Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# PWYLLGOR IECHYD A DIOGELWCH
# HEALTH & SAFETY COMMITTEE

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| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 11 September 2023 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Waste Management Policy |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Andrew Carruthers, Director of Operations |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Terri Shaw, Senior Environmental Officer |

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)
**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The Waste Management Policy is due for review by October 2023; however, the Health and Safety Committee is asked to approve an extension of 6 months to the current policy (https://nhswales365.sharepoint.com/sites/HDD_Environment/_layouts/15/viewer.aspx?sourcedoc={4f7e61f9-d020-4618-9563-cb38a6bd6cf2}) to enable the Health Technical Memorandum (HTM) review to be completed in Wales to enable any changes to be reflected in the updated Health Board's Waste Management Policy.

## Cefndir / Background

The HTM 07-01 'Management and disposal of Healthcare waste' is the main source of guidance to inform the Health Board's Waste Management Policy. This guidance has recently been reviewed in England and is currently under review in Wales. NHS Wales Shared Services Partnership (NWSSP) have advised that they anticipate this review will be completed by mid - September however this could take longer.

## Asesiad / Assessment

The current Waste Management Policy is compliant with the current HTM 07-01 and is still fit for purpose however would benefit from waiting for the outcome of the HTM review in Wales before it is updated.

## Argymhelliad / Recommendation

An extension of 6 months is requested to enable the HTM review to be completed in Wales and any changes to be reflected in the updated Health Board's Waste Management Policy.

The committee are asked to:

- Note the position and approve the extension request for 6 months.

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 2.1 Provide assurance around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers contractors etc.<br><br>3.16 Approve organisational health and safety policies, procedures, guidelines and codes of practice (policies within the scope of the Committee). |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | 551<br>8 |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 2.1 Managing Risk and Promoting Health and Safety |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 6. Sustainable use of resources |
| Amcanion Cynllunio<br>Planning Objectives | Not Applicable |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | HTM 07-01 'Management and disposal of Healthcare waste' |
| Rhestr Termau:<br>Glossary of Terms: | N/A |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd lechyd a Diogelwch:<br>Parties / Committees consulted prior to Health and Safety Committee: | N/A |

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
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| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | No direct impact |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | No direct impact |
| **Gweithlu:**<br>**Workforce:** | No direct impact |
| **Risg:**<br>**Risk:** | No direct impact |
| **Cyfreithiol:**<br>**Legal:** | No direct impact |
| **Enw Da:**<br>**Reputational:** | No direct impact |
| **Gyfrinachedd:**<br>**Privacy:** | No direct impact |
| **Cydraddoldeb:**<br>**Equality:** | No direct impact |

# Waste Management Policy

## Prevention, Safe Handling, Sustainable Disposal

| Policy Number: | 258 | Supersedes: | - | Classification | Corporate |
|---|---|---|---|---|---|

| Version No | Date of EqIA: | Approved by: | Date of Approval: | Date made Active: | Review Date: |
|---|---|---|---|---|---|
| V3 | | PPPAC | 29/10/2020 | 9/11/2020 | 29/10/2023 |

| | |
|---|---|
| Brief Summary of Document: | Health Board arrangements for the segregation, handling and disposal of waste |
| Scope: | All staff and services employed or contacted by the Health Board |
| To be read in conjunction with: | 190 – Written Control Documentation Policy<br>172 – Confidentiality Policy<br>093 – FP14/03 Procedure for the disposal of surplus and obsolete furniture and equipment, the sale of scrap and other waste materials<br>390 – Infection Prevention and Control Policy for the Cleaning and Decontamination of Equipment Prior to Inspection, Servicing, Repair of Disposal<br>187 – Exposure management including needlestick (sharps) injuries policy and procedures<br>236 – Outbreak Management Policy<br>273 – Manual Handling Policy |

| Owning Committee | Capital Estates IM&T Sub-Committee Approved: 6.6.2020 | | |
|---|---|---|---|
| Executive Director: | Karen Miles | Job Title | Director of Planning Performance & Commissioning |

| Reviews and updates | | |
|---|---|---|
| Version no: | Summary of Amendments: | Date Approved: |
| 1 | New Policy | 21.06.2012 |
| 2 | Additional information on disposal processes, information on minimisation and reuse, information on the disposal of waste from treating patients at home, sign posts to supporting downloadable content. | 10.2.2017 |
| 3 | Full review (lead by Terri.shaw@wales.nhs.uk)<br>Minor changes only | 29/10/2020 |

| Keywords | Waste management |
|---|---|

## CONTENTS

## 1. Introduction

This document aims to describe in a user friendly and concise manner, the policy and correct procedures for managing all waste types produced as a result of the activities and services of Hywel Dda University Health Board.

## 2. Policy Statement

Hywel Dda University Health Board are committed to managing wastes arising in accordance with Welsh Government strategy, current legal and other requirements and, as far as reasonably and economically practicable, the principles of the Waste Management Hierarchy in order to continually improve the organisations environmental impacts.


Figure 1: Waste Management Hierarchy

## 3. Scope

This document applies to all waste produced by the Health Board in relation to the services it provides and activity on organisational premises. All Health Board employed and contracted staff must be made aware of this policy and act in accordance with its requirements.

## 4. Aim

The purpose of this document is to ensure there are rigorous processes in place to allow waste to be managed safely and sustainably, in line with Welsh Government strategy and current legal and other requirements.

## 5. Objectives

In order to achieve its aim, this document will;

- Detail safe and correct segregation, handling, transportation and disposal practices
- Signpost systems to manage compliance with legal and other requirements
- Specify training and auditing requirements
- Highlight best practice action to facilitate continual improvement

## 6. Waste Management Procedure

### 6.1 Prevention

Waste is legally defined as;

'....any substance or object which the holder discards, or intends or is required to discard...'

The top tier of the waste hierarchy details action to be taken before an object becomes waste. Prevention is a key concept in healthcare delivery and sustainable services. In waste management this benefits the organisation by avoiding the costs and impacts of unnecessary purchasing as well as those linked to waste disposal. There are many ways we can all minimise waste generation and all staff should consider;

- Long Term Thinking – Quality over Quantity; Paying a higher price for a quality item that will last longer is often more time, resource and cost efficient. We have to consider the lifecycle of our purchases.

- Genuine need; Does your department undertake stock control? Do we need to buy new items when we already have usable but older products? We should replace when we need, rather than want to. Guidance on replacing items is given through our specialist teams which include Infection Prevention and Control, Manual Handling, Health and Safety, EBME and Maintenance.

- Is there an alternative? Can we use reusable rather than disposal products? Mains instead of battery charged?

- Can we collaborate? Do we need to purchase items what we use occasionally? Caught out by minimum purchase quantities? Use staff networks and communication tools to find out if other individuals or departments are in the same position and can share quantities or costs.

### 6.1.1 The role of Procurement

When you need to replace an item, schedule time to talk with Procurement colleagues that are here to help and to;

- Advise on different options, alternatives available, delivery consideration etc

- Check on the services suppliers should be providing us, such as take back schemes on items and packaging.

- Signpost items that have standardised lists on Oracle, such as pedal bins

To help make your decision, a Purchasing Checklist is available in the downloadable content linked to this policy on the intranet.

## 6.2 Reuse

Many items are, and should be, disposed of when they are no longer fit for purpose. However many items are currently put out for disposal when they are no longer required, but could still be of value to others both within the Health Board and beyond.

Known barriers to reuse include the time needed to look at other options and make plans, sometimes short timescales to make a change and a lack of storage space. It is imperative that action supporting reuse is taken as soon as possible once an item has

been identified as surplus to requirements. Table 3 provides information on when action can be taken to reuse a product. This includes as a minimum;

- Advertising on the staff bulletin board
- Using email distribution lists to advertise with colleagues and departments on your own and other sites
- Contact the Environment Team to identify potential options
- WARP IT

Need support transporting an item? Contact the Central Transport Unit (CTU) for advice.

## 6.3 Waste disposal options

**Table 1 – Options for waste disposal**

| Disposal Option | Description | Example wastes |
|---|---|---|
| **Anaerobic Digestion (AD)** | Breakdown of biodegradable waste creating fertiliser and energy from waste | Food<br>Biodegradable wastes |
| **Alternative Treatment** | Treatment by heat, chemicals or irradiation to render clinical waste safe | Orange clinical bags |
| **Composting** | The decomposition of biodegradable solid waste | Food<br>Biodegradable wastes |
| **Energy From Waste** | Creating energy (electricity or heat) from the treatment of waste | Various |
| **Incineration** | Combustion of waste at high temperatures (between 800 – 1100ºC) | Medicines<br>Purple / Yellow Sharps<br>Hazardous Waste |
| **Landfill** | Burial of waste in the ground. Some wastes require burial at a deeper level, or in a specially licensed landfill | Domestic<br><br>Hygiene (deep landfill)<br>Hazardous Waste |
| **Recycling*** | Processing of waste to make new products | Paper<br>Plastics<br>Cardboard<br>Glass<br>Metals |

* Note some wastes sent for recycling, e.g. confidential waste, will be expensive to dispose of

## 6.4 Segregation, Storage and Disposal – Clinical Healthcare Waste

Table 2 has been complied in line with 'HTM 07 01 - Safe Management of Healthcare Waste'. These are wastes which are segregated because they may prove hazardous to persons coming into contact with them. They must be segregated, stored and disposed of safely.

**Table 2- Summary of the segregation, storage and disposal of Clinical Healthcare Waste**

## Clinical Healthcare Waste

**--- Clinical waste is defined as: "*any waste which consists wholly or partly of human or animal tissue, blood or other bodily fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with*" ---**

| Waste type | Description | Correct storage/disposal method |
|---|---|---|
| **Potentially infectious and known infectious waste**<br><br>**EWC: 18 01 03*** | Examples:<br><br>Waste from patients treated in isolation<br><br>Dressings wound packs, soiled bandages, swabs, wound drains, suction containers, used chest drains and central lines.<br><br>Items contaminated with blood. | Discard into UN approved orange bags, which must be clearly labelled or tagged.<br><br>  <br>**ORANGE BAG**<br><br>These bags must be transferred to a designated wheelie bin or storage cupboard that is appropriately colour coded and/or labelled.<br><br>Disposal by Alternative Treatment. |
| ------- *Please see the Table 3 (Non Clinical Healthcare Waste) for information on the disposal of non infectious hygiene waste disposed of in tiger stripe bags* ------- | | |
| **Sharps (non hazardous medicines)**<br><br>**EWC: 18 01 03* / 18 01 09** | Sharps, which have been used to administer medicinal products (not Cytotoxic or Cytostatic)<br><br>Examples:<br><br>Needles, ampoules, vials, medicinal IVs, tonsillectomy equipment<br><br>Larger metal items used in clinical procedures e.g. | Discard into UN approved rigid sharps boxes with yellow lids. The label must be signed when the box is assembled.<br><br>  <br>**YELLOW LIDDED SHARPS BOX** |

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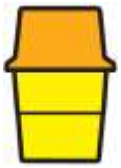
| | replacement hip joints, should also be disposed of in these containers if clinical metal recycling is not available. | When full to the line, or open over 3 months, the box must be locked and the label completed in full.<br><br>These containers must be taken to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>Disposal by Incineration. |
| **Sharps (non-medicinal)**<br><br>**EWC: 18 01 03*** | **Sharps which have <u>not</u> been contaminated with medicinal products**<br><br><u>Examples</u>:<br><br>Phlebotomy Blades<br>Scissors<br>Cannula | Discard into UN approved yellow rigid sharps boxes with orange lids. The label must be signed when the box is assembled.<br><br>  <br>**ORANGE LIDDED SHARPS BOX**<br><br>When full to the line, or open over 3 months, the box must be locked and the label completed in full.<br><br>These containers must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>Disposal by Alternative Treatment. |
| **Medicinal IVs**<br><br>**EWC: 18 01 03* / 18 01 09** | **IV bags and lines where the sharp securely contained ONLY**<br><br><u>Examples</u>:<br><br>Any IV bag containing | Discard into UN approved yellow cardboard box. The label must be signed when assembled. |

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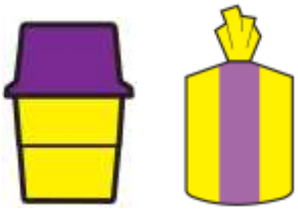
| | medicines<br><br>NB Empty saline and glucose bags should be disposed of in tiger stripe bags. |  <br>**YELLOW CARDBOARD BOX**<br><br>When full to the line, the box must be closed and the label completed in full.<br><br>These containers must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>Disposal by Incineration. |
| **Cytotoxic and Cytostatic Sharps (hazardous medicinal)**<br><br>**EWC: 18 01 03*/18 01 08*** | **Sharps, which have been used for the administration of Cytotoxic/ Cytostatic medicinal products.**<br><br>Other clinical waste which may be contaminated with Cytotoxic / Cytostatic products.<br><br><u>Examples</u>:<br><br>See list of Cytotoxic and Cytostatic Medicines, available as downloadable content linked to this policy on the intranet. | Discard into UN approved yellow rigid sharps boxes with purple lids. The label must be signed when assembled.<br>Contaminated soft waste can be disposed of in a yellow bag with a purple stripe, or a labelled yellow bag.<br>  <br>**PURPLE LID SHARPS BOX**<br>**YELLOW / PURPLE BAG**<br><br>When full to the line, or open over 3 months, the box must be locked and the label completed in full. These containers must be taken to a designated wheelie bin or waste cupboard that is appropriately colour coded and/or labelled, or |

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| | | collected on request by portering staff.<br><br>Disposal by Incineration. |
| **Pharmaceutical waste**<br><br>**EWC: 18 01 09 (Non Hazardous Medicines)**<br><br>**EWC: 18 01 08* & 18 01 03* (Cytotoxic and Cytostatic Medicines)** | **Medicines either in or not in their original packaging**<br><br><u>Examples</u><br><br>Expired / unused medicines | <u>Return to Pharmacy.</u><br><br>Pharmacy to discard into;<br><br>UN approved yellow rigid container with a blue lid (Non Hazardous Medicines) or<br><br>• Preferably a blue cardboard box with blue liner (Non Hazardous Medicines)<br><br>  <br><br>**BLUE LIDDED SHARPS / CARDBOARD BOX**<br><br>When full to the line, or open over 3 months, the box must be locked and the label completed in full. These containers must be taken to a designated wheelie bin or waste cupboard that is appropriately colour coded and/or labelled, or collected on request by portering staff.<br><br>Disposal by incineration<br><br>A purple lid (Cytotoxic and Cytostatic Medicines). |

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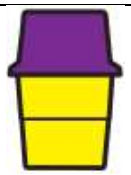
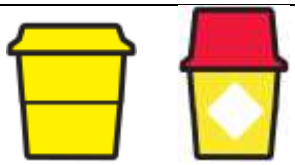
| | |  <br>**PURPLE LIDDED SHARPS BOX**<br><br>The label must be signed when the box is assembled.<br><br>Note: Solid and liquid medicines should be disposed of in separate containers and should not be mixed.<br><br>When full to the line, or open over 3 months, the box must be locked and the label completed in full. These containers must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>OR<br><br>Collected on request by portering staff and disposed of in line with local operational procedures<br><br>Disposal by Incineration. |
| **Anatomical waste**<br><br>**EWC: 18 01 02 & 18 01 03*** | **Recognisable body parts**<br><br>Examples: Limbs, bones, placenta | Discard into UN approved yellow rigid containers with red lids. Yellow lids must be used in the absence of red lids. The label must be signed when the box is assembled. |



**YELLOW / RED LIDDED CONTAINERS**

These containers must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.
OR
Collected on request by portering staff and disposed of in line with local operational procedures

Disposal by Incineration.

*Notes relating to disposal of anatomical waste*

1. *Removal, storage and disposal of human organs and tissues must be carried out in accordance with the Human Tissue Authority 'Code of Practice 5 – Disposal of human tissue', approved by parliament in July 2009 and brought into force via Directions 002/2009.*

2. *The section above relating to anatomical waste does not include the disposal of foetal remains, which should be carried out in accordance with the following guidance:*
   - *"Sensitive disposal of all foetal remains, guidance for nurses and midwives." (Published by the Royal College of Nursing, 2007)*
   - *Human Tissue Authority 'Code of Practice 5 – Disposal of human tissue'*

**Please contact the Environment Team in advance of disposing of this waste**

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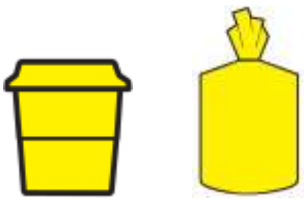
| Infectious or hazardous waste which requires disposal by incineration<br><br>EWC: 18 01 03* | Medicinally or chemically contaminated waste<br><br>Clinical waste which is known or suspected to be contaminated with Category A pathogens if unable to be treated on site<br><br>Examples:<br><br>Items infected with CJD<br><br>Reagent containers, chemically contaminated samples and diagnostic kits containing chemical | Discard into UN approved yellow bag / box as required. The label must be signed when the box is assembled.<br><br>  <br><br>**YELLOW LID BOX / BAG**<br><br>These containers must be transferred to a designated wheelie bin or waste storage cupboard |

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| | residues<br><br>Chemically contaminated spill kits. | that is appropriately colour coded and/or labelled.<br>OR<br>Collected on request by portering staff in line with local operational procedures<br><br>In the event that this waste cannot be pre-treated e.g. autoclave breakdown, local departmental contingency procedures apply.<br><br>Disposal by Incineration. |
| **Mattresses**<br><br>**EWC: Contact Environment Team for guidance** | **Damaged mattresses from clinical applications**<br><br>NB: Page 24-25 provides details on how to dispose of non-clinical / decontaminated mattresses<br><br>Examples<br><br>Damaged & heavily soiled mattresses | Mattresses that are damaged / heavily soiled and cannot be decontaminated must be disposed of as clinical waste.<br><br>**Department Responsibility**<br><br>The Environment Team must be made aware as soon as possible. A designated orange bag will be provided for the mattress to be bagged securely on the ward.<br><br>Mattresses are collected on request by portering staff in line with local operational procedures.<br><br>Disposal by Alternative Treatment. |
| **Dental Waste** | | Discard into designated container. |
| **Amalgam waste**<br>**EWC: 18 01 10*** | Includes used and surplus or unused “waste” amalgam and associated |  |

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| | dental waste. | **AMALGAM CONTAINER** |
| **X Ray Fixer**<br>**EWC: 09 01 04*** | Waste photographic fixer |  <br>**WASTE FIXER** |
| **X Ray Developer**<br>**EWC: 09 01 01*** | Waste photographic developer |  <br>**WASTE DEVELOPER** |
| **Lead Foils**<br>**EWC: 15 01 04** | Lead foils from x ray film packaging |  <br>**LEAD FOIL BIN**<br><br>Dental service to contact the Environment Team to arrange a container exchange. |
| **Medical devices and implanted devices**<br><br>**EWC: Contact Environment Team for guidance** | **Electronic devices removed from a patient**<br><br><u>Examples</u><br><br>Pacemakers | Department arrange via approved specialist collection.<br><br>OR<br><br>Items should be disinfected, and returned to EBME for disposal. Contact IP&C for advice on disinfection.<br><br>Sent for recycling. |
| **Radioactive waste**<br><br>**EWC: Contact Environment Team for guidance** | Any radioactive waste. | Please contact the Environment Team for advice. |

**6.5 Segregation, Storage and Disposal – Non Clinical Healthcare Waste**

Waste is a resource. This applies to most waste types listed in Table 3. Utilising waste as a resource will bring positive impacts to our health, surroundings and communities.

Tiger Stripe and black bags have their place, to dispose of waste which does not have the infectious properties of clinical waste and cannot be recycled. When options become available, these may also become a resource by generating energy from waste.

**Table 3 - Summary of the segregation, storage and disposal of Non Clinical Healthcare Waste**

| Non Clinical Healthcare Waste | | |
|---|---|---|
| **Waste type** | **Description** | **Correct storage/disposal method** |
| **Hygiene / Offensive waste**<br><br>**EWC: 18 01 04** | **Non-infectious healthcare waste**<br><br>Examples<br><br>Continence pads, sanitary waste, Stoma / catheter bags, faecal contaminated items. Lightly soiled gauze, cotton wool including from phlebotomy and cannulation<br>Empty IV bags containing saline and glucose (sharp concealed in the bag)<br><br>Note: No free flowing liquid. Non-infectious bodily fluids must be disposed of via the sluice. | Discard into a yellow bag with black stripes (tiger stripe bag).<br><br>  <br>**BLACK / YELLOW STRIPE BAG**<br><br>Bags must be transferred to a designated wheelie bin or storage cupboard that is appropriately colour coded and/or labelled.<br><br>Disposal in landfill |
| **Domestic waste**<br><br>**EWC: 20 03 01** | **Any non-hazardous general waste, where recycling facilities are not available**<br><br>Examples<br><br>**Non-recyclable items** e.g. crisp packets, coffee cups, many plastic packaging, paper plates uncontaminated wipes and cloths, some | Discard into black bags.<br><br>  <br>**BLACK BAG**<br><br>Bags must be transferred to a designated wheelie bin or waste cupboard that is appropriately colour coded |

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| | nutritional product packaging | and/or labelled.<br><br>Disposal in landfill. |
| **Confidential Paper**<br><br>**EWC 20 01 01** | **Any paper containing information deemed confidential by the Health Board.**<br><br><u>Examples</u><br><br>Please see Appendix D of approved policy 172 - Confidentiality Policy.<br><br>Items where the confidential element has been removed e.g. using a black permanent marker | Where facilities are available, confidential paper should be shredded to a minimum DIN Level 3 standard and disposed of in a clear paper recycling bags.<br><br>  <br>**SHRED PAPER WHEN POSSIBLE**<br><br>All other confidential paper must be disposed of in a designated confidential waste bag.<br><br>  <br>**CONFIDENTIAL WASTE BAG**<br><br>Confidential paper must not be disposed of in any other bag.<br><br>When full to the line, the confidential waste bag must be secured and a collection request made to portering staff in line with local operational procedures.<br><br>• Please contact the Environment Team in advance if you intend to undertake a clear out of records, to allow a suitable supply of bags to be available and appropriate collection to occur. |

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| | | • Confidential bags must always be collected on request, and never left with other waste awaiting collection.<br><br>Sent for secure destruction and then recycling. |
| **Non Confidential Paper**<br><br>**EWC 20 01 01** | **Any paper waste not classified as confidential**<br><br>**Soft cardboard packaging**<br><br><u>Examples</u><br><br>Newspapers<br>Unusable envelopes<br>Medicine / glove boxes<br>Junk Mail<br>Catalogues<br>Instruction booklets<br>Food Menus<br>Publically available information | Discard into clear bags, in bins labelled for the collection of non-confidential paper.<br><br>  <br>**CLEAR BAG**<br><br>Bags must be transferred to a designated wheelie bin or waste cupboard, which is appropriately colour coded and/or labelled.<br><br>Sent for recycling. |
| **Cardboard**<br><br>**EWC: 20 01 01** | **All cardboard packaging**<br><br><u>Examples</u><br><br>Corrugated cardboard<br>Paper boxes | **<u>Flat packed</u>** and placed next to a domestic waste bin for collection, or put directly in a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>  <br><br>Sent for recycling. |
| **Metals - Tins** | **Tins and cans, empty and free from residues.** | Discard into clear bags in bins labelled for the collection of |

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| **and cans**<br><br>**EWC 15 01 04** | **Small miscellaneous metal items**<br><br>Examples:<br><br>Drinks Cans, food tins. Other small items which are 100% metal such as paper clips | tins and cans.<br><br>  <br>**CLEAR BAG**<br><br>Bags must be transferred to a designated wheelie bin or waste cupboard that is appropriately colour coded and/or labelled.<br><br>Sent for recycling. |
| **Plastics (bottles and containers)**<br><br>**EWC**<br>**15 01 02**<br>**19 12 04** | **Plastic bottles and containers, rinsed and free from residues**<br><br>Examples:<br><br>Milk bottles, drinks bottles, salad trays, margarine container, microwavable meal trays, packaging films, orange juice pots<br><br>Containers with the following markings on the base<br><br>  <br><br><br>  <br><br><br>**An A- Z of waste and what can be recycled is available as downloadable content linked to this policy on the intranet.** | Squash plastics when possible and discarded into clear bags, in bins labelled for the collection of plastics.<br><br>  <br>**CLEAR BAG**<br><br>Bags must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>Sent for recycling. |

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| **Glass bottles and jars**<br><br>**EWC 20 01 02** | **Empty glass jars and bottles free from residues.**<br><br>Examples:<br><br>Coffee jars, milk bottles | Where facilities are available, discard directly into grey bin, or a container, labelled for the collection of glass.<br><br>  <br><br>**GREY CADDY**<br><br>Bin contents must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>Sent for recycling. |
| **Crockery**<br>**20 03 01**<br><br>**Aerosols**<br>**16 05 05** | **Broken crockery. Used and/or empty non hazardous aerosol containers**<br><br>Examples;<br><br>Broken plates and cups<br>Air fresheners | Discard into grey bags. These thicker gauge bags are used securely contain the waste and identify that the bag must be handled with care due to the content.<br><br>  <br>**GREY BAG**<br><br>Bags must be transferred to a designated wheelie bin or waste storage cupboard that is appropriately colour coded and/or labelled.<br><br>Disposal of with black bags in landfill. |
| **Food Waste**<br><br>**EWC 20 01 08** | Waste from the preparation of meals and drinks, surplus food.<br><br>Examples: | Where available, dispose of food waste in designated containers. |

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| | Catering and restaurant waste<br>Waste patient meals<br>Tea bags and coffee grounds<br>Fruit remains and peelings |  <br>**FOOD CADDY**<br><br>Or, where identified;<br>  <br>**CLEAR BAG**<br><br>Dispose of in line with local operating procedures.<br><br>Bags must be emptied into a designated wheelie bin that is appropriately colour coded and/or labelled.<br><br>Sent for waste to energy. |
| **Ink Cartridges**<br><br>**EWC**<br><br>**08 03 17* or 08 03 18**<br>**20 01 27* or 20 01 28** | Cartridges from printers, photocopies, fax machines and multifunctional devices<br><br>Examples<br><br>All ink cartridges<br>Toners | Take to a site based central collections points.<br>Cartridges must be disposed of in the plastic bag only.<br>Cardboard and packaging must be disposed of locally.<br><br>**A list of site based central collection points is available as downloadable content linked to this policy on the intranet.**<br><br>Contact the Environment Team for further guidance.<br><br>This waste is sent for reuse where possible, or recycling. |
| **Batteries**<br><br>**EWC**<br><br>**16 06 04** | **Used / replaced batteries**<br><br>Examples | Alkaline battery terminals should be covered with tape and sent via internal mail to the Environment Team or Maintenance Helpdesks. |

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| **20 01 34**<br>**16 06 01***<br>**16 06 03***<br>**16 06 02***<br>**20 01 33*** | Alkaline; AAA - D<br>  <br>Lead acid, Pb<br>  <br>Lithium, Li<br>  <br>Nickel metal hydrides, NiMH<br>Nickel cadmium Ni Cd<br>  <br>**Note: remove wires** | Where possible, please use the central collection facilities.<br><br>**A list of site based central collection points is available as downloadable content linked to this policy on the intranet.**<br><br>All other batteries, terminals should be covered with tape, contact porters to collect in line with local operating procedures. These should not be mixed with alkaline batteries.<br><br>Departments that frequently dispose of batteries can contact the Environment Team for further advice.<br><br>Sent for recycling. |
| **Waste IT equipment**<br><br>**(Waste Electrical and Electronic Equipment, WEEE)**<br><br>**EWC: 20 01 35* or 20 01 36**<br><br>  | **Any IT related equipment, including all items capable of storing data.**<br><br>Examples<br><br>Monitors, base units, printers.<br><br>Floppy Disks, hard drives, DVDs, CD, pen drives, audio and video tapes, fax machines (including carbon paper) etc | Log a call with the IT Service Desk.<br><br>This waste must be kept secure at all times pending collection.<br><br>IT will arrange for this waste to be removed, securely stored and disposed of.<br><br>Sent for recycling. |
| **Waste electrical and electronic equipment (WEEE), Other** | **Any waste electronic or electrical items**<br><br>Examples | Disposal of items must be considered when ordering replacements and action taken before new equipment arrives. |

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| **than IT waste**<br><br>**EWC: 20 01 35* or 20 01 36**<br><br>  | Medical Electronic Equipment<br>Washing Machines<br>Fans, Radios, TVs<br><br>Hazardous;<br>Fridges, Freezers<br>Microwaves<br>Monitors | Many companies have 'take back schemes' for WEEE, please confirm prior to placing an order. The cost is already factored in the purchase price and the Health Board pay twice for disposal when items are not returned. This is particularly important for items including fridges, microwaves and TVs.<br><br>**Policy 093 - Disposal of surplus equipment;**<br><br>• Item value up to £1000<br><br>Refer to Procurement to be advertised for sale<br><br>• Items of minimal value<br><br>***Manager Responsibility***<br><br>Equipment that is in a usable condition should be advertised via the Staff Bulletin Board or Warp it for reuse.<br><br>Utilise take back scheme and dispose of with contractor when new item is delivered.<br><br>If Health Board disposal is required, arrange a collection with portering staff inline with local operating procedure. *Sufficient notice must be provided*, particularly when multiple items require disposal<br><br>**Policy 390 – Cleaning and Decontamination of Equipment**<br><br>Where applicable, items will |

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| | | only be collected when the 'Declaration of contamination status certificate' is complete.<br><br>**Condemned Items**<br><br>A condemned form must be completed in full prior to a request for collection to portering staff in line with local operational procedures. Items will only be collected when the form is completed in full. A condemned form is available as downloadable content linked to this policy on the intranet.<br><br>All medical electronic equipment for disposal must be returned to EBME.<br><br>WEEE is sent for recycling via specialist waste contractor. |
| **Furniture and equipment (that is not electrical or electronic)**<br><br>**EWC 20 03 07** | **Any items of furniture that are surplus to requirement or no longer suitable for use**<br><br>Examples:<br><br>Desks<br>Chairs<br>Cabinets<br>Bed side tables | Disposal of items must be considered when ordering replacements and action taken before new equipment arrives.<br><br>**Policy 093 - Disposal of surplus equipment;**<br><br>• Item value up to £1000<br><br>Refer to Procurement to be advertised for sale<br><br>• Items of minimal value<br><br>***Manager Responsibility***<br><br>Equipment that is in a usable condition should be advertised via the Staff Bulletin Board or Warp it for reuse.<br><br>Items valued at less than |

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| | | £20 can be purchased with manager approval and completion of an official receipt relating to the item (from General Office).<br><br>For disposal if required, arrange a collection with portering staff in line with local operating procedures. *Sufficient notice must be provided*, particularly if many items require disposal<br><br>**Policy 390 – Cleaning and Decontamination of Equipment**<br><br>Where applicable, items will only be collected when the 'Declaration of contamination status certificate' has been completed.<br><br>**Condemned Items**<br><br>A condemned form must be completed in full prior to a request for collection to portering staff in line with local operational procedures. Items will only be collect when the form is completed in full. The condemned form is available as downloadable content linked to this policy on the intranet.<br><br>If internal or external reuse is not viable, disposed of via recycling or landfill depending on material and condition. |
| **Mattresses**<br><br>**EWC 20 03 07** | **Non clinical / decontaminated mattresses**<br><br>Example: | **Policy 390 – Cleaning and Decontamination of Equipment**<br><br>Where applicable (e.g. |

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| | Mattresses from residential properties<br><br>Undamaged, decontaminated mattresses from clinical environments | mattress from a clinical area) items will only be collected when the 'Declaration of contamination status certificate' has been complete.<br><br>For disposal, arrange a collection with portering staff in line with local operating procedures. *Sufficient notice must be provided*, particularly if many items require disposal<br><br>Disposal in landfill. |
| **Chemicals and Hazardous Materials**<br><br>**EWC: Various, refer to Environment Team** | **Various types of chemical and hazardous wastes**<br><br>Examples<br><br>Materials which are -<br><br>Flammable<br>Corrosive<br>Hazardous to the environment<br>Health hazard<br>Acute toxicity<br><br>From -<br>Laboratories<br>Pharmacy<br>Boiler treatment<br>Cleaning and decontamination | Must be stored in accordance with COSHH requirements<br><br>An approved waste contactor should be contacted to arrange a collection. The Environment Team can be contacted for advice where departments have their own disposal arrangements.<br><br>For ad hoc requirements, contact the Environment Team for a collection providing the following information per item;<br><br>• MSDS / Data Sheet<br>• Container Size<br>• Volume remaining in the container<br><br>Sent for recycling where possible or disposal in specialist landfill or by incineration depending on the nature of the waste |
| **Mercury**<br><br>**EWC 16 01 08*** | **Any items containing mercury**<br><br>Examples | Log a call with the local maintenance help desk.<br><br>Maintenance will arrange for this waste to be removed, |

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| | Sphygmomanometers<br>Thermometers | securely stored and disposed of.<br><br>This waste must be kept secure at all times, pending collection by maintenance.<br><br>Sent for recycling. |
| **Oil**<br><br>**EWC: Various, refer to Environmental Officer** | Various types of waste oil, both hazardous and non-hazardous).<br><br>Examples<br><br>Cooking Oil<br>Engine Oil | All waste oils should be stored in suitable leak proof containers.<br><br>These containers must then be stored within an appropriate secondary containment e.g. a drip tray / bund able to retain 110% of the total quantity stored<br><br>An approved waste contactor should be contacted to arrange a collection.<br><br>Contact the Environment Team for further guidance.<br><br>Sent for recycling. |
| **Asbestos**<br><br>**EWC: 17 06 05 (Bonded).**<br>**17 06 01 (Fibrous)** | **Any waste material likely to contain or be contaminated with asbestos** | All Asbestos waste should be managed in line with approved Asbestos Management Plan and related policy and procedures.<br><br>Contact the Operations Compliance Team for guidance.<br><br>If any material suspected of containing asbestos is found DO NOT DISTURB, MOVE OR TOUCH. Please contact the relevant Estates Department Helpdesk immediately and request urgent assistance. |

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| | Bronglais GH 01970 635770<br>Glangwili GH 01267 227942<br>Prince Philip GH 01554 783689<br>Withybush GH 01437 773463<br><br>This waste is sent to a specialist landfill for disposal. |

### 6.6 Segregation, Storage and Disposal – Additional Notes:

Tables 2 and 3 must be considered alongside the following;

- For collections undertaken 'in line with local operating procedures' please refer to the locality based downloadable content linked to this policy on the intranet.
- For information on the disposal of wastes not included in the above tables, contact the Environment Team for advice.
- Departmental arrangements must be in place to ensure that wastes are correctly stored and collections arranged in line with the requirements of this policy, allowing appropriate timescales for collections to be arranged and undertaken.
- Items designated 'Single Use' must be disposed of immediately after use
- When an appropriate bin is available, do not 'over treat' waste e.g. in an office use the paper recycling rather than black bag; in a sluice paper towels should be in a black and not orange / tiger stripe bag.

### 6.7 Packaging of Waste Materials

Packaging should occur in line with the colour coding and containers (bags / boxes) detailed in Sections 6.4 and 6.5. Please specifically note the following points;

- All clinical waste containers and wheelie bins must be UN approved, to contain waste without puncture or spillage during handling and transport.
- All clinical waste containers shall be exchanged and sealed when filled to the specified level. Sharps boxes will be in use no more than 3 months after assembly.
- All clinical waste containers shall be labelled (tagged or in writing) with details of ward/department of origin. Labels must be completed in full prior to disposal in local waste storage cupboard pending collection.

  Note: Clinical waste bags from health centres and clinics must be suitably labelled.

- All waste containers shall be adequately stored so as to prevent pollution and the risk of injury.

### 6.8 Collection, storage and disposal requirement

#### 6.8.1 Local waste disposal points

- Waste shall only be stored at designated waste disposal points within the ward/department. Waste containers must never be left awaiting collection in corridors or other public areas.

- All waste disposal points shall be clearly marked with the type of waste and the associated colour coding, to ensure that waste is clearly segregated and prevent mixing.

- Areas must be secure and not accessible by unauthorised personnel.

- All waste disposal points shall be provided with the appropriate storage containers and/or fixtures.

- Storage containers and/or fixtures must not be used if broken. Action must be taken to ensure such items are removed and replacements introduced.

- Must be kept clean and cleared of waste on a regular basis.

**6.8.2 Removal from local waste disposal points**

This will be undertaken by Facilities - Soft FM in line with local operating procedures, available as downloadable content linked to this policy on the intranet.

**6.8.3 Removal from site**

- Waste must only be removed from site by a suitably registered waste carrier for onward treatment or disposal at suitably permitted waste sites.

  Health board wide collections, such as those for clinical, black bag and recycling wastes, will be managed by the Environment Team who will undertake the necessary compliance checks and management arrangements.

  When departments are disposing of waste specific to their own function (e.g. some chemicals, IT equipment), each departmental manager must ensure that all waste contractors removing waste from site on their behalf are authorised to do so.

  All sites that produce more than 500kg of hazardous waste in a 12 month period are required to register with Natural Resources Wales on an annual basis. The Environment Team holds a central record of all site registrations and updates them as required. They will be able to provide the Premise code for a specific site, which is required before the waste contractor will collect the hazardous waste

- Each waste collection must be recorded when the collection occurs, on a waste transfer note (for non-hazardous waste) or a waste consignment note (for hazardous waste). These notes are a legal record of the waste transfer.

  Guidance on the completion of transfer and consignment notes is available as downloadable content linked to this policy on the intranet.

  Transfer Notes must be retained for a minimum of 2 years and Consignment Notes a minimum of 3 years. These must be retained in a designated file and made available for review on request.

- If any doubts arise as to the correct method for conducting such checks, or about the legitimacy of a particular waste contractor, the advice of the Environment Team should be sought immediately.

**6.8.4 Waste produced by contractors employed by Hywel Dda University Health Board**

All contractors working on behalf of HDUHB will be required to manage their waste in line with applicable legal and other requirements and in accordance with this Waste Management Policy and their own policies and procedures

It is the responsibility of each person hiring a contractor to ensure that suitable processes are place for the effective management of waste in relation to the work being undertaken. These requirements shall be communicated to contractors via the "Environmental Rules for Contractors" statement, available as downloadable content linked to this policy on the intranet.

**6.8.5 Waste returned to Health Board premises by the Ambulance Service**

Ambulance staff must dispose of waste in line with this policy. In particular, waste must be;

- Identifiable as Ambulance Service waste
- Placed in designated bins
    - Acute Hospitals – disposed of within the clinical wheelie bin located in the A&E Department.
    - Community Hospitals – the porter or Facilities - Soft FM representative must be notified and will advise on the correct means of disposal.

## 6.9 Disposal of clinical waste from households

This section of the policy covers waste produced by self-managing patients through the treatment of patients at home. Services could be provided by (not an exhaustive list);

- District Nurses
- Specialist Nurses
- Midwives
- Acute Response Team
- Health Visitors
- School Nurses
- Occupational Therapy
- Physiotherapy
- Podiatry

**6.9.1 Assessment of Waste**

Healthcare workers are responsible for assessing the waste produced (on a patient specific basis), ensuring that the waste is correctly classified / identified and disposed of via an appropriate route.

The infectious properties of waste is a main factor in determining whether waste should be classed as clinical or hygiene waste for disposal. The following must be considered when risk assessing the infectious nature of waste;

- Healthcare waste definitions and classifications;
- Clinical signs and symptoms
- Professional assessment
- Prior knowledge of the patient.

Please see the downloadable content linked to this policy detailing advice contained in HTM 07 01 on the waste assessments for home patients.

### 6.9.2 Disposal Procedure

Once waste has been appropriately classified, one of the following disposal procedures must be adopted.

| Waste type | Description | Correct disposal method |
|---|---|---|
| **Hygiene Waste**<br><br>**Non-infectious healthcare waste**<br><br>**EWC: 18 01 04** | Domestic waste collected by Local Authorities traditionally contains a small quantity of hygiene waste. When similar waste is produced by a healthcare worker during treatment, which is deemed **non-infectious**, this can be disposed of within the domestic waste stream. Items that can be included varies from one Local authority to another<br><br>**CEREDIGION**<br>Items include;<br>• Continence Waste<br>• Nappies<br>• Stoma, catheter, colostomy bags (see exceptions also)<br>• Clean dressings<br>• Lightly blood soiled items<br>• Packaging from medical equipment and supplies<br>• Gloves & aprons<br>• Wipes<br><br>Note: Free flowing liquids cannot be disposed of in landfill; non-infectious bodily fluids must be disposed of via the foul sewer. |  <br>**BLACK BAG** |

Waste should be packaged e.g. in a carrier bag (bags should not be orange or yellow in colour) and placed in a black bag for collection by the local authority.

**PEMBROKESHIRE**

**PURPLE BAG**

Items include;

- Continence Waste
- Nappies
- Stoma, catheter, colostomy bags (see exceptions also)
- Non-infectious absorbent pads/bandages

**BLACK BAG**

Items include;

- Clean dressings
- Lightly blood soiled items
- Cotton wool including from phlebotomy and cannulation,
- Empty IV bags containing saline and glucose
- Packaging from medical equipment and supplies
- Gloves & aprons
- Wipes

**CARMARTHENSHIRE**

Hygiene waste collections can be arranged by calling the council customer services.

**TIGER STRIPE BAG**

Items include;

- Continence Waste
- Nappies
- Stoma, catheter, colostomy bags (see exceptions also)
- Clean dressings
- Lightly blood soiled items
- Packaging from medical equipment and supplies
- Gloves & aprons
- Wipes

**EXCEPTIONS**
**Dispose of as clinical waste in an orange bag**

- Stoma / Catheter / Colostomy bags – If a healthcare worker is involved in treatment and the bags are used in bulk, or if the site becomes infected / develop a gastrointestinal infection
- Quantity – when dressings are changed regularly and produced in a large volume
- When the waste is recognisable hygiene healthcare waste, and not normally found in a black bags

## Clinical Waste

**Potentially infectious and known infectious waste**

**EWC: 18 01 03***

These wastes are classed as clinical and must be disposed of appropriately

- Infectious dressings and bandages
- Suction canisters
- Wound drains
- Blood transfusion waste
- Heavily blood soaked items
- Dialysis waste

Discard into UN approved orange bags, which must be clearly labelled (signed and dated).

**ORANGE BAG**

## DISPOSAL ROUTES

**From a patients homes by a clinical waste contractor**;

- Healthcare worker to provide the Environment Team contact details (01267 227 641) to the patient for them to arrange a suitable collection. Alternatively, the healthcare worker can arrange the collection by providing the patients name, address and contact number, type of waste, recommended frequency of collection and expected length of treatment.
- Environment Team or healthcare worker to provide advice to home patient on collection procedure.
- Healthcare worker to provide an initial supply of orange bags. These will be supplied by the clinical waste contractor once collections commence.
- The Environment Team must be notified if any amendments are required to the collection e.g. a change of address or the cancellation of a collection.

**Return to base by healthcare workers;**

- Waste must be appropriately stored within the healthcare workers vehicle i.e. in a rigid container e.g. a 30 litre box
- Containers must be disposed of in a secure designated location, and not mixed with other waste -
  - Community Hospitals, Health Centres and Clinics – liaise with Facilities - Soft FM to identify an appropriate point of storage on site.
  - Acute Hospitals – dispose of in A&E clinical waste storage
  - GP surgeries – in line with onsite disposal procedures

Important - under no circumstances should bags be left outside waste storage compounds, wheelie bins or waste storage rooms.

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| **Sharps Waste**<br><br>**EWC: 18 01 03* / 18 01 09** | Medicinally and non-medicinally contaminated sharps and metal single use items<br><br>▪ Insulin and diabetics sharps<br>▪ Needles, ampoules, vials, medical IVs<br>▪ Clexane and Innohep injections | Discard into UN approved yellow rigid sharps boxes with yellow lids, which must be clearly labelled.<br><br>  <br>**YELLOW LIDDED SHARPS BOX** |
| **Cytotoxic and Cytostatic Waste**<br><br>**EWC: 18 01 03*/18 01** | Sharps, which have been used for the administration of Cytotoxic/ Cytostatic | Discard into UN approved yellow rigid sharps boxes with purple lids, which must |

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| | 08* | medicinal products.<br><br>Other clinical waste which may be contaminated with Cytotoxic / Cytostatic products. | be clearly labelled.<br>  <br>**PURPLE LIDDED SHARPS BOX** |

## Disposal Routes

**Return to base by healthcare workers**;

- Waste must be appropriately stored within the healthcare workers vehicle. The box must be securely closed and out of sight.
- Containers must be disposed of in a secure designated location, and not mixed with other waste -
    - Community Hospitals, Health Centres and Clinics – liaise with Facilities - Soft FM to identify an appropriate point of storage on site.
    - Acute Hospitals – dispose of in A&E clinical waste storage
    - GP surgeries – in line with on-site disposal procedures

Important - under no circumstances should sharps boxes be left outside waste storage compounds, wheelie bins or waste storage rooms.

**Disposal by self-managing patients;**

- Healthcare worker to provide advice to the self-managing patient on correct assembly, storage and labelling of sharps boxes.
- Patient to obtain a prescription for 1 litre sharps boxes from their GP.
- Patient to return full sharps boxes to Community Pharmacy for disposal (1-5L sharps only). Lists of participating Pharmacies **is available in the downloadable content linked to this policy on the intranet**. For collection over 5L contact the Environment Team to arrange collection.

Important – for patients that are housebound or those who dispose of a high volume / larger sharps, please contact the Environment Team (01267 227 641) to arrange a collection.

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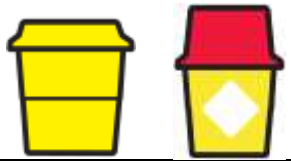
| | **Anatomical waste**<br><br>**EWC: 18 01 03*** | Recognisable body parts e.g. placenta from a home birth | Discard into UN approved yellow rigid containers with red lids, which must be clearly labelled. Yellow lids may be used in the absence of red lids.<br>  |

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| | | **YELLOW / RED LIDDED CONTAINERS**<br><br>Containers must be returned to maternity at an acute hospital or to a community hospital with designated facilities.<br><br>Disposal is in line with the Waste Management Policy and local operating procedures. |
| **Waste Medicines**<br>**EWC: 18 01 09**<br>**EWC: 18 01 08* & 18 01 03*** | Non Hazardous Medicines, Cytotoxic and Cytostatic Medicines that have expired or are no longer required. | Patients to return to a Community Pharmacy. |

### 6.10 Spillages and Emergency Preparedness

In the event of a spillage;

- In line with Infection Prevention and Control Policy for the spillage of bodily fluids
- Each department must have procedures in place for dealing with incidents involving waste. These procedures must relate to the types of waste likely to be encountered.
- Any incident involving waste must be reported to, and investigated by the relevant Supervisor. The investigation must establish the cause of the incident and what action needs to be taken to prevent recurrence.
- If necessary, the supervisor must report the incident to the Environment Team.
- When required, an IR1 form must be completed by the appropriate Manager.
- Periodic testing of procedures dealing with waste spillage and reporting is required. This will be carried out under departmental auditing programmes, and as part of the waste management audit schedule.

There may also be instances where contingency measures must be brought into action to deal with an onsite disruption to waste collections and storage. These are detailed within local Facilities - Soft FM and Estates procedures.

In the event of a potential major disruption to services, caused by problems relating to current waste contractors (e.g. clinical waste collection), the Estates Department should

be contacted in the first instance. Service continuity arrangements will be initiated by this department where required.

### 6.11 Training

It is the responsibility of all departmental managers to ensure that all **new starters** receive waste management induction training, prior to them being deemed competent to fulfil their roll. New staff must receive the following information;

- An overview of this waste policy and procedure, together with instructions explaining how to obtain a current copy
- Instructions relating to the correct procedures for handling, segregating, disposing and storing wastes, in relation to their activities
- Communication of roles and responsibilities in relation to waste management
- Explanation of current environmental objectives relating to waste management
- Emergency procedures relating to waste and incident reporting
- Correct use of PPE (where required)
- The need to acquire appropriate vaccinations, where applicable

It is also the responsibility of departmental managers to ensure that all **existing employees** have had training as described previously in this section. Provision of training can be delivered via;

- Specific waste management training sessions
- Sections on waste disposal within other training programmes e.g. infection prevention and control, medical devices etc.
- Departmental training on request

The need for training will be determined via a training needs analysis, departmental training plan(s) and Personal Appraisal Development Review (PADR).

All relevant employees will be retrained as and when significant changes are made to waste policies and procedures.

Training records will be retained in line with Health Board record retention procedures, and the process approved / managed by Learning and Development.

### 6.12 Audit

The Environment Team are responsible for the preparation of an annual environmental audit schedule, in line with the requirements of the ISO 14001:2015 Environmental Management Standard. As a significant environmental aspect, waste management will always be included within the schedule. The extent to which waste will be audited during any particular year will be decided based on risk and results of previous audits.

The scope of each waste management audit will be designed to evaluate compliance with the waste management policy and procedures. As a minimum, an audit will review the following:

- safe handling practices
- appropriate use of waste containers

- appropriate condition of wheelie bins
- appropriate sealing, labelling and storage of waste
- appropriate staff training
- appropriate record-keeping
- correct functioning of local waste procedures
- correct functioning of local waste management roles and responsibilities

Note: The purpose of this audit is to evaluate the whole waste management system. This is in addition to more frequent audits undertaken departmentally to ensure that procedures are being adhered too. See Section 6.14.

Off-site waste management audit will also be undertaken to ensure that each contractor can demonstrate that waste produced by the Health Board is being managed in line with relevant legal and other requirements. As a minimum, a 'Duty of Care' audit shall review the following:

- safe handling and storage practices
- traceability of waste (i.e. can the contractor prove that waste collected from the Health Board on any particular date was received at the site being audited?). This element of the audit will involve examination of waste transfer/consignment notes
- proof that the carrier was suitably registered and that the site is suitably licensed
- any regulatory issues with the site being audited
- appropriate staff training
- appropriate record keeping
- standard of house-keeping on site

### 6.13 Monitoring

Managers have responsibility for monitoring compliance with this policy at a local level. Overall, monitoring will be undertaken by the Environment Team. Table 4 details processes that contribute to the monitoring of action taken in line with this policy.

**Table 4 – Means of monitoring compliance with the Waste Management Policy**

| What? | How? | When? | By Whom? |
|---|---|---|---|
| **Pre Acceptance Waste Audits** | Examines the correct segregation of clinical waste. Results distributed to local management | Annually | External Independent Auditor<br><br>Environment Team |
| **Training** | Competence Testing, Feedback Forms, Training Records | On going | Learning and Development<br><br>Environment Team |
| **Invoicing** | Monitor waste volumes | Monthly | Environment Team |
| **Departmental Accreditations** | Monitor compliance with this policy as required by professional accreditations | Ad hoc | Relevant Departments |

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| **Local Monitoring** | Monitor correct handling, transportation, segregation and storage in line with local operating procedures and C4C programme | On going | Facilities - Soft FM<br><br>Infection Prevention and Control |
| **ISO 14001 Audit Programme** | Review waste management in line with this policy, key objectives and targets, legal requirements and improvement plans | On going | Environment Team |
| **Pharmacy Claim Forms** | Information on volume of sharps boxes provided and disposed of | On going | Pharmacy Contracts Manager<br>Environment Team |

## 7. Responsibilities

### 7.1 Chief Executive Officer and Board

The CEO and Board of Directors are responsible for ensuring that adequate resources are available to allow for the effective management of waste in line with the Health Board's Waste Management Policies and Strategy. This shall include human resource and specialised skills, organisational infrastructure, technology and financial resources.

### 7.2 Operational Lead

The Assistant Director of Capital, Estates and Facilities is the lead for waste management and responsible for ensuring that a robust management system is in place which will enable waste to be managed in a safe manner. This includes ensuring that processes are in place to undertake the following;

- Development of a waste policy and strategy;
- Identification of environmental aspects associated with waste;
- Keeping abreast of changes in legal and other requirements associated with waste management;
- Setting objectives aimed at continually improving waste management practices and performance;
- Provision of appropriate resources;
- Process for defining roles and responsibilities;
- Relevant personnel are competent;
- Internal and external communications are managed effectively;
- Related documents and records are controlled effectively;
- Waste procedure in place which accurately transposes the requirements of relevant legal and other requirements and incorporates emergency response;
- Monitoring performance against the requirements of the waste policy and related procedures and objectives (including internal audit) and periodically evaluating compliance with relevant legal and other requirements;

- Effectively managing non-conformances with this policy, and any corrective or preventive actions;
- Periodically evaluating the effectiveness of the waste management processes and reporting on related performance to the Capital, Estates and IM&T Sub Committee and other forums as required.

### 7.3 Environment Team

- Keep abreast of changes in waste related legal and other requirements and report to the Capital, Estates and IM&T Sub Committee on any relevant implications for the Health Board.
- Develop, implement and monitor waste management strategies in line with national objectives and targets.
- Develop and implement a training and awareness programme aimed at ensuring the requirements of the waste policy and procedure are met, together with any related improvement objectives (e.g. waste minimisation).
- Act as a central point of contact for all matters relating to the management of waste (internal and external communications).
- Respond to and investigate any environmental incidents relating to waste management.
- Monitor the performance of the Health Board with regard to waste management, including the quantity of waste produced (per waste stream) together with financial costs.
- Collate and input waste related data into the Estates & Facilities Performance Management System (EFPMS) as and when required.
- Develop an annual internal audit programme, designed to ensure that the level of implementation of the waste policy and procedure is suitably monitored across the Health Board on an ongoing basis.
- Report to the Capital, Estates and IM&T Sub Committee on internal audit results; relevant communications, incidents and complaints and changes in legal and other requirements, which could result in a need to amend the waste management policy and procedure. Also to report any Infection Prevention and Control concerns through the IP&C Group.
- Develop and implement projects to ensure a continued improvement in the sustainable disposal of Health Board waste.

### 7.4 Ward and Department Managers

All wards and department managers within the Health Board have a direct responsibility for the management of waste produced by their department, to ensure that it is correctly segregated and safely stored prior to collection, and where appropriate, transported correctly in accordance with departmental procedures. All managers will ensure that:

- A Standard Operating Procedure (SOP) is in place (where appropriate).
- All staff receives appropriate training in waste management policy and procedures. (Further detail is given in Section 6.11)
- The waste hierarchy is followed and all options for waste minimisation and reuse are investigated in full, and instigated as appropriate, prior to recycling or final disposal.
- Waste management is included within the scope of relevant audits, and results are reported to the Environment Team.
- Staff are fully briefed on communications from the Environment Team.

- Appropriate feedback is provided to all staff following spillages or other incidents, or following any improvement or deterioration in waste management.
- Staff are provided with adequate Personal Protective Equipment and clothing where necessary and equipment e.g. bins.
- Waste is stored safely and securely at all times.
- Staff are aware of the need to obtain inoculations where appropriate.
- Issues of concern are reported to the Environment Team.
- Suitable departmental representatives are made available to progress initiatives approved by the Capital, Estates and IM&T Sub Committee.

### 7.5 Staff

All staff are responsible for ensuring that;

- Waste production is kept to a minimum.
- Waste is correctly segregated at source in line with the Sections 6.4 and 6.5 of this policy.
- Waste containers are sealed correctly and never over filled.
- Personal protective equipment will be used where required when handling waste.
- Any incidents or accidents relating to waste are dealt with in line with departmental procedures and that prompt actions will be taken to safeguard individuals from injury or ill health and to protect the environment in the event of an incident.

### 7.6 Department Specific Waste Management Responsibilities

Above and beyond those already stated, certain departments have specific defined responsibilities in relation to waste management. These are detailed below.

#### 7.6.1 Facilities - Soft FM

Facilities - Soft FM Assistant Operations Managers are responsible for;

- Ensuring that local operating procedures relating to waste management are implemented, periodically reviewed, and updated where necessary.
- Ensuring that waste is correctly and efficiently collected, transported, processed (where appropriate) and stored pending removal from site, in line with local operating procedures.
- Ensuring that their staff are competent to undertake waste management duties, on the basis of appropriate education, training and/or experience.
- Periodically conducting internal audits to ensure that waste management processes are working efficiently i.e. waste is correctly segregated, transported, and stored.
- Supporting the work of the Environment Team, including the provision of data on waste collections and arising's, and the development of sustainable waste systems.
- Where appropriate, ensuring that waste management records are correctly completed and retained (namely waste transfer and consignment notes).

Copies of all waste management records must be forwarded to the Environment Team when requested.

- Nominating a suitable representative to progress initiatives approved by the Capital, Estates and IM&T Sub Committee.

### 7.6.2 Infection Prevention and Control

Senior Infection Prevention and Control Nurse are responsible for;

- Ensuring that all Infection Prevention and Control Nurses are suitably competent to undertake waste management duties, on the basis of appropriate education, training and/or experience.

- Providing healthcare waste management training to staff when required (NB this excludes the disposal of chemical wastes).

- Ensuring that waste management is included within the scope of relevant audits, and reporting the results of these audits to the Environment Team.

- The identification of potential improvements to waste management practices, and supporting the delivery of strategic changes to healthcare waste management practices.

- The provision of infection prevention and control advice in relation to waste handling, storage, treatment and disposal.

- Nominating a suitable representative to progress initiatives approved by the Capital, Estates and IM&T Sub Committee.

**SUMMARY EQUALITY IMPACT ASSESSMENT –**

| | |
|---|---|
| **Organisation:** | Hywel Dda University Health Board |

| | | |
|---|---|---|
| **Proposal Sponsored by:** | **Name:** | Terri Shaw |
| | **Title:** | Senior Environmental Officer |
| | **Department:** | Estates and Facilities |

| | |
|---|---|
| **Policy Title:** | Waste Management Policy<br><br>Review 1 – November 2016<br>**Review 2 – October 2019** |

| | |
|---|---|
| **Brief Aims and Objectives of Policy:** | • It is the policy of Hywel Dda University Health Board to manage its waste arisings in accordance with current legal and other requirements and to apply, so far as is reasonably and economically practicable, the principles of the waste management hierarchy in order to continually improve the Health Board's environmental impacts.<br>▪<br>• Risks associated with environmental and health and safety impacts will be strictly controlled through implementation and adherence to suitable waste management and related procedures.<br><br>• The purpose of the policy is to ensure there are rigorous processes in place to allow waste to be managed safely and sustainably, in line with Welsh Government strategy and current legal and other requirements through the following objectives:- |

| | |
|---|---|
| | • Detailing correct segregation, handling, transportation and disposal practices<br>• Signposting systems to manage compliance with legal and other requirements<br>• Detailing correct segregation, handling,<br>• Prevention of injury or ill health<br>• Continual improvement |

| **Was the decision reached to proceed to full Equality Impact Assessment?:** | **Yes** | **No√** |
|---|---|---|
| | Following assessment of the original policy, there was little evidence to suggest the policy would impact on equality issues.<br><br>Review 1 24/11/2016 – Version 2 of the policy included additional information on disposal routes, information on minimisation and reuse, information on disposal of waste from treating patients at home, signposts to additional downloadable content.<br><br>**Review 2 – 18/10/2019 – Version 3 of the policy includes updated information on home collections in Pembrokeshire and other minimal changes, with no additional impact from changes made.**<br><br>**It is anticipated that the current updated procedure in place for waste collections will have a positive impact for older people and disabled people in providing a more streamlined service than previously available. There is no evidence at this stage to indicate that the changes would result in any adverse impact in relation to protected characteristics. Therefore, a full EqIA has not been undertaken at this stage. Should any issues of concern arise at any stage, a full EqIA will be undertaken as appropriate.** | |

| | | |
|---|---|---|
| | **No complaints in relation to equality, diversity or human rights have been received following implementation of the original policy or subsequent review.**<br><br>**Any updated review of similar policies elsewhere indicated a neutral or positive impact on protected groups:-**<br><br>**https://www.google.co.uk/?gws_rd=ssl#q=Waste+Management+Policy+nhs+wales+equality+impact+assessment+** | |
| **If no, are there any issues to be addressed?** | **Yes √** | **No** |
| | The main factors that affect the outcome of this policy are:-<br><br>Training and Awareness – all staff need to be aware of the procedures for correctly managing and disposing of waste.<br><br>Resources – The Waste Management Policy depends on the ongoing availability of the resources required to ensure compliance and continued improvement.<br><br>Amendments to legislation | |

| | |
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| | Consider on a case by case basis the requirements of an individual that may arise e.g the identification of colour coded containers for staff members who are colour blind. Also the provision of copies of the policy in alternative formats as required.<br><br>Possible consideration of provision of foot operated bins with a lid to have a handle on the lid to assist people whose physical impairments hinder effective use of the pedal – or potentially no touch activated bins. |

| | | |
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| **Is the Policy Lawful?** | **Yes √** | This policy is in line with Welsh Government Strategy and current legislative requirements. |

| | | |
|---|---|---|
| **Will the Policy be adopted?** | **Yes √** | This is an update of an existing policy. |
| | **If no, please record the reason and any further action required:** | |

| | | |
|---|---|---|
| **Are monitoring arrangements in place?** | **Yes √** | Any complaints received in relation to equality, diversity or human rights will be addressed on an individual basis and appropriate action taken. |
| | | |

| | | |
|---|---|---|
| **Who is the Lead Officer?** | **Name:** | Associate Director of Capital – Estates and Facilities |
| | **Title:** | |
| | **Department:** | |
| **Review Date of Policy:** | Three yearly or sooner if required | |

| **Signature of all parties:** | **Name** | **Title** | **Signature** |
|---|---|---|---|
| | Rhian Corcoran | Senior Environmental Officer | Review 1 24/11/2016 |
| | Jackie Hooper | Senior Equality and Diversity | Review 1 24/11/2016 |

| | | | |
|---|---|---|---|
| | | Officer ( Strategy, Policy and Advice) | |
| | **Review 2** | **10 October 2019** | |
| | Terri Shaw | Senior Environmental Officer | 10/10/2019 |
| | Jackie Hooper | Senior Diversity and Inclusion Officer | 25/10/2019 |
| | | | |
| | | | |
| | | | |

**Please Note: An Action Plan should be attached to this Outcome Report prior to signature**

**n/a at this stage**

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# PWYLLGOR IECHYD A DIOGELWCH
# HEALTH & SAFETY COMMITTEE

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 11 September 2023 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Updated Procedure (273) – Manual Handling Policy V4 |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Tim Harrison, Head of Health, Safety and Security<br>Adam Springthorpe, Health & Safety Manager |

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)
**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

The Health and Safety Committee (HSC) is requested to approve the revised and updated 273 – Manual Handling Policy – (Version 4). This report provides the required assurance that this Written Control Document has been developed in line with all relevant legislation / regulations and available evidence and can therefore be implemented within Hywel Dda University Health Board (HDdUHB).

### Cefndir / Background

Manual handling injuries are part of a wider group of musculoskeletal problems. 2020/2021 statistics identified that 477,000 workers were suffering from a work-related musculoskeletal disorder which was 27% of all work-related ill health (longstanding and new). There was an estimated 7.3m lost working days with an average of 15.2 days lost for each case. Human health/social work was the third highest occupation group.

The Health and Safety at Work Act 1974 (Section 2) and Management of Health and Safety at Work Regulations 1999 (Regulations 10 and 13) require employers to provide employees with health and safety information and training, with updates as required. This should be supplemented as necessary with more specific information and training and updating on manual handling injury risks and prevention, as part of the steps to reduce risk required by the Manual Handling Operations Regulations (MHOR) 1992 (as amended).

The implementation of this policy will ensure a suitable framework exists within the organisation to manage risks associated with manual handling, whilst ensuring legal compliance with all relevant legislation. This, in turn, will protect and promote the health and wellbeing of all employees and service users, whilst providing optimal care for our patients.

### Asesiad / Assessment

There have been no fundamental changes to the relevant legislation or guidance since the 2020 Version 3 of this policy, however, the opportunity has been taken to undertake a full review of how this policy works in practice within the Health Board. A number of changes / improvements have therefore been made to the policy including:

- Clarification of roles and responsibilities (including updating job titles of key stakeholders).
- Updated training specifications, including levels of training required for staff and timeframes for refresher training.
- Updated references.

The reviewed and updated policy was circulated to the full membership of the Health and Safety Advisory Group (HSAG) for comment for a period two weeks. The Group comprises of representation from Health and Safety, Occupational Health, Operational Compliance and Manual Handling. No comments were received.

The policy was then sent for Global consultation for the period 20/07/2023-04/08/2023. No comments were received.

The updated policy was approved locally by the HSAG on 9 August 2023 ahead of approval at the Health and Safety Committee in September 2023.

This policy will be available in all areas via the HDdUHB Policy Intranet site.

The effectiveness of this policy will be assessed by the analysis of Datix manual handling incident data and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable data. This data will also be used to identify causal trends to allow measures to be taken to prevent future accidents. RIDDOR reportable manual handling incidents will form part of an annual RIDDOR report presented to the Health and Safety Committee.

The Health, Safety and Security Department will monitor and review this policy on a three-yearly basis (or sooner in light of changes in legislation or practice). This will provide a measurement of performance and ensure adequate processes and structures are in place, as well as continuing compliance with statutory responsibilities.

## Argymhelliad / Recommendation

For the Health and Safety Committee to

- Approve the revised and updated 273 – Manual Handling Policy – (Version 4).

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.16 Approve organisational Health and Safety Policies, Procedures, Guidelines and Codes of Practice (policies within the scope of the Committee). |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | 1540 |
| Galluogwyr Ansawdd: | 6. All Apply |

| | |
|---|---|
| Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 2.1 Managing Risk and Promoting Health and Safety<br>2.3 Falls Prevention<br>3.1 Safe and Clinically Effective Care<br>3.5 Record Keeping |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 1. Putting people at the heart of everything we do<br>4. The best health and wellbeing for our individuals, families and communities |
| Amcanion Cynllunio<br>Planning Objectives | 2a Staff health and wellbeing |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | • All Wales NHS Manual Handling Training Passport and Information Scheme 2003 (revised 2020).<br>• Health and Safety at Work etc. Act 1974, HMSO, London. https://www.legislation.gov.uk/ukpga/1974/37/contents (accessed: 6 July 2023).<br>• Health and Safety Executive (2020) 'Work-related musculoskeletal disorders statistics in Great Britain, 2022'. Available at: https://www.hse.gov.uk/statistics/causdis/msd.pdf (Accessed: 6 July 2023).<br>• Health & Safety Executive 1992. Manual Handling Operations Regulations (as amended) HSE books, London. Available at: https://www.legislation.gov.uk/uksi/1992/2793/made (accessed: 6 July 2023).<br>• Health & Safety Executive L24 Workplace (Health, Safety and Welfare) Regulations 1992 Approved Code of Practice and guidance. Available at: https://www.hse.gov.uk/pubns/priced/l24.pdf (accessed: 6 July 2023).<br>• Health and Safety (Display Screen Equipment) Regulations (2002). Available at: https://www.legislation.gov.uk/uksi/1992/2792/made (accessed: 6 July 2023). |

| | |
|---|---|
| | • Lifting Operations and Lifting Equipment Regulations 1998. Available at: https://www.legislation.gov.uk/uksi/1998/2307/contents/made (accessed: 6 July 2023).<br>• Management of Health and Safety at Work Regulations 1999. Available at: https://www.legislation.gov.uk/uksi/1999/3242/contents/made (accessed: 6 July 2023).<br>• Provision and Use of Work Equipment Regulations 1998. Available at: https://www.legislation.gov.uk/uksi/1998/2306/contents/made (accessed: 6 July 2023).<br>• The Guide to the Handling of People, 2011, 6th edn. BackCare, Teddington. |
| Rhestr Termau:<br>Glossary of Terms: | As contained within the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch:<br>Parties / Committees consulted prior to Health and Safety Committee: | Health & Safety Advisory Group<br>Local consultation |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | There are no direct costs associated with the Policy. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | There is a positive impact on staff safety, health and wellbeing through compliance with this Policy. |
| **Gweithlu:<br>Workforce:** | There will be no adverse impact upon staff. |
| **Risg:<br>Risk:** | Not applicable. |
| **Cyfreithiol:<br>Legal:** | A breach of health and safety regulations can result in the issue of prohibition or improvement notices or criminal proceedings. |
| **Enw Da:<br>Reputational:** | Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity. |
| **Gyfrinachedd:<br>Privacy:** | Not applicable. |
| **Cydraddoldeb:<br>Equality:** | No evidence gathered at this stage to indicate a negative impact on any protected group(s). |

# Manual Handling Policy

## Policy information

**Policy number:**
**273**

**Classification:**
Corporate

**Supersedes:**
V3

**Local Safety Standard for Invasive Procedures (LOCSSIP) reference:**
N/A

**National Safety Standards for Invasive Procedures (NatSSIPs) standards:**
N/A

**Version number:**
V4

**Date of Equality Impact Assessment:**
*10/08/2023*

## Approval information

**Approved by:**
*Health and Safety Committee*

**Date of approval:**
*Enter approval date*

**Date made active:**
*Enter date made active (completion by policy team)*

**Review date:**
**Enter review date (normally three years from approval date)**

**Summary of document:**
This policy provides a framework for the provision of manual handling systems and processes for Hywel Dda University Health Board (HDdUHB).

**Scope:**
The scope of this policy is to cover all employees or other persons who may have occasion to visit HDdUHB premises or who may be affected by the actions of HDdUHB employees whilst carrying out their duties. Where employees work in environments not directly controlled by HDdUHB (e.g. staff providing services in the community), or in a varied number of locations (e.g. Estates staff), there is an added emphasis on these persons to take special care of their own health and safety, and for that of others.

**To be read in conjunction with:**
010 – Health and Safety Policy – opens in a new tab
100 – Organisational Induction Policy – opens in a new tab
113 – Learning and Development Policy – opens in a new tab
139 – Uniform and Dress Code Policy for All Health Board Staff – opens in a new tab
195 – Clinical Record Keeping Policy – opens in a new tab
201 – All Wales Disciplinary Policy and Procedure – opens in a new tab
608 – Risk Management Framework – opens in a new tab
674 – Risk Assessment Procedure – opens in a new tab
767 – New and Expectant Mothers / Birthing Parents Procedure – opens in a new tab
982 – Incident, Near Miss and Hazard Reporting Procedure – opens in a new tab
All Infection Control Policies

**Patient information:**
Include links to Patient Information Library

**Owning group:**
Health & Safety Advisory Group / Health and Safety Committee
*09/08/2023*

**Executive Director job title:**
Director of Nursing, Quality and Patient Experience

**Reviews and updates:**
V1. New Policy – 2015
V2. Amendments and full review – 14/09/2017
V3. Amendments – 02/11/2020
V4. Amendments and full review – 11/09/2023

**Keywords**
Manual Handling, Moving and Handling

**Glossary of terms**
SSoW – Safe System of Work
MHOR – The Manual Handling Operation Regulations 1992
HSE – Health and Safety Executive
PPE – Personal Protective Equipment

# Contents

## Introduction

Manual handling injuries are part of a wider group of musculoskeletal problems. 2020/2021 statistics identified that 477,000 workers were suffering from a work-related musculoskeletal disorder which was 27% of all work-related ill health (longstanding and new). There were an estimated 7.3million lost working days with an average of 15.2 days lost for each case. Human health/social work being the third highest occupation group. Health and Safety Executive, 2022.

The Health and Safety at Work etc. Act 1974 (Section 2) and Management of Health and Safety at Work Regulations 1999 (Regulations 10 and 13) require employers to provide employees with health and safety information and training, with updates as required. This should be supplemented as necessary with more specific information and training and updating on manual handling injury risks and prevention, as part of the steps to reduce risk required by the Manual Handling Operations Regulations (MHOR) 1992 (as amended).

This policy relates specifically to above legislation (and its relation to staff, patients and visitors) and will also comply with the standards as set by the All-Wales NHS Manual Handling Training Passport and Information Scheme (2003) (revised 2020).

## Policy Statement

The implementation of this policy will ensure a suitable framework exists within the organisation to manage risks associated with manual handling whilst ensuring legal compliance with all relevant legislation. This, in turn, will protect and promote the health and wellbeing of all employees and service users, whilst providing optimal care for our patients.

## Scope

The scope of this policy is to cover all employees or other persons who may have occasion to visit HDdUHB premises or who may be affected by the actions of HDdUHB's employees whilst carrying out their duties. Where employees work in environments not directly controlled by HDdUHB (e.g., staff providing services in the community), or in a varied number of locations (e.g. Estates staff), there is an added emphasis on these persons to take special care of their own health and safety, and for that of others.

## Aim

This policy aims to:

- Assist HDdUHB to comply with all relevant legislation.
- Comply with all aspects of the All-Wales NHS Manual Handling Training Passport and Information Scheme.
- Protect and promote the health and wellbeing of all employees and patients.

- Protect other persons who may have occasion to visit HDdUHB premises or who may be affected by the actions of HDdUHB employees whilst carrying out their duties.

## Objectives

The objectives of this document are:

- To ensure a suitable framework exists within the organisation to manage risks associated with manual handling activities.
- To ensure that suitable arrangements are in place for systematic audit for manual handling activities.
- To ensure that HDdUHB provides competent persons to advise, assess risk and deliver training as appropriate and to lead the development of the service both locally and nationally.
- To ensure the Manual Handling Clinical Nurse Specialists (MH CNS), Trainers and Workplace Assessors maintain up-to-date knowledge of best practice and equipment by regular training, development, and suitable networking.
- To implement all aspects of the All-Wales NHS Manual Handling Training Passport and Information Scheme.
- To ensure that those with managerial responsibility have appropriate knowledge and skills to be able to identify, assess, reduce, and control risks arising from manual handling activities within HDdUHB.
- To ensure that every effort is made to make those premises which are not within the normal precincts of HDdUHB, in which employees must work, safe and free from risks.
- To ensure suitable systems are in place for managers to monitor and review manual handling arrangements.
- To ensure that all staff have the relevant skills and knowledge of safe manual handling working practices by accessing and attending appropriate training prior to commencing workplace activities.
- To ensure that systems are in place for all staff to attend classroom update training/workplace assessment as appropriate.
- To ensure those providing workplace assessments have access to appropriate training and development to undertake the role in a competent manner.
- To ensure that sufficient and appropriate equipment is provided by HDdUHB, maintained, and used for its intended purpose.
- To ensure the safety of patients and staff is not compromised which may include the limiting/withdrawing of handling activities.
- To ensure that all records of training attendance are kept centrally on the Electronic Staff Record System.

- To ensure systems are in place to access specialist advice from the Manual Handling Team (Please see Appendix 1).
- To ensure that there is a system in place to investigate manual handling accidents, incidents and near misses and that appropriate action is taken to prevent reoccurrence (Please see Appendix 2).
- To ensure that there is a system in place for staff to access advice and support from the occupational health services, in conjunction with the Manual Handling Co-ordinator, in the event of musculoskeletal disorders and or absence from work (Please see Appendix 3).

## Legislation

**Principal legislation and publications referred to:**

- Health & Safety at Work etc. Act 1974
- The Management of Health & Safety at Work Regulations 1999
- The Manual Handling Operations Regulations 1992 (as amended)
- The Provision and Use of Work Equipment Regulations 1998
- The Lifting Operations Lifting Equipment Regulation 1998
- The Guide to the Handling of People, 2011, 6th edn
- The Workplace (Health, Safety & Welfare) Regulations 1992
- All Wales NHS Manual Handling Training Passport and Information Scheme 2003 (revised 2020)
- The Health and Safety (Display Screen Equipment) Regulations (2002)

**Specifically**

The Health & Safety at Work etc. Act 1974 places a general duty on the employer 'to ensure so far as is reasonably practicable, the Health and Welfare at work of all employees'. Section 2 (1).

These duties include providing:

- Information; Instruction; Training and Supervision to ensure the health and safety of all employees.
- There are further duties placed on the employees which require them to take 'reasonable care for the Health and Safety of themselves and of other persons who may be affected by their acts or omissions'.

## Definitions

The Manual Handling Operation Regulations 1992 (as amended) (MHOR) refers to the moving of loads whether the load is animate or inanimate and apply to the '***Transporting, supporting, lifting, pushing, pulling and carrying of loads'*** and places a statutory duty on HDdUHB to control risks

associated with the handling of loads, and where the risks are deemed significant to reduce or eliminate those risks to employees.

The MHOR regulations place a requirement on the employer to:

- Avoid – the need for hazardous manual handling, so far as is reasonably practicable.
- Assess – the risk to staff and clients/loads, where manual handling operation cannot be avoided.
- Reduce – take appropriate steps to reduce the risk of injury to the lowest level reasonably practicable. Develop and implement safe systems of work.
- Inform – All relevant staff of outcome of risk assessment and recommended controls.
- Review – to take place on an annual basis, or if there has been significant changes or it is no longer valid.

**Minimal Manual Handling**

HDdUHB recognises that the handling of patients and inanimate loads presents a risk of injury to staff, service users and other people, and that MHOR places a statutory duty on HDdUHB to control risks associated with the handling of loads, and where the risks are deemed significant to reduce or eliminate those risks to employees.

In complying with MHOR, HDdUHB considers the total elimination of patient handling to be impracticable. A balance will be sought between the needs and ability of the patients and the safety of staff. Patients must, wherever practicable, be encouraged to assist in handling activities. HDdUHB is committed to developing a minimal manual handling/lifting approach.

In all respects HDdUHB will address MHOR, and its effects, in a reasonable manner having regard to all the circumstances. Risk assessment and planning can eliminate or reduce identified manual handling hazards. However, where assessments indicate there is absolutely no alternative but to lift animate or inanimate loads manually, a more detailed assessment of risk and methods must be undertaken and recorded.

Animate loads – the manual lifting of a patient is eliminated in all but exceptional or life-threatening situations. Patients are encouraged to assist in their own transfers and handling aids should be used whenever they can, in order to help to reduce risks and maintain/increase functional mobility.

## Responsibilities

**Chief Executive**

The Chief Executive has overall responsibility to ensure that HDdUHB complies with health and safety legislation and guidelines and for the organisational arrangements necessary to achieve these aims and will keep HDdUHB informed of developments.

The Chief Executive will delegate strategic manual handling management to an appropriate Executive within HDdUHB. The Chief Executive also delegates to Director of Workforce and OD the responsibility for the effective management of manual handling within their Directorates.

**Director of Nursing, Quality and Patient Experience**
The Director of Nursing, Quality and Patient Experience is the Executive Lead with responsibility for manual handling. The main responsibilities of this post are to determine overall policy including the organisational development needs of HDdUHB. Included in this role is monitoring and review of the manual handling status of HDdUHB and the taking of appropriate action where deficiencies are identified.

This post shall not have specific responsibility for the management of manual handling within each Service but will be responsible to the Chief Executive for:

1. Determining overall HDdUHB manual handling strategy and performance including the organisation arrangements, policies, instructions and compliance with legislation, guidelines, and strategies.
2. The provision of advice as necessary to General Managers or Service Heads and Senior Managers on aspects of manual handling.

All the above responsibilities will be undertaken by an appropriate Senior Manager, on behalf of the Director of Nursing, Quality and Patient Experience.

**Assistant/Associate Directors, County Directors, General/Senior Managers, Clinical Leads, Heads of Service/Divisions** are responsible for all aspects of health and safety of staff, patients, and others in areas where they provide a service or under their control. This includes compliance with legislation and the following:

- The implementation of HDdUHB policy to ensure the effective management of manual handling.
- The identification, assessment, and control of manual handling risk, in line with HDdUHB's Risk Management Guidelines.
- Ensuring that equipment, premises, and systems of work are safe.
- The provision of training and information to staff and others, as appropriate.
- The investigation of accidents and incidents, taking appropriate corrective action to prevent a recurrence and reporting details promptly.
- Monitoring and review of manual handling performance.

**All Managers** have the following responsibilities:

- To attend appropriate training sessions to enable them to be aware of their responsibilities in relation of manual handling to include the risk assessment process.
- To ensure that Manual Handling Risk Assessments are carried out and safe systems of work are devised and implemented.
- To request assistance from the Manual Handling team where significant moving and handling risks are identified or where a patient has complex needs beyond the normal presentation of ward patients, via the Manual Handling Referral Form. For more information on deciding if specialist advice is required, please see Appendix 1.
- That incidents are correctly recorded and investigated, and remedial actions are taken.
- That Workplace Assessors are supported by ensuring that sufficient time and resources are given to allow them to undertake the full range of their duties.
- That Staff are supported by being released to attend all appropriate manual handling training provided by HDdUHB.
- That monitoring and auditing of manual handling activities within their area are undertaken, and any findings are acted upon.
- That all mechanical and handling equipment is regularly maintained in accordance with legislation, and that records are maintained.
- That patients and relatives receive information about HDdUHB's Manual Handling Policy and are made aware that patients and staff will not be placed at risk whilst handling patients.

**Manual Handling Manager**

Role:

To support Assistant/Associate Directors, County Directors, General/Senior Managers, Clinical Leads, Heads of Service/Divisions and Managers in ensuring that robust arrangements are in place to ensure that risks within their area of responsibility are effectively managed and minimised to a level acceptable to both the service and HDdUHB.

Responsibility:

- To provide evidence-based, competent advice to HDdUHB, enabling HDdUHB to comply with current legislation and relevant standards.
- Maintain an up-to-date knowledge of legislation and current best practice and lead the development of the service both locally and nationally.
- To ensure there are systems in place to enable the Manual Handling team to access advice and support from senior management/clinicians representing all areas of the organisation.
- Undertake regular review of the Manual Handling Policy and develop supporting guidance as necessary.
- To ensure HDdUHB's Manual Handling Policy is implemented through monitoring and audit via the health & safety audit tool, the outcome of which is reported to the appropriate channels.

- Reports will be provided on a regular basis to the appropriate committees.
- To ensure managers have access to advice and support when managing and monitoring the risks associated with manual handling.
- Provide managers and staff with appropriate advice and support when investigating manual handling incidents/accidents/near misses.
- Provide advice and support in complex handling situations.
- Provide advice on equipment/furniture provision and purchase.
- Provide advice on new builds and refurbishments.
- To ensure the development and implementation of appropriate training programmes in line with current best practice and commensurate with the employee role is in place.
- To ensure those providing training/update training have access to appropriate training and development to undertake the role in a competent and confident manner.
- To provide support to the Manual Handling team by ensuring regular team meetings are in place to enable discussion and review of current practice.
- Ensure that the delivery and content of all training is of sufficient standard to ensure compliance with the All-Wales NHS Manual Handling Training Passport and Information Scheme.
- Ensure there is an appropriate system in place to record all manual handling training activity on the Electronic Staff Record System.
- To raise awareness of the services available to staff from the Occupational Health department, staff psychological health and wellbeing service etc.
- To actively promote an organisational climate that encourages the reporting of adverse incidents whilst ensuring that lessons are learnt from events as they occur.

**Manual Handling Clinical Nurse Specialist (MH CNS) and Manual Handling Trainers**

Role:

To facilitate manual handling provisions through direct delivery, to meet the learning needs amongst the various professions within HDdUHB.

Responsibilities:

- Maintain up to date knowledge of manual handling issues and disseminate through training programmes.
- Assist the Manual handling Manager in the implementation of HDdUHB's Manual Handling Policy.
- Implement, review and deliver training programmes in order to comply with the All-Wales NHS Manual Handling Training Passport and Information Scheme for patient handlers and non-patient handlers as specified.

- Develop and support the workplace assessor network and provide update training on an annual basis and advise as necessary.
- Work with the Manual Handling Manager in the appropriate selection and provision of equipment, furniture, and aids.
- Assist managers in the investigation of manual handling incidents where appropriate.
- Assist with manual handling risk assessments as appropriate.
- Provide clinical advice on complex patients following a patient referral form (MH CNS only) (Please see Appendix 1).
- Undertake manual handling audits on an annual basis of all patient areas and high-risk non-patient areas (for example, Portering).

**Manual Handling Workplace Assessors**

- Liaise with Manual Handling Team to assist in the implementation of the organisation's Manual Handling Policy and the All-Wales NHS Manual Handling Training Passport and Information Scheme.
- Attend appropriate training sessions to develop the skills and knowledge required to undertake role.
- Attend appropriate update sessions and meetings to maintain an up-to-date knowledge of manual handling issues.
- To undertake workplace competency assessments on an allocated group of staff.
- Time commitment will be dependent on area of work, and numbers of staff requiring assessment.
- Act as a resource for staff to pass on concerns raised in relation to manual handling issues.
- To assist managers in undertaking the manual handling risk assessments, including the monitoring and review processes as required.
- Ensure records of workplace assessments undertaken are forwarded to the Manual Handling Department as soon as is practicable.
- Ensure accurate record keeping is in place regarding training, workplace assessments, and equipment inventory etc, providing copies to the individual managers and to the Manual Handling Department.
- Continue to raise the profile of manual handling in their own areas of work and liaise/co-operate with other Manual Handling Workplace Assessors to provide and receive support.

**Employees (Contracted and Honorary) will:**

- Take reasonable care for their own health and safety and for that of others who may be affected by their acts or omissions.
- Attend manual handling training sessions organised by HDdUHB commensurate with their role.

- Participate in the risk assessment process.
- Report to managers, and document any incidents, hazards, near misses related to manual handling using HDdUHB's incident reporting procedure. Including non-compliance of other staff with the requirements of this policy.
- Use appropriate manual handling or lifting equipment provided to minimise the risk of injury in accordance with instruction or training received and which is documented in the manual handling risk assessment.
- Inform their manager / supervisor if they become aware of any medical condition and pregnancy which may place them at increased risk when performing any manual handling task. This information, when possible, is to be treated as confidential.
- Report to their manager and/or take appropriate action regarding defects in equipment or where a patients presentation required specialist manual handling advice.
- Adhere to any policy that affects the provision of safe manual handling operations.

**Voluntary Workers Etc (Non-HDdUHB Employees)**
HDdUHB will ensure that appropriate training is provided, and that they adhere to any policy that affects the provision of safe manual handling operations.

**Individuals such as Suppliers, Service Engineers etc, who work on HDdUHB premises, will:**
- Take reasonable care to ensure their safety and that of others in relation to manual handling.
- Report to HDdUHB managers any incidents relating to manual handling.

## Manual Handling Risk Assessments

It is a manager's responsibility to ensure that manual handling risk assessments are undertaken within their area of responsibility and that safe systems of work are devised, implemented, and communicated to all relevant staff. Managers who supervise staff, or a delegated competent person, must undertake manual handling risk assessments.

Training, guidance, and support in undertaking manual handling risk assessments is available from the Manual Handling Co-ordinators and trainers. All those undertaking such assessments must have the necessary knowledge and skills to do so. Advice may also be sought from the Health, Safety and Security Department.

<u>In order to implement a suitable and sufficient process the following tools will be used:</u>

**Generic Manual Handling Risk Assessment Form** (Please see Appendix 4).
Generic risk assessment should be undertaken and reviewed annually or when changes in work activities occur. Review should also take place whenever there is a reason to suppose that the

assessment is no longer valid e.g. because the working conditions, the personnel carrying out the operation, the manual handing operation itself has changed, or following a near-miss incident or personal injury.

Upon completion, records of the risk assessment should be retained locally at department level. Any workplace redesign, equipment and training needs identified will be incorporated into an action plan, which will be implemented so far as is reasonably practicable. It is the responsibility of the manager to ensure that action is taken, and that action should ensure the risk is reduced to its lowest practicable level. Unresolved risks need to be reported via the directorates' risk management system, to be included into HDdUHB risk register. A copy of the action plan should be forwarded to the Manual Handling Manager.

Tasks requiring a safe system of work should have a documented procedure. This should be kept in an accessible place and reviewed annually along with the risk assessments.

Managers should carry out a systematic review of the risk assessments on an annual basis or sooner as appropriate (e.g., following incident or accident).

**Individual Patient Manual Handling Risk Assessment Form**
Completion of the patient handling assessment, either on paper records or on the Welsh Nursing Care Record (WNCR), will be the responsibility of the registered practitioner, directly involved in that patient's care, excluding medical staff. The handling plan will ideally be kept at the end of the patient's bed and should be easily accessible to those needing to assist the patient. This information needs to accompany the patient to other departments e.g., Radiography, Theatre.

The re-assessment of individual patients should occur daily/weekly, or as appropriate, or if there is a change in their condition, or if there is a change of clinical area.

## Incidents

Following a near miss, incident, or accident, the Datix Form should be completed within 24 hours and forwarded to the Line Manager who is responsible for investigating the incident and taking the appropriate action. The Manual Handling Manager may need to advise further action.

Manual handling incident and accident statistics will be collated and presented as part of the annual Manual Handling Report.

Any identified issues will be fed into the appropriate advisory group for further analysis.

## Equipment

Appropriate handling equipment, for both patients and inanimate loads should be provided where a risk has been identified. It is essential that the Managers are aware of the availability, suitability, and maintenance of equipment within their own Directorate/Department. To ensure this is carried out, the following steps must be taken:

- Each Associate Medical Director/General Manager has the responsibility to provide equipment required following a risk assessment so far as is reasonably practicable.
- If a need for further manual handling equipment is identified by staff or managers, the Manual Handling Manager/Trainer should be consulted for advice on selection and suitability.
- Prior to purchase/hire/trial, all manual handling equipment should be evaluated by the appropriate group to ensure its fitness for purpose.
- Departments wishing to purchase/hire/trial equipment should contact the Procurement Department. It should be ensured that indemnity insurance is in place where applicable.
- Staff must not use equipment until appropriate training has been received.
- Routine maintenance of mechanical equipment must be carried out as per HDdUHB 'Maintenance Policy' and in accordance with LOLER Regulations 1998.
- Other non-mechanical equipment must be regularly inspected / maintained on a departmental basis by a competent person.

## Training

Training and instruction in safe handling should occur in conjunction with other risk control measures. Sole reliance on training is not effective in controlling risk. It is recognised that there are manual handling risks specific to each ward and department in HDdUHB, which cannot be highlighted during Induction. Therefore, the department/ward manager has a duty to provide information and/or training covering such risks before the new employee is exposed to those risks

HDdUHB will provide an induction programme and training in accordance with best practice and will comply with the 'Passport Scheme'. This will ensure consistency of manual handling training / assessment within the NHS in Wales. It will allow staff to transfer their skills when moving between Health Boards and ensuring consistency across Wales thus, minimising duplication and time lost to the service.

All managers and staff must support and implement the contents of the `Passport Scheme`.

No new employee should perform a manual handling activity unless they have received appropriate training and instruction.

In order to achieve this, HDdUHB will ensure that:

- The Manual Handling Manager / MH CNS / Trainers receive adequate training and updating in order to ensure that up to date knowledge and skills are maintained.
- Unless exceptional circumstances prevent them from doing so, all new employees must attend HDdUHB induction sessions to include manual handling foundation training prior to commencing workplace activities. This comprises of modules commensurate with their role unless a current manual handling 'Passport' can be produced and verified. In such cases, the employee must attend update training as soon practicable. Training provided will reflect the individual's duties and include a work-based assessment where appropriate. On completion of this training, each employee will then be issued with a manual handling Passport. New staff will be made aware of workplace manual handling arrangements during their local induction session.
- All employees who have a significant change in role will be assessed for further manual handling training needs by their manager. The manager will be responsible for booking any further training as needed.
- Training records will be kept centrally on the Electronic Staff Record System.
- Training records will be accessible through the Employee Self Service System.
- Bank staff will not commence employment until foundation manual handling training is completed, or a current manual handling 'Passport' is produced and verified by the Manual Handling Department.
- Staff that are unable to demonstrate the required level of skill and knowledge will be given further training. The trainer will liaise with the individual's line manager who, if necessary, may seek guidance from other specialist HDdUHB departments.
- Attendances at manual handling courses are mandatory, and the trainer will record all attendance. Non-attendance at induction training will be reported to the appropriate manager, all other non-attendance will be communicated to the manager by the Manual Handling team.
- Appropriate clothing and footwear should be worn for training sessions and in the workplace in accordance with HDdUHB's Uniform Policy.

**Refresher Training**

All staff will have access to regular updating in manual handling. The level of risk in the workplace area and the needs of the individual, will determine the content. Generally, patient handling staff will require an annual intervention of either a workplace assessment or update training in the classroom dependant on their needs with no more than 3 years between classroom refresher sessions.

Non-patient handling staff will require updating interventions between one and three years depending on the risks associated with their role.

The workplace assessments will be undertaken by the Manual Handling Workplace Assessors and the update training will be provided by members of the Manual Handling team, either in the workplace, or the classroom as required. The number of classroom-based training sessions will be determined by an annual training needs analysis across HDdUHB.

## Monitoring and Review

The Manual Handling Manager, in conjunction with the Manual Handling Team, will carry out regular review of the implementation process of the Manual Handling Policy which includes all of the training programs. The review will consider the manual handling operations, the results of assessments, audits, incident reports and the development of techniques, equipment and other control measures, and will include current best practice.

## Key Performance Indicators

- Annual audit to ensure that HDdUHB is compliant with relevant legislation.
- A representative from HDdUHB to participate in regular meetings of the All-Wales Manual Handling Advisory Group to ensure that HDdUHB is regularly updated in order to comply with all aspects of the All-Wales NHS Manual Handling Training Passport and Information Scheme.
- Maintain an 80% compliance rate in manual handling training.
- Monthly Datix review to ensure that there is appropriate investigation of accidents and incidents, and that suitable corrective action has been taken to prevent a recurrence.
- Risk assessment documentation is completed and appropriately reviewed.

## Occupational Health

Prospective employees receive pre-employment assessment by the Occupational Health Department to ensure that individuals are fit for the job and the job is 'suitable' for the individual. Knowledge of the capabilities of the employee, the nature of the working environment and demands of the job allow the Occupational Health staff to make an appropriate assessment.

A change in health status for example, pregnancy or the development and progression of an illness, or return to work following musculoskeletal injury, should result in an assessment of competence being undertaken by the manager and if necessary, reported to the Occupational Health Department so that appropriate advice can be given. Please see: 767 – New and Expectant Mothers / Birthing Parents Procedure – opens in a new tab.

## Disciplinary Procedure

HDdUHB reserves the right to take disciplinary action against any University Health Board employee who fails to follow safe practice or puts themselves or others at risk by their own omission or neglect. Please refer to disciplinary procedure for further guidance.

## References


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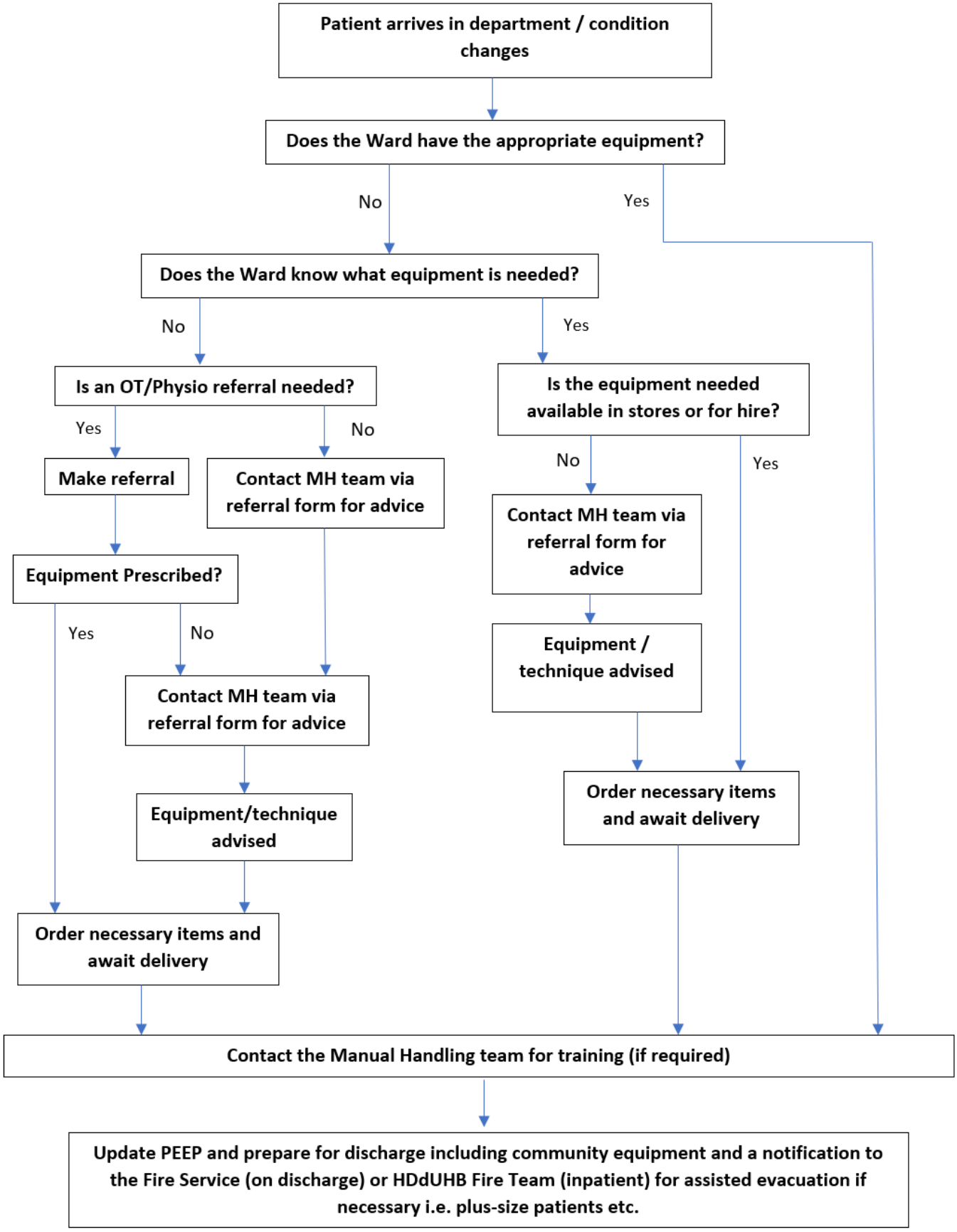
The Guide to the Handling of People, 2011, 6th edn. BackCare, Teddington.

# Appendix 1: Do I Need Specialist Manual Handling Advice?



## Appendix 2: Manual Handling Investigation Report Form

| MANUAL HANDLING INVESTIGATION REPORT FORM |
|---|
| **Datix Reference:** |

| INCIDENT INFORMATION – FACTS ONLY | | | |
|---|---|---|---|
| **Please ensure any equipment/aids that have been used in an incident are taken out of use until the appropriate tests/investigations are completed** | | | |
| **Background information:** | | | |
| **Staff members involved:** | | | |
| **Description of Incident:**<br>**Describe manoeuvre, method equipment/aids used and number of staff involved. Consider: Task, Load, Individual Capability, Environment and other factors.**<br>**(Reconstruction of the event may be useful to determine accuracy)** | | | |
| **Immediate action taken:** | | | |
| **Staff members involved in investigation:** | | | |
| **Were there any particular factors or difficulties with the activity on this occasion that had not been experienced before?**<br>If **YES** – please describe: | ☐ **Yes** | ☐ **No** | |
| **Have witness statements been provided from all involved?** | ☐ **Yes** | ☐ **No** | **Comments:** |
| **No of staff working at time:** | | | |
| **Workload:** | | | |
| **Skill mix:** | | | |
| **Photographs/drawings:** | ☐ **Yes** | ☐ **No** | |
| **If required, has an Individual Patient Manual Handling Risk Assessment been completed?** | ☐ **Yes** | ☐ **No** | |
| If **NO** – please explain why not:<br>If **Yes** – Is the information accurate? | | | |
| **If a patient handling incident, are there any other assessments available e.g. Physio/OT?** | ☐ **Yes** | ☐ **No** | |
| **Is there a current written procedure or safe system of work for this activity?** | ☐ **Yes** | ☐ **No** | |

| | | | |
|---|---|---|---|
| If **NO** – please explain why not: | | | |
| **Was the above being followed when the incident occurred?** | ☐ **Yes** | | ☐ **No** |
| If **NO** – please explain why not: | | | |
| **How are departmental written procedures, risk assessments and /or safe system of work communicated to all staff?** | | | |
| **Has the written procedure, risk assessment and /or safe system of work been reviewed following the incident, documented and communicated to all staff?** | ☐ **Yes** | | ☐ **No** |
| If **NO** – please explain why not: | | | |
| **Was the injured person familiar with:**<br>**Location (eg. were they casual or temporary staff)**<br>**Equipment used (if relevant)**<br>**Task/activity being undertaken**<br>**Patient/Load** | ☐ **Yes**<br>☐ **Yes**<br>☐ **Yes**<br>☐ **Yes** | ☐ **No**<br>☐ **No**<br>☐ **No**<br>☐ **No** | ☐ **N/A**<br>☐ **N/A**<br>☐ **N/A**<br>☐ **N/A** |
| If **NO** – please explain why not: | | | |
| **Was there a problem with, or failure of, the equipment at the time of the incident?**<br>**If YES – please provide required information and ensure the item is marked and taken out of use until examined** | ☐ **Yes** | ☐ **No** | ☐ **N/A** |
| **Has the injured person/ any other person involved received appropriate training?** | ☐ **Yes** | ☐ **No** | ☐ **N/A** |
| **Are there detailed training records available for all involved?**<br>**Please record dates:** | ☐ **Yes** | | ☐ **No** |
| If **NO** – please explain why not: | | | |
| **Has the injured person existing medical condition/s?** | ☐ **Yes** | | ☐ **No** |
| **Describe extent of current injury (if appropriate)** | | | |
| **Does the person require A&E/Occupational Health referral?** | ☐ **Yes** | ☐ **No** | ☐ **N/A** |
| **Does the injured person require workplace assessment/update?** | ☐ **Yes** | ☐ **No** | ☐ **N/A** |

| | | | |
|---|---|---|---|
| If **YES** – when will this be undertaken? | | | |
| **Have there been other similar incidents?** | ☐ **Yes** | | ☐ **No** |
| If **YES** – please provide details: | | | |
| **Has the person had any similar injuries?** | ☐ **Yes** | ☐ **No** | ☐ **N/A** |
| If **YES** – please provide details: | | | |
| **Date of last PDR** (if applicable): | | | |

| **ADDITIONAL INFORMATION:** | | |
|---|---|---|
| **Media interest (actual or potential)** | ☐ **Yes** | ☐ **No** |
| Please state: | | |
| **Have other agencies been informed and involved in this incident?** | ☐ **Yes** | ☐ **No** |
| **Possibility of a complaint or litigation?** | ☐ **Yes** | ☐ **No** |
| **What lessons have been learnt as a result of the incident?** | | |
| **Summary** | | |
| **Considerations/recommendations:** | | |
| **Could this be of value to other Directorates/other health bodies or the NHS as a whole?** | | |

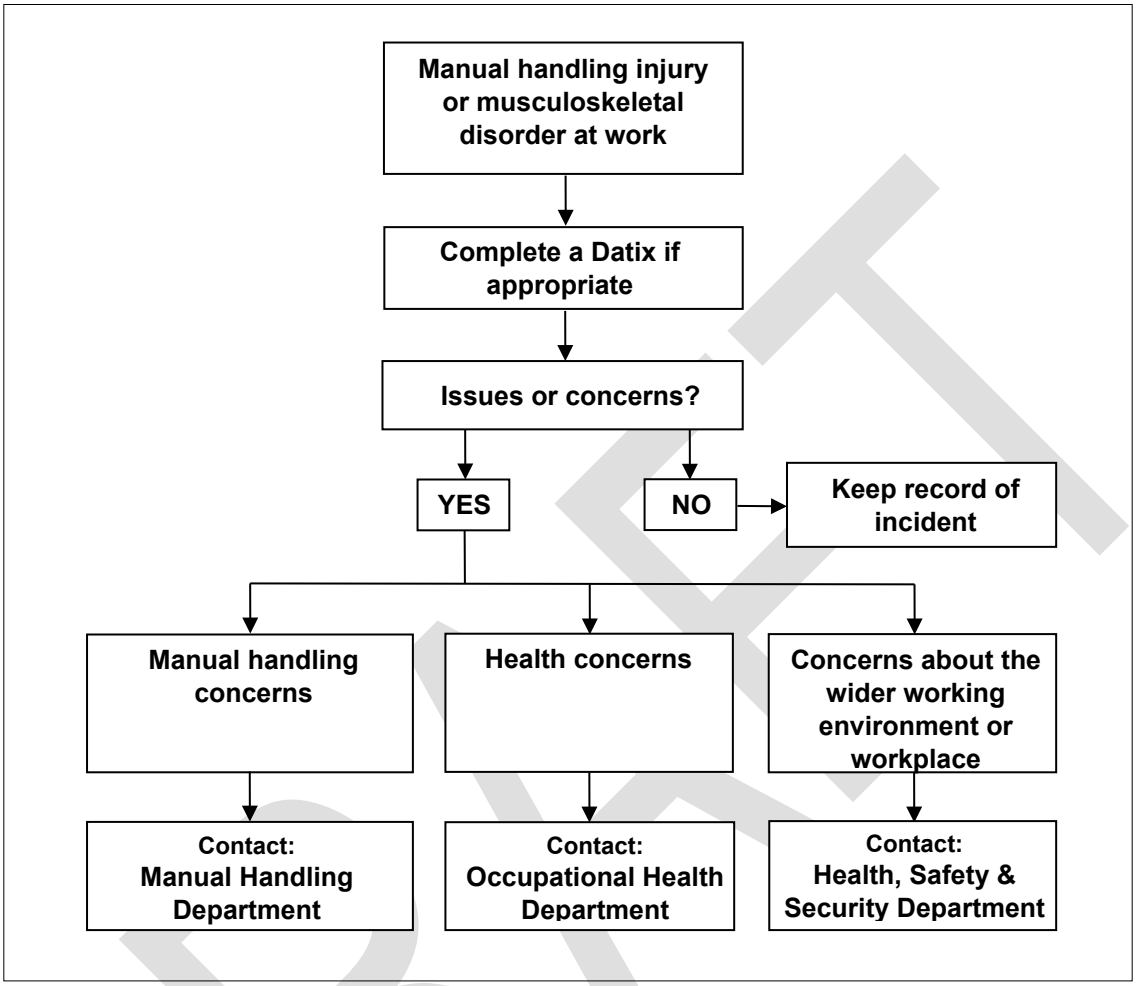
**What action(s) need to be undertaken to either prevent recurrence or reduce the level of risk?**

| Action(s) Needed | By Whom | By When | Review Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Investigation report and action plan agreed:**

| | | | | |
|---|---|---|---|---|
| **Senior Nurse/Manager** | Name: | Signature: | **Date** | |
| **Directorate Manager or Equivalent** | Name: | Signature: | **Date** | |

## Appendix 3: Flowchart for staff who experience a MH injury or musculoskeletal disorder at work



## Appendix 4: Manual Handling Assessment Form

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# HANDLING ASSESSMENT FORM

| SECTION A: ADMINISTRATION DETAILS | |
|---|---|
| **Primary Location:**<br>**Secondary Location:**<br>**Precise Location:** | **Date of Review:……**<br>**Signature of Assessor:……** |
| **Name of Assessor:**<br>**Designation:**<br>**Date of Initial Assessment:** | **Date of Review:……**<br>**Signature of Assessor:……** |
| | **Date of Review:……**<br>**Signature of Assessor:……** |
| | **Date of Review:……**<br>**Signature of Assessor:……** |

| SECTION B: MANUAL HANDLING TASK |
|---|
| Description of task: |
| Personnel involved: |

| SECTION C: CURRENT RISK CONTROL MEASURES | |
|---|---|
| Control measures currently in use: | Equipment currently in use: |

## Manual Handling Risk Level

In each of the sections, task, load, individual capability, environment - tick the appropriate box [yes or no]
A 'Yes' tick indicates that further action is required to reduce the risk

## SECTION D: ASSESSMENT OF RISK

| Initial Assessment | Task | | | Initial Assessment | Load | |
|---|---|---|---|---|---|---|
| **Does the task involve** | **Yes** | **No** | | **Is the load/patient** | **Yes** | **No** |
| Holding load away from trunk | | | | Heavy? Indicate weight [ ] | | |
| Twisting | | | | Body/unwieldy one side heavier > 75cm in diameter | | |
| Stooping | | | | Difficult to grasp – no conventional hand holds | | |
| Reaching upwards | | | | Unsteady/unpredictable | | |
| Large vertical movements from floor | | | | Harmful, e.g. sharp, hot, contaminated, patient behaviour | | |
| Long carrying distances | | | | | | |
| Strenuous pushing/pulling | | | | | | |
| | | | | | | |
| **Initial Assessment** | **Individual Capability** | | | **Initial Assessment** | **Environment** | |
| **Does the task:** | **Yes** | **No** | | **Does the environment have:** | **Yes** | **No** |
| Require unusual capabilities ie strength, height, age | | | | Constraints on posture ie restricted space, low work surfaces | | |
| Constitute a hazard to those with health problems | | | | Poor floors, eg uneven, slippery, unstable | | |
| Constitute a hazard to those who are pregnant | | | | Strong air movements | | |
| Require special information and/or training | | | | Poor lighting conditions | | |
| Require personal protective clothing | | | | Hot, cold, humid condition | | |
| Other Factors | | | | | | |

## SECTION E: FREQUENCY OF TASK

Record the number of times the activity takes place during one working shift. The frequency could require additional control measures.

Frequency of activity ☐ Number of staff involved in the task ☐

## SECTION F: INITIAL RISK RATING FIGURE

Initial Risk Rating Figure: (to calculate see Risk Matrix)

Potential consequence rating ☐ x ☐ Possible likelihood rating ☐ = Risk Rating Figure

**SECTION G: Additional Risk Control Measures Required**

Additional control measures to be recorded within this box. The request for these measures should be subjected to a risk priority along with other risks within the location and will form part of a prioritised risk register.

| No | Risk Reduction Measures |
|---|---|
| | |

If the above control measures are implemented, calculate the New Risk rating Figure:

Potential consequence rating ☐ x Possible likelihood Rating ☐ = Risk Rating Figure: ☐

**SECTION H: Action Plan Agreed with Manager**

| No | Action Plan | Responsible Person | Projected Completion Date | Date Completed/ Signature |
|---|---|---|---|---|
| | | | | |

Once the above action has been implemented, calculate the final Risk Rating Figure

Potential consequence rating ☐ x Possible likelihood rating ☐ = Risk Rating Figure: ☐

**Additional Comments**

**Safe System of Work**

Task:……

Area:……

| Equipment<br>No of Staff etc | Method/Technique |
|---|---|
| | |

**Risk Assessor:-……**

**Risk Assessor Signature:-……**

**Date:-……...**

**MANUAL HANDLING RISK ASESSMENT ACTION PLAN**

| Risk Identified | Risk Rating | Action Recommended | Time Frame | Person Responsible | Review Date |
|---|---|---|---|---|---|
| | | | | | |

**SIGNED**……

**RISK ASSESSOR:**……

**MANAGERS SIGNATURE** ……

## MANUAL HANDLING RISK ASSESSMENT FORM

### GUIDELINES FOR USE

**This form can be used for assessing inanimate load handling tasks or generic patient tasks. There is a separate Risk Assessment Form for individual/named patient handling tasks.**

The Manual Handling Operations Regulations 1992, require that tasks that involve risk should be eliminated. Only when this is not possible should an assessment be carried out to reduce the risks associated with that task to the lowest level that is reasonably practicable.

**HAZARD** Source of potential harm or damage or a situation with potential for harm or damage

**RISK** Is a combination of the likelihood and severity of a specified hazard occurring?

The Manual Handling Operations Regulations 1992 support the Health and Safety at Work etc Act 1974. A breach of these statutory requirements is a criminal offence

**ACCOUNTABILITY** - lies with the head of services/designated director/manager

**RESPONSIBILITY** - day to day responsibility of managing risk lies with departmental/ ward managers

The person carrying out a manual handling assessment (assessor) should be a competent member of staff who has undertaken the appropriate training in Manual Handling Risk Assessment. The assessment should be reviewed in accordance with the specified review period, whenever there is any change of following a manual handling incident. The objective of risk management is to identify and reduce the **LIKELIHOOD** of incidents occurring that could have significant consequences for staff, patients or the Trust, as far as is reasonably practicable.

There are no absolute values for incidents, but effective risk assessment, applying appropriate control measures and monitoring those measures, together with training, can help minimise the potential for injury and/or other losses. The Risk Matrix will help with this process.

**The completed form must be accessible at all times.**

**Filling in the form**:

**SECTION A:**
Primary Location, e.g. hospital/premises/community
Secondary Location. e.g. ward/department, clinic, residential/care facility
Precise Location, e.g. side room, store-cupboard, corridor

**SECTION B: Description of Manual Handling Task**
Write down the step-by-step details of the task for which the assessment applies, e.g. moving people, heavy equipment etc.
Personnel involved:
Identify the staff that are likely to be involved in the task, remember to consider students and other personnel e.g. porters, store men, nurses, care workers etc.

**SECTION C: Current Risk Control Measures**
List control measures currently in use e.g. staff training, written information/protocols. List any equipment in use in the appropriate column.

**SECTION D: Assessment of Risk**
Consider the headings Task, Patient/Load, Individual Capability and Environment. Tick the appropriate box that reflects most accurately what is involved in the manual handling task.

**SECTION E: Frequency of the Task**
Record the estimated number of times the task takes place during any one working shift. The frequency of task may identify the need for additional control measures, e.g. more than one hoist to be accessible, more appropriate equipment required etc. Make reference to the number of staff involved in the task.

**SECTION F: Initial Risk Rating Figure**
Refer to the risk matrix.

**SECTION G: Additional Risk Control Measures Required**
This part of the form is used to determine and justify the need for additional risk control measures. There will be occasions when the additional control measures required may take some time to implement. The request for these controls should form part of the Action Plan (agreed with the manager). The new Risk Rating Number will quantify the projected reduction in risk.

**SECTION H: Action Plan Agreed with the Manager**
The Action Plan is documented confirmation that the additional risk control measures have been identified and agreed with the manager. This should identify the expected completion date and confirm when controls have been implemented. A final Risk Rating Number should then be calculated.

**SUMMARY EQUALITY IMPACT ASSESSMENT – 273 – Manual Handling Policy V4**

| | |
|---|---|
| **Organisation:** | Hywel Dda University Health Board |

| | | |
|---|---|---|
| **Proposal Sponsored by:** | **Name:** | Adam Springthorpe |
| | **Title:** | Health & Safety Manager |
| | **Department:** | Health, Safety & Security Department |

| | |
|---|---|
| **Policy Title:** | Manual Handling Policy (Version 4) |

| | |
|---|---|
| **Brief Aims and Objectives of Policy:** | This policy provides a framework for the provision of manual handling systems and processes for Hywel Dda University Health Board (HDdUHB). This policy aims to:<br>• Assist HDdUHB to comply with all relevant legislation.<br>• Comply with all aspects of the All-Wales NHS Manual Handling Training Passport and Information Scheme.<br>• Protect and promote the health and wellbeing of all employees and patients.<br>• Protect other persons who may have occasion to visit HDdUHB premises or who may be affected by the actions of HDdUHB employees whilst carrying out their duties. |

| | | |
|---|---|---|
| **Was the decision** | | **No√** |

| | |
|---|---|
| **reached to proceed to full Equality Impact Assessment?** | **Record Reasons for Decision:**<br><br>**No evidence gathered to indicate a negative impact.**<br>The Manual Handling policy promotes and encourages good safe working practices for everyone.<br><br>A change in health status for example, pregnancy, should result in an assessment of competence being undertaken by the manager and, if necessary, reported to the Occupational Health Department.<br><br>Regarding the care of plus-sized patients, there is the potential for an adverse impact, where staff have a disability, for example back/shoulder pain. This is addressed via the risk assessment process, Manual Handling Team training and advice, the Occupational Health Department and incident reporting.<br><br>**A search of similar policies elsewhere indicated similar results:-**<br><br>https://www.google.co.uk/search?q=Manual+Handling+Policy+NHS+Equality+Impact+Assessment&source=hp&ei=u-W4ZKiiNo2_0PEPzO6FqAc&iflsig=AD69kcEAAAAAZLjzyzKfvoUw4NhUiuM5-rUIWSOEfR1e&ved=0ahUKEwjo69j75JyAAxWNHzQIHUx3AXUQ4dUDCAw&uact=5&oq=Manual+Handling+Policy+NHS+Equality+Impact+Assessment&gs_lp=Egdnd3Mtd2l6IjVNYW51YWwgSGFuZGxpbmcgUG9saWN5IE5IUyBFcXVhbGl0eSBJbXBhY3QgQXNzZXNzbWVudEjdpwFQzBBYnZ4BcAN4AJABAZgBmQagAcZ1qgEMMi00MC45LjEuMC4xuAEDyAEA-AEBqAIKwgIQEAAYAxiPARjqAhiMAxjIAsICCxAuGIMBGLEDGIAEwgILEAAYgAQYsQMYgwHCAhEQLhiDARjHARixAxjRAxiABMICERAuGIAEGLEDGIMBGMcBGNEDwgIOEC4YgAQYsQMYxwEY0QPCAggQLhiABBixA8ICCxAuGIAEGLEDGIMBwgILEC4YigUYsQMYgwHCAggQLhixAxiABMICCxAAGIoFGLEDGIMBwgIREC4YgAQYsQMYgwEYxwEYrwHCAg0QLhiDARixAxiABBgKwgIFEC4YgATCAgQQABgDwgIIEAAYgAQYsQPCAggQABiKBRixA8ICBRAAGIAEwgIGEAAYFhgewgIIEAAYigUYhgPCAgUQIRigAcICCBAhGBYYHhgdwgIHECEYoAEYCsICBBAhGBU&sclient=gws-wiz |

| | | |
|---|---|---|
| **If no, are there any issues to be addressed?** | | **No√** |
| | | |

| | | |
|---|---|---|
| **Is the Policy Lawful?** | **Yes** | Complies with relevant health and safety legislation. |

| | | |
|---|---|---|
| **Will the Policy be adopted?** | **Yes** | |
| | **If no, please record the reason and any further action required:** | |

| | | |
|---|---|---|
| **Are monitoring arrangements in place?** | **Yes** | |
| | Any complaints received in relation to equality, diversity or human rights will be addressed on an individual basis and appropriate action taken. | |

| | | |
|---|---|---|
| **Who is the Lead Officer?** | **Name:** | Adam Springthorpe |
| | **Title:** | Health & Safety Manager |
| | **Department:** | Health, Safety & Security Department |
| **Review Date of Policy:** | The policy will be reviewed on a three-yearly basis. | |

| **Signature of all parties:** | **Name** | **Title** | **Signature** |
|---|---|---|---|
| | Jeni Bryant | Health & Safety Manager | August 2020 |
| | Jackie Hooper | Senior Equality and Diversity Officer | August 2020 |
| | Adam Springthorpe | Health & Safety Manager | Reviewed – 20th July 2023 |
| | Alan Winter | Senior Diversity & Inclusion Officer | 10/8/2023 |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# PWYLLGOR IECHYD A DIOGELWCH
# HEALTH & SAFETY COMMITTEE

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 11 September 2023 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Updated Policy (649) - Workplace Slips, Trips & Falls Policy (Version 3) |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Tim Harrison, Head of Health, Safety and Security<br>Adam Springthorpe, Health & Safety Manager |

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)
**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

The Health and Safety Committee (HSC) is requested to approve the revised and updated 649 - Workplace Slips, Trips & Falls Policy (Version 3). This report provides the required assurance that this Written Control Document has been developed in line with all relevant legislation / regulations and available evidence and can therefore be implemented within Hywel Dda University Health Board (HDdUHB).

### Cefndir / Background

This policy contains information and guidance on the management of non-patient slip, trip and fall (STF) risks within HDdUHB. The scope of this policy includes all paid employees of HDdUHB and all individuals who are not direct employees, but who undertake duties on any premises owned, leased or managed by HDdUHB, including bank or agency staff, volunteers, contractors or suppliers working on HDdUHB premises.

The main objective of this policy is to reduce preventable workplace non-patient STF incidents through appropriate risk assessment, effective planning and positive management. The aim of this policy is to set out the measures required to ensure that the risks of non-patient STFs in the workplace are identified and that appropriate measures are in place to reduce the risk of incidents occurring.

### Asesiad / Assessment

There have been no changes to the relevant legislation or guidance since the 2020 Version 2 of this Policy.

The only changes that have been made are to update the corporate Lead Executive Director for the Policy who is now the Director of Nursing, Quality and Patient Experience not the Director of Operations, and to put the Policy into the latest format.

The reviewed and updated Policy was circulated to the full membership of the Health and Safety Advisory Group (HSAG) for comment for a period two weeks. The Group comprises of representation from Health and Safety, Occupational Health, Operational Compliance and Manual Handling. No comments were received. As only minor amendments to the policy have been made, there has been no requirement to undertake consultation via Global email to staff.

The updated policy was approved by the HSAG on 9 August 2023.

This policy will be available in all areas via the HDdUHB Policy Intranet site.

The effectiveness of this policy will be assessed by the analysis of Datix STF incident data and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable data. This data will also be used to identify causal trends to allow measures to be taken to prevent future accidents. RIDDOR reportable STF incidents will form part of an annual RIDDOR report presented to the Health and Safety Committee.

The Health, Safety and Security Department will monitor and review this policy on a three-yearly basis (or sooner in light of changes in legislation or practice). This will provide a measurement of performance and ensure adequate processes and structures are in place, as well as continuing compliance with statutory responsibilities.

**Argymhelliad / Recommendation**

For the Health and Safety Committee to:

- Approve the revised and updated 649 - Workplace Slips, Trips & Falls Policy (Version 3).

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.16 Approve organisational Health and Safety Policies, Procedures, Guidelines and Codes of Practice (policies within the scope of the Committee). |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable. |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 1. Leadership<br>4. Learning, improvement and research |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 2.1 Managing Risk and Promoting Health and Safety |

| | |
|---|---|
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 1. Putting people at the heart of everything we do |
| Amcanion Cynllunio<br>Planning Objectives | 2a Staff health and wellbeing |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | The following reference sources have been used in the compilation of this Workplace Slips, Trips & Falls Policy:<br>• Preventing slips and trips at work, A brief guide, HSE Guidance INDG225(rev2), 2012<br>• Slips and Trips, Hazard spotting checklist, HSE Checklist CK4), 2013<br>• Preventing slips and trips in kitchens and food service, HSE Information Sheet No.6 CAIS6(rev2), 2012<br>• Assessing the slip resistance of flooring, HSE Technical Information Sheet GEIS2, 2012<br>• Slips and trips: The importance of floor cleaning, HSE Information Sheets Slips and Trips 2, 2005<br>• Framework/ Strategy for Managing Slips, Trips and Falls, Louise Jenkins, Clinical Specialist Physiotherapist Occupational Health, HDUHB, 2017<br>• Workplace Slips, Trips & Falls Policy, Portsmouth Hospitals NHS Trust, 2013<br>• Slips, Trips & Falls Policy (Staff), East Cheshire NHS Trust, 2015<br>• Slips, Trips & Falls Policy (Staff), Wirral Community NHS Trust, 2013<br>• Slips, Trips & Falls Policy for Staff, Visitors and Contractors, Worcester Acute Hospitals NHS Trust, 2015<br>• Slips, Trips & Falls Policy for Employees, Worcestershire Health & Care NHS Trust, 2014 |
| Rhestr Termau:<br>Glossary of Terms: | As contained within the body of the report. |

| | |
|---|---|
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch:<br>Parties / Committees consulted prior to Health and Safety Committee: | Health & Safety Advisory Group<br>Local consultation |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | There are no direct costs associated with the Policy. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | There is a positive impact on staff safety, health and wellbeing through compliance with this Policy. |
| **Gweithlu:<br>Workforce:** | There will be no adverse impact upon staff. |
| **Risg:<br>Risk:** | Not applicable. |
| **Cyfreithiol:<br>Legal:** | A breach of health and safety regulations can result in the issue of prohibition or improvement notices or criminal proceedings. |
| **Enw Da:<br>Reputational:** | Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity. |
| **Gyfrinachedd:<br>Privacy:** | Not applicable. |
| **Cydraddoldeb:<br>Equality:** | The Equality Impact Assessment (EqIA) document from 2017 has been reviewed and updated.<br><br>No evidence gathered at this stage to indicate a negative impact on any protected group(s). |

# Workplace Slips, Trips & Falls Policy

## Policy information

Policy number: 649

Classification:
*Corporate*

Supersedes:
*Previous versions*

Version number:
*3*

Date of Equality Impact Assessment:
*29/06/2023*

## Approval information

Approved by:
*Health & Safety Committee*

Date of approval:
Click or tap to enter a date.

Date made active:
*Enter date made active (completion by policy team)*

Review date:
Enter review date (normally three years from approval date)

Summary of document:
This policy contains information and guidance on the management of non-patient slip, trip and fall risks within Hywel Dda University Health Board (HDdUHB).

Scope:
The scope of this policy includes all paid employees of HDdUHB and all individuals who are not direct employees, but who undertake duties on any premises owned, leased or managed by HDdUHB, including bank or agency staff, volunteers, contractors or suppliers working on HDdUHB premises.

To be read in conjunction with:
010 – Health and Safety Policy - opens in a new tab
273 – Manual Handling Policy – opens in a new tab
401 – Preventing Falls and Post Fall Care in In-patient Areas Policy – opens in a new tab
608 – Risk Management Framework – opens in a new tab
674 – Risk Assessment Procedure – opens in a new tab
696 – First Aid at Work Procedure – opens in a new tab
982 – Incident, Near Miss and Hazard Reporting Procedure – opens in a new tab

Patient information:
Include links to Patient Information Library

Owning group:
*Health and Safety Advisory Group*
*09/08/2023*

Executive Director job title:
*Director of Nursing, Quality and Patient Experience*

Reviews and updates:
*1 – 20.11.2017*
*2 – review 2.11.2020*
*3 – review 11.09.2023*

Keywords:
*Slips, Trips, Falls, STF, Non-Patient, Workplace, RIDDOR*

Glossary of terms:
STF - Slip, Trip or/and Fall
HSE - Health and Safety Executive
RIDDOR - Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2013

# Contents

## Introduction

The Hywel Dda University Health Board (HDdUHB) has statutory obligations under the Health and Safety at Work Act (HSWA) to ensure the health and safety of all employees and anyone affected by their work, so far as is reasonably practicable. This includes taking steps to control slip, trip and fall (STF) risks.

Regulation 3 of the Management of Health and Safety at Work Regulations 1999 (MHSWR) builds on the HSWA and includes duties on employers to assess risks (including STF risks) and take action where necessary. The Workplace Health, Safety and Welfare Regulations 1992 (WHSWR) require any floor surface to be in good condition, suitable for its purpose and kept free from hazard or obstruction which may cause a person to slip, trip or fall.

## Policy Statement

People should be able to move around safely. This policy outlines HDdUHB's requirement to assess the risks associated with non-patient slips, trips and falls on its premises and to make provision to remove or reduce the associated risks of harm occurring.

## Scope

The contents and requirements of this policy are applicable to the following groups;

- All paid employees of HDdUHB;
- Individuals who are not direct employees but who undertake duties on any premises owned, leased or managed by HDdUHB. These may include:
    - Bank or agency staff
    - Volunteers
    - Contractors and suppliers working on HDdUHB premises.

## Aim

The aim of this policy is to set out the measures required to ensure that the risks of non-patient STFs in the workplace are identified and that appropriate measures are in place to reduce the risk of incidents occurring.

A recent benchmarking exercise highlighted that 53% of HDdUHB notifications to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2015 (RIDDOR) over a 12-month period were as a result of a slip, trip or fall on the same level (i.e. not from height).

The main causes of STFs, both at HDdUHB and in the wider workplace environment are:

- Slippery surfaces due to being wet, dusty or contaminated by other substances or fluids;
- Obstructions of passageways and aisles, either permanent or temporary;
- Uneven surfaces and changes of level such as unmarked ramps;
- Environmental conditions such as poor lighting, wet weather etc.

## Objectives

The main objective of this policy is to reduce preventable workplace non-patient STF incidents through appropriate risk assessment, effective planning and positive management.

## Definitions

**Slip** -To slide unintentionally for a short distance by losing balance, footing or by unintended sliding, usually resulting in either the regaining of balance or a fall.

**Trip** - To make a false or unintended step or stumble over an obstacle by unintentionally making contact with that obstacle with part of the anatomy, usually resulting in the regaining of balance or a fall.

**Fall** – 1. If someone or something falls, they move quickly downwards onto or towards the ground, by accident or because of a natural force. 2. To move from a higher to a lower level, typically rapidly and without control.

## Responsibilities

**All Employees** have a responsibility to ensure that the workplace is maintained in a condition that will minimise the risks of injury or ill health to others. All employees can play their part in reducing STFs in the workplace by following these simple steps, as suggested by the HSE in their publication *Preventing slips and trips at work*, INDG225(rev2) 2012:

- If you have an accident or a near miss, make sure you report it to your line manager promptly. The Health Board can use this information to prevent future accidents. (All incidents and near misses must reported via the Datix system).
- If you see a spillage, clean it up or make arrangements for it to be cleaned.
- Report any damaged floors or mats.
- Play your part and keep the workplace tidy.
- If you see items on the floor where someone could trip over them, remove them or arrange for them to be removed or for the situation to be made safe.
- If you are given PPE, wear it and look after it. Report any faults or damage to your employer and make arrangements for a replacement.

- Tell your employer about any work situation that you think is dangerous, or if you notice that something has gone wrong with their health and safety arrangements.

**The Chief Executive** has overall responsibility for this policy, to ensure a safe working environment where reasonably practicable control measures can be applied to minimise the risks from slips, trips and falls.

**The Director of Nursing, Quality and Patient Experience** has delegated Executive Board responsibility for the management of Health and Safety and therefore operational implementation of this and other Health and Safety policies.

**Departmental and Premises Managers** are responsible for ensuring that the Workplace Slips, Trips and Falls Policy is implemented and monitored within their areas of responsibility. In particular they must identify any potential STF related hazards in their areas, risk assess any hazards identified and implement measures to control any identified risks. For specific details see Section 8. Additionally, departmental and premises mangers should:

- Investigate all STF incidents ensuring that a post incident risk assessment is completed;
- Ensure good housekeeping standards are adhered to in their areas to minimise STF hazards. This includes ensuring that all articles are stored in designated areas;
- Promptly remove equipment that is not safe or suitable for its purpose;
- Raise awareness in relation to the management of STFs.

**The Head of Facilities, Estates & Capital Management** is responsible for:

- Ensuring cleaning regimes are adequately risk assessed and sufficient safety equipment is provided for employees so they may comply with the preventative and protective measures designed to reduce STFs;
- Ensuring floor surfaces replaced or newly fitted as part of a modification, extension or new build comply with standards of slip resistance/surface roughness;
- Ensuring adequate control of contractors to ensure potential hazards associated with their work that may cause persons to slip, trip or fall are eliminated where possible or are adequately controlled;
- Ensuring sufficient arrangements are in place to deal promptly with leaks and other defects which may cause a person to slip and fall;
- Ensuring that arrangements are in place for gritting of external areas in the event of adverse weather conditions.

**The Health and Safety Assurance Committee** is responsible for:

- Monitoring all staff accidents and incidents, including those events and claims relating to STFs;
- Discussion of specific risks and potential escalation to the appropriate HDdUHB risk register.

**The Health, Safety and Security Team** are responsible for:

- Providing advice to managers and staff on the prevention of STFs within the work environment;
- Supporting managers as required in the investigation of incidents that have occurred;
- Monitoring the environment during inspections and audits and providing advice to managers on areas of non-compliance or when hazards are identified;
- Reporting incidents to the Health and Safety Executive (HSE) as required by the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) as appropriate.

**The Occupational Health Departments** are responsible for**:**

- Providing advice and support to employees and management following slip, trip or fall injuries;
- Supporting employees to return to work or other courses of action as appropriate, taking into account both the health and wellbeing of the employee, and the needs of the service.

## Hazard Identification and Risk Assessment

In line with the Management of Health and Safety Regulations and the Workplace (Health, Safety and Welfare) Regulations, HDdUHB is required to assess the workplace for STF hazards and outline the control measures in place to ensure the risks of injury are removed or kept as low as possible. At HDdUHB this responsibility sits with the Departmental and Premises Managers. In particular the managers must:

- Identify any potential STF related hazards within their areas of responsibility or control. The Slips, Trips and Falls Workplace Checklist in Appendix 1 can be used to assist the process of hazard identification;
- Ensure that risk assessments are undertaken for any hazards identified on the Checklist using the HDdUHB general risk assessment (see 199 - Risk Management Procedure) and attaching the completed checklist to the assessment;
- Immediately implement measures to control any identified risks;
- Escalate any risks for which the controls cannot be immediately implemented to the local risk register until those controls become effective;
- Escalate any risks that cannot be controlled locally to their director for review and potential inclusion on the departmental risk register.

## Information, Instruction and Training

Awareness information on slips, trips and falls prevention and/or reduction is included in:

- Health Board corporate induction for new starters;
- Local induction;
- The Mandatory Health & Safety E-learning module.

In addition to the training modules, managers should make their employees aware of the findings of any STF risk assessments that have been conducted and any subsequent controls that have been put in place.

Managers should also ensure that the findings of any investigations into STF incidents and the lessons learned are shared with the relevant employees.

The HSE has a free online learning tool, called the Slips and Trips eLearning Package, referred to as 'STEP' (www.hse.gov.uk/slips/step/start.htm) (opens in a new tab). This tool is designed for both employers and workers in all sectors, providing help on assessing and managing slip and trip risks in the workplace. It provides an overview of slips and trips, how they are caused and how to prevent them, from introductory to advanced level.

## RIDDOR Reporting

If an STF incident is reportable to the Health and Safety Executive (HSE) under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), the line manager must contact a member of the Health, Safety and Security Team at the earliest opportunity to ensure that the incident is promptly reported in line with statutory requirements.

## Monitoring and Review

The effectiveness of this policy will be assessed by the analysis of Datix STF incident data and RIDDOR reportable data. This data will also be used to identify causal trends to allow measures to be taken to prevent future accidents. STF incidents will form part of an annual report presented to the Health, Safety and Emergency Planning Sub-Committee.

The Health, Safety and Security Team will monitor and review this policy on a three-yearly basis (or sooner in light of changes in legislation or practice). This will provide a measurement of performance and ensure adequate processes and structures are in place, as well as continuing compliance with statutory responsibilities.

## Safety Advice

Advice on safety issues associated with flooring and slip, trip and fall risks can be obtained from a number of sources as follows:

Health, Safety and Security Department:

- Head of Health, Safety and Security 01437 773771 (WGH)
- Health and Safety Manager 01267 227334 (GGH)
- Health, Safety and Security Officer 07929 832707 (CICC)
- Health, Safety and Security Officer 07811 711426 (PPH)
- Health and Safety Advisor 07977 273021 (PPH)

Occupational Health:

- Bronglais  Hospital 01970 635811
- Prince Philip Hospital 01554 783518
- Glangwili Hospital 01267 227338
- Withybush Hospital 01437 773215

To report defective flooring, please contact your local Maintenance Help Desk:

- Bronglais Hospital 01970 623131 ext. 5770
- Prince Philip Hospital 01554 783689 ext. 3689
- Glangwili Hospital 01267 235151 ext. 2942
- Withybush Hospital 01437 764545 ext. 3463

## Acknowledgements & Reference Material

The following reference sources have been used in the compilation of this Workplace Slips, Trips & Falls Policy:

- Workplace Slips, Trips & Falls Policy, Portsmouth Hospitals NHS Trust, 2013
- Slips, Trips & Falls Policy (Staff), East Cheshire NHS Trust, 2015
- Slips, Trips & Falls Policy (Staff), Wirral Community NHS Trust, 2013
- Slips, Trips & Falls Policy for Staff, Visitors and Contractors, Worcester Acute Hospitals NHS Trust, 2015
- Slips, Trips & Falls Policy for Employees, Worcestershire Health & Care NHS Trust, 2014
- Preventing slips and trips at work, A brief guide, HSE Guidance INDG225(rev2), 2012
- Slips and Trips, Hazard spotting checklist, HSE Checklist CK4), 2013
- Preventing slips and trips in kitchens and food service, HSE Information Sheet No.6 CAIS6(rev2), 2012
- Assessing the slip resistance of flooring, HSE Technical Information Sheet GEIS2, 2012
- Slips and trips: The importance of floor cleaning, HSE Information Sheets Slips and Trips 2, 2005
- Framework/ Strategy for Managing Slips, Trips and Falls, Louise Jenkins, Clinical Specialist Physiotherapist Occupational Health, HDdUHB, 2017

Relevant law:

- health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- Workplace (Health, Safety and Welfare) Regulations 1992
- Provision and Use of Work Equipment Regulations 1998
- Construction (Design and Management) Regulations 2015
- Personal Protective Equipment at Work Regulations 2002
- Work at Height Regulations 2005

Further information is available on the HSE website:

http://www.hse.gov.uk/slips/index.htm

# Appendix 1 - Slips, Trips and Falls Workplace Checklist

| | | | |
|---|---|---|---|
| Hospital Site: | | | |
| Ward / Department: | | | |
| Area being assessed | | | |
| Name of Assessors: | | | |
| Job Titles: | | | |
| Contact Telephone: | | Date: | |

| **Hazard** | Please tick if hazard relevant to area being assessed | |
|---|---|---|
| | Yes | No |
| Loose flooring | | |
| Loose and worn mats / carpets | | |
| Uneven indoor / outdoor surfaces | | |
| Holes / cracks / potholes | | |
| Bumps / ridges / protruding nails | | |
| Spills and splashes of liquids, solids or dusts | | |
| Presence of mists, smoke, dust or vapour clouds | | |
| Unsigned / unguarded wet floors (*e.g.* following cleaning) | | |
| Cleaning at unsuitable times | | |
| Unsuitable footwear | | |
| Adverse weather (*e.g.* rain, sleet, snow or loose leaves) | | |
| Change from a wet to dry surface (footwear still wet) | | |
| Passageways with heavy pedestrian / trolley traffic use | | |
| Unsuitable floor surface / covering | | |
| Dusty / dirty floors | | |
| Accumulation of waste | | |
| Low wall and floor fixtures | | |

| | | |
|---|---|---|
| Filing systems or drawers that can open at ground level | | |
| Poor location of electrical and telephone sockets | | |
| Items stored on floor - lack of storage | | |
| Unmarked sloping surfaces | | |
| Lack of handrails on severe slopes / steps / stairs | | |
| Grab rails are suitable and sufficient for purpose | | |
| Equipment not stowed appropriately | | |
| Unsecured cables, service pipes or conduits | | |
| Use of extension leads | | |
| Unguarded floor openings | | |
| Unsuitable lighting levels | | |
| Distracting noises / levels | | |
| Vulnerable staff (*e.g.* poor eyesight, general health, fatigue, lack of care *etc.*) | | |

If the ‘YES’ box has been ticked, please confirm what control measures are being implemented by completing the HDUHB general risk assessment document and attaching this completed checklist to the assessment.

**SUMMARY EQUALITY IMPACT ASSESSMENT – 649 - Workplace Slips, Trips & Falls Policy**

| | |
|---|---|
| **Organisation:** | Hywel Dda University Health Board |

| | | |
|---|---|---|
| **Proposal Sponsored by:** | **Name:** | Adam Springthorpe |
| | **Title:** | Health & Safety Manager |
| | **Department:** | Health, Safety & Security Department |

| | |
|---|---|
| **Policy Title:** | Workplace Slips, Trips & Falls Policy (Version 3) |

| | |
|---|---|
| **Brief Aims and Objectives of Policy:** | The aim of this policy is to set out the measures required to ensure that the risks of non-patient STFs in the workplace are identified and that appropriate measures are in place to reduce the risk of incidents occurring.<br><br>A recent benchmarking exercise highlighted that 53% of HDdUHB notifications to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2015 (RIDDOR) over a 12-month period were as a result of a slip, trip or fall on the same level (i.e. not from height).<br><br>The main objective of this policy is to reduce preventable workplace non-patient STF incidents through appropriate risk assessment, effective planning and positive management. |

| | | |
|---|---|---|
| **Was the decision reached to proceed to full Equality Impact Assessment?** | | **No√** |
| | **Record Reasons for Decision:**<br>**The following groups may be at more risk of slips, trips or falls or sustaining injury following a slip, trip or fall:-**<br>High risk groups for falls, include people over the age of 65 and those with a physical disability or mobility difficulty, who may be under 65. Women are at a higher risk of developing osteoporosis, which may impact upon their risk of injury from a fall.<br>However, there is no evidence to indicate at this stage that anyone will be discriminated against or negatively impacted as a result of this policy in relation to any protected characteristic/s.<br>**Whilst the UHB employs a disproportionate number of women compared to men and has a generally ageing workforce with some staff having single or multiple disabilities, there is no evidence available at this stage that the policy will impact adversely on any particular protected group/s.**<br><br>**A search of similar policies elsewhere indicated similar results:-**<br>https://www.google.co.uk/search?source=hp&q=workplace+slips+trips+and+falls+policy+nhs+wales+equality+impact+assessment+&oq=workplace+slips+trips+and+falls+policy+nhs+wales+equality+impact+assessment+&gs_l=psy-ab.12...955.14769.0.16838.76.47.0.0.0.0.584.7808.2j7j5j5j7j1.27.0....0...1.1.64.psy-ab..49.20.5745...0j0i131k1j0i22i30k1j0i22i10i30k1j33i22i29i30k1j33i21k1j33i160k1.0.eAgvBHpKLd | |

| | | |
|---|---|---|
| **If no, are there any issues to be addressed?** | | **No√** |
| | | |

| | | |
|---|---|---|
| **Is the Policy Lawful?** | **Yes** | Complies with relevant health and safety legislation. |

| | | |
|---|---|---|
| **Will the Policy be adopted?** | **Yes** | |
| | **If no, please record the reason and any further action required:** | |

| | | |
|---|---|---|
| **Are monitoring arrangements in place?** | **Yes** | |
| | Any complaints received in relation to equality, diversity or human rights will be addressed on an individual basis and appropriate action taken. | |

| | | |
|---|---|---|
| **Who is the Lead Officer?** | **Name:** | Adam Springthorpe |
| | **Title:** | Health & Safety Manager |
| | **Department:** | Health, Safety & Security Department |
| **Review Date of Policy:** | The policy will be reviewed on a three-yearly basis. | |

| **Signature of all parties:** | **Name** | **Title** | **Signature** |
|---|---|---|---|
| | Adam Springthorpe | Health & Safety Manager | 25 September 2017 |
| | Jackie Hooper | Senior Equality and Diversity Officer, Strategy, Policy and Advice | 25 September 2017 |
| | Adam Springthorpe | Health & Safety Manager | Reviewed - 28th June 2023 |
| | Alan Winter | Senior Diversity & Inclusion Officer | 29/6/2023 |
| | | | |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# PWYLLGOR IECHYD A DIOGELWCH
# HEALTH & SAFETY COMMITTEE

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 11 September 2023 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Updated Procedure (770) – Medical Laser Safety Policy – V.3 |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Tim Harrison, Head of Health, Safety and Security<br>Adam Springthorpe, Health & Safety Manager |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**Purpose of the Report** (select as appropriate) |
|---|
| Ar Gyfer Penderfyniad/For Decision |

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

The Health and Safety Committee (HSC) is requested to approve the revised and updated 770 – Medical Laser Safety Policy – (Version 3). This report provides the required assurance that this Written Control Document has been developed in line with all relevant legislation / regulations and available evidence and can therefore be implemented within Hywel Dda University Health Board (HDdUHB).

### Cefndir / Background

Medical lasers are used by HDdUHB for the treatment and benefit of patients. They can be found within various departments in all the major hospital sites – such as dermatology, ophthalmology, surgical theatres and physiotherapy departments. Unfortunately, due to the nature of laser radiation, they also present a potential hazard to the eyes and skin of patients, staff and visitors.

The Health and Safety at Work Act (1974) places a general duty on the Health Board to ensure, so far as is reasonably practicable, the health and safety of its employees. This duty includes in particular the provision of safe equipment, systems of work and a working environment.

Several pieces of legislation, guidance and standards are relevant to medical lasers, a full list of which are detailed in Section 11 of the policy. The Health Board is fully committed to following and implementing all legislation and guidance relating to the safe use of medical lasers, thus ensuring that risks to its staff, patients and visitors arising from the use of medical lasers are eliminated or minimised so far as is reasonably practicable. This policy describes the framework by which HDdUHB manages the safe use of medical lasers.

### Asesiad / Assessment

There have been no fundamental changes to the relevant legislation or guidance since the 2022 Version 2 of this policy, however, when the Health Board lost the services of the Laser

Protection Advisor (LPA) function previously supplied by Swansea Bay University Health Board, this prompted an internal review of current procedures.

This has led to a number of changes / improvements within the Policy including:

- Clear link to the Medicines and Healthcare Regulatory Agency (MHRA) document at the beginning – signposting people there for more detailed guidance.
- Insertion of a new role of Internal Laser Protection Advisor (ILPA). This gives HDdUHB the ability to train its own LPA within the Clinical Engineering Department, rather than relying on costly external provision.
- New section on managing exposure, including eyes, skin/tissue, plume and fire. This includes reference the need for local procedures informed by risk assessment. Includes reference to smoke evacuators for plume, and links to both Control of Substances Hazardous to Health (COSHH) and Fire policies.
- New section on equipment maintenance and repair.
- Clarification that Clinical Laser Experts are per speciality.

The reviewed and updated Medical Laser Safety Policy was first taken to the Medical Devices Group on 17/02/2023 for discussion and agreement of direction. Following the actioning of comments received, the Policy was agreed in principle by the Radiation Protection Group on 17/05/2023 before being sent for Global consultation for the period 18/05/2023-01/06/2023.

A number of comments were received following the consultation period, all of which were actioned. The policy was taken back to the Medical Devices Group on 28/06/2023. As the Radiation Protection Group only meets biannually the policy was circulated to the full membership of the group for comment and approval. No comments were received, therefore approved by the Chair on 17/07/2023.

The policy was also tabled at the Health and Safety Advisory Group on 09/08/2023 ahead of the Health and Safety Committee.

The policy will be available in all areas via the HDdUHB Policy Internet site. For the Medical Laser Safety Policy to be successful, all managers will need to ensure that all Laser users within their areas of responsibility comply with the requirements of the procedure.

The Radiation Protection Group will ensure that the policy is implemented and monitored. This will be re-enforced within localities by local risk management and health and safety arrangements.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within HDdUHB indicate otherwise.

## Argymhelliad / Recommendation

For the Health and Safety Committee to:

- Approve the revised and updated 770 – Medical Laser Safety Policy (Version 3).

| Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed) | |
|---|---|
| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.16 Approve organisational Health and Safety Policies, Procedures, Guidelines and Codes of Practice (policies within the scope of the Committee). |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | 1651 – Score 8 |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 2.1 Managing Risk and Promoting Health and Safety<br>2.9 Medical Devices, Equipment and Diagnostic Systems<br>3.1 Safe and Clinically Effective Care<br>3.5 Record Keeping |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 1. Putting people at the heart of everything we do<br>4. The best health and wellbeing for our individuals, families and communities |
| Amcanion Cynllunio<br>Planning Objectives | 2a Staff health and wellbeing |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS |

| Gwybodaeth Ychwanegol:<br>Further Information: | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | Directives<br>• The Medical Devices Directive. The European Commission. Council Directive 93/42/EEC concerning Medical Devices, OJ 169/ 12.7.93.<br>• Directive 2006/25/EC of the European Parliament and of the Council of 5 April 2006 on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation).<br><br>Acts<br>• Health and Safety at Work etc. Act 1974 |

Regulations

- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- The Control of Artificial Optical Radiation at Work Regulations 2010
- The Personal Protective Equipment Regulations 2002
- The Control of Substances Hazardous to Health Regulations 2002
- The Management of Health and Safety at Work Regulations 1999
- The Provision and Use of Work Equipment Regulations 1998
- Health and Safety (Signs and Signals) Regulations 1996
- The Personal Protective Equipment at Work Regulations 1992

Guidance

- Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices, MHRA, Sep 2015.
- ICNIRP Guidelines on limits of exposure to laser radiation of wavelengths between 180nm and 1,000µm; Health Physics 105 (3): 271 – 295; 2013.
- Non-binding guide to good practice for implementing Directive 2006/25/EC 'Artificial Optical Radiation' European Commission, Jun 2010.
- Laser radiation: Safety advice, Public Health England, updated 15 August 2017 (www.gov.uk/government/publications/laser-radiation-safety-advice/laser-radiation-safety-advice).

Standards

- BS EN 60825-1:2014/A11:2021/AC:2022 Safety of Laser Products - Equipment Classification and Requirements.
- PD IEC/TR 60825-8: 2006 Safety of laser products - Guidelines for the safe use of laser beams on humans.
- PD IEC TR 60825-14: 2022 Safety of laser products - A user's guide.
- BS EN 207: 2017 Personal eye protection equipment – Filters and eye protectors against laser radiation.
- BS EN 60601-2-22: 2020 Medical electrical equipment - Particular requirements for basic safety and essential performance of surgical, cosmetic, therapeutic and diagnostic laser equipment.
- PD CLC/TR 50448: 2005 Guide to Levels of Competence Required in Laser Safety.

| | |
|---|---|
| | • IEC EN 62471: 2008 Photo-biological Safety of Lamps and Lamp Systems.<br>• Health and Care Standards, Welsh Government, April 2015.<br><br>Other References<br>British Medical Laser Association Website: www.bmla.co.uk/ |
| Rhestr Termau:<br>Glossary of Terms: | As contained within the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch:<br>Parties / Committees consulted prior to Health and Safety Committee: | Radiation Protection Group<br>Medical Devices Group<br>Health & Safety Advisory Group<br>Local consultation |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | There are no direct costs associated with the policy. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | There is a positive impact on staff safety, health and wellbeing through compliance with this Procedure. |
| **Gweithlu:<br>Workforce:** | There will be no adverse impact upon staff. |
| **Risg:<br>Risk:** | Not applicable. |
| **Cyfreithiol:<br>Legal:** | A breach of health and safety regulations can result in the issue of prohibition or improvement notices or criminal proceedings. |
| **Enw Da:<br>Reputational:** | Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity. |
| **Gyfrinachedd:<br>Privacy:** | Not applicable. |
| **Cydraddoldeb:<br>Equality:** | The Equality Impact Assessment (EqIA) document from 2022 has been reviewed and updated.<br><br>No evidence gathered at this stage to indicate a negative impact on any protected group(s). |

# Medical Laser Safety Policy

## Policy information

**Policy number: 770**

**Classification: Corporate**

**Supersedes: Previous versions**

**Version number: 3**

**Date of Equality Impact Assessment:**

*29/06/2023*

## Approval information

**Approved by:**

*Health and Safety Committee*

**Date of approval:**

Click or tap to enter a date.

**Date made active:**

Click or tap to enter a date.

**Review date:**

Click or tap to enter a date.

**Summary of document:**

This document describes the framework by which Hywel Dda University Health Board (HDdUHB) manages the safe use of medical lasers.

**Scope:**

This policy applies to all HDdUHB employees (including trainees, holders of honorary contracts and locum staff) who use or are involved in the use of medical lasers, ILS and LEDs.

**To be read in conjunction with:**

010 – Health and Safety Policy - opens in a new tab
242 – Fire Safety Policy – opens in a new tab
467 – Medical Device Management Policy– opens in a new tab
608 – Risk Management Framework – opens in a new tab
674 – Risk Assessment Procedure– opens in a new tab
703 – COSHH Policy and Procedure – opens in a new tab.
982 – Incident, Near Miss and Hazard Reporting Procedure – opens in a new tab

**Patient information:**

Include links to Patient Information Library

**Owning group:**

Radiation Protection Group / Health and Safety Committee
17/07/2023

**Executive Director job title:**

Director of Nursing, Quality and Patient Experience

**Reviews and updates:**

1.0 – new policy 5.11.2019
2.0 – revised 14.11.2022
3.0 – revised 11.09.2023

**Keywords**

Medical Laser, Lasers, Safety, Radiation

**Glossary of terms**

LASER – light amplification by stimulated emission of radiation
MPE – maximum permissible exposure
NOHD – nominal ocular hazard distance
ILS – intense light sources
LED – light emitting diodes
LPA – laser protection advisor
ILPA – internal laser protection advisor
LPS – laser protection supervisor

## Table of Contents

## Introduction and Policy Statement

Medical lasers are used by Hywel Dda University Health Board (HDdUHB) for the treatment and benefit of patients. They can be found within various departments in all the major hospital sites – such as dermatology, ophthalmology, surgical theatres and physiotherapy departments. Unfortunately, due to the nature of laser radiation, they also present a potential hazard to the eyes, tissue and skin of patients, staff and visitors. Additional hazards from laser radiation include fire and smoke inhalation from laser plume.

The Health and Safety at Work Act etc. (1974) places a general duty on the Health Board to ensure, so far as is reasonably practicable, the health and safety of its employees, see the Health and Safety Policy for further information (010 – Health and Safety Policy – opens in a new tab).

This duty includes in particular the provision of safe equipment, systems of work and a working environment. **For detailed guidance, please see MHRA document Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices, Sep 2015 (opens in new tab).**

Further duties and responsibilities specific to medical lasers are detailed in several other pieces of legislation, guidance and standards (refer to section references and relevant legislation).

The health board is fully committed to following and implementing all legislation and guidance relating to the safe use of medical lasers, thus ensuring that risks to its staff, patients and visitors arising from the use of medical lasers are eliminated or minimised so far as is reasonably practicable.

This document describes the framework by which HDdUHB manages the safe use of medical lasers.

## Scope

Device Use

This policy applies to medical lasers (including intense light sources (ILS) and light emitting diodes (LEDs)) used by HDdUHB services, irrespective of whether the device is owned, loaned, leased, on trial, being demonstrated, brand new, second hand or transferred from another location within HDdUHB. This policy also applies to medical lasers (including ILS and LEDs) used by any external service providers commissioned by HDdUHB.

Staff

This policy applies to all HDdUHB employees (including trainees, holders of honorary contracts and locum staff) who use or are involved in the use of medical lasers, ILS and LEDs.

Location

This policy applies to all HDdUHB premises where medical lasers, ILS and LEDs are used.

Laser Classification

This policy applies to medical lasers that may produce harmful levels of accessible laser radiation under normal use, in particular Class 3R, Class 3B and Class 4 lasers.

Exclusions

This policy does not apply to lasers with classifications: 1, 1M, 1C, 2, 2M. The laser classification scheme only considers the laser beam hazard. Under normal viewing conditions (e.g. without the use of magnifying optics or anaesthetics), only class 3B and 4 lasers pose a hazard (MHRA, p.52). It should be noted that a small risk remains with Class 2 and 2M lasers through deliberate misuse or when the beam is viewed using magnifying optical instruments. This should be controlled at local level through appropriate management. If in any doubt, the Laser Protection Advisor (LPA) / Internal Laser Protection Advisor (ILPA) should be consulted for advice.

Risk Group Classification

This policy applies to ILS and LEDs classified as 'Risk Group 3' as defined in standard IEC EN 62471.

Exclusions

This policy does not apply to ILS or LEDs in the Exempt Group or Risk Group 1. Devices in Risk Group 2 are safe if used appropriately, however, the LPA/ILPA should be consulted if there is concern regarding the safety of particular conditions of use.

Other Specific Exclusions

This policy does not apply to lasers used to aid positioning of the patient e.g. as found on CT scanners and Radiotherapy Treatment Machines. Such lasers are usually no higher than Class 2. However, caution should be exercised by the users of such equipment when dealing with anaesthetised patients or others in whom the aversion response may be inhibited; some form of eye protection may be required. The LPA/ILPA should be consulted for advice in these circumstances.

## Aims

- To help ensure the effective organisation and management of safety associated with medical lasers.
- To help ensure that the necessary standards for the protection of all persons on Health Board premises from the associated risks of medical lasers are implemented and maintained.
- To assist with the dissemination of health and safety information related to medical lasers to all relevant parties to ensure awareness of contemporary safety issues.
- To assist in the production, maintenance and adherence to local documents relating to the safe use of medical lasers.

## Objectives

- To define the key terms with regards to medical lasers.
- To outline roles and responsibilities to ensure the safety of all parties associated with the use of medical lasers.
- To provide general arrangements for managing laser safety including risk assessment, local rules, Laser Controlled Areas, Personal Protective Equipment (PPE), control and security of laser key, reporting of adverse incidents and equipment maintenance and repair.
- To outline the requirements in terms of information, instruction and training for staff that use medical lasers to ensure their competency.
- To provide information on who to contact for strategic and local advice to the Health Board on matters of Medical Laser safety.

## Definitions

### Laser

Means any device which can be made to produce or amplify electromagnetic radiation in the wavelength range from 180nm to 1mm(60825-1, p.7). primarily by the process of controlled stimulated emission. Note: Although lasers exist which emit at wavelengths less than 180 nm (within the vacuum ultraviolet), these are not included in the scope of the BS EN 60825-1 standard since the laser beam normally has to be enclosed in an evacuated enclosure, and, therefore, the potential optical radiation hazards are inherently minimal.

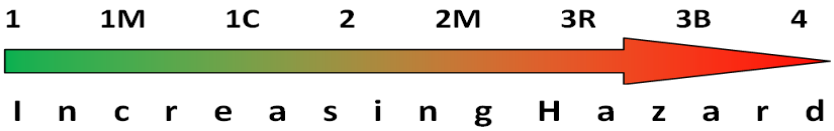
'Laser' is an acronym for Light Amplification by Stimulated Emission of Radiation.

### Medical Laser

Means any laser product designed, manufactured, intended or promoted for purposes of in-vivo diagnostic, surgical, cosmetic or therapeutic laser irradiation of any part of the human body (60825-1, p.18).

### Laser Classification

To help users select appropriate control measures to minimise the risk from laser radiation, a laser can be classified according to its potential to cause harm. There are currently eight classes: the higher the class, the greater the potential to cause harm. The laser classes are 1, 1M, 1C, 2, 2M, 3R, 3B and 4.




The laser classification scheme only considers the hazard from the laser beam itself and not other hazards presented by the laser (so called 'non beam hazards') (MHRA, p.52).

The classification relates only to the normal use of the laser - it might not be applicable if the laser is undergoing service, repair or is faulty.

It is the responsibility of the laser manufacturer to provide the correct classification of the laser (60825-1, p.23).

The manufacturer is also required to implement all appropriate safety and engineering controls that are applicable to each class of laser.

Note that in the previous laser classification scheme, lasers were grouped into four main classes and two sub-classes (i.e. 1, 2, 3A, 3B and 4). These classifications will still apply to older lasers that may still be currently in use (MHRA p.52).

**Laser Controlled Area**

Means an area where the occupancy and activity of those within is subject to control and supervision for the purpose of protection from laser radiation hazards (60825-1, p.16).

**Maximum Permissible Exposure (MPE)**

Means the maximum level of laser radiation to which, under normal circumstances, the eye or skin can be exposed without suffering injury or adverse effects (60825-1, p.18).

The MPE depends upon the wavelength of the laser radiation, the pulse duration or exposure duration, the tissue at risk and, for visible and near infra-red laser radiation in the range 400 nm to 1,400 nm, the size of the retinal image (60825-1, p.19).

**Nominal Ocular Hazard Distance (NOHD)**

Means the distance from the laser at which the level of laser radiation equals the appropriate MPE; hence, exposure of the eye or skin at this distance will not cause injury (MHRA, p.26).

**Intense Light Sources**

Intense Light Sources (ILS) are devices used in conjunction with application-based filters. They emit a broad spectrum of incoherent light and have a similar effect on the skin as lasers.

The devices are generally used in the cosmetic sector for aesthetic purposes, such as hair reduction. In recent years, the technology has been developed to include other procedures, including skin treatments such as photo-rejuvenation.

These devices are also marketed by some manufacturers as Intense Light Pulsed Sources (ILPS) or Intense Continuous Light Systems (ICLS).

### Light Emitting Diodes

Light Emitting Diodes (LEDs) are semiconductors that emit, in general, incoherent light over a range of wavelengths: typically 260 – 2100nm. LEDs are often used in conjunction with optical fibres. Radiation is produced primarily by the process of spontaneous emission, although some stimulated emission may be present.

### Risk Group Classification

To help users select appropriate control measures to minimise the risks from incoherent light sources, such devices are grouped according to their potential to cause harm (EN 62471).

There are currently four Risk Groups as indicated in the following table:

| Group | Risk | Hazard |
|---|---|---|
| Exempt | None | No photo-biological hazard |
| Group 1 | Low Risk | No photo-biological hazard under normal behavioural limitations |
| Group 2 | Moderate Risk | Does not pose a hazard due to aversion response to bright light or thermal discomfort |
| Group 3 | High Risk | Hazardous even for momentary exposure |

## Roles & Responsibilities

### Chief Executive

The employer, as defined in the regulations, is HDdUHB with the Chief Executive taking overall responsibility for the safe use of medical lasers.

The Chief Executive will delegate tasks, but not responsibility, for medical laser safety appropriately through the following organisational arrangements in order to effectively manage and control the risk from the use of medical lasers.

**Medical Director**

The Medical Director should ensure that, where necessary, medical personnel receive appropriate training in the safe use of medical laser equipment.

**Chair of the Radiation Protection Group**

The Radiation Protection Group (RPG), chaired by the Executive Director of Therapies and Health Science (DOTH), oversees the implementation of radiation protection arrangements on behalf of the Chief Executive in relation to both ionising and non-ionising radiations (which includes lasers).

The DOTH should ensure that:

- The Radiation Protection Group is convened regularly with a remit to report to the Chief Executive on policy matters concerning medical lasers;
- Assurance is provided to the HDdUHB that laser safety is managed in compliance with HDdUHB's policies and procedures;
- A Laser Protection Adviser is appointed, in writing, to advise the Health Board on compliance with legislation relating to the safe use of medical lasers, and that the appointed LPA/ILPA is appropriately consulted;
- Records of incidents and investigations are kept and identified corrective action is implemented;
- This policy is reviewed at least once every three years.

**Managers of Departments using Medical Lasers**

Managers of Departments using medical lasers should ensure that:

- All medical lasers within their department (over which they have control) have received a suitable and sufficient risk assessment. This requirement applies irrespective of whether the laser is owned, loaned, leased, on trial, being demonstrated, brand new, second hand or transferred from another location within HDdUHB;
- A Risk Assessment is carried in respect of any material changes (e.g. building, engineering) in or around a Laser Controlled Area;
- The LPA/ILPA is consulted for advice in relation to risk assessments for medical lasers;
- A suitable number of Laser Protection Supervisors (LPS) are appointed to supervise all working practices using potentially hazardous medical lasers, within their defined area of responsibility, to ensure they are undertaken in accordance with the local rules and that the LPA/ILPA is notified of this appointment;
- Staff within their department who have responsibilities under this policy are aware of the extent of those responsibilities and comply with the requirements of the policy and associated Departmental documents;
- An inventory is kept of each item of equipment and an appropriate maintenance and periodic calibration is performed in line with the equipment risk assessment;
- A list of all Authorised Users and Authorised Assistants is maintained;
- Training records are maintained for all Authorised Users and Authorised Assistants;
- Risk assessments are reviewed annually, and any subsequent actions implemented;

- Records of clinical use of medical lasers are maintained;
- There are written Departmental Clinical Protocols for the use of medical lasers.

**Laser Protection Adviser**

The Laser Protection Adviser (LPA) has responsibility for advising service managers, departmental managers, members of staff and others on compliance with legislation relating to the safe use of Medical Lasers associated with practices carried out by the Health Board.

In the NHS, an employer should appoint or consult an LPA where Class 3B and/or Class 4 lasers are used. The employer should give the LPA adequate information, including a statement of the scope of advice required, and facilities to perform the work effectively (MHRA).

The LPA will be knowledgeable and have expertise in matters related to medical laser equipment safety. Note: MHRA p.11 states: '*There are no defined criteria for LPA competence' and 'It is for the employer to judge what level of competency they require for an LPA. In order to ensure competency the prospective employer may also wish to review a candidate's references or LPA certificate if they are certificated. In general terms, the LPA should be knowledgeable in the evaluation of laser hazards and should have responsibility for advising on their control (such a person may have responsibility for advising on other related hazards, e.g. from ionising radiation). The duties of the LPA will be defined by their employer, though they should include undertaking hazard analysis and risk assessment for each laser and IPL installation and ensuring that suitable local rules are drawn up for each installation'.*

The following is an example of the *typical* duties expected of an LPA:

- Advising on compliance with statutory requirements concerning the use of medical lasers;
- Undertaking a risk assessment in conjunction with the LPS before the laser is brought into operation, and reviewing annually;
- Confirming the NOHD, MPE and the protective eyewear recommended by a laser manufacturer;
- Determining the extent of the Laser Controlled Area;
- Advising on the control of hazards arising from the use of medical lasers;
- Assisting the Laser Protection Supervisor in writing Local Rules;
- Providing safety training in line with MHRA guidelines for the LPS, laser users and assistants, or identify relevant training courses for them to attend;
- Performing a periodic audit of all locations where medical lasers are being used in order to review compliance with legislation, guidance and Local Rules;
- Liaising with all appropriate LPSs, laser users and those who assist with medical procedures involving lasers to promote the safe operation of medical lasers;
- Assisting with the investigation of any adverse events, including reporting the incident to the employer;
- Providing advice on equipment purchase, installation planning, and acceptance testing
- Reporting laser safety issues to the Radiation Protection Group.

**Internal Laser Protection Adviser**

Where no NHS Wales-based LPA services are available, the Health Board can appoint an Internal Laser Protection Advisor (ILPA) within the Clinical Engineering function, as an alternative to utilising contracted LPA services (managed by the respective clinical service user). The ILPA will have the same training as an LPA and complete the same duties as above, however they will be working towards accreditation by compiling a portfolio of evidence whilst undertaking their duties. Prior to undertaking the duties of an ILPA the staff member must have satisfactorily completed the 'core of knowledge' training.

The ILPA shall only undertake the duties of an LPA with the sole focus of HDdUHB until such time they are fully accredited. Contracted LPA services will be used to supervise the ILPA during their training period.

Once accredited, the ILPA will assume the full role of LPA.

**Laser Protection Supervisor**

A Laser Protection Supervisor (LPS) shall be appointed for each locality where Class 3B or Class 4 medical lasers are in use. The LPS acts as a focal point for all laser safety matters on a day-to-day basis and must be available (or a suitably nominated deputy) whenever a laser is to be used to ensure that all laser safety procedures are followed.

The LPS must be appropriately trained and is responsible for ensuring compliance with the Local Rules (and will be named in the Local Rules).

The manager of the locality will nominate an LPS and will seek the advice of the LPA/ILPA on the appointment and training requirements of the nominated LPS.

The LPS is not responsible for the safe operation of the laser equipment – this lies with the authorised laser user.

Competence

The LPS is expected to have a certain level of equipment understanding, practical experience and knowledge of the clinical application that they are working in. This may be achieved through an interview, documentary evidence, and having a certificate of attendance of an appropriate safety course.

PD CLC/TR 50448: 2005 contains details of the expected levels of proficiency for individuals who use laser equipment. The level of competency described is not a mandatory requirement. It is dependent on the specific LPS duties and the requirements of the healthcare establishment.

The LPS will have received instructions from the LPA as to what their duties involve and will have received safety training from either the laser manufacturer, the laser supplier or the LPA/ILPA.

### LPS Responsibilities

The exact responsibilities of the LPS will need to be agreed by all parties (i.e. LPA/ILPA and departmental manager) and documented. The following is an example of the *typical* duties expected of an LPS:

- Risk Assessment
  - The LPS should undertake a risk assessment, in conjunction with the LPA, before a laser is brought into clinical operation. The LPS should review this assessment on a regular basis as advised by the LPA/ILPA.

- Local rules
  - With assistance and advice from the LPA/ILPA, the LPS should write the Local Rules. This document details the appropriate safe working practices and procedures that should be followed by all staff within the Laser Controlled Area;
  - The LPS should ensure that all staff who enter or work within the Laser Controlled Area sign statements to acknowledge that they have read and understood the Local Rules and agree to abide by them. Copies of these signed statements should be kept by the LPS;
  - The LPS should ensure that the Local Rules are followed and should monitor their adherence.

- Key Control
  - The LPS should ensure that the key for each laser is clearly labelled and is kept in safe custody (e.g. such as in a locked drawer) when the laser is not in use;
  - The LPS shall ensure that the key for each laser is issued only to a registered authorised user or assistant.

- PPE and Warning Signs
  - The LPS should ensure that laser protective eyewear is made available and checked prior to treatment with a medical laser;
  - The LPS will ensure that any staff (and patients) who are required to wear protective eyewear do so;
  - The LPS should regularly check the condition of any laser PPE;
  - The LPS should ensure that all laser-specific protective eyewear is kept separately from other safety eyewear;
  - The LPS should ensure that safety signs are placed at all entrance sites, at eye level, before treatment commences, and removed promptly after treatment;
  - The LPS should check the condition of warning signs, any protective blinds and any screens on a regular basis.

- Authorised Users & Assistants
  - The LPS should maintain an up-to-date register of authorised users and authorised assistants: only the personnel on this list are permitted to use, or assist with, the laser. However, the

employer should decide whether to add a person's name to the register, with advice from the LPA/ILPA.

- Training
  - The LPS should ensure that those who work in the Laser Controlled Area have received appropriate training commensurate with their level of involvement with the laser. However, it is not the duty of the LPS to deliver this training.

- Maintenance, Loan, Demonstration
  - The LPS should co-ordinate with service engineers to ensure that laser equipment is made available for maintenance on a regular basis;
  - The LPS should ensure that service engineers have followed the correct equipment handover procedures and satisfy themselves that the laser equipment has undergone any appropriate quality assurance checks prior to returning to clinical use;
  - The LPS must ensure that loan or demonstration equipment complies with, and is covered by, the local rules;
  - The LPS must inform the LPA/ILPA of any loan equipment as this will require a risk assessment prior to clinical use.

- Record Keeping
  - The LPS should ensure that records of training, servicing and other laser safety matters are kept filed;
  - This file should be kept up-to-date and in an organised format that will allow audit by a suitable external body (such as HSE or HIW);
  - The LPS should maintain an inventory of all medical laser equipment in their department and provide a copy to the LPA/ILPA

- Liaising with LPA or ILPA
  - The LPS should inform the LPA/ILPA of any matters which might give rise to a potential hazard;
  - The LPS should inform the LPA/ILPA, without any delay, of any hazardous event occurring. The LPS should record as much information as possible concerning the circumstances and make this available to the LPA/ILPA;
  - The LPS should inform the LPA/ILPA of any changes in laser related equipment, changes to the controlled area, or changes in operating procedure, as soon as possible;
  - The LPS should inform the LPA/ILPA of any matters which require the Local Rules to be amended;
  - The LPS should liaise with the LPA/ILPA during laser audits and act upon any recommendations.

**Clinical Laser Expert (Per Speciality)**

The clinical laser expert works in an advisory capacity. They are generally the lead clinician (senior consultant), who is associated with each laser. The role of the clinical expert would relate to making clinical assessments of the suitability of junior clinicians or other authorised users who are to use the equipment for a particular procedure.

**Authorised Laser User**

The authorised user is the individual who physically operates the laser.

The authorised user's clinical laser expert, LPS or LPA/ILPA will specify and assess the level of competence required. They will also determine when the authorised user is sufficiently competent to start using the equipment after suitable training.

They should also have attended an appropriate safety course, e.g. 'core of knowledge'. The authorised user must be knowledgeable in how to operate the particular laser and how the controls will affect the treatment.

The following is an example of the *typical* duties expected of an Authorised User:

- Ensuring the safety of all persons present, including the patient, visitors and themselves, during the operation of the laser;
- Using all personal protective equipment that has been provided;
- Reading, understanding and signing the Local Rules;
- Understanding the nature of the hazards involved;
- Using the laser safely;
- Only using the laser for specific purposes for which they have been trained;
- Using the laser only in compliance with the manufacturer's operating instructions;
- Keeping records of all training.

**Authorised Laser Assistant**

There will be times when the authorised user needs help from assisting staff (authorised laser assistants) during a laser procedure. Assisting staff need to be trained to use the equipment that they will help with. They will need to follow the appropriate safety measures, including the local rules.

The LPS or LPA/ILPA will authorise the assisting staff.

The following is an example of the *typical* duties expected of an Authorised Assistant:

- Attending laser safety training.
- Attending training in the use of any laser equipment they may use.
- Reading, understanding and signing the Local Rules.
- Understanding the nature of the hazard involved.
- Using all personal protective equipment that has been provided.
- Following instructions from the LPS and authorised user regarding laser safety.

### Other members of staff

There may be occasions when a member of staff is present within the controlled area, but they may not be operating or assisting in the operation of laser equipment.

The LPS and/or LPA should ensure that these staff members are aware of laser radiation hazards and risks and have received basic laser safety training.

## General Arrangements for Managing Laser Safety

### Hierarchy for Controlling Safety

There is a hierarchy for controlling safety:

1 Equipment/Engineering: Establish these controls first. They will include device interlocks, enclosed light sources, room interlocks (if appropriate), warning lights, barriers and laser-proof blinds etc.

2 Administration: Use of local rules, operating procedures, designated controlled areas, user training and warning signs are all effective methods of controlling hazards. These practices, in conjunction with equipment/engineering safety measures should be the principal control mechanisms.

3 Personal Protection: Personal eye protection and other patient/client/user protective clothing may be introduced as a safety control measure. However, personal protective equipment (PPE) should not be used as the primary method of controlling a hazard.

### Risk Assessment

Before first clinical use of a medical laser of Class 3R, Class 3B or Class 4; the employer should undertake a 'suitable and sufficient' risk assessment in order to comply with regulation 3 of the Management of Health and Safety at Work Regulations 1999.

Risk assessment is a tool for assessing the effectiveness of existing controls and helps identify shortfalls that need further control. The law does not expect all risks to be eliminated, but rather to protect people as far as is reasonably practicable. For further information on risk assessment and management refer to 608 – Risk Management Framework – opens in a new tab - and 674 – Risk Assessment Procedure – opens in a new tab.

The legal responsibility for the risk assessment process lies with the employer. In practice, the LPA/ILPA usually undertakes the risk assessment along with the LPS with additional assistance from the laser manufacturer or supplier.

The assessment involves assessing the laser’s technical suitability (which requires the provision of information from the supplier/manufacturer), an assessment of the intended treatment room, an

assessment of the suitability of any personal protective equipment, making sure that any users of the lasers have had equipment and/or procedural training (usually provided by the supplier/manufacturer) and identifying the updates required to the Local Rules.

**Local Rules**

The purpose of Local Rules is to ensure that all employees are working in a safe environment and that all patients are treated safely. Local Rules form part of an employer's means of complying with the Health and Safety at Work Act 1974.

Local Rules shall be issued for each locality where Class 3B or Class 4 medical lasers are used. This may also extend to Class 3R lasers (the LPS should consult with the LPA/ILPA regarding Class 3R lasers).

It is the responsibility of the LPS to ensure that all staff who have any involvement with a particular laser have read and signed the relevant Local Rules.

**Laser-Controlled Area**

The intention of a laser-controlled area is to establish a zone around the laser equipment within which hazards could arise and over which there is some element of control or restriction. The need for control measures should be decided on the basis of a risk assessment.

For practicable purposes, a laser-controlled area will usually be physically defined by the walls of a room even where the NOHD is smaller than the room dimensions.

Advice should be sought from the LPA/ILPA on the designation of the controlled area.

All persons within the controlled area must obey the Local Rules.

All entry points to the laser-controlled area must be appropriately and adequately signed and access controlled when the laser is in use.

**Personal Protective Equipment (PPE)**

The requirement for PPE, such as protective eyewear, should be based upon the risk assessment. If deemed necessary, all personnel within the controlled area must wear protective eyewear appropriate for the laser being used.

The appropriate eyewear to be used is usually stated by the laser manufacturer or laser supplier – regardless of their advice, the LPA/ILPA should always be consulted to ensure the eyewear is suitable.

Some types of lasers have special filters built into the viewing optics to protect the operator's eyes from laser radiation. For practicable reasons, wearing protective eyewear in this circumstance is not required – but the LPA/ILPA should be consulted for advice.

Only eyewear having a CE marking [indicating compliance to the Personal Protective Equipment Regulations (2002) and BS EN 207] are permitted to be used.

**Control and Security of Laser Key**

For all lasers that are classified as 3R, 3B or 4 the system should incorporate a key-operated master control. The 'key' may be a software password incorporated into the laser's operating system or may be an actual physical key.

Either at the end of the clinical session or working day, whichever is appropriate, the laser should be powered down and the key removed to an appropriate safe store. If the unit is password protected this should be initiated. *The key should not be left in the proximity of an unattended laser*.

**Reporting of Adverse Incidents**

Adverse incidents involving medical lasers should be reported immediately to the departmental manager, the LPS and the LPA/ILPA.

Adverse incidents should also be reported via the Datix incident reporting system and investigated accordingly in line with 982 – Incident, Near Miss and Hazard Reporting Procedure – opens in a new tab.

**Equipment Maintenance & Repair**

Medical device inventory

To ensure clinical requirements are met effectively, the Health Board requires wards / services / departments to ensure they compile and maintain a comprehensive record of their re-usable medical devices on the Health Board inventory. Managed and maintained by the Clinical Engineering department, the inventory identifies the management and maintenance responsibilities (Maintenance Overseer) for each device. Responsibility for the compiling and maintaining of inventories rests with the relevant directorate working with Clinical Engineering, as defined under the responsibilities section of the Medical Device Management Policy (467 – Medical Device Management Policy).

Equipment Standards

- All medical equipment, which has an electrical component associated with it, should meet the appropriate safety requirements for that product;
- Equipment standards are widely used and are now a statutory requirement of the UK MDR 2002 (amended 2020). Compliance with a harmonised standard is accepted as evidence that a product meets the directive's essential requirements;
- The primary product safety standard is BS EN 60601-1 Medical electrical equipment - part 1: general requirements for safety;
- In addition, there are standards specific to medical lasers, such as BS EN 60601-2-22 and BS EN 60825-1.

Equipment Maintenance

Maintenance and performance validation testing is an important safety measure aimed at ensuring that medical devices continue to perform in the way the manufacturer intended and the user expects and hence are safe to be used. As with acceptance and commissioning procedures, these are provided/coordinated by the in-house Maintenance Overseer & Clinical Engineering Departments along with others including devices manufacturers or their agents. There must be regular reporting from Maintenance Overseers & Clinical Engineering Departments to the OQSESC and the Medical Devices Group. The medical devices that fall into this category are expected to be low risk so far as patients' safety and critical dependency is concerned. In such cases the risk considerations presenting will be documented in accordance with HDUHB procedure 199-Risk Management and reported by the OQSESC and assurance provided to the Medical Devices Group It is sometimes the case that decisions can be taken to forego maintenance or performance validation programmes and this situation can be found when a medical device is of low replacement cost and it is considered more cost effective to replace the item outright rather than incur lifecycle servicing costs.

- The employer shall ensure that work equipment is maintained in an efficient state, in efficient working order and in good repair (PUWER);
- Only appropriately qualified and trained personnel should carry out equipment maintenance. Maintenance logs for all equipment should be held and kept up to date;
- Standard 2.9 of the Health & Care Standards requires employers to have processes to ensure that equipment and devices are maintained, cleaned and calibrated in accordance with manufacturer's guidelines, ensuring they are appropriate for their intended use and for the environment in which they are used.

For further information refer to 467 – Medical Device Management Policy – opens in a new tab.

## Managing Exposure

When using lasers it must be ensured that suitable and sufficient local procedures are in place for the management of eye risks, tissue and skin risks, smoke plume risk and fire risks.

### Eye Risks

The eye is particularly susceptible to damage from optical radiation if focused onto the retina and can be sufficient to cause local heating; it may damage both the pigment epithelium and the adjacent light-sensitive rods and cones, resulting in temporary or permanent loss of vision. Lasers can be a risk to patients, clients and equipment users.

The requirement for protective eyewear for the operator and patient/client and others should be based on the hierarchy for controlling safety. Equipment/engineering and administrative safety control measures should be established first, before introducing personal protective measures. A risk assessment should then be conducted to consider when it is appropriate for eye protection to be used.

### Tissue and Skin Risks

Both tissue and skin are susceptible to damage from optical radiation i.e. burns. Large areas of skin may be protected by light-absorbing or light-scattering materials. Hazards to hands and face may require shielding. Local procedures informed by risk assessment should be in place to manage the risks.

### Smoke Plume Risks

Smoke plume can be harmful to the respiratory system of both healthcare workers and patients. The Control of Substances Hazardous to Health Regulations (COSHH) require that exposure to substances hazardous to health are adequately controlled to prevent occurrence of ill health. Where there is likely to be an exposure to smoke plumes, it should be ensured that a risk assessment of any such exposure is undertaken and ensured that steps are implemented to reduce the risks. This may include preventative measure such as masks and/or smoke evacuation. Please to refer to the COSHH Policy and Procedure (opens in a new tab), and any local procedures that are in place to manage the risk.

### Fire Risks

Surgical fires may occur on or in a patient during laser procedures. The fires can have serious consequences for the patient, the surgical staff and critical care equipment. Higher powered laser beams are more likely to cause a fire. However, if a lower-class laser has a focused beam, there is also a potential for a fire.

In order to significantly reduce the potential for a fire the LPA/ILPA and Fire Safety Officer, in conjunction with the LPS and authorised user(s) should review all risks. A contingency plan should be drafted with details of what to do in the event of a fire. Please refer to the Fire Safety Policy (opens in a new tab), and any local procedures that are in place to manage the risk.

## Implementation / Policy Compliance

### Implementation

This policy applies at all sites within the Health Board where Medical Laser equipment falling within the scope of this policy is in use.

### Policy Compliance

Compliance with this policy will be assessed and enforced through a combination of internal audits and external inspection by regulatory agencies.

The policy will be reviewed three yearly at the Radiation Protection Group or following new/amended legislation and guidance governing the safe use of medical lasers.

## Information, Instruction and Training

In general, employee training will cover 3 areas: *equipment-based* training, *safety* training and *procedural* training. All staff should have the appropriate competency training to undertake their role. The employer should keep training records.

### Equipment Based Training

The laser manufacturer or their supplier usually provides the equipment-based training to the authorised user(s) and authorised assistants at the time of installation. After this, training may be provided to additional staff members either by the LPS, manufacturer / supplier, or the individual who has been designated the training supervisor.

### Safety Training – Core of Knowledge

All laser operators and those assisting with laser procedures, should attend a 'Core of Knowledge' course as outlined in Appendix C of MHRA document 'Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices'.

There is no statutory approvals body for core of knowledge courses but there are organisations and professional bodies, such as the British Medical Laser Association, that have 'approved' courses (MHRA, p.67).

The core of knowledge courses should be delivered by persons who have a high level of knowledge and understanding of different optical radiation devices, optical radiation safety and the risks and hazards associated to the equipment: for example a certified LPA/ILPA.

It is good practice for staff to periodically re-attend a core of knowledge course (e.g. at least every 5 years) in order to maintain their awareness levels (MHRA, p.19).

**Safety Training – Laser Awareness**

Other staff members, who do not use medical lasers, but may be present during laser use (e.g. nursing staff, theatre assistants, and trainees) should have a basic understanding of the risks they may face and how they can be prevented.

As for Core of Knowledge courses, there is no statutory approvals body for Laser Awareness Training, but the British Medical Laser Association (BMLA) has a list of approved courses and a typical syllabus.

Laser Safety Awareness training may be provided by the LPA/ILPA.

It is good practice for staff to periodically re-attend a Laser Awareness course (e.g. at least every 5 years).

**Procedural Training**

Procedural based training may be provided by the equipment manufacturer or their supplier and is frequently supported by an appropriate training course. The clinician who oversees the procedures may provide the clinical based training to specific staff.

Changes to procedures or the introduction of new treatments to a department or healthcare facility may require additional training from clinical experts, the manufacturer/supplier or other healthcare related personnel.

## Getting Help

The following persons should be available to provide strategic and local advice to the Health Board on matters of Medical Laser safety:

Laser Protection Advisor (LPA) or Internal Laser Protection Advisor (ILPA)

The Laser Protection Adviser is identified in the locality's Local Rules for Medical Laser Safety. The role of the LPA/ILPA is defined in the LPA responsibilities section.

Laser Protection Supervisor (LPS)

The Laser Protection Supervisor is identified in the locality's Local Rules for Medical Laser Safety. The role of the LPS is defined in the LPS responsibilities section.

# References & Relevant Legislation

### Directives

- The Medical Devices Directive. The European Commission. Council Directive 93/42/EEC concerning Medical Devices, OJ 169/ 12.7.93.
- Directive 2006/25/EC of the European Parliament and of the Council of 5 April 2006 on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation).

### Acts

- Health and Safety at Work etc. Act 1974

### Regulations

- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- The Control of Artificial Optical Radiation at Work Regulations 2010
- The Personal Protective Equipment Regulations 2002
- The Control of Substances Hazardous to Health Regulations 2002
- The Management of Health and Safety at Work Regulations 1999
- The Provision and Use of Work Equipment Regulations 1998
- Health and Safety (Signs and Signals) Regulations 1996
- The Personal Protective Equipment at Work Regulations 1992

### Guidance

- Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices, MHRA, Sep 2015.
- ICNIRP Guidelines on limits of exposure to laser radiation of wavelengths between 180nm and 1,000µm; Health Physics 105 (3): 271 – 295; 2013.
- Non-binding guide to good practice for implementing Directive 2006/25/EC 'Artificial Optical Radiation' European Commission, Jun 2010.
- Laser radiation: Safety advice, Public Health England, updated 15th August 2017 (www.gov.uk/government/publications/laser-radiation-safety-advice/laser-radiation-safety-advice).

### Standards

- BS EN 60825-1:2014/A11:2021/AC:2022 Safety of Laser Products - Equipment Classification and Requirements.
- PD IEC/TR 60825-8: 2006 Safety of laser products - Guidelines for the safe use of laser beams on humans.
- PD IEC TR 60825-14: 2022 Safety of laser products - A user's guide.

- BS EN 207: 2017 Personal eye protection equipment – Filters and eye protectors against laser radiation.
- BS EN 60601-2-22: 2020 Medical electrical equipment - Particular requirements for basic safety and essential performance of surgical, cosmetic, therapeutic and diagnostic laser equipment.
- PD CLC/TR 50448: 2005 Guide to Levels of Competence Required in Laser Safety.
- IEC EN 62471: 2008 Photo-biological Safety of Lamps and Lamp Systems.
- Health and Care Standards, Welsh Government, April 2015.

**Other References**

British Medical Laser Association Website: www.bmla.co.uk/

**SUMMARY EQUALITY IMPACT ASSESSMENT – 770 – Medical Laser Safety Policy – (Version 3)**

| | |
|---|---|
| **Organisation:** | Hywel Dda University Health Board |

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|---|---|---|
| **Proposal Sponsored by:** | **Name:** | Adam Springthorpe |
| | **Title:** | Health & Safety Manager |
| | **Department:** | Health, Safety & Security Department |

| | |
|---|---|
| **Policy Title:** | 770 – Medical Laser Safety Policy – (Version 3) |

| | |
|---|---|
| **Brief Aims and Objectives of Policy:** | This document describes the framework by which HDdUHB manages the safe use of medical lasers. This document will help ensure the effective organisation and management of safety associated with medical lasers and help ensure that the necessary standards for the protection all persons on Health Board premises from the associated risks of medical lasers are implemented and maintained. |

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| **Was the decision** | **Yes** | **No√** |

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| **reached to proceed to full Equality Impact Assessment?** | The Equality Impact Assessment (EqIA) document from 2022 has been reviewed and updated.<br><br>There was no evidence to indicate that the policy would have an adverse effect on any group or individual with any one or multiple protected characteristics that could not be mitigated.<br><br>It is more likely to have a positive impact in that it protects the health and safety of staff in the workplace.<br><br>It will be the responsibility of managers to ensure that the policy is applied fairly and equitably on an individual basis and that staff with any single or multiple protected characteristics will be afforded the same opportunities and protections as those who do not share any protected characteristics.<br><br>A search of similar policies elsewhere indicated similar results:-<br>https://www.google.co.uk/search?source=hp&ei=er2UXZqFCo-4kwXnpbYQ&q=medical+laser+safety+policy+NHS+equality+impact+assessment&oq=medical+laser+safety+policy+NHS+equality+impact+assessment&gs_l=psy-ab.12...3444.3444..7859...0.0..0.256.256.2-1.....0....2j1..gws-wiz.v-BLTEtUnP4&ved=0ahUKEwiaqsXB7f3kAhUP3KQKHeeSDQIQ4dUDCAs | |
| **If no, are there any issues to be addressed?** | **Yes** | **No √** |
| | The needs of individuals in relation to their protected characteristics need to be taken into account when providing associated training e.g. assistance with accessibility, language, learning and literacy skills.<br><br>The needs of individuals in relation to their protected characteristics need to be taken in to account when undertaking risk assessments. Staff will need to cross-reference with the Risk Management Procedure. | |

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| **Is the Policy Lawful?** | **Yes** | This Policy complies with relevant health and safety legislation. |

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| **Will the Policy be adopted?** | **Yes** | |
| | **If no, please record the reason and any further action required:** | |

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| **Are monitoring arrangements in place?** | **Yes** | |
| | Any complaints received regarding the implementation of the Policy around issues of equality and diversity will be addressed appropriately on an individual basis and appropriate action taken. | |

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| **Who is the Lead Officer?** | **Name:** | Adam Springthorpe |
| | **Title:** | Health & Safety Manager |
| | **Department:** | Health, Safety & Security Department |
| **Review Date of Policy:** | The policy will be reviewed on a three-yearly basis. | |

| **Signature of all parties:** | **Name** | **Title** | **Signature** |
|---|---|---|---|
| | Adam Springthorpe | Health & Safety Manager | 2nd October 2019 |
| | Jackie Hooper | Senior Diversity and Inclusion Officer | 2nd October 2019 |
| | Adam Springthorpe | Health & Safety Manager | 7th October 2022 |
| | Kathryn Cobley | Diversity & Inclusion Manager | 7th October 2022 |
| | Adam Springthorpe | Health & Safety Manager | 29th June 2023 |
| | Alan Winter | Senior Diversity and Inclusion Officer | 10/7/2023 |

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| | | | |
| **Please Note: An Action Plan should be attached to this Outcome Report prior to signature** | | | |

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# PWYLLGOR IECHYD A DIOGELWCH
# HEALTH & SAFETY COMMITTEE

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|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 11 September 2023 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | New Policy (1132) – Control of Vibration at Work Policy |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Mandy Rayani, Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Tim Harrison, Head of Health, Safety and Security<br>Adam Springthorpe, Health & Safety Manager |

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)
**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The Health and Safety Committee (HSC) is requested to approve the new 1132 – Control of Vibration at Work Policy. This report provides the required assurance that this Written Control Document has been developed in line with all relevant legislation / regulations and available evidence and can therefore be implemented within Hywel Dda University Health Board (HDdUHB).

## Cefndir / Background

Exposure to vibration for prolonged periods, through regular working with hand-held power tools, such as concrete breakers, percussion drills, and hand-guided equipment such as lawn mowers, strimmers, hedge trimmers, or by holding materials being processed by machines such as pedestal grinders, can have adverse effects on the hands and arms of users. Without effective controls, workers using such equipment may suffer various forms of damage, including impaired circulation and damage to the nerves or muscles.

HDdUHB recognises the risks posed to staff when working with vibratory tools and will manage, so far as is reasonably practicable, vibration hazards falling under its control. This Policy demonstrates HDdUHB's commitment to reducing the risks associated with handheld vibratory tools and the continued improvement of employee health, safety and welfare.

Until now, HDdUHB have not had a formal Control of Vibration at Work Policy. The need for one was brought to the Health Board's corporate attention following our neighbouring Powys Teaching Health Board (PTHB) receiving two Improvement Notices (INs) from the Health and Safety Executive (HSE) in 2019 for their management of Hand Arm Vibration Syndrome (HAVS). These INs were confirmed as complete in April 2020, however the HSE's investigation into the historic cases continued with the end result of PTUHB recently being fined £160000 + Costs (£5599) + Fees for Intervention (FFI) (c£10k) for their HAVS-related failures. They will also likely face personal injury claims following the prosecution. It should be noted that the fine was originally set at £1.1m but was lowered by the judge in recognition of the work that PTHB had done to address the issues once highlighted.

## Asesiad / Assessment

This new policy has been developed over a number of months with key stakeholders in Operational Compliance, Estates and Occupational Health and forms part of an action plan to address the management of vibration within the Health Board.

The policy was circulated to the full membership of the Health and Safety Advisory Group (HSAG) for comment for a period two weeks. The Group comprises of representation from Health and Safety, the Legal Team, Occupational Health, Operational Compliance and Manual Handling. All comments received were actioned appropriately.

The policy was then sent for Global consultation for the period 10/07/2023-24/07/2023. No further comments were received.

The policy will be available in all areas via the HDdUHB Policy Internet site.

For the Control of Vibration at Work Policy to be successful, all managers will need to ensure that all users of vibrating equipment within their areas of responsibility understand and comply with the requirements of the policy.

The Health, Safety and Security Department will monitor and review this policy on a three-yearly basis (or sooner in light of changes in legislation or practice). This will provide a measurement of performance and ensure adequate processes and structures are in place, as well as continuing compliance with statutory responsibilities.

## Argymhelliad / Recommendation

For the Health and Safety Committee to:

- Approve the new 1132 – Control of Vibration at Work Policy.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Committee ToR Reference:<br>Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.16 Approve organisational Health and Safety Policies, Procedures, Guidelines and Codes of Practice (policies within the scope of the Committee). |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score: | N/A |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 1. Leadership<br>3. Data to knowledge<br>4. Learning, improvement and research |

| | |
|---|---|
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 2.1 Managing Risk and Promoting Health and Safety<br>7.1 Workforce |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 1. Putting people at the heart of everything we do<br>4. The best health and wellbeing for our individuals, families and communities |
| Amcanion Cynllunio<br>Planning Objectives | 2a Staff health and wellbeing<br>5a Estates Strategies |
| Amcanion Llesiant BIP:<br>UHB Well-being Objectives:<br>Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | • L140 'Hand-Arm Vibration – The Control of Vibration at Work 2005 Regulations: Guidance on Regulations,'<br>• HSG170 'Vibration Solutions: Practical Ways to Reduce the Risk of Hand-Arm Vibration Injury',<br>• INDG175 'Hand-Arm Vibration at Work, a Brief Guide for Employers,'<br>• INDG296 'Hand-Arm Vibration: A Guide for Employees,'<br>• PTHB HSP-004 Hand Arm Vibration Policy V2, Powys Teaching Health Board.<br>• Evaluation of Hand-Arm and Whole-Body Vibrations in Construction and Property Management. Marie A. Coggins, Eric Van lente, Margaret Mccallig, Gurmail Paddan, Ken Moore. *The Annals of Occupational Hygiene*, Volume 54, Issue 8, November 2010, Pages 904–914.<br>• Health and Safety Executive (HSE) website: www.hse.gov.uk/vibration |
| Rhestr Termau:<br>Glossary of Terms: | As contained within the body of the report. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch:<br>Parties / Committees consulted prior to Health and Safety Committee: | Key Stakeholder Consultation<br>Health & Safety Advisory Group |

| Effaith: (rhaid cwblhau)<br>Impact: (must be completed) | |
|---|---|
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | There are no direct costs associated with the Policy. |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | There is a positive impact on staff safety, health and wellbeing through compliance with this Policy. |
| **Gweithlu:**<br>**Workforce:** | There will be no adverse impact upon staff. |
| **Risg:**<br>**Risk:** | Not applicable. |
| **Cyfreithiol:**<br>**Legal:** | A breach of health and safety regulations can result in the issue of prohibition or improvement notices or criminal proceedings. |
| **Enw Da:**<br>**Reputational:** | Prosecutions and claims due to breaches in legislation or personal injury claims can lead to negative publicity. |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable. |
| **Cydraddoldeb:**<br>**Equality:** | No evidence gathered at this stage to indicate a negative impact on any protected group(s). |

# Control of Vibration at Work Policy

## Policy information

**Policy number:**
**1132**

**Classification:**
Corporate

**Supersedes:**
N/A

**Local Safety Standard for Invasive Procedures (LOCSSIP) reference:**
N/A

**National Safety Standards for Invasive Procedures (NatSSIPs) standards:**
N/A

**Version number:**
V1

**Date of Equality Impact Assessment:**
*17/08/2023*

## Approval information

**Approved by:**
*Health and Safety Committee*

**Date of approval:**
*Enter approval date*

**Date made active:**
*Enter date made active (completion by policy team)*

**Review date:**
*Enter review date (normally three years from approval date)*

**Summary of document:**
This document provides guidance on the arrangements for managing the control of vibration as part of the Health Board's responsibility to staff under Health & Safety Legislation.

**Scope:**
This policy is applicable to all Hywel Dda University Health Board (HDdUHB) staff, including Independent Members, volunteers, those seconded into the Organisation or holding honorary contracts, locums and students.

**To be read in conjunction with:**
010 – Health and Safety Policy - opens in a new tab
608 – Risk Management Framework – opens in a new tab
674 – Risk Assessment Procedure– opens in a new tab
982 – Incident, Near Miss and Hazard Reporting Procedure – opens in a new tab

**Patient information:**
Include links to Patient Information Library

**Owning group:**
Health & Safety Advisory Group / Health and Safety Committee
*09/08/2023*

**Executive Director job title:**
Mandy Rayani, Director of Nursing, Quality and Patient Experience

**Reviews and updates:**
New policy

**Keywords**
Vibration, HAVS

**Glossary of terms**
HAVS – Hand Arm Vibration Syndrome
SSoW – Safe System of Work
HSE – Health and Safety Executive
EAV – Exposure Action Value
ELV – Exposure Limit Value
PPE – Personal Protective Equipment

# Contents

## Introduction

Exposure to vibration for prolonged periods, through regular working with hand-held power tools, such as concrete breakers, percussion drills, and hand-guided equipment such as lawn mowers, strimmers, hedge trimmers, or by holding materials being processed by machines such as pedestal grinders, can have adverse effects on the hands and arms of users. Without effective controls, workers using such equipment may suffer various forms of damage, including impaired circulation and damage to the nerves or muscles.

Although there are many names for the injuries caused by excessive exposure to vibration, such as “vibration induced white finger”, they are collectively known as Hand Arm Vibration Syndrome (HAVS), as well as specific diseases such as Carpal Tunnel Syndrome.

The primary cause of HAVS, is from work that involves holding vibrating tools or work equipment. The risk depends on both the vibration magnitude of the piece of equipment and how long people are exposed to that vibration, in effect a daily ‘vibration dose’.

Other factors that that have an effect on this include:

- The grip, push and other forces used to guide and apply vibration tools. A tight grip transfers more vibration energy to the hand;
- The exposure pattern – length and frequency of work and rest periods. It is better to break up periods of exposure;
- How much of the hand is exposed to vibration;
- Factors affecting blood circulation, such as temperature and smoking. Some medical conditions – Raynaud’s disease, coronary artery disease, blood disorders, pregnancy, epilepsy and some medications;
- Individual susceptibility.

## Policy statement

Hywel Dda University Health Board (HDdUHB) recognises the risks posed to staff when working with vibratory tools and will manage, so far as is reasonably practicable, vibration hazards falling under its control. This policy demonstrates HDdUHB’s commitment to reducing the risks associated with handheld vibratory tools and the continued improvement of employee health, safety and welfare.

## Scope

This policy is applicable to all HDdUHB staff, including Independent Members, volunteers, those seconded into the Organisation or holding honorary contracts, locums and students. This policy relates to all staff whose work requires them to use vibratory tools in the workplace.

## Aim

This policy aims to protect employees and others, so far as is reasonably practicable, from the risks posed to staff when working with vibratory tools in the workplace. HDdUHB will aim to achieve this by putting measures in place to control vibration exposure levels at work so far as is reasonably practicable. When selecting controls to manage exposure to vibration risks, HDdUHB will apply the hierarchy of controls as set out in the Management of Health & Safety at Work Regulations 1999 and the Control of Vibration at Work Regulations 2005.

## Objectives

The aim of this document will be achieved by the following objectives, following the hierarchy of controls:

- HDdUHB will, so far as is reasonably practicable, eliminate vibration at source.
- Where elimination is not practical, the HDdUHB will, reduce vibration exposure to as low a level as is reasonably practicable;
- Where employees are likely to be exposed to a risk from vibration, HDdUHB shall make and keep up to date suitable & sufficient vibration risk assessments;
- HDdUHB will provide employees with suitable information, instruction & training;
- Where an assessment indicates that vibration exposure is a risk to the health of employees, then health surveillance shall be carried out in line with HDdUHB's Occupational Health Policy and associated procedures.

## Responsibilities

**Chief Executive**

The Chief Executive is responsible to the Board of HDdUHB for the implementation of the arrangements and procedures required to implement this policy and to achieve compliance with legislation in standards of health and safety. These are outlined in more detail within HDdUHB 010 – Health and Safety Policy.

**Executive Directors**
Executive Directors are responsible to the HDdUHB Board and for ensuring that all risks associated with vibration at work are adequately controlled within their areas of responsibility and that any health issues resulting from exposure to vibration at work are reported and investigated in line with this policy. Executive Directors are also responsible for ensuring suitable and sufficient risk assessments are undertaken as required and suitable control measures are implemented to control the risk from vibration exposure. Action plans are adequately monitored and any instances where hand arm vibration is diagnosed this is investigated thoroughly.

**Senior Managers**
All Senior Managers including Assistant Directors, Heads of Departments etc are responsible for service delivery etc Senior Managers for each locality/directorate have responsibility for the day-to-day management of health and safety within their area of responsibility. They are directly accountable to their management for ensuring full compliance with health & safety legislation, which includes compliance with the Control of Vibration at Work Regulations 2005 and for ensuring staff follow safe systems of work (SSoW).

Senior Managers will ensure that staff are able to attend relevant training sessions run by the organisation and ensure that agency staff, apprentices or bank staff have received appropriate vibration awareness training prior to undertaking any work with vibratory equipment.

In addition they need to ensure that systems are in place to achieve the following:

- arrangements are in place for suitable and sufficient risk assessments to be undertaken, which properly assess any work activities where vibration is a risk;
- systems of work are devised, documented and implemented in order to reduce risk;
- to make arrangements to bring this policy, arrangements and any revisions to the notice of all employees within their area of responsibility and others who may be affected;
- that Line Managers and Supervisors receive sufficient training to undertake their role;
- to identify the resources required to implement this Policy and ensure that financial requirements are included in budget bids.

**Line Managers/Supervisors**
All Line Managers / Supervisors including Estates Officers, Estates Supervisors, Facilities Managers and Facilities Supervisors & Co-ordinators etc are responsible for:

- identifying employees who are exposed to vibration at work;

- ensuring that suitable and sufficient risk assessments which properly assess any work activities undertaken by employees where vibration is a risk and implement control measures which reduce the risk so far as is reasonably practicable;

- ensuring that all employees receive information, instruction and training on the management of hand arm vibration;

- assessing any equipment used by employees, and ensuring that information on appropriate work practices have been communicated to the employees;

- ensuring that control measures resulting from the risk assessment and safe working practices are adhered to by employees, including; job rotation, appropriate breaks etc.

- reporting any issues or conditions to your Senior Manager and a member of the ;

- ensuring that a proper assessment of the vibration levels of work equipment are undertaken prior to purchase or hire i.e. measure or use certified data;

- ensure that all tools, plant and equipment are properly maintained, inspected and used in a safe manner; and that those instructions are followed;

- ensuring the vibration exposure of staff is monitored on a regular basis;

- ensuring staff attend health surveillance as and when requested;

- eliminating exposure to vibration where advised by Occupational Health or another clinical physician;

- ensuring that low vibration design is considered when purchasing/hiring/utilising tools e.g. tools with anti-vibration mountings or vibration-isolating handles;

- ensuring that all new vibrating equipment purchased by the Health Board is added to the appropriate vibration exposure level asset log, with points logged, calculated and communicated to all end users. Tools, as well as ancillaries such as grinding discs, drill bits etc may, also need to be added to a local asset log (please check locally);

- ensuring that the vibration exposure level asset logs are updated to reflect where tools are removed from service / disposed of.

**Employees**
In addition to their duties under the Health and Safety at Work etc. Act 1974, Management of Health and Safety at Work Regulations 1999 and subsequent legislation and guidance, employees will assist their managers by:

- complying with requirements of this policy, local procedures and risk assessed control measures;
- advising the employer on any medically related issues or conditions which may affect their work with vibratory tools or equipment;
- reporting any concerns or symptoms to their line manager as soon as possible, including issues of work practices, in order that remedial actions can be taken;
- attending the Occupational Health Department for the purposes of health surveillance, as and when directed;
- adhering to safe systems of work or training and awareness for the purposes of reducing the risks of hand arm vibration;
- using only the powered hand operated equipment provided by the employer.

**Health, Safety and Security Department**
Reporting to the Director of Nursing, Quality and Patient experience, the Health Safety and Security Department will be responsible through HDdUHB's Health and Safety management system for:

- reporting to Health and Safety Committee any reported issues relating hand arm vibration and the action taken to prevent recurrence;
- development of HDdUHB Hand Arm Vibration Policy and advising on the local implementation procedures;
- monitoring and review of the effectiveness of HDdUHB Policy and locally implemented procedures, in conjunction with the Operations Compliance Team in the Estates Department;
- assisting and reviewing the process of risk assessment;
- communicating changes in legislation and best practice ;
- reporting any diagnosed instances of hand arm vibration or vibration associated ill health to the HSE.

**Occupational Health**
Reporting to the Assistant Director for Workforce and Organisational Development, the Occupational Health Department will be responsible for:

- providing a confidential service to all staff and deliver specialist advice on the effects of health on work and the effects of work on health;
- working closely with managers and provide advice, when requested on the suitability, availability and appropriateness of health surveillance;
- undertaking appropriate health surveillance as identified through risk assessment and legislation;
- keeping records for the appropriate lengths of time;
- giving feedback and guidance on risk to individuals following health surveillance;
- advising the appropriate manager if there are restrictions on an individual's ability to work due to health risks;
- giving feedback on the results from health surveillance to the appropriate managers, operational safety groups and Senior Safety Officers.

# Arrangements

## Legal framework

HDdUHB has a duty under the Health & Safety at Work etc. Act 1974, to secure the health, safety and welfare of its employees and others who may be affected by its working activities.

In addition, the Management of Health and Safety at Work Regulations 1999 require the Health Board to assess the risk to employees' safety and welfare, implement adequate controls and health surveillance where necessary.

The Control of Vibration at Work Regulations 2005 require HDdUHB to protect employees against risks from the exposure to vibration at work. HDdUHB must make sure that risks from vibration are assessed and controlled. It must provide information, instruction and training to employees on the risks identified and the actions being taken to control them and provide suitable health surveillance.

The Provision and Use of Work Equipment Regulations 1998 require employers to select and use equipment that is suited to maintain the health and safety of the user. This duty extends to the consideration of vibration control when purchasing or hiring any new equipment.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) lists HAVS as a reportable disease. As a result of this legislative requirement, all cases of clinically diagnosed HAVS and associated conditions i.e. Carpal Tunnel Syndrome linked to HAV must be reported to the Health and Safety Executive (HSE).

## Risk assessment

To effectively manage the risk from exposure to vibration, suitable and sufficient risk assessments must be undertaken by the services, to identify the main sources of vibration within the workplace, who is exposed, the levels of exposure and what work equipment is involved.

Where activities or equipment are identified that expose employees to vibration, it is essential that an assessment is made to determine the levels of exposure for each piece of equipment and the activity as a whole, to identify if employees' daily vibration exposure is likely to be at or above the Exposure Action Value (EAV) or Exposure Limit Value (ELV).

Regulation 4 (1) of the Control of Vibration at Work Regulations sets the following values for HAV:

(a) the daily exposure limit (ELV) value is 5 m/s2 A(8);
(b) the daily exposure action value (EAV) is 2.5 m/s2 A(8).

The ELV is the maximum amount of vibration an employee may be exposed to on any single day. The EAV is the level of daily exposure to vibration at or above which the Health Board would be required to take certain actions to reduce exposure.

Calculating the EAV and ELV requires complex calculations (See Schedule 1 of the Control of Vibration at Work Regulations). In order to simplify the process the HSE created an Exposure Points system to be used instead of values in m/s2, where the EAV = 100 exposure points and the ELV = 400 exposure points.

Where exposure levels are likely to be at, or above the EAV (100 points), suitable control measures must be implemented to mitigate any risk. Where exposure is likely to be at or above the ELV (400 points), action must be taken to prevent the ELV being exceeded and to reduce the levels of exposure to a level as low as is reasonably practicable.

To be relevant, the vibration magnitude used during the assessment process must be representative of the equipment you plan to use and the way in which you plan to use it. There are several possible sources of suitable information on vibration magnitudes.

These include:

(a) vibration emission values declared in the equipment handbook (see examples in Appendix 2);
(b) additional information from the equipment supplier;
(c) internet databases;
(d) research organisations;
(e) vibration consultancies;

(f) HSE's website – (L40);
(g) trade associations;
(h) measurements made in the workplace.

Where vibration measurements have been taken or are available via another source (as identified above), the HSE have produced a "Vibration Calculator". This is available to download free from the HSE website and will assist with working out exposure rates during the risk assessment process. If using a source other than actual vibration measurements, then an uncertainty value - "K" value must be added to the listed vibration magnitude before the calculation is done. The "K" values will be listed with the vibration information.

Where deemed necessary by risk assessment, services may need to physically measure certain vibratory equipment and/or activities in the workplace. Measurements should be representative of the actual work, including how the tools are used operationally and on a variety of materials. This will enable the services to build up an accurate database. All measurements must be undertaken by a competent person.

Where equipment measurements are not available, equipment will be replaced or quarantined until such time as the vibration magnitudes can be measured by a competent person.

Where vibration equipment is regularly used, managers must remain alert for symptoms among employees. Once reported, symptoms must be referred to HDdUHB Occupational Health Department, who will undertake the necessary investigations.

The Regulations require the careful consideration of employees whose health may be at particular risk from vibration due, for example, to circulatory problems, joint or muscular problems and this must be considered during the risk assessment process.

## Control measures

HDdUHB will ensure that risk from the exposure of employees to vibration is either eliminated at source or, where this is not reasonably practicable, reduced to as low a level as is reasonably practicable and will assess exposure levels and effects. Control measures to achieve this include, following the hierarchy of control where feasible:

- avoiding where possible the process that generate vibration i.e. Eliminate the risk;
- substituting a process for one involving less vibration, for example by replacing manual concrete breaker with a remote control or robotic breaker;
- purchasing/hiring/utilising tools designed for low vibration e.g. tools with anti-vibration mountings or vibration-isolating handles. When any new vibrating equipment is purchased by the Health Board it must be added to the appropriate vibration exposure level asset log, with points logged,

calculated and communicated to all end users. Tools, as well as ancillaries such as grinding discs, drill bits etc, may also need to be added to a local asset log (please check locally);

- providing supports for tools or work pieces to reduce the grip, push and other forces;
- calculating exposure levels, following the processes in the previous section, coupled with suitable and sufficient risk assessment. Physical measurements may be undertaken where deemed necessary by the risk assessment;
- ensuring correct and routine maintenance of tools;
- introducing work rotation / work sharing to reduce individual risk;
- providing suitable and sufficient raining for employees;
- advising on the proper selection of tools for the task – suitable for the purpose for and working conditions in which they are to be used, used only for the purposes for which they are suited and used only under conditions for which they are suitable;
- providing robust HAVS health surveillance.
- NOTE: 'Anti-vibration' gloves should not be relied upon to control risk (See next section).

## HAVS gloves policy and outdoor working

There is no personal protective equipment (PPE) that can be shown to reduce the risks from hand-arm vibration. 'Anti-vibration' gloves are available, but at best will only provide a small reduction in vibration exposure. Gloves must not be provided as a means of reducing vibration risk unless vibration exposure reduction has been demonstrated. Some workers like the feel of anti-vibration gloves and they can be used to protect against abrasion and to keep the hands warm.

Keeping the hands and body warm and dry is likely to reduce the risks from hand-arm vibration because this helps ensure that good blood circulation is maintained throughout the body and especially in the hands and fingers. In outdoor working it is advisable to use gloves, body warmers and layered clothing to maintain a good body and hand-arm temperature.

## Training

Where identified by risk assessment, persons who use vibratory equipment during the course of their work must receive suitable information, instruction, training and supervision in the safe operation of such equipment.

Information, instruction and training will include:

- the health effects of vibration;
- sources of vibration;
- the level of risk, where identified, whether the risk is high (above the ELV), medium (above the EAV) or low (below the EAV);
- the risk factors (e.g. the levels of vibration, daily exposure duration, regularity of exposure over weeks, months and years);
- how to recognise and report symptoms of hand arm vibration;
- the need for health surveillance, how it can help them remain fit for work, how it is provided;
- Personal Protective Equipment (PPE);

Ways to minimise risk to health, including:

- changes to working practices to reduce vibration exposure;
- correct selection, use and maintenance of equipment;
- correct techniques for equipment use, how to reduce grip force etc.;
- maintenance of good blood circulation at work by keeping warm, massaging fingers and where relevant, cutting down on smoking.

Training records will be kept on ESR, along with a declaration of attendance sheet, signed and dated by operatives.

Refresher training will be provided at regular interval to ensure that members of staff retained their knowledge and competencies in relation to vibration at work.

## Maintenance

Vibration emissions can be dramatically reduced by good tool maintenance. Managers must ensure that equipment is properly cared for and any damage reported immediately.

Power tools and other work equipment will be serviced and maintained in accordance with the manufacturers' maintenance schedules to prevent unnecessarily high vibration levels and ensure efficient operation.

Staff will be reminded to report any tools perceived to be giving rise to excessive vibration to their supervisors. The supervisors will subsequently arrange for such tools to be examined and repaired where necessary.

Maintenance schedules will, where appropriate, make specific reference to inspection and repair of any anti-vibration measures.

Equipment should only be modified in line with the manufacturer's instructions using appropriate accessories and by those competent to do so; but this may affect vibration exposure and the risk assessment should be updated accordingly. Removal or replacement of accessories such as handles etc may increase or decrease vibration exposure.

## Tool Age

Research suggests strong associations between tool age and vibration magnitudes and the possible increase in vibration values over time. This strengthens the need for a suitable and sufficient maintenance schedule to be in place to reduce vibration emissions.

A replacement programme should be considered for all old, obsolete and/or insufficiently maintained vibrating equipment.

## Procurement

HDdUHB will adopt a procurement policy that prioritises low vibration tools and processes. Staff engaged in the procurement and purchase of tools and equipment must be familiar with Control of Vibration at Work Regulations practical guidance for employers Part 4: a sample of suggested questions for manufacturers and suppliers of equipment is contained in Appendix 1.

Managers/Supervisors will ensure that procurement requests are clearly accompanied by advice that low vibration characteristics are a priority in selecting tools and equipment.

Procurement must respond positively to requests for low vibration tools and equipment, even though cheaper alternatives may be available. Selection of such tools and equipment shall be carried out in consultation with / or at the request of a competent person, e.g. line manager of persons who will be exposed to vibration during their work activities and appropriate Health and Safety Manager or Officer. As far as possible, HDdUHB will standardise the tools used for various tasks i.e. minimise the range of tool brands and models in use to assist with the reduction in vibration exposure.

In addition to the tools themselves, due consideration should be given to the evaluation and purchasing of effective ancillaries, including grinding discs, drill bits etc as they are an important part of the tool. For example, an effective disc will have lower exposure levels due to the shorter trigger time. More expensive ancillaries may be better than cheaper discs and are often accompanied by suitable and sufficient data on performance. As with tools, Managers/Supervisors should ensure that procurement requests are clearly accompanied by advice that low vibration characteristics are a priority.

When any new vibrating equipment is purchased by the Health Board it must be added to the appropriate vibration exposure level asset log, with points logged, calculated and communicated to all end users. Tools and ancillaries may also need to be added to a local asset log (please check locally).

## Health surveillance

The Management of Health and Safety at Work Regulations 1999, along with the Control of Vibration at Work Regulations 2005 require appropriate health surveillance to be provided to employees, where the risk assessments identify it to be necessary. Health surveillance shall be carried out by HDdUHB Occupational Health Department, where:

- a risk assessment indicates there is a risk to health of employees who are likely to be exposed to vibration; or
- employees are likely to be exposed at or above an exposure action value;
- an employee indicates they may be suffering with symptoms associated with HAVS;
- a direct link can be established between an exposure and an identifiable disease or adverse health effect;
- it is probable that the disease or adverse health effect may occur under the conditions of work;
- valid techniques are available for detecting the disease or adverse health effect.

Evidence of all employees undergoing health surveillance shall be recorded and maintained for at least 40 years.

To identify employees with symptoms that require further investigation, while avoiding unnecessary use of specialist resources, a tiered approach to health surveillance will be implemented, as follows:

**Tier 1** Initial or baseline assessment. Before any employee is exposed to Hand Arm Vibration, Occupational Health will undertake an initial assessment, upon notification of such by the manager/supervisor or as part of the pre-employment process. Initial screening will be carried out using a self-administered questionnaire that includes questions about the person's medical history and is to be returned in confidence to Occupational health.

**Tier 2** Annual (screening) questionnaire. Managers of operatives working with vibratory tools that pose a risk will ensure on an annual basis, their employees complete **a Hand Arm Vibration** screening questionnaire, and return this to Occupational Health. This will form the routine health surveillance for employees who are at risk but have not reported any symptoms suggestive of HAVS.

**Tier 3** Assessment by qualified person. If any symptoms are reported at Tier 2 stage the operative may be required to be assessed by the Occupational Health Advisor*, who will then decide whether the operative is referred to the Occupational Health Physician for further assessment.

**Tier 4** Formal Diagnosis. Any formal diagnosis is made by the Occupational Health Physician*, who may also wish to refer the operative to a vascular Consultant.

* Note: These assessment services may need to be sought from an external provider and paid for by the requesting department.

## Confirmed cases of HAVS and restrictions

Where Occupational Health have diagnosed an employee with hand arm vibration syndrome or Carpal Tunnel Syndrome where a restriction has been placed on the employee, health and safety in conjunction with the Manager will carry out a risk assessment detailing the controls required to comply with the recommendations / restrictions advised by Occupational Health.

## Reporting of vibration related ill health

If staff members suffer any symptoms that are related to hand arm vibration or vibration related ill health, these must be reported to their Line Manager immediately. If following an Occupational Health referral vibration related ill health is diagnosed, these instances must be reported via Datix.

All cases of work-related hand arm Vibration, or vibration related ill health such as Carpal Tunnel Syndrome, diagnosed by HDdUHB's Occupational Health Physician, will be reported to the Health and Safety Executive as required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

## Monitoring compliance, audit & review

Monitoring and auditing of compliance with this policy will be undertaken as part of the corporate health & safety audit schedule.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within HDdUHB indicate otherwise.

## Records

It is essential that records maintained on all aspects of the above. These records will include:

- details of any vibration measurements taken by a competent person;
- risk assessments;

- details of work practices, periods of exposure for employees and monitoring;
- equipment purchase information;
- a register of all plant and equipment;
- pre-employment assessments of employees;
- health surveillance questionnaires/reports, including any Occupational Health Physician reports or other specialist medical information.

## References

L140 ‘Hand-Arm Vibration – The Control of Vibration at Work 2005 Regulations: Guidance on Regulations,’

HSG170 ‘Vibration Solutions: Practical Ways to Reduce the Risk of Hand-Arm Vibration Injury’,

INDG175 ‘Hand-Arm Vibration at Work, a Brief Guide for Employers,’

INDG296 ’Hand-Arm Vibration: A Guide for Employees,’

PTHB HSP-004 Hand Arm Vibration Policy V2, Powys Teaching Health Board.

Evaluation of Hand-Arm and Whole-Body Vibrations in Construction and Property Management. Marie A. Coggins, Eric Van Iente, Margaret Mccallig, Gurmail Paddan, Ken Moore. *The Annals of Occupational Hygiene*, Volume 54, Issue 8, November 2010, Pages 904–914.

Health and Safety Executive (HSE) website: www.hse.gov.uk/vibration (link below)
Hand arm vibration at work (hse.gov.uk)

## Appendix 1: Suggested Questions for Tool Manufacturers

1. Is the vibration of any handle or other surface likely to be held by the operator likely to exceed 2.5 ms-2 in normal use?

2. If yes, what is the frequency weighted acceleration under:
   i) Operating conditions producing the highest vibration.
   ii) Typical operating conditions.
   iii) Other standard conditions.

3. Under what operating conditions were the measurements made?

4. If the tests were in accordance with a published standard, provide details and indicate the extent to which vibration may differ from the quoted values in normal use.

5. Details of steps you have taken to minimise vibration.

6. Are any additional measures practicable? Provide details of design changes, additional cost and any production penalties.

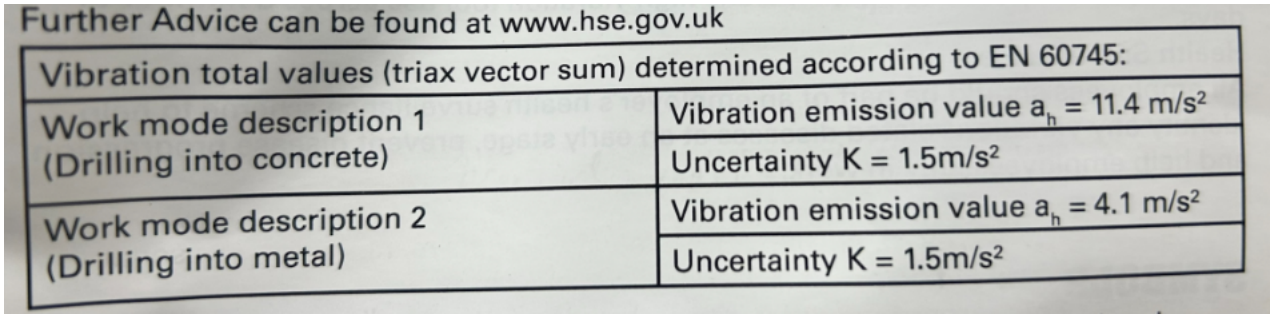
7. What is the maximum frequency weighted vibration that the tool can be guaranteed not to exceed?

8. What tests were carried out to confirm claims made in answer to question 7?

9. Please give details of any other measures required to minimise operator exposure to vibration resulting from use of the tool in question.

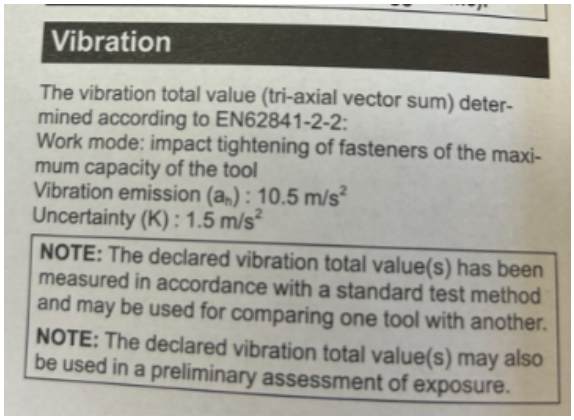
## Appendix 2: Equipment Manufacturer Manual Examples

Examples can be found below of vibration emission values declared in manufacturer's equipment handbooks. Note the vibration emission values (magnitude) and the uncertainty values (K). When working out exposure rates the uncertainty value (K) must be added to the listed vibration magnitude before the calculation is done. Manufacturers will often provide separate values depending on the material being worked on and method used e.g. Drilling into concrete, drilling into metal etc.



Further Advice can be found at www.hse.gov.uk

| Vibration total values (triax vector sum) determined according to EN 60745: | |
|---|---|
| Work mode description 1 (Drilling into concrete) | Vibration emission value $a_h$ = 11.4 m/s² |
| | Uncertainty K = 1.5m/s² |
| Work mode description 2 (Drilling into metal) | Vibration emission value $a_h$ = 4.1 m/s² |
| | Uncertainty K = 1.5m/s² |

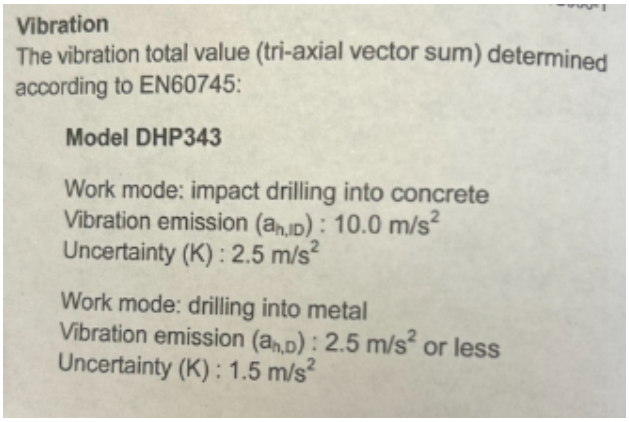


**Vibration**

The vibration total value (tri-axial vector sum) determined according to EN62841-2-2:
Work mode: impact tightening of fasteners of the maximum capacity of the tool
Vibration emission ($a_h$) : 10.5 m/s²
Uncertainty (K) : 1.5 m/s²

**NOTE:** The declared vibration total value(s) has been measured in accordance with a standard test method and may be used for comparing one tool with another.

**NOTE:** The declared vibration total value(s) may also be used in a preliminary assessment of exposure.



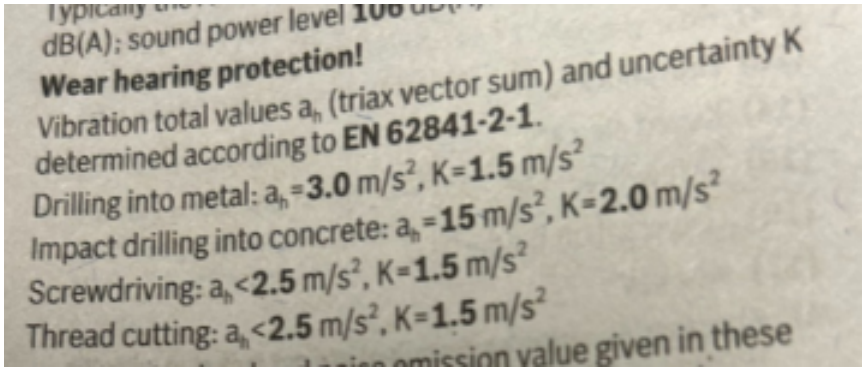
**Vibration**

The vibration total value (tri-axial vector sum) determined according to EN60745:

**Model DHP343**

Work mode: impact drilling into concrete
Vibration emission ($a_{h,ID}$) : 10.0 m/s²
Uncertainty (K) : 2.5 m/s²

Work mode: drilling into metal
Vibration emission ($a_{h,D}$) : 2.5 m/s² or less
Uncertainty (K) : 1.5 m/s²



dB(A); sound power level **106**

**Wear hearing protection!**

Vibration total values $a_h$ (triax vector sum) and uncertainty K determined according to **EN 62841-2-1**.

Drilling into metal: $a_h$=**3.0** m/s², K=**1.5** m/s²

Impact drilling into concrete: $a_h$=**15** m/s², K=**2.0** m/s²

Screwdriving: $a_h$<**2.5** m/s², K=**1.5** m/s²

Thread cutting: $a_h$<**2.5** m/s², K=**1.5** m/s²

emission value given in these

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Equality Impact Assessment (EqIA) Screening Template

The Equality Impact Assessment Screening Template is a short exercise that involves looking at the overall proposal and deciding if it is relevant to the Public Sector Equality Duty, and other key areas.

The questions in the Screening Template below will help you to decide if the proposal is relevant to the Equality Act 2010 and whether a detailed EqIA is required. The key question is whether the proposal is likely to an impact (either positive or negative) on any of the protected characteristics.

Quite often, the answer may not be obvious, and staff, service-user or provider information will need to be considered to make a preliminary judgment.

There is no one size fits all approach, but the screening process is designed to help fully consider the circumstances and to inform evidence-based decisions.

**Note: If the proposal is of a significant nature and it is apparent from the outset that a full Equality Impact Assessment (EqIA) will be required, then it is not necessary to complete the Screening Template and you can proceed to complete the full EqIA.**

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**What to do:**

In general, the following questions all feed into whether an EqIA is required:

- How many people is the proposal likely to affect?
- How significant is its impact?
- Does it relate to an area where there are known inequalities?

At this initial screening stage, the point is to try to assess obvious negative or positive impacts.

You will need to provide sufficient information within the template to justify the assessment of impact.

If a negative/adverse impact has been identified (actual or potential) during completion of the screening tool, a full EqIA must be undertaken.

If no negative / adverse impacts arise from the proposal, it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded.

**On completion of the Screening Template, staff should:**

- Check that all sections of the template are fully completed.
- Ensure that the Project/Policy owner has signed off the Screening Template
- Send a copy of the completed template along with the related policy to the Diversity & Inclusion Team for them to review – email this to Inclusion.hdd@wales.nhs.uk

| | |
|---|---|
| **Date of commencement of Screening Assessment:** | **17/08/2023** |
| **Screening conducted by (name and email address):** | **Adam Springthorpe** |
| **Title of programme, policy or project being screened:** | **1132 – Control of Vibration at Work Policy** |

**Description of the programme/policy/project being screened (including key aims and objectives)**

This policy aims to protect employees and others, so far as is reasonably practicable, from the risks posed to staff when working with vibratory tools in the workplace. HDdUHB will aim to achieve this by putting measures in place to control vibration exposure levels at work so far as is reasonably practicable. When selecting controls to manage exposure to vibration risks, HDdUHB will apply the hierarchy of controls as set out in the Management of Health & Safety at Work Regulations 1999 and the Control of Vibration at Work Regulations 2005.

**Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)**

Reviewer is Policy author and subject matter expert.

Knowledge of the work undertaken by those affected by the Policy.

Knowledge of the staff groups affected by the requirements of this Policy.

**Assess which protected characteristics will potentially be affected by the proposal:**

| Group | Positive Impact | Negative Impact | No Impact |
|---|---|---|---|
| **Age**<br>Is it likely to affect older and younger people in different ways or affect one age group and not another? | It is more likely to have a positive impact in that it protects the health and safety of staff in | | |

| | | | |
|---|---|---|---|
| | the workplace. | | |
| **Disability**<br>Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes | It is more likely to have a positive impact in that it protects the health and safety of staff in the workplace. | | |
| **Gender Reassignment**<br>Consider the potential impact on individuals who either:<br>• Have undergone, intend to undergo or are currently undergoing gender reassignment.<br>• Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth | | | No impact |
| **Marriage / Civil Partnership**<br>This also covers those who are not married or in a civil partnership. | | | No impact |
| **Pregnancy and Maternity**<br>Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave | It is more likely to have a positive impact in that it protects the health and safety of staff in the workplace. | | |
| **Race / Ethnicity**<br>People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers. | | | No impact |
| **Religion or Belief**<br>The term 'religion' includes a religious or philosophical belief. | | | No impact |

| | | | |
|---|---|---|---|
| **Sex**<br>Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other? | | | No impact |
| **Sexual Orientation**<br>Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. | | | No impact |

**Consider the potential impacts of the programme/policy/project on the following wider determinants:**

| Additional Determinants | Positive Impact | Negative Impact | No Impact |
|---|---|---|---|
| **Armed Forces Community**<br>Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'<br><br>For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:<br>**Armed-Forces-Covenant-duty-statutory-guidance** | It is more likely to have a positive impact in that it protects the health and safety of staff in the workplace. | | |
| **Socio Economic Duty**<br>Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.<br><br>For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see:<br>more-equal-wales-socio-economic-duty | | | No impact |
| **Welsh Language**<br>Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language. | | | No impact |

## Summary of Potential Impacts Identified

### Positive Impacts

| |
|---|
| The Policy is more likely to have a positive impact in that it protects the health and safety of staff in the workplace. |

### Negative Impacts

| |
|---|
| There was no evidence to indicate that the policy would have an adverse effect on any group or individual with any one or multiple protected characteristics that could not be mitigated. |

| | | |
|---|---|---|
| **Has the screening identified any negative impacts?**<br><br>**If yes, a full Equality Impact Assessment will need to be undertaken.** | | No |

### If No negative impacts were identified, please give full justification here

| |
|---|
| No negative impacts identified.<br><br>A search of similar policies elsewhere indicated similar results:-<br>https://www.bing.com/search?q=Control+of+vibration+at+work+policy+NHS+equality+impact+assessment&cvid=050fb594ee7a458b988b4831b2a25951&aqs=edge..69i57j69i11004.30231j0j1&FORM=ANAB01&PC=U531<br><br>The needs of individuals in relation to their protected characteristics need to be taken into account when providing associated training e.g. assistance with accessibility, language, learning and literacy skills. |

| |
|---|
| It will be the responsibility of managers to ensure that the policy is applied fairly and equitably on an individual basis and that staff with any single or multiple protected characteristics will be afforded the same opportunities and protections as those who do not share any protected characteristics. |

| | | |
|---|---|---|
| Screening Completed by: | Name | **Adam Springthorpe** |
| | Title | **Health & Safety Manager** |
| | Contact details | **adam.springthorpe@wales.nhs.uk** |
| | Date | **17/08/2023** |
| Screening Authorised by: (Project / Policy Owner) | Name | **Adam Springthorpe** |
| | Title | **Health & Safety Manager** |
| | Contact details | **adam.springthorpe@wales.nhs.uk** |
| | Date | **17/08/2023** |
| Seen by Diversity & Inclusion Team: | Name | **Alan Winter** |
| | Title | **Senior Diversity & Inclusion Officer** |
| | Contact details | **Alan.winter@wales.nhs.uk** |
| | Date | **21/8/2023** |