

PRACTICE OBSERVED

Practice Organisation

How safe is your surgery?

ANNE PAINE

The Health and Safety at Work Act 1974 is a fact of our working lives, and there is a great deal for the doctor or the practice manager to consider.

Crime prevention

The police say that breaking and entering is on the increase and is likely to remain so. What can we do to ensure that we have taken all practical steps to prevent a break in?

In the first instance the police favour physical security—that is, special doors and windows, grilles, bars, and strengthened doors; and double glazing. Drains, hypodermic needles, and petty cash should always be kept in a strong store area when not in use.

Should you decide on an electrical alarm system you are faced with two choices, one based on detecting movement in the building and the other

activated by the opening of a door or window. Often a mixture of both types produces the best result. Literature and a list of approved installers is available from The National Supervisory Council for Intruder Alarms, 31 Ives House, 31 Ives Road, Maidenhead, Berks.

Fire precautions

Under the Fire Precautions Act (1971) premises that are used as a place of work require a fire certificate unless (a) not more than 20 persons are employed to work on the premises at any one time, or (b) not more than 10 people are so employed to work elsewhere than the ground floor.

If you think you require a fire certificate apply to the local fire authority, who will then require you to provide information concerning the premises and the use to which they are put. They will then inspect the building and issue a certificate provided that the premises are reasonably equipped with the means of escape, of fighting fire, and for giving warning of fire.

Fire exit doors should be clearly marked, and staff trained in the use of fire fighting equipment. Staff should be instructed concerning their duties in case of fire—with particular regard to patients in all parts of the building, including the lavatories. Fire drills should be held every six months.

The Surgery, Crowthorne, Berks RG11 4JL. ANNE PAINE, practice manager.

- (3) Heating
(a) Suitable temperature; no extremes
(b) Thermostats available
(c) Portable heaters or fans are safe and in working order
(4) Lighting
(a) Lighting is adequate in all rooms and passageways
(b) The artificial light does not cause glare or eye strain
(c) Lighting is correctly positioned
(d) Check for defective lighting and see that repairs and replacements are done as soon as possible
(5) Furniture
(a) There is sufficient furniture for the use of all staff
(b) The furniture is in a good state of repair
(c) Furniture or fittings are not causing an obstruction
(d) All furniture is suitable for the use to which it is put
(6) Equipment
(a) All equipment is regularly maintained
(b) Service installations are regularly checked
(c) Where necessary, written instructions and safety codes of practice are displayed for the use of the equipment
(7) Services (water, electricity, etc)
(a) Service installations are regularly checked
(b) There are sufficient installations in the workplace to prevent overloading of services
(c) Installations correctly installed
(d) Services clearly marked

- (8) First aid
(a) First aid box well equipped
(b) Accident book available
(c) Supply of accident report form F2506
(9) Structure
(a) Doors and windows regularly maintained
(b) Features secure
(c) Everywhere in good state of repair and redecoration
(d) External pathways safe, in good state of repair, and adequately lit
(e) Manholes maintained
(f) Guttering and drains clear
(10) Fire
(a) Fire exits clearly marked
(b) Alarm correctly maintained and in working order
(c) Fire fighting equipment correctly placed and maintained
(d) All staff aware of location of fire fighting equipment and alarms and of procedure in case of fire
(e) Fire procedure notices drawn to attention of visitors to workplace
(f) Access for fire engines adequate and hydrants worked
(11) Security
(a) Check door and window locks
(b) Security alarms are in working order
(c) Review security procedures
(d) Staff informed of security procedures

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Practice Research

Respiratory consultations in asthmatic compared with non-asthmatic children in general practice

MARK LEVY, MOHINI PARMAR, DAVID COETZEE, STEPHEN W DUFFY

Abstract

In a retrospective study we found that before a diagnosis of asthma had been made children with asthma had consulted their general practitioner more often with respiratory symptoms than children who were non-asthmatic under the age of four. In the second, third, and fourth years the number of consultations differed significantly between the two groups. Asthma should be suspected in any child who presents often with respiratory symptoms. This should lead to earlier diagnosis in most cases.

Introduction

A recent audit of respiratory consultations in children with asthma had been diagnosed showed that these children had

Northolt, Middlesex. MARK LEVY, MB, MRCP, general practitioner and trainer. MOHINI PARMAR, MB, MRCP, trainee in general practice. DAVID COETZEE, medical student on placement. Division of Computing and Statistics, Clinical Research Centre, Harrow, Middlesex. STEPHEN W DUFFY, MR, MRCP. Correspondence to: Dr Mark Levy, 173 Castle Road, Northolt, Middlesex UB8 4SQ.

had an average of 16 respiratory consultations before their doctor diagnosed asthma. Although all these children had consulted their doctor with respiratory symptoms before their fifth birthday, only half had been diagnosed by then.

The aim of this study was to compare the consultation rate for respiratory symptoms in children with asthma with that of non-asthmatic children in our general practice.

Patients and methods

Our practice is an urban, National Health Service, group practice of mainly middle class Caucasian patients. From 470 children aged between 18 months and 11 years two groups of patients were identified. Group 1, the group with asthma, was described in an earlier paper where asthma was defined as (a) variable airways obstruction as shown by a history of recurrent wheeze, shortness of breath, or cough and a subsequent response to anti-asthma treatment; or (b) variation in peak expiratory flow rates of 20% or more, or both (a) and (b). Fifty two children (prevalence of 11%) were diagnosed as having asthma. 31 objectively (criterion b) and 21 according to the subjective criterion (a). Group 2, the group without asthma, was obtained by sampling at random the records of the remaining 418 children who had not previously been diagnosed as having asthma. In this group the asthma was excluded by two independent observers. Complete records only—that is, starting from birth—were available for 367 children. Sixty nine patient records met these criteria and these children were included in group 2. Some children with mild, undiagnosed asthma may have inadvertently been included in group 2. We think that this is unlikely in view of the results and the 11% prevalence of children with asthma in this

In the event of a major fire one of the most serious losses could be your medical records. The only way to protect them is to put them in fire safe or fire resistant cabinets. Some would say that this is very expensive and highly impractical. A fireproof cover might be a worthy alternative. It is worth putting appointment books, ledgers for private patients, and practice accounts into metal cabinets at night.

As a preventive measure periodically check all external electrical wiring, plugs, and appliances. Make sure that where possible all electrical appliances are switched off at night. It is a simple rule, which is often overlooked.

Fire prevention officers are helpful, and it is advisable to consult them if you are moving into new premises or having an extension to existing buildings built. Finally, should you consider installing an electrical fire alarm, and provided you can get written authority from the fire officer that a system is required by them, the family practitioner committee will consider the application for an improvement grant in the same way as for intruder alarms.

Health and safety

Under the Occupiers Liability Act of 1957 doctors owe a common duty of care to all visitors to their premises; this duty requires only reasonable precautions to be taken for their well being. The Health and Safety at Work Act 1974, however, requires doctors to provide and maintain a safe place of work and states that "it shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety, and welfare at work of all his employees." Doctors' responsibilities are the same as those of any other employer in the Health and Safety Executive, whose address and telephone number are in the local telephone directory. Any proceedings that may be taken under the Act are criminal.

There are many publications on this subject to choose from, but a very useful booklet may be obtained from the BMA: Health and Safety at Work Act 1974 by Anne Cullinan and Norman Ellis. It will tell you how to maintain your building against the hazards when the building is in use, your duties to the staff, and the duties of the staff themselves. It will also advise you of the things the health and safety officer will look for.

It is essential that all practitioners with more than five ancillary staff prepare and display a written statement of their general policy "with respect to health and safety" of their employees and the organisation and arrangements for carrying out this policy. It is important to review this statement regularly in the light of changing requirements to keep it up to date. The statement must refer specifically to the needs of the practice for which it is written (it is not sufficient to copy someone else's statement). The policy must make clear that there is a continuing review, and it must be dated and signed. It must have objectives and should state how these should be achieved. Finally, it must be monitored regularly for effective implementation.

Though it may seem superfluous to a doctor's surgery, first aid is important under health and safety regulations. The Health and Safety Executive will provide you with a leaflet on "First aid in small work places," which will tell you most of what you need to know, including how to keep records. The accident book is the most important item and must record the date of an accident or dangerous occurrence, the place, circumstances, and name, sex, age, and occupation of the injured person and the nature of the injury. The Health and Safety Executive like to be informed when there has been a major injury, accident, or dangerous occurrence. Their definitions of a major injury are: fracture of skull, spine, or pelvis; fracture of arm, leg, but not foot, ankle, or hand; amputation of hand or foot; loss of sight in an eye; any other injury requiring admission to hospital for more than 24 hours (except for observation). A dangerous occurrence could be a piece of electrical equipment blowing up, whether it is a typewriter or electrocardiograph. All such incidents must be reported to the Health and Safety Executive; a written report on F2506 submitted within seven days, the accident book completed, and records kept for three years.

All of the foregoing deals with employers' duties, but employers also have duties under this Act. The Act states: "It shall be the duty of every employee while at work to take reasonable care for the health and safety of themselves and other persons who may be affected by their acts or omissions at work. It also states that: "No person shall intentionally or recklessly interfere with or misuse anything provided in the interests of health and safety or in pursuance of the relevant statutory provisions."

It is essential that all employees see and understand the policy statement and that they know the various hazards and correct methods of procedure. Their own responsibilities should be pointed out to them, and the best way to do this is to include health and safety in the employees' training programme. HM Stationery Office has helpfully published "Reporting an accident" and "Advice to employers, safety representatives and committees," and these, together with the booklet mentioned above, will provide most of the information you should need. Your local Health and Safety Executive office will be happy to advise you if you have any problems.

Emergencies

Do all receptionists know exactly what to do in an emergency? There is a strong case for training receptionists to recognise a real emergency, giving them access to emergency telephone numbers, and teaching what information to obtain in the case of poisoning, when to send for an ambulance, and how to give appropriate first aid. Many doctors would disagree with the last point, fearing that they may be held responsible for any repercussions originating from the actions of the staff. Might they not be considered negligent, however, if none of their staff can provide first aid should a patient collapse in the surgery?

Violence and vandalism are on the increase, and who has not had to deal with a belligerent patient? A violent incident might occur at any time, and staff should be trained to deal with this in a calm, unflinching, and quiet way—above all with patience and the ability to listen to what the patient is saying, while further help is summoned. Each practice should have instructions or guidelines, or both, to safeguard everyone.

Discussion

Many people find health and safety a boring subject, but, after all, it might be a matter of life and death and few of us are bored by that. A coordinated approach to the matter is needed. Start by writing things down under four subject headings. Firstly, the statement of policy. Remember that it must be tailored for your surgery and that it applies to all staff, including nurses, who of course handle potentially more hazardous equipment than clerical staff. Consult your staff and encourage them to help to formulate the statement and to bring to your notice (or that of the health and safety officer if you have one) any changes that need to be made. Finally, remember to date, sign, and distribute the statement.

Secondly, write out a list of the security procedures that need to be followed at your surgery. Ensure that each room is visited at night in case any unauthorised persons are still on the premises. Check window and door locks, and place important items such as your staff and encourage them to help to formulate the statement and to bring to your notice (or that of the health and safety officer if you have one) any changes that need to be made. Finally, remember to date, sign, and distribute the statement.

Thirdly, write out your instructions in case of fire. These should have details of routes to be followed and of where to assemble. Each member of staff should be aware of any designated tasks that they should perform before leaving the surgery to ensure that evacuation is completed—for example, the receptionist checks the patients' lavatories. As everyone is unlikely to be in their designated position at all times ensure that the staff read and understand all the instructions so that they may cover any gaps caused by absences.

Lastly, the Health and Safety Act requires you to ensure that the premises and services are kept in good repair and are suitable for the purposes to which they are put. To do this I suggest that you carry out a regular health and safety audit, which means inspecting the building and its activities, following the guidelines at the end of this paper, writing down anything that needs attention. Try to walk around on a different day and at a different hour each time you carry out your check, and in that way you will cover all activities taking place in your surgery and appreciate their various needs. Instructions on what measures the staff should take in emergencies should be given by the doctors in each surgery and not by the practice manager. The situations that might arise should be examined, and the practice policy made clear to everyone. How safe your surgery is depends on how well you have prepared and trained your staff. Careful thought can make your surgery a safer, healthier place in which to work.

Health and safety audit

- (1) Hygiene
(a) Everywhere cleaned to a good standard
(b) Washing facilities, etc., adequate
(c) Everywhere a tidy and uncluttered
(d) Check disposal of sharp objects and contaminated waste
(2) Ventilation
(a) Everywhere is sufficiently ventilated
(b) Means of ventilation and any equipment used for that purpose regularly checked and maintained
(c) There is no pollution of this air due to fumes from toxic substances

study, indicating that we have probably identified most of the children with asthma.

The following information was extracted from the records: name, age, date of birth, and records of consultations for both groups for the first four years of life and for respiratory symptoms—that is, cough, wheeze, shortness of breath, and sleeping difficulty owing to respiratory symptoms. In group 1 only those consultations before asthma was diagnosed were considered. To compare the two groups only completed years of life were studied so that data from incomplete years were excluded. This procedure applied to those children with asthma in whom the diagnosis of asthma was made before the age of 4, and to those in group 2 who were under 4 at the time of the study. Distribution free methods were used for analysis because the data were not normally distributed. Differences between the two groups were assessed by the Mann-Whitney U test; median and interquartile ranges are presented instead of means and standard deviations.

Results

The table shows medians and interquartile ranges of numbers of consultations categorised into sex, group, and year of life, along with Mann-Whitney U values. In the first year the number of consultations did not differ significantly between the children with asthma and those who were non-asthmatic for either boys or girls. In the second, third, and fourth years there was a significant difference between the two groups—in both sexes the children with asthma consulted more often.

Median and interquartile ranges of numbers of consultations for group, sex, and year, with a number of children between groups

Table with 4 columns: Year, Sex, Group, and Median (IQR). Rows include Asthmatic and Non-asthmatic for Boys and Girls across Years 1, 2, 3, and 4.

The results were confirmed by the median test, a more conservative test than the Mann-Whitney U test. By censoring the data in the year of diagnosis we could conceivably have biased the comparison by attenuating the difference between the groups. Given the results, however, this does not seem to have occurred. If anything, the true difference may even be greater than that reported.

100 YEARS AGO

We learn that the idea of erecting a memorial to General Gordon in the shape of a hospital at Port Said, as unfavourably commented on by many of his admirers, European and Egyptian, in Egypt. It is stated that Port Said is unsuited for a hospital which would do honour to the memory of General Gordon, or be a credit to its promoters. Port Said is a small town almost outside of Egypt, with a few English families in its population, where a British seaman or a rare passenger to or from India may occasionally be sufficient to fill Port Said, and could be kept up at small expense, whereas the elements do not cease for a moment to threaten. One would hope that the memorial hospital will not be for the treatment of English only, but, like other hospitals in Egypt, will be open to Egyptians and others, and be Anglo-Egyptian in character, as Gordon lived much of his life for, and died for, the Egyptian. If so, its usefulness at Port Said would be very limited, and a large institution thrown away. The Egyptians do not repair to Port Said, but gravitate towards two centres, Cairo and Alexandria. At Alexandria, the

English population, rich and poor, is large; it is one of the chief Mediterranean ports where British ships congregate from all parts of England. Englishmen employed in the service of the country, who have no proper home, nor means for proper medical and surgical treatment, repair to Alexandria to enter one of the foreign hospitals there. A large number of British seamen are there left yearly for treatment in a foreign hospital, which has also given hospital to many officers of the army and navy. There is no British hospital in Alexandria, and, of all places in Egypt, it has a strong claim for one, and for many reasons, it is the place best suited for a memorial hospital. The hospitals already existing there would do credit to any city in Europe, but an English hospital is conspicuous amongst them by its absence, though other less wealthy nationalities have theirs. The town possesses a large body of medical men of high scientific acquirements. Egyptians and Bedouin Arabs repair thither from all parts of the country, many of them attracted by the reputation there of English surgery. We hope the Committee will not be too hasty in deciding finally on the place for a hospital memorial, before they have made full inquiries. (British Medical Journal 1884: 709)

Previous studies have estimated consultation rates for respiratory illness in children. The second (UK) national morbidity study for respiratory illness found a rate of 1.26 respiratory consultations a year in the one to four age group. The overall consultation rate for this age group was 3.01 a year. In Livingston New Town a rate of 0.94 respiratory consultations per child a year was reported in 1970; another study in Aberdeen noted 1.3 episodes of respiratory illness per child a year.

Discussion

In our practice we find that children with asthma consult more often than children who are non-asthmatic during their first four years. Although it has been stated that asthmatic children are exposed to the same range of respiratory pathogens as other children, we believe that the "tricky" or hyperreactive nature of their airways leads to increased and persisting respiratory symptoms. Asthma is underdiagnosed and therefore undertreated in the community. It has been argued that it may be impossible to identify children with asthma clinically until overt symptoms and signs of asthma develop. The findings of this study and the evidence that most children with asthma have consulted their doctors with respiratory symptoms by their fourth birthday indicate the potential for an early diagnosis of asthma. The results of this study therefore challenge doctors to consider the diagnosis of asthma in all children who consult frequently for "respiratory" symptoms.

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References

- 1 Levy ML, Bell LC. General practice study of asthma in childhood. Br Med J 1983; 287: 1115-6.
2 Cooper WJ. Practical respiratory medicine. New York: Wiley, 1980: 1717.
3 Astorson M, Morfitt M, Smeaton J, et al. Asthma in childhood. A study of 1970-17. Studies in medical and population medicine No. 26. London: H.K. Lewis, 1974.
4 Duncan AH. The Livingston New Town study. Scottish Health Service No 29. Edinburgh: Scottish Home and Health Department, 1973.
5 Horne JCH, Bagg AB. Family trends in psychotropic and antibiotic prescribing in general practice. Br Med J 1982; 285: 94-6.
6 Underwood TP, Barber JH. General practice study of asthma in childhood. Br Med J 1983; 287: 1023-6.
7 Spriggs ANP, Lee DA, Hay EN. Underdiagnosis and undertreatment of asthma in childhood. Br Med J 1982; 285: 125-7.
8 Spriggs ANP. Childhood asthma being underdiagnosed and undertreated. Br Med J 1978; 2: 312.
9 Lee DA, Whittow NR, Spriggs ANP, Hay EN. Prevalence and spectrum of asthma in childhood. Br Med J 1981; 283: 1264-7.
10 Anderson HR, Heath PJ, Cooper JS, Palmer PJ. Incidence of morbidity, illness, and hospitalisation, and health service factors on drug treatment of childhood asthma. Lancet 1981; 1: 1063.
11 Goldson S. Problems peculiar to the diagnosis and management of asthma in children. BTTA Review 1974; 1: 16.

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