



Supporting occupational health
and wellbeing professionals



Managing Skin Health at Work

*A Practical Guide for Those Managing Occupational
Skin Disease and Those Undertaking Skin Health Surveillance*

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Introduction

This document is a practical guide for those managing occupational skin disease and those undertaking skin health surveillance.

Occupational skin conditions arise due to work-related exposure to hazards including sensitisers, irritants, wet work, frequent glove use, or an existing skin condition being made worse by exposure to these hazards. Skin cancer, friction and burns may also occur through workplace exposure. Occupational skin conditions account for up to 4% of all notifiable occupational diseases in Europe.¹

Under the Control of Substances Hazardous to Health (COSHH) Regulations,² employers must protect workers from health and safety risks in accordance with the Health and Safety at Work etc. Act 1974,³ the Management of Health and Safety at Work Regulations 1999 (MHSW)⁴ and the Construction (Design and Management) Regulations 2015.⁵ In addition, employers are required to evaluate risks to health, decide on necessary measures to comply with COSHH Regulations 7-13, record assessments, and determine when the assessment needs to be reviewed – Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended).

The Society of Occupational Medicine would like to thank the Skin Special Interest Group who gave their time and expertise in developing these guidelines. This publication does not provide prescriptive rules for individual cases. The Special Interest Group welcomes comments or suggestions regarding this publication. The SOM will assist members by directing specific enquiries about the publication to an appropriate member of the Group. The views expressed do not necessarily represent the views of any particular member of the Special Interest Group but are considered best practice by members at the time of publication. Practitioners are encouraged to seek further specialist advice where appropriate.

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Aims

The document aims to provide comprehensive, clear evidence-based guidance on the roles and responsibilities of those involved in preventing, identifying, and managing occupational skin disease in the construction, manufacturing, and allied industries. It is aimed at non-clinical staff. Health surveillance serves to identify the effects of both acute exposure and prolonged low-dose exposure to weak irritants and other hazards on the skin. Employees with underlying skin conditions may be more susceptible to developing skin disease following exposure to very weak irritants.

This document does not replace reading and understanding of all relevant legislation.

Scope

- This guidance is for human resources staff, managers, health, and safety representatives and appointed responsible people whose duty it is to undertake skin health surveillance. It is not intended for clinical practitioners.
- This guidance is not focused on healthcare workers – other guidance is available for this area – although hazards encountered within healthcare are identified in Concise Guidance to Good Practice, produced by the Faculty of Occupational Medicine,⁶ and Dermatitis: Occupational Aspects of Management 2009, produced by the Health and Work Development Unit.⁷
- The terms “worker” and “employee” have both been used, according to the legislation or practice in question.

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Definitions

Allergic contact dermatitis (ACD)⁸

Allergic contact dermatitis is a form of dermatitis/eczema caused by an allergic reaction to a material, called an allergen. Allergic contact dermatitis is also called contact allergy. Allergic contact dermatitis is a type 4 or delayed hypersensitivity reaction and occurs 48–72 hours after exposure to the allergen.

Occupational allergic contact dermatitis is caused by work-related exposure to a sensitiser. At-risk occupations include metal workers, hairdressers, beauticians, healthcare workers, cleaners, painters, and florists. It is a diagnosis that can only be made by a specialist test called patch testing, which is carried out by a dermatologist specialised in contact allergy.

Once developed, the allergy persists lifelong, and it often worsens with subsequent exposure. The only remedy is to remove exposure, in the form of redeployment.

Annotation Sk

Can be absorbed through the skin. The assigned substances are those for which there are concerns dermal absorption will lead to systemic toxicity.

Clinical/Medical Notes/Records

Clinical notes are medical records kept in medical confidence by the responsible occupational health professional. They may contain confidential clinical notes and test results. These notes can only be accessed and shared with the written consent of the worker, e.g. where that information would “need to be known” by the employer. Medical practitioners are accountable to their code of practice with the Nursing and Midwifery Council or the General Medical Council to record and maintain accurate medical records. Other occupational health service employees may have access to clinical notes and will be bound by the confidentiality agreement not to disclose confidential clinical information.

The clinical notes are considered to be “sensitive personal data” for the purposes of the Data Protection Act (DPA) 2018⁹ and as such cannot be processed without the consent of the employee.

See also Health Record(s) as to the difference. These are kept separately.

Competent Person/Practitioner

The Management of Health and Safety at Work Regulations 1999¹⁰ state that employers must appoint a competent person to enable them to meet their health and safety obligations.

As defined by the Occupational Safety and Health Administration (OSHA), a competent person/practitioner is someone who “is capable of identifying existing and predictable hazards in the surroundings or working conditions which are unsanitary, hazardous, or dangerous to employees, and who has the authorization to take prompt corrective measures to eliminate them”.¹¹

For occupational health purposes, a competent person/practitioner is defined by Regulation 7 of the Management of Health and Safety at Work Regulations 1999¹² as having “sufficient training and experience or knowledge and other qualities” to do the job in health protection.

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Definitions (cont)

A competent person/practitioner need not have formal qualifications, though it would be advantageous. It is also the business's responsibility to provide the competent person with adequate information and support such as adapted risk assessments.¹³

The terms competent person/practitioner can be interchangeable with 'responsible person'.

The Health and Safety Executive (HSE) explains that if you're not confident in your ability to manage your health and safety responsibilities in-house, or if you are a higher-risk business, you can appoint an external professional as a source of competent health and safety advice.

If health and safety professionals are Institution of Occupational Safety and Health (IOSH) members, they need to abide by the code of conduct guidance and disciplinary procedures to ensure they are competent to undertake the proposed work.¹⁴

The occupational health service does not replace the requirement to appoint a competent person/practitioner or to provide risk assessments for identifying individual needs for health surveillance.

See also Responsible Person.

Contact urticaria (hives)

This is a hypersensitivity reaction. Contact urticaria gives a brief hive-like rash shortly after contact with a particular compound or chemical, for example latex. Contact urticaria is associated with proteins in food and latex gloves. The reaction can be immediate or delayed.

Hazardous substances

A hazardous substance is any substance, including liquids, gases, solids, powders, granules, dust fumes, medication, bodily fluids, and process by-products (waste), with the potential to cause harm.

Health record(s)/Management records^{15,16}

'A health record is a legal record of the outcome of health surveillance. Employers must keep them for all workers under health surveillance. 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 any breaches of medical confidentiality.

Health records must contain information about the worker's details, where they work, the hazards they have been exposed to and their fitness to continue to be exposed to those hazards. They should not contain confidential medical information unless you have the worker's written consent.'

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Definitions (cont)

What information should be included in health records?

Health records should include details about the employee and the related health surveillance procedures.

Employee details should include:

- Surname
- Forename(s)
- Gender
- Date of birth
- Permanent address, including postcode
- National Insurance number
- Date present employment started
- A historical record of jobs in this employment involving exposure to identified substances requiring health surveillance

Recorded details of each health surveillance check should include:

- The date they were carried out and by whom
- The results of the checks carried out
- The results of decisions made by an appropriately qualified doctor or nurse on the employee's fitness for continued exposure, or any restrictions they have advised, where skin problems are identified
- Whether increased health surveillance is required
- The date of, or the interval before, the next health surveillance check

See also Clinical Notes/Medical Records for the difference. These are kept separately.

Health surveillance^{17, 18}

Health surveillance can be defined in various ways. In the context of this guideline, it is a strategy or method to systematically detect and assess the adverse effects of work or workplace exposures on the health of workers.

Irritant

An irritant is a chemical or biological agent which is not corrosive but causes a reversible inflammatory effect on living tissue by chemical action at the site of contact. This can be an acute irritation called acute irritant contact dermatitis, or a chronic irritation, which develops over a prolonged period. Both types are reversible, and symptoms often resolve on cessation of exposure.

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Definitions (cont)

Irritant contact dermatitis – occupational (ICD)¹⁹

Occupational irritant contact dermatitis is the most common type of occupational contact dermatitis. It can occur when the employee has workplace contact with substances such as wet work, detergents, alkalis, solvents, or friction. It occurs at the site of contact. Irritant contact dermatitis is a non-immune response. Signs include redness of the skin, blisters, scales, or crusts. Lighter skin can become red, and darker skin can become dark brown, purple, or grey.

For example, pepper spray is a severe eye irritant, but causes no lasting effects.

Medical records (which may include clinical notes)^{20, 21}

‘Medical records must be kept in medical confidence by the occupational health professional responsible for the health surveillance scheme. They may include confidential clinical notes, test results and more general information about workers’ health.’

Clinical records, sometimes referred to as medical records, are compiled by a doctor, nurse or technician and may contain information obtained from the individual during an occupational health consultation/health assessment. This information may include clinical notes, biological results and other information related to health issues not associated with work.

For the purposes of the Data Protection Act (DPA) 2018, the clinical record is considered to be “sensitive personal data” and as such cannot be processed without the consent of the employee.

Must²²

The General Medical Council (GMC)’s definition of “must”: “You must” is used for an overriding duty or principle.’

Occupational exposure limit (OEL)²³

Occupational exposure limits (OELs) indicate the level of admissible exposure for a length of time – usually 8 hours (and a 40-hour work week) – to a chemical or physical hazard that is not likely to affect the health of a worker. These are guidelines and do not provide definitive levels of “safe” and “unsafe”, which depend on levels of control and human factors such as behaviour for example.

An OEL is the maximum concentration of a harmful substance that a person can be exposed to without getting sick or hurt. For example, you can clean with household bleach, but if the bleach is strong and you smell it for too long, you could get bleach poisoning.

Oil acne

Oil acne is an inflammation of the hair roots from mineral oils such as cutting oil, which results in small boils on the skin called pustules.

Responsible person²⁴

A responsible person is someone in your organisation who is given the responsibility to help deliver a health surveillance system from within the workplace. Following instruction from a medical practitioner, such as an occupational health practitioner, the responsible person is deemed competent to recognise the signs and symptoms of

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Definitions (cont)

workplace skin conditions. The responsible person reports on their findings to their employer but also requires access to a suitably qualified person, such as an occupational health practitioner. The responsible person must not make a diagnosis and must keep any clinical notes/records confidential. A responsible person should access training once every three years. See also Competent person.^{10, 11, 12, 13, 14}

Responsible officers²⁵

The Medical Profession (Responsible Officers) Regulations 2010 Responsible Officers Regulations give specified senior doctors (responsible officers) in certain organisations (designated bodies) functions that ensure all doctors work within a managed environment in which their performance, conduct and behaviour are monitored against agreed national standards. (Whilst these are not referred to in this document, they have been included for clarity regarding the term 'responsible person'.)

RIDDOR²⁶

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (1997 in Northern Ireland) place duties on employers to report a wide range of work-related incidents, injuries and diseases to the Health and Safety Executive (HSE) or to the nearest local authority environmental health department.

Dermatitis is reportable when associated with work-related exposure to any chemical or biological irritant or sensitising agent. This includes any chemical with the warning 'May cause sensitisation by skin contact', or 'Irritating to the skin'.

A reportable disease must be diagnosed by a doctor. Diagnosis includes identifying any new symptoms or any significant worsening of existing symptoms.

Only responsible persons including employers, the self-employed and people in control of work premises should submit reports under RIDDOR.

Risk

The possibility that a harmful event arising from exposure to a substance, or mixture of substances, may occur under specific conditions.

Risk assessment

A five-step process similar to general risk assessment:

1. List hazardous substances
2. Assess hazards to health from substances and who might be exposed
3. Determine suitable control measures
4. Implement control measures (eliminate, reduce, isolate, etc.)
5. Review

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Definitions (cont)

Risk control measures²⁷

Risk control measures are workplace precautions put in place to reduce the risk to a tolerable level.

Sensitiser

A skin sensitiser or allergen is a substance capable of causing allergic contact dermatitis. Skin sensitisers can penetrate the barrier of the layer of the skin to provoke an immunological response. It takes about seven days to complete the process of sensitisation and after that time any further skin contact with the sensitiser will cause allergic contact dermatitis. Skin and respiratory sensitisers can produce different allergic mechanisms.

A higher level in the concentration of the sensitiser is required to induce the initial sensitisation and, thereafter, a weaker level. Even a very low concentration of the sensitiser will produce a reaction. Reactions typically worsen in severity with each subsequent exposure, and sensitisation is permanent.

Sensitisation can occur following the very first contact or, progressively, following repeated contact. Sometimes a sensitiser may be tolerated for many years before a reaction occurs.

Skin integrity

Skin integrity means that the skin is healthy, undamaged, and able to perform its basic functions. A skin integrity issue might mean the skin is damaged, vulnerable to injury or unable to heal quickly.

Should²⁸

“You should” is used when we are providing an explanation of how you will meet the overriding duty. “You should” is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you follow the guidance.

Wet worker; wet trades²⁹

Wet work is defined as long-lasting or repeated contact with water. Long-lasting means two or more hours per day and repeated means washing hands more than 20–25 times a day, or wearing occlusive gloves for a cumulative time of two hours or more, in any 24-hour period.

Workplace exposure limits (WELs)³⁰

WELs are British occupational exposure limits and are set to help protect the health of workers. WELs are concentrations of hazardous substances in the air, averaged over a specified period, referred to as a time-weighted average (TWA). Two time periods are generally used: long-term (eight hours) and short-term (15 minutes).'

They may also be expressed as a workplace environmental exposure limit (WEEL). For example, the OSHA PELs (Permissible Exposure Limits) for methyl chloride is 100ppm per eight-hour TWA.

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Key Messages

Emphasis should be placed on the hierarchy of controls³¹ model and on risk assessments, in descending order of effectiveness:

- Elimination – where possible, physically remove the hazard.
- Substitution – replace the hazard with a less hazardous substance.
- Engineering controls – isolate people from the hazard.
- Administrative controls – change the way people work, such as their work pattern.
- PPE (the final control option) – protect the worker with equipment. Where PPE is required, employers must make sure workers have sufficient information, instruction, and training for its use, and it must be provided free of charge.

Management responsibilities increase the further down the hierarchy, for example maintenance regimes for respiratory protective equipment (RPE) use such as issuing new filters, and ensuring face fit with clean shaving (if applicable). The lower down the hierarchy, the greater the reliance on human behaviour, human reliability, and the potential for human failure.

Health surveillance is legally required where work undertaken by employees has the potential to cause a specific disease or if the employee is exposed to any substance and process specified in Schedule 5 of the COSHH Regulations. The risk assessment must be suitable and sufficient and the following three factors all apply:

- If it is likely that certain disease(s) will occur under the work conditions.
- There is a valid way to detect the disease.
- Health surveillance will benefit the employee.

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Triggers for Occupational Skin Disease

Occupational skin disease is common, and the most common reaction of penetration through the skin is dermatitis. This can be irritant or allergic in nature. A substance must first penetrate the surface layer of the skin to provoke a reaction; other hazardous substances may pass through it and damage other parts of the body.

Contact with skin sensitisers can result through:

- immersion in solutions
- contact with contaminated tools
- contact with contaminated clothing or surfaces – including contact with contamination inside protective gloves and with other clothing, e.g. trousers, overalls
- sensitisers landing on or splashing the skin directly, including airborne dust.

The factors that determine the likelihood of developing occupational skin conditions are:

1. the strength or the hazard, including irritants and sensitisers
2. the frequency and duration of the exposure
3. worker-related factors, including underlying skin conditions and disregard for safety measures, personal hygiene, and PPE use.

Examples of skin hazards

- Water-based detergents, liquids, alcohol gels and chemicals can cause dermatitis.
- UVA and UVB sun rays can cause solar damage and skin cancers.
- Foods including citrus fruits, flour, fish, meat, and vegetables account for 40% of dermatitis cases.
- UVC rays (the shortest form of UV) from arc welding can result in eye damage, skin cancer and ocular melanoma.
- Mechanical oils, greases, solvents and cutting fluids can result in dermatitis.
- Resins, adhesives, paints, and sealants can result in allergic contact dermatitis.
- Dust, powders, and airborne substances can irritate the eyes, skin, and respiratory tract.
- Abrasion from handling of tools, components and materials which can result in mechanical trauma.
- Sweating from wearing PPE such as gloves and safety footwear can cause skin irritation and dermatitis.
- Wet work – prolonged or repeated contact of hands with water can cause dermatitis.
- Cold conditions: indoors or outdoors can cause dermatitis and chilblains.

Hazards the employee is exposed to that may not be in the workplace, e.g. detergents, foods, outdoor hobbies.

A comprehensive guide to hazards in particular industries is available in Appendix 1 Hazards by Occupation and Appendix 2 Examples of Hazards by the Classification, Labelling and Packaging (CLP) Regulation/the Globally Harmonized System of Classification and Labelling of Chemicals (GHS); the Health Hazard Codes; and the R Safety Phrase.



Health Surveillance Key Considerations and Benefits

- Should only be used for employees who need it.
- Provide feedback about actions you may need to take to prevent further harm and protect employees.
- Allow employees to raise concerns about how work affects their health.
- Provide the opportunity to reinforce employees' training and education and employee ownership and involvement.
- Illustrate the company cares about its employees.
- Allow for employee consultation.

Legal Issues

In addition to the requirements stated under COSHH to undertake a risk assessment and health surveillance – where indicated, following a confirmed diagnosis of occupational dermatitis (where the person's work involves significant or regular exposure to a known skin sensitiser or irritant by a medical practitioner – the responsible person will be advised that contact dermatitis is reportable under Regulation 8 of RIDDOR,²⁶ (which is then the responsibility of the employer). Failure by an employee to attend assessments or participate in the skin health surveillance programme should be referred to management and/or Human Resources. Employees who do not cooperate could, unknowingly, exclude themselves from certain work.

Clinical Responsibility and Competency

Refer to the Royal College of Nursing (RCN) Skin Disease Competency Framework.³²

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Assessment of Risk

Legislation and Skin at Work

The law requires employers to adequately control exposure to hazards in the workplace that cause ill health. A hazard is the potential of a substance to cause harm or adverse effect. Risk is the probability or likelihood of harm from that hazard and is usually dependent on the nature and extent of the exposure.

Under the Management of Health and Safety at Work Regulations 1999, the minimum an employer must do is:

- identify what could cause injury or illness in your business (hazards)
- decide how likely it is that someone could be harmed and how seriously (risk)
- take action to eliminate the hazard or, if this isn't possible, control the risk.

Employers and employees must also comply with the Control of Substances Hazardous to Health Regulations (COSHH) 2002.²

The Regulations require employers to:

- assess risk
- provide adequate control measures and ensure they are being used and maintained
- monitor the effectiveness of the controls
- provide information, instruction, and training
- provide health surveillance in appropriate circumstances.

Completing and recording a risk assessment

Refer to:

- Appendix 3 Reference Guide for Managers/Responsible Persons
- Appendix 4 COSHH Risk Assessment Proforma (Example)

Risk assessments should be undertaken by a competent person. In most workplaces, this will be done by the health and safety team/professional or an external safety practitioner/consultancy.

A useful source of the likelihood of risk from a potential hazard are the manufacturers' data sheets, which include the potential effects of exposure to a substance in its various forms. Categorisation has been updated from Risk (R) phrasing to Hazard H Statements and, most recently, the Classification, Labelling and Packaging (CLP) Regulation. Some Material Data Sheets (MDS) may still only contain R phrasing H codes or CLP Statements. See the two examples below:

- [SAFETY DATA SHEET TORCURE MC METALLIC PRIMER](#)
- [F38 ISOCYANATE](#)

REFERENCES

2. The Control of Substances Hazardous to Health Regulations 2002 (COSHH), SI 2002/2677. Legislation.gov.uk. Available at: <https://www.legislation.gov.uk/uksi/2002/2677/made> [Accessed 30 June 2023]



Assessment of Risk (cont)

Occupational Health can input into the process by reviewing how the work is done, reviewing the clinical signs or symptoms observed by groups of workers and whether controls may change or increase the risk from the existing or the new hazard.

The safety professional should use a risk assessment template to help keep a simple record of:

- who might be harmed and how
- what is already being done to control the risks
- what further action needs to be taken to control the risks
- who needs to carry out the action
- when the action is needed by
- a suitable review date (when there are any changes to the work, or a suitable periodic review, e.g. every 6–12 months).

Controlling risk from a hazard

The Hierarchy of Controls³¹ and the HSE's eight generic principles set out in Schedule 2A Principles of Good Control Practice approach specifically for COSHH³³ use a systematic approach to reduce risk in the workplace. The controls are ranked in order of effectiveness, with PPE as a requirement when all other controls cannot reduce the risk sufficiently. The controls include the following headings in order of priority:

- Elimination – where possible, physically remove the hazard
- Substitution – replace the hazard with a less hazardous substance
- Engineering controls – isolate people from the hazard
- Administrative controls – change the way people work, such as their work pattern
- PPE – protect the worker with equipment. Where PPE is required, employers must make sure that workers have sufficient information, instruction, and training for its use, and it must be provided free of charge

The first consideration should be to prevent exposure through:

- Eliminating the substance with the potential to cause health effects following skin contact (for example, using a scraper to remove paint instead of paint stripping with a solvent).
- Substituting the substance. Choose something less hazardous (for example, replacing an aggressive cleaning product with a milder one or even changing the form of a substance such as changing a powder to a less dusty pellet form).

Where adequate control of exposure cannot be achieved by other means, provide suitable personal protective equipment (PPE) in combination with other control measures.

REFERENCES

31. Hierarchy of Controls. National Institute for Occupational Safety and Health. Available at: <https://www.cdc.gov/niosh/topics/hierarchy/default.html#:~:text=The%20hierarchy%20of%20controls%20is,Elimination> [Accessed 30 June 2023]
33. Principles of good control practice. Hse.gov.uk. Available at: <https://www.hse.gov.uk/coshh/detail/goodpractice.htm> [Accessed 30 June 2023]



Health Surveillance

High-and low-level skin surveillance³⁴

The successful implementation of health surveillance is only possible when managers take effective steps to assess and control risks. It is the responsibility of managers to inform Occupational Health of those staff requiring health surveillance.

Refer to Appendix 5 Example Letter to Employee to Participate in skin health surveillance.

HSE guidance describes the requirement for high- and low-level skin surveillance in specific workplace exposure circumstances.

High-level skin surveillance is appropriate for employees when high-risk agents are in use and the nature and duration of skin contact have the potential to cause harm:

- Any product labelled with the hazard statement 'May cause sensitisation by inhalation and skin contact'.

Best practice high-level surveillance requires a questionnaire and skin examination:

1. at baseline*, plus skin examination
2. in week 6 (from the start of exposure)
3. in week 12
4. annually.

*Baseline is defined as the time prior to when an individual is first exposed to any hazards – not necessarily the date the employment or training begins on.

Whenever a skin problem is identified in the questionnaire, this must be followed up by a visual skin examination and documentation of the findings.

Low-level skin surveillance is appropriate when:

1. The handling process would usually prevent direct skin contact.
2. Control is adequate.
3. There is only occasional or potential exposure to a sensitiser.
4. There is only suggestive evidence of a hazard.

In low-level skin surveillance, following baseline assessment, employees will complete an annual questionnaire. If symptoms are detected, they will be asked to attend a skin examination, and the frequency of surveillance may need to be increased in addition to reviewing the risk assessment and control measures.

REFERENCES

34. Health surveillance. Higher and lower-level health surveillance. Hse.gov.uk.
Available at: <https://www.hse.gov.uk/skin/professional/health-surveillance.htm> [Accessed 30 June 2023]



Health Surveillance

When the task involves very small amounts of substances, even if these are harmful, when there is little chance of them coming into contact with the skin, the risk is low. But the risk in a different task – such as dealing with spillages, contact with open skin lesions, or prolonged use – will be higher because the harmful substance may be breathed in or get onto the skin.

In both high- and low-level surveillance, employees are encouraged to take an active role in monitoring their skin health at work and are advised to report any skin changes to their line manager, who may refer them to Occupational Health for further guidance.

The HSE 'Skin Checks for Dermatitis' information poster can be displayed in the work areas and include the contact's name, for employees to report any work-related skin problem.

Refer to the Skin Checks for Dermatitis poster.^{35, 36}

Facial skin irritation from surgical mask-wearing does not necessitate skin surveillance and can be managed with advice from Occupational Health on the use of emollients as a hydrating skin barrier.

Taking a Skin History (Guidance for the Competent Person)

An occupational health dermatological history taken as part of health surveillance should include the following information:

Refer to Appendix 6 Aide Memoire for Skin Assessment.

REFERENCES

35. Skin checks for dermatitis. Hse.gov.uk. Available at: <https://www.hse.gov.uk/skin/posters/skindermatitis.pdf> [Accessed 30 June 2023]

36. Keep Your Top On, INDG147, Health Risks From Working In The Sun. Advice For Outdoor Workers From The Health And Safety Executive And The Health Departments In England, Scotland And Wales. Hse.gov.uk. <https://books.hse.gov.uk/product/9780717667215/Industry-Guidance-INDG/Keep-Your-Top-On-INDG147-Leaflet-pack-of-10> [Accessed 30 June 2023]



Basic Screening Information

- Full name³⁷
- Age³⁷
- Gender
- National Insurance number³⁷
- Address³⁷
- Contact number
- History of skin complaints (most notably eczema)
- Allergies
- Hobbies (e.g. model making, gardening, metal or woodworking, food handling)
- Place of work
- Date of commencement in post
- Job role^{38, 39}
- Exposures at work (chemical, biological, UV, radiation, physical trauma)³⁷
- Handwashing frequency and use of gloves
- Control measures in the workplace including protective equipment, ventilation, and enclosure³⁷

These screening questions help the responsible people undertaking skin surveillance identify skin problems which are underlying (endogenous) or the result of workplace exposure. They are not for the purpose of diagnosis or clinical management. Any individuals with skin problems should be referred to a medical practitioner for further assessment. Dermatitis may only be diagnosed by an occupational health physician as best practice and by a medical practitioner in the event of this provision not being available or if the condition is clearly not work-related. Where referral to the general practitioner is likely to be delayed, then it would be preferable to seek a referral to the occupational health physician.

Does the worker report any problems with their skin?

If they do not, proceed to the visual skin assessment.

REFERENCES

37. G403 COSHH Essentials: General guidance. Health surveillance for occupational dermatitis. Hse.gov.uk. Available at: <https://www.hse.gov.uk/pubns/guidance/g403.pdf> [Accessed 30 June 2023]
38. How do I prevent skin problems in my business? Hse.gov.uk. Available at: <https://www.hse.gov.uk/skin/employ/prevention.htm> [Accessed 30 June 2023]
39. G403 COSHH Essentials: General guidance. Health surveillance for occupational dermatitis. Available at: <https://www.hse.gov.uk/pubns/guidance/g403.pdf> [Accessed 30 June 2023]



Basic Screening Information (cont)

If they describe a skin problem, the following questions will help assess it in more detail:

- Where is the affected skin?
- When did the problem start?
- Are there any associated symptoms – itching, burning, soreness, pain, weeping, oozing, blisters?
- Is it there all the time or does it improve when away from work, such as during holidays?
- Is there anything that makes the condition better?
- Is there anything that makes the condition worse?
- What does the employee think may be causing their skin problem?

Once the relevant information is documented, the assessor can proceed to a visual skin assessment.

Visual Skin Assessment

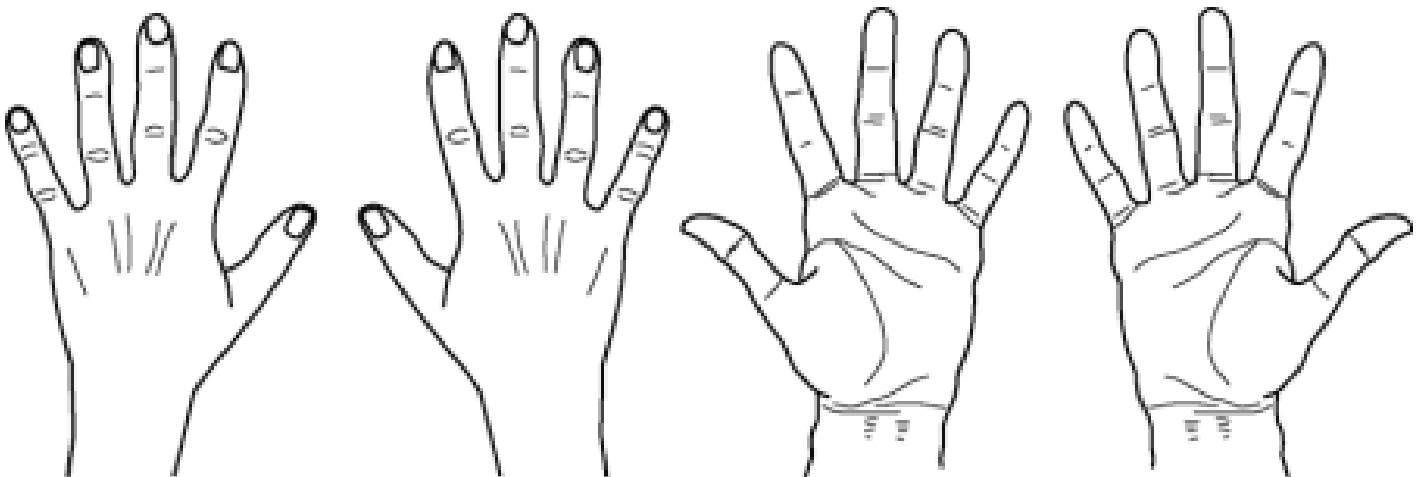
Mark on the diagram any of the following and grade from 1 (mild) to 5 (severe), e.g. D4, R3

Dryness, **R**edness, **C**racking, **B**listers, open **S**ores, **B**leeding, signs of **I**nfection

Refer to Appendix 6 Aide Memoire for Skin Assessment for the diagram.

If they report no issues and the visual examination is normal, this is an opportunity to discuss control and prevention measures^{40, 41} as part of ongoing employee training and education, and skin surveillance can be repeated in 12 months.

HANDS



REFERENCES

40. Skin at work. Hse.gov.uk. Available at: <https://www.hse.gov.uk/skin/employ/prevention.htm> and the HSE Skin at Work website <https://www.hse.gov.uk/skin/> [Accessed 30 June 2023]

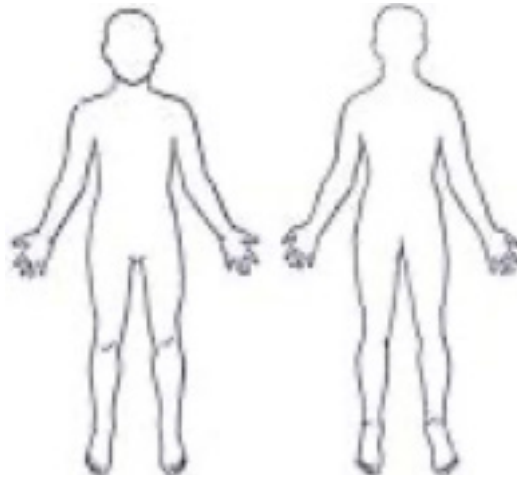
41. It's in your hands. Publications. Hse.gov.uk. Available at: <https://www.hse.gov.uk/skin/professional/publications.htm> [Accessed 30 June 2023]



Basic Screening Information (cont)

If a skin problem is identified, a referral should be made to an occupational health doctor, nurse or general practitioner, a practice nurse, or a pharmacist for further advice and assessment.

WHOLE BODY



The assessor needs to provide interim advice to the employee and employer, which may include stopping working with a particular substance until further assessment is undertaken.

Photographs could be taken using the employee's digital device as a clinical record of the skin changes.

Image 1 is an example of mild hand eczema/dermatitis, which has been scored by a dermatologist as follows:

Dryness	2
Redness	3
Cracking	1
Blisters	0
open Sores (fissures)	0
Bleeding	0
Signs of Infection	0



IMAGE CITATION 1

Hand dermatitis [internet]. Hand dermatitis images. 2007. [cited 31 May 2023]. Available at: <https://dermnetnz.org/topics/hand-dermatitis-images>



Basic Screening Information (cont)

Image 2 is an example of moderate hand eczema/dermatitis, which has been scored by a dermatologist as follows:

Dryness	4
Redness	5
Cracking	4
Blisters	0
open Sores (fissures)	4
Bleeding	1
Signs of Infection	0



Image 3 is an example of severe hand eczema/dermatitis, which has been scored by a dermatologist as follows:

Dryness	5
Redness	5
Cracking	5
Blisters	0
open Sores (fissures)	5
Bleeding	3
Signs of Infection	1





Management of Employees with Occupational Skin Disease

Potential outcomes of skin surveillance

Normal assessment

Where the HS assessment does not identify any skin condition of concern, the employee may continue to work in their usual role, with advice on using the appropriate PPE and hand care. The responsibility for ongoing skin surveillance may revert to the employee and the responsible person.

At the end of the consultation, advise the employee of the outcome and provide them with a copy of the occupational dermatitis leaflet (the HSE 'It's in your hands')⁴¹ and/or the HSE 'Preventing contact dermatitis and urticaria at work' leaflet⁴² and update the occupational health/HS record. Refer to Appendix 7 Occupational Health Surveillance Record.

Skin symptoms related to poor compliance with, or lack of use of, PPE/hand care/specific cleaning agents.

Some individuals may report skin symptoms that may be attributed to poor compliance or lack of use of appropriate skin protection or hand care. In this situation:

- Advise the employee of the appropriate procedures for hand washing and hand care and issue the occupational dermatitis leaflet (the HSE 'It's in your hands').
- Emphasise the importance of PPE. Refer to Appendix 8 Memory Aid for Selecting Protective Gloves.
- The risk assessment should consider suitable and sufficient glove type and "breakthrough" times.
- Arrange increased monitoring of the employee by the manager/responsible person, focusing on correct working practices and the use of PPE and hand care as appropriate.
- Arrange an OHS review at an agreed interval – two months is usually an appropriate timeframe for a review of the impact of the above measures.

If the assessment suggests the skin condition may be related to work exposure, it may be necessary to consider temporary removal of the employee from further exposure while information is obtained from the manager/H&S officer/advisor about work tasks and substances/chemicals used. Such assessments should be discussed with an occupational health physician (OHP). (See next section.)

Referral for Occupational Health Physician Assessment

Prior to escalation of a case to an OHP, the occupational health nurse or technician assessing the case should ensure:

- The clinical skin health questionnaire is completed.
- Safety data sheets and relevant risk assessment outcomes have been obtained and are on the employee's file.
- Interim advice has been provided to the manager regarding fitness for work, with the employee's consent. (See previous section.)

REFERENCES

41. It's in your hands. Publications. Hse.gov.uk. Available at: <https://www.hse.gov.uk/skin/professional/publications.htm> [Accessed 30 June 2023]

42. Preventing contact dermatitis and urticaria at work. Hse.gov.uk. Available at: <https://www.hse.gov.uk/pubns/indg233.pdf> [Accessed 30 June 2023]



Management of Employees with Occupational Skin Disease (cont)

When there is a high suspicion of a link between skin symptoms/conditions and work, as identified via skin surveillance or a case management assessment, the case should be referred to an OHP, ideally with clinical experience in advising on both clinical and workplace management aspects before any specialist review is arranged. Special consideration should be given to those with atopy.

The role of the OHP is to determine whether there is a high likelihood of the skin symptoms and clinical signs resulting from occupational exposure. A decision will be made considering the clinical picture, all relevant information about workplace practices and exposures, samples of and data sheets for workplace substances used, and the outcomes of skin surveillance to date.

In some cases, the OHP will ask the employee to be assessed by their general practitioner/practice nurse/pharmacist to receive appropriate treatment to help manage the problem while they provide workplace-specific advice to the employer.

The onward pathway will depend on whether all aspects of the case can be managed by the OHP or whether more specialist advice is required. In more complex cases, where the diagnosis is unclear for example, the OHP is advised to escalate the case to an occupational health physician with skin experience, or a clinical dermatologist.

A list of occupational physicians with skin experience can be obtained by contacting the Society of Occupational Medicine at admin@som.org.uk or by searching on LinkedIn.

Onward Referral for Patch Testing and Dermatological Advice

A clinical dermatologist can assist in providing a diagnosis, investigations including biopsy for suspicious rashes/lesions, and treatments ranging from topical emollients and steroids to systemic immunosuppressants and biologic therapies. In cases when an allergen is suspected to be the cause of work-related skin issues, a referral for patch testing will be required.

For more complex cases and where ongoing employment in a particular job role is at risk, referral to centres of excellence in occupational skin disease is recommended, such as the St John's Institute of Dermatology at St Thomas' Hospital.

Conclusion of OHP Assessment and the Onward Referral Process

Once the results of specialist assessment are available, the employee should be reviewed by an OHP for guidance regarding continued workplace exposure and, where relevant, advice as to whether a RIDDOR reportable diagnosis has been made.



Advice for the Employer

As outlined above, the purpose of health surveillance is to detect conditions caused by work exposure. It is important therefore that employers implement a programme which allows onward further assessment for investigation or diagnosis (for example to exclude other underlying conditions or to confirm work-related causes).

When there is a suspected or confirmed skin condition from work, employers should:

- Remove the employee from current work activities where there is a likely/suspected exposure (including from the PPE itself, e.g. a reaction to gloves).
- Avoid contact by substitution.
- Avoid or reduce contact by using engineering controls.
- Avoid or reduce contact by using the 'Safety by Distance' approach.
- Avoid all work activities where a period of treatment/stability or recovery of skin is needed (guided by Occupational Health).
- Where sensitisation is confirmed, consider redeployment to another role where the exposure to the causative substance is removed.
- Review the work being undertaken, risk assessments and controls. This should be done by a suitable person (usually a line manager, work supervisor or health and safety specialist).
- Review all other employees who are in the health surveillance programme for potential or actual skin conditions.
- Educate the workforce and management about good hand care – no rings, bracelets or watches to be worn, where moisture can be trapped – how to wash and dry hands correctly, use of creams and emollients and correct use of PPE, including frequency of use and disposal.

Confirmed skin exposure – legal responsibilities RIDDOR reporting

Regulation 8 requires employers and self-employed people to report cases of certain diagnosed reportable diseases which are linked with occupational exposure to specified hazards. Dermatitis is reportable when associated with work-related exposure to any chemical or biological irritant or sensitising agent. This includes any chemical with the warning 'May cause sensitisation by skin contact', or 'Irritating to the skin'. Dermatitis can be caused by exposure to a range of common agents found outside the workplace. If there is good evidence that the condition has been caused solely by such exposure, rather than by exposure to an agent at work, it is not reportable.

Quality Control

Please refer to Appendix 9 Skin Surveillance Audit Questions to Be Completed by the OH Auditor.



Skin Surveillance/ Occupational Skin Condition

Process Case Study 1

Fred has secured employment in the NHS as a laboratory worker. The risk assessment of his work area identified he will be exposed to formaldehyde and xylene, which are skin sensitisers. Based on the HSE guidance, Fred requires high-level skin surveillance. Before commencing his employment, his line manager informed him of the risks of exposure, the requirement for skin health surveillance, the control measures in place, including PPE, and the importance of reporting any skin problems in between health surveillance checks. Fred completed the baseline skin surveillance questionnaire; his skin was examined by a responsible person and the findings were clinically documented. The outcome of the health surveillance, including the frequency and nature of future health surveillance, was conveyed to Fred and his line manager in writing. He repeated the questionnaire in weeks 6 and 12 and then annually, as per the requirements for high-level skin surveillance.

Fifteen months into his employment, the skin on Fred's right wrist became itchy, red, flaky, and broken. He reported this to his line manager, who sought advice from an occupational health/responsible person. Fred was not the first person to have reported a skin problem in recent weeks – several other employees had developed similar skin changes on their wrists. The workplace risk assessment was reviewed, including the control and PPE measures. It was found that new gloves had been supplied to the department which did not fit well on the wrists and allowed accidental splashes of formaldehyde to come into direct contact with the employees' skin.

The employees were signposted to obtain clinical advice on how to manage their symptoms and the supply of gloves was changed back to ones which provide adequate protection to the skin at the wrist.

Key learning points

- Skin surveillance is required when working with sensitisers.
- Managers have a key role in the risk assessment of the workplace and the enrolment of at-risk employees in skin health surveillance.
- Worker education is a key component of a health surveillance programme.
- Employees must be encouraged to report skin problems early so control measures can be reviewed and risks minimised for all employees in that work area.
- Skin surveillance is not a form of control but acts to detect skin changes which have not been spontaneously reported by employees so that control measures can be reviewed.

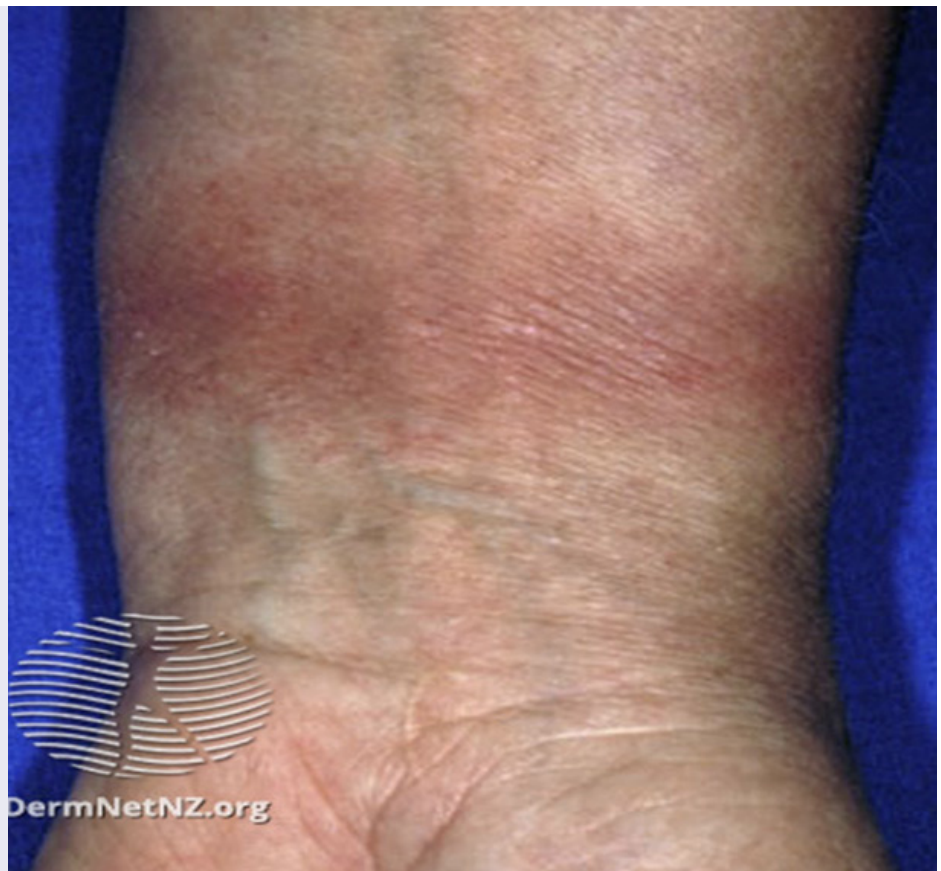


IMAGE CITATION

Hand dermatitis [internet]. Hand dermatitis images. 2007. [cited 31 May 2023]. Available at: <https://dermnetnz.org/topics/hand-dermatitis-images>



Skin Surveillance/ Occupational Skin Condition (cont)

Process Case Study 2

William started work in 1973 and has been in construction and civil engineering his entire working life. William has historic exposure to respirable crystalline silica dust, cementitious materials, specialist chemical resistant coating, and resins containing a wide range of chemical substances in concentrations including xylene, isocyanates and methyl methacrylate.

In 1991 William started working with an epoxy resin (a structural adhesive) used to secure carbon fibre plates to the underside of concrete beams. The carbon fibre plates are used to strengthen concrete structures. William remembers the days when chemicals were used without PPE or controls and when workers would clean their hands using a mixture of sand and solvents. After using the epoxy material frequently for about seven months, William woke one morning in pain, the skin on his face and hands had become inflamed, felt like it was burning and had the appearance of eczema. He visited his GP and was prescribed medication to help manage the reaction.

He was referred to dermatology and underwent specialist patch testing which confirmed he had become allergic to epoxy resin resulting in the allergic contact dermatitis he had experienced.

Sensitisation to an allergen such as epoxy resin is permanent and requires life-long avoidance to prevent a recurrence of symptoms. His employer reported the case to RIDDOR as dermatitis caused by exposure to a known allergen is a notifiable event.

Later in the 1990s, William found himself on another project where carbon fibre plates were specified and again experienced a severe allergic reaction, which required a period of day treatment under the care of a dermatology specialist. The link between the allergic reaction he experienced and his known contact allergy to epoxy resin was recognised and William's employer took action to prevent William from working with epoxy resins or working in the vicinity of people using epoxy resins.

William has been subject to occupational health surveillance including high-level skin surveillance since 2000 and remains vigilant about coming into contact with colleagues who may visit his workplace with contaminated workwear or tools, because even very small exposure to epoxy resins can cause him to experience a recurrence of allergic contact dermatitis. William continues to work in the construction/civil engineering industry, and he and his employer schedule his work and arrange his work placements so that contact with epoxy resins is avoided.





Bibliography

Medical aspects of occupational skin disease. Guidance Note MS24. Hse.gov.uk.
Available at: <https://www.hse.gov.uk/pubns/priced/ms24.pdf> [Accessed 30 June 2023]

Skin Exposures and Effects. National Institute for Occupational Safety and Health (NIOSH).
Available at: <https://www.cdc.gov/niosh/topics/skin/default.html> [Accessed 30 June 2023]

Working with substances hazardous to health: A brief guide to COSHH. Hse.gov.uk.
Available at: <https://www.hse.gov.uk/pubns/indg136.pdf> [Accessed 30 June 2023]

Appendices

- Appendix 1** Hazards by Occupation
- Appendix 2** Examples of Hazards by the Classification, Labelling and Packaging (CLP) Regulation/the Globally Harmonized System of Classification and Labelling of Chemicals (GHS); Health Hazard Codes; and the R Safety Phrase
- Appendix 3** Reference Guide for Managers/Responsible Person
- Appendix 4** COSHH Risk Assessment Proforma (Example)
- Appendix 5** Example Letter to Employee to Participate in Skin Health Surveillance
- Appendix 6** Aide Memoire for Skin Assessment
- Appendix 7** Occupational Health Surveillance Record
- Appendix 8** Memory Aid for Selecting Protective Gloves
- Appendix 9** Skin Surveillance Audit Questions to Be Completed by the OH Auditor

With thanks to

- NHS Greater Glasgow and Clyde: Managing Skin at Work Procedure
- Solent NHS Trust Occupational Health Service – Detection of Occupational Skin Disease: Organisational Standard Operating Procedure (O-SOP)
- SOM Special Interest Skin Group

Appendix 1

Hazards by Occupation

Adapted from: Occupational skin diseases and dermal exposure in the European Union (EU-25): policy and practice overview. (2008). European Agency for Safety and Health at Work. Willy De Craecker, Nele Roskams, Rik Op de Beeck. Luxembourg: Office for Official Publications of the European Communities. ISBN 978-92-9191-161-5.

Example Occupations	Some occupational contact with irritants and sensitisers These lists are not intended to be exhaustive, but to provide examples. Many items can be both irritants and sensitisers. In the case of collective terms such as 'dusts', it is not implied that all dusts can harm the skin, only that certain ones can. Some specific chemicals or materials:	Examples of sensitisers Allergic contact dermatitis is caused by direct contact with allergens such as jewellery (nickel), fragrances, dyes, natural rubbers or plants (poison ivy). This typically presents as a delayed reaction on the skin, or about 12 to 72 hours after coming into contact with the substance.	Examples of causes of contact urticaria	Other skin conditions
Cleaning Food Hotels Restaurant Catering Cleaners, Domestic help Food handlers <ul style="list-style-type: none"> • Butchers • Delicatessen dealers • Bakers • Pastry makers • Grocers • Cheesemakers • Cheesemongers • Fishmongers Brewers Wine growers Wine merchants Cooks Restaurateurs Waitpersons Hotelkeepers Café owners	<ul style="list-style-type: none"> • Solvents (acetone) • Wet work • Diluted Javelle water (sodium hypochlorite) • Vinegar • Soaps • Detergents • Hydrogen peroxide • Juices (fish, meat, fruit, vegetable, citric acid) 	<ul style="list-style-type: none"> • Nickel of utensils, coins, mesh gloves, chromium, cobalt impurities in detergents, gloves • Seafood products • Fruit (limonene) • Animal and vegetable proteins • Enzymes (detergents, flour) • Vegetables (lactones, sesquiterpenic agents), aromatics, spices, condiments • α-Amylase, rye, flour • Antioxidants, preservatives: sorbic acid, gallates • Kathon CG with isothiazolinones • Antiseptics and disinfectants (formaldehyde, glutaraldehyde, glyoxal, Javelle water with yellow sodium dichromate, quaternary ammonium and other allergenic biocides) • Gloves and other rubber articles • Floor polishes, waxes (turpentine: δ-3 carene, δ-limonene) • Silver cleaners, brass cleaners (thiourea) • Bleaching agents: persulfates, peroxides 	<ul style="list-style-type: none"> • Cleaning solvents with DCM (dichloromethane or methylene chloride) • Urticating plants (nettles: histamine, acetylcholine) • Marine products, enzymes, proteins (meat) 	Chemical burns <ul style="list-style-type: none"> • Acids (phosphoric, hydrochloric, acetic, citric, vinegar) • Bases/alkalis (sodium hydroxide, potassium hydroxide, ammonium hydroxide, concentrated Javelle water) Abrasion dermatitis, or "housewife's" dermatitis: <ul style="list-style-type: none"> • Exposure to chemical products and repeated physical microtrauma (abrasion) • Cereal beards Irritation dermatitis, or "housewife's" dermatitis: <ul style="list-style-type: none"> • Solvents (acetone), wet work • Diluted Javelle water, vinegar • Soaps, detergents • Hydrogen peroxide • Juices (fish, meat, fruit, vegetable, citric acid)

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
Construction	<p>Abrasive and irritation dermatitis</p> <ul style="list-style-type: none"> • Cement (very dust-producing: airborne) • Handling traumas, heat, cold • Washing hands with detergents, washing powders or soaps with abrasives, alkalis (pH>10) 	<p>Allergic contact eczema: 'cement disease'</p> <ul style="list-style-type: none"> • Chromium, cobalt, nickel of cements, chromium of leather gloves (chromium is a principal allergen in males) • Epoxy resins of very permeable cements • Fluids and oils in formwork and dismantling • Rubber gloves and boots (natural, latex) 		<p>Airborne glass fibre dermatitis</p> <ul style="list-style-type: none"> • Glass fibres (reinforced, composite plastics), possibly ensimated (resin covered) <p>Neoplastic lesions: Pitch keratosis Malignant epithelioma Carcinomas Melanomas Skin tumours</p> <ul style="list-style-type: none"> • Hexavalent chromium VI • Solar UV • Tars, pitches, bitumens, asphalt, roof felt and derivatives, creosote (wood tar): polycyclic aromatic hydrocarbon (PAH) <p>Chafing Frostbite</p> <ul style="list-style-type: none"> • Cold <p>Chemical burns ("cement burns"):</p> <ul style="list-style-type: none"> • Cement, particularly rapid-hardening or quick-setting cement, very alkaline (pH = 13–14) • Lime <p>Skin infections:</p> <ul style="list-style-type: none"> • Dermatomycoses or intertrigo of the toes ("athlete's foot") • Pyodermatitis from irritation or allergic infection
Quarry workers Miners	<p>Allergic contact eczemas</p> <ul style="list-style-type: none"> • Rubber boots • Cements 			<p>Airborne</p> <ul style="list-style-type: none"> • dermatoses from glass fibres
Carpenters Cabinetmakers		<p>Allergic eczemas</p> <ul style="list-style-type: none"> • Plastic glues (epoxides, neoprene, urea-formaldehyde, phenol-formaldehyde) • Varnish (acrylates, plasticisers) • Exotic woods, fir, pine (terpenes) • Colophony <p>Turpentine (δ-3 carene, δ-limonene)</p> <p>Preservatives:</p> <ul style="list-style-type: none"> • dichromates • pesticides: • captafol • CTPN, creosote, creolin, chlorothalonil 		<p>Airborne</p> <ul style="list-style-type: none"> • dermatoses from glass fibres

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
<p>Painters</p>	<p>Irritation dermatitis</p> <p>Paint removers</p> <ul style="list-style-type: none"> • DCM • Detergents • Washing powders • Acids • Alkalis (bases) <p>Solvents and thinners</p> <p>Additives</p>	<p>Allergic contact eczemas or urticarias (airborne or otherwise)</p> <p>Plastic resins: glues and varnishes, paints, among others, with epoxy resin bases (DGEBA), acrylics, PUR (TDI, MDI, IPDI)</p> <p>Pigments and dyes:</p> <ul style="list-style-type: none"> • Chromium (zinc chromate rust-inhibiting paints) • Cobalt (salts: blue paints) • Nickel (metallic paints) • Mercury (red protective paint) • PPD (paraphenylenediamine: azo dyes) <p>Additives: biocides, preservatives, antiseptics</p> <ul style="list-style-type: none"> • Kathon-MW, TCPN • Thiurams • Diamines • Peru balsam • Rosin (pine tar) • Formaldehyde • "Natural" solvents <p>Turpentine (δ-3 carene, δ-limonene)</p>	<p>Allergic contact eczemas or urticarias (airborne or otherwise)</p> <p>Plastic resins: glues and varnishes, paints, among others, with epoxy resin bases (DGEBA), acrylics, PUR (TDI, MDI, IPDI)</p> <p>Pigments and dyes:</p> <ul style="list-style-type: none"> • Chromium (zinc chromate rust-inhibiting paints) • Cobalt (salts: blue paints) • Nickel (metallic paints) • Mercury (red protective paint) • PPD (paraphenylenediamine: azo dyes) <p>Additives: biocides, preservatives, antiseptics</p> <ul style="list-style-type: none"> • Kathon-MW, TCPN • Thiurams • Diamines • Peru balsam • Rosin (pine tar) • Formaldehyde • "Natural" solvents <p>Turpentine (δ-3 carene, δ-limonene)</p>	<p>Skin cancers</p> <ul style="list-style-type: none"> • Tar and coal tar pitch: polycyclic aromatic hydrocarbons (PAHs) • Bitumen, asphalt and petroleum products: PAHs • Creosote or wood tar: PAHs • Solar UV <p>Traumatic tattooing</p> <ul style="list-style-type: none"> • Subcutaneous injection of paint under high pressure (gun spraying)

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
<p>Healthcare</p>	<ul style="list-style-type: none"> • Soaps, detergents, antiseptics, and disinfectants • Wet work 	<p>Allergies</p> <p>a) contact urticaria (immediate hypersensitivity)</p> <p>b) contact eczema (delayed hypersensitivity)</p> <ul style="list-style-type: none"> • Vegetable protein powdered latex (para rubber tree: natural rubber) • Propanidid (Epontol): general anaesthetic • Procaine: local anaesthetic • Mercury of amalgams and disinfectants • (Meth)acrylates • Impressions • Rosin (red-brown glue with a pine-tar base: colophony for adhesive tape) • Antiseptics (formaldehyde, glutaraldehyde, glyoxal, quaternary ammoniums, Javelle water with dichromate, Kathon CG with isothiazolinones) • Nickel tools • Excipients (lanolin, propylene glycol) • Preservatives (parabens) • Antioxidants • Perfumes • Anti-inflammatories (piperazine) • Antibiotics and sulphonamides • Benzodiazepines • Neuroleptic phenothiazines • Antimitotics (anticancer agents) • Fixatives (chromium, glutaraldehyde) • Epoxy resins • Dyes (Sudan III, IV) • Plant extracts • Peru balsam • Radiology (hydroquinone, pyrocatechol, Kathon CG) 	<p>Allergies to the constituents of synthetic and natural rubber (allergic contact eczemas)</p> <ul style="list-style-type: none"> • Gloves • Rubber vulcanisation accelerators and antioxidants: <ul style="list-style-type: none"> - thiurams - carbamates - mercaptobenzothiazole (MBT) and derivatives • IPPD (isopropylparaphenylene diamine) 	<p>Skin burns</p> <ul style="list-style-type: none"> • Ethylene oxide (gas for sterilising, for example surgical clothing) • Mercury <p>Radiodermatitis and radio cancers of the skin</p>

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
<p>Hairdressing</p> <p>Cosmetology</p> <p>Hairdresser assistants</p> <p>Beauticians</p> <p>Manicurists</p> <p>Footcare specialists are an example of the occupation most exposed to the risk of developing occupational dermatitis</p>	<p>Irritation dermatitis</p> <ul style="list-style-type: none"> • Soaps, detergents, wet work • Perms (base: ammonium thioglycolate and acid) • Bleach (hydrogen peroxide) • Irritant shampoos • Creams (perfumes, excipients, preservatives) 	<p>Hairdressers' skin allergies</p> <ul style="list-style-type: none"> • PPD (paraphenylenediamine), for example in temporary tattooing with black henna, modified vegetable dye • PTD (paratoluylenediamine) • Resorcinol, pyrogallol • Basic Blue 99 • Hydroquinone • Aminophenol • Nickel (metal instruments) (= principal allergen in females) • Rubber additives • Alkaline persulphate and ammonium persulphate (APS): bleaches <p>Acid perms (glyceryl monothioglycolate GMTG, cysteamine hydrochloride)</p> <p>Shampoos:</p> <ul style="list-style-type: none"> • Formaldehyde • Kathon CG with isothiazolinones • Quaternary ammoniums • Trichlorocarbonyl chloride • Phenoxyethanol: Euxyl K4000 • Cocamidopropylbetain (CAPB), amido-amines (surfactants) • Alkyl glucosides • Perfumes: aldehyde, alcohol, terpene • Parabens: acid esters • Coconut oil, lanoline <p>Nail varnish (formaldehyde and derivatives)</p> <ul style="list-style-type: none"> • Resins (epoxides, (meth) acrylates, cyanoacrylates: LOCTITE®) • Peru balsam • Latex gloves (para rubber tree vegetable proteins), particularly powdered <p>Depilatory waxes with very allergenic modified rosin (brown-pink pine tar)</p>	<p>Allergies to the constituents of synthetic and natural rubber (allergic contact eczemas)</p> <ul style="list-style-type: none"> • Gloves • Rubber vulcanisation accelerators and antioxidants: <ul style="list-style-type: none"> - thiurams - carbamates - mercaptobenzothiazole (MBT) and derivatives • IPPD (isopropylparaphenylene diamine) 	<p>Chemical burn if the dose is incorrect</p> <p>Chemical burn</p>

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
<p>Plastic materials</p> <p>Plastic manufacturers</p> <p>Plastic-process operators</p> <p>Applicators of glues and adhesives</p>	<p>Contact dermatitis irritations</p> <ul style="list-style-type: none"> • Resins (meth)acrylates • Cyanoacrylates (LOCTITE®) • Epoxides (DGEBA) and hardeners • PUR (MDI, TDI, IPDI) composites (fibreglass) • Painters (dyes, pigments, additives, solvents) 	<p>Allergic contact eczemas</p> <ul style="list-style-type: none"> • Resins (meth)acrylates • Cyanoacrylates (LOCTITE®) • Epoxides (DGEBA) and hardeners • PUR (MDI, TDI, IPDI) composites (fibreglass) • Painters (dyes, pigments, additives, solvents) 		<p>Physical traumas</p> <ul style="list-style-type: none"> • Hyperkeratoses • Haematomas • Excoriations • Calluses • Cuts <p>Airborne dermatitis</p> <p>Caustic dermatitis</p> <p>Abrasion dermatitis</p>

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
Metal, electromechanical Engineering Metalworkers Steelworkers Rolling mill operators Smelting workers Solderers Brazers Welders Oxycutters Machinists (garage) Mechanics Coachbuilders Surface treaters Cadmium platers Chromium platers Nickel platers Electrical appliance repairers Electricians Electronics workers Silversmiths Goldsmiths Jewellers	Irritation dermatitis, or alkali burns Motor fuels Abrasives Battery electrolytes (sulphuric acid) Glues with cyanoacrylates Degreasing agents (TRI, gasoline, bases) Dewaxing agents Protection removers (alkalis: pH>12) Window-cleaning products (ammonia: pH>10) Cleaning products for bumpers, doorsills, doorways (hydrocarbons) Cleaning products for aluminium wheel rims: interior <ul style="list-style-type: none"> Aluminium hydrogen fluoride Sulphuric acid Phosphoric acid Sodium hydroxide 	Allergic contact dermatitis Rubbers: additives <ul style="list-style-type: none"> Mercaptobenzothiazole (MBT) Carbamates Thiurams IPPD CPPD Motor fuels <ul style="list-style-type: none"> Dyes (red or blue furfural) Antiseptics Oils and greases <ul style="list-style-type: none"> p-t-butylcatechol Diphenylamine Cutting fluids <ul style="list-style-type: none"> Metal traces Anticorrosives (ethylenediamine, MBT) Biocides (Kathon CG) Dispersants (rosin) Stabilisers (epoxide) Perfumes Turpentine (δ-3 carene, δ-limonene) Peru balsam Tin soldering <ul style="list-style-type: none"> Rosin (fluxing, remover) Hydrazine Aminoethylethanolamine Anticorrosives and antifreezes <ul style="list-style-type: none"> Chromium derivatives Mercaptobenzothiazole (MBT) Benzotriazoles Metals <ul style="list-style-type: none"> Cobalt (special metals, rubber, paints) Nickel (metals, soldering fumes) Chromium (metals, paints, fumes) Glues and resins <ul style="list-style-type: none"> (Cyano)acrylates (LOCTITE®) Epoxides and hardeners PUR Acrylics Polyesters Diesel cleaners <ul style="list-style-type: none"> Chromium (sodium chromates) External cleaners <ul style="list-style-type: none"> Frothing agents (ethylenediamine) Metallic impurities of detergents (chromium, cobalt, nickel) Antiseptics or motor oil preservatives		Physical traumas <ul style="list-style-type: none"> Hyperkeratoses Haematomas Excoriations Calluses Cuts Physical agents (repeated action of the hands) Antiquated equipment <ul style="list-style-type: none"> Thromboses Necroses Infection Airborne dermatoses from oxides of slag, RCF <ul style="list-style-type: none"> Sharp particles of various metallic oxides, constituting the pulverulent slag added to steel in continuous smelting Various fibres, particularly RCF, insulating materials replacing asbestos in ovens Oil acne or blackheads Follicular elaiokonioidosis (acne originating from hair follicles/sebaceous glands) <ul style="list-style-type: none"> Mineral oils Skin cancers Malignant epitheliomas <ul style="list-style-type: none"> Lubricating and cutting oils (aromatic amines) Chromium VI, arsenic Polycyclic aromatic hydrocarbons (PAHs) UV (welding, oxygen cutting)

Appendix 1

Example Occupations	Some occupational contact with irritants and sensitisers	Examples of sensitisers	Examples of causes of contact urticaria	Other skin conditions
<p>Occupations involving contact with animals and plants</p> <ul style="list-style-type: none"> • Animal breeders • Beekeepers • Farmers • Butchers, sausage makers • Abattoir employees • Meat salvagers • Fishermen • Veterinary surgeons • Other occupations involving contact with animals (e.g. dog groomers) <p>Miscellaneous:</p> <p>Occupations involving contact with plants:</p> <ul style="list-style-type: none"> • Compost producers • Dockers • Florists • Foresters • Forestry producers • Fruit growers • Gardeners • Horticulturists • Market gardeners • Wine producers 	<p>Irritation dermatitis, chemical burns or urticaria</p> <p>Soaps, detergents, wet work</p> <p>Disinfectants</p> <p>Fertilisers, pesticides</p> <p>Thorns, cereal beards, wood</p> <p>Calcium oxalate (crystals, raphides or microscopic airborne needles)</p> <p>Flowers:</p> <ul style="list-style-type: none"> • Nettles (histamine, acetylcholine) • Western buttercups <p>Processionary caterpillars from oak, pine (in the spring)</p> <p>Sea products:</p> <ul style="list-style-type: none"> • Jellyfish • Coral 	<p>Allergic contact eczemas</p> <ul style="list-style-type: none"> • Wood protection pesticides (chromium, cobalt, nickel, mercury) • Fungicides • Acaricides • Insecticides • Herbicides • Nematocides <p>Plants (sesquiterpenic lactones, primin, allicin, tulipalin A, catechol, vanillin)</p> <p>Weeds (idem)</p> <p>Oakmoss resin (frullania)</p> <p>Spices, aromatic plants, condiments</p> <p>Flowers: arnica, camomile, primroses, chrysanthemums, daisies</p> <p>Insect bites/stings (hymenoptera)</p> <p>Pine tar</p> <p>Turpentine (δ-3 carene, δ-limonene)</p> <p>Pink-brown rosin (pine tar)</p> <p>Nickel of metallic mesh gloves</p> <p>Synthetic and natural rubber of gloves or boots:</p> <ul style="list-style-type: none"> • Mercaptobenzothiazole (MBT) • Carbamates • Thiurams • IPPD, CPPD • Antiseptics: see 3.3 • Vermifuges (piperazine) <p>Preservatives (chromium, Kathon CG, bronopol)</p> <p>Antioxidants</p> <p>Antibiotics and sulphonamides (veterinary medicines, feed additives for animals)</p> <p>Anaesthetics</p> <p>General: propanidid (Epontol)</p> <p>Local: procaine</p> <p>Agricultural fuel dye (Sudan IV)</p>		<p>Zoonotic diseases transmitted to man</p> <p>Viral infections</p> <ul style="list-style-type: none"> • Plantar, butcher's Warts • Contagious ecthyma • Cowpox <p>Mycotic infections</p> <ul style="list-style-type: none"> • Ringworm • Onychomycosis: mycosis of the nails • Sycosis and suppurating tinea kerion: infection of the hair • Interdigital candidiasis <p>Bites</p> <p>Microbial infections (Sub)cutaneous tuberculosis</p> <ul style="list-style-type: none"> • Cutaneous brucellosis ("veterinary eczema") • Dermatitis from swine erysipelas • Pasteurellosis • Granulomas <p>Anthrax or malignant oedema of the face</p> <p>Cat scratch disease (Purulent) pyodermatitis</p> <p>Erythema chronicum migrans</p> <p>Lyme disease Parasitosis:</p> <ul style="list-style-type: none"> • Mange • Scabies • Itch <p>Acne - among other forms, chlorine acne or chloracne</p> <p>Phototoxic reaction</p> <p>Parsley family: celery, fennel, dill (psoralens), glyphosate, sesquiterpenic lactones</p> <p>Skin cancers</p> <ul style="list-style-type: none"> • Arsenic or chromium-based insecticides • Solar UV

Appendix 2

Examples of Hazards by the Classification, Labelling and Packaging (CLP) Regulations/the Globally Harmonized System of Classification and Labelling of Chemicals (GHS CAT); Health Hazard Codes; and the Obsolete R Safety Phrase

The (CLP) Regulation 2008 (EC) No 1272/2008 aims to globally harmonise hazard identification and refers to mixtures and substances, with Statement 1 being the most severe and Statement 4 being the least severe.

*Wording may be similar between risk phrases, hazard codes and CLP statements; however, these are not readily interchangeable, therefore it is recommended that the material data sheets are available. Risk phrases were superseded by GHS Hazard Statements in June 2015. Currently in the EU, GHS guidelines should be used for pure substances, with the requirements for mixtures coming into effect by 1 June, 2015. This summary is being kept because you may receive material safety data sheets (MSDSes) or safety data sheets (SDSes) with R and S (safety) phrases, depending on the product.

CLP	CLP Signal Word*	H Code	Health Hazard Statement*	Hazard Class*	Risk (R) Safety Phrases Obsolete since 1 June 2015	Examples: Not Inclusive
1 2	Danger	H310	Fatal in contact with skin	Acute toxicity, Dermal	R27	Cyanides Cyanogens Hydrogen fluoride (Hydrofluoric acid)
3	Danger	H311	Toxic in contact with skin	Acute toxicity, Dermal	R24	Aluminium phosphide Pure methanol Mercury sulphate p-cresol o-cresol
4	Warning	H312	Harmful in contact with skin	Acute toxicity, Dermal	R21	benzyl alcohol sd alcohol (alcohol denat.) A concentration of methanol between 14.99 and 30.03%
	Not adopted/ categorised	H313	Represents a chemical with category 5 Acute toxicity. May be harmful in contact with skin	Acute toxicity, Dermal	-	This classification is not included in the CLP Regulation, which only consider acute toxicity in categories 1-4
1 1A 1B 1C	Danger Refer to the full document for exposure times	H314	Causes severe skin burns and eye damage	Skin corrosion/irritation	R34 R35	Acid and alkalis, e.g.: Sulphuric acid Sulphurous acid Hydrochloric acid Nitric acid Acetic acid Chromic acid Hydrofluoric acid
4	Warning	H315	Causes skin irritation	Skin corrosion/irritation	R238	Epoxy resins Pesticides Certain flowers, plants, and trees

Appendix 2

CLP	CLP Signal Word*	H Code	Health Hazard Statement*	Hazard Class*	Risk (R) Safety Phrases Obsolete since 1 June 2015	Examples: Not Inclusive
	Not adopted/ categorised	H316	Causes mild skin irritation	Skin corrosion/ irritation	-	Latex
4	Warning	H317	May cause an allergic skin reaction	Sensitisation, Skin	R43	Metalworking fluids Isocyanates Cooling lubricants Epoxy resins Formaldehyde Pesticides Plants and flowers Cresol Latex
2A	Danger Refer to the full document for exposure times	H319	Causes severe eye damage	Serious eye damage/ irritation	R36	Isopropyl alcohol

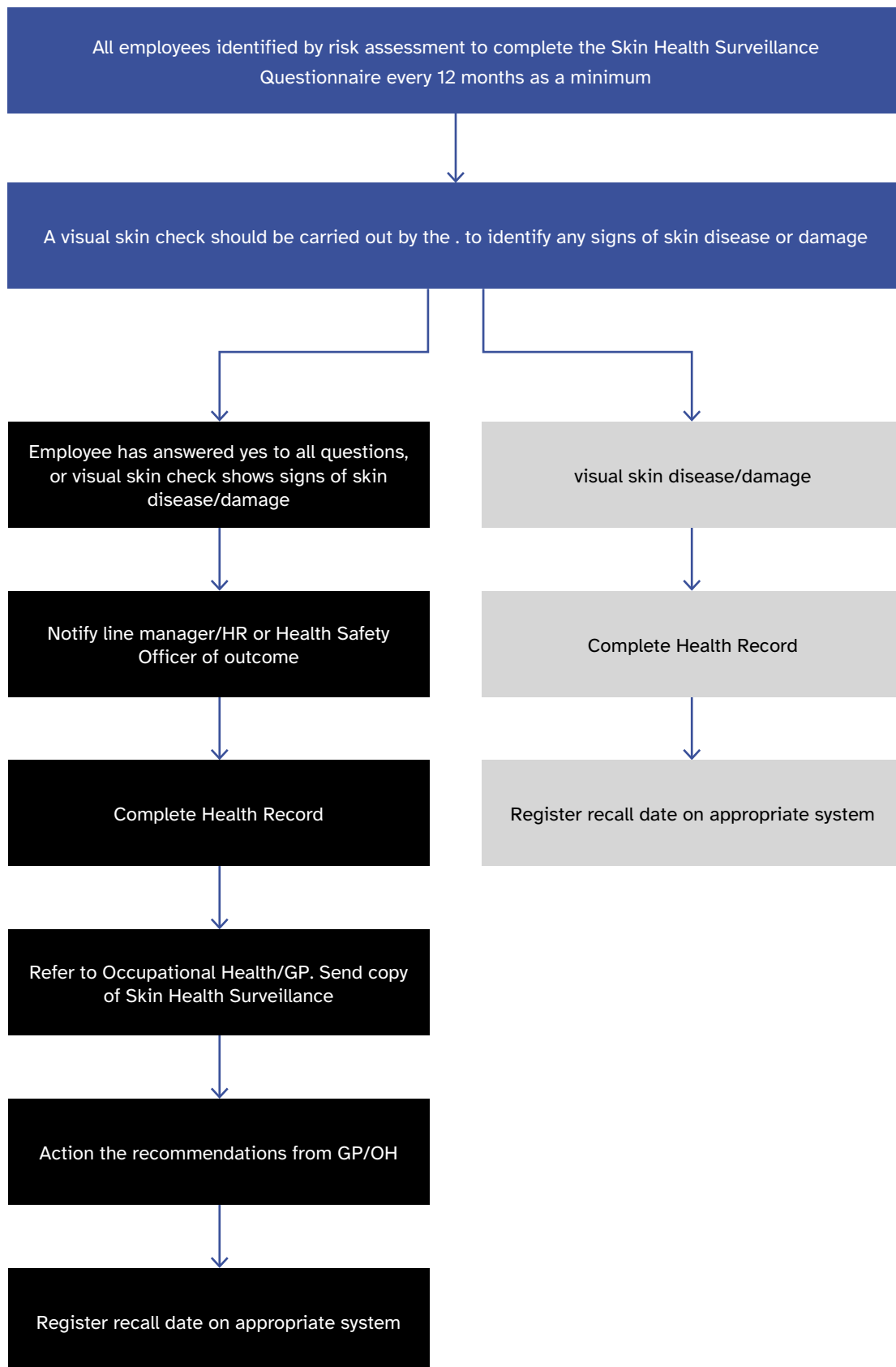
Ref: The Classification, Labelling and Packaging of Chemicals (Amendments to Secondary Legislation) Regulations 2015; SI 2015, No. 21

Available at: <https://www.legislation.gov.uk/uksi/2015/21/made> GHS Classification.

Available at: <https://pubchem.ncbi.nlm.nih.gov/ghs/>

Appendix 3

Reference Guide for Managers/Responsible Persons



Appendix 4

COSHH Risk Assessment Proforma (Example)

COSHH Assessment for Material Code

1	The hazardous properties of the substance	
2	Information on health effects provided by the supplier, including information contained in any relevant safety data sheet	
3	The level, type, and duration of exposure	
4	The circumstances of the work, including the amount of the substance involved	
5	Activities, such as maintenance, where there is the potential for a high level of exposure	
6	Any relevant occupational exposure standard, maximum exposure limit or similar occupational exposure limit	
7	The effect of preventive and control measures which have been or will be taken in accordance with Regulation 7 (Prevention or control of exposure to substances hazardous to health)	
8	The results of relevant health surveillance	
9	The results of monitoring of exposure in accordance with Regulation 10 (Monitoring exposure at the workplace)	
10	In circumstances where the work will involve exposure to more than one substance hazardous to health, the risk presented by exposure to such substances in combination	
11	The approved classification of any biological agent	
12	Such additional information as the employer may need in order to complete the risk assessment	
13	Does the worker have any susceptible factors, e.g. a pre-existing pregnancy, or a skin or respiratory condition?	

Date of Assessment:

Undertaken By:

Ref: Control of Substances Hazardous to Health Regulations (COSHH) 2002, SI 2002/2677.

Legislation.gov.uk. Available at: <https://www.legislation.gov.uk/uksi/2002/2677/made> [Accessed 30 June 2023]

Appendix 5

Example Letter to Employee to Participate in Skin Health Surveillance

Dear

Your role has been identified as one that requires participation in statutory skin health surveillance. For instance, you may have exposure to hazardous chemicals which could cause skin irritation or damage. Health surveillance is designed to safeguard your health and where necessary provide advice to your manager or refer you on to your GP or specialist occupational health professional. In exceptional circumstances, it may be necessary to provide advice to remove you from any sensitisers which have resulted in a significant skin disorder.

Surveillance will be undertaken by the identified responsible person who has received training for this role. The responsible person may be one of your colleagues and is required to maintain any medical information you disclose as confidential. You may also be seen by an occupational health technician, nurse, advisor or physiologist or doctor.

This is a legal requirement under the Management of Health and Safety at Work Regulations 1999 and the Control of Substances Hazardous to Health Regulations 2002, as amended for you to participate in this surveillance.

Participation requires the following:

- You should only be expected to attend this assessment during your working hours unless other arrangements are required.
- Completion of a skin health questionnaire on at least an annual basis, with a visual assessment of your skin.
- You may request access to an alternative responsible person at any time if you have any concerns of confidentiality or conflict of interest.
- Consent is required to store information about you for the purposes of the skin health surveillance programme. Information will be always stored securely.
- Your explicit consent will also be required prior to sharing any relevant information with your manager.
- You may be required to undertake further discussions with your manager to determine any adjustments if any issues have been identified.
- You may be referred to your GP or an occupational health practitioner for further advice and/or diagnosis of any skin condition.
- You may request to have an assessment with the responsible person if you develop any concerns about your skin before your planned recall date.
- You may be required to follow any advice such as the use of PPE or the avoidance of certain gloves or chemicals.
- Should you fail to attend your assessment, your manager and/or HR will be notified.
- Should you decline to participate in the surveillance, your manager and/or HR will be notified to discuss the implications this may have on your job role. If your employer is unable to determine your fitness/suitability to undertake a certain role, in certain circumstances you may need to be removed from that role and this may require participation in your company's disciplinary process.

I acknowledge that I will participate in a statutory skin health surveillance programme and have read and understood my obligations as outlined above.

Name (block capitals):

Signature:

Date:

Appendix 6

Aide Memoire for Skin Assessment

Clinical Assessment of Occupational Skin Disease

Aide Memoire for Skin Assessment

Date of assessment	
Employee name	
Date of birth	
Sex (at birth)/Gender	
Skin assessment type	Questionnaire F-2-F Remote
Data protection checks confirmed	
Consent and process of informing the manager of the outcome of the assessment discussed	
Manager's email address	
Job Role	
Job title	
Hours of work	
Description of job	
Location	
Date employment started (exposure)	
Previous employment	
Is a mask worn routinely at work?	
Other PPE?	
Has a risk assessment been undertaken?	
Are control measures in place?	
Are control measures adequate?	

Appendix 6

Aide Memoire for Skin Assessment

Dermatological History					
Nature of problem, e.g. rash, itch, pain, cracking					
Site of problem, e.g. hands, face					
Duration of problem, e.g. months, weeks					
Date symptoms started					
Changes to symptoms since started					
Current symptoms					
Seen by GP?					
Any prescribed or non-prescribed treatment					
Aggravating factors					
Handwash or moisturising products used at work, e.g. brands					
Do symptoms improve when not at work?					
Observed Symptoms	0 Not present	1 Mild	2 Moderate -	3 Moderate +	4 Severe
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness/discolouration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thickening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blisters or sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of scratching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 6

Aide Memoire for Skin Assessment

Past Medical History

Atopic history, e.g. eczema, asthma, hay fever, rhinitis

Allergies

Previous history of skin problems, e.g. any treatments

Areas affected

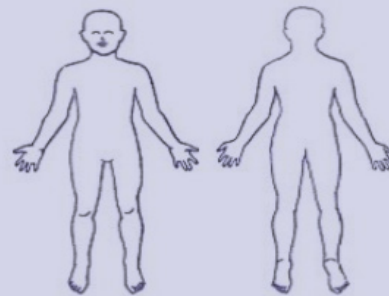
Mark on the diagram any of the following and grade from 1 (mild) to 5 (severe), e.g. D4, R3.

Dryness, **R**edness, **C**racking, **B**listers, open **S**ores, **B**leeding, signs of **I**nfection

Hands



Body



Relevant Social History

Hobbies and other activities, e.g. car restoration, woodwork

Household or other activities, e.g. gardening, cleaning, animal care, care of a dependent

Types of gloves used in the household, e.g. washing-up gloves/Marigolds, gardening gloves

Hand hygiene awareness, e.g. frequent moisturising

Outcome of Assessment

Satisfactory outcome/no further action

Report to the manager with advice on exposure controls or restrictions

Risk assessment of work activity recommended

Report to Health & Safety/Infection Control

Refer to OHP/GP

Are symptoms likely to be caused or triggered by work activity?

Statutory health record completed

Review

One year

6 weeks/12 weeks/other

Name and designation of assessing person

Appendix 7

Occupational Health Surveillance Record

Employee					
Date of birth		Sex			
Job role		Start date			
Address including postcode					
NI number					
Company					
Date employment started		Job history of exposure	Oils, solvents		
Date of Surveillance	Hazard	Type of Surveillance	Outcome/ Fitness to Work	Review Date	Name of the Responsible Person
1 Jan 2023	Cutting oil	Skin assessment	Signs of skin disease/damage. Must be referred to Occupational Health	Jan 2024	

A health surveillance/health assessment should be repeated in 12 months unless indicated otherwise above. Please arrange an occupational health assessment sooner if there are any observed or reported concerns or symptoms of ill health. Managers should refer to this record and consider any adjustments advised. Managers should make arrangements for any further health assessments where indicated and ensure risk assessments are monitored and recorded. This health record MUST be stored for 40 years from the date of last entry. It should be made available for inspection by the HSE etc.

Signed

Print Name

Designation Appointed Responsible Person

Appendix 8

Memory Aid for Selecting Protective Gloves

Most Suitable Glove Material to Protect the Wearer from Exposure

Five key points identified:

- Identify the substances handled
- Identify all other hazards
- Consider the type and duration of the contact
- Consider the user – size and comfort
- Consider the task

'To protect the hands from wet work, choose a glove that meets the European Standard EN374-2.

This shows that the gloves are waterproof'. Available at: <https://www.hse.gov.uk/skin/employ/gloves.htm>

There are chemical protective gloves that also give protection against mechanical hazards (those marked EN388) and thermal hazards (those marked EN407).

Refer to: Choosing the right gloves to protect skin: a guide for employers protecting against substances in the workplace.

Available at: <https://www.hse.gov.uk/skin/employ/gloves.htm>

Refer to: Managing skin exposure risks at work HSG262 (second edition).

Available at: <http://www.hse.gov.uk/pubns/priced/hsg262.pdf>

Refer to: Memory aid for selecting protective gloves. Extracted from HSG262 – Appendix 3.

Available at: <https://www.hse.gov.uk/skin/resources/glove-selection.pdf>

The risk assessment should consider suitable and sufficient glove type and “breakthrough” times.

Table One adapted from Selecting protective gloves for work with Chemicals.

Available at: <https://www.hse.gov.uk/pubns/indg330.pdf> page 3

Table One: Selecting protective gloves for work with chemicals

Chemical group	Natural rubber	Nitrile rubber	Neoprene™	PVC	Butyl	Viton™
Water-miscible substances, weak acids/alkalis	✓	✓	✓	✓		
Oils		✓				
Chlorinated hydrocarbons						✓
Aromatic solvents						✓
Aliphatic solvents		✓				✓
Strong acids					✓	
Strong alkalis			✓			
PCBs						✓

Appendix 9

Skin Surveillance Audit Questions to Be Completed by the OH Auditor

Assessor Name:

Date of Audit:

1	Have the health risks been identified and assessed?
2	Is a managed programme in place for health surveillance?
3	Has health surveillance been commenced prior to exposure?
4	Has the initial assessment been carried out via a questionnaire alone?
5	Has the initial assessment been carried out with a face-to-face visual inspection of the skin?
6	Has the Skin Assessment document been completed?
7	Has the completed Skin Assessment document been stored in a secure safe location?
8	If a face-to-face appointment is indicated, has an appointment been booked?
9	Has clear advice been provided and documented in the clinical notes on hand hygiene/maintaining good skin condition?
10	If indicated, have barrier creams or glove use been advised to the employee?
11	If a follow-up appointment with Occupational Health or the GP is indicated, is this documented and has an appointment been booked?
12	If indicated, has the employee been advised to see their GP about their skin symptoms?
13	If indicated, has the employee been advised to see their GP about other symptoms, e.g. stress, other physical illness?
14	If indicated, has the employee been given a copy of the completed Skin Surveillance Health Questionnaire to take to their GP?
15	If the skin condition is suspected as work-related, has an onward referral to Occupational Health been booked?
16	Has the manager been advised of the outcome of the assessment, including details of follow-up appointments?
17	Has a Skin Surveillance Outcome/Health Record been issued to the manager after each clinical interaction with an OHN?
18	Has clear clinical advice been provided and documented in the Health Record on fitness, with recommendations or restrictions to work activity?
19	Has the review date been documented?
20	Is the length of storage of the Health Record been documented, i.e. 40 years?

Audit Outcome	Yes/No/Comments
Full compliance met	
Areas for improvement identified	
Actions required	
Review date for improvement(s) if identified	
Do any risk assessments require review?	
Has it been identified that workplace controls are adequate?	
Date of next audit: One year if no identified concerns	

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Supporting occupational health
and wellbeing professionals

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