Estates and Facilities Alert

Reference:	Issued:	Review Date:
EFA/2019/002	**28 Feb 2019**	**28 Feb 2021**

Ingestion of Cleaning Chemicals

Summary

In a recent one-year period there have been eighteen incidents including one death reported to NHS Improvement where patients have ingested cleaning chemicals. This alert aims to clarify existing guidance and emphasises the importance of considering multiple factors in assessing risk to both staff and patients when using these products.

Action

- Bring this alert to the attention of all appropriate managers, staff, specialist advisors and persons undertaking COSHH risk assessments

- Review organisational COSHH policy, risk assessments and associated forms/toolkits to ensure they are accessible to all staff in terms of language and format; taking into consideration the potential for variable degrees of literacy or that English may be a second language

- Undertake a multidisciplinary *in situ* COSHH risk assessment by 7 June 2019 to identify risks in areas where patients are admitted, assessed or receive treatment. The risk assessment should take account of multiple environmental, clinical, and operational health and safety factors, including but not limited to:

    - equipment and therapeutic environment needs of the room/space
    - operation and services undertaken in the room/space
    - staff resource and ability to observe a patient in the room/space
    - patient population risk especially vulnerable groups such as dementia, mental health, children, etc.
    - type of healthcare facility.

- Develop and implement action/mitigation plans ensuring staff are aware of the identified COSHH risk

- Progress on action/mitigation plans should be submitted to executive management for their information and action if required.

Action by

- Estates/facilities
- Clinical leaders – e.g. nurse directors, medical directors
- Health and safety
- Risk management
- Persons undertaking COSHH risk assessments.

Deadlines for action

Actions underway: 07 March 2019
Actions complete: 07 June 2019

Problem / background

Many cleaning chemicals used in healthcare premises are covered by The Control of Substances Hazardous to Health Regulations (COSHH, 2002) requiring that employers have a duty for the protection of employees and others that may encounter such substances. Employers and organisations must ensure all cleaning chemicals are stored and used safely and that all staff receive training appropriate to their job role.

In a recent one-year period there have been 18 incidents* reported to NHS Improvement where patients ingested cleaning chemicals. One patient died, one became critically ill and received treatment in ITU/ICU, and three required assessment in an emergency department.

Products involved included floor cleaner, toilet cleaner, limescale remover, cleaning sprays, cream cleaner, glass cleaner, kitchen and laundry detergents.

In most cases, the cleaning items were either left in areas easily accessible to patients (wards/bedrooms/ toilets) or removed by patients from unattended and/or unsecured cleaning trollies or cupboards. Reports were received from acute, mental health and community providers. Some examples read:

'…. Medication [for an older patient in an acute hospital] was prepared together with a beaker of squash for the patient to take the tablets. The nurse diluted the squash with a small amount of what was understood to be water from the water jug at the bedside. Shortly after the patient became unwell, coughing and producing phlegm. The nurse attended to give the patient a drink using a clear glass and noted the colour and distinctive smell from the jug. The jug was immediately removed and examined, and it was confirmed the liquid was of the same colour and smell as a floor cleaning product.'

Patient [in a mental health unit] …. Disclosed having been sick …. Due to consuming what she described to be a near – full bottle of cleaning spray which she reported stealing from the cleaner trolley earlier this morning when it was in communal areas.

'Patient [in a mental health unit] found in laundry room, lights off around the corner behind hanging clothes. There was a bottle of toilet cleaner next to them and Patient stated they had drunk it. ...Patient was unable to state how much they had consumed and stated that they saw an opportunity and took it and had noticed that the laundry door had been left ajar.

*

The NRLS was searched for incidents reported as occurring between 1st April 2017 and 30th September 2018 and including the keywords 'ingest' [or] 'swallow' [and] 'chemical' [or] 'clean' and these incidents were reviewed to identify those where ingestion of cleaning chemicals had occurred or was suspected to have occurred. We additionally searched StEIS for the same period and located one additional incident not identified in the NRLS search.

Learning from local investigations has suggested the importance that COSHH safety training and notices consider the needs of staff with low literacy or for whom English is not their first language, for example, specific instructions/procedures for decanting cleaning fluids from large containers. Additionally, consideration of adoption of practical measures to allow secure but convenient access to cleaning cupboards to avoid unnecessary journeys to replenish.

Trusts and providers should be particularly mindful of vulnerable patients who may access cleaning chemicals left unattended or unsecured. Areas of concern are that:

- Cleaning chemicals must be safely and securely stored considering vulnerable patient groups who may access such products
- Cleaning chemicals must not be left unattended or in unlocked/unsecured areas/trolleys/cupboards where they may be accessed by vulnerable patients
- Guidance on decanting and dilution of cleaning chemicals must be followed, for example only using a labelled secondary container expressly used for that purpose and not using drinking or other vessels intended for patient or staff use
- Measures to limit/prevent the exposure of patients and staff to ingestion of cleaning products, etc. must be in good working order; for example, locks on cleaning trollies must always work and be fit for purpose with keys removed when not in use
- Work techniques must be followed that avoid or minimise contact with harmful cleaning chemicals and minimise leaks and spills for staff and patients
- Information, training and instruction for employees must be provided appropriate to their job role and in a suitable style of delivery and language.

Distribution

Directors of Nursing, Directors of E& F, Facilities Managers, Risk Managers, Health & Safety

References

Health and Safety Executive COSHH guidance:
http://www.hse.gov.uk/coshh/

Health and Safety Executive risk management guidance:
http://www.hse.gov.uk/risk/index.htm

Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives (2017)
https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

Suicide prevention: resources and guidance – Public Health England (2017)
https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

Health Building Note 03-01: Adult acute mental health units (2013)
https://www.gov.uk/government/publications/best-practice-design-and-planning-adult-acute-mental-health-units

Health Building Note 03-02: Facilities for child and adolescent mental health services (2017)
www.gov.uk/government/publications/facilities-for-child-and-adolescent-mental-health-services-hbn-03-02

Enquiries

This alert has been compiled under a partnership arrangement by the organisations below and it has been distributed across the UK. Enquiries should be directed to the appropriate Regional Office quoting the alert reference number.

England

Enquires should quote reference number EFA/2019/002 and be addressed to:-
nhsi.mb-defectsandfailures@nhs.net

Reporting adverse incidents in England
Defects or failures should be reported on this system: http://efm.hscic.gov.uk/

The web-based D&F reporting system is managed by the NHS and Social Care Information Centre on behalf of the Department of Health. For further information on this system, including obtaining login details, please contact the efm-information Helpdesk. Tel 0300 303 5678.

Northern Ireland

Enquiries and adverse incident reports in Northern Ireland should be addressed to:

Northern Ireland Adverse Incident Centre, CMO Group,
Department of Health
Tel: 028 9052 3868 Email: niaic@health-ni.gov.uk
http://www.health-ni.gov.uk/niaic

Reporting adverse incidents in Northern Ireland
Please report directly to NIAIC using the forms on our website.

Scotland

Enquiries and adverse incident reports in Scotland should be addressed to:

Incident Reporting and Investigation Centre (IRIC)
Health Facilities Scotland, NHS National Services Scotland
Tel: 0131 275 7575 E-mail: nss.iric@nhs.net

Reporting adverse incidents in Scotland
Use our online report form (http://qpulseextweb.nss.scot.nhs.uk/ReportingIRIC) or download the PDF form
Independent facilities which only provide private care should report to the Care Inspectorate.

Wales

Enquiries and adverse incident reports in Wales should be addressed to:

NHS Wales Shared Services Partnership – Specialist Estates Services, 4th Floor, Companies House, Crown Way, Cardiff CF14 3UB

Tel: 029 2090 4118
E-mail: efa.ses@wales.nhs.uk