HUMBERSIDE FIRE AND RESCUE SERVICE

People & Development

Health Surveillance and Health Monitoring Policy

Owner	**Executive Director of People & Development**
Responsible Person	**Head of Occupational Health & Wellbeing**
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What we must do well

How we support our communities

We value and support the people we employ

We efficiently manage the Service

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1. INTRODUCTION

The Health and Safety at Work Act (HSAWA) requires Humberside Fire and Rescue Service (HFRS) to ensure (as far as is reasonably practicable) the health, safety and welfare of all employees who may be affected by work activity.

Health surveillance is about having systematic, regular and appropriate procedures in place to detect early signs of work-related ill health among employees exposed to certain risks or hazards and acting on the results to prevent its progression. It is also useful in monitoring the effectiveness of existing controls, though it is not in itself a control measure or a substitute for controlling risk as source.

The provision of appropriate health surveillance will assist the Service in:

- Keeping the workforce healthy
- Complying with legislation
- Managing sickness absence
- Helping to reduce the incidence of claims due to industrial disease.
- Health risks which require health surveillance include noise, vibration and substances hazardous to health. Medical surveillance is carried out by an appointed doctor for asbestos.

'Health surveillance' is not the same as health monitoring, health promotion or health screening'. Health surveillance should be introduced where a health risk has been identified on a risk assessment.

- It should only be used for workers who need it.
- It provides feedback about actions that may need to be taken to prevent further harm and protect employees.
- It allows employees to raise concerns about how work affects their health.
- It provides the opportunity to reinforce employees training and education.
- identifiable disease or adverse health condition related to the work process or tools and equipment used.
- A valid and approved technique available to detect indications of disease or condition:
    - Audiometry – to detect noise induced hearing loss.
    - Spirometry – to detect occupational asthma and other respiratory diseases.
    - Vibration – to detect hand arm vibration syndrome.
    - Asbestos
- It is likely that the surveillance will further protect the health and safety of the workforce and where a baseline is required for measurement against exposure in previous employment.

- Night Workers – to detect health effects of night-time working.
- Routine Health including vision – to detect overall health and deterioration in eyesight.

Core Code of Ethics

HFRS has adopted the Core Code of Ethics for Fire and Rescue Services. The Service is committed to the ethical principles of the Code and strives to apply them in all we do, therefore those principles are reflected in this Policy.

National Guidance

Any National Guidance which has been adopted by HFRS, will be reflected in this Policy.

2. EQUALITY AND INCLUSION

HFRS has a legal responsibility under the Equality Act 2010, and a commitment, to ensure it does not discriminate either directly or indirectly in any of its functions and services nor in its treatment of staff, in relation to race, sex, disability, sexual orientation, age, pregnancy and maternity, religion and belief, gender reassignment or marriage and civil partnership. It also has a duty to make reasonable adjustments for disabled applicants, employees and service users.

3. AIM AND OBJECTIVES

HFRS is committed to establishing and maintaining a positive working environment where the dignity and respect of employees is not undermined. It is committed to working practices that ensure the fair treatment and professional and personal dignity of all its employees. No employee will be treated less favourably on the grounds of race, gender, disability, age, sexual orientation, religion or belief or for any other reason that cannot be justified in job related terms.

HFRS recognises and accepts its duties and responsibilities to ensure, so far as reasonably practicable, the health, safety and wellbeing of its employees and others who may be at risk from its activities. The purpose of this Policy is to ensure employees health is not adversely affected by their work activity.

The document is intended to be a framework, with other sections supplementing it by having in place their own procedures and guidelines. They must reflect the principles of this policy, and dovetail to the Occupational Health and Wellbeing (OH), Human Resources (HR) and health surveillance procedures and reflect the individual needs of their Service units.

All Directorates within the Fire Service must be able to demonstrate compliance with this policy via audit.

Managers may choose to delegate their duties but cannot delegate their responsibilities.

All employees, operational, support staff and volunteers, identified by their manager via risk/COSHH assessment, exposed to the identified risks or hazards in the workplace, and require health surveillance must attend health surveillance appointments either in the OH department, on site at Stations or at their own workstation in relation to DSE assessment. (See Appendix A)

This policy links with the Health, Safety & Environment Statement and should be read in conjunction with it.

4. ASSOCIATED DOCUMENTS

- Equality Impact Analysis
- Legal References
    - The Health and Safety at Work Act (HSAWA) 1974
    - The Management of Health and Safety at Work Regulations 1999
    - The Control of Noise at Work Regulations 2005
    - The Control of Vibration at Work Regulations 2005
    - The Control of Substances Hazardous to Health Regulations 2002 (COSHH)
    - The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).
    - The Control of Asbestos Regulations 2012
    - Work at Height Regulations 2005 (WAHR)
    - The Confined Spaces Regulations 1997
    - Control of Vibration at Work Regulations 2005.
    - Control of Noise at Work Regulations 2005.
    - Data Protection Act 2018 and the UK General Data Protection Regulations (UK GDPR).
    - Hse.gov.uk/health-surveillance
- **National Guidance**
  There is no specific national guidance related to this policy.
- Health, Safety & Environment Statement

5. RISKS AND HAZARDS

Potential risks or hazards which members of both operational and support staff are exposed to and require health surveillance, include substances known to cause

dermatitis or occupational asthma, carcinogens, mutagens, respirable silica dust and biological agents (micro-organisms). Physical hazards for which health surveillance is appropriate include:

- Working with vibrating tools and equipment (Control of Vibration at Work Regulations 2005).
- Working in a noisy environment (Control of Noise at Work Regulations 2005).

Note: Health Surveillance is not required when assurance is obtained that there is no exposure or where exposures that do take place are so rare, short and slight and where there is only a minimal risk of the employee being harmed.

6. LEGISLATION

The Health and Safety at Work Act (HSAWA) 1974 places general duties on employers and employees. Section 2 of the Act requires employers to ensure, so far as is reasonably practicable, the health safety and welfare at work of all their employees.

The Management of Health and Safety at Work Regulations 1999 requires employers to assess the health and safety of their employees so that necessary preventative and protective measures can be identified. Processes of assessment include appropriate health surveillance.

The Control of Noise at Work Regulations 2005 requires employers to provide health surveillance as appropriate and to provide adequate information, instruction and training about risks to hearing.
The Control of Vibration at Work Regulations 2005 requires employers to provide health surveillance to those employees who continue to be regularly exposed above the action value or who are considered to be at risk.

The Control of Substances Hazardous to Health Regulations 2002 (COSHH) requires, where employees are exposed to a substance that is linked to a particular disease or adverse health effect including skin irritation, dermatitis and asthma, employers to provided health surveillance.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

The Control of Asbestos Regulations 2012 places a duty on the employers to ensure that employees who are exposed to asbestos should be “under adequate medical surveillance by a relevant doctor”. A relevant doctor is one appointed in writing by the Health and Safety Executive (HSE) for the purposes of the regulations. Further guidance published by HSE allows for elements of the medical examination to be delegated to suitably trained and competent occupational health nurse or technicians.

The purpose of the Work at Height Regulations 2005 (WAHR) is to prevent death and injury caused by a fall from height. Falls from height are one of the biggest causes of workplace fatalities and major injuries. Common causes are falls from ladders and through fragile roofs. The purpose of WAHR is to prevent death and injury from a fall from height. Processes of assessment include appropriate health surveillance.

The Confined Spaces Regulations 1997 provide guidance on how to carry out work in confined spaces safely. They also provide information on the likely hazards and suitable precautions. Processes of assessment include appropriate health surveillance.

7. EXPOSURE LIMITS AND ACTION VALUES

Noise is measured in decibels (dB). Unwanted sound measured in decibels (dB) includes low-volume nuisance noise all the way up to a value known to cause hearing loss and tinnitus.

Lower exposure action values (EAV) are:

- 80 dB averaged over a day or week. Exposure to this lower of two statutory values (see 5.3) must be eliminated or reduced to as low a level as is reasonably practicable. **Hearing protection must be provided if requested by employees** who should be informed of this right.

Upper exposure action values (EAV) are:

- 85dB averaged over a day or week. Exposure to this upper of two statutory values (see 5.2) must be reduced to as low a level as is reasonably practicable by organisational and technical measures excluding hearing protection. **If unable to reduce the noise level, hearing protection must be provided and worn.**
- Use of a weekly exposure, rather than a daily exposure, may be appropriate where exposure to noise varies from day to day, e.g. the use of power tools on one day but not on others. No allowance should be made for the effects of wearing hearing protection when determining an employee's noise exposure in relation to the upper or lower action levels.

Exposure limit value (ELV)

- 87dB averaged over a week. This is a limit of noise experienced at ear which **must not be exceeded.** *
- See further information in the Health & Safety Noise at Work Policy

Peak sound pressure impact noise

- Peak sound pressure Lower EAV = 135 dB and Upper EAV = 137 dB, ELV =140 dB. Sudden short duration, very loud noise can cause immediate, temporary or permanent hearing damage. *****

* See further information on Health & Safety Noise at Work Policy

Hand Arm Vibration occurs when mechanical vibration is transmitted into the operator's hands via the tool/equipment being used. This generally occurs via the tool handles into the operator's hands.

Vibration magnitude is measured in terms of its acceleration, relating to the total energy entering the hand through the tool handle and the time the tool is used for. A (8) = the daily vibration exposure.

Exposure levels are:

- Exposure action value (EAV), the daily amount above which employers must act to reduce exposure = 2.5m/s2 A (8) which equates to 100 points.
- Employees who regularly operate hammer action tools for > about 15 minutes a day; or some rotary and action tools for > about 1 hour a day are likely to be exposed above the EAV.
- Exposure limit value (ELV), the most vibration an employee may be exposed to on any given day = 5 m/s2 A (8) which equates to 400 points. This is the maximum limit of vibration to which an employee may be exposed to in a working day – their exposure must NOT exceed this level and immediate action must be taken to reduce exposure.
- Employees who regularly operate hammer action tools for > about 1 hour a day; or some rotary and other action tools for > 2 hours a day are likely to be exposed above the ELV.
- The regulations do permit for weekly averaging of daily exposure; however, it is not designed to be used for routine work but rather in response to an emergency situation, e.g., dealing with fallen trees following a storm.

Calculating Exposure

- Health, Safety & Environment Team to carry out Hand Arm Vibration Assessment
- Manufacturers Data.

Hazardous substances: (e.g., chemicals, dust, fumes, fibres), exposure to these substances is controlled by workplace exposure limits (WELs), which are set by the Health and Safety Commission. Workplace Exposure Limits (WELs) are concentrations of hazardous substances in the air, averaged over a specific period of time.

Skin: Staff at risk of occupational dermatitis. Some of the key irritants include latex, wet-work and chemicals or other materials use in the manufacture of personal protective equipment (PPE).

Asbestos: Staff at risk of exposure to asbestos. Asbestos can be found in any building built before the year 2000.

Note: Whilst the OH Physician is performing his face to face assessment with the employee, they will take the opportunity to assess the employee's mental health and wellbeing.

8. FREQUENCY OF SURVEILLANCE

All employees are screened at pre-placement using the confidential pre-placement health questionnaire.

Where the job description/risk assessment indicates that the substantive role involves exposure to any of the above hazards, or in some cases where an individual reports exposure in a previous occupation, base-line health surveillance is carried out prior to commencement in post.

Advice will then be provided to HR Recruitment as to the individual's fitness to carry out the role, including exposure to known workplace hazards. Further surveillance will then be performed as per the schedule for each hazard subject to the results of the surveillance.

Audiometry

Baseline test and then annually for 2 years after baseline test. Then if:

- Results are H1 or H2 – 2 yearly recall.
- Results H3 –yearly recall. Refer to OHA/OHP and for vocational hearing test to be performed by the Training Department.
- Results H4 – Take off the run. Yearly recall. Refer to OHA/OHP and vocational hearing test to be performed by Training Department.
- If dip in 4KHZ notch (if dip new or progressive) repeat test in 1 month if same refer to GP/OHP and treat as HSE Category 3.
- If a dip in 4 KHZ stable across 3 years, then treat as HSE Cat 2 and keep on an annual recall.
- Any unilateral loss of 40 KHZ refer to GP/OHP.
- Any rapid hearing loss of 30 DBA + in one or more frequency then refer for medical assessment and recall as per medical advice.
- If an employee requires a VHT then they should be placed on a 1 year recall for the rest of their employment. At next test if the result remains the same another VHT is not required if the audio result deteriorates then they will require another VHT.

See Appendix B

Spirometry

- Initial baseline at pre-employment.

- Then annual surveillance for 2 years.
- Then bi-annually.
- BA training personnel - 6 monthly surveillance

See Appendix C

Skin

- Yearly surveillance

See Appendix D

Hand Arm Vibration

Research into the potential exposure to HFRS employees, determined that due to the intermittent use of equipment users are within safe limits, their exposure duration is low and do not reach the exposure limits.

Confined space workers

- Every 3 years

See Appendix G

Work at Height

- Every 3 years

See Appendix G

Group 2 License (PSV, LGV, HGV Fork-lift truck drivers)

- Issued at age 21 and is valid until age 45 unless medical fitness changes.
- Thereafter, it is subject to review every 5 years, or shorter periods depending on medical condition until age 65. After age 65 licenses are renewable annually.

Night workers questionnaire

- Annual questionnaire

See Appendix F

General Health

- This includes vision test, urine analysis, general well-being questions.
- Every 3 years.

See Appendix G

Asbestos

- Three yearly questionnaire – Health assessment carried out by an appointed doctor.

See Appendix H

9. HEALTH SURVEILLANCE RECORD KEEPING

CONFIDENTIALITY

All OH staff, both clinical and non-clinical cannot and will not disclose medical information of employees without prior consent of those employees.

OH will provide advice without breaching medical confidentiality by disclosing any medical conditions. This advice should be treated by the recipients as special category data in respect of the Data Protection Act 2018 and the UK General Data Protection Regulations (UK GDPR).

It is a legal requirement to keep health records and any personal information generated by completion of any Health Surveillance activity. We keep electronic records of the information provided to Occupational Health. All personal and special category data that we hold is processed according to the requirements of the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR).

Health records, or a copy, should be kept in a suitable form for at least 40 years from the date of last entry because there is a long latent period between exposure and onset of ill health.

A health record must be kept for **ALL** employees under health surveillance. Records are important because they allow links to be made between exposure and any health effects. The retention of personal data will be in accordance with the Service's Data Protection Policy, the Records Management and Data Quality Policy and recorded in their Information Asset Register.

Each employee health record should include details about the employee and the health surveillance procedures relating to them.

Employee details should include:

- Surname
- Forename(s)
- Gender
- Date of Birth
- Permanent address, including post code.
- National Insurance Number
- Date present employment started.

Recorded details of each health surveillance check should include:

- The date they were carried out and by whom.
- The outcome of the test/screening/check
- The decision made by the OH professional in terms of fitness for task and any restrictions required. This should be factual and only relate to the employee's functional ability and fitness for specific work, with any advised restrictions.

Storage: The record should be kept in a format so that it can be linked with other information (e.g., with any workplace exposure measurements). They should be stored securely.

Access to Health Records: It is good practice to offer employees a copy of their health records when they leave the organisation. Employees can have access to their own health records through a written request. Health records can only be released to third parties, such as the employer, on receipt of the informed written consent of the employee, or by a court order.

What health records should not contain: Health records are different to medical records in that they should not contain confidential medical information. Health records and medical records must therefore be kept separate to avoid breaches of medical confidentiality. Any personal medical information should be kept in confidence and held by the OH professional responsible for the health surveillance programme.

Medical Records: Medical records are compiled by a doctor, OH Advisor, OH Nurse or OH Technician and may contain information shared/obtained from the individual during the course of health surveillance. This information may include clinical notes, biological results and other information related to health issues not associated with work. The information is confidential and should not be disclosed without the consent of the individual. The OH professional should only provide employers with information on fitness to work and any restrictions that may apply in that respect.

10. OCCUPATIONAL HEALTH DEPARTMENT, MANAGEMENT AND EMPLOYEE RESPONSIBILITIES

Occupational Health Responsibility: The OH department is responsible for providing specialist advice to employees and managers in relation to Health Surveillance programmes carried out in the Service including to:

- Identify those applicants during the Health Assessment process who may be at risk in a role, for example applicants who declare asthma and/or blood circulatory diseases such as Raynaud's Disease, carpal tunnel syndrome, applying for role identified as needing HAVs surveillance.
- Initiate the annual health surveillance programmes through management.
- Review all completed health surveillance questionnaires received to the OH department. Taking action where required to arrange follow up appointments with individual members of staff.

- Carry out the relevant health surveillance, discuss the results with the individual member of staff and provide reports to management.
- Provide employees attending OH with appropriate information leaflets relevant to their health surveillance programme.
- Ensure safe storage of individual's health surveillance records.
- Monitor referrals to the department for the number of problems associated with Health Surveillance programmes.
- All assessments will be performed by appropriately trained personnel within the department. Any problems identified will be escalated via the appropriate route i.e. OH Technician to OH Nurse to OH Advisor to OH Physician.

The Occupational Health department will:

- Maintain a relevant health surveillance programme as identified under relevant acts of Parliament and best practice.
- Record health surveillance activity in the employee OH record which must be kept in accordance with data protection legislation.
- Liaise with management and Health & Safety colleagues to clarify and confirm the need for and the type/level or surveillance required.
- Where required, report those cases of ill health effects to the Health & Safety Executive.
- Maintain a register of employees requiring health surveillance kept separately from the employee's occupational health medical records.

Management Responsibility

Managers

Managers of staff identified as requiring health surveillance following risk assessment will be responsible for the following:

- Provide OH with an up-to-date list of current staff requiring health surveillance.
- When contacted by OH ensure all staff requiring health surveillance have completed their health surveillance questionnaire prior to their OH appointment.
- Inform staff of the individual statutory obligation to complete the appropriate health surveillance questionnaire.
- Refer any member of staff who reports health problems associated with their work to OH.

Employees

All employees have a duty of care to take reasonable care of themselves and others who may be affected by their actions as required by the HSAWA 1974 and must:

- Complete their individual health surveillance questionnaires provided to them by their manager and return their completed questionnaires to the OH department.
- Attend OH for any health surveillance programme.
- Inform their manager if they feel or they are experiencing any health problems related to their work, in the workplace.
- Report immediately to line managers all occupational incidents/episodes of occupational ill health, skin conditions, respiratory conditions or hearing loss regardless of severity.
- Report any suspected or confirmed cases of occupation ill health by GP or other specialist to line manager.
- Comply with Health & Safety legislation in the workplace including any recommendations made to practice for example, wearing protection provided by the Service, limiting time spent on vibrating equipment etc.
- Participate in risk assessment processes including reviews following any changes to processes, equipment or substances. Risk assessments are required when ill health or injury may arise from a particular work activity.

- Health surveillance is mandated for all Grey Book members of staff. **Every effort** should be made to attend Health Surveillance Appointments whilst on duty. This can be completed on station or by visiting the OH&W facility in Beverley. If a Health Surveillance appointment cannot be attended whilst on Duty, then the appointment may be attended whilst Off Duty. Individuals are expected to utilise Service vehicles for the appointments were reasonably practical. If a service vehicle is unavailable, then individuals are entitled to claim for their millage to and from the appointment using the Casual Car user process. Individuals can also claim over time for the duration of the appointment. This will be signed off through the individual's operational chain of command.

- Asbestos medical appointments are mandated for all Grey Book members of staff. **Every effort** should be made to attend the Asbestos medical whilst on Duty. If the Asbestos medical cannot be attended whilst on duty, then the medical may be attended whilst Off Duty. Individuals are expected to utilise Service vehicles for the appointments were reasonably practical. If a service vehicle is unavailable, then individuals are entitled to claim for their millage to and from the appointment using the Casual Car user process. Individuals can also claim over time for the duration of the appointment. This will be signed off through the individual's operational chain of command.

If anyone needs any further information / guidance regarding this document, please contact Occupational Health & Wellbeing

APPENDIX A: Roles requiring Surveillance

Areas requiring Health Surveillance	Type of Health Surveillance Required	Where Health Surveillance Performed	Health Surveillance Carried out by:
Operational Roles: Fire Fighter Crew Manager Watch Manager	Audiometry, Spirometry, Vision, Asbestos, HAVs, Work at Heights, Confined Spaces, Skin, DSE, General Health, Night Workers	Occupational Health & Wellbeing, and/or on-site at Stations DSE - By employee and manager at work station	For: Audiometry, Spirometry, Vision, Working at Heights, Confined Spaces, Skin, General Health, Night Workers, DSE Occupational Health Technician and/or Occupational Health Nurse and/or Occupational Health Advisor **For: Asbestos** Occupational Health Technician and/or Occupational Health Nurse and/or Occupational Health Advisor and Occupational Health Physician **For: HAVs** Occupational Health Technician and Occupational Health Physician and Occupational Health Physician

Management and Safety Roles: Station Manager Group Manager Area Manager Chief, Deputy and Assistant Chief Fire Officers Fire Safety Manager Training	Audiometry, Spirometry, Vision, Asbestos, HAVs, Work at Height, Confined Spaces, DSE, Skin, General Health, Night Workers	Occupational Health, and/or on-site at Stations DSE - By employee & manager at work station	See above
Control Roles: Control Manager Crew Manager Control Watch Manager Control Fire Fighter Control	Audiometry, DSE, Night Workers	Occupational Health, and/or on-site at Stations DSE - By employee & manager at work station	See above
Falls Team	Audiometry, Asbestos, Vision, DSE	Occupational Health, and/or on-site at Stations DSE - By employee & manager at work station	See above
Public Safety	Confined Spaces, Work at Height, Asbestos, DSE	Occupational Health, and/or on-site at Stations DSE - By employee & manager at work station	See above
Support Staff	DSE	DSE - By employee & manager at work station	See above
Cleaning Staff	Skin	Occupational Health and/or on-site at Stations	See above

APPENDIX B: OCC_02 Audiometry questionnaire

Reason for Assessment (please tick)	**Pre-Employment**		**Routine Follow up**		**Post Exposure**	

Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call	Location:

Please complete the following questions which will form part of your hearing assessment as required by the 'Controlling Noise at work regulations 2005'. Personal information generated by the completion of this form contributes to a medical view of your fitness for employment or a specific task. Further information may be needed, and your consent will be sought in these circumstances. All information will be kept in strict medical confidence.

- Do you have difficulty hearing?
- Do you wear a hearing aid?
- Are you undergoing or awaiting treatment or investigation for a hearing problem?
- Have you suffered any trauma/injury to your ears? If yes, please describe
- Have you suffered earache/ ear discharge or another ear disease as a child or adult? If yes, please describe.
- Do you have any problems with balance, vertigo, giddiness or dizziness?
- Do you take any medication? If so, please state the name of medication.
- Any family history of deafness? If yes, please describe.
- Have you ever suffered a head injury/ unconsciousness/ concussion? If yes, please describe.
- Do you ever suffer from ringing sounds or tinnitus in your ears?
- Have you been exposed to gunfire/blasts/explosions? If yes, please describe
- Do you have any noisy hobbies? **Please circle those which apply:**
  Motor sports/motorbike use/DIY/disco/concerts/shooting/listening to music using headphones?
  Any other, please describe.
- Do you have trouble understanding normal conversation?
- Have you had ear wax removal? Please indicate when.

PREVIOUS NOISE EXPOSURE

This includes jobs where you have had to shout to be heard, most recent first:

- Previous job (Please indicate how long and when)
  (E.g., Army 1989 for 6 months)
  Hearing protection worn? Yes/No
  Type provided – wool/earplugs/earmuffs/other.

- Previous job (Please indicate how long and when)
  Hearing protection worn? Yes/No
  Type provided – wool/earplugs/earmuffs/other.

- Previous job (Please indicate how long and when)
  Hearing protection worn? Yes/No
  Type provided – wool/earplugs/earmuffs/other.

I confirm that the above information is true and accurate to the best of my knowledge.

Signed by employee: _____

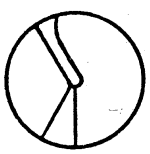
Date: _____

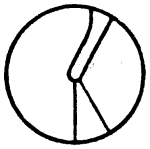
Print name: _____

OCCUPATIONAL HEALTH USE ONLY

At each examination

OTOSCOPIC EXAM





Wax present in canal Left Right

Discharge? Left Right
Tympanic membrane Normal/ Scarred/ Perforated LEFT

Normal/ Scarred/ Perforated RIGHT

Comment:

Temporary Threshold Shift Effects

Exposure to noise in past 24 hours? (Specify)

Hearing protection worn before the test?

RESULTS
HSE Category 1 2 3 4

Unilateral hearing loss?

Fire Service level

ACTIONS

Advice given:

Recall due:

Signed		**Print Name**	
Position	**OH Advisor/ Nurse / Technician**	**Date**	

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APPENDIX C: OCC_20 Respiratory (Lung Function) Assessment Questionnaire

Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call	Location:

Reason for Assessment (please tick)	Pre-Employment		Routine Follow up		Post Exposure	

MEDICAL HISTORY, OCCUPATIONAL & LIFESTYLE QUESTIONS –

Please circle your responses

1	Have you **currently or ever** had heart or lung trouble?	Yes	No
2	Have you ever had or been told you have Asthma or been prescribed an inhaler? **If yes** at what age?	Yes	No
3	Have you **currently or ever** had pleurisy, tuberculosis, bronchitis, any significant chest infection?	Yes	No
4	Are you currently taking any medication? **(please list)**	Yes	No
5	Have you **currently or ever** had any significant chest infection?	Yes	No
6	Have you **currently or ever** had a serious chest injury or operation?	Yes	No
7	Have you **currently or ever** any allergies? E.g. hay fever, animals, dust.	Yes	No
8	Do you currently have a cold/flu/chest or sinus infection?	Yes	No
9	Have you consulted a GP for any chest or breathing problems in the last year?	Yes	No

10	Do you currently smoke, or have you previously smoked? Current Ex-smoker Non-Smoker **If yes** • How many do/did you smoke? • When did you start smoking? • How long have you smoked for? • How many per day? • What do/did you smoke? E.g., Cigarettes, Cigars, Pipe, Vapes • When was your last cigarette?	 Yes Yes Yes	No
11	Do you or have you ever worked with any of the following substances? (please circle which) welding fumes, Isocyanates (e.g., two-pack spray paints), glues and resins, laboratory animals, flour dust, grain dust, latex, glutaraldehyde, coal dust, solder fumes, wood dust, filler dust, any other respiratory sensitiser or irritants? **If yes** to any of the above, How many years where you exposed for?	Yes	No
12	Do you wear respiratory protection at either your primary or secondary job role or hobby?	Yes	No

13	Do you get the following on a regular basis? (please circle which) • Red, sore watery or itchy eyes? • Stuffy nose, nasal catarrh or sneezing attacks? • Early morning cough or cough lasting more than 2 weeks? • Irritation or soreness of the throat? • Wheezing, shortness of breath or chest tightness?	Yes	No
14	Any other health condition or surgery in the last 6 months – e.g., heart attack, angina, high blood pressure, blood clot, stroke, or surgery to the chest, bowel, abdominal or eyes?	Yes	No
15	Are you pregnant?	Yes	No
16	Is this information accurate and correct to the best of your knowledge?	Yes	No

Any additional comments:

_____

_____

_____

_____

_____

_____

SIGNED BY EMPLOYEE: _____

PRINT NAME: _____

DATE: _____

Left intentionally blank

APPENDIX D OCC_25 - Annual – Skin Surveillance Questionnaire

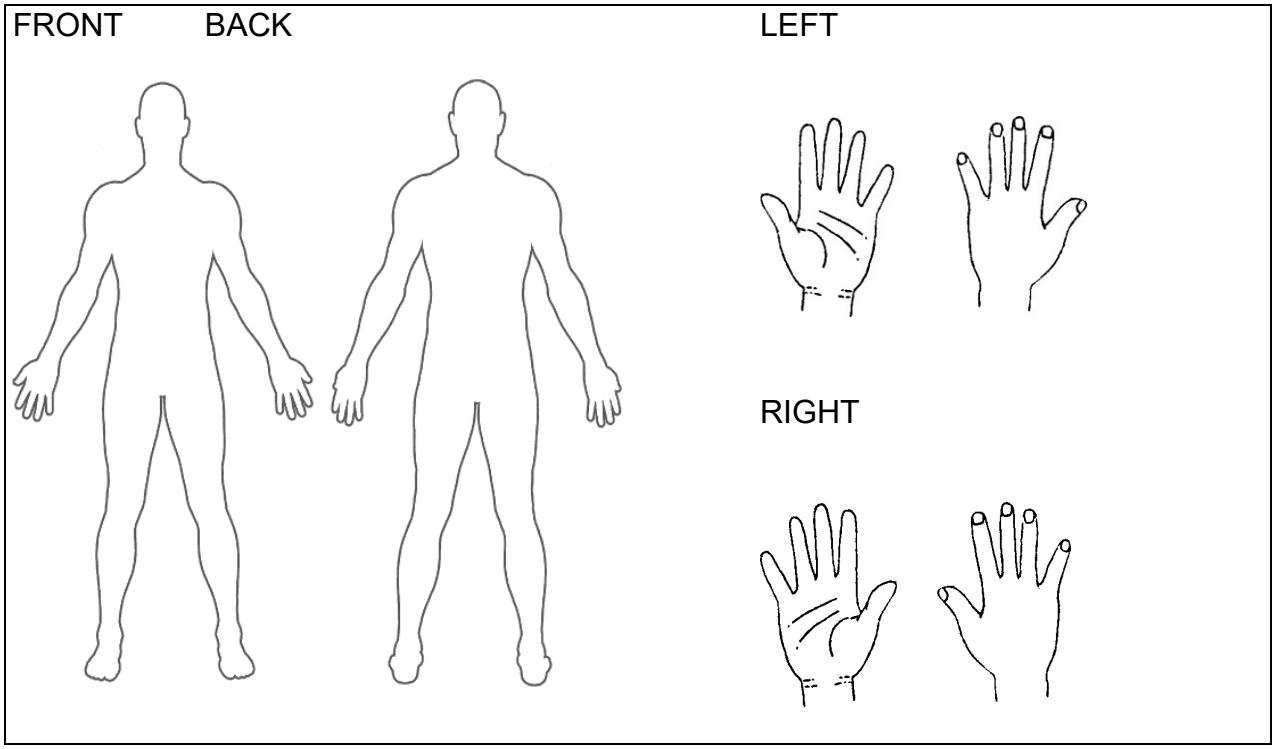
Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call	Location:

Please answer the following questions. If yes, please describe the circumstances around your answer.

1	**Please indicate if any of the following apply or have applied to your skin during this employment** (please tick all that apply). ☐ Blistering ☐ Bleeding ☐ None ☐ Cracking ☐ Dry ☐ Itchy ☐ Flaky ☐ Weeping ☐ Red or discoloured		
2	**Please indicate what Personal Protective Equipment (PPE) is used to protect your skin** (please tick all that apply). ☐ Gloves/Gauntlets/Latex or Nitrile Gloves ☐ Barrier creams ☐ None ☐ Fire issued kit/other protective clothing ☐ Sun creams ☐ After care/Moisturising creams		
3(a)	**Do you come into contact with any of the following during your employment? (please tick all that apply).** ☐ Resins/Adhesives ☐ Birds/Livestock ☐ None ☐ Solvents ☐ Flour/Grains ☐ Oils/Greases ☐ Tar/Asphalt/Creosote ☐ Dust ☐ Chemicals ☐ Cement/Concrete ☐ Other – please state	Yes	No
3(b)	**Do you come into contact with any of the above outside of work? If Yes, please give details.**	Yes	No
4	**Any other significant medical information?** e.g., Allergies, past medical history (please detail).	Yes	No
5	**Are you taking any medication?** including over the counter or herbal remedies (please list).	Yes	No

BODY MAP

Please indicate on the diagram below any areas of damaged skin (please circle)



Comments:

_____
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_____
_____
_____

SIGNED BY EMPLOYEE: _____

PRINT NAME: _____

DATE: _____

OCCUPATIONAL HEALTH USE ONLY

Is this condition likely to be caused or made worse by work related exposure? If Yes, give full details.

Action taken/treatment received for condition (raise management note if required)

Signed		**Print Name**	
Position	**OH Advisor/ Nurse/ Technician**	**Date**	

Left intentionally blank

APPENDIX E: OCC_29 Hand Arm Vibration Questionnaire Tier 1 – Initial Screening Questionnaire - Baseline

INITIAL SCREENING QUESTIONNAIRE FOR WORKERS USING HAND-HELD VIBRATING TOOLS, HAND-GUIDED VIBRATING MACHINES AND HAND-FED VIBRATING MACHINES

DATE……

NAME……

OCCUPATION……

ADDRESS……

……...

DATE OF BIRTH……

NATIONAL INSURANCE NUMBER…….

EMPLOYERS NAME……

1	Have you been using hand-held vibrating tools, machines or hand-fed processes in your job? If yes, please describe type of tool & nature of use.	Yes	No
2	If Yes to Q1: (a) list year of first exposure …….. (b) when was the last time you used them? (detail work history overleaf) .... …… ……..		
3	Do you have any tingling of the fingers lasting more than 20 minutes after using vibrating equipment?	Yes	No
4	Do you have any tingling of the fingers at any other time?	Yes	No
5	Do you wake at night with pain, tingling or numbness in your hand or wrist?	Yes	No

6	Do one or more of your fingers go numb for more than 20 minutes after using vibrating equipment?	Yes	No
7	Have any of your fingers gone white in response to cold exposure? (Whiteness means a clear discoloration of the fingers with a sharp edge, usually followed by a red flush).	Yes	No
8	Is Yes to Q7, do you have difficulty rewarming them when leaving the cold?	Yes	No
9	Do your fingers go white at any other time?	Yes	No
10	Are you experiencing any other problems with the muscles or joints of the hands or arms?	Yes	No
11	Do you have difficulty picking up very small objects, e.g. screws or buttons, or opening tight jars?	Yes	No
12	Have you ever had a neck, arm or hand injury or operation? If so, give details.	Yes	No
13	Have you ever had any serious diseases of joints, skin, nerves, heart or blood vessels? If so, give details.	Yes	No
14	Are you on any long-term medication? If so, give details.	Yes	No

OCCUPATIONAL HISTORY

Dates: **Job Title:**

I certify that all the answers given above are true to the best of my knowledge and belief.

SIGNED:_____

PRINT NAME: _____

DATE: _____

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APPENDIX E: OCC_26 Hand Arm Vibration Questionnaire Tier 2 - Annual

Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call	Location:

Please answer all questions. If Yes, please give further details in the space provided.
Please note that current HAVS regulations require HAV-exposed workers to have a more detailed HAVS assessment periodically, and you will be further notified if this is required.

1	Have you been using hand-held vibrating tools, machines or hand-fed processes in your job? If yes, please describe type of tool & nature of use. Was this in your: Current Job ☐ Previous Job ☐ Since Last Assessment ☐	Yes	No
2	If yes to Q1 above, have you used these tools in the last two years?	Yes	No
3	Please provide date of last screening:		
If you have not been using tools, or it is more than two years since your last exposure (i.e., have answered NO to questions 1 & 2 above) you do not need to complete the rest of this section.			
4	Do you experience any or tingling in your fingers lasting more than 20 minutes after using vibrating equipment?	Yes	No
5	Do you experience numbness or tingling in your fingers at any other time?	Yes	No
6	Do you wake up at night with pain, tingling or numbness in your hand or wrist?	Yes	No
7	Have any of your fingers gone white in response to cold exposure?	Yes	No

8	Have you noticed any change in your response to your tolerance of working outdoors in the cold?	Yes	No
9	Are you experiencing any other problems in your hands or arms?	Yes	No
10	Do you have difficulty picking up very small objects, e.g. screws or buttons, or opening tight jars?	Yes	No
11	Has anything changed about your health since your last assessment? If Yes, please provide details.	Yes	No

Any additional comments:

_____
_____
_____
_____
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_____
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_____

SIGNED BY EMPLOYEE:_____

PRINT NAME: _____

DATE: _____

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APPENDIX E: OCC_27 Hand Arm Vibration Tier 3 Questionnaire - 3 Yearly

Name:	DOB:
Service No:	Job Title:
Full-Time/ On-Call	Location:

Please answer all questions. If Yes, please give further details in the space provided. If you are not currently using tools and it is more than two years since your last exposure, you do not need to complete the rest of this section.

1	Are you right or left handed?	Left ☐	Right ☐
2	Are you currently experiencing problems with your hands/arms? If Yes, please specify.	Yes	No
3	Have you ever had a neck/arm/hand injury (not necessarily at work)? If Yes, please state what and when.	Yes	No
4	Have you ever had an operation on your neck/arm/hand? If Yes, please state what and when.	Yes	No
5	Have you had any serious disease of the joints/nerves/heart or blood vessels? If Yes, please give details.	Yes	No

WORK AND FAMILY HISTORY			
6	Do you currently use vibrating tools in the course of your: Current Employment ☐ Secondary Employment ☐ Hobby ☐		
7	Have you stopped using vibrating tools within the last 12 months?	Yes	No
8	Please list which tools you use/used regularly.		

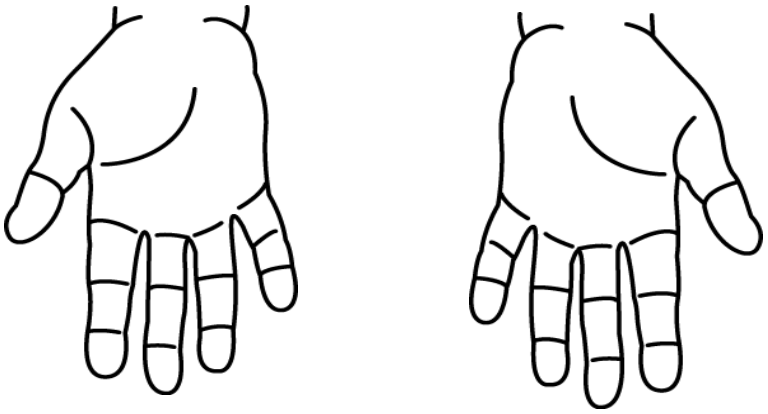
9	Which of the above tools do/did you use most often?		
10	On average, how many hours do you spend in total using vibrating tools each week? ☐ Less than 5 hours per week ☐ Between 5 & 10 hours per week ☐ Between 10 & 20 hours per week ☐ 20 or more hours per week		
11	How many hours did you spend using vibrating tools last week?		
12	How long have you been doing your current job?		

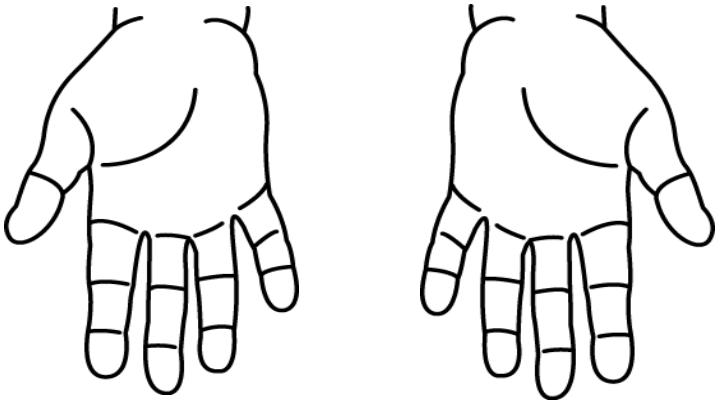
Please list below any jobs you have held outside of HFRS that involved the use of vibrating tools.

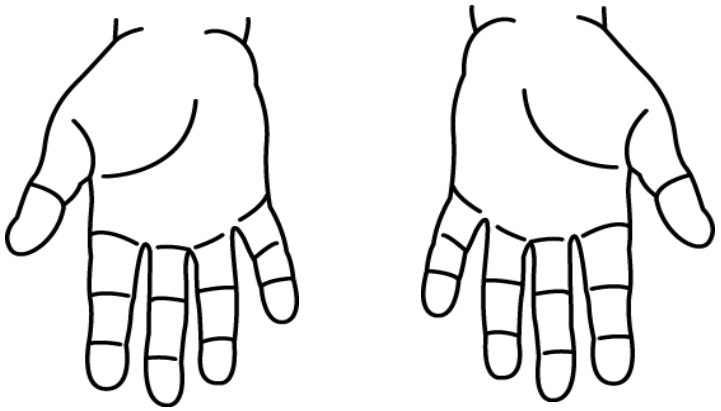
	Hours/Days	Years
----------	----------	----------
----------	----------	----------
----------	----------	----------
----------	----------	----------
----------	----------	----------

13	Do you have any leisure pursuits which expose you to hand-transmitted vibrations? If Yes, please specify.	Yes	No
14	Do you work in the evening or at weekends with vibrating tools outside of work? If Yes, please specify what tools are used.	Yes	No
15	How many minutes/hours per week do you use vibrating tools outside of work? Please delete as appropriate. In summer minutes/ hours (per week) In winter minutes/ hours (per week)		
16	Is there any family history of circulatory problems?	Yes	No
17	Have any members of your immediate family suffered from vibration white finger? If Yes, please give details.	Yes	No

SYMPTOMS BLANCHING			
18	Have you ever had attacks in which any or all of your fingers suddenly becoming cold and numb, and at the same time turning white or pale (blanching)? If so: • Has the attack been brought on by cold, damp or wet conditions? • During the attack, have you noticed a clear edge between the white or pale part of your finger and the normal colour of your hand? • Has this occurred during the past 12 months? • How long have you noticed the blanching?	Yes ☐ ☐ ☐	No ☐ ☐ ☐
	If you suffer from blanching, when does this occur? ☐ All the year round ☐ Only in cold weather ☐ Several times a year ☐ Several times a month ☐ Every day ☐ Several times a day		
20	Is the blanching: ☐ Getting better? ☐ Staying the same? ☐ Getting worse?		
	Do you experience whiteness in your feet or other periphery? If Yes, please state where.	Yes	No

22	Please mark which parts of your fingers are affected by blanching. Right Hand Left Hand 		
TINGLING **(excluding tingling lasting for up to 20 minutes after using vibrating tools)**			
23	Do you suffer from tingling of the fingers? If so: Does this occur in response to cold? Does this occur at the same time as blanching? Does this occur whilst you are working?	Yes ☐ ☐ ☐	No ☐ ☐ ☐
24	Does the tingling occur at any other times (e.g. at night) or disturb your sleep? If so: When does this occur/how long does it last?	Yes	No
25	Do you have any tingling or pain in your forearm (between wrist and elbows)?	Yes	No
26	How long have you suffered from tingling?		
27	Is the tingling: ☐ Getting better? ☐ Staying the same? ☐ Getting worse?		

28	Please mark which parts of your fingers are affected by tingling. Right Hand Left Hand 		
NUMBNESS **(Exclude transient numbness that lasts for less than 20 minutes after using vibrating tools).**			
29	Do you suffer from numbness of the fingers? If so: Does this occur in response to cold? Does this occur at the same time as blanching? Does this occur whilst you are working?	Yes ☐ ☐ ☐	No ☐ ☐ ☐
30	Does the numbness occur at any other times (e.g., at night) or disturb your sleep? If so: When does this occur/how long does it last?	Yes	No
31	How long have you suffered from numbness?		
32	Is the numbness: ☐ Getting better? ☐ Staying the same? ☐ Getting worse?		

33	Please mark which parts of your fingers are affected by numbness. Right Hand Left Hand 		
34	Do any of these symptoms (blanching, tingling or numbness) affect your work? If yes, please give details.	Yes	No
35	Do any of these symptoms affect your leisure activities? If yes, please give details.	Yes	No
36	Do you have difficulty handling or manipulating small objects? If yes, when does this occur?	Yes	No
37	Are you experiencing any problems with the muscles or joints of your hands/arms/wrists/elbows/shoulders, such as pain, stiffness, swelling or weakness? If so, please give details.	Yes	No

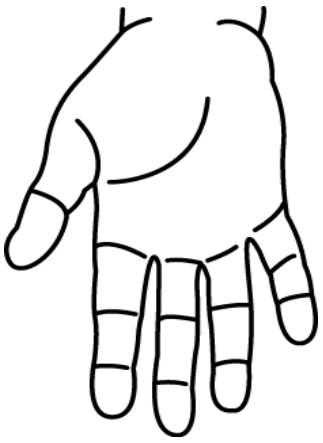
SIGNED BY EMPLOYEE: _____

PRINT NAME: _____

DATE: _____

OCCUPATIONAL HEALTH USE ONLY

ASSESSMENT	YES	NO
Evidence of blanching?	☐	☐
Evidence of tingling?	☐	☐
Evidence of numbness?	☐	☐
Previous assessment for HAVS? (T2 / T3 / T4) Date if known: _____	☐	☐

EXAMINATION	RIGHT	LEFT
Appearance of hands Note any signs of vascular disease, deformity, scars, callosities or muscle wasting.		
Circulation: Blood pressure:	_____/_____ _____/_____	_____/_____ _____/_____

Nervous system: Light Touch: Dexterity: Details of any abnormality:	☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal _____ _____ _____	☐ Normal ☐ Abnormal ☐ Abnormal ☐ Abnormal _____ _____ _____
Function: Grip strength (KG):	1. ___ 2. ___ 3. ___ Average: ___ ☐ Normal ☐ Reduced	1. ___ 2. ___ 3. ___ Average: ___ ☐ Normal ☐ Reduced

SUMMARY		Yes	No
Vascular:	Evidence or history of blanching?	☐	☐
Neurological:	Indications of neurological impairment present? Carpal tunnel syndrome suggested by history or tests?	☐	☐
Musculoskeletal:	Muscular or soft-tissue disorder present?	☐	☐

OUTCOME OF HAVS TIER 3	☐ FIT (Stage 0)	Escalated for further consideration

Comments:

Signed		**Print Name**	
Position	**OH Advisor/ Nurse / Technician**	**Date**	

Left intentionally blank

APPENDIX F: OCC_24 - Annual - Night Shift Questionnaire

Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call	Location:

Please answer the following questions. If yes, please describe the circumstances around your answer.

1	Are you currently in good health?	Yes	No
2	Do you suffer with any medical condition, on-going health issue, psychological disorder or disability?	Yes	No
3	Do any of the above cause any difficulties or issues in relation to working at night?	Yes	No
4	Are you Diabetic?	Yes	No
5	Have you ever suffered faints, fits, blackouts, sudden collapse or epilepsy?	Yes	No
6	Do you have problems being alert during waking hours or suffer with a sleep disorder?	Yes	No
7	Are you taking any medication? If so, please list:	Yes	No
8	Do you have any impairment of vision, or hearing which may impact on your safety at work at night?	Yes	No
9	Do you require any adjustment for any gastro intestinal disorders, or special dietary considerations due to night shift working?	Yes	No

If you would like an appointment to discuss night shift working, in relation to any health issue you have, with an Occupational Health nurse practitioner please indicate:

Yes please /No thank you

Comments:

_____
_____
_____
_____
_____
_____

SIGNED BY EMPLOYEE: _____

PRINT NAME: _____

DATE: _____

Left intentionally blank

APPENDIX G: OCC_19 Routine Health/Confined Space/Work at Heights 3 yearly Assessment Questionnaire

Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call/Support Staff	Location:

Please CIRCLE to indicate if, during your employment you are exposed to any of the following?

Physically demanding work	Breathing Apparatus	Chemicals	Microbiological hazards
Driving	Noise	Lone Working	Display Screen Equipment

Please circle your responses

1	Has your health changed since your last health assessment?	Yes	No
2	Have you consulted your GP or health practitioner since your last health assessment (physio, chiropractor etc)	Yes	No
3	Are you currently receiving or awaiting any medical treatment or therapy?	Yes	No
4	Have you been absent from work due to illness, injury or a health condition in the last 12 months? If yes, please state the number of days and reason for absence?	Yes	No

5	Are you allergic to:	Yes	No
	Any medication?	☐	☐
	Any substance within the workplace?	☐	☐
	Dust?	☐	☐
	Mould?	☐	☐
	Pollen?	☐	☐
	Any household products?	☐	☐
	Any foodstuffs?	☐	☐
	Animal dander, fur or feathers?	☐	☐

6	Do you have a circulatory condition, e.g., angina, heart attack, high blood pressure, chest pain, anaemia, varicose veins, stroke, thrombosis, oedema?	Yes	No
7	Do you have a respiratory condition, e.g., shortness of breath, asthma, bronchitis, pleurisy, pneumonia, TB, emphysema or habitual cough?	Yes	No
8	Are you taking any medication (including over the counter or herbal remedies)?	Yes	No
9	Do you drink alcohol? If yes, how many units per week?	Yes	No Units
10	Are you currently, or have you previously smoked? If yes, how many do/did you smoke per day? For how many years?	Current	Ex - Smoker
11	Have you or do you misuse drugs, alcohol or other substances?	Yes	No
12	Do you have any skin conditions?	Yes	No
13	Do you have a stomach or bowel condition?	Yes	No
14	Do you have a kidney or bladder condition?	Yes	No

15	Do you have diabetes? If yes, please indicate how it is managed - Diet controlled, Medication or insulin?	Yes	No
16	If you have diabetes - Do you have episode of low blood sugar levels?	Yes	No
17	Do you have claustrophobia (a fear of enclosed or confined spaces)?	Yes	No
18	Do you suffer from chronic fatigue syndrome or ME (Myalgic Encephalomyelitis)?	Yes	No

19	Do you have a sleep disorder or any problems being alert during waking hours, e.g., sleep apnoea, excessive daytime sleepiness, insomnia, restless leg syndrome?	Yes	No
20	Have you any conditions affecting your joints, muscles or ligaments, e.g., arthritis, back, neck problems, fibromyalgia?	Yes	No
21	Do you suffer from restricted movement or pain in your neck or back? If yes, please state when and how frequently.	Yes	No
22	Do you suffer from restricted movement or pain in your upper limbs (shoulders, arms, wrists or hands)? If yes, please state when and how frequently.	Yes	No
23	Do you suffer from restricted movement or pain in your lower limbs (hips, legs, knees or feet)? If yes, please state when and how frequently.	Yes	No
24	Do you have a neurological condition, e.g., Seizures or fits, epilepsy, blackouts, sudden dizziness, vertigo, fainting, loss of balance or coordination, collapse?	Yes	No
25	Do you exercise regularly? Please state - What exercise you do and for how long	Yes	No
26	Do you have any mental illness or psychological problems? e.g., Depression, mood swings, psychosis, anxiety, self-harm or attempted suicide? If yes, please give details.	Yes	No
27	Do you have an eating disorder?	Yes	No
28	Do you have a skin condition?	Yes	No

29	Do you have recurrent headaches, migraines?	Yes	No
30	Do you have an ear, nose throat or sinus condition?	Yes	No
31	Do you suffer from hearing difficulties?	Yes	No

32	Do you have an eyesight problem, e.g., colour vision deficiency, reduced distance or close vision?	Yes	No
33	Do you have an eye condition or disease, e.g., glaucoma, loss of vision, double vision or blurring?	Yes	No
34	Do you wear spectacles or contact lenses?	Yes	No
35	Do you have any problems which affect your ability to drive?	Yes	No
36	Do you have any health problems which may affect your ability to wear BA? (Breathing Apparatus)	Yes	No or N/A
37	Do you regularly work alone?	Yes	No
38	Do you have any infectious condition E.g. hepatitis, TB, HIV?	Yes	No
39	Is this information accurate and correct to the best of your knowledge?	Yes	No

Any additional comments:

_____
_____
_____
_____
_____
_____
_____
_____

SIGNED BY EMPLOYEE: _____

PRINT NAME: _____

DATE: _____

Left intentionally blank

APPENDIX H: OCC_28 Asbestos – Non-Licensed - 3 yearly Assessment Questionnaire

Name:	DOB:
Service No:	Job Title:
Full-Time/On-Call/Support Staff	Location:

Please indicate your responses

Occupational Information			
1	Does your work involve working with asbestos containing materials?	Yes	No
2	How long have you been doing this work?		
Respiratory Symptoms			
3	Have you ever, or since your last medical examination had: (a) an injury or operation affecting your chest? (b) pleurisy? (c) pulmonary tuberculosis?	Yes	No
4	Do you usually cough during the day (or at night when on night work)?		
5	Do you usually bring up any phlegm from your chest on most days (or nights) for as much as three months each year?		
6	Do you usually get short of breath when walking with people of your own age on level ground?		
7	During the past three years, or since your last examination, have you had any chest illness, which has kept you from your usual activities for as much as a week? If no, go to question 10.	Yes	No
8	Did you bring up more phlegm than usual in any of these illnesses? If no, go to question 10.	Yes	No

9	How many illnesses like this have you had in the past three years or since your last examination?		
Smoking			
10	Have you ever smoked? If No, this is the end of the questionnaire	Yes	No
11	(a) Do you smoke at present?	Yes ☐	No ☐
	(b) Have you given up smoking in the last month?	☐	☐
	(c) How old were you when you started smoking regularly? **Enter age in years.** (A regular smoker is defined as one who has smoked as much as one cigarette a day, one small cigar a day or one ounce of tobacco a month, for as long as a year)		
	(d) How many manufactured cigarettes do you usually smoke or were you smoking per day?		
	(e) How much tobacco do you usually smoke or were you smoking per day? Enter number of grams (1 ounce = 28 grams)		
	(f) How much pipe tobacco do you usually smoke or were you smoking per day? Enter number of grams (1 ounce = 28 grams		
	(g) How many small cigars do you usually smoke or were you smoking per day?		
	(h) How many large cigars do you usually smoke or were you smoking per week?		
12	**Ex-Smokers Only** How old were you when you last smoked?		

Any additional comments:

_____

_____

_____

_____

_____

_____

_____

SIGNED BY EMPLOYEE: _____

PRINT NAME: _____

DATE: _____

TEST RESULTS (This page to be completed by Occupational Health)				
LUNG FUNCTION	SPIROMETRY ☐ PEAK FLOW ☐ Please attach trace and flow Loop		**Measured**	**% Predicted**
		FVC		
		FEV1		
		FEV1/FVC		
		PEAK FLOW		
Blood Pressure	/	**Pulse -**		
COMMENTS				
.....				
.....				
.....				
.....				
.....				
Signed:		**Print name:**		
Position: **OH Advisor / Nurse / Technician**		**Date:**		

CLINICAL EXAMINATION CONSULTATION NOTES (This page to be completed by OH Doctor)		
Date	Comments (Including CE, clubbing and breath sounds)	Signature

ASSESSMENT OUTCOME (This page to be completed by OH Doctor)		
Certificate of Medical Examination	☐ Yes	☐ No
Further action required:	☐ Yes	☐ No
PLEASE COMPLETE IF FURTHER ACTION REQUIRED		
GP letter issued:	☐ Yes	☐ No
Refer for further investigation:	☐ Yes	☐ No
COMMENTS		
…… …… …… …… …… …… …… …… …… …… …… …… ……		
Signed:	**Print name:**	
Position: OH Doctor	**Date:**	