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HEALTH & SAFETY LABORATORY

Analysis of injuries to UK Care Assistants employed by Local Authorities in Health and Social Care, 2002-2003

HSL/2006/116

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ACKNOWLEDGEMENTS

The authors would like to thank Heather Wake and Kate Sweeney (HSE) for providing the RIDDOR datasets. Thanks also to HSL colleagues Mark Stephens, Chris Boorman, Diane Connell, and Janet Nash who assisted with different aspects of this work. The assistance provided was greatly appreciated.

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EXECUTIVE SUMMARY

Objectives

The Health and Safety Laboratory (HSL), the research agency for the Health and Safety Executive (HSE), was commissioned by HSE to analyse data from a sample of RIDDOR reported injuries sustained by care assistants, employed by Local Authorities in the Health and Social care sector between 2002-2003. The aim of the analysis was to gain a clearer picture of the factors that were contributing to these prevalent injury levels.

This report details the findings of the present analytical study based on 1848 RIDDOR reports, whilst highlighting limitations and offering recommendations for further research to gain more detailed insight into the contributory causes and circumstances.

Main Findings

- From the sample of 1848 injuries to Care Assistants, handling injuries were found to be the most prevalent type of injury (35%) followed by slip and trip injuries (33%) and violent injuries (13%). The remaining 19% either did not fall within these categories, or had too little information in the report to be classified conclusively.

- Handling injuries predominantly resulted from activities involving direct client handling, but also resulted from the handling of inanimate objects and equipment, and were subsequently found to be most likely to be sustained in the care home setting. Bedrooms were the most common place for a handling injury to occur in both care homes and client homes.

- Only 7.5% of handling injuries reportedly resulted from a failure to follow procedures.

- Slip injuries tended to result from wet surfaces such as rain or ice. Other slips resulted from wet floors following cleaning, loose gravel or leaves and spills. Slip injuries tended to be associated with non-specific activities such as walking or running. Slips tended mostly to occur outdoors.

- Trip injuries commonly resulted from obstructions, which in this context tended to be electrical leads, doorstops, laundry and rubbish. Other trips resulted from inadequate maintenance of manhole covers and carpeting. Trip injuries tended to be commonly associated with non-specific activities such as walking or running, and tended to occur outdoors or at the home of clients.

- Violent injuries tended to result from physical attacks, compounded by the unpredictable behaviour of the client, whilst alcohol use by the client contributed to less than 2% of violent injuries and inadequate procedures accounted for just over 2% of violent injuries. Violent injuries resulted from carers closely assisting/attending to clients or restraining them, and most commonly occurred in the care home. Also, 5% of violent injuries incurred by care assistants resulted from the general public.

- Overall, direct client handling was a contributory factor to nearly one third of injuries (32%), whilst handling aids were only implicated in 8% of injuries.

- Female carers were most likely to be injured (90%), however, this may be attributable to the disproportionate number of female care assistants employed in this sector.

Recommendations

- RIDDOR is not a sensitive enough tool for capturing certain aspects of injuries such as verbal violence, and non-physical harm such as anxiety. Therefore to provide a clearer picture of contributory factors to care assistant injuries the results of the present analysis should be considered in combination with further, more detailed work.

- Inclusion of care assistants in a qualitative data collection setting would increase the validity of the current analysis through the provision of additional details regarding high-risk tasks or clients. This methodology would also allow data to be collected on issues not covered by RIDDOR, such as verbal violence, stress and anxiety. Additionally, care assistants could be questioned about what interventions could be realistically applied to their jobs.

- A consideration of the frequency and other factors affecting violent injuries to carers would help to identify if there were specific care homes, and therefore a subset of care assistants who were more at risk of sustaining violent injuries.

- As violence has been identified as a relatively prominent issue for care assistants, training or information covering this issue may be beneficial. This should consider covering issues relating to violence from the public, such as lone working.

- The Health and Safety Executive (HSE) has produced guidance on violence (for an example see: 'Violence and aggression to staff in health services – Guidance on assessment and management', 1997: HSE Books), handling injuries (for an example see: 'Manual handling in the health services', 1998: HSE Books) and slip and trip injuries (for an example see: 'Slips and trips: Guidance for employers on identifying hazards and controlling risks', 1996: HSE Books). A review of this guidance may provide interventions relevant to the care assistant setting.

- Encouragement of good housekeeping within care-homes and client's homes is also recommended. This is because slip and trip injuries often appeared related to poor housekeeping (a major cause of trips was obstructions, such as rubbish bags, and a major cause of slips was wet floors). As many slip injuries were incurred outdoors, further research would be required to identify interventions for this environment.

1 INTRODUCTION

Recent years have seen an increase in the number of reportable injuries to employees in the health services. The Labour Force Survey (LFS) showed a reported 11% increase in reportable injuries to employees in the Health Services between 2000-2002.

In 2001/02 and again in 2003/04 the Self-reported Work related Illness survey (SWI) found employees in health and social care reported a higher than average prevalence rate for injuries caused or 'made worse' by their job.

This present research was carried out at the request of Debo Kahlon and Vicky Fletcher (HSE), in support of the ongoing work for the Public Services Programme (PSP). One of the work areas is to understand and reduce sickness absence in the public sector, and it was felt that targeting key social service departments would have an impact in reducing sickness absence, due to the prevalence in size and numbers of injuries identified here.

Previous work had established the extensive number of injuries suffered by social service departments, in particular by care home assistants. Therefore the aim of this research was to analyse the relevant RIDDOR data further in order to develop a clearer picture of the underlying causes and circumstances that were resulting in these prevalent injury levels.

1.1 OBJECTIVES

The objectives of this work were as follows:

- Isolate and analyse RIDDOR data from 2002/03 regarding injuries to care assistants employed by Local Authorities in Health and Social care.

- Evaluate the causes and underlying causes of the RIDDOR reported injuries in order to identify emergent trends.

- Identify any trends relating to activities or locations where the injuries were sustained.

- Draw relevant conclusions regarding the causes and circumstances leading to these prevailing injury levels, therefore identifying key areas for targeting efficient interventions.

- Provide a written report on the analysis and interpretation of the RIDDOR reported injuries resulting from the initial analysis, highlighting limitations and offering recommendations for potential interventions.

2 METHOD

2.1 SAMPLE

The project aimed to identify any trends in reported incidents involving injury to care assistants in the public services. To achieve this aim, a sample of RIDDOR reports was obtained for more detailed analysis.

The data was selected through Standard Occupation Classification (SOC) code 6115, care assistants. The data obtained from HSE resulted in a sample of 1869 RIDDOR entries. These were then analysed for common trends.

2.2 DATA ANALYSIS

The RIDDOR sample was exported into a basic Microsoft Access database. From here data was viewed and categorized against a set of criteria based on the customer's initial requirements. The criteria ranged from the initial cause of the injury to the activity and underlying cause, a full breakdown of which can be found in Appendix 1.

RIDDOR reports dictate that the type of injury is mutually exclusive, however, for the purposes of this analysis each injury report was systematically assessed for the affect of a series of factors. (See Appendix 1 for a description of the rationale for selecting different categories for the RIDDOR injury reports). Some RIDDOR reports failed to provide adequate information in the 'notifiers comments', making it difficult to (robustly) identify a definite cause, however, where possible contributory factors were identified.

As already noted, the initial sample of RIDDOR reports was 1869. However, following categorisation of the data, 21 records were omitted from further analysis: 11 records due to lack of information, 9 records due to repetition and 1 record due to lack of relevance to care assistant work. Therefore, the resultant analyses and charts are based on the remaining sample of 1848 RIDDOR entries.

Each RIDDOR report was reviewed by HSL (the researcher) and coded according to a fixed set of criteria. The results are therefore based on the HSL judged figures. It must be noted, however, that the categorisation of the data was subject to researcher interpretation due to the level of detail within the RIDDOR report and the 'notifier comments'. Every effort was made to categorise injury reports accurately, but due to the nature of some reports, best judgements were made on the available information.

Due to the nature of the incidents and therefore the coding criteria, RIDDOR injuries which satisfied the 'handling incident' search criteria may also have satisfied the 'violent incident' search criteria. Therefore some RIDDOR reports may have been analysed under more than one category, however this was believed to be an accurate reflection of the accumulative nature of numerous factors.

3 RESULTS

3.1 INTRODUCTION

The initial sample of RIDDOR reports was 1869. However, following categorisation of the data, 21 records were omitted from further analysis: 11 records due to lack of information, 9 records due to repetition and 1 record due to lack of relevance to care assistant work. Therefore, the resultant analyses and charts are based on the remaining sample of 1848 RIDDOR entries. For a description of the rationale for selecting different categories for the RIDDOR injury reports see Appendix 1. Table 1 below summarises the number of injuries under the three key injury categories relevant to this research: 'Handling', 'Slip or Trip' and 'Violent'. The 'other' category highlights injuries which either did not fall within the key categories, or had too little information in the report to be classified conclusively.

Type of injury	Number of injuries judged to be relevant by HSL
Handling	644
Slip or Trip	603
Violent	243
Other	358

Table 1: Number of injuries by type, as coded by HSL

3.2 HANDLING

Injuries resulting from manual handling tasks were the most prevalent type of injury identified from the data, contributing to 644 of the 1848 incidents in the sample.

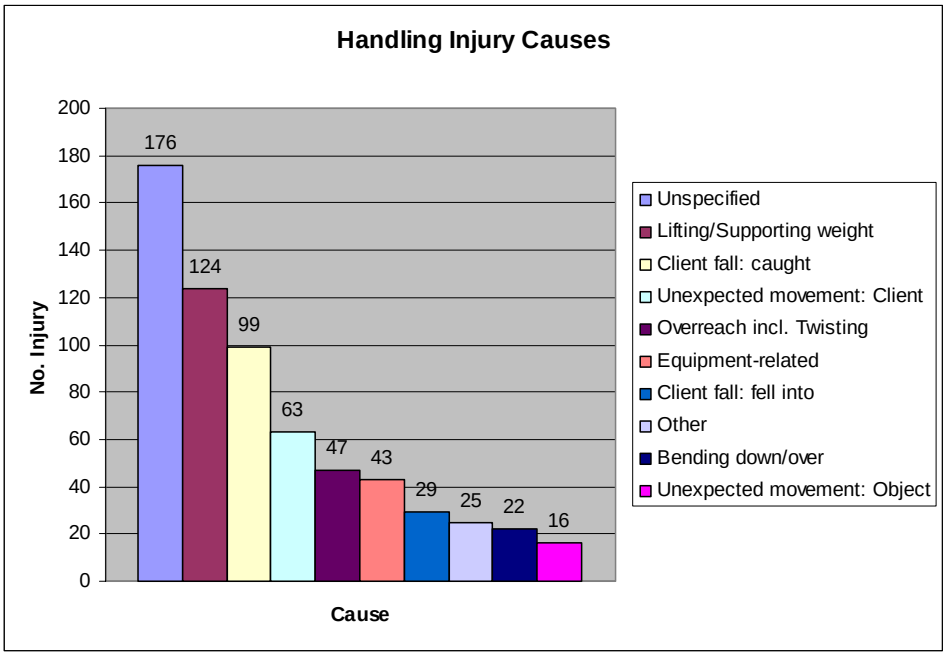

Figure 1 – Primary causes of handling injuries

The majority of handling injuries were primarily judged to be caused by lifting or supporting weight, contributing to 19% of handling injuries.

Another prevalent cause, contributing to 15% of handling injuries, was when a client fell and was caught by the injured person.

The third most common cause of handling injuries (12%) was unexpected movements of either the client (10%) or an object (2%). Movement of the carer (the carer bending down, bending over, over-reaching or twisting) closely followed with a combined total of 11% of the injuries.

A total of 27% of injury reports for handling injuries could not be classified regarding the cause, due to inadequate information and were categorised as 'unspecified'. A further 4% of injury reports referred to additional causes that occurred infrequently and were classified as 'other'.

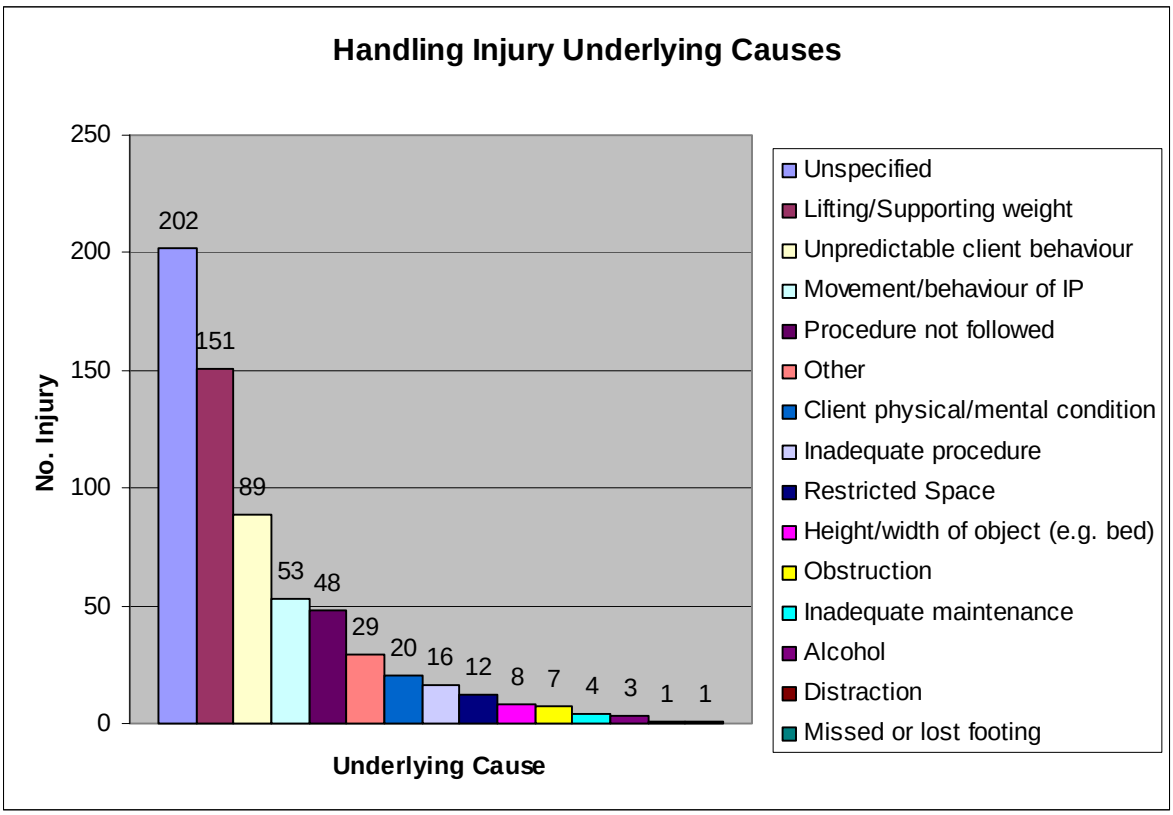

Figure 2 - Underlying causes of handling injuries

In a number of RIDDOR reports it was possible to identify underlying causes of injuries (i.e. a key contributor to the cause of the injury). Of the handling injuries identified in this sample 23% were the result of lifting or supporting weight. This was followed by injuries resulting from the unpredictable behaviour of clients (14%). A further 8% of the handling injuries identified were the result of the movement/behaviour of the carer, closely followed by failure to follow procedures (7.5%).

A total of 31% of injury reports for handling injuries could not be classified regarding the underlying cause, due to inadequate information and were categorised as 'unspecified'. A further 4.5% of injury reports referred to additional underlying causes that occurred infrequently and were classified as 'other'.

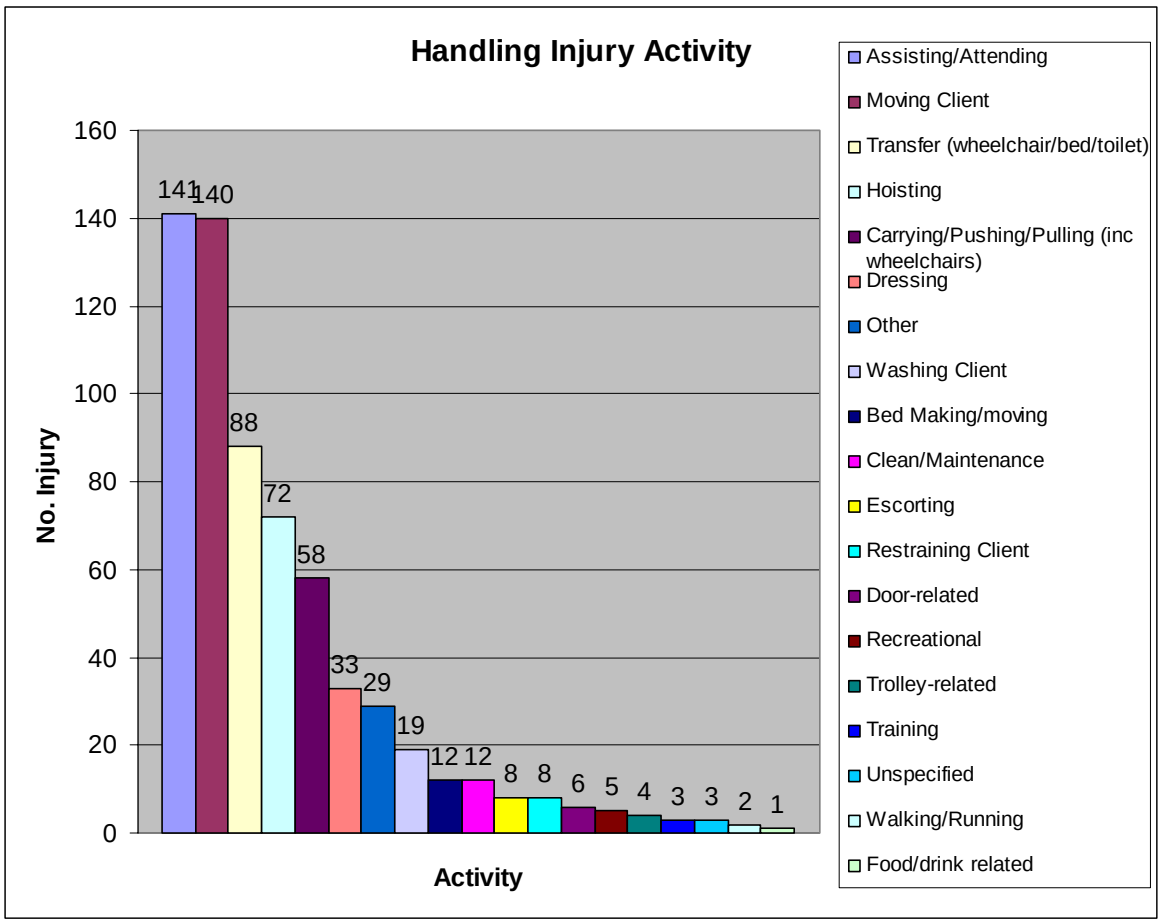

Figure 3 – Activity when handling injury sustained

The highest number of handling injuries were incurred whilst the carer was assisting or attending to the client (22%) or moving the client (22%). A further 14% of injuries were sustained during transfer activities (i.e. between wheelchair, bed and commode etc). The next largest category of injuries occurred whilst the carers were involved in hoisting activities (11%).

A combined total of 79% of these handling injuries resulted from activities where direct handling interaction between the carer and the client was involved. Whilst 12.5% of the handling injuries resulted from handling of equipment or other inanimate objects.

Only 0.5% of injury reports for handling injuries could not be classified regarding the activity the carer was involved in, due to inadequate information and were categorised as 'unspecified'. A further 4.5% of injury reports referred to additional activities that occurred infrequently and were classified as 'other'.

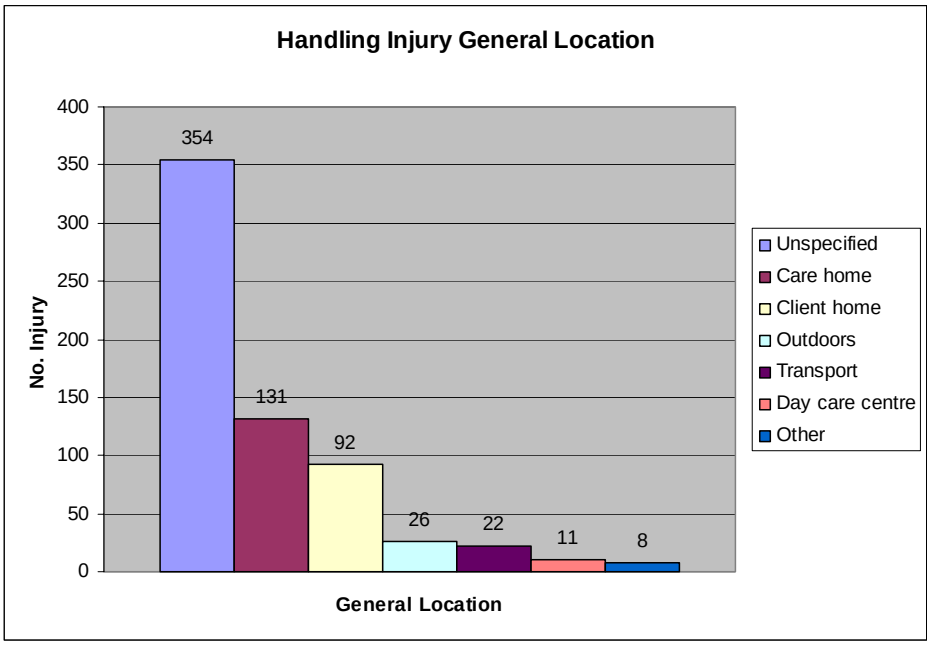

Figure 4 – General location where handling injury was sustained

Most of the incidents occurred in the care home (20%), with 14% occurring in the client's home. A further 4% of injuries were incurred out-doors.

A large number of handling injuries identified in the sample (56%) could not be categorised with regard to their location due to inadequate information or referred to another location (i.e. classified as either 'unspecified' or 'other').

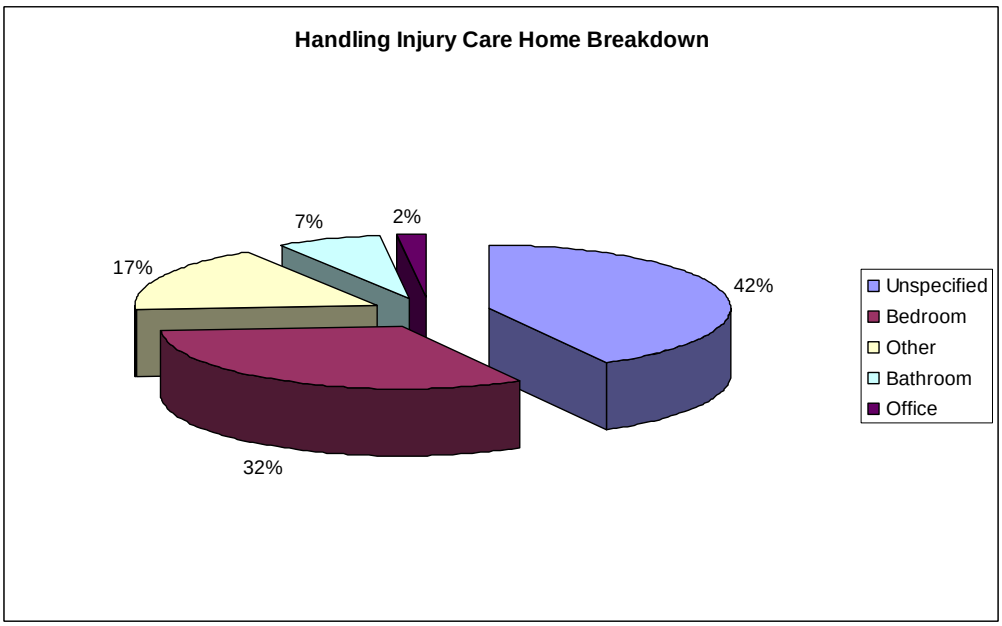

Figure 5 – Breakdown of handling injuries sustained in care homes

Figure 5 represents a more detailed breakdown of the handling injuries identified as occurring within care homes (n = 131), as seen in Figure 4. The majority of injuries (32%) referred to injuries occurring within the bedroom. A small number of handling injuries occurred in the bathroom (7%), whilst even fewer were in an office (2%). However, 42% of incidents were unspecified and 17% occurred in another location. Also, it must be noted that these figures are based on a limited sample due to the majority of locations in Figure 4 being unspecified.

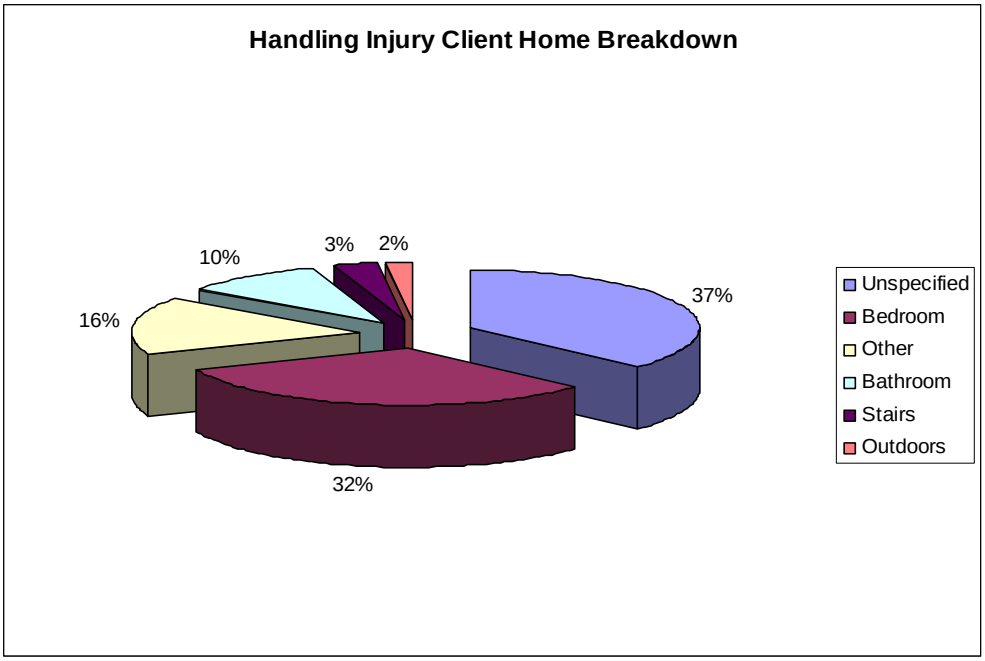

Figure 6 – Breakdown of handling injuries sustained in client homes

Figure 6 represents a more detailed breakdown of the handling injuries identified as occurring within client homes (n = 92), as seen in Figure 4. The majority of injuries (32%) referred to injuries occurring within the bedroom. A total of 10% of handling injuries occurred in the bathroom, whilst 3% occurred on stairs and 2% were in out-doors. However, 37% of incidents were unspecified and 16% occurred in another location. Also, it must be noted that these figures are based on a limited sample due to the majority of locations in Figure 4 being unspecified.

3.3 SLIPS AND TRIPS

The second most prevalent type of injury was that resulting from slip or trip incidents. 603 of the sample of 1848 injuries to carers were judged to be the result of a slip or a trip.

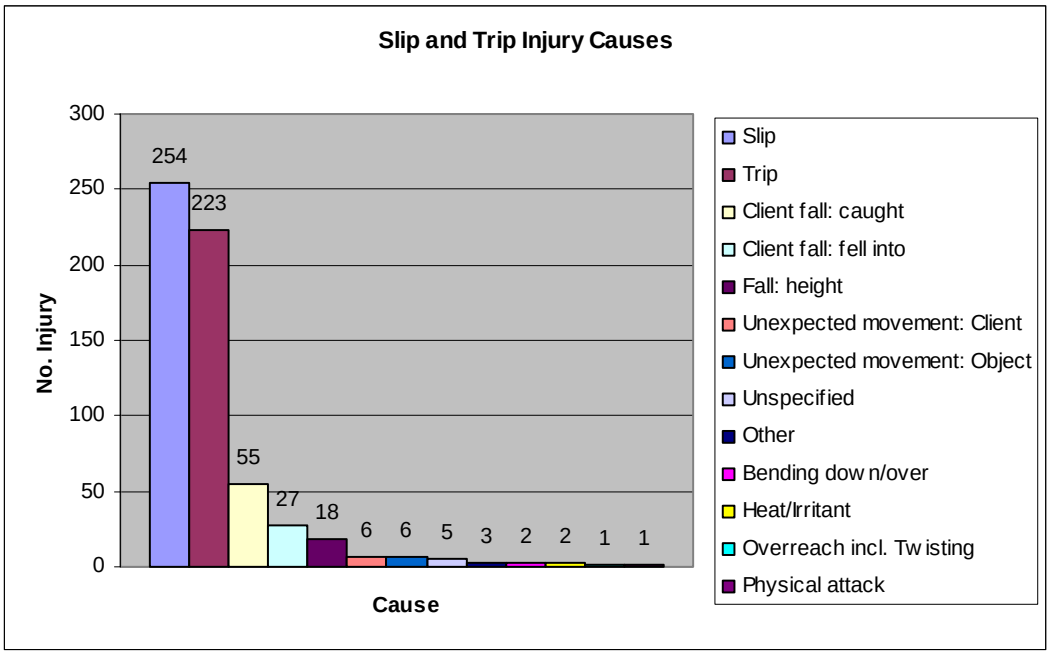

Figure 7 – Primary causes of slip and trip injuries

The majority of injuries in this selection of the sample were caused by slips (42%) whilst a further 37% of injuries were caused by trips. Some slip and trip incidents occurred indirectly. The main indirect cause of slip and trip accidents was client falls (caught or fell into), accounting for 14%.

Only 1.5% of injuries were classified as either 'Other' (0.5%) or 'Unspecified' (1%).

1.3.1 Slips

The underlying causes of slip and trip injuries are predominantly specific to the injury type, either slip or trip. Therefore the underlying causes of the 254 slip-related injuries has been analysed separately in the following section.

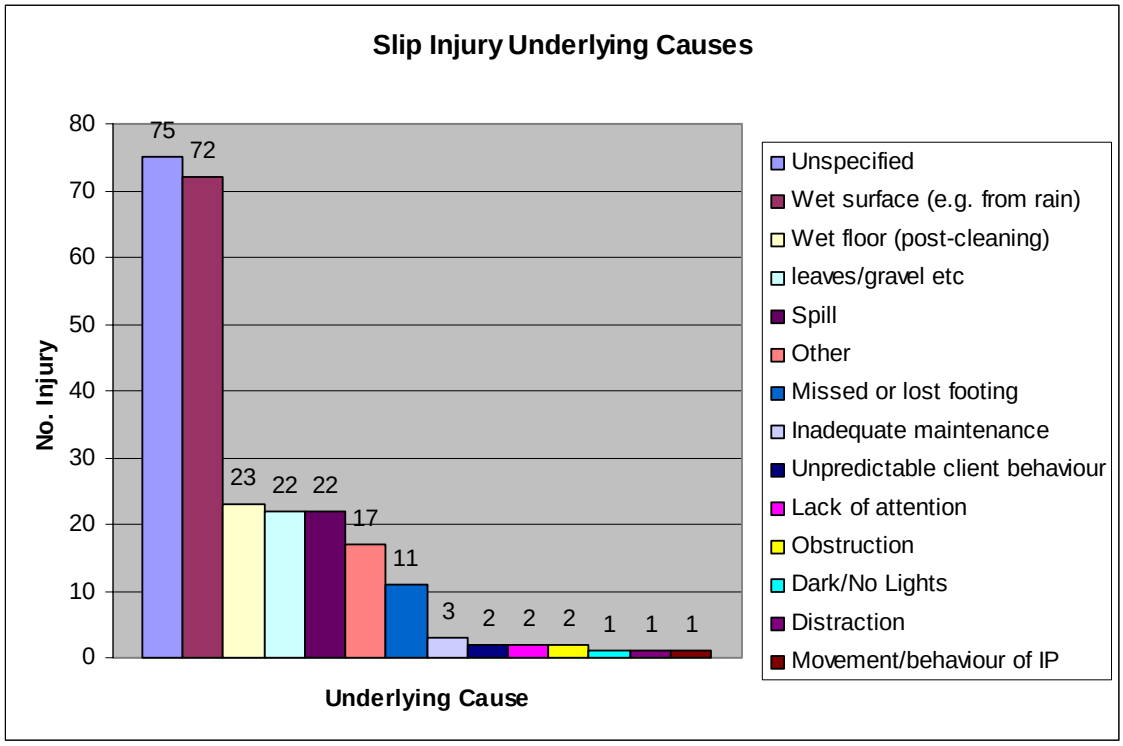

Figure 8 – Underlying causes of slip injuries

The majority of slip injuries were caused by wet surfaces out-doors (28%) caused primarily by rain and ice. The next three most prevalent underlying causes of slip injuries were wet leaves and loose gravel (9%), wet floors following cleaning activities (9%), and spills (9%).

A further 29.5% of injury reports for slip injuries could not be classified regarding the underlying cause, due to inadequate information and were categorised as 'unspecified'. Another 7% of injury reports referred to additional underlying causes that occurred infrequently and were classified as 'other'.

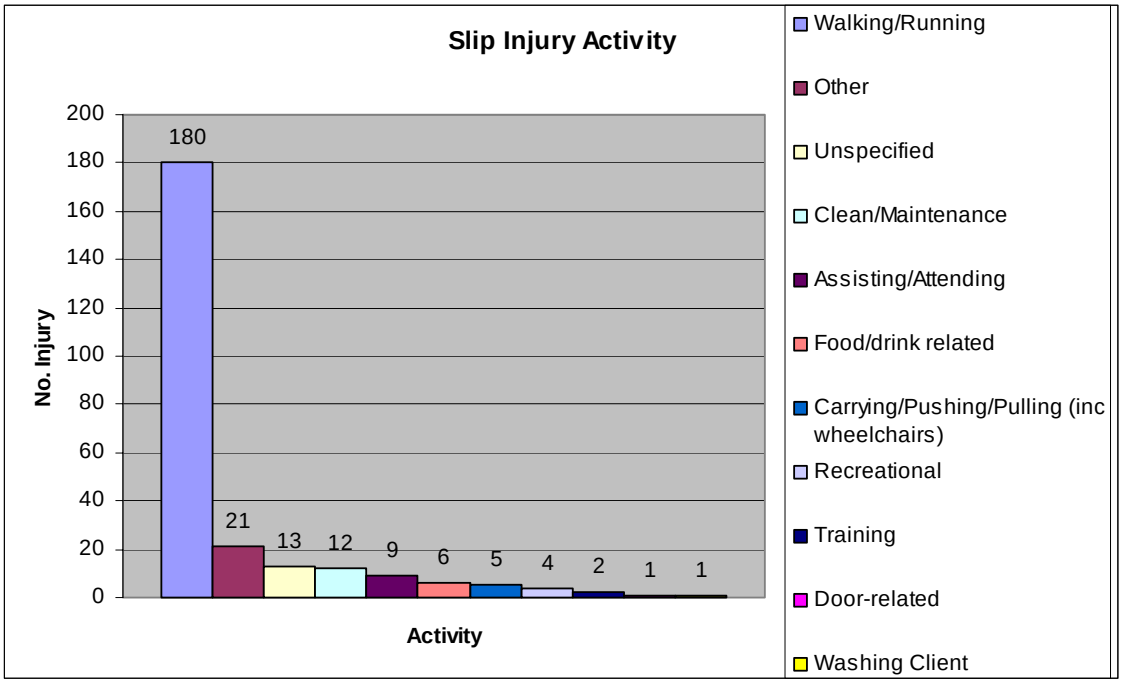

Figure 9 – Activity when slip injury sustained

Figure 9 shows that the majority of slip incidents (71%) occurred whilst the carer was 'Walking/Running' (i.e. during activities which did not primarily involve patient handling, and where no further detail was available). A further 5% of slip injuries were sustained during cleaning and maintenance activities.

A total of 5% of injury reports for slip injuries could not be classified regarding the activity the carer was involved in, due to inadequate information and were categorised as 'unspecified'. A further 8% of injury reports referred to additional activities that occurred infrequently and were classified as 'other'.

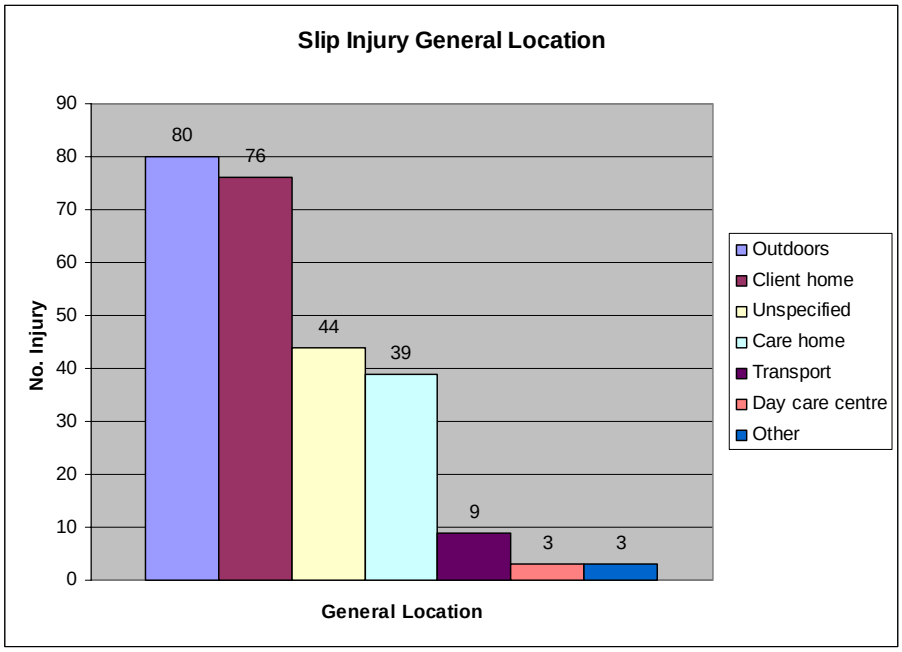

Figure 10 – General location where slip injury was sustained

Most slip incidents identified occurred out-doors (31.5%). A further 30% of injuries were incurred in the client home whilst 15% occurred in the care home.

A total of 18% of slip injuries identified in the sample could not be categorised with regard to their location due to inadequate information or reference to another location (i.e. classified as either 'unspecified' or 'other').

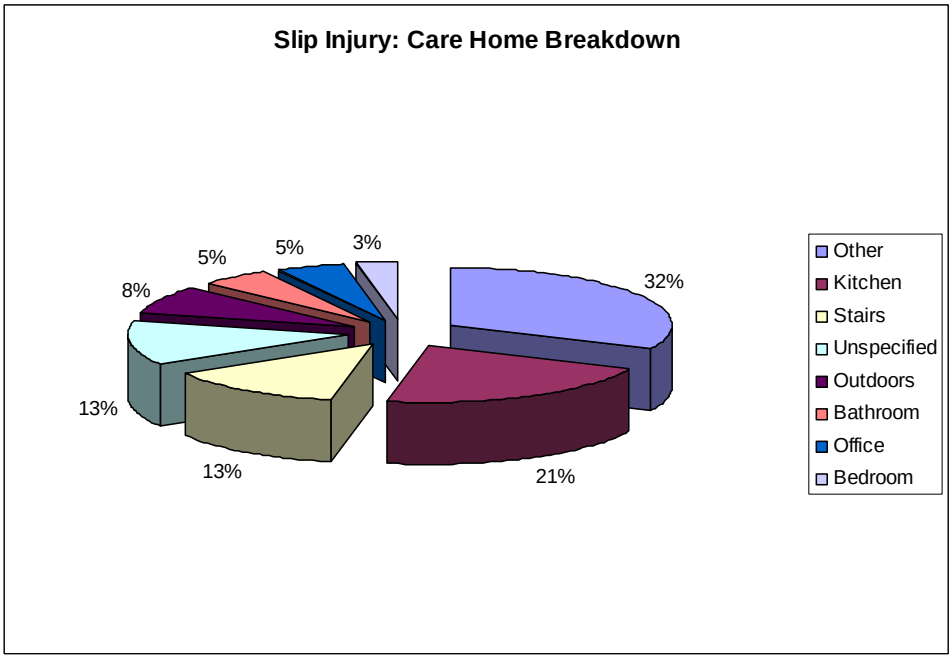

Figure 11 – Breakdown of slip injuries sustained in care homes

Figure 11 represents a more detailed breakdown of the slip injuries identified as occurring within care homes (n = 39), as seen in Figure 10. The majority of injuries (21%) referred to injuries occurring within the kitchen. This was followed by slip injuries occurring on the stairs (13%), whilst 8% occurred just outside the care home ('out-doors').

A further 13% of injuries occurred in unspecified locations and 32% in other locations. It must also be noted that these figures are based on a limited sample (n = 39).

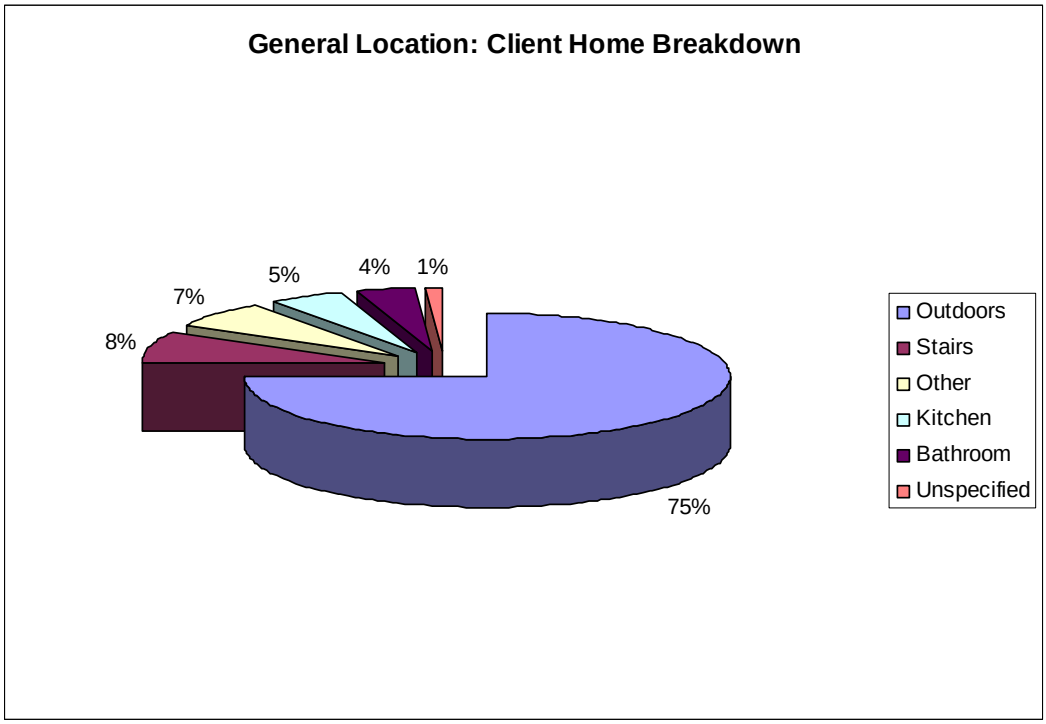

Figure 12 – Breakdown of slip injuries sustained in client homes

Figure 12 represents a more detailed breakdown of the slip injuries identified as occurring within care homes (n = 76), as seen in Figure 10. The majority of injuries (75%) occurred just outside the client home. This was followed by slip injuries occurring on stairs (8%), whilst 5% occurred in the kitchen.

A further 1% of injuries occurred in unspecified locations and 7% in other locations. It must be noted that these figures are based on a limited sample.

1.3.2 Trips

Trip injuries accounted for 223 of the 603 slip or trip injuries in this sample. These injuries have been analysed separately in the following section.

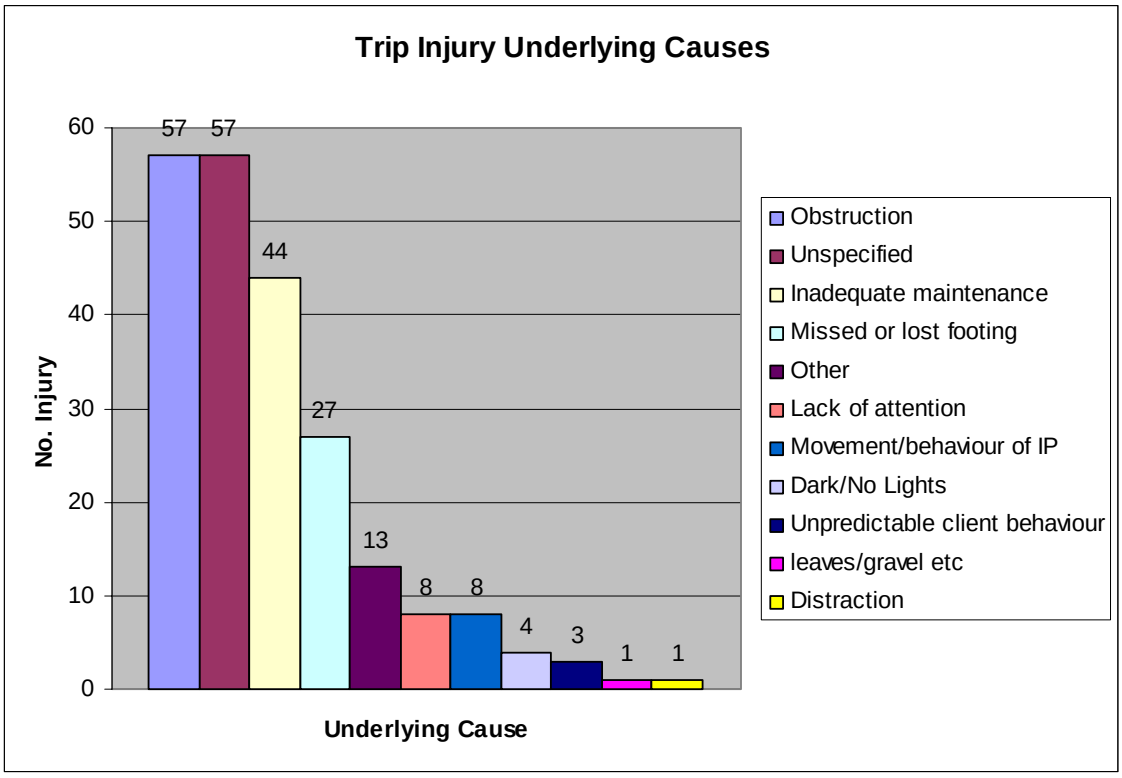

Figure 13 – Underlying causes of trip injuries

The majority of trip injuries identified in this sample were the result of obstructions (26%) such as electrical leads, doorstops, chairs, or laundry/rubbish. A further 20% of injuries resulted from inadequate maintenance, for example, uneven ground or potholes, loose manhole covers, or loose flooring. Another 12% of trip injuries were caused by missed or lost footing.

A total of 26% of injury reports for trip injuries could not be classified regarding the underlying cause, due to inadequate information and were categorised as 'unspecified'. A further 6% of injury reports referred to additional underlying causes that occurred infrequently and were classified as 'other'.

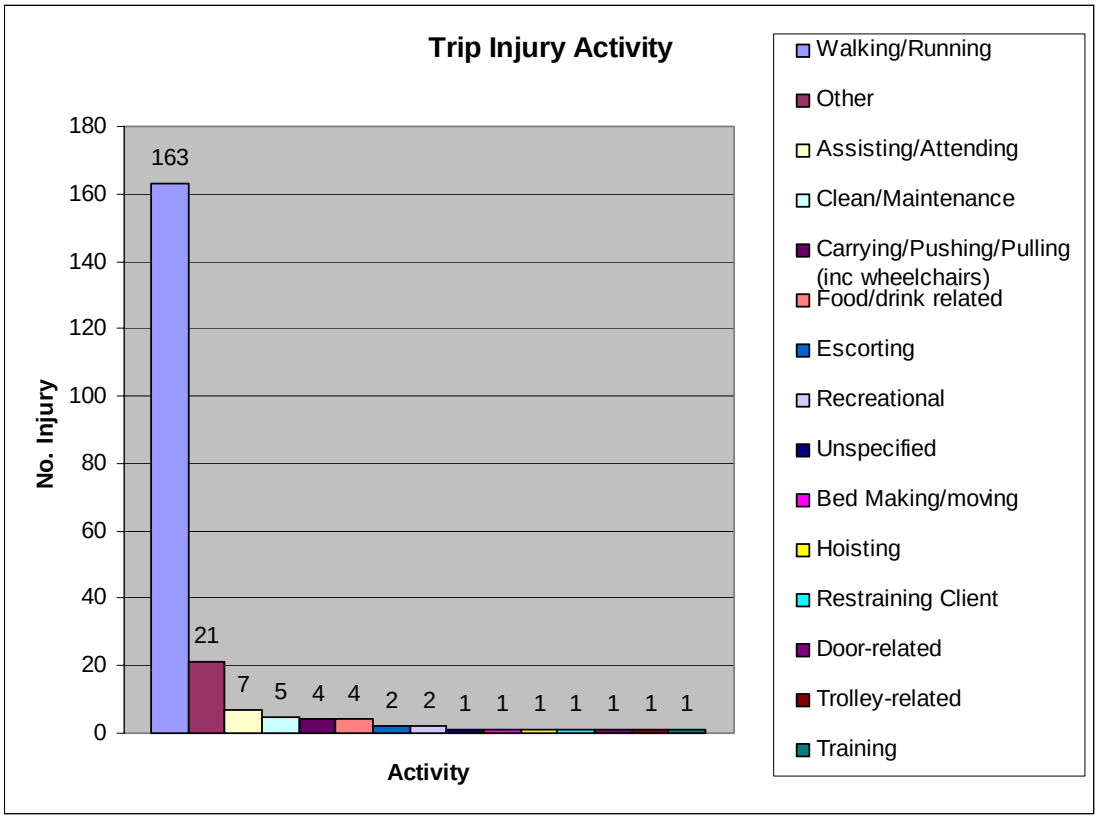

Figure 14 – Activity when trip injury sustained

The large majority (73%) of trip injuries identified from the sample were sustained whilst the carer was 'Walking/Running' (i.e. involved in activities which did not primarily involve patient handling, and where no further detail was available). A further 3% of injuries were sustained whilst the carer was assisting or attending to the client.

Escorting, hoisting and restraining clients were identified as discrete categories, separate from 'assisting/ attending client'. These resulted in minimal trip injuries within this sample.

Only 4% of injury reports for trip injuries could not be classified regarding the activity the carer was involved in, due to inadequate information and were categorised as 'unspecified'. A further 9% of injury reports referred to additional activities that occurred infrequently and were classified as 'other'.

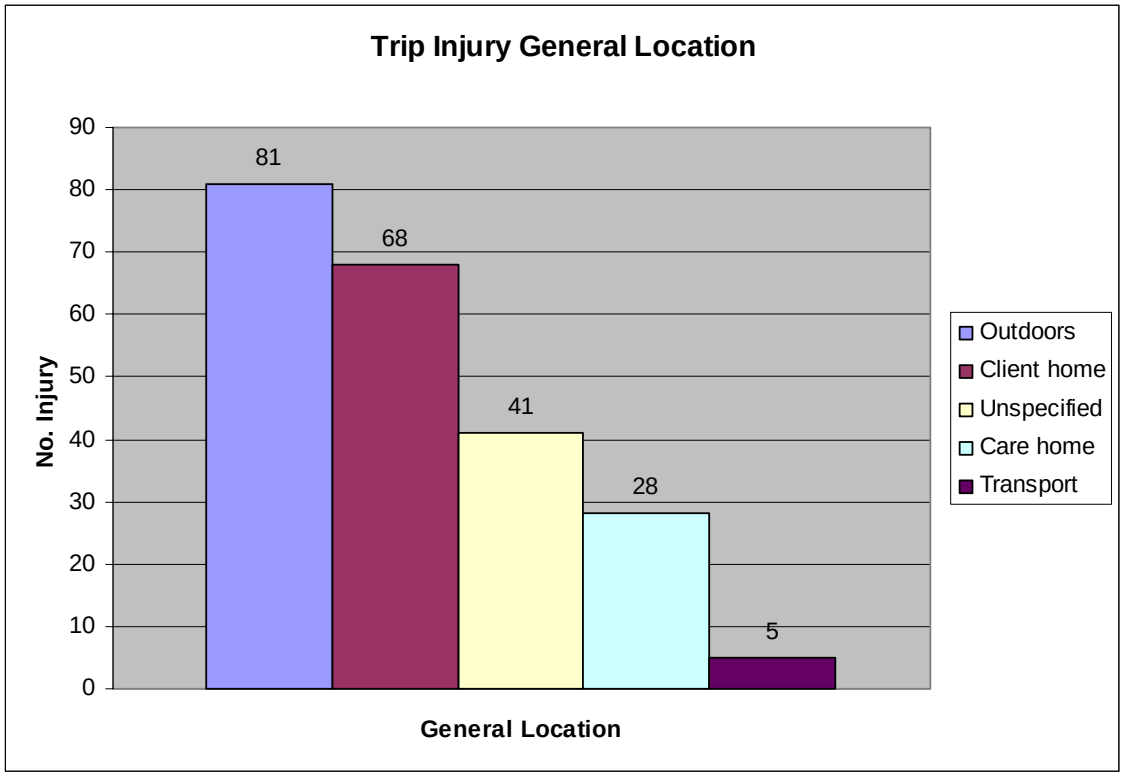

Figure 15 – General location where trip injury was sustained

The majority of trip incidents were incurred out-doors (36%). A further 30.5% of incidents occurred in the client home and 13% of incidents occurred in the care home.

A total of 20% of trip injuries identified in the sample could not be categorised with regard to their location due to inadequate information or reference to another location (i.e. classified as either ‘unspecified’ or ‘other’).

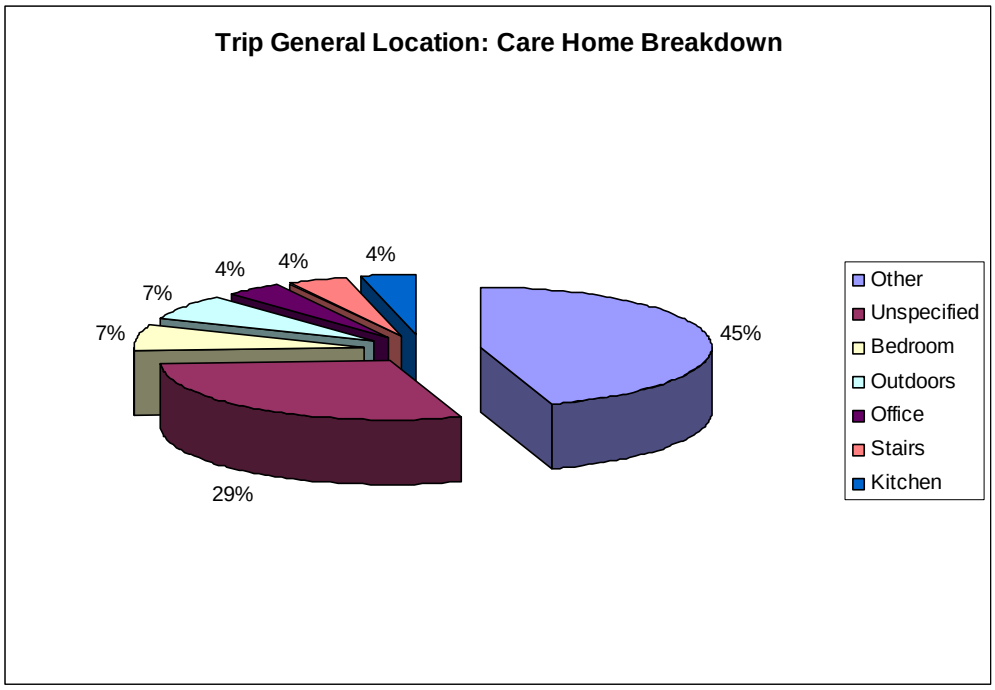

Figure 16 – Breakdown of trip injuries sustained in care homes

Figure 16 represents a more detailed breakdown of the trip injuries identified as occurring within care homes (n = 28), as seen in Figure 15. A total of 7% of trip injuries occurred in the bedroom and a further 7% occurred just outside the care home. There was a minority of incidents in the kitchen (4%), office (4%), or on the stairs (4%).

However, the majority of injuries were either unspecified (29%) or categorised as another specific location (45%). Also, it must be noted that these figures are based on a limited sample size.

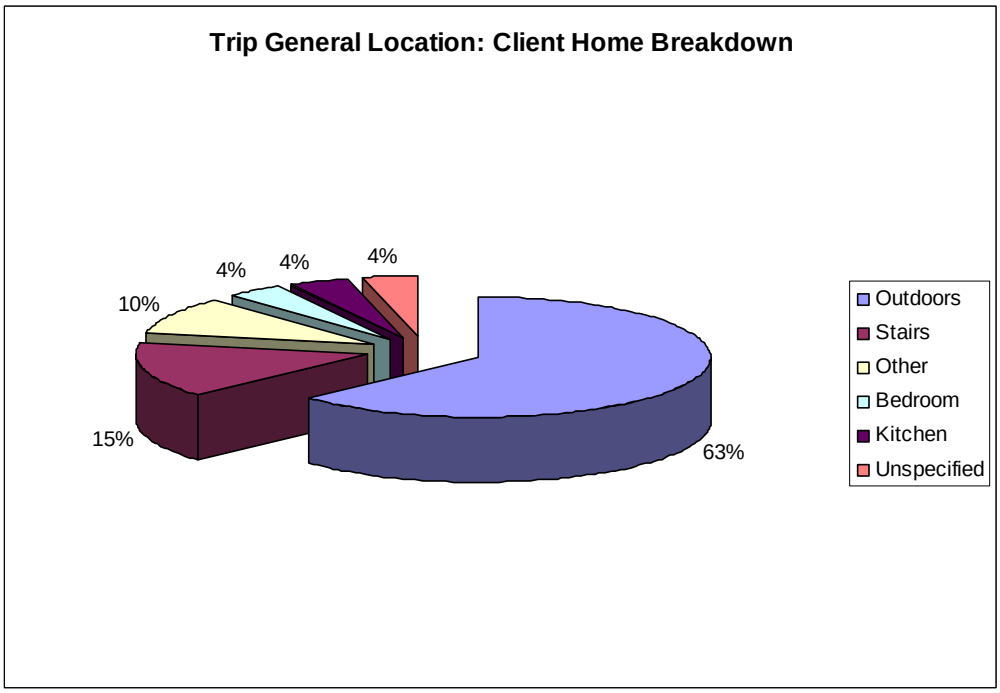

Figure 17 – Breakdown of trip injuries sustained in client homes

Figure 17 represents a more detailed breakdown of the trip injuries identified as occurring within care homes (n = 68), as seen in Figure 15. The majority of trip injuries (63%) occurred outside the client home and 15% of injuries occurred on stairs. A further 4% of injuries were incurred in the bedroom and another 4% occurred in the kitchen.

A total of 14% of trip injuries identified in the sample could not be categorised with regard to their location due to inadequate information or reference to another location (i.e. classified as either 'unspecified' or 'other'). Also, it must be noted that these figures are based on a limited sample size.

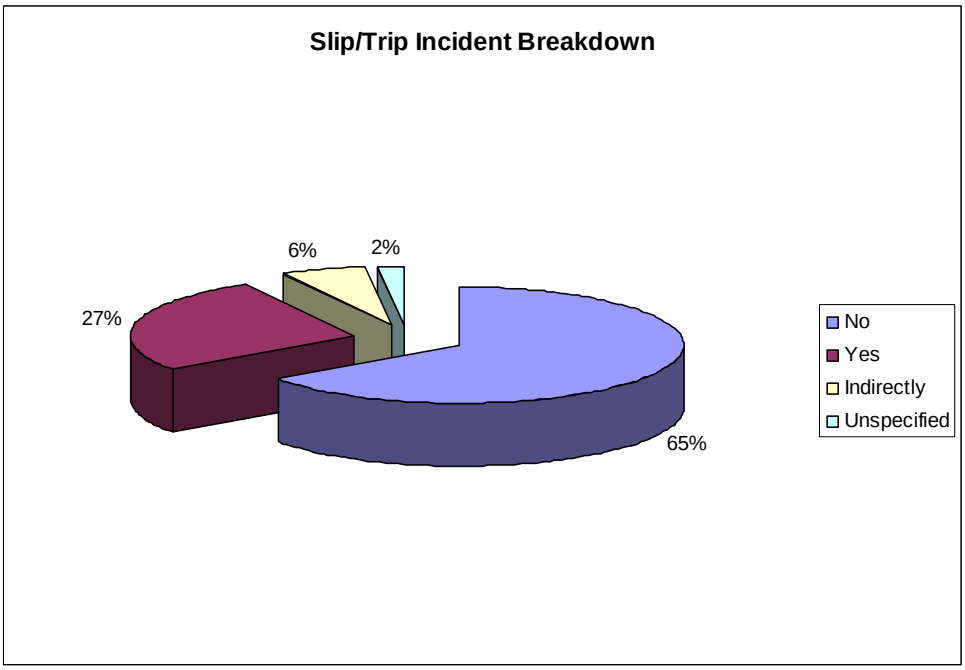

Figure 18 – Injuries where slips or trips were a contributory factor (n = 1848)

A further 102 injuries (n = 1848) were judged to have resulted from incidents where, although slips or trips were not the main cause of the injury, they were considered to be a contributory factor. These are represented under 'indirectly' in Figure 18.

3.4 VIOLENCE

The third most prevalent types of injury were those resulting from violent incidents. 243 of the sample of 1848 injuries to carers were judged to be the result of a violent incident.

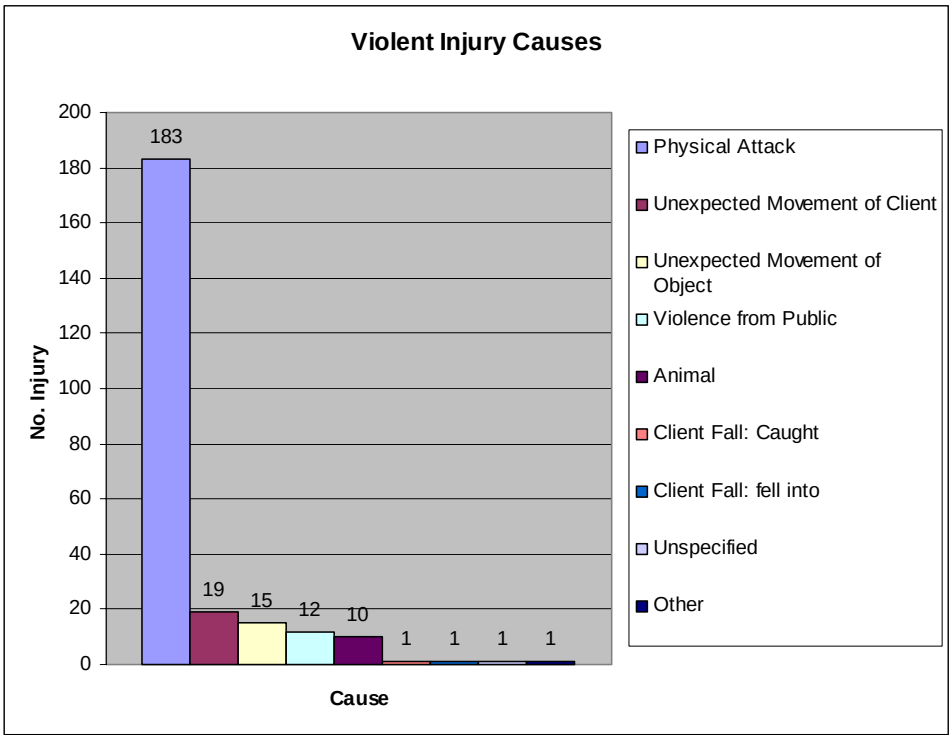

Figure 19 – Primary causes of violent injuries

The majority of violence-related injuries (75%) resulted from some form of physical attack. For example, in one instance an employee was 'hit twice in the face and then on the chest by a service user'.

Another 8% of violent injuries were caused by the unexpected movement of the client, and 6% of injuries were caused by the unexpected movement of an object (i.e. throwing objects at carers). A further 5% of violent injuries were incurred from the public whilst out and about visiting clients.

A low number of violent injuries (1%) identified in the sample could not be categorised due to inadequate information or reference to another cause (i.e. classified as either 'unspecified' or 'other').

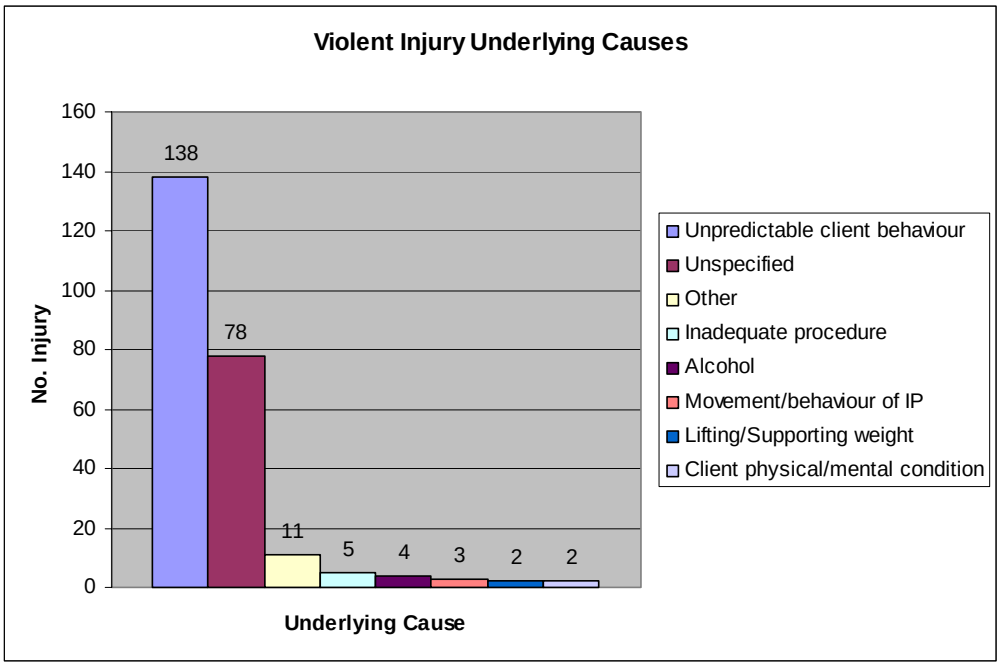

Figure 20 – Underlying causes of violent injuries

The majority of violent injuries from the sample were a result of the unpredictable behaviour of the client (57%).

A further 32% of injury reports for violent injuries could not be classified regarding the underlying cause, due to inadequate information and were categorised as 'unspecified'. Another 4.5% of injury reports referred to additional underlying causes that occurred infrequently and were classified as 'other'.

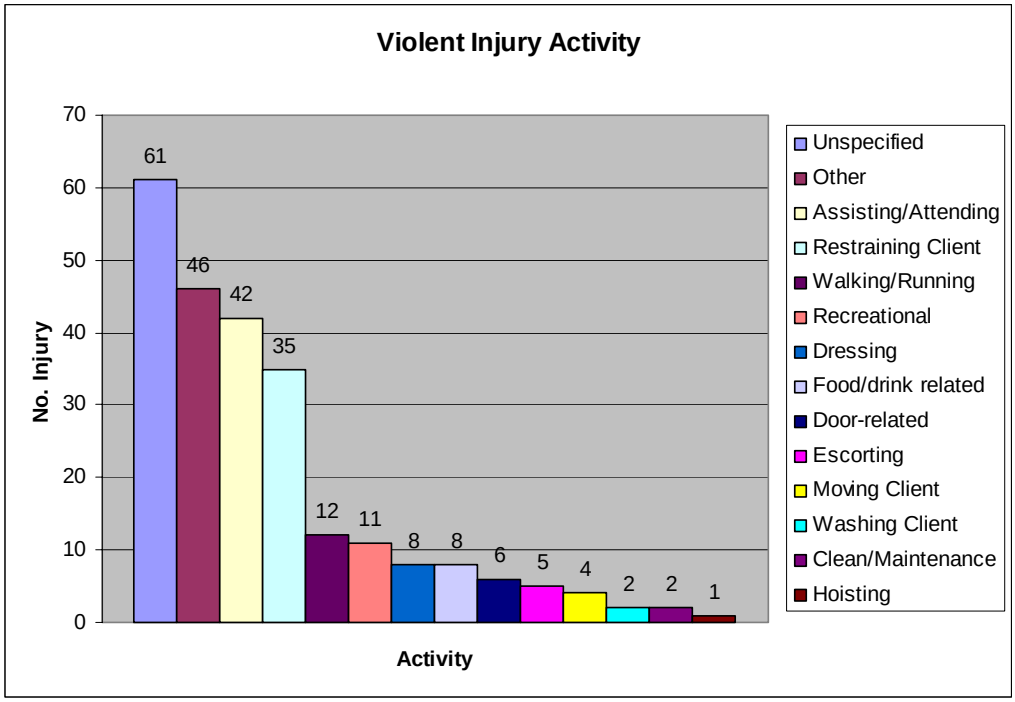

Figure 21 – Activity when violent injury sustained

A total of 17% of violent injuries identified from the sample were sustained whilst the carer was assisting or attending to the client. A further 14% of injuries were sustained whilst restraining the client i.e. intervening in an already violent situation. For example, one RIDDOR report states that a member of staff intervened when 'a young person was attacking another young person, and during restraint of the young person, IP sustained injury to her leg'. A further 5% of carers' injuries were sustained whilst they were 'walking/running' (i.e. during activities which did not primarily involve patient handling, and where no further detail was available).

A quarter (25%) of injury reports for violent injuries could not be classified regarding the activity the carer was involved in, due to inadequate information and were categorised as 'unspecified'. A further 19% of injury reports referred to additional activities that occurred infrequently and were classified as 'other'.

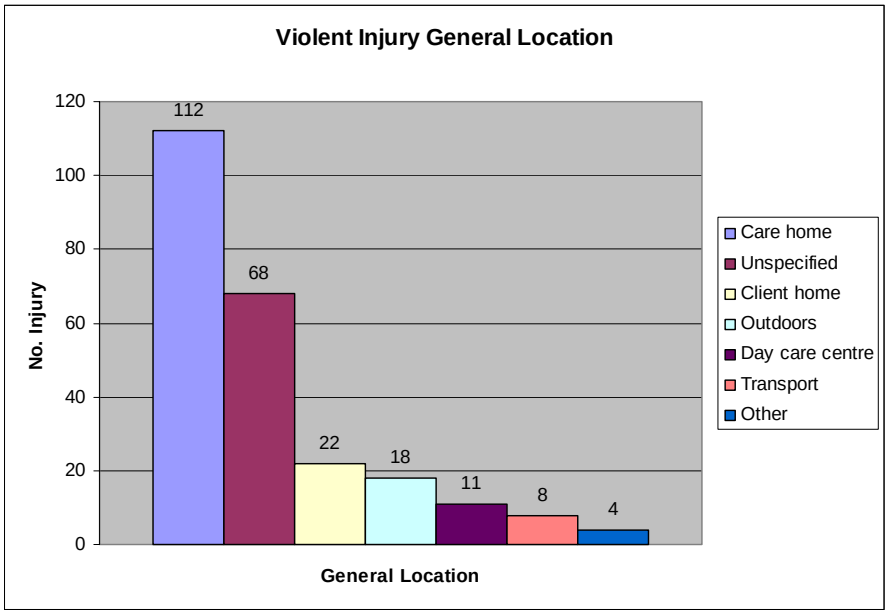

Figure 22 – General location where violent injury was sustained

Most violent incidents occurred in the care home (46%). A further 9% of injuries were incurred in the client home and 7% of injuries happened while the carers were out-doors.

A total of 30% of violent injuries identified in the sample could not be categorised with regard to their location due to inadequate information or reference to another location (i.e. classified as either 'unspecified' or 'other').

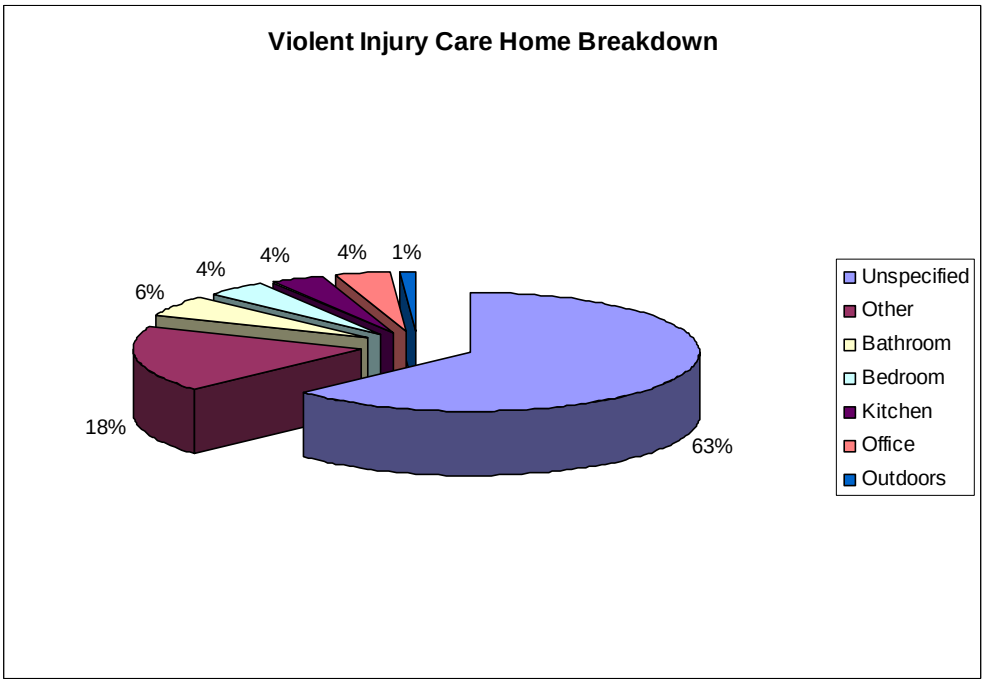

Figure 23 – Breakdown of violent injuries sustained in care homes

Figure 23 represents a more detailed breakdown of the violent injuries identified as occurring within care homes (n = 112), as seen in Figure 22. A total of 6% of violent injuries occurred in

the bathroom, whilst a small number of violent injuries occurred in the bedroom (4%), kitchen (4%) or office (4%).

A large number of injury reports for violent injuries (63%) could not be classified regarding the activity the carer was involved in, due to inadequate information and were categorised as 'unspecified'. A further 18% of injury reports referred to additional activities that occurred infrequently and were classified as 'other'. Also, it must be noted that these figures are based on a limited sample (n = 112).

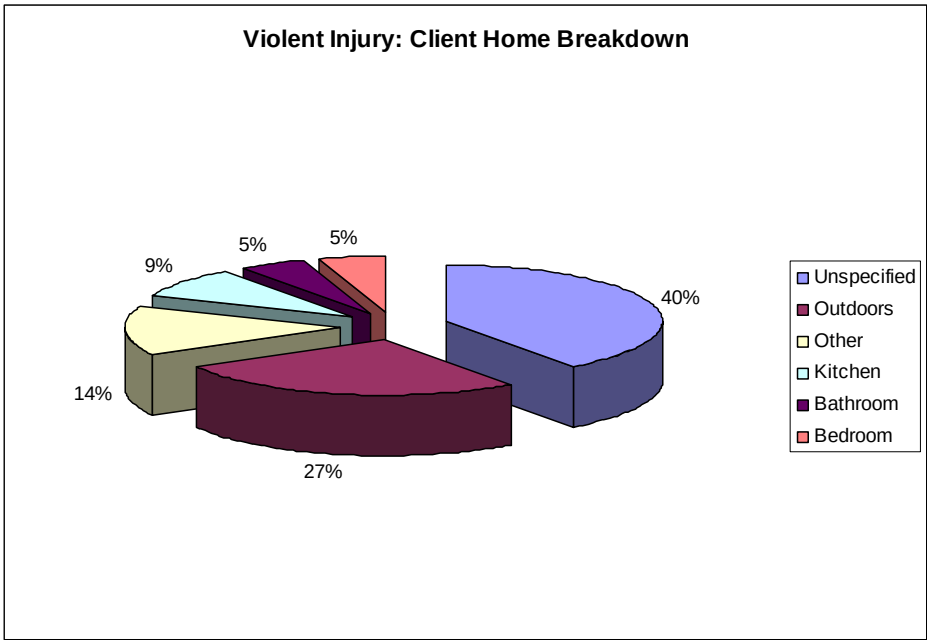

Figure 24 – Breakdown of violent injuries sustained in client homes

Figure 24 represents a more detailed breakdown of the violent injuries identified as occurring within client homes (n = 22), as seen in Figure 22. The majority of violent injuries occurred outside the client's home (27%). A further 9% of violent injuries occurred in the kitchen, whilst a small number of violent injuries occurred in the bedroom (5%) and bathroom (5%).

A total of 40% of injury reports for violent injuries could not be classified regarding the activity the carer was involved in, due to inadequate information and were categorised as 'unspecified'. A further 14% of injury reports referred to additional activities that occurred infrequently and were classified as 'other'. Also, it must be noted that these figures are based on a very small sample.

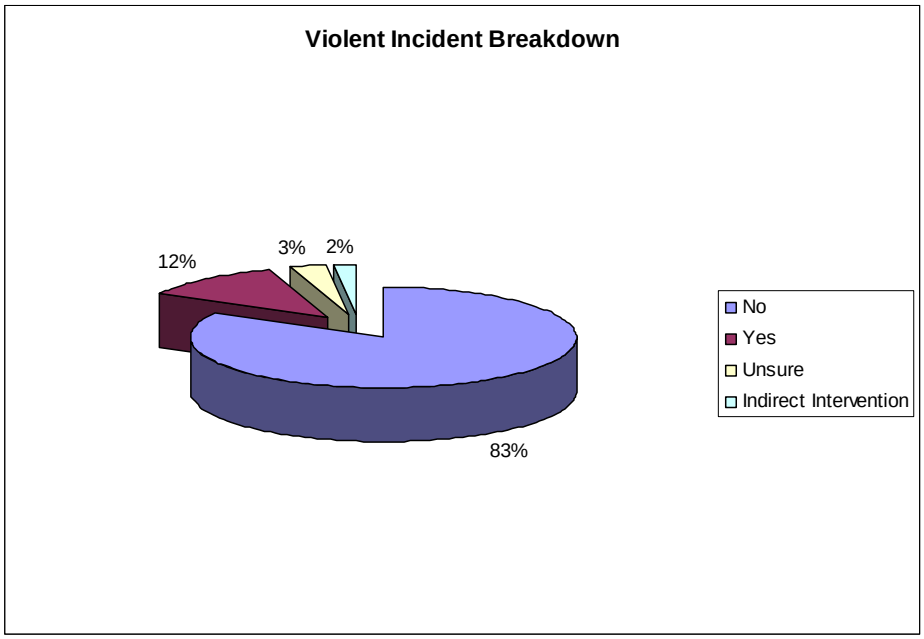

Figure 25 – Injuries where violence was a contributory factor (n = 1848)

A further 28 injuries in the overall sample (n = 1848) were judged to have resulted from incidents where, although violence was not the main cause of the injury, it was considered to be a contributory factor. These are represented under 'indirect intervention' in figure 25, accounting for 2% of the overall sample. The Figure also highlights that 12% of injuries in the total sample were deemed to be violence related. Also, a further 3% of the sample comprised injuries which may have been a result of violence. These injuries were categorised as 'unsure', as it was not clear from the RIDDOR data whether the incident was definitely violent. Figure 25 also illustrates that 83% of injuries in the total sample were not deemed to be violence related.

3.5 OTHER RESULTS

All the data (n = 1848) were analysed in order to identify general trends. The results are presented in the following section.

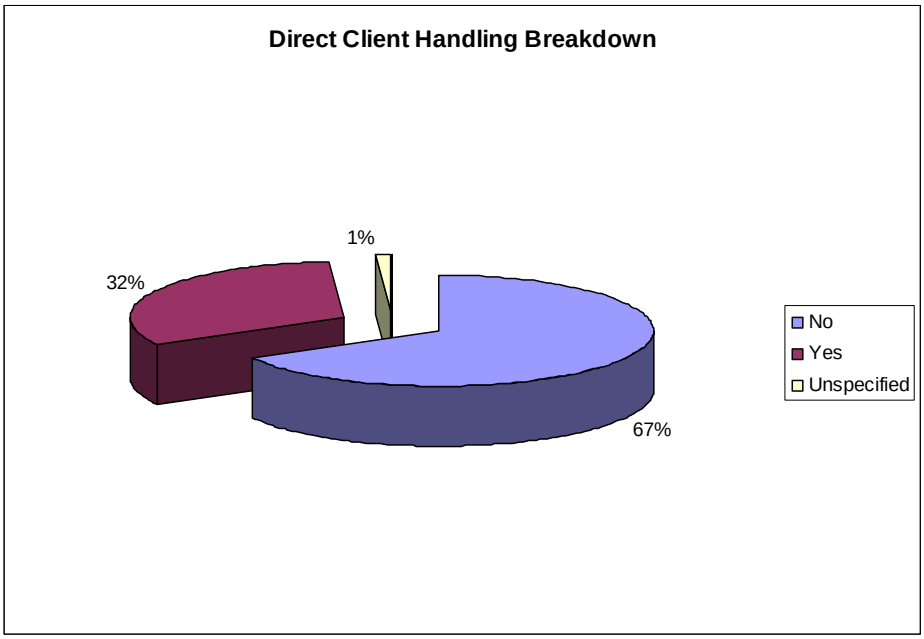

Figure 26 – Injuries involving direct client handling (n = 1848)

Figure 26 shows that 32% of all carer injury reports (n = 1848) in the sample involved direct client handling as a contributory factor to the carers injury. It should be noted that this is representative of both the nature of the carers role and the specific sample analysed in this research. A further 67% of injuries in the overall sample did not involve direct client handling.

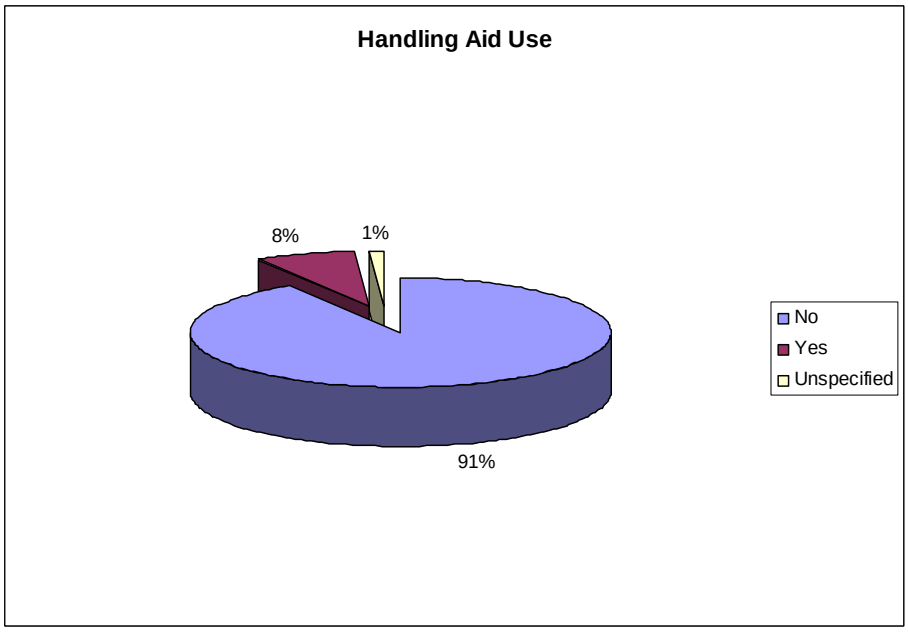

Figure 27 – Use of handling aids

Figure 27 represents the number of injuries where the use of a handling aid contributed to the injury sustained (n = 1848). The majority of injuries in the sample (91%) did not involve use of a handling aid, whilst only 8% of injury reports implicated the handling aid.

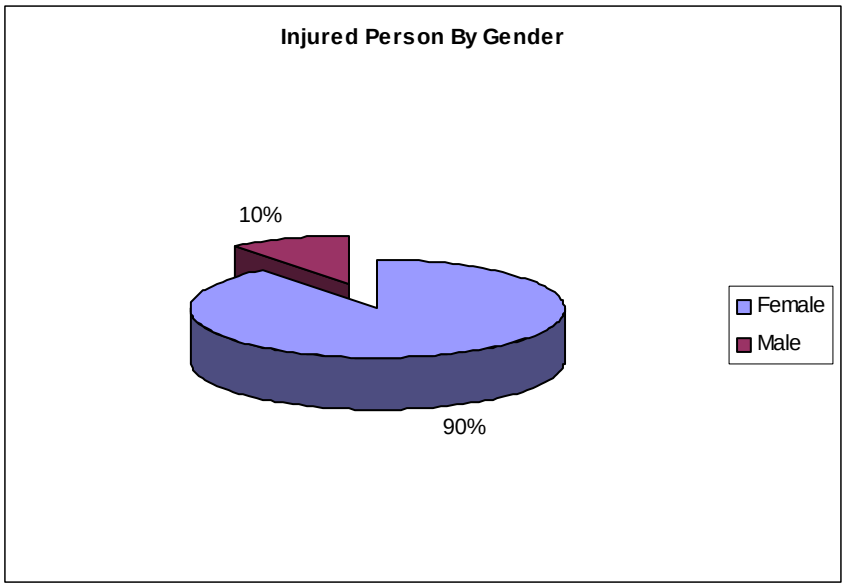

Figure 28 - Breakdown of injured person by gender

Figure 28 represents the gender breakdown of the injured persons (i.e. the carer) in the overall sample (n = 1848). The majority of injuries were sustained by females, with 90% of the total sample of 1848. It should be noted that this might be representative of the disproportionate numbers of female to male carers.

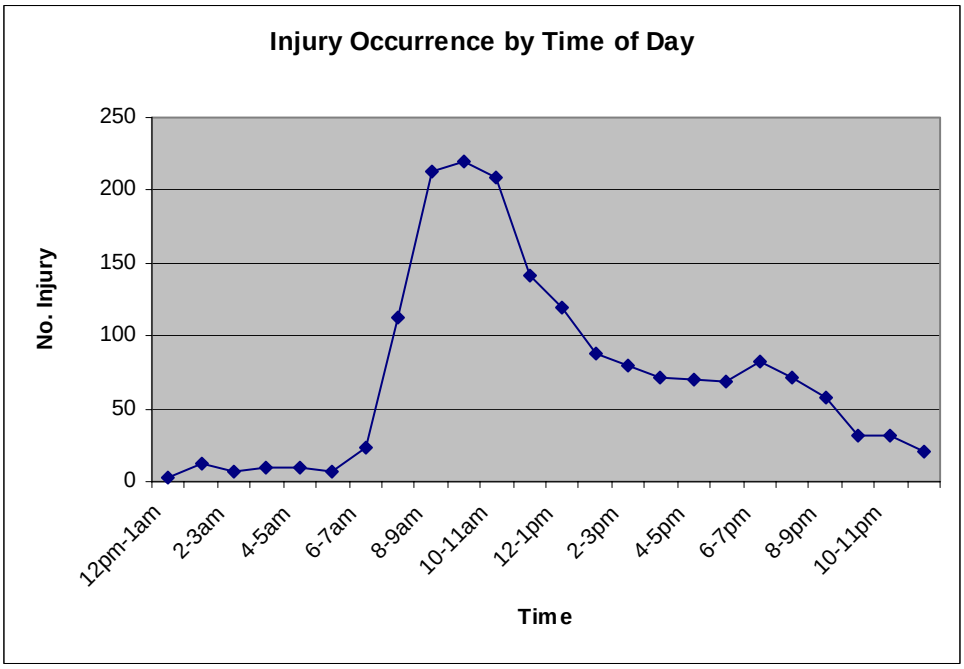

Figure 29 – Injury occurrence throughout the day

Figure 29 represents the pattern of injury occurrences throughout the day, according to the sample (n = 1756[1]). The main trend observed is the fairly constant and low level of injury early morning, which is compounded by a sharp increase in injuries from approximately 6am to 8am and a peak between 8 and 11am, a timeframe when 642 injuries were sustained. A second smaller peak can be observed between 6 and 7pm when 82 injuries were reported.

[1] *A further 92 of injury reports from the sample were not included due to a lack of 'time' data in the RIDDOR reports.*

4 DISCUSSION

Recent years have seen an increase in the number of reportable injuries to employees in the health services. The Labour Force Survey (LFS) showed a reported 11% increase in reportable injuries to employees in the Health Services between 2000-2002. Whilst in 2001/02 and again in 2003/04 the Self-reported Work related Illness survey (SWI) found employees in health and social care reported a higher than average prevalence rate for injuries caused or 'made worse' by their job.

4.1 DATA

The aim of this analysis was to identify trends or common risk factors in care assistant injuries. Data was selected from RIDDOR entries focussing on care assistants as reported to HSE in 2002/03.

The data reported to HSE through RIDDOR classifies incident types as mutually exclusive (i.e. as either a handling or violent incident). For the purposes of this analysis additional information provided in the 'notifier comments' section of the RIDDOR entry was utilised in order to ascertain, where possible, information regarding all potential contributory factors to each incident.

Some RIDDOR reports may have been relevant and therefore analysed under more than one category; however, this was believed to be an accurate reflection of the contributory nature of numerous factors.

4.2 INJURY TRENDS ACROSS THE WHOLE SAMPLE.

The analysis found that between 2002/03 handling injuries were the most commonly reported injury type for carers to HSE (under RIDDOR). This was followed by slip and trip injuries and then violent injuries. It is believed these results reflect the nature of the carers' role, with the high prevalence of handling injuries attributable to the client's reliance on the carer for extensive assistance in a number of tasks. The risk to carers of sustaining handling injuries is currently recognised, with production of targeted versions of HSE guidance (see Manual Handling in the Health Services, HSE Books, 1998).

It is believed that slip and trip injuries are common due to the increased movements of the carers, again a reflection of the nature of their role. Whilst a number of carers in the sample work within care homes, others were community based. The high rate of slip and trip incidents may therefore relate to this type of job role, working regularly in unfamiliar environments. The violent injuries incurred by carers were believed to result from the frequency of carer-client interaction, as well as the increased likelihood that clients requiring the assistance of a carer may have disabilities that lead to their behaviour being unpredictable and potentially violent.

Results of the RIDDOR injury report analysis show that a consistently high percentage of injuries were classed as either 'Other' or 'Unspecified' by the researcher. This is considered to be an accurate reflection of the limitations of using RIDDOR report descriptions, where many entries do not contain adequate information for these judgements to be made.

4.3 TRENDS ACROSS HANDLING INJURIES

A clear trend was seen in carer's handling injuries, where lifting and supporting weight was a common injury cause. This was followed by injuries caused by client falls, and unexpected movements of the clients or objects. The movement of the carer was also a relatively common

cause of injuries. All of these factors can be classified as physical work factors. The analysis also demonstrates that the most prevalent underlying causes of handling injuries to carers were lifting or supporting weight, the unpredictable nature of the clients' behaviours, and the movements or behaviours of the carers. This was compounded by the unpredictable nature of client behaviour.

Reportedly, only 7.5% of handling injuries incurred by carers were judged to result from a failure to follow procedures.

Carers tended to sustain handling injuries whilst assisting, attending, or moving clients. This finding is potentially attributable to the specific circumstances and responsibilities of the carers' role (i.e. clients dependence on their carers).

The majority of handling injuries (79%) resulted from activities where direct handling interaction between the carer and the client was involved. Handling injuries were most prevalently sustained within the care home, most often in the bedroom. Data on the location of the injury was, however, severely limited in the RIDDOR reports which reduces the accuracy and generalisability of this finding.

Despite the high number of handling injuries there was a degree of ambiguity associated with some handling injury reports. It is believed this is due to the nature of handling injuries where the exact cause may be difficult to identify. It is possible that handling incidents are the most likely to be inaccurately coded, and even the initial entry into RIDDOR is open to some amount of personal interpretation.

It was noted that numerous reports mentioned that the injured person (IP) did not go home sick immediately, but instead completed their shift before calling in sick the next day. It is possible that carers feel under pressure to finish their shift, at the same time compounding the injury sustained. However it is possible this is an inherent characteristic of this type of injury.

Carers are consistently considered to be at risk from sustaining handling injuries. Therefore interventions aimed at alleviating or improving carer movements, client falls and unpredictable client behaviour would be most likely to result in an appreciable decline in handling injuries. Further analysis would be required in order to determine the mechanism for this.

4.4 TRENDS ACROSS SLIP INJURIES

Clear trends were also seen for the precursors to slip or trip injuries, with specific underlying causes for each. Slip injuries tended to be caused by wet surfaces out-doors, primarily caused by rain or ice. Wet leaves and loose gravel, wet floors following cleaning activities and spills were also common causes of slip injuries. This also reflects the relatively high incidence of slip injuries in kitchens, on stairs, and out-doors.

The carer tended to be at most risk from a slip injury whilst 'walking/running' (i.e. during activities which did not primarily involve client handling) or assisting to a client. This analysis of carer's slip injuries has not identified risk factors specific to the care home environment However, this may, more accurately, be a reflection of the limited level of detail contained within the RIDDOR 'notifiers' comments' section.

Slip injuries are a recognised area for general targeting of interventions. It is likely this prevalent number of slip injuries is not specific to the care assistant job role and are similar to those seen in other places of work. Existing interventions may therefore already exist which could be employed.

4.5 TRENDS ACROSS TRIP INJURIES

Trip injuries tended to result from obstructions or inadequate maintenance, such as electrical leads, doorstops, chairs, laundry/rubbish, loose carpets, damaged fencing or loose manhole covers, uneven ground and potholes. Also, the injured person missing or losing their footing was a relatively common cause of trip related injuries. Within care homes most trip incidents occurred in the bedroom or outdoors, whilst visiting client's homes, most trip incidents occurred outdoors.

The carer tended to be at most risk from a trip injury whilst walking or running (i.e. during activities which did not primarily involve client handling).

4.6 TRENDS ACROSS VIOLENT INJURIES

A clear trend was seen with the analysis of violent injuries sustained by carers. These injuries tended to result from physical attacks, or unexpected movements of clients or objects, the vast majority of which were compounded by unpredictable client behaviours. Carers were at most risk from sustaining a violent injury whilst assisting or attending to a client or trying to restrain them. These risk factors are all primarily associated with the nature of both the carers' role and the nature of the clients residing in care homes. It is also important to highlight that 5% of violent incidents occurred outside of the care home from the public. Violence is therefore an issue which is not only associated with clients. Whilst interventions targeted at violence from clients is likely to be the most efficient, this additional aspect should not be overlooked.

The large majority of violent injuries occurred within the care home. Where more detail was available these injuries tended to occur in the bathroom, a trend potentially due to the increased interaction between carer and client within a bathroom situation.

A number of reports suggest the potential for the client to behave violently was recognised prior to the incident, through the application of a risk assessment. This raises the question of how adequate the risk assessment process was and how well the actions identified to minimise the risk were implemented.

Whilst it is expected that the emergent trends regarding handling and slip or trip injuries to carers would be generally consistent across care homes, it is suggested by the researchers that further analysis of violent injuries to carers could potentially identify care homes and therefore a subset of carers who are at increased risk of sustaining violent injuries, information key to developing highly targeted, efficient interventions.

The Health and Safety Executive (HSE) defines work-related violence as 'any incident in which a person is abused, threatened or assaulted in circumstances relating to their work'. However, due to the information source and method used, there was no way of capturing instances of verbal abuse. For the purposes of this project only physical violence was considered. Serious or persistent verbal abuse can be a significant problem, potentially leading to anxiety or stress and eventually low staff morale and high levels of turnover (HSE, 2006). Therefore a method of analysis that makes provision for the non-physical factors would give a more accurate picture of the current situation.

4.7 OTHER FINDINGS

Overall findings showed that unsurprisingly, the majority of incidents implicated direct client handling as a precursor to carer injury. However, only a small percentage of injuries implicated the use of a handling aid. Additional information regarding frequency of handling aid use is required to put this finding into context (i.e. identify whether the low levels of handling aid-

related injuries are a result of low usage, or whether this method is an efficient injury prevention aid).

Findings showed more carer injuries were sustained by female carers; however, this is attributable to the disproportionate number of female to male care assistants employed in this profession. The time of day data demonstrated two peaks throughout the twenty-four hour period. Perhaps unsurprisingly the injury rate began to rise sharply from approximately 8am, peaking at about 11am. Another small peak occurred at approximately 6pm. It would seem logical to assume that this finding relates to times of increased activity for care assistants. However, this is not necessarily identifiable due to the level of detail used in the notifier comments. This finding may also be due to the nature of care work, where nighttime activities may be minimal (i.e. supervisory roles).

4.8 LIMITATIONS

Information reported to RIDDOR is primarily to monitor a company's performance and was not originally intended for such a detailed analysis employed here. Therefore inadequate information in the RIDDOR reported injuries are to be expected.

Although the RIDDOR report sample used in this analysis has been invaluable for identifying risk factors for carer injuries, the nature of RIDDOR reports meant this is not a sensitive enough tool for capturing certain aspects of injuries such as verbal violence, and non-physical injuries such as anxiety that may be useful in informing future interventions.

Due to the low level of sensitivity, it is possible that some incidents coded as having occurred in a (residential) care home might actually have occurred in a day centre. It was decided to include these entries in the ensuing analyses due to the assumption that there was some commonality in environments, and therefore in the relevant interventions.

Instances were identified by the researcher where seemingly similar incidents were not coded consistently by HSE (through RIDDOR). For example a seemingly violent injury was coded as a handling injury. It is possible this is the result of the different accounts received by the 'inputer', however, for the purposes of internal consistency within this project the 'reviewer' (researcher) made a judgement based on the 'notifiers comment' text and the alternative information available.

In some of the more ambiguous RIDDOR reports where the correct classification of the incident was unclear, it is worth considering that the final coding applied by the researcher may have been affected by the nature of the language used in the 'notifier comment' (i.e. whether there were aggressive or 'accidental' overtones). For example whether an injury incurred whilst handling a violent client was primarily associated with the violence or the handling.

Apart from the potential presence of personality-based differences in the RIDDOR report compilation, no standard terms are consistently used in RIDDOR reports of injuries. Therefore, in an attempt to uphold consistency, the researcher attempted to interpret and code the meaning behind the entry as well as the surface level incident report.

The nature of the sample means that the results could be drawn from limited sources. RIDDOR reported injuries rely on companies conforming to the RIDDOR regulations (1995). As is widely recognised (see Daniels and Marlow 2005) under-reporting of incidents to RIDDOR is a recognised occurrence, and therefore it should be considered that the RIDDOR sample used in this analysis is not exhaustive.

Some of the analyses are based on small sample sizes when the data is broken down into subsets (e.g. see Figure 5 showing a breakdown of handling injuries in care homes). Similarly, the validity of the generalisations is further reduced when breaking down the sample by injury types, and generalising from such small numbers of incidents is not prudent.

Due to the method of analysis, some RIDDOR reports may have been analysed under more than one category (injury type). However, this was believed to be an accurate reflection of the contributory nature of numerous factors.

4.9 RECOMMENDATIONS

- RIDDOR is not a sensitive enough tool for capturing certain aspects of injuries such as verbal violence, and non-physical harm such as anxiety. Therefore to provide a clearer picture of contributory factors to care assistant injuries the results of the present analysis should be considered in combination with further, more detailed work.

- Inclusion of care assistants in a qualitative data collection setting would increase the validity of the current analysis through the provision of additional details regarding high-risk tasks or clients. This methodology would also allow data to be collected on issues not covered by RIDDOR, such as verbal violence, stress and anxiety. Additionally, care assistants could be questioned about what interventions could be realistically applied to their jobs.

- A consideration of the frequency and other factors affecting violent injuries to carers would help to identify if there were specific care homes, and therefore a subset of care assistants who were more at risk of sustaining violent injuries.

- As violence has been identified as a relatively prominent issue for care assistants, training or information covering this issue may be beneficial. This should consider covering issues relating to violence from the public, such as lone working.

- The Health and Safety Executive (HSE) has produced guidance on violence (for an example see: 'Violence and aggression to staff in health services – Guidance on assessment and management', 1997: HSE Books), handling injuries (for an example see: 'Manual handling in the health services', 1998: HSE Books) and slip and trip injuries (for an example see: 'Slips and trips: Guidance for employers on identifying hazards and controlling risks', 1996: HSE Books). A review of this guidance may provide interventions relevant to the care assistant setting.

- Encouragement of good housekeeping within care-homes and client's homes is also recommended. This is because slip and trip injuries often appeared related to poor housekeeping (a major cause of trips was obstructions, such as rubbish bags, and a major cause of slips was wet floors). As many slip injuries were incurred outdoors, further research would be required to identify interventions for this environment.

5 APPENDIX 1 - CODING RATIONALE

The data was received from Heather Wake, HSE who selected the RIDDOR entries using the search terms 'injuries to care assistants', 'employed by local authorities', in 'health and social care', as reported to HSE in 2002/03.

The sample of carer injuries had already been reported to HSE under RIDDOR. Therefore they were already coded according to who the local authority was, site of the injury (i.e. body part), nature of the injury, age of the injured person (IP), kind of incident, gender of the IP, and a short description of the incident (i.e. 'notifiers comments').

In order to draw out as much detail as possible HSL performed a second coding of the entries based on the following criteria.

Injury: Location

Injury reports were analysed, and where appropriate were categorised according to where the injury had taken place: in the care home, a clients home, a day care centre or 'other'. The category 'care home' also includes incidents occurring at nursing homes, which are not easy to distinguish between from RIDDOR descriptions.

Injury: Specific location

This question broke down the location into sub categories to provide more detailed information. The options here included: bathroom, kitchen, office, on stairs, transport or outdoors.

Direct Client handling

This question aimed to distinguish injuries that had occurred as a result of, or in circumstances where the carer was involved in activities which require direct contact (most often physical) with the client. This was classified simply by selecting 'yes', 'no', 'indirectly' or 'unspecified', and was based on an assessment of the information available.

Injury: Activity

The analysis then focused on the activity that the carer was involved in when the injury was sustained.

Assisting/Attending - this refers to activities where the carer is directly involved with the client, usually as part of the general duties of their role.

Bed Making/ moving – cleaning or maintenance-type activities which specifically relate to client beds. This is an activity specifically relevant to the role of carer in a care home.

Clean/ Maintenance – this refers to general cleaning or other maintenance activities (not including bed-related activities). (This category was used to cover injury reports where the IP may not necessarily have been a carer).

Door-related – injury reports where a door or doorway was involved were categorised as 'door-related'. (For examples where a door and a trolley were implicated a judgement was made as to the factor having the most affect over the injury occurrence).

Dressing – this refers to injuries incurred whilst the carer and client were interacting in dressing-related activities.

Escorting – escorting refers to injuries which have occurred whilst the carer is 'passively' escorting a client somewhere (where direct physical handling of the client is not required).

Food/drink related – refers to injuries incurred whilst the carer is working with food or drink, either through supervising clients who are eating, or from physically preparing, cooking or serving the food/drink. Injuries incurred whilst transferring food, (where the food was not directly linked to the injury) specifically when using a trolley were classified as 'trolley-related'.

Hoisting – this involves the set up and movement of the client and hoist, and includes adjusting or application of the harness.

Moving client – refers to incidents where the client is unable to move themselves either due to their level of disability or following a fall. (These injuries did not include those incurred whilst working with a hoist, and were predominantly of the 'handling' variety.

Other – this refers to activities which do not fit into any of the other categories mentioned.

Recreational – refers to injuries incurred during activities such as sport, art or cooking lessons. The carer was generally acting in a supervisory role (as opposed to physically handling a client).

Restraining client – this category was selected for injuries incurred whilst restraining the client, usually following a violent incident (a later category attempts to define whether the violence was directly or indirectly aimed at the carer).

Training – a small number of injuries were sustained during training, and were categorised as such.

Transfer – this refers to injuries incurred whilst moving the client between any combination of wheel chair, bed, hoist or commode. This was defined separately from moving client or hoisting due to the prominence of injuries during this specific activity.

Trolley-related – refers to injuries incurred due to the carer being involved in activities where a trolley was utilised. These activities mostly included cleaning or food transfer, where trolleys were used to move items or equipment around. These activities did not usually involve direct contact with clients.

Unspecified – this category was selected in cases where insufficient information was available to make an accurate judgement.

Walking – this refers to injuries incurred whilst the carer was not involved in any specific activity (or where the activity was not specified in detail) i.e. a slip on the stairs where there was no mention of a client being present, or an unexpected physical attack from behind where no specific details are given.

Injury: Cause

The analysis then focused on the initial cause of the injury.

Animal – a small number of injuries were caused by an animal attack (usually whilst on a visit to a client's home, or whilst running errands for a client.

Bending down/ over – this refers to injuries sustained where the carer bending was implicated in the injury.

Client fall: caught – refers to instances where an injury has been incurred following a client fall. In most cases the carer has acted instinctively to save the client, or unexpectedly taken the clients full weight, thus sustaining the injury.

Client fall: fell into – this refers to instances similar to those above, but where the injury was caused by the client falling into or on top of the carer.

Equipment-related – this injuries occurred directly as a result of interaction between the carer and a piece of equipment. In most cases this referred to instances where the equipment (i.e. a hoist or other handling aid) failed (i.e. collapsed) resulting in the injury to the carer.

Fall: height – a fairly small number of injuries were caused by a fall from a height. This does not include falls down stairs, but refers to falls from tables or chairs (after climbing on top of them).

Heat/Irritant – the majority of injuries resulting from contact of the carer with excessive heat or an irritant usually resulted in injuries such as burns, allergic reactions or soap in the IPs eye, and were classified as such.

Lifting/ supporting weight – this referred to injuries sustained following the carer being involved in lifting or supporting the client's weight. This was relevant in some cases following a client fall or failure of equipment whilst moving a client.

Other – this refers to causes which do not fit into any of the other categories mentioned.

Overreach incl. Twisting – this refers to injuries which resulted from the carer straining themselves through either twisting or reaching. This cause was commonly associated with dressing clients.

Physical attack – this refers to injuries that resulted from a physical attack by the client on the carer. (For more detail the results of this question should be analysed in conjunction with the 'Violent incident' question, below).

Slip – this refers to injuries sustained following a slip. (For more detail see 'slip/trip' question, below).

Trip – this refers to injuries sustained following a trip. (For more detail see 'slip/trip' question, below).

Unexpected movement: Client – this refers to incidents where the client has moved or behaved in an unexpected way, resulting in injury to the carer.

Unexpected movement: Object - this refers to incidents where an object has moved or behaved in an unexpected way, resulting in injury to the carer. (These incidents did not usually involve direct client handling, and injuries were usually sustained whilst the carer was involved in non-client handling activities).

Violence from the public – This referred to incidents of violence from specifically from the public, rather than clients.

Unspecified - this category was selected in cases where insufficient information was available to make an accurate judgement.

Injury: Underlying Cause

The analysis then focused on the underlying cause of the injury.

Alcohol – a small number of injuries (predominantly violent attacks) were caused by intoxication of a client or young person.

Distraction – a small number of injuries were the result of a distraction to the carer, usually during a lifting or moving activity.

Fall (from chair) – this underlying cause mostly relates to cases where a fall from height was caused by the IP climbing onto chairs or a table.

Inadequate maintenance – this refers mainly to injuries occurring out doors such as slips or trips that resulted from loose or broken manhole covers, pavements, or overgrown shrubbery.

Inadequate procedure – this refers to incidents where it is clearly stated that the procedure was adhered to, but where following the incident and reassessment procedures were updated.

Leaves/ gravel – this refers to injuries occurring out doors such as slips and trips, mainly during visits to client homes or whilst helping in 'transport' activities.

Lifting/ Supporting weight – This category also appears as an initial cause, and was used as an underlying cause in instances where another more prevalent factor was responsible for the initial cause of the injury.

Movement/ behaviour of IP – this category referred to incidents where the IP's movement or behaviour has a contributory cause of the injury. (This does not include instances where the procedures were not followed – see below), but instead refers to instances where the IP's actions led to the incident.

Obstruction – this relates to trip injuries which resulted form obstructions such as equipment, machinery, hoists or clients' body parts.

Other - this refers to underlying causes which do not fit into any of the other categories mentioned.

Procedure not followed – this refers to incidents where injuries were directly related to the carer failing to follow the prescribed procedure.

Spill – this refers to spilled substances such as food or urine, (not including water during cleaning, see below) usually contributory causes in slip injuries.

Unpredictable client behaviour – this refers to the element of lack of control which a carer has over the client. This was implicated in a number of handling and violence-related injuries.

Wet surface – This referred to incidents where a flooring surface was wet from conditions such as rain or ice, but not from spills or due to cleaning activities.

Missed or lost footing – This referred to incidents where the injured person fell and the cause was them losing their footing missing a step.

Restricted space – This referred to injuries which appeared to have been caused due to a way of working which was adopted purely due to the limitation of space within an enclosed environment (e.g. a bathroom).

Lack of attention – This referred to injuries which were caused by a lack of attention by the injured person.

Client's physical/mental condition – This referred to injuries which appeared to have been caused by the physical or mental condition of the client.

Dark/ no lights – This referred to injuries which appeared to have been caused by lack of lighting.

Height/ width of object – This category referred to injuries which appeared to have been caused by objects that were high or wide, generally relating to overstretching injuries.

Unspecified - this category was selected in cases where insufficient information was available to make an accurate judgement.

Wet floor (post cleaning) – this refers to wet surfaces following cleaning which were commonly a contributory factor in slip injuries.

Handling Aid

The analysis then looked at whether a handling aid was implicated in the incident. This was categorised as either 'yes', 'no', 'indirectly' or 'unspecified', dependant on the information supplied in the report. Where option 'yes' was selected more detail was provided in the next question, see below.

Handling Aid Type

Following the above stage of analysis, where mentioned in the injury report, the handling aid type was recorded.

Slip/ Trip?

The analysis then looked at whether the injury had resulted from a slip or trip. This was categorised as either 'yes', 'no', 'indirectly' or 'unspecified'. The 'indirectly' option was selected where a client's slip contributed to the injury to the carer. It was considered as useful in this unusual situation where carers spend a large proportion of their time caring for clients, some of whom are unsteady on their feet, and are also greatly affected by any slips or trips the client is involved in.

Violent incident?

The analysis then looked at whether the injury had resulted from a violent incident. This was categorised as either 'yes', 'no', 'indirect intervention' or 'unspecified'. The 'indirect intervention' option was selected where a carer was injured following intervention in a violent situation, but where the violence was not directly concentrated at the carer. It was considered as useful in this unusual situation where carers may be required to intervene in a semi-violent situation, or may be involved in caring for clients who are agitated or frustrated.

Correctly identified as handling incident?

As explained above, the data was already classified when received by HSL. The final analysis carried out on each injury report was to identify whether the HSL analysis was in agreement with the original (RIDDOR) analysis categorisation. The options 'yes', 'no', 'indirectly', 'unspecified', or 'agreed: not handling injury' were available and related to whether the original classification was agreed to be accurate. Therefore option 'no' meant that the original category

was not agreed with, and so the resultant analysis was able to consider injuries that were thought by one party to be a specific type of injury, even if the second party was not in agreement.

The categories explained above resulted from the customer's requirements and were generated from the details given in the injury reports supplied. Every effort was made to categorise injury reports accurately, but due to the nature of some reports, best judgements were made on the available information.

6 REFERENCES

Daniels, C. and Marlow, P. (2005). Literature Review on the Reporting of Workplace Injury Trends. HSL Report RMS/05/03.

HSE. (1996). Slips and trips: Guidance for employers on identifying hazards and controlling risks: HSE Books.

HSE. (1997). Violence and aggression to staff in health services – Guidance on assessment and management: HSE Books.

HSE. (1998). Manual handling in the health services: HSE Books.

HSE. (2006). Work-Related Violence. http://www.hse.gov.uk/violence/index.htm.

Health and Safety Commission/Health and Safety Executive. (2003). Health and Safety Statistical Highlights 2002/03. National Statistics (UK).

RIDDOR Explained - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. In RIDDOR Explained. (2003). Health and Safety Executive: HSE Books.

7 GLOSSARY

HSE = The Heath and Safety Executive

HSL = The Health and Safety Laboratory

IP = Inured Person

LFS = The Labour Force Survey

PSP = Public Services Programme

SOC = Standard Occupation Classification

SWI = Self-Reported Work Related Illness