OH SERVICES
FOR
HEALTH CARE WORKERS
IN THE
NATIONAL HEALTH SERVICE OF SOUTH AFRICA

A GUIDELINE BOOKLET

CONTENTS

LIST OF ANNEXURES

Foreword

The origin of this guideline booklet was a Know How Fund study into the development of Occupational Health facilities for health service staff in the public sector. The study arose from a perception that health service staff should have available sound Occupational Health services to support them as they strive to provide high standards of patient/client care. One of the outcomes of the study, was the suggestion for a booklet that Occupational Health practitioners could use as a resource to guide the development of their local services. The result has been the production of this manual.

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Responsibility

The task team of the South African Department of Health, who finalised it, accepts the responsibility for the final draft of this document.

PURPOSE OF GUIDELINES

It has become necessary to develop these guidelines for the provision of OH services by the Department of Health as part of its health service responsibilities to the public, and especially to its own personnel. The key strategy for OH service delivery is through OH units attached to public health facilities.

This guidelines document addresses the breadth of responsibility of OH services. These guidelines comprise:

Part 1 OH Services for Health Care Workers within the Department of Health

Part 2 Medical surveillance (Monitoring of Respiratory Health) of Ex-Miners

Part 3 OH Services for other Government Departments and the general public.

Introduction

The World Health Organisation/ILO defines Occupational Health as being "to promote and maintain the physical, mental and social well-being of all workers, and not merely the absence of disease". As such, Occupational Health deals with the *impact of work on health and health on work*. Since 1999 it has become necessary to develop guidelines for the provision of Occupational Health services in the Department of Health as part of health service responsibilities for Public Health Services, including its own personnel. Key strategy for OH service delivery for the Department of H is through OH units attached to Provincial Health facilities.

The DoH and Provincial Health Departments are currently engaged in developing OH services as fast as it is practicable to do so. The challenges of availability of resources can best be met by integrating OH services with other programmes to achieve efficiency, economy, and equity. Policies are in place and service frameworks continue to be developed. Training of OH practitioners must continuously be expanded to meet service needs. Most encouraging of all, OH units are increasingly playing their part in the provision of OH services.

This booklet has been produced to help all those involved in provision of OH services for health care workers. Based on international good practice, it contains practical suggestions that can be used as models in developing the service further. As such it compliments the current and completed policy and planning work.

1. BACKGROUND

Erasmus Commission of Inquiry 1974

The Commission found many inadequacies in the provision of health services in industry. These covered areas of hazardous exposure; lack of statistics regarding environment, state of health of the workers and the nature of diseases; and inadequate rehabilitation of workers affected by occupational diseases.

It further revealed that the state of legislation affecting occupational health was grossly deficient, grossly duplicated (12 separate Government Departments involved), and that 71% of workers were not covered by legislation. No single body was responsible and the ability to change the legislation was hampered by the slowest departments. This inquiry resulted in the passing of the Machinery & Occupational Safety Act in 1983.

Occupational Health and Safety Act

An Act of Parliament was passed in 1993 – the Occupational Health & Safety Act (Act. No. 85 of 1993). This legislation provides for more protection for employees as well as responsibilities of the employer to ensure that the workplace is safe and healthy. Whilst it covers the roles and responsibilities of employers and employees, it also covers the roles and responsibilities of health and safety representatives.

Compensation for Occupational Injuries & Diseases Act.

COID Act also passed in 1993, Act No. 130 of 1993, replaced the Workmen's Compensation Act. This Act provides for compensation to workers who have sustained an injury on duty, or who have contracted an occupational disease. Exempted from the Act are Domestic Workers in private households, and members of the South African National Defence Force, and the South African Police.

The Abdullah Report

The Abdullah Report of January 1996, reports on the investigation into Occupational Health services in South Africa. It covers the legislation and statutory agencies dealing with Occupational Health in South Africa; profiles on occupational injuries and diseases and services provided; issues such as human resources, information systems and research, as well as proposals for a coherent Occupational Health and safety system, and the role of the Department of Health at National, Provincial, and District levels.

Mine Health & Safety Act 1996

This legislation was promulgated to protect the health and safety of persons at mines
by making provision for effective monitoring of conditions and enforcement of health and safety measures. It also facilitates the promotion of training in health and safety, as well as cooperation and consultation between State, Employers, Employees and their representatives.

The White Paper for the Transformation of the Health System in South Africa

In 1997 "The White Paper for the Transformation of the Health System in South Africa" was published and presented to the people of the country as a set of policy objectives and principles in which a Unified National Health System of South Africa will be based. Chapter 14 covers the issue of OH. It recognizes that Occupational Health has been sadly neglected in the past, and the development of such services is a key priority of the Reconstruction and Development Programme (R.D.P) and the Department of Health. It states that Occupational Health services must focus on providing services, human resource development, conducting research and disseminating information to improve workers' health status.

Benjamin and Greef Report 1997

The investigation of this committee into a National Occupational Health & Safety Council in South Africa, resulted in a report, which suggested that the practice of occupational health and safety across industries in South Africa is uncoordinated, fragmented and a burden on resources. It suggested that occupational accidents and work-related ill health imposes a considerable cost on the South African economy and society. It also revealed the critical shortage of personnel to develop policy and enforce legislation while at the same time, existing human resources are insufficiently utilised.

The committee suggested that failure to meet the challenges of technology, the expectations of employees, the requirements for enhanced productivity and competitiveness, and the obligations of the state, will result in occupational accidents and work-related ill health, taking an immense toll on human and economic resources.

The Provincial Health Restructuring Committee (PHRC)

The PHRC resolved at a meeting on 21 and 22 January 1999 a number of issues regarding Occupational Health. Among the issues were 6.1 on the agenda of which part reads, "Establish OH services for staff of the Department of Health, render assistance to other government departments in this regard and provide Occupational Health services for the general public at health facilities within health districts."

2. ESTABLISHING AN OCCUPATIONAL HEALTH SERVICE

2.1 Definition

"A service established in or near a place of employment for the purpose of:

- Protecting the workers against any health hazards which may arise out of the work, or the conditions in which it is carried on;
- Contributing towards the workers physical and mental adjustment, in particular by the adaptation of the work to the workers and their assignments to jobs for which they are suited; and
- Contributing to the establishment and maintenance of the highest possible degree of physical and mental well being of the workers."

(3 June 1959 I.L.O)

The establishment of an occupational health service will depend upon the policy of the organization/institution; the size and composition of the work force; and the needs of the organization.

2.2 What should be included in the programme?

A comprehensive Occupational Health service should include:

2.2.1 Promotion of wellness.
This will enable the organization to conduct employee medical/health surveillance, and encourage personal responsibility for health care, as well as contributing to reducing sickness absenteeism.

2.2.2 Prevention of occupational injuries and diseases
To monitor risks in the work place, and contribute to reducing occupational injuries and diseases,

2.2.3 A clinical service should offer emergency or urgent Primary Health Care, as well as emergency medical care and monitoring of chronic conditions.

2.2.4 Occupational Hygiene will identify and recognize workplace hazards, (including chemical, physical, psychosocial, biological, mechanical, and ergonomic). The practitioner will also make recommendations, for control, monitoring and evaluation of risks.

2.2.5 Consultation Services. The OH service acts as consultants on OH matters to persons in the workplace, e.g. management, labour, unions; and to persons outside the workplace, e.g. N.G.O's, C.B.O's, referral centers and other health institutions.

2.2.6 Administration includes developing and maintaining an information management system, as well as statutory records and reports.

2.2.7 Research: It is necessary for Occupational Health services to become involved in relevant research in order to evaluate the effectiveness of the services, and the developments of new trends in Occupational Health.

2.2.8 Special Programmes. From time to time certain health needs may arise among the workforce. These needs will be addressed in special programmes e.g. for vulnerable groups as well as HIV/AIDS, and the chronic diseases of lifestyle.

2.2.9 Employee Assistance Programme

2.3 Why an Occupational Health service is needed for health care workers

The personnel of the health service is its most valuable asset, so it is only sensible to make sure that everything possible is done to help them provide the highest quality of care. If health care workers are troubled by their own ill-health, or other stressful circumstances, then they will not be able to give their full attention to this demanding task. In addition, apart from being good employment practice, no hospital or clinic can function effectively if there is a high incidence of ill health among health care workers.

A good OH service will help to minimise health and social problems for staff so that they can render high quality services to their clients. Consequently, this will minimise exposure to health hazards not related to their primary illness.

Setting up a well- managed OH service makes good economic sense. The reduction in costs due to preventing occupationally related injuries and diseases would more than offset the budget required. In addition, an OH service has a unique potential to generate revenue to be self-sustaining. It is the only health programme with this capability.

2.4 Check List for Establishing Occupational Health Services and Indicators

The following simplified checklist assumes that a new service is to be commenced. Some already established services might also find it helpful.

2.4.1 Management leadership and endorsement is obtained

As with any new initiative, the commitment and support of the Executing and Accounting Authorities, including Executive Managers, Programme Managers, Service Delivery Managers and client acceptance, is invaluable.

The endorsement of the Executive and Accounting Authorities will enable this to be achieved and will ensure that there is a wide understanding of the practical value of the OH services.

2.4.2 Clear terms of reference are agreed upon by all Executing Authorities.

These should set out the functions of the OH unit and the way it will operate, including lines of accountability and the basis of funding. The terms of reference should be approved by the executing and accounting authorities, managers responsible for the units, as well as by the senior management team. The purpose of this is to ensure that there is a full understanding of the reasons for setting up the OH unit and what is expected of it.

It is of critical importance that the lines of accountability are well defined for the service to be effectively provided.

2.4.3 A job description is prepared for the post of Programme Coordinator

The responsibilities of the Programme Coordinator/Manager, must be specified in a job description. This should be developmental, specifying the scope of the post and indicating the range of duties to be performed. The job description should make clear that the post-holder must exercise initiative and look actively for ways to develop the effectiveness of the OH services. Reference could also be made to some form of performance agreement which specifies the way the post-holder will be expected to achieve quality in OH services. (See also section 5: Auditing OH services.)

2.4.4 Profile of a Programme Coordinator/Manager.

The competencies required by the Programme coordinator include a qualification in OH and other skills including managerial/administrative, inter-personal, clinical and leadership, knowledge of appropriate legislation and relevant experience.

2.4.5 The appointment of the Programme Coordinator/Manager.

This will follow Public Service protocols/procedures.

2.4.6 A business plan

Using the terms of reference as a starting point, the Programme Manager/Coordinator must draw up a business plan setting out the way the

OH service will be developed. This will require a situational analysis to be completed in consultation with a wide cross-section of other professional personnel and labour representatives. The plan will set out detailed objectives, funding arrangements, accommodation, equipment requirements, human resource requirements, time frames and expected outcomes.

The plan will need to be considered and approved by all relevant management echelons. Once approved, it must be communicated for implementation.

2.4.7 Business plan implementation

To ensure the buying in and support of management, employees, organized labour and all other relevant stakeholders, a marketing strategy need to be developed and implemented prior to service delivery. A marketing strategy could include but not limited to road shows and presentations illustrating cost benefits and value added of Occupational Health Service

A marketing strategy needs to be commenced, and service delivery will follow.

2.4.8 Monitoring and Evaluation

OH services should be evaluated by regular audits, informal visits and spot checks. Set indicators, can measure the impact e.g. reduction in absenteeism, reduction in number of occupational injuries and diseases.

See also section 5: Auditing OH services.

3. ADVANTAGES OF PROVIDING A WELL MANAGED OCCUPATIONAL HEALTH SERVICE

- Reduced staff turnover and the retention of valued staff.
- Reduction of recruitment, training and induction costs.
- Helps to promote job satisfaction and enhances work relationships
- Reduces potential injuries and acquired occupational diseases.
- Increases quality service delivery and productivity
- It promotes employee's loyalty to the organization
- It assists in reducing absenteeism and excessive sick leave
- Reduces temporary or permanent loss of employees
- Assists in rehabilitation of the injured or sick employee into the workplace
- The promotion of employee's morale.
- It assists in the prevention of too much time away from the workplace through utilization of the on-site service.
- On-site care and counseling provides for legal requirements.
- Reducing medical expenses and legal claims.

4. ELEMENTS OF AN OH SERVICE

4.1 Promotion of wellness and prevention of injuries and diseases

- Medical/Health surveillance, including where necessary, biological monitoring
- Monitoring of special vulnerable groups
- Monitoring of personal protection methods including immunization
- Epidemiological surveillance
- Risk assessments in the workplace
- Health promotion and maintenance
- Job placement and rehabilitation
- Impairment assessment and disability management
- Employees Assistance Programme
- Counseling and referral when necessary
- Research
- HIV/AIDS in the work place

4.2 Clinical

- Emergency Medical care
- Management of occupational injuries and diseases.
- Primary health care
- Continuing health care – monitoring chronic conditions.

4.3 Occupational Hygiene

- Identification and recognition of hazards (Chemical, physical, psychosocial, biological, mechanical and ergonomic)
- Recommendations and motivation for control
- Evaluation

4.4 Consultative

Within the workplace – the OH medical officer, the employer, workforce, Unions, human resource managers, risk managers, on matters relating to employee re-placements and transfers on medical grounds, and on other OH related issues.

- Participation in Emergency /Disaster Planning (First-Aiders, Fire-fighters)
- Coordination of First Aid training including responsibility for First Aid boxes.

Outside the workplace – other referral centers/agencies and health institutions for:

- fostering community relations
- professional development through Information Systems and research

4.5 Administrative

- Policies and procedure manual
- Hazards documentation
- Standing medical directives and protocols
- Records (Personal medical, environmental, sickness absenteeism, accidents, medicine control, man-job specifications, risk assessments)
- Statutory records and reports according to relevant legislation (e.g. Radiation medicals, COID documentation)
- Integrated information management systems
- Appropriate research documents

4.6 Research

Identify priority areas for research in OH, participate in research projects, and implement research recommendations

4.9 Special Programmes

This refers to programmes that require special attention in a continuous way because of their contribution to morbidity and mortality rate. These may include HIV/AIDS, nutrition, TB, cancers and life related conditions

5 OCCUPATIONAL HEALTH SERVICE ACTIVITIES IN DETAIL

5.1 Employee Medical Surveillance – main purpose

All employees should be subject to health surveillance, which may include examinations for pre-placement, transfer, periodic, or on leaving the organization.

The main purposes are to:

- Establish a baseline of the candidate's health against which any future changes can be measured
- Identify possible risk of deterioration in the health status which might be caused by the job process and work environment.

- Establish whether the candidate's physical and mental status is suitable for the performance of the work requirements of the job.

5.2 Pre-placement screening - complementing the appointment process

Pre-placement screening should fit into the overall personnel engagement process, as follows. *See **Annex A**: Pre-placement screening - flow chart*.

- A hazard profile of the job is outlined and provided
- The candidate is selected.
- Successful candidate is referred for health assessment.
- The Occupational Health service using a questionnaire, interview process, physical examination and/or special tests makes a health assessment.
  (See Annexure B& C?)
- As the need may arise, the OH service may arrange counseling for the candidate.
- The OH service notifies the human resource administration of the outcome of the assessment and makes recommendations.
- In appropriate circumstances, the candidate is provided with immunisation before commencing work. (E.g. for hepatitis B or tuberculosis.)

Note: Sometimes additional medical information is required from another source in order to complete an assessment. If so, written consent has to be obtained from the candidate to enable the OH service to do this. (Human Resources must be notified of the delay in the recruitment process.)

5.3 Pre-placement screening - the responsibilities of those involved

5.3.1 <u>The Occupational Health Practitioner</u>

- To demonstrate the care and concern the organisation has for the well being of the individual and the importance of OH in providing effective patient/client care.

- To conduct the assessment in a sensitive yet thorough manner
- To provide the employer with the appropriate information about how the job demands and hazards will affect the candidate's health.
- To initiate the education of a candidate about the importance of health and safety as well as healthy lifestyle.

5.3.2 The human resource department

- To arrange for health assessment of candidate with the OH service.
- To provide the OH service with the job specification, including the job hazard profile and any specific health requirements relating to the work.

5.3.3 The new employee

- To attend the Occupational Health appointment as requested.
- Ensure that all the necessary information is brought to the OH service, including exit medical certificate from previous employer.
- Sign a declaratory statement that all information is true and correct on the veracity of the information given.

*See **Annex B**: Health Questionnaire*.

5.4 Tranfer, periodic and Exit medicals
All employees shall be eligible for the above medical examination, which will be determined by occupational risks, exposure profile (see annexure B)

5.5 Monitoring staff sickness absence and working to reduce it

*See **Annex D**: Sickness absence monitoring system - flow chart.*

5.4.1. The nature of sickness absence
Sickness absence has been defined as 'absence from work which the employee attributes to sickness or injury and the employer accepts as such'. Therefore there is a need for clear policies. Sickness absence is a drain on the efficiency of the organization. Management should be concerned and institute a monitoring system to identify possible related causes.

This could include:

- intermittent medical conditions
- accidents
- occupation related disease
- psychosocial disorders

- chronic diseases of lifestyle

Sickness absence can be divided into:

- Monitoring short-term sickness absence could identify a number of issues which will need investigation, e.g. poor work organization, poor inter-personal relationships, inadequate management supervision, psychosocial factors.

*See **Annex E:** Management of short-term sickness absence - flow chart*

- Long term sickness can be related to either:
  i. Occupational related problems – injury or disease.
  ii. Non-occupational related problem, e.g. injury outside of the workplace, home, sport, road; or acute medical condition.

*See **Annex F:** Management of long-term sickness absence - flow chart*

5.4.2 Managing sickness absence

Management of sickness absence depends on strict record keeping and good communication between OH service, human resources and line management.

5.4.3 The function of management in sickness absence monitoring

Apart from record keeping referred to above, a manager concerned may refer a member of personnel for assessment to the OH service after a consultation with the employee concerned. This could occur for several reasons including:

- persistent or intermittent absence on either a short or long term basis
- occurrence of an occupational injury or disease
- otherwise unexplained alteration to an employees work performance

5.4.4 Referral procedure

A protocol for referral should be clearly devised and agreed to between management, the OH service, the human resource department, and organized labour, and should be in line with public service administration/ protocols/ relevant legislations.

*See **Annex G:** Guidelines for managers on sickness absence referral*
*See **annexure H**: General guidelines on sick leave management*
*See **Annex I:** Referral for assessment of fitness to work - proforma*

5.4.5 The role of the OH service in sickness absence management

The OH service becomes involved in sickness absence issues in two principal ways:

- monitoring overall trends and joining with management and organized labour in finding ways to eliminate unwarranted absence. Long-term strategies should be created, monitored and evaluated on a regular basis.

- supporting management, employees, colleagues and families in dealing with individual cases of absence. Some will be complex cases where a member of personnel has a persistent condition that impairs their ability to work to full capacity. Others will be instances of recurring absence allegedly due to sickness. Both require well-defined procedures that should be set out in a policy document made available to all personnel.

*See **Annex J:** Information for managers on sickness absence and OH services.*

When approached by management to assist, in certain cases the response should be in accordance with referral procedures and protocols.

*See **Annex K:** Health assessment report - proforma*

5.4.6 Failure to change sickness absence behaviour

After necessary steps have been taken to support the personnel member, human resource department should follow normal disciplinary procedures. OH Service should not be involved in this part of the process.

5.4.7 Working environment

The OH service assists in monitoring workplace environment, job procedures, inter-personal relationships, in order to advise management and workforce by making recommendations for improvements and being pro-active in maintaining high levels of morale, staff attendance at work and commitment.

5.5 Assessing hazardous exposures in the workplace

The following steps should be used to assess hazardous exposures in the workplace

***5.5.1 Look for the hazards*.** This may include slipping and tripping hazards, or fire, chemicals, gas, dust, noise, fumes, etc. and decide which could be reasonably expected to result in significant harm.

5.5.2 Decide who might be harmed and how. Employees should be grouped into categories, e.g. Medical and nursing staff, Cleaners, Office staff, Maintenance Personnel. Particular attention should be paid to staff with disabilities, inexperienced staff and visitors.

5.5.3 Evaluate the risks arising from the hazards and ***decide whether existing precautions are adequate***, or more should be done. The purpose is to reduce the risk as far as is reasonably practicable by ensuring that health care workers are adequately informed and trained, and that standards set by legal requirements are met, as well as representing good practice by implementation and monitoring of adequate systems and procedures.

5.5.4 Record your findings. It is strongly advised that the main points are kept on record for future reference. These should include the checklists and whether the precautions are reasonable. It also assists the inspector in carrying out his responsibilities, and in cases where civil liability is involved.

5.5.5 Review the assessment regularly and revise if necessary. Changes in workplace environment or specific job procedures become inevitable from time to time. This may necessitate taking account of a new hazard, which would indicate a review of the assessment.

5.6 Management of occupational injuries and diseases and non-occupational injuries and diseases.

One of the functions of the OH service is to provide first line care for personnel who become ill or injured at work. On occasion, as in the case of a serious incident, they will do this in conjunction with emergency medical services in and accordance with prescribed referral procedures.

OH service is totally responsible for management of all occupational related injuries and diseases, in compliance with Compensation for Occupational Injuries Disease Act (COIDA) and other relevant legislations.

In order to ensure personnel return to work as quick as possible, arrangements may be needed for them to receive “fast track” specialist care. It may become necessary

for OH service to coordinate rehabilitation of personnel back into the working environment.

5.7 The Role of First-Aid trained personnel.

First – Aid Service in the workplace should ensure that personnel who sustain an injury at work or suffer a medical emergency condition, receive immediate, appropriate treatment, prior to referral for further management.

These arrangements should consist of a few selected personnel being trained in First Aid

Employers should ensure that trained personnel receive written appointments. First Aid equipment should be provided, accessible, clearly marked and controlled by First- Aid trained personnel.

5.8 The role of OH service in disaster management

- Involvement in planning with other relevant stakeholders within and outside the organization, including evacuation procedures.
- Coordinate first-aid activities
- Coordination of emergency medical services.
- Continuous evaluation and improvement of the disaster management plans.

5.9 Accident reporting and recording occupational injuries and diseases

All accidents or incidents that occur at work must be reported and recorded immediately on or before the end of the shift, on a specially designed form by the appropriate personnel involved, e.g. OH practitioner, safety representative d supervisor. The primary purpose of accident reporting is to identify problems and enable immediate remedial action to be taken.

5.10 Incident Investigation

Minimum information required should include:

- the full circumstances of the incident/accident, including place, date and time
- details of the official and unofficial custom and practice of work process involved in the accident/incident
- Causative factors should be fully investigated, e.g. buildings, machinery, human factors, work procedures etc.
- Acquire statements from any witnesses.
- any immediate action taken to avoid a recurrence.

The above information should be submitted to the relevant authorities for collation, analysis, and identify trends which will influence further management.

5.11 Comprehensive preventative programmes

The range of potential preventative programmes is considerable. OH practitioners need to assess local requirements based on their observation of the workplace,

analysis of risk and health assessments reports. This would include analysis of accident and sickness absence records. The contribution of the health and safety representatives and committees is crucial.

Examples of three contrasting types of preventive programmes are outlined below.

5.11.1 Example 1 - Immunisation protection programmes

Employers in the Public Health Sector, like all employers, have a duty to care for their employees by protecting them from all hazards including infectious diseases in the workplace. To meet the responsibility to protect against infectious diseases, employers should have an immunisation programme which is part of a wider safe system of work. Immunisation is not a substitute for good infection control practice.

The need for any member of staff to be immunised will be determined by a risk assessment.

Features of a sound immunisation protection programme include:

- The existence of an 'Immunisation Policy' that has been approved by policy makers. This will ensure uniformity of practice.
- Completion of a risk assessment of all relevant jobs to identify the preventative immunizations and related actions that are required.
- A qualified OH practitioners or health care provider must manage the immunization programme
- The implementation of immunization programme. A typical immunisation programme **may** consist of the following:
- Heaf test to identify TB immunity levels. BCG vaccination may be indicated
- Screening for hepatitis B immunity
- Immunity identification against rubella and varicella
- Immunisations (mainly laboratory workers) for hepatitis A and typhoid

Immunisations must be recorded in the personnel health record maintained by the health facility. Personal record card may also be given to personnel to keep for future reference.

*See **Annex L:** Immunisation record card.*

Employers must also have a policy dealing with compliance by locum agency staff, students and visiting academic staff. Appropriate documentation demonstrating

compliance with the agreed standards should be maintained to ensure the safety of the individual and avoid risk of litigation against the health service.

5.11.2 Example 2 - Musculo-skeletal injury prevention

Musculo-skeletal injuries are a major cause of ill health and sickness absence.

The effect on an employee can include:

- pain and suffering
- loss of income
- loss of long term employability
- domestic and social inconvenience
- complicated compensation claims.

For an employer the on-costs can include:

- lost working time
- loss of trained and experienced staff
- payment for sickness absence
- payment for replacement staff and their training
- compensation awards.

Using the correct moving and handling techniques can avoid most musculo-skeletal injuries. A programme of training can assist and may need to be accompanied by correct lifting equipment. Management supervision is crucial to ensure success.

Apart from initial training at time of recruitment, there needs to be a continuing in-service education programme. Further training is also required when new equipment or other changes in work practices occur. Supplementary training may be needed following an accident or a prolonged absence from work.

*See **Annex M:** Factors to be considered in a moving and handling assessment*
*See **Annex N:** Moving and handling assessment - flow chart*
*See **Annex O:** Moving and handling training programme*

5.11.3 Example 3 – Visual Display Units (VDUs) related injury prevention

The use of VDUs will invariably result in health related problems. As with other hazards, it is important that they are acted on by management, and that personnel is trained in risk avoidance. The existence of VDU health related effects demonstrate the need to consider the working environment of personnel using such equipment. Health related issues associated with VDUs include:

5.11.3.1 Musculo-skeletal disorders

The causes are often poor ergonomic design of the workstation, wrongly adjusted equipment and sitting on chairs with poor body support, as well as incorrect use of equipment, all of which can be compounded by high work-load and tight deadlines.

Musculo-skeletal disorders may include pain in the hands, wrists, shoulders, neck and back. The effects can be either short or long-term and may lead to deteriorating health with subsequent consequences.

5.11.3.2 Eye related disorders

These may include headaches, sore eyes and blurring of vision. Working with VDU may reveal previous eye defects that personnel were not previously aware of, such as short sightedness.

These effects may be caused by poor work organization, badly designed, adjusted or positioned equipment, poor lighting, glare and poor flickering images on the screen.

5.11.3.3 Stress and physical fatigue

This may be caused by similar circumstances as for musculo-skeletal and eye-related problems.
Personnel should receive training on how to set up their own workstation, which should include input relating to their own job content, desk layout, workflow and general environment.

5.11.3.4 Effects on expectant women

As pregnancy progresses, ergonomic issues can cause problems due to restricted postures. It may become difficult for the expectant woman to adopt comfortable positions.

Guidance must be sought from an ergonomists, physician looking after the expectant woman, Occupational health physician or nurse depending on who is easily available
*See **Annex T:** VDU and workstation training programme (includes posture diagram)*

5.12 Maintaining health surveillance programmes

A discussion of medical surveillance in greater details was undertaken in 5.1 to5.4. This section attempts to broaden health surveillance beyond medical surveillance. Health surveillance is the continuing process of monitoring the health and well being of personnel.

The OH practitioner should develop a monitoring programme for implementation of appropriate health surveillance on all personnel, in accordance with the occupational risk exposure profile.

Accurate recording should be maintained at all times, and records retained for 30 to 40 years for future reference.

5.13 Access to Employee Assistance Programmes

Stress has become recognized as a possible health related issue, which can arise in any area of the lives of personnel. These may include work, e.g. workload, work relationships, working environments, as well as psychosocial problems. In other instances social relationship difficulties may flow into the work- situation from the outside.

The health care environment is particularly challenging and the stress on individuals can be enormous.

The OH services need to develop a comprehensive programme that is both pro-active and reactive to deal with stress related problems, i.e.:

- When conducting a risk assessment of the workplace, stress related issues should be included and recorded in the document. Recommendations and remedial actions should be adopted to minimize stressors. In particular, those factors that may act as incentives for stress to manifest itself must be carefully noted and their management planned.

- Training in stress awareness and coping strategies should be provided to all personnel including managers. Counseling services should be available to those who require it. Training should be provided to those who will carry out this function. Where such skills are not available, a referral system should be in place. Managers must be sensitive to the support that those who report to them may require in this regard and act accordingly.
  *See **Annex P:** Stress awareness training programme*

5.14 Workplace health promotion
The tern workplace Health Promotion refers to joint measures taken by the employer, employeesand workplace organisationin order o promote and support the work availability and functioning capabilities of all workers at every stage of their career

5.15 Promoting health and safety issues

Amongst its many tasks, the OH service has a part to play in reducing workplace risks to health. By making the work environment safer the incidence of work-related illnesses and accidents is reduced, personnel well-being is improved and client care is benefited.

Promoting health and safety requires a three-way partnership between management, staff and their organizations as well as the OH service. It also calls for a systematic approach, the framework for which would normally be set out in a Health and Safety Policy document. This would be endorsed by policy makers, senior management and labour representatives and may include the following details:

- Commitment of employer to work with employees to create a safe and healthy workplace.
- Names of managers or positions of those responsible for overall responsibility for health and safety and those who will take over the responsibility in the event of those primarily responsible are not present.
- Identity by name or position of those responsible for identifying hazards.
- Procedures to identify, assess, eliminate or control hazards.
- Arrangements and responsibility for regular monitoring of known hazards.

- Reporting procedures following discovery of a new hazard.
- Reporting procedures following a hazard related incident.
- Method of reviewing performance on reduction of hazard related incidents
- Obligation of the organisation for promoting health and safety.
- Requirement for health and safety responsibilities to be part of performance contracts of managers.
- Responsibility of personnel for following approved safe working practices.
- Arrangements for publicising the policy to all managers and personnel
- Requirements for health and safety considerations in tender procurement
- Responsibility of contractors to comply with policy

In certain instances, it may be appropriate for individual departments to have their own supplementary policies reflecting their operating conditions. E.g. laboratories. Copies should be made available to the OH unit. Supplementary protocols of this kind should be compatible with the overall health and safety policy.

5.16 Promoting wellness in the workplace

Workplace wellness relates to the whole organisation. It is concerned with the overall health of working people as well as with the impact of work on their health. It involves a number of disciplines including health and safety, human resources, management and lifestyles.

Workplace health promotion makes use of activities designed to improve the health of and reduce risk factors for employees. Employers already have a responsibility to

create a safe working environment and systems of work. Health promotion goes beyond that and encourages better health for all employees. It also encourages individuals to take responsibility for improving and maintaining their own health.

Health promotion programmes should be designed to meet the needs of individuals in the organisation who should be consulted on their views. The following are examples of activities that are often called for:

- Screening programmes to detect the need for lifestyle changes
- Smoking cessation programmes
- Substance abuse programmes (including alcohol, drugs and solvents)
- Dietary programmes to encourage healthy eating
- Active life programme including exercises and maintanance of fitness and facilities
- Stress recognition and management programmes
- Change awareness programmes
- General Health and safety issues

An OH service has a key role in the development and implementation of programmes designed to inform, educate and advise workers about health issues at work.

5.16.1 Advantages to personnel and the organisation of a health promotion programme

OH promotion contributes to enabling personnel to have their social, emotional, economic and functional needs met within the workplace to enable them give their best to quality service delivery.

5.16.2 Benefits of health promotion and lifestyle programmes for an employee may include:

- More knowledge and awareness of personal health issues
- Changes in lifestyle leading to improvements in their own general health and that of their families.
- Greater feeling of well-being and satisfaction in the workplace
- Higher morale and greater capacity to cope with everyday issues
- Reduced sickness and general absenteeism
- Improved sense of job satisfaction

*See **Annex Q:** Setting up a health promotion programme*

5.17 Identifying hazards and conducting risk assessments

The steps for assessing hazardous exposures in the workplace have been discussed in 5.5 above.
Risk assessment uses environmental surveys and health surveillance to identify hazards and evaluate the scale of risk they pose to workers, patients or others in workplace. Once identified and evaluated, appropriate further action can then be decided.

*See **Annex R:** Checklist of common hazards in health service premises.*

A *hazard* is something that may cause people harm. The *risk* is the potential for that hazard to do so. The *scale of the risk* is the risk multiplied by the number of people who might be affected by the hazard. This formula makes it easier to judge the seriousness of a hazard and to decide the priority for action.

Hazards can be identified through

1) An environmental survey that involves a 'walk through' of work sections observing the working environment against a comprehensive checklist.

2) This also involves having discussions with the workers. In most cases, they come up with ugeneous ways of simple supplementary environmental screening measures are also useful, such as the measurement of noise and light levels.
3) Sometimes pointers to the existence of hazards can be found in other ways, such as by reference to accident or sickness records or manufacturers' safety data sheets. These should be scrutinised to supplement any environmental survey.
4) Health surveillance reports may also serve to indicate the effect the environment is having on the individual's quality of health.
5) Material safety data sheets of material used in workplaces will also help identify and dealing with the hazards of their jobs.

Health and Safety Representatives should also be involved in surveys and be given the opportunity to draw attention to hazards in different locations.

A completed departmental environmental survey would include reference to the:

- Process details like design, speed, materials used
- site and structure
- conditions in the workplace
- existence of any special OH provisions
- obvious hazards present in that location
- people at risk from the hazard
- preventative measures in place to handle the hazards

- effectiveness of the preventive measures
- general safety measures operating in the department
- first aid arrangements
- relevant welfare arrangements for the personnel

The outcome of a risk assessment should be to establish:

- existence and extent of any hazard
- level of risk presented by the hazard
- action needed to minimise the risk presented by the hazard
- action already taken to eliminate the hazard or minimise risk
- further action required
- timetable for taking further action and the identity of those responsible for taking such action
- means of verifying the action has been taken

It is imperative that comprehensive written records are made of all environmental surveys, aggregated health surveillance and risk assessments. These provide the baseline against which follow up assessments are made and subsequent queries are answered. These will also help in the assessment of the effectiveness of any corrective measure taken.

6. PERSONNEL HEALTH RECORDS

6.1 Purpose of the health record

Employees' health record provides vital information on the quality of their health. It is the thread which links all services that may be provided to them. It sets out the chronology of events affecting individual personnel and the consequential treatment or other action taken. It is also a written means of communication between the health care providers on which they rely. For all these reasons, it is essential that personnel health records are accurately kept and are available for immediate reference.

*See **Annex S:** Employee health records - function, content and completion*

6.2 Creation and maintenance of records

A routine system is required for notifying the OH unit of the engagement of new personnel. This alerts this unit to undertake its responsibilities to the individual employees as they commence work. It is at this stage that their personal health record should be created.

A reverse process is required to notify the OH unit of employees who are leaving employment. This should precede departure of the employees for the OH unit to conduct an exit medical examination and interview them on health related matters.

For example, the OH unit must be involved with exit interviews as part of a strategy to reduce staff turn over. On departure, records should be retained in accordance with legal or other requirements. Employees must be given results of their exit medical examination. Check the legislation that may be specific to certain medical surveillance reports e.g. Lead, Hazardous chemical substance, Asbestos, Biological Hazardous Agents etc.

6.3 Storage and security of records

Employees' OH records must be kept in a confidential manner, separate from any other filing system, ideally within the OH facility. All records should be locked securely in tamper proof cabinets.

Where some or all records are stored electronically, it is essential that these be backed up with duplicate copies to safeguard against computer failure. There should also be effective arrangements in place to safeguard the confidentiality of computer-based records, including the back-up copies, with rigorous password protection.

Good working relationships should be established with the Information Technology/Computer section in order to ensure that correct protocols are established and followed. These should include use of anti-virus software.

6.4 Access to Records

Only occupational health unit personnel should be able to access personnel health records. When OH personnel are recruited they must be made fully aware of their personal responsibility to keep clinical information confidential and secure.

The written consent of the employee should be obtained before any information is given to a third party, including management.

6.5 Ownership and retention of records

OH records of an employee remain the property of the employing organisation after that person has left employment.

The OH unit is responsible for the guardianship of the employee’s health information whether held manually or electronically. This information should be retained for 30 to 40 years. Some records may have to be retained indefinitely due to the possible exposure of the employee to hazardous substances, occupational disease or injury. These records should be clearly identified in a way that ensures they are not destroyed prematurely. Relevant legislation must be checked for guidance.

7. AUDITING OH SERVICES

Monitoring performance is a constructive process that offers the opportunity to adjust activities to match changing demands and to ensure that resources are being used to maximum effect.

7.1 Benefits to the organisation of auditing OH services

- Ongoing assessment of the value of the service to the organisation
- Identifying health trends among personnel to enable action plans to be developed.
- Evaluation of the merit of new services
- Measurement of the satisfaction levels amongst service users
- Judging value for the money invested in the services
- Reviewing performance against targets

7.2 Benefits to the OH service of an audit process

- Dialogue with users and management about current and future services
- Measurement of performance against predetermined standards
- Existence of systematic documentary evidence of the services' value
- Opportunities for research and development
- Trend analysis to point the way to future activities
- Attitude of questioning and inquiry that stimulates unit performance

7.3 The audit cycle

The audit cycle gives the opportunity to generate learning which can be fed back into future practice. The principal stages are:

- Setting benchmark standards
- Observing and recording practice
- Comparing practice against the pre-determined benchmarks
- Drawing conclusions from the comparison
- Deciding on action to be taken arising from the analysis
- Implementing the changes
- Repeating the cycle

7.4 Selecting suitable audit measures

Careful consideration will lead to the identification of a series of simple performance indicators that are outcome based rather than input orientated. E.g. measuring the reduction in incidence of accidents, not the number of accident prevention training courses held each year.

The following are simple examples of performance indicators, based on analysis over pre-determined periods of time. Each would have a target set in advance and measurement of performance would be against that benchmark. The baseline data could be used to judge the extent of the improvement.

- For pre-placement screening: the number of health issues subsequently occurring and resolved
- For sickness absence: the number of work days lost (say in key departments) after corrective actions taken
- For needle stick injuries: the number of incidents after introduction or modification of preventative programme introduced
- For slips, trips and falls: the number of accidents (say in known high risk areas) after specific preventative programme introduced
- For violence in the workplace: the number of confrontations after training and information made available
- For health promotion: the number of heart attacks, amongst staff after preventative programme introduce and stress related cases
- For satisfaction levels: the number of management or self referrals to the unit

Targets such as these could be included as key performance indicators for an OH Unit.

Overall, the OH unit should aim to demonstrate its dedication to effective practice, a willingness to be judged on merit and a capacity to learn from experience.

BENEFIT MEDICAL EXAMINATIONS

WHAT ARE BENEFIT MEDICAL EXAMINATIONS

These are medical examinations for a lifelong monitoring and surveillance of former miners, and evaluation of both former and active miners for possible compensable occupational lung diseases. This is a provision of Occupational Diseases in Mines and Works Act no 73 of 1973(ODMWA).

For former miners this takes place at the Medical Bureau for Occupational Diseases and in some public health institutions in all nine provinces. All former miners are

entitled to undergo these examinations every twenty-four months, till an individual has been certified as having second-degree disability caused by the occupational lung diseases.

For the active mine workers these examinations take place at the mines, as provided for by the Mine Health and Safety Act(1997). This Act tasks the employer to forward information to the Medical Bureau for Occupational Diseases (MBOD), should any employee be found or suspected of suffering from an occupational lung disease(OLD).

OCCUPATIONAL LUNG DISEASES THAT ARE COMPENSABLE IN TERMS OF ODMWA.

Tuberculosis(contracted during service or within 12 months of last risk work), this is diagnosed on the chest x- ray, sputum, histology or any other documentation that the examining doctor can provide. TB is attributable to risk work, if the worker has performed a minimum of 200 shifts, which are equivalent to one year.

NOTE WELL:

(A) Initial Pulmonary tuberculosis(PTB):

The person should contract PTB While actively working in the mines or His or her PTB occurs within 12 months of last risk work.

(B) PTB Relapse:

If the person does not have the previous records but claims to have had PTB during employment, the MBOD can attribute his ptb to mine work if he was previously submitted during his working life. In certain cases the MBOD may have to request the mine to submit the former mineworker's exit chest x-ray and medical records.

Pneumoconiosis (Silicosis, Asbestos, Coal workers Pneumoconiosis) is diagnosed only on chest X-rays.

Joint Pneumoconiosis and Pulmonary Tuberculosis, Permanent Obstructive Airways Diseases (The person must have been exposed to high dust for more than 10 years and the last risk shift must not be longer than 10 years) is diagnosed on Lung Function test, chest X-rays and clinical examination.

Platinum Sensitivity is confirmed by Skin Prick test and/ or Lung Function test

Progressive Systemic Sclerosis is confirmed on clinical examination

Asbestos related lung cancer or Mesothelioma is confirmed on histology.

OCCUPATINAL INJURIES AND DISEASES THAT ARE NOT COMPENSABLE UNDER ODMWA

DISEASES NOT COMPENSABLE

Medical conditions contracted during employment asthma, bronchitis, pneumonia, congestive cardiac failure and all other lung diseases, hypertension, which are not caused by occupational exposure even though these diseases resulted in miner being retrenched due to ill health.

INJURIES

There are no injuries that are compensable in terms of ODMWA

Loss of hearing due to machine drilling, amputated limbs, blindness etc for this, the employer if still existing, should be contacted.

e.g. pneumonia, cardiac failure etc,

INFORMATION NECESSARY TO EVALUATE OCCUPATIONAL LUNG DISEASES IN TERMS OF ODMWA

- Labour history indicating where the person worked, for how long, and the last time he/she worked.
- Clinical history, recent medical examination which will give detail of heart and lung examination..
- Always a chest X-ray 35 x43cm size
- Lung Function tests where indicated. In case of Obstructive Airways Diseases, the minimum LFT that are use for the committee are measurements of forced expiratory volume in one second(FEV1) and vital capacity(VC).
- Sputum results if Pulmonary Tuberculosis is suspected
- Previous certifications.

. For a deceased former miner, organs are removed with the consent of the deceased's family and are sent through to the NCOH (011) 7126400 or if procedural information is needed the MBOD should be contacted at (011) 403-6322.

NB. DEATH CERTIFICATES ONLY, ARE NOT CONSIDERED AS MEDICAL INFORMATION THAT CAN ASSIST IN CERTIFYING THE DECEASED.

The Certification Committee (CC) comprises doctors representing the tripartite stakeholders namely the Dept of Health Employer and Employee Organizations. This is the first committee that deals with the mineworkers' applications for certification. This committee is chaired by the Director of the MBOD or by the alternate chairpersons who are the doctors permanently employed by the Dept of Health.

Reviewing Authority: comprises doctors representing employee and employer organisations. It handles appeals .The Reviewing Authority may confirm the findings of the Certification Committee or request the chairperson of the committee to submit the appeal case for final review at the joint meeting between the Certification Committee and itself.

Joint Committee is made of the above-mentioned two committees that deals with the appeal cases that have been referred to it by the reviewing committee.

CERTIFICATIONS MADE BY THE COMMITTEES.

1. No Compensable Disease defined as less than 10% cardio respiratory disability, or any other medical condition that does not require Compensation.

2. First degree defined as disability between 10 and 40%.

3. Second degree as disability more than 40%. This is maximum certification, which result in maximum compensation. Therefore the individual falls out of the compensation system. Joint pneumoconiosis and tuberculosis irrespective of the percentage of disability is certified as second degree.

Certification is uniform to all miners, however compensation calculations are based on salary. This results in miners with same diseases receiving different compensation.

SOME IMPORTANT NOTES TO REMEMBER IN THE GRADING OF PULMONARY IMPAIRMENTACCORDINGTOPERCENTAGE OF PREDICTED SPIROMETRY.

	FEVI	FVC	FEVI / FVC	PERCENTAGE	IMPAIRMENT
Normal	**>80%**	**> 80%**	**>75%**	**<10**	**Nil (no compensation)**
Mildly impaired	**79 – 65%**	**79 – 65%**	**79 – 65%**	**<10**	**Nil (No compensation**)
Moderately Impaired	**65 - 52**	**65 - 52**	**65 – 55%**	**10 – 40**	**First degree (compensation**)
Severely impaired	**<51%**	**<51%**	**<55%**	**>40**	**Second degree (maximum compensation**)

Blood gas studies showing consistent hypoxia or hypoxia with hypercabia, which is attributed to Obstruction Airways Diseases and

are severely impaired are considered as second degree. The clinical presentation of the miner has to be taken into account.

TABLE SHOWING WHAT CERTIFICATION FINDING CAN MEAN IN TERMS OF FUTURE MONITORING.

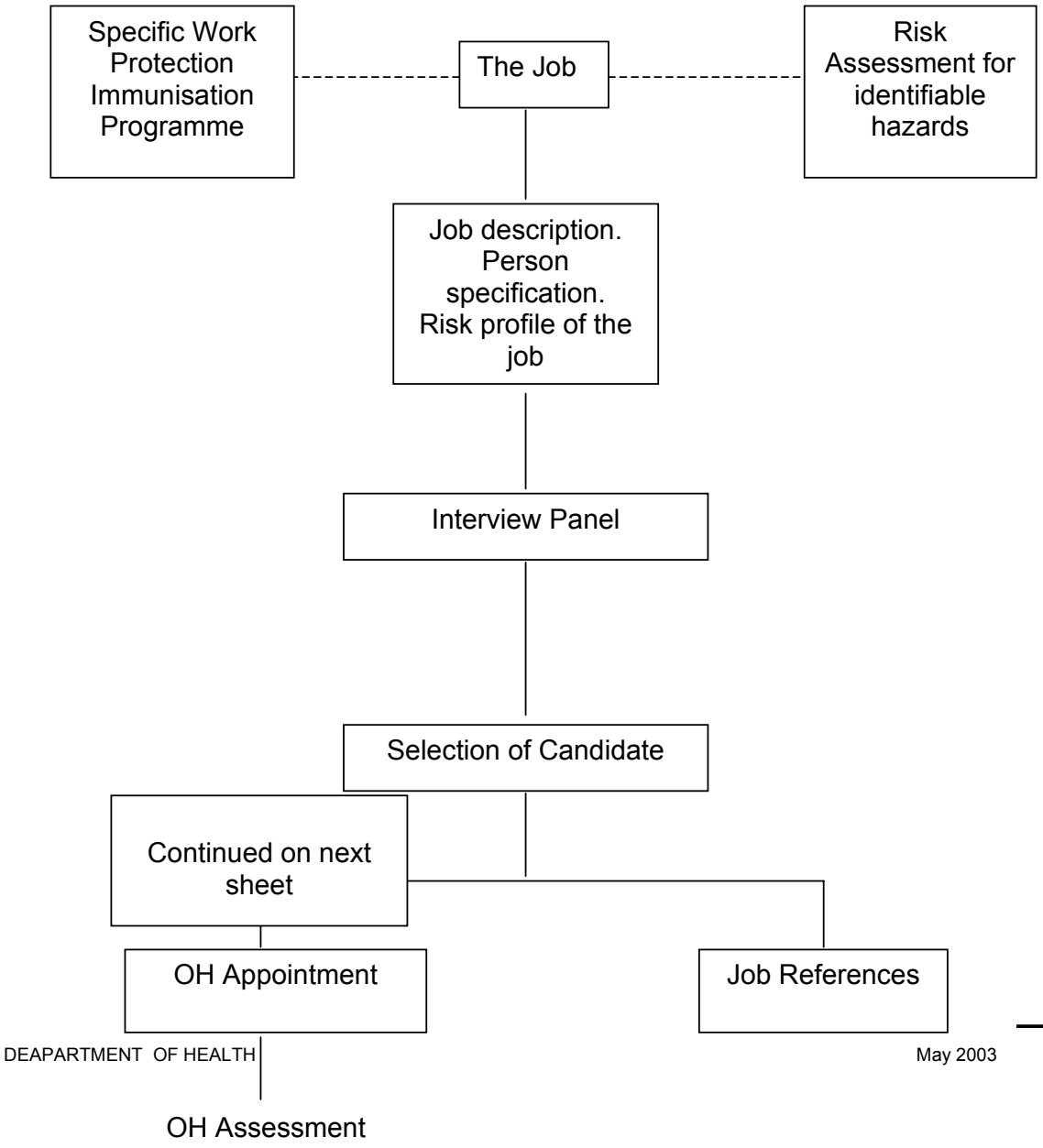
CERTIFICATION	PERCENTAGE OF DISABILITY	COMPENSATION	CONTINOUS MONITORING
NCD (No Compensable Diseases)	**10%**	**NO**	**Every 2 years or when detoriation is picked by his / her medical doctor.** *NB. Monitoring is for life until death or second degree.*
First degree	**10 – 40%**	**YES**	**Until death or second degree**
Second degree	**40%**	**YES**	*No further monitoring by the MBOD.* **The person gets monitored through public health services. If diagnosed at the time of leaving employer, the employer pays for medical treatment.**

NB. ONLY FIRST AND SECOND DEGREE OCCUPATIONAL LUNG DISEASES GET COMPENSATED.

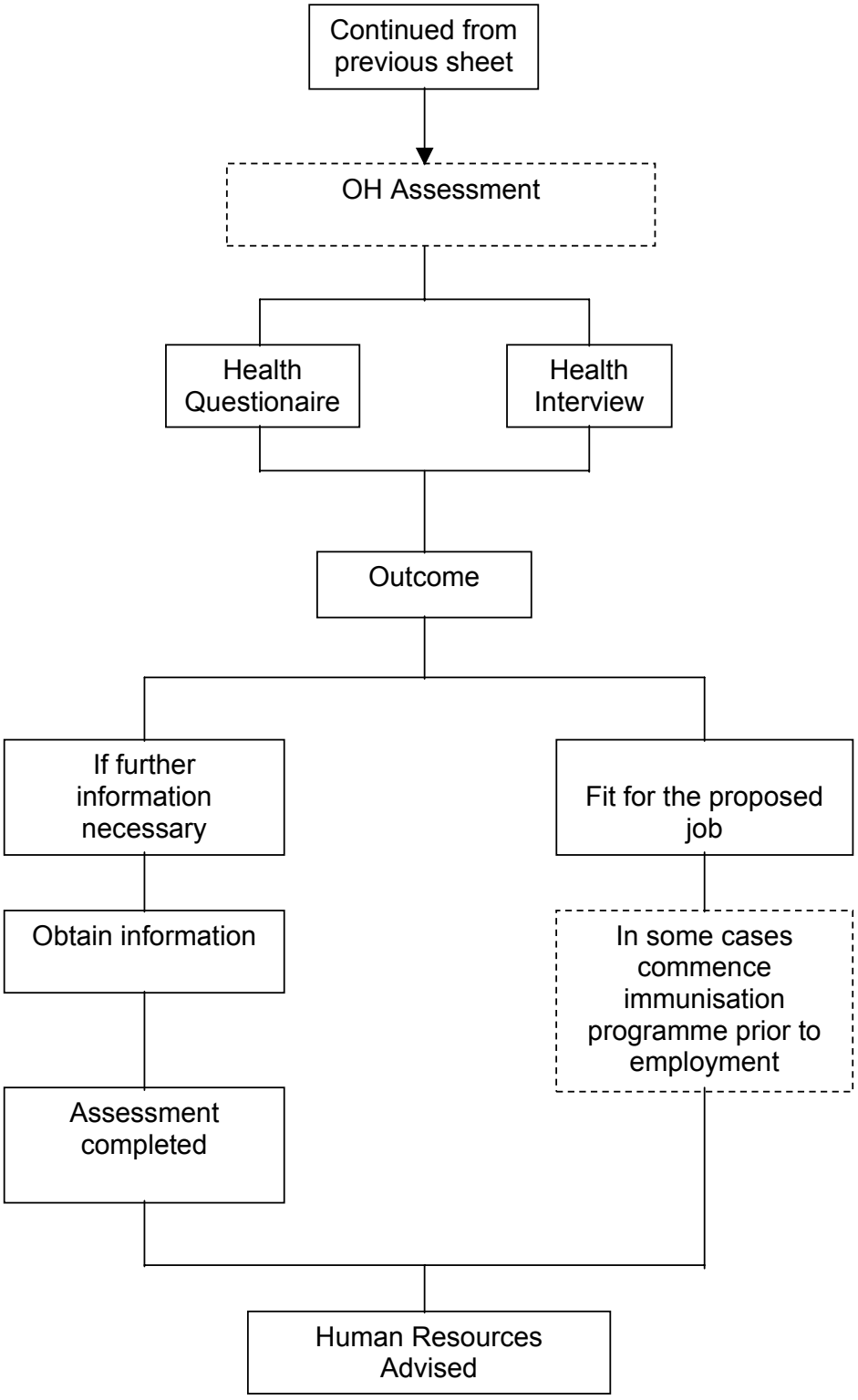
Tuberculosis: TB is only compensable if there is a loss of earnings by the sufferer during treatment, or it healed leaving the person with an assessment after treatment of either first degree or second degree disability. Clinical history, examination, lung function tests, and chest x – ray appearance confirm the disability.

Annex A

Pre-placement Screening - Flow Chart 1 of 2



Pre-placement Screening - Flow Chart No. 2 of 2



Annex B

CONFIDENTIAL - HEALTH QUESTIONNAIRE
Please complete this form and return it in the enclosed envelope to the OH Unit or bring it with you when you attend for health screening. All the information on the form will be **strictly confidential to the OH Unit. It will not be divulged to any third party without your written consent.** Advice given to third parties about the health and fitness of individuals is only ever given in general terms.

SECTION A - PERSONAL DETAILS [To be completed by the employee]

Family name ……First names. ……

Date of Birth. ……Male/Female……

Address
……

…… Post Code……

Your home phone no …… Your work phone number. ……..

Your doctor's name …… Your doctor's phone No……..……

Your doctor's address

… ……

……Post Code. ……..

Your job title …… Your department ……

Your previous occupation for the past five years, with dates if known.

Name of Organization	Dates employed	Occupation	Health hazard exposure

SECTION B - JOB PROFILE [To be completed by the manager]

Please tick the relevant boxes below to indicate what the job entails.

Question	Yes or No	Comments
Working in confined spaces?		
Exposure to any chemicals? Specify which.		
Contact with patients to give personal care?		
Exposure to blood and/or body fluids?		
Handling food?		
Handling pharmaceuticals?		
Exposure Prone Invasive Procedures?		
Working at heights?		
Night working?		
Shift rotation?		
Driving? Specify what		
Moving and handling patients?		
Moving and handling other objects? Say what.		
Exposure to radiation		
Computer screen use? Over 1hr/day continuous?		

Substantial ongoing access to children?		
Any other significant hazards? Please specify.		

SECTION C - YOUR PERSONAL MEDICAL HISTORY

Please answer all of the following questions. If you answer **YES** to any question, please give details in the space provided in **SECTION H** of this form.

Do you have now, or have you ever had, any of the following?	**YES**	**NO**	**DON'T KNOW**
1. Any impairment that may affect your ability to work safely?			
2. Eyesight problems not corrected by glasses or contact lenses?			
3. Hearing problems not corrected by a hearing aid?			
4. Difficulty in standing, bending, lifting or other movements?			
5. Are you waiting for any treatment or investigation?			
6. Skin problems of any kind?			
7. Back problems of any kind?			
8. Joints problems of any kind including pain, swelling or stiffness?			
9. Discomfort when using a computer keyboard?			
10. Mental illness or psychological problems? e.g. depression, nervous breakdowns, eating disorders, substance misuse			
11. Drug or alcohol problems?			
12. Fits, blackouts or epilepsy?			
13. Allergies of any kind?			
14. Asthma, bronchitis or chest problems?			
15. Treatment for tuberculosis?			

16. A cough for more than 3 weeks coughed up blood or had any unexplained loss of weight or fever?			
17. Hepatitis or jaundice?			
18. Diabetes, thyroid or gland problems?			
19. An illness that may have been caused or made worse by your work?			
20. Episodes of chest pain or breathlessness?			
21. Heart disease or high blood pressure?			
22. Dysentery, typhoid, paratyphoid fever, food poisoning, salmonella, severe gastro-enteritis or diarrhoea			
23. Medication to take in any form?			
24. Operations of any kind?			
25. Investigation, treatment or counselling?			
26. Ill health resulting in retirement?			
27. Doctor's consultation for any kind of health problem? [In last 12 months.]			
28. Work related stress?			
29. Frequent headaches or episodes of migraine?			
30. Medical conditions not mentioned elsewhere?			
31. A disability of any kind?			
32. Is there any additional information regarding your health not covered by the above questions?			

SECTION D - NIGHT WORKERS

Please complete the following section if you will be working regularly at night. If you answer **YES** to any question, please give details in the space provided in **SECTION H** of this form.

Question	**YES**	**NO**	**DON'T KNOW**
1. Are you currently taking drugs prescribed by a doctor or purchased from a pharmacy?			
2. Do you consider you have any medical condition that may affect your ability to work at night?			
3. Have you ever felt that night work was harming your health?			

SECTION E - SICKNESS ABSENCE

How many days have you been away from work or school during the past year?

…….

To what was your absence due?

……

……

……[Please continue at section G if necessary]

SECTION F - LIFESTYLE

What is your height?…… What is your weight?

…….

Do you smoke?…… If yes, how many a day?

…….

Do you drink alcohol? …… If yes, how much per week?

……

What type of diet do you follow?

……

.

Do you take regular exercise? Please give details.

……

.

What are your main hobbies or recreation?

……

.

SECTION G - IMMUNISATIONS

Certain jobs carry with them a risk of infection. In such cases, we offer immunisation to prevent this happening. Please provide details below of your immunisation history. When attending the OH Unit you should bring proof if identity with you. E.g., identity card; passport.

Please answer the questions below and enclose copies of any certificates/laboratory reports that you have.

Which of the following tests and immunisations have you had?	**YES**	**NO**	**DON'T KNOW**	**DATE**	**TEST RESULT**
TB test [Heaf, Tine, Mantoux]					
BCG [TB Vaccination]					
Tetanus					
Poliomyelitis					
Rubella [German Measles]					
Hepatitis A					
Hepatitis B [Give date of last immunisation]					
Meningitis A and C					
Please give any blood test results you have received for the following:					
Hepatitis B					
Rubella [German Measles]					
Varicella [Chicken Pox]					
Please give details below of any other immunisations you have had.					

SECTION H - FURTHER INFORMATION

If you have answered 'YES' to any of the questions in section C please give further particulars below.

Question number	Details

SECTION I - DECLARATION

I declare that to the best of my knowledge the information given by me on this form is true. I understand that my contract can be terminated without notice if:

- I have knowingly made a false statement regarding my medical history, either in answering this questionnaire or in giving other information to the OH Unit staff,
- I have concealed a material fact about my health status.

Candidate's signature. Name in capitals.

Date…….

Name and Surname_____Number_____(Annexure C

PERIODIC, TRANSFARE AND EXIT MEDICALS

Occupational Risk Exposure Profile									
1. Brief details of any illness, accident and Brief treatment since last examination 2. Systematic history to be probed at each periodic medical examination. Record any deviation									
Mass / Pulse Rate / Blood Pressure / Height									
	NAD	ABN		NAD	ABN		NAD	ABN	
Head, face, scalp and neck									
Ears, nose and throat									
Lungs, chest and breast									
Heart (size and sounds)									
Vascular system and lymphatics (pulses/ glands									
Abdomen (viscera and hernia)									
Genito. urinary system (external and rectal)									
Neurological system (cranial nerves, motor sensory reflexes									
Upper and lower limbs (strength, range of motion)									
Spine and musculoskeletal (cervical, thoracic, lumbar)									
Skin and appendages									
Psychological evaluation/impression									
	R		**L**	**R**		**L**	**R**		**L**
Visual acuity (corrected) Far (6 m)	6/		6/	6/		6/	6/		6/
Near (50 cm)	6/		6/	6/		6/	6/		6/
Visual fields NAD/ABN									
Categorization (Schilling)	1	2	3					2	3
Binaural impairment: Low fr	L.	%	H. %				%	H.	%
Spirometry: FVC		%							%
FEV1		%							%
Chest X-ray NAD/ABN									
Rest and stress ECGs NAD/ABN									
FBC, Hb									
Cholesterol; HDL; TG									
Liver function; SGPT; SGOT									
Toxicology, lead, etc.									
Other (HIV)									
Urinalysis:Protein/Sugar/Blood	Pr.	Su	Bl	Pr	Su	Bl	Pr	Su	Bl
COMMENTS / RECOMMEDATIONS									
Occupational Heath Practitioner									

Obtain information

Assessment completed

In some cases commence immunisation programme prior to employment

Human Resources Advised

Name _____ Signature_____
Date_____

Baseline Health Assessment

Name and Surname_____Number_____(Annexure D

PHYSICAL EXAMINATION

1. Mass (kg)	2. Height (cm)	3. Pulse rate	4. Blood pressure	Lying	Sitting	5. Urinalysis normal / Abnormal				
							Appearance	pH	sugar	Blood
BM1		/min	mm Hg							

Mark each item in an appropriate column	NAD	ABN	Mark each item in an appropriate column	NAD	ABN
6. Head, face, scalp and neck			12. Genito-urinary system (external and rectal)		
7. Ears, nose and throat			13. Neurological system (cranial nerves, motor, sensory, reflexes		
8. Lungs, chest and breast			14. Upper and lower limbs (strength, range of motion		
9. Heart (size and sound)			15. Spine and muscoloskeletal (cervical, thoraic and lumbar		
10. Vascular system and lymphatics (pulses/glands)			16. Skin and appendages		
11. Abdomen (viscera and hernia)			17. Psychological evaluation report/impressions		

SPECIAL MEDICAL INVESTGATIONS

18. Vision examination			**19. Screening Audiometry**			**20. Special examinations (Attach reports)**		
Corrective lenses used	Yes	No	Frequency(H^3)	R	L	Lung function test (spirometry)	NAD	ABN
Opthalmoscopy	NAD	ABN	250			FVC % / FEV_1 % / PEFR %		
Cornea/Lens/Fundi			500			Chest X-ray (attach report)		
Visual acuity (corrected)	**R**	**L**						
Far (6m)	6/	6/	1000			Effort tolerance: indirect V_{O2} max.		
Near (50 cm)	6/	6/	2000			Rest and stress EGGS (attach ECGS)		
Night vision	6/	6/	3000			**Blood analysis (Attach report)**	**NAD**	**ABN**
Visual fields	R	L	4000			Haematological FBC, Hb)		
Stereopsis		%	6000			Liver functions (GGT, SGOT, SGPT		
Colour vision (State method)	**Grade**		8000			Lipogram (cholesterol, HDL, IDL, TG		
Orthorator	I		**Categorization (Schilling)**			Toxicology (lead, PCB, Cholinesterase, etc.)		
Ishihara	II							
Colour wires					Binaural Impairment %			
Practical test	III		1 2 3	L.	H.	Other		

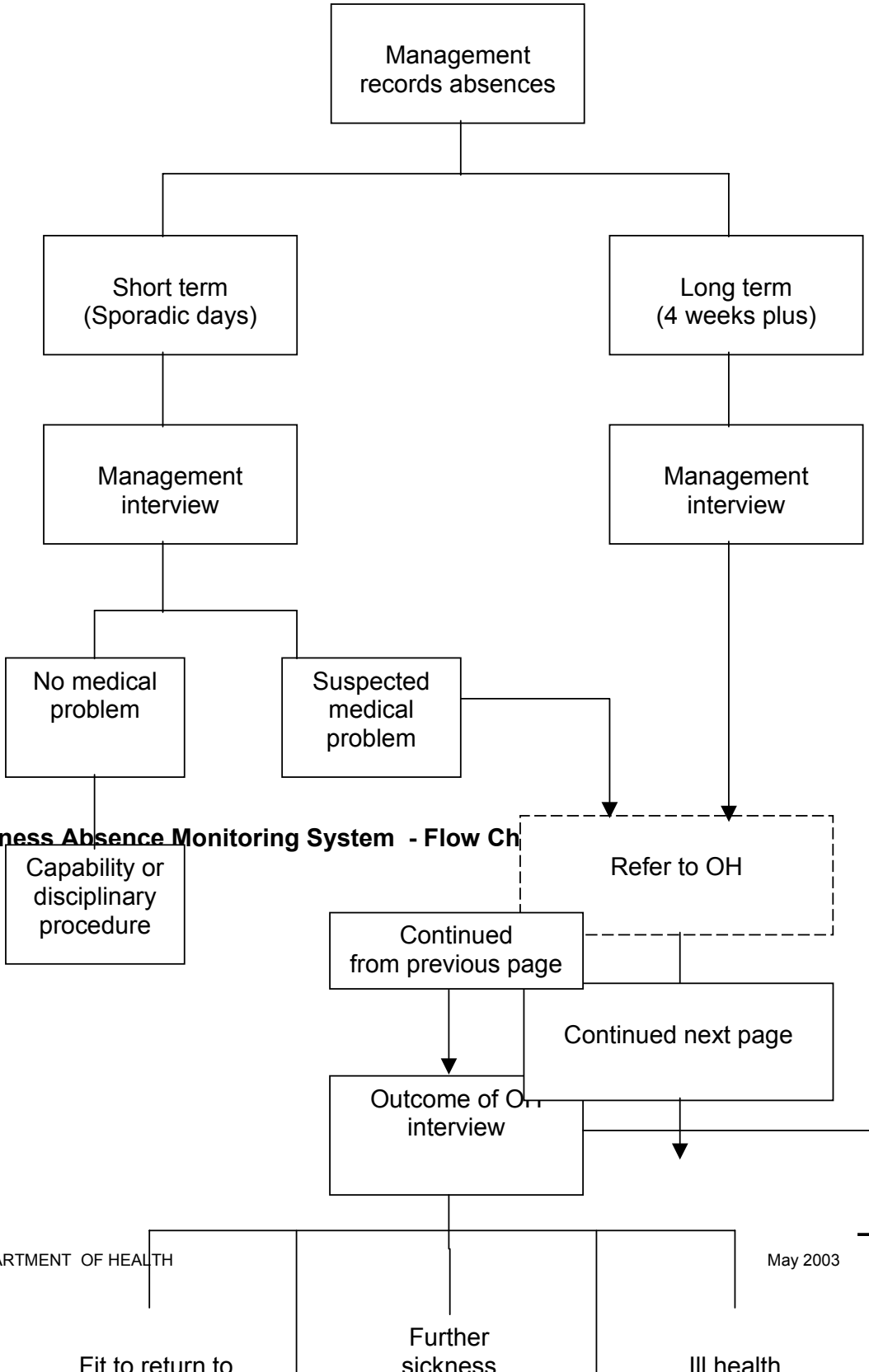
mmary of findings: Describe every abnormality in detail

- ❑ Significant medical history/findings
- ❑ No abnormal medical findings

Telephone no. _____ **Signature _____** **Date _____**

Annex E

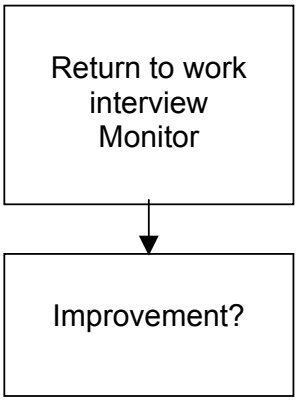
Sickness Absence Monitoring System - Flow Chart 1 of 2



Sickness Absence Monitoring System - Flow Ch

Annex F

Management of Short Term Sickness Absence – Chart 1 of 2



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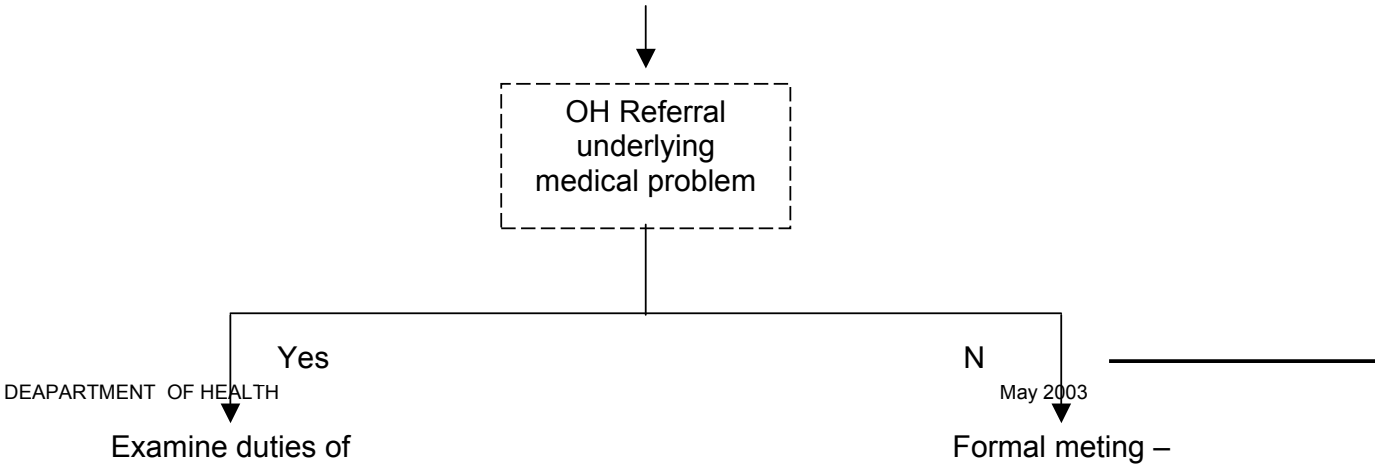
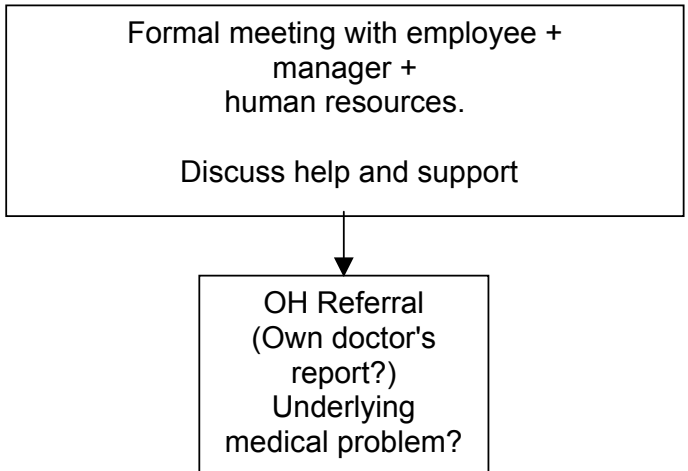
Management of Short Term Sickness Absence – Chart 2 of 2



Annex G

Management of Long Term Sickness Absence



Annex H

Guidelines for managers on sickness absence referral

All sickness absence referrals to the OH unit must be in writing

1. General information required by the OH Unit

a. Name, title, DOB, occupation and location of person being referred for health evaluation.

b. Name, title and location of the personnel officer or manager who is requesting the health evaluation.

c. The personnel officer/manager must state clearly in the letter of referral the reason(s) why the referral is being made and the employee must be told why they are being referred.

d. Enclose with a letter of referral the current and proposed job description if this is applicable.

e. Enclose employee's absence record for the past 6-12 months with dates and reasons.

2. **Examples of specific areas/questions on which managers/personnel officers may wish to seek guidance**

a. Can it be established that there is a medical reason for sickness absence? (Be it frequent or long-term sickness absence).

b. Is the condition amenable to treatment, and is the employee being treated?

c. Is this employee likely to require further sickness absence in the future?

d. Could this illness be attributed to, or aggravated by work?

e. Can an estimate of the length of time of sickness absence be given?

f. Can the OH Department provide the employee with further support to enable him/her to fulfil his/her contract?

g. Can it be determined that the employee will be fit to return to his/her full duties following this period of long-term sickness absence. And if so, when?

3. OH Response to a Sickness Absence Referral

A letter will be returned to the initiator of the referral with a copy to the personnel officer/manager if known. All specific questions in the referral letter will be answered as far as possible.

Depending on the query, the response may indicate one of the following:

a. The employee is able to return to full duties with no restriction.

b. The employee is able to return to work but with certain restrictions or recommendations.

c. The employee is able to return to full duties and will be periodically reviewed by the OH Department.

d. Medical recommendation for retirement on grounds of ill health.

e. A specific health problem may be identified which makes it unlikely that the person will be able to return to full duties. Specific reasons require to be given so that personnel officer/manager can offer alternative employment where possible.

f. There is no medical explanation for sickness absence.

4. Audit of System

If at any time the personnel officer or manager is unhappy or unclear about the information returned to them from the OH Department, they are encouraged to discuss all issues with the OH Manager and Medical Officer concerned.

ANNEX I

GENERAL GUIDELINES ON SICK LEAVE MANAGEMENT

DEFINITIONS

1. SICK LEAVE

Absenteeism from work where the ostensible reason is either certified or non certified in ill health

SCK LEAVE ABSENCE RATE: (SAR)

Provides a measurable rate of man days lost due to sick leave, is expressed as a percentage, and is calculated as follows:

$$SAR = \frac{\text{Total number of days sick leave for a period} \times 100}{\text{Total potential man days for a period}}$$

2. SICK CERTIFICATE

Any medical certificate that conforms to the guidelines laid down the Medical Association and the Society for Occupational Medicine.

Organisation will accept sick certificates issued by the following professional categories.

- Any registered medical practitioner or dentist
- Any clinical psychologist
- Any alternative healer, whether traditional or Western, provided that they are registered with the perspective bodies, such certificates are subject to verification by the Occupational Health Practitioner /Medical practitioner.

2 RESPONSIBILITY

The responsibility for the immediate management of sick leave lies jointly with the line management and Human resources Department.

Ultimate responsibility lies with the individual Executive Director or CEO

3 ABSCENCE NORMS

While DPSA condition of service allows 36 days sick leave over a three year cycle, it emphasise that the benefit is provided with serious illness, accident or operation requiring hospitalisation.

The South African Society for Occupational Medicines (SASOM) guidelines indicates that the

- 0-7 sick leave per annum is fair
- 7-12 day per annum is question enable in certain circumstances.
- More than 12 days per year for two consecutive years would be rated as “unacceptable”

5 SUBMISSION OF SICK CERIFICATES

Sick certificates are required fro the absence in excess of (3) Conservative working day .How ever a departmental Manager may require a certificate for any absence because of the alleged illness.

6 INDICATORS OF THE SICK LEAVE ABUSE IN AN INDIVIDUAL EMPLOYEE

Indicators of abuse could include one or more of the following:

- Taking of excessive leave (7-12 days or more) in multiple of 1-3 day period through out the year
- Producing sick notes with a variety of diagnosis from a variety of different doctors
- Monday /Friday sick absenteeism pattern may be enough to pinpoint abuse even before the seven day limit has been exceeded.

REASONS FOR SICKLEAVE ABUSE

As a rule, employees do not abuse sick leave privileges out of intrinsic laziness. There is almost always an underlying cause which almost always lies in the realm of psychosocial distress rather than physical illness.

The underlying problem has often to do with:

- Poor interpersonal relationships or conflict at work.
- Job monotony, job dissatisfaction, and poor adaptation to job requirements.
- Social/financial/family problems
- Alcohol or drug addiction.

The assistance of an EAP Practitioner is indispensable in the identification and remediation of these problems.

Annex J

OH UNIT

Referral for assessment of fitness to work

To be completed by the referring manager after discussion with the employee

Please assess the following member of staff for fitness to work.

Family Name: First names:……..……

Job title: ……Time in present post:……

Department: ……Phone number:

Home address:

……
……

--**Key job responsibilities** - note particularly any tasks that may have a bearing on the employee's fitness to work.

……
……
……
……

Please continue on a supplementary sheet if necessary

Reasons for referral
Please include full background to the situation and relevant personal circumstances.

……
……
……
……

Please continue on a supplementary sheet if necessary

Before referral managers should discuss the issues fully with the employee involved.

I confirm I discussed the reasons for this referral with the employee on [date].../…../….

Manager's signature……. Date. …/…../…..

Manager's Name [in capital letters]……..

Employee's signature…… Date. …/…. /…..

Please attach: Any other reports relevant to this referral.

The employee's previous twelve months sickness absence record.

Annex K

Information for managers on types of sickness absence and the role that the OH unit can play in reducing its incidence

Note: This sample information is based mainly on practice in the UK. Whilst in general it can be followed in South Africa, there may be local employment law or other reasons why some of the details are not applicable there.

There are two kinds of sickness absence, short-term and long-term and they need to be considered separately as their causes are usually different.

1. Short-term Sickness Absence

This is the more common form and accounts for the greater amount of time lost at work. There is seldom a serious medical condition underlying short-term sickness absence, although it may be symptomatic of alcohol or drug abuse. The OH unit role in handling short-term sickness is:

a. To confirm the presence or absence of an underlying medical condition.

b. To confirm, so far as it is possible, the presence or absence of an alcohol or drug related problem.

c. To comment on the prognosis or any medical problem that may be present and on its likelihood of recurrence.

2. Long-term Sickness Absence

By contrast with short-term absence, medical conditions are almost always at the root of long-term absence. Typically medical input will be sought when an individual returns to work from a prolonged absence - prolonged in this context may mean more than four weeks. The OH unit role here is to answer some or all of the following questions:

a. Has the condition that caused the absence remitted or if it is a chronic condition, is it well controlled with treatment?

b. Is it likely to recur in the future and if so, is it possible to prognosticate when this might be?

c. Is the individual now completely fit for work or are there some limitations that must be placed upon them?

d. If the individual is completely unfit, would some other form of employment be appropriate or should early retirement on the grounds of ill health be considered?

e. If some limitation on activity is recommended, for how long will this limitation last?

There may be other questions to which managers would like answers in addition to those listed above and if so, then they should be clearly stated in the referral letter.

In most cases of serious illness a graded return to work is preferable and would usually extend over four to six weeks after which time a return to full duties would be expected. During this period it would be helpful if the individual were monitored both by their manager and by the OH Nurse Advisor. An appointment would be made for the individual to see the occupational physician at the end of the period at which time reports from the manager and the OH Nurse Advisor would also be available.

In order to obtain the best quality of information it is important that managers state clearly in their referral letter the questions to which they require answers and that the occupational physicians give answers which are as complete and unequivocal as possible (see guidelines on Sickness Absence Referrals). It has to be recognised, however, that the question of fitness to work is often not a simple one to decide and that prognosis is a far from exact science. In all but the simplest cases (recovery after a fracture, for example), a trial period at work is likely to be required.

3. Case Conference

It is recognised that in a residuum of cases, there may be a discrepancy between the views of the occupational physician and the managers on an individual's capacity for work and this may not be resolved by frequent medical referrals. In these cases, it is much more productive to hold a case conference at which the Manager, Occupational Physician, OH Nurse Advisor and Personnel Officer can discuss matters in a more constructive manner than through the exchange of letters.

Annex L

Confidential

OH UNIT - HEALTH ASSESSMENT REPORT

A. To: [Human Resources / Manager]
……

Name of staff member: D.o.B…... /…..……/……

Post ……...Dept.
……

B. This report is based on: [Tick appropriate heading]

a. Health questionnaire assessment ☐
b. Health interview ☐
c. Health update ☐
d. Medical examination/opinion ☐

C. The member of staff has been assessed as:

a. Fit for the proposed employment ☐
b. Unfit for the proposed employment ☐
c. Temporarily unfit. Re-examine in ….. months time ☐
d. Fit subject to the following restrictions ☐

……

……

……

D. Please arrange an appointment with the OH Unit for:

a. Further health assessment ☐
b. Immunisation update ☐
c. Vision screening ☐

d. Other purpose
Assessed by: OH nurse / medical adviser Date: ……/……./…….   Signed…… Name [Block letters].

Annex M

Immunisation Record Card

All staff who are immunised should be issued with a personal record card to retain for their own reference.

A convenient format is a small card which, when folded over, makes four pages.

A layout for each page is suggested below.

Back cover Front cover

Please keep this card in a safe place and bring it with you when you attend for immunisation. Thank you.	**HEALTH FACILITY NAME** **WORK PROTECTION VACCINATION RECORD** Issued to:……. Address of organisation Phone number of OH Unit

Page 2

Page 3

Vaccine - Tetanus					**Vaccine - Typhim – VI**				
Date	Dose/ Route	Manufact/Batch	Effective till	Signature/Stamp	Date	Dose/ Route	Manufact/ Batch	Effective till	Signature/Stamp
Vaccine - Polio					**Vaccine - Typhoid – Oral**				
Vaccine - Rubella (German Measles)					**Vaccine - Meningococcal Meningitis A and C**				

Note The vaccinations exampled above may need to be changed for conditions in South Africa

Annex N

Factors to be considered in a moving and handling assessment
It is important to consider the ILO Guidelines for lifting loads.

1 The tasks Do they involve:

- holding or manipulating loads at a distance from trunk of the body ?
- unsatisfactory bodily movement or posture, especially:
- twisting the trunk and stooping?
- reaching upwards?

- excessive movement of loads, especially:
- excessive lifting or lowering distances?
- excessive carrying distances?

- excessive pushing or pulling of loads?
- risk of sudden movement of loads?
- frequent or prolonged physical effort?
- insufficient rest or recovery periods?
- a rate of work imposed by a process?

2 The loads Are they:

- heavy, bulky or unwieldy?
- difficult to grasp?
- unstable, or with contents likely to shift?
- sharp, hot or otherwise potentially damaging?

3 The environment Are there:

- space constraints preventing good posture?
- uneven, slippery or unstable floors?
- variations in level of floors or work surfaces?
- extremes of temperature or humidity?
- conditions causing ventilation problems or gusts of wind?
- poor lighting conditions?

4 Individual capabilities does the job:

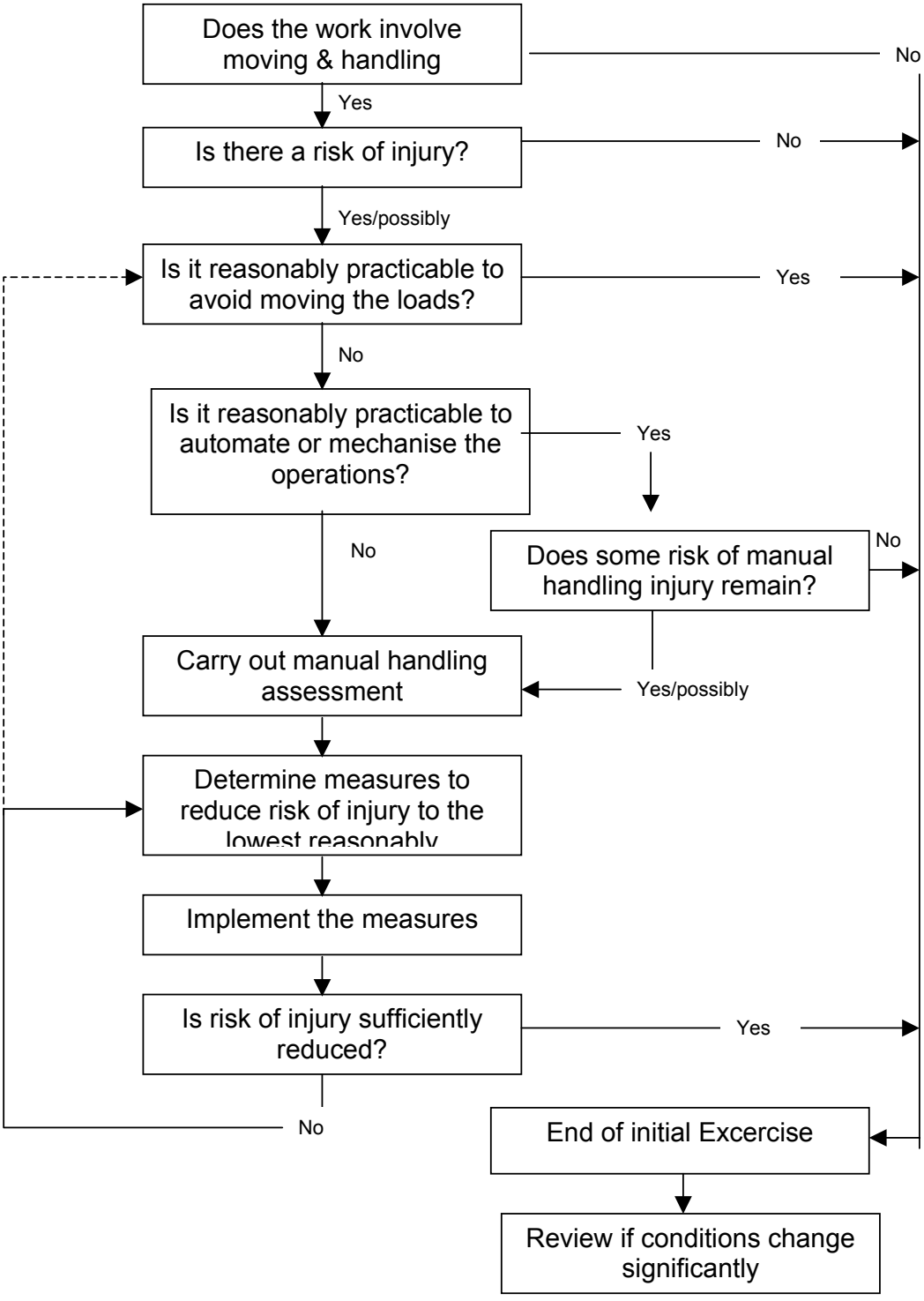
- require unusual strength, height, etc?
- create a hazard to those who might reasonably be considered to be pregnant or to have a health problem?
- require special information or training for its safe performance?

5 Other factors Is movement or posture hindered by protective equipment or clothing?

Annex O

Moving and Handling Assessment

(May be used for single or repetitive movement of loads.)



Annex P

Moving and Handling Training Programmes

The contents of a moving and handling training programme will include:

- Understanding the importance of good health and good back care.
- Principles of back care.
- Principles of moving and handling people and objects.
- Ergonomics and how to recognise risks in the workplace.
- Use and maintenance of moving and handling aids.
- Dealing with unfamiliar handling operations.
- Recognising the importance of good housekeeping.
- Awareness of each employee's own capabilities and limitations.
- Reporting procedures for accidents and incidents relating to moving and handling
- Reference to frequent injuries revealed by local reports from the institution
- Importance of including moving and handling arrangements in each individual patient care plan
- Understanding the OH support facilities that are available and how to access them.

Training programmes should aim to minimise the overall number of injuries that occur. Additionally, they can be used to target specific patterns of injury revealed by the collection of data on all accidents. The link between the two underscores the importance of having a sound accident reporting system to help pinpoint hazards that are causing recurrent injury.

All training programmes should be audited for their effectiveness both at the time of staff attendance on the course as well as on their return to the ward, unit or office. On going monitoring is important to assess the formative value of the training and determine if further training is required.

Annex Q
Stress Awareness Training Programme

Training should take place at both the management and individual level.

Management needs to be sensitive to staff psychological needs and be able to recognise the signs and symptoms of stress in individuals. They should also be familiar with coping skills, understand stress management and be aware of the value of counseling. Through this knowledge they can ensure that appropriate support is available to staff.

Individual members of staff should be offered training in ways to recognise and handle stress in themselves. It is good practice to offer training in exercise programmes and relaxation methods, including complementary therapies.

Suitable components to include in a stress awareness programme

A stress awareness programme could usefully comprise all or a selection of the topics listed below. If required, the topics could be spread over two or more learning sessions. Alternatively, a selection could be made according to the needs of a special group.

- Workplace stress policy
- Health and safety issues including legislation
- Defining stress
- What stress means to you and other individuals
- Physical and mental manifestations of stress: recognizing stress
- Organisational stress - cause and effect
- Personal stress - cause and effect
- Short and long term stress
- Good and bad stress
- Coping mechanisms
- Awareness – balance – control
- Stress reduction techniques
- Time management,
- Assertiveness,
- Managing change,
- Defining priorities
- Working smarter not harder
- Personal well-being
- Healthy eating,
- Regular exercises,
- Relaxation,
- Rest and sleeping well
- Emotional release
- Practical relaxation techniques

Annex R

Setting up a health promotion programme

Step 1. Identifying organisations needs:

- Staff need analysis including consultation with staff organised, labour and management
- Review national and local health statistics
- Analyse sickness absence records
- Review accident records

Step 2. Convince management, staff and labour by presenting:

- The outcomes of the research
- The benefits to be gained from any investment of resources

Step 3. Agree priorities with staff and set appropriate goals: E.g.

- Early detection of disease by health screening
- Encouraging of individuals to change behaviour e.g. cease smoking
- Motivating individuals towards healthier living
- Raising awareness to health and safety issues such as prevention of sharps injuries.

Step 4. Develop methods of getting the message across: E.g.

- One to one education/counselling
- Group work
- Lectures informal/formal seminars using a variety of educators
- Audio-visual presentations
- Organising health events/Health Fairs
- Use of communication media
- On-site journals, newsletters, posters, booklets and computer media

Step 5. Agree with staff how the programme is to be evaluated

- Identify a small number of indicators of progress (preferably related to outcomes)
- Set up a method of measuring progress against the indicators
- Make adjustments to the programmes in the light of feedback from the evaluation

Annex S

Checklist of common hazards in health service premises

The following is a checklist of known or frequently occurring hazards grouped by their common characteristics.

1. Chemical Hazards

Cleaning Substances
Photocopier Fumes
Mercury
Drugs
Office Agents

2. Biological Hazards

Hepatitis B
Tuberculosis
Aids/HIV
Food Hygiene
Hepatitis A
Legionella
General Cross Infection Issues
Clinical Waste

3. Ergonomic Hazards

Moving and Handling
Display Screen Equipment

4. Psycho-social Hazards

Work Related Stress
Working Alone
Violence
Security

5. Physical Hazards

Noise
Electricity
Fire

6. Mechanical Hazards

Machinery or moveable objects
Filing Cabinets
Torn Carpets
Trailing Flexes
Mobile Furniture etcetera

7. Other Hazards

Vehicle Drivers
Pregnant workers
(not a hazard but require special consideration)

Annex T

Employee health records - function, content and completion

1. Function

The employee's OH record is an important clinical tool which is essential to the proper functioning of the OH unit. It provides a clear and accurate record of the health of the individual at work. It demonstrates the chronology of events, including each contact the person has with the unit and any treatment they received. It is also a form of written communication among the professional staff of the OH unit.

2. Content of clinical files

- **Front cover**

- **Name**
- Status
- Ward or Department
- Computer Number
- Appropriate hazard/risk warning e.g.

- Allergy Status
- EPIP identification

- **Inside the health record**

- Front sheet – personal details to be updated at each visit (name, address, telephone, own doctor's name)
- Health Questionnaire
- Baseline Health Assessment
- Health Surveillance Forms
- Vaccination details
- Vision Screening Forms
- Clinical Notes – plus continuation sheets (which should follow in date order and be numbered sequentially)
- Correspondence in date order, most recent first
- Pathology Results - In date order, most recent first
- Accident records in date order
- Sharps injuries in date order
- Sickness Absence records (if held) in date order

3. Completion of the health record

It is important to pay attention to the following points when making notes in the employee health records:

Notes should be:

- Clear and unambiguous, accurate yet brief
- Legible and written in indelible black ink.
- Completed without use of abbreviations.
- Have alterations made by scoring out in ink. All alterations must be initialed and have the date and time inserted alongside. Correcting fluid should never be used to make alterations.
- Without large gaps between entries.
- Completed at time of consultation. Being unable to do so should be a rare exception.
- Signed, dated and timed after each entry.
- Kept in chronological order

Clinical Notes made at consultation should include:

- A clear statement of the reason for each attendance.
- Details of examinations or other procedures conducted.
- A record of all advice and information given.
- The patient's name and date of birth entered on the top of each continuation sheet.
- Continuation sheets should be numbered sequentially in chronological order.
- A record of the date and time of the consultation and the signature of the health professional who undertook it.

4. Security and confidentiality

Health records should be stored in a secure locked cabinet to which only designated OH unit staff has access. Any unauthorised individual should handle keys securely to avoid access. Staff health records should be treated with complete confidentiality and not be made available to anyone outside the unit except with the written authorisation of the staff member who owns the records.

Annex U

Visual Display Unit (Computer Screen), and Workstation Training Programme

Deskbound staff are sometimes thought to face low hazard levels. With proper workstation ergonomics and suitable work routines this is normally so. Without these, employees face risks which could be avoided. With computer terminals now standard equipment in most offices, their positioning and use needs to be arranged correctly. Even in situations where there are no VDUs, proper seating and desk arrangements are important to prevent musculo-skeletal or other problems.

The principal components of a workstation

- Work desk, including the desk return work surface
- Chair
- Display screen,
- Keyboard
- Computer case with disk drive
- Computer accessories e.g. modem
- Computer software
- Printer
- Document holder
- Telephone,
- Fax machine
- Filing or other cabinets requiring constant access
- The immediate work environment taking account of noise, temperature, humidity, light and space both around and underneath the desk.

The content of a Workstation and VDU training programme will include:

- Understanding what constitutes a workstation.
- The importance of arranging it in an ergonomically sound way
- Explaining how users can contribute to the assessment of workstations.
- Recognition of hazard and risk e.g.
  - Positioning of equipment
  - Desk and chair height
  - VDU positioning, screen reflections and glare
  - Prolonged sitting in a fixed position with a lack of breaks
  - Poor posture
- Giving information about eye tests, rest breaks and standards for workstations.
- Reporting to musculo-skeletal symptoms and taking appropriate action.
- Introduction of a simple workplace exercise programme to prevent musculo-skeletal fatigue and promote positive health.
- Procedure for reporting problems with work procedures and workstations.
- An understanding of health and safety responsibilities.

See also diagrams on the following pages.

CORRECT SEATING AND POSTURE FOR TYPICAL OFFICE TASKS

1. SEAT BACK ADJUSTABILITY

2. GOOD LUMBAR SUPPORT

3. SEAT HEIGHT ADJUSTABILITY

4. NO EXCESS PRESSURE UN UNDERSIDE OF THIGHS **AND** BACK OF KNEES

5. FOOT SUPPORT IF NEEDED

6. SPACE FOR POSTURAL CHANGE. NO OBSTACLES UNDER DESK.

7. FOREARMS APPROXIMATELY HORIZONTAL

8. MINIMAL EXTENSION, FLEXION OR DEVIATION OF WRISTS

9. SCREEN HEIGHT AND ANGLE SHOULD ALLOW COMFORTABLE HEAD POSITION

10. SPACE IN FRONT OF KEYBOARD TO SUPPORT HANDS/WRISTS DURING PAUSES IN KEYING