flawed organisational policy and arrangements for reporting or diagnosing dermatitis, explains this under-reporting.

As evidenced in 45% of organisations (20), individuals, their managers and the OHS could work together to keep the affected worker (once identified) at work, thereby eliminating the need for sickness absence as the guidance suggests.[17–22]

Organisations' use of the occupational health service (OHS) within their health and safety management systems

There was a wide variation between organisations and how they used their OHS. Most OHS delivered a range of core activities such as pre-placement screening, provision of immunisations and management referrals for sickness absence. However, the OHS tended to work in isolation with little evidence of formal inclusion of the OH functions where organisation matters could affect staff health. Where this did happen, it generally took place informally and was dependent on personalities and existing networks so inclusion was variable and inconsistent.

Only two organisations had health-related strategic objectives as part of their business plan. Consequently, there was little evidence of the OHS contribution to the organisations' business plan, reflection of corporate strategy or objectives. Some did provide the organisation with figures indicating employee attendance at OHS though none were seen which focused on outcomes. Only four provided their organisation with numbers of employees presenting at the OHS with skin problems whereby trend analysis was then possible.

Some were not routinely included at organisation induction training.

No organisation was found to have either a health surveillance programme or a health surveillance policy so were unable to provide the organisation with grouped, anonymous data and trend analysis of the programme outcome, as required by COSHH 2002 Regulations (as amended) 12(2)(e). In most organisations, once individuals were identified as having an allergy to latex, a health surveillance programme was instigated for **that individual alone**.

There may be very real and local reasons for lack of inclusion of the OHS which have been explored in *Common deficiencies in occupational health services*.[23] Deficiencies in OH service provision have been linked with the lack of competencies in occupational health professionals to provide such services. The organisations need to ensure that their OHS staff are sufficiently trained to play a visible and proactive role within their specific organisation. However, organisations were identified where the OHS was not permitted or was discouraged from taking an inclusive role. Even a highly competent manager of an OHS, metaphorically speaking, will only 'bang their head against a wall' for so long before falling into apathy, or do the bare minimum or leave the organisation. Organisations need to develop a partnership approach with the occupational health provider and the OHS. See *Evaluation research in occupational health services: general principles and a systematic review of empirical studies*,[24] *An audit of occupational medicine consultation records*[25] (*Also references*[13,14]).

Only 20% (nine) of the OHSs provided their organisation with any feedback about the work they undertook. There was a wide variety of content in the information provided. In the main, such information demonstrated the number of employees seen, and may have included the reasons why the OHS saw them, eg sickness absence management, pre-employment screening, immunisations etc. It did not specify the numbers seen with dermatitis, specific work-related health issues or outcomes.

Adequacy of OHS provision

Though not inspected in detail during the course of this project, in five organisations, the OHS was identified as being under-resourced according to Association of National Health Occupational Physicians (ANHOPS) guidance.[26]

Where organisations' OHS generated income under the 'NHS Plus' umbrella, service level agreements and contracts with clients were agreed. No in-house service level agreements between the organisation and their OHS were found. Furthermore, no model of OH service provision was found which ensured adequate OH provision for organisations' employees, thereby ring-fencing OH time and resources to ensure OH delivery to the organisation. Occupational health services need to be managed and resourced effectively[9,12,13] to ensure both customers receive an adequate service.

An organisation's clinical governance arrangements, which should be multi-faceted and multi-disciplinary[8,12,13] to encourage excellence, should include the activities of its Occupational Health Service. Two recent NHS Plus National Clinical audits[21,22] into (a) management of staff with long-term sickness absence and depression and (b) back pain, found significant variation in OH practices from very high levels of compliance to low levels of compliance with the Faculty of Occupational Medicine's Guidelines for the management of low back pain or the NICE guidelines on the management of depression. A similar wide variation of the standard of the general OHS provision within the organisations was noted.

Involvement of OHS in the investigation of a case of dermatitis

In 45% of organisations (20), the OHS was involved in the medical investigation of those employees with non-resolving or recurring dermatitis. The purpose of this investigation was to identify the allergen(s) which had caused the dermatitis. In some organisations, they had a 'fast-track' referral to one of the organisation's dermatologists. No member of the OH team took part in the on-site organisation investigation, either on their own, with the health and safety department or the employee's manager, to observe working practices and identify root causes.

The inspection findings supported anecdotal evidence that many health carers in the NHS self manage any skin problem, without any involvement of the OHS or even their manager. The OHS may be complicit in obscuring the actual frequency or incidence of skin problems within the organisation. As an example: in one organisation, employees presenting themselves at the OHS with skin problems may be advised and treated by the occupational health nurses. The occupational health nurse thereby making a 'presumptive diagnosis' of dermatitis. These cases may not be followed up, reviewed, or referred to the occupational health physician unless their symptoms were not resolved and the worker re-presented themselves at the OHS.

The generally accepted approach of this flawed case management system is 'no news is good news'. This is not good occupational health practice in the interests of either the organisation or the individual. Although, there have been no national guidelines setting standards to date as there are with depression screening,[19] a Royal College of Physicians publication[18] offers some direction. However, despite the lack of clinical guidelines for consistency and transparency, it is expected that the OHS should have stated and documented its department's protocols to investigate, manage and review cases of dermatitis.

In general, OH nurses are not able to make a medical diagnosis or write a medical report which could trigger off a RIDDOR report. However, they are able to work to an agreed OH operational procedure or standing orders and advise the organisation to report under RIDDOR. Though this project did not specifically inspect internal occupational health protocols or documents, this was an area where there were wide variations of OH practices between organisations.

In most organisations, when the manager had made the OH referral in writing, they were provided with advice by the OHS to manage the employee with a work-related health condition. Informal requests or employee self-referral did not result in information being shared with the manager without the express request or permission of the employee concerned. Substantial evidence was obtained during the visits indicating the OHS had knowledge of the dermatitis issues presenting within the organisation but did not necessarily share this information. As part of the risk management strategy, the organisation should be made aware of the percentage (numbers) identified with early symptoms (such as dry and cracked skin) as well as cases of diagnosed dermatitis and the OHS should play an integral part in collecting the data and providing it to the organisation in a suitably anonymised form.

There was anecdotal evidence that organisation-wide information of dermatitis was not made available to the organisation due to (a) inadequacies in capturing and reporting such data with the limited IT systems available to the OHS and/or (b) failure of the organisation to request the information.

The onward management of employees with dermatitis varied. Some OHSs referred the employee to their GP for treatment, or to a dermatologist if indicated. For some organisations, no other option was available should the GP decline to refer to a dermatologist and so just sign the worker off sick. Some occupational health physicians referred directly to their organisation's dermatologist. One organisation used income generated from NHS Plus contracts to fund such referrals. Several

organisations had established a 'fast-track' referral process by which employees could be referred by the OHS to a consultant dermatologist for further investigation. Unfortunately, in one organisation, surgical consultants bypassed the OHS and referred themselves directly to the consultant dermatologist for investigations. Latex allergy was subsequently identified by the consultants. There was no involvement of the OHS or other key players in the organisation's health and safety management system to reduce or control the risk further.

Individuals with the signs and symptoms of dermatitis need to be managed to a consistently high standard and involve the OHS, health and safety, human resources (HR) and managers as appropriate.

To ensure a robust procedure which involves the OHS when and if necessary, the areas where clarification within organisations' OHS policy and procedures was required include:

- who makes the diagnosis and treats dermatitis within the OHS;
- the case management protocol for dermatitis;
- what information is provided, when and how often, to the organisation about employees presenting with symptoms of dry skin or dermatitis at the OHS;
- implementation and reporting arrangements for skin health surveillance;
- the role of the OHS in both the medical investigation and full investigation looking at work activity; and
- any fast tracking arrangements for medical opinion or treatment.

Training in the prevention of dermatitis

The Health Act 2006[27] and the Code of Practice in England and the corresponding Welsh and Scottish documents (*Healthcare associated infections – A strategy for Hospitals in Wales*,[28] *Standards Healthcare associated infections*[29] and *Healthcare associated infections (HAI) infection control in NHS Scotland national overview Edinburgh*[30]) establish a clear framework for prevention and containment of healthcare associated infection. The contribution of the infection control teams to delivery of the required training covering hand hygiene was in evidence at all organisations. This included their contribution to induction training.

Induction training was not mandatory in all organisations or for all personnel. Doctors were cited as the most likely not to attend.

The primary focus of the training content was about hand hygiene; only in 34% of organisations (15) did this training cover skin care requirements, signs and symptoms of dermatitis or what to do in the event of any skin problem. Some OHSs delivered sessions during mandatory organisation induction training. However, this was not the norm.

Training to undertake COSHH assessments was available in most organisations, although attendance was not mandatory even for those managers who have delegated duties to undertake the health risk assessments.

There was a complicated picture in some organisations where an individual's training record was scattered between the infection control team, health and safety department, personnel/HR, occupational health as well as their line manager. This may have, in part, explained why there was variable attendance leaning towards poor attendance at health and safety related courses. As information, instruction and training is required to comply with either COSHH where employees are exposed to substances hazardous to health, or to comply with the Management of Health and Safety at Work Regulations 1999, organisations need to ensure they have clear systems to demonstrate they have complied and provided this training as identified by their risk assessments.

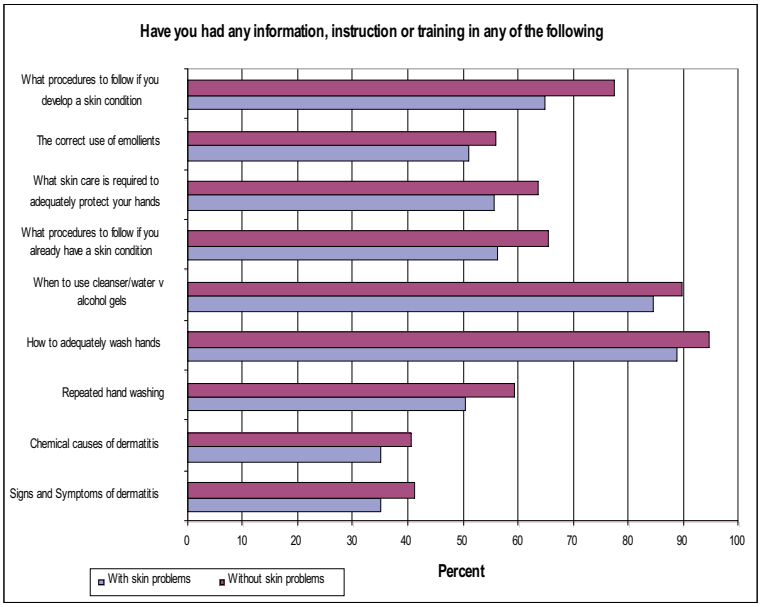

Chart 3 Have you had any information, instruction or training in any of the following?

Chart 3 shows the topic areas where training was provided. Those workers questioned who had never had skin problems were consistently found to have received training in the appropriate topics. Those topics most likely not to be covered were the signs and symptoms of dermatitis as well as the chemical causes of dermatitis.

Recommendations

Organisations visited should develop an improvement action plan to address the omissions or deficiencies identified in the visit report.

Organisations not visited as part of this project should review their arrangements for COSHH in relation to the risk of work-related contact dermatitis, paying particular attention to:

- providing a written policy with clear lines of accountability;
- carrying out suitable and sufficient risk assessments;
- ensuring staff are trained and competent to undertake the assessments;
- ensuring the hierarchy of COSHH is followed, ie elimination, substitution or control of exposure to substances hazardous to health, including latex; and
- ensuring appropriate monitoring arrangements are in place and followed.

Organisations should review their policy and arrangements for RIDDOR paying particular attention to:

- ensuring they have a robust mechanism for identifying and reporting work-related contact dermatitis;
- reviewing the specific role line managers and others such as human resources, health and safety and occupational health services play in the reporting and investigation process once WRCD has been identified; and
- reviewing how employee ill-health data is collected, monitored and used proactively.

Organisations should review the contribution their occupational health service provider makes to their arrangements for the prevention and management of health risks, paying particular attention to:

- involving the OHS in the development and review of policies and procedures;
- identifying and agreeing the specific proactive contribution the OHS can make;
- specifying clear reporting arrangements in terms of reports of ill health, trends, data etc to senior management; and
- ensuring there are written in-house policies, procedures and standards against which the provider works and is audited.

Appendix 1 Inspection checklist

Compliance with COSHH in the management of occupational contact dermatitis

Inspectors: Visit date:

Client: Location:

People spoken to (include role):

Occupational health and safety arrangements (HSG65)

		Findings	Recommendations
Policy/Control	Are roles and responsibilities of occupational health & safety (H&S) staff, human resources staff, procurement, managers, employees, safety representatives and the H&S committee described explicitly in the organisation's H&S policy? What contribution do OH staff make to the development of OH&S policies and to the provision of information on those policies to employees?		
Control	Level of OH staffing.		
Co-operation	Consider: ■ Employee access to OH services. ■ OH representation on H&S committee. ■ Sickness absence arrangements and rehabilitation.		
Communicating	Does the organisation have a system for communicating health-related information (to employees, trade union managers & trade unions)? How much time do OH staff spend in the workplace, ie risk-based, proactive, visible? What arrangements are there for information flow into and out of the OH organisation, to/from employees and line managers, eg COSHH health surveillance results?		
Competence	What means are there to ensure the competence of OH team? Qualifications of OH team? Referral systems? Are resources adequate (facilities, equipment, information sources)? Have managers/risk assessors had training in H&S management of OH issues?		

		Findings	Recommendations
Control	Is there a clear allocation of responsibility among managers for controlling the H&S management of occupational contact dermatitis within the organisation? Is it clear who will: ■ Plan and make decisions? ■ Implement the plans? ■ Measure performance (job descriptions)? ■ Review and secure improvements? ■ Audit the arrangements? Issues to explore: (1) Risk assessment process for substances hazardous to health and corporate issues, eg latex. (2) Involvement in the elimination or substitution of substances hazardous to health. (3) Involvement in designing out risks by adapting to technical progress. (4) Involvement in reporting under RIDDOR. (5) Does it investigate dermatitis/ allergy? (6) Policy on the prevention/control of dermatitis [or similar].		
Policy/Strategy	Does the OH service have priorities/targets for contact dermatitis within an overall planning strategy (built into a business plan)?		

		Findings	Recommendations
Planning and implementation	Has occupational contact dermatitis been identified as a health risk at this site? What evidence was used to do this? (Risk-based?) Issues to explore: (1) Level of work-related contact dermatitis and latex allergy within organisations by causation. (2) Occupational health service provider role in case investigation. (3) Fast track/referral system to dermatologist. (4) Individual case management system. (5) Are health surveillance systems low–high level? Check OH involvement. (6) OH involvement in organisation's information, instruction training provision. (7) OH involvement in dermatitis prevention and risk management system, including procurement, of subs hazardous to health. (8) What information does OH provide to the organisation – group/individual? (9) Is OH involved in observation audits of healthcare workers safety-related behaviour? (10) How is OH involved in RIDDOR reporting? (11) How does OH hear of cases of dermatitis?		
Measuring performance	Does the organisation monitor procedures which are proactive (including site visits) and reactive (including investigation of ill health & how are cases bought to your attention)? Does it collate and use OH statistics (attendance, work-related sickness absence, outcomes)? Are performances of managers in controlling work-related sickness absence (including dermatitis) monitored? (At appraisal?)		
Audit and review	Is there a system in place within the organisation for reviewing performance in order to modify/ develop the management of dermatitis as a recognised OH risk at this site?		
	Is information collected on the efficiency, effectiveness and reliability of the OH service & used to review OH policies, targets, procedures and staff performance?		

Control of Substances Hazardous to Health compliance

		Findings	Recommendations
Regulation 6 – Assessment	In the organisation visited are there suitable and sufficient COSHH assessments available [reg 6(2)(a)–(l)] either by department or corporate?		
	Does the assessment consider all groups who are likely to be exposed (eg contractors)?		
	Are any of the substances likely to cause contact dermatitis (allergic or irritant)?		
	Are material safety data sheets available? If so, where are they kept and who has access to them?		

		Findings	
Regulation 7 – Prevention or control of exposure (Schedule 2A)	Does the organisation design and operate processes and activities to minimise emission, release and spread of substances likely to cause dermatitis? (a) reduce people, (b) level and (c) duration of exposure, (d) quantities of substances used.) Issues to explore with procurement and OH: (1) Who is involved in agreeing what will/will not be purchased? (2) Is employee H&S considered? If so who by, how often? (3) What provision is there for alternative skin care/products for individuals? (4) Who or what dictates what is purchased, or not? (5) How much liquid soap/ emollient/alcohol gels are currently used/head of patient/per week?		
	Does the organisation take into account all relevant routes of exposure – inhalation, skin absorption, inoculation and ingestion – when developing control measures?		
	Does the organisation control exposure by measures that are proportionate to the health risk?		

		Findings	
	How are the most effective and reliable control options, which minimise the escape and spread of substance likely to cause dermatitis, chosen? (Handling, storage and transport of substances and waste) Issues to explore: (1) Level of healthcare associated infection within the organisation. (2) Their involvement in finding alternative skin care/ PPE products for susceptible individuals. (3) Infection control department (ICD) involvement in organisation's information, instruction and training provision. (4) ICD involvement in organisation's clinical/non-clinical risk management system, including procurement of PPE and skin care products. (5) What information does ICD provide to organisations? (6) Is ICD involved in observation audits of healthcare workers safety related behaviour?		
	Where adequate control of exposure cannot be achieved by other means, does the organisation provide, in combination with other control measures, suitable personal protective equipment (eg gloves, overalls)?		
	Does the organisation check and review regularly all elements of control measures for their continuing effectiveness?		
	Are all employees informed and trained on the hazards and risks from the substances with which they work and the use of control measures developed to minimise the risks (including specific 'Protect your skin' training)?		
	Does the organisation ensure that the introduction of control measures does not increase the overall risks to health and safety?		
	Are welfare facilities (including standard, 'clean v dirty' area policy in changing rooms and canteen) present?		

		Findings	Recommendations
Regulation 8 – Use of controls	Is there evidence that control measures are used appropriately?		
	Is there evidence of inappropriate work practices, eg high-risk activities without the use of suitable PPE?		

		Findings	Recommendations
Regulation 9 – Maintenance of controls	Is PPE that is provided to prevent dermatitis appropriate and adequate (with a suitable purchasing policy behind it)?		
	Is there an appropriate choice (access)/disposal/cleaning/storage of all PPE?		
	Is training provided in the donning and removal of gloves?		

		Findings	Recommendations
Regulation 10 – Monitoring	Is workplace monitoring performed (are WELs exceeded) and are R21, R24, R38, R43 and risks to skin kept as low as reasonably practicable?		
	If employees require health surveillance, are individual records of any workplace monitoring maintained for that employee?		

		Findings	Recommendations
Regulation 11 – Health surveillance	Is skin health surveillance performed in accordance with MS24[31]?		
	Do any responsible persons have access to an OH nurse or doctor familiar with the process and principles of health surveillance for referral of 'cases' if identified?		
	Are health records for employees undergoing health surveillance available for inspection and do they include the relevant information?		
	Is there evidence that workers have acquired contact dermatitis consistent with work activity exposures?		
	Are the outcomes of health surveillance fed back to managers into the risk assessment process?		
	Is notification in writing made to the employer by a medical practitioner of a case of occupational contact dermatitis that has resulted in reporting under RIDDOR? How many such RIDDORs in the last 12 months?		

		Findings	Recommendations
Regulation 12 – Information, instruction and training	Are employees aware of contact dermatitis as a possible OH risk (eg posters, training and leaflets) and how to report problems?		
	Do employees have access to COSHH assessments, MHDS, workplace monitoring results and collective health surveillance results?		
	Are employees aware of the precautions/controls needed, how to use them and how to report any deterioration?		
	Do employees report problems with health and/or controls?		

		Findings	Recommendations
Regulation 13 – Accidents, incidents and emergencies	What first-aid facilities are available?		
	Are there emergency arrangements available on site?		
	What warning systems are in place?		

Appendix 2 Employee questionnaire

1 Job Title	Assistant clinical worker	Dr	Nurse	Other – please specify

2 Unit	A&E	Acute medical	ITU	Surgical/rehab	Theatres	Other – please specify

3a Since working in the healthcare sector, have you had problems with your skin?	No	Yes – in the last year	Yes – more than a year ago

3b If yes, which signs and symptoms apply/ applied?	Stinging	Redness	Tenderness	Itching	Dryness
	Peeling/ flaking	Bleeding skin	Urticarial rash/blisters	Cracking	None of these

4a Was the skin problem diagnosed? If so, who by? (if not go to 4c)	Dermatologist	GP	Manager	OHSP	Self	Other – please specify

4b If diagnosed, was anything at work identified as causing or making worse the skin?	Alcohol gel	PVC disposable glove	Liquid soaps	Other hand disinfectants
	NRL disposable glove	Nitrile disposable glove	Vinyl disposable glove	Other – please specify

4c If not diagnosed what do you think caused or made your skin problems worse?	Alcohol gel	PVC disposable glove	Liquid soaps	Other hand disinfectants
	NRL disposable glove	Nitrile disposable glove	Vinyl disposable glove	Other – please specify

5 How many times PER DAY (typical) do you use these products in connection with your work?	Alcohol gel	0	1–20	20–40	40+
	Liquid soap	0	1–20	20–40	40+
	Disposable non-latex gloves – SPECIFY TYPE	0	1–20	20–40	40+
	Disposable natural rubber latex gloves	0	1–20	20–40	40+
	Workplace emollient hand cream	0	1–20	20–40	40+

6 How many times PER WEEK (typical) do you use these products in connection with your work?	Alcohol gel	0	1–2	3–4	5+
	Liquid soap	0	1–2	3–4	5+
	Disposable non-latex gloves – SPECIFY TYPE	0	1–2	3–4	5+
	Disposable natural rubber latex gloves	0	1–2	3–4	5+
	Workplace emollient hand cream	0	1–2	3–4	5+

7 Have you had any information, instruction or training on any of the following:	a	Signs and symptoms of dermatitis	Yes	No
	b	Chemical causes of dermatitis	Yes	No
	c	Repeated hand washing can be a cause of dermatitis	Yes	No
	d	How to adequately wash your hands	Yes	No
	e	When to use cleanser/water vs. alcohol gels	Yes	No
	f	What procedures to follow if you already have a skin condition	Yes	No
	g	What skin care is required to adequately protect your hands	Yes	No
	h	The correct use of emollients (eg how/when)	Yes	No
	i	What procedures to follow if you develop a skin condition	Yes	No

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