



Work Health and Safety  
Essentials for Nurses and Midwives





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# Foreword

Welcome to the 2nd Edition of *OHS Essentials for Nurses*, now called *WHS Essentials for Nurses and Midwives*. This revised publication coincides with the introduction of new work health and safety (WHS) legislation, which came into effect in NSW on 1 January 2012.

The legislation introduces a number of new considerations – terminology, standards and penalties, as well as providing ways for workers to participate in how WHS is managed at their workplace. In particular, this legislation provides an opportunity for health care providers and workers to reflect and review how the work of nurses and midwives has changed and consider how the risks resulting from this work can be effectively eliminated or managed.

Nurses and midwives work in a variety of roles in many different workplaces. This resource has been developed by NSW Nurses and Midwives' Association, in partnership with WorkCover NSW, to provide the essentials for all nurses and midwives to meet the challenges of WHS in daily practice. We hope you find this resource a useful tool and reference.



Brett Holmes  
General Secretary  
NSW Nurses and Midwives' Association  
May 2013

# Glossary

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<b>Due Diligence</b>	<p>It is the standard for an officer of the PCBU and means actively taking all reasonable steps to ensure compliance with the legislation. In exercising due diligence, an officer must take reasonable steps to:</p> <ul style="list-style-type: none"><li>• acquire and keep up-to-date knowledge of work health and safety matters</li><li>• know the industry, the hazards and risks associated with work</li><li>• ensure application of appropriate resources and processes to enable hazards to be identified and risks, eliminated or minimised</li><li>• ensure effective incident management and timely response to hazard and risk reporting, and</li><li>• ensure compliance with all duties and obligations.</li></ul>
<b>Duty holder</b>	<p>Duty holders are PCBUs, workers, officers and others, who each have responsibilities under the Work Health and Safety Act. The glossary contains a brief description of the responsibilities for each duty holder with more information provided in the body of this document.</p>
<b>Hazard</b>	<p>Something with the potential to cause injury, illness, damage to property, damage to the environment or a combination of these.</p>
<b>Hazardous Chemicals</b>	<p>A substance used at work that has the potential to harm health. It can include chemicals in all forms such as solids, liquids, gases and mixtures.</p>
<b>HSC</b>	<p>A Health and Safety Committee.</p>
<b>HSR</b>	<p>A Health and Safety Representative (HSR) who is elected from a group of workers, a work group, to represent that group when consulting on health and safety matters with the employer (now called the PCBU).</p>
<b>Incident</b>	<p>An event that results in injury, illness, harm or damage, or an event that could have caused any of these adverse outcomes.</p>
<b>Inspector</b>	<p>A person appointed by WorkCover NSW and given powers to enforce WHS and workers compensation legislation. Inspectors can enter workplaces, investigate, take samples and equipment, take statements, issue notices and initiate prosecutions.</p>
<b>Notifiable incident</b>	<p>The following incidents must be reported immediately to WorkCover:</p> <ul style="list-style-type: none"><li>• death of any person in the workplace. This could include a patient if the injury causing death resulted from a WHS risk, eg. failure of a sling supporting the patient during a transfer</li><li>• a serious injury, eg. amputation, serious head or eye injury, burn, spinal injury</li><li>• a serious illness, eg. exposure to fumes at work causing illness, traumatic event causing psychological injury, and</li><li>• a dangerous incident, eg. electric shock, collapse of structure or equipment.</li></ul>
<b>Nurses and midwives</b>	<p>This guide has been developed specifically for nurses, enrolled nurses, assistants in nursing, midwives, and students of these disciplines. However, much of the information in this guide could apply to other workers engaged in the care of patients, residents or clients, such as personal care assistants working in aged, community and disability sectors.</p>

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<b>Officer</b>	An officer is a person who makes, or participates in making, decisions on behalf of the PCBU that affect how the organisation operates. Officer includes board member, director, company secretary, CEO, owner, or anyone who has a significant impact on the decisions that affect the whole or a substantial part of the organisation – this may include members of the executive team. Officers have specific responsibilities (see due diligence).
<b>PCBU</b>	A person conducting a business or undertaking (PCBU) is the legal entity conducting the business. It is a broader term than employer as it includes companies, partnerships, sole traders, associations and government. A PCBU is the principal duty holder.
<b>Reasonable care</b>	It is the standard for a worker. It means that the worker must: <ul style="list-style-type: none"> <li>• take reasonable care of their own health and safety. This includes the right to cease work or refuse to carry out work they believe to be unsafe</li> <li>• take reasonable care their actions or omissions do not adversely affect the health or safety of others, and</li> <li>• comply with reasonable instruction and workplace safe work procedures.</li> </ul>
<b>Reasonably practicable</b>	That which is reasonably able to be done to ensure health and safety, taking into account: <ul style="list-style-type: none"> <li>• the likelihood of the hazard or the risk occurring</li> <li>• the degree of harm that could result from the hazard or risk</li> <li>• what is known, or ought reasonably be known, about the hazard or risk and how to eliminate or minimise this risk</li> <li>• the availability of ways to eliminate or minimise risk, and then</li> <li>• after consideration of the above, the cost of eliminating or minimising the risk and whether this is disproportionate to the risk.</li> </ul> <p>What is <i>reasonably practicable</i> is determined objectively. This means that a duty holder must meet the standard of behaviour expected of a reasonable person in the duty holder's position.</p>
<b>Representative</b>	In relation to a worker, means: <ul style="list-style-type: none"> <li>• the health and safety representative for the worker, or</li> <li>• a union representing the worker, or</li> <li>• other person the worker authorises to represent them.</li> </ul>
<b>Transitional arrangements</b>	Consideration given to certain requirements under the previous OHS Act during the changeover period to the WHS Act, eg. certain authorisations automatically valid until renewal, recognition of prior records, certain training qualifications.
<b>WHS</b>	Work health and safety.
<b>WHS Entry Permit Holder</b>	Formerly an authorised representative, ie. a union official holding a Fair Work Australia entry permit and authorised under the WHS Act to enter work premises in order to investigate suspected breaches of the WHS legislation, consult with workers or assist in the establishment of work groups and HSR elections.
<b>Worker</b>	A worker is anyone who undertakes work for a PCBU. This work can be in any capacity including as an employee, contractor, labour hire worker, apprentice, student on placement, volunteer or an employee of another PCBU working at the workplace. Workers must exercise reasonable care (refer to <i>reasonable care</i> ).
<b>Work group</b>	A work group is a group of workers who share similar WHS concerns and conditions.
<b>Workplace</b>	A workplace is any place where work is carried out.





A photograph of a hospital room with three beds. The beds are covered with white sheets and dark grey blankets. Medical equipment, including monitors and IV stands, is visible in the background. The room has light green walls and a grey carpet.

Work Health and Safety  
Essentials for Nurses and Midwives

# Background



# Background

## Preamble

Over recent years, the nature of work has changed and OHS legislation had become outdated in dealing with these changes. In health, for example, there have been many changes, including new technology, new conditions and diseases to deal with and even new ways of providing care, such as in a patient's own home rather than in a hospital. These changes all present challenges for those managing and providing care, particularly when provided against a backdrop of funding constraints, staff shortages, increasing work hours, casualised workforce, new skill mix and an ageing workforce.

So, it was time for a new approach, a national approach to managing OHS called *harmonisation*, involving all states and territories. The result was a Model Work Health and Safety Act and Regulation. These were adopted with some modification in NSW as the NSW Work Health and Safety Act 2011 and NSW Work Health and Safety Regulation 2011, in force from 1 January 2012.

This *Work Health and Safety* legislation is intended to provide a uniform approach with flexibility for workers and management to work together to develop systems that address health, safety and welfare for all who work in and visit the workplace.

This resource provides an update to the 2004 *OHS Essentials for Nurses*, outlining how the current legislation can provide improved work health and safety (WHS) outcomes for all.

## WHS issues affecting nurses and midwives

Nursing and midwifery are dynamic and evolving professions. While the general nature of the work has remained consistent for centuries, the workplace continues to expose nurses and midwives to many risks associated with their work. In 2006, the International Council of Nursing (ICN)<sup>1</sup> updated its position paper on OHS issues affecting nurses and midwives to include:

- environmental contamination from waste products produced as a result of health care delivery, including human waste
- risks including chemical, biological, physical, noise, radiation, manual handling and other repetitive work

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<sup>1</sup> International Council of Nurses, 2006, Position statement: occupational health and safety for nurses, Geneva.

- medical technology, including insufficient training for safe usage and lack of maintenance
- inadequate access to protective clothing and safe equipment
- impact of shift work and the disturbance of everyday life patterns
- the increasing demands made on the emotional, social, psychological and spiritual resources of the nurse or midwife working in complex political, social, cultural, economic and clinical settings
- incidents of violence, including sexual harassment
- poor ergonomics, including the poor design of equipment and facilities
- inadequate allocation of resources, and
- working in isolation.

Each year Safe Work Australia<sup>2</sup> publishes a compendium of the statistics on workplace injuries for all jurisdictions, including NSW. Injuries resulting from manual handling continue to be the most common injury associated with work. For nurses and midwives specifically, sprains and strains account for approximately one third of all injuries. However, other issues continue to result in injury including acts of aggression or violence, exposure to biological and chemical contaminants and workplace stress.

Notably, in the Health and Community Services Sector, the incidence of injury has been progressively falling in recent years, except in the community sector (residential aged care and disability sectors) where the incidence is actually increasing. With the move towards providing complex care to patients and clients in the community, this trend is particularly worrying.

When nurses and midwives experience a workplace injury it can have a profound affect on their life, their relationships, their career and their financial situation. For some, they will be unable to continue working in their chosen career.

The impact of a workplace injury is also felt in the workplace. Every nurse and midwife has a skill set which has a particular value where they work. When the nurse or midwife is away from work or unable to work to their full potential because of injury, this skill set is compromised. This has the potential to compromise care and increase the burden on work colleagues. Even where relief personnel are provided to fill the gap, their experience, skill set and familiarity with the workplace and patients rarely matches that of the injured worker.

Workplace injuries increase the financial burden for organisations. Apart from the direct cost of injury management, there are costs associated with injury investigation, replacement and/or retraining of staff, damaged equipment replacement costs and the

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<sup>2</sup> Safe Work Australia, 2012, Compendium of Workers' Compensation Statistics Australia 2009–2010.

administrative costs associated with all aspects of claims management and increased workers compensation premiums. Importantly, the cost of workplace injuries funnels funds away from the provision of care.

The solution is to prevent injury.

Nurses and midwives work in a range of capacities within organisations, including as owners, CEOs and executives, as well as unit managers, team leaders and in clinical positions. The legislation provides a framework for nurses and midwives, in whatever capacity they work, to demonstrate commitment to a safe workplace for all and prevent injury.

This guideline details the specific WHS responsibilities for all levels of nurses and midwives working in NSW.

## WHS and patient safety

In recent years there has been an increased focus on the risk to patients and clients of injury while receiving care, eg. falls, burns, injuries from poor patient handling, medication errors. An injury sustained while receiving care can have a profound effect on the outcome and cost of care and the patient's life after discharge.

### IMPORTANT

The principle of 'do no harm' is a cornerstone of care. It is no less important when considered against the backdrop of legislation addressing work health and safety. *Patient safety and worker safety must complement each other – one does not override the other.* Importantly, a task is not safe unless it is safe for everyone engaged in or affected by the task – this includes the patient and all workers.

As part of the primary duty of care, outlined in Section 19(2) of the WHS Act, the PCBU is required to ensure, as far as is reasonably practicable, that the health and safety of others, which includes patients, is not put at risk from the work undertaken.

Patients too have responsibilities. Section 29 of the WHS Act requires that anyone at a workplace must take reasonable care for their own safety, must not do, or fail to do anything that could adversely affect others, and must comply with reasonable instruction with respect to their safety.

## About WorkCover NSW

WorkCover NSW is the state government agency that administers work health and safety, workers compensation and injury management laws by:

- giving advice and other information to businesses, workers and other members of the community on work health and safety issues
- developing initiatives that focus on specific issues, such as programs that focus on young workers or the challenges some injured workers face when they return to work, and
- investigating work health and safety complaints and incidents and, where necessary, prosecuting breaches of work health and safety laws.

Over the last decade, a number of projects have been undertaken addressing the work of nurses and midwives, specifically:

- *Manual Handling Guide for Nurses* – a policy guide for the management of patient and other manual handling
- *Implementing a Safer Patient Handling Program* – a collection of case studies
- Project to evaluate the use of *Manual Handling Competencies for Nurses* and to identify barriers to their use
- Development of a training resource specifically for nurses and midwives, the *Manual Handling for Nurses* programs, based on the above competencies
- *Barriers and Solutions to Return to Work Programs* – project to investigate the factors that prevent effective rehabilitation of nurses and midwives after injury.

Through the WorkCover Assist program of grants, WorkCover NSW has also funded a number of other projects of benefit to nurses and midwives:

- *OHS Essentials for Nurses*
- *Design and handling of surgical instrument transport cases*
- *Manual handling audits of aged care facilities*
- *Design guidelines for aged care facilities*
- *An integrated risk assessment tool for aged care*
- *Manual handling: a program for low care residential aged care facilities*
- *Resistance to care, workplace injury and effects on the nursing workforce in NSW*, and
- *A cross sectional survey of sharps, including needlestick injuries among NSW nurses in 2007.*

Links to the above documents that are available are included in the Resources section. Note that these documents have all been developed prior to 2012 and consequently may not reflect current legislative requirements.

## What can WorkCover inspectors do?

A key part of a WorkCover inspector's role is to provide advice and information on WHS, workers compensation and injury management issues. Inspectors also carry out enforcement for all WHS, workers compensation and injury management legislation.

Inspectors may attend a workplace in response to an incident. However, in many cases they get involved because someone has asked for help or made a complaint, eg. to resolve a WHS issue or to provide advice.

Inspectors have right of access to any workplace at any time when work is being carried out – *they do not need to give advance notice*. They have extensive powers to obtain information from anyone about a suspected breach of WHS legislation, to assist in monitoring, and to enforce compliance. Inspectors can require proof of identity, require a person to answer questions, take copies of records, take photographs, take statements, and remove samples or equipment.

## Enforcement options

Under the WHS Act 2011, there is now a much wider range of law enforcement options which can be applied.

<b>WorkCover inspector</b>	<b>Infringement Notice</b>	Notice for breach of a specific section of the legislation, eg. fail to notify WorkCover NSW of a notifiable incident (WHS Act, s38).
	<b>Non-disturbance Notice</b>	Notice to leave an incident site undisturbed for a specific period.
	<b>Improvement Notice</b>	Notice to improve equipment, work practices or other aspects of work, eg. undertake a risk assessment of a particular task and implement risk elimination or control strategies.
	<b>Prohibition Notice</b>	Notice that prohibits use of equipment or the performance of a particular task until certain conditions are met, eg. prohibit the use of glutaraldehyde until exhaust ventilation is installed.
<b>WorkCover and PCBU</b>	<b>Injunction</b>	Court order that requires a party to do or refrain from doing specific acts.
	<b>Prosecution</b>	Initiate a prosecution for breaches of the legislation or non-compliances with a prohibition notice, which can include fines and/or jail terms.
	<b>Enforceable Undertaking</b>	A written agreement between WorkCover NSW and a person (usually a PCBU) to correct a problem or address WHS issues as an alternative to prosecution for specific offences, eg. provide risk management training for managers and supervisors, implement a program to address workplace bullying, develop resources to support WHS outcomes for nurses/midwives.



Anyone issued with a notice by a WorkCover inspector must comply with the requirements of the notice within the time frame written on the notice:

- for a *Non-disturbance Notice*, the incident site is to be left undisturbed for up to seven days
- for an *Improvement Notice*, to rectify a hazard or prevent a risk, within a designated time period, and
- for a *Prohibition Notice*, to cease the specific activity immediately.

Further information on WorkCover NSW's approach to enforcement can be obtained in the WorkCover compliance policy and prosecution guidelines available at [www.workcover.nsw.gov.au/compliance](http://www.workcover.nsw.gov.au/compliance)



## CASE STUDY

**I am a Nursing Unit Manager and recently an inspector came to the workplace in response to an incident. The inspector wanted to speak with me about incident reporting in our unit. What should I do?**

Sections 160–165 of the WHS Act outline the functions and powers of WorkCover inspectors, which includes monitoring for compliance with WHS legislation. The WHS Act requires the immediate notification of certain incidents and injuries – *for notifiable incidents refer to glossary*. As part of compliance monitoring, WorkCover inspectors may periodically investigate whether such incidents are being reported.

Section 171 of the WHS Act requires any person at a workplace to answer questions put by a WorkCover inspector.

So YES, you must comply with this request for information.

In this case, you may need to provide evidence that there have been no incidents (not just injuries), such as:

- showing the inspector the incident register
- showing the inspector any hazard reports or equipment maintenance logs, and
- showing the inspector the *Register of Injuries* or referring them to the person responsible for maintaining this register at your workplace.

## Making a formal statement to WorkCover

In the event that a specific incident or serious WHS risk occurs, a WorkCover inspector may request nurses and midwives to make a formal statement. In such circumstances you are entitled to union and legal advice and to have someone with you when you make the statement. If you believe that any statement you make could be self incriminating, and you are a member of the NSWNMA, you are strongly advised not to make any statement without first contacting the union. WorkCover inspectors are obliged to warn you about self incrimination.



## NSW Nurses and Midwives' Association

The NSW Nurses and Midwives' Association (NSWNMA) is an industrial and professional organisation for nurses and midwives. The Association represents nurses and midwives at all levels – registered nurses and midwives, enrolled nurses, assistants in nursing and midwifery, employees through to managers and officers, and all nursing specialties.

NSWNMA's focus is on the prevention of injuries, the fair and equitable treatment of nurses and midwives who are injured at work or develop a work related illness, and building collaborative relationships with workplaces. Nurses and midwives have the right to work in an environment that does not threaten their health, safety or welfare and NSWNMA will do everything in its power to protect and enforce this right.

NSWNMA provides members, including managers and HSRs, with up-to-date advice on WHS issues, both current and emerging (eg. manual handling, violence, latex, legislative changes), and works with employers and Government on WHS issues relevant to nurses and midwives in order to develop protective legislation and policies. NSWNMA also provides support and advocacy to members who raise WHS issues.

To this end, NSWNMA employs professional WHS officers as well as organisers, information officers and member support officers, all with considerable experience and commitment to WHS. Publications such as *The Lamp*, the official journal of NSWNMA, and the NSWNMA website regularly feature articles on topical WHS issues.

NSWNMA participates in many committees at national and state level that address WHS issues, including the ACTU and Unions NSW WHS Committees, Standards Australia, and those of the Ministry of Health and other agencies that employ nurses and midwives.

## NSWNMA's role investigating WHS

**The NSWNMA WHS Officers and other NSWNMA officials hold WHS Entry Permits, which will be presented on request when visiting a workplace.**

The WHS Act requires NSWNMA union officials to hold a *WHS Entry Permit* to deal with WHS issues on site at a workplace where nurses and midwives work.

The *WHS Entry Permit* enables the NSWNMA official to exercise certain powers under the WHS legislation, including the power to enter a workplace where nurses and midwives work, consult with nurses and midwives, make searches and inspections and require the production and copying of any document relevant to the health and safety of nurses and midwives. Where the visit is announced and notice given of requiring access, the WHS Entry Permit Holder can also access relevant employee records.

The employer or occupier of the premises cannot refuse the holder of the *WHS Entry Permit* the right of entry or obstruct them in carrying out their powers. This includes providing reasonable facilities for them to consult with nurses and midwives in confidence.

When investigating a suspected breach, a NSWNMA official holding a *WHS Entry Permit* can enter the workplace without providing advance notice, however they must provide notification as soon as possible afterwards. In other circumstances, the NSWNMA official is required to provide a minimum of 24 hours notice.



## CASE STUDY

**In our workplace there is an ongoing concern that workers are not being consulted about workplace changes which potentially have WHS implications. How can the NSWNMA help?**

The NSWNMA may take one of the following actions to help resolve this matter:

- provide phone advice on how to proceed using internal workplace mechanisms, eg. determine whether the issue has been raised formally with the PCBU, liaise with the HSR
- forward a letter, call, or set up a meeting with the PCBU
- visit the workplace to consult with nurses and/or midwives about their concerns, or
- make a complaint to WorkCover NSW on a member's behalf.

NSWNMA officers holding a *WHS Entry Permit* cannot direct unsafe work to cease. However, it is a right of any worker to refuse to do work they believe puts them at imminent risk. Further, HSRs who have completed the required training, can order work to cease if it is unsafe and presents imminent risk.

If there is a potential breach of the *WHS* legislation, the NSWNMA may request that WorkCover NSW be involved. In limited circumstances, the NSWNMA General Secretary can also initiate a prosecution.

To contact NSWNMA for advice on a *WHS* issue, phone 1300 367 962 or (02) 8595 1234 or email [gensec@nswnma.asn.au](mailto:gensec@nswnma.asn.au).

A close-up photograph of a female nurse in blue scrubs holding a newborn baby. The nurse is looking down at the baby with a gentle expression. The baby is lying on its back, wearing a light-colored onesie, and has its mouth slightly open. The nurse's stethoscope is visible around her neck. The background is plain white.

Work Health and Safety  
Essentials for Nurses and Midwives

## Legislation framework



# Legislation framework

## Overview

On 1 January 2012, NSW introduced a WHS legislation framework comprising the:

- NSW Work Health and Safety Act 2011
- NSW Work Health and Safety Regulation 2011
- Codes of Practice, and
- Guidelines.

The WHS Act provides the framework for the protection of the health, safety and welfare of workers at work as well as others affected by the the work undertaken at the workplace.

The WHS Regulation provides more detail on how the duties prescribed under the WHS Act must be performed, as well as procedural and administrative matters to support the WHS Act.

The Codes of Practice provide the 'how to' advice to support aspects of the legislation. They provide guidance on how to meet the legislative requirements. However, they are not mandatory and the PCBU can opt to use other standards that provide equivalent or higher compliance for WHS (the PCBU should be able to demonstrate the effectiveness of this alternative approach).

Guidelines comprise other documents that provide general advice, usually on specific issues. They may take the form of fact sheets or guides, such as those produced by WorkCover NSW or Safe Work Australia.

Key aspects of the legislation framework will be outlined in the following sections.



### DEFINITION

#### **Workplace – what does it mean?**

A workplace is any place where work is carried out. This includes any place where a worker goes, or is likely to go, and may therefore not only include traditional workplaces like a hospital, aged care facility or clinic, but also a client's home, an off-site training or conference venue, airport and aeroplane, boat, office, prison or construction site.

## What's required of a PCBU?

PCBU – person conducting business or undertaking, such as:

### Individual

- Partner in partnership, eg. medical practice.
- Sole trader, self employed, eg. nurse/midwife practitioner in private practice.

### Organisation

- Public or private company, eg. private hospital, aged care organisation, nursing agency, airline.
- Government departments and authorities, eg. NSW Health, schools, gaols.
- Independent schools and universities.
- Incorporated association.

Section 19 of the WHS Act places the primary *duty of care* with the entity conducting the business, now called the *person conducting the business or undertaking (PCBU)*. This term replaces the term *employer* and encompasses companies, partnerships, sole traders, associations and government.

The PCBU must ensure, as far as is *reasonably practicable*, the health and safety of all workers at the workplace. This duty is not limited just to employees, but any worker whose work is influenced or directed by the PCBU. This duty also extends to workers placed with another PCBU to carry out work, such as applies in labour hire (agency) personnel and contractors.

The PCBU must also ensure, again as far as is reasonably practicable, that the health and safety of others at the workplace, such as patients and visitors, is not put at risk by work carried out by the PCBU.

This requires the PCBU to:

- ensure that the work environment is safe
- provide and maintain safe equipment and structures, including special provisions for the commissioning of plant or structures, eg. building work, refurbishment
- provide and maintain safe systems of work, eg. safe work procedures, best practice, adequate staffing and skill mix
- ensure anything used at the workplace is safe when used properly, eg. equipment, chemicals, personal protective equipment, furniture and fittings

- provide adequate facilities for the welfare of workers, eg. first aid, drinking water, toilets, place to secure the worker's property, facilities for eating and preparing food and well-maintained accommodation for workers who live at premises controlled by the PCBU
- provide information, training, instruction and supervision
- establish and maintain effective worker participation in WHS
- ensure notification to WorkCover NSW of certain incidents
- ensure registration of all HSRs through WorkCover NSW's on-line portal <http://hsr.workcover.nsw.gov.au>
- monitor the conditions of the workplace and the health of workers
- provide for the safety of patients, visitors and others who visit the workplace, and
- establish effective cooperation and consultation with other PCBUs that work at your workplace or where your PCBU places workers. This is of particular relevance to Private Public Partnerships and other inter-agency relationships.

## DEFINITION

### **Reasonably practicable – what does it mean?**

Reasonably practicable is the standard for the PCBU. It means that the PCBU takes reasonable steps to effectively manage WHS issues. The standard is based on what a reasonable person could be expected to do in the same circumstances. It is a balance between what is known about the risk and ways of eliminating or controlling the risk, time, effort and, and after all other considerations, whether the cost of risk elimination or control is disproportionate to the risk.

Whether something is reasonably practicable is to be determined objectively and not by reference to the PCBU's capacity to fund the control. If a PCBU cannot afford to implement a strategy to eliminate or control a risk, then the PCBU should not continue that activity.

## CASE STUDY: Joint duty holders

**I work for a pathology company as a blood collection nurse. I am based in a large GP practice. Who's responsible for my safety?**

The pathology company, as your employer is a PCBU and responsible for your safety. However, the GP practice where you work is also a PCBU. Both PCBUs are responsible and have to cooperate in ensuring your safety at work.





## CASE STUDY: Joint duty holders

**I work as an agency midwife. Who's responsible for my safety at work?**

As a labour hire organisation, the agency is a PCBU and is required to ensure that wherever you work (hospital, clinic, private home) is safe. However, the workplace where you are placed is also a PCBU, and therefore responsible for the health and safety of all workers, including agency staff.

The WHS Act requires that the PCBU with whom you are employed and the PCBU where you are placed must communicate and cooperate in respect to the work you will be doing to ensure it is safe. So, in practice, this should mean that before you are placed in the host workplace, both the agency and the host facility have consulted to ensure that the environment, work practices, supervision, equipment and facilities will not place you at risk of injury, that you have had all necessary training, and have been inducted to the workplace.

In many cases agency midwives work under the direction of the host facility and, in most cases, are doing the same or similar work to employees of that host facility. Both the agency and the host PCBUs should ensure that the same standards for safety apply to all midwives, irrespective of whether they are employed directly or through an agency. As an agency midwife you should not be expected to do any work that you or an employee would consider unsafe.



## CASE STUDY: Who's responsible when away from base

**I work for a NSW-based organisation that sends me interstate and overseas periodically to work. Who is responsible for my safety while I am working outside NSW?**

WorkCover NSW has no jurisdiction outside NSW. However, the obligation on the PCBU to ensure the health and safety, to the extent that is reasonably practicable, extends to wherever you work, including beyond the borders of NSW. In practice this means that the PCBU must consider whether the work required of you while working away poses any additional risks to those you would be exposed to routinely and what actions need to be taken to control these additional risks, eg. protection against a specific disease endemic to the area you were going to work, risks associated with travel. The PCBU should also alert you to any specific WHS requirements relevant to the area in which you are to travel for work, eg. different road rules if your work involves driving.



## What's required of an officer?

A corporation is an artificial entity that cannot make decisions or act other than through individuals. A corporation cannot comply with a duty of care placed upon it, unless those who manage the corporation make appropriate decisions to ensure necessary actions are taken.



### DEFINITION

#### Officer – what does it mean?

An officer is an owner/proprietor, director or secretary of a corporation, or senior executive who makes, or participates in making decisions that affect the whole, or a substantial part, of the business.

Section 27 of the WHS Act outlines the primary duty of an officer, that of ensuring that the PCBU complies with its duties and obligations. The officer governs the PCBU and makes decisions involving a range of governance issues including finance and resource allocation.

## Am I an officer?

Factors that determine whether you are an officer include how much influence you have in making decisions that affect the whole or a substantial part of the organisation.

You are an officer if:

- you are the owner/proprietor/administrator of a PCBU, eg. an aged care facility, labour hire firm or clinic, or
- you are the director, secretary of the corporation or board member, or
- you are a person who:
  - makes or participates in making decisions that affect the whole or a substantial part of the organisation
  - determines and/or has control over resource allocation for all or a substantial part of the organisation.

You are not an officer if:

- you manage a resource budget that has been allocated to you, and
- you implement the policies and procedures of the organisation.

The term *officer* is a legal term. Your job title may include the word officer, executive or manager, however for you to be considered an officer for the purposes of WHS legislation, your responsibilities and authority must fall within the prescribed definition.

Officers have a duty to exercise due diligence, which includes taking reasonable steps to:

- know and understand WHS duties and obligations
- know the industry and understand the hazards and risks associated with this work
- ensure the allocation of sufficient and appropriate resources for safe work
- ensure that there are processes for receiving and evaluating information about incidents, hazards and risks, and responding in a timely way, and
- monitor and verify to ensure the organisation is actually doing what it says it is doing about WHS.

Importantly, the officer is liable for his or her own conduct or omission – ignorance of WHS legislation is not a defence. Also, officers can only delegate *tasks* associated with their role, eg. reporting certain incidents to WorkCover NSW. They cannot delegate their *duties* under the WHS Act to managers, supervisors, workers, or others, such as a WHS Coordinator or Consultant.



## DEFINITION

### Due diligence – what does it mean?

Due diligence is the standard that must be met by the officer. It means that the officer will have to demonstrate they have taken reasonable steps to:

- ensure WHS systems and practices are effective
- act on unsafe work practices, conditions and incidents
- report on safety performance
- ensure appropriate WHS expertise is retained, and
- ensure that WHS is considered in all decision making.

Ultimately, due diligence is about leadership – establishing, promoting and facilitating a safety culture within the workplace so that health and safety becomes part of how the PCBU does business and delivers health care services.

## My responsibilities as a worker

In workplaces such as hospitals, aged care and other health care facilities, work is performed by many people, not just employees. The term employee was replaced with worker as it was too limiting because everyone in the workplace must be protected from health and safety risks. So, who is a worker?

A worker can include:

- employee
- labour hire personnel
- contractor, eg. plumber, electrician
- volunteer
- sales representatives
- researcher working on a project
- equipment service technicians.
- student on placement
- apprentice
- funeral transfer personnel
- ambulance, police or fire officer
- work experience/exchange student
- person who delivers supplies

Section 28 of the WHS Act outlines your responsibilities as a worker. Specifically, while at work you are required to:

- take reasonable care of your own health and safety
- take reasonable care not to endanger anyone else by your actions (what you do) or your omissions (what you fail to do)
- comply, as far as you are able, with any reasonable instruction given by the PCBU in respect to WHS, and
- once advised, cooperate with any reasonable policy or procedure at the workplace relating to WHS, ie. follow safe work practices, use equipment, wear protective equipment or clothing, participate in training, and report hazards, faulty equipment, an incident or injury.

## DEFINITION

### **Reasonable care – what does it mean?**

Reasonable care is the standard for the worker. Assessment of a worker's failure to take reasonable care is balanced against the PCBU's actions to do what was reasonably practicable, that is:

- the safety systems in place at the time
- the training, instruction and supervision provided
- whether the worker was working in their usual role
- whether any other person was placed at risk, or
- whether the worker acted intentionally or recklessly.

Reasonable procedures that all nurses and midwives would be expected to comply with could include:

- follow safe work practices, eg. safe patient handling, security procedures
- use equipment, eg. trolley for moving supplies, wear a duress alarm
- wear protective equipment or clothing, eg. gloves, apron and face shield when handling waste
- participate in training, eg. training in the use of a new item of equipment
- report hazards and risks
- report an injury or incident, including those involving patients
- report faulty equipment, eg. faulty brake on a bed
- report unsafe practices, eg. bullying or harassment
- report work practices that you are unable to comply with, eg. a practice that is out-of-date or unworkable.



### **CASE STUDY: Hazardous chemicals**

**I work in the endoscopy clinic. Part of the clinic is blocked off at present because of renovations. Because the clinic is operating, the air-conditioning is functioning. While working on a case today we were suddenly aware of an odd and offensive smell coming through the air-conditioning. Within ten minutes I suddenly experienced shortness of breath, sore eyes and vomiting. The other staff were all right, but I was sent to the ED and diagnosed with a reaction to a solvent adhesive being used by the builders. I have asked to be reassigned work away from the clinic while these renovations continue.**

Section 84 of the WHS Act supports your right to cease, or refuse to carry out, work if you have reasonable concern that the work or the workplace exposes you to a serious and imminent WHS risk. If you avail yourself of this right, you must notify your manager and remain available to be allocated to other suitable work. It is also recommended you consult with your HSR.



## CASE STUDY: Hazardous chemicals

**As the WHS Coordinator for my hospital, the CEO advised me that I am responsible for all aspects of WHS under the new legislation. Is this correct?**

Section 272 of the WHS Act says that anyone, not just the PCBU, who has a duty under the WHS legislation cannot, through any agreement or contract, transfer their duty to another person.

The CEO is an officer and, as part of their duty of due diligence, they are responsible for ensuring that suitable WHS expertise is retained. While it is expected that the WHS Coordinator's role will involve tasks that enable the PCBU to comply with the legislation, due diligence still rests with the officer.

Tasks can be delegated but not the duty, so no, you cannot be held accountable for your organisation's overall WHS performance. That duty rests with the PCBU through the officers.

## Advice for managers and supervisors

WHS legislation does not define a specific role for middle managers and supervisors – they are defined as workers.

Middle managers such as DDONs/DDOMs or shift supervisors and line managers, such as NUMs/MUMs would be expected to implement the organisation's WHS policies and procedures and lead, guide and support workers reporting to them in the safe performance of work.

**A checklist for activities relevant to middle managers should include:**

- Engage with workers about the work they do, deal effectively with their WHS concerns
- Consult with HSRs on WHS matters
- Develop, implement and monitor how WHS is managed within the area of responsibility
- Allocate resources – staffing and equipment
- Support and promote WHS training
- Support, mentor and encourage worker participation in WHS
- Act on hazard and incident reports
- Deal promptly and fairly with workers who exhibit unsafe behaviours
- Ensure WHS is a consideration in all planning
- Lead by example – set the standard you want workers to follow
- Ensure HSRs and HSC members are rostered so they can attend meetings and fulfil their health and safety duties, and
- Report any issues outside your delegation and authority to senior management.

## Important – all nurses and midwives

Some nurses and midwives take on director roles on professional bodies and foundations associated with their work, or their leisure, such as with sporting or recreational clubs. Some nurses and midwives may be part of a family or partner's business, or even run their own business from home.

In this capacity you may have responsibilities under the WHS legislation, even if your role is voluntary or you are considered a 'silent partner'. The key to determining this is whether the business or partnership is a PCBU. If you are a volunteer (non paid) director, more information can be sourced at <http://www.workcover.nsw.gov.au>

## Others in the workplace

Anyone at a workplace who is not a worker or officer is termed 'other', for example:

- residents, patients, clients
- visitors to the workplace, such as relatives, people attending lectures or other education (but not on student placement) and union officials
- trespassers.

Section 29 of the WHS Act outlines the responsibilities of others in the workplace, including:

- taking reasonable care for their own health and safety
- taking reasonable care not to endanger anyone else by their actions or omissions, and
- complying with reasonable instruction from the PCBU.

Reasonable instruction could include:

- comply with hand hygiene procedures
- comply with smoke-free environment requirements
- advice that the PCBU will not tolerate worker bullying or harassment by others while visiting the workplace
- not interfere or misuse anything provided for safety, eg. activate or disable warning alarms
- comply with security requirements, eg. not leaving doors open, not letting others through locked doors, not bringing matches or a lighter into a mental health unit, and
- cooperate with safe patient handling requirements, eg. allow patient handling equipment such as hoists and slide sheets to be used.

In addition to the requirements under the WHS legislation, everyone in the workplace has a common law responsibility to ensure that they do not harm anyone.

To enable patients and visitors to comply with WHS advice, they need to be informed. Health care facilities may need to use a range of media to ensure these WHS messages are communicated, eg. through the hospital TV or radio channels, the facility website, posters, information brochures, resident committees, patient orientation. Specific WHS requirements/obligations should also be included in service contracts with clients, eg. community health, disability.

## Do patients have responsibilities?

As many nurses and midwives have experienced, patients can cause injury. While this is often unintentional, sometimes it is done with purpose and intent.

As noted in the previous section, patients are incorporated within the term *Others*. Therefore, patients should not do, or ask for anything to be done or not done, eg. refuse a hoist, that could place staff or other workers at risk of injury.

Patients, like everyone in the community, are accountable for criminal behaviour. Nurses and midwives are encouraged not to tolerate any threatening behaviour or violence, to distance themselves and others from the threat if necessary, and to report this immediately.



### CASE STUDY

Mrs Black is a client in the community receiving daily nursing care in her home for a leg ulcer. She is able to transfer and walk short distances but requires a mobile showerchair to go to the bathroom. Mrs Black weighs 150kg and refuses to pay for the carpet in her bedroom to be replaced with vinyl to make it easier for the nurses to move her by showerchair. Mrs Black's daughter lives nearby and provides care to her mother after hours.

Nursing staff feel frustrated – balancing care needs, client wishes and staff safety is sometimes difficult. To resolve the matter, nursing staff undertook a risk assessment, involving Mrs Black and her daughter, listening to their concerns – the carpet had not long been put down.

However, the risk assessment clearly showed it was unsafe for the nursing staff to continue to manoeuvre the showerchair on carpet. It was also unsafe for Mrs Black as the chair could overbalance if the wheels caught in the carpet.

Mrs Black agreed to a temporary floor surface being placed over the carpet which could be removed when she no longer needed the showerchair. Until this was fitted, Mrs Black accepted that the nurses would need to bath her in bed.

## Who pays for safety?

Section 273 of the WHS Act requires the PCBU to pay for anything required to fulfil their responsibility for providing a healthy and safe workplace. The PCBU is therefore required to provide anything a nurse needs to do their work safely, which can include:

- equipment such as patient handling hoists, slide sheets and gait/walk belts
- furniture, such as computer workstations with task seating, adjustable electric beds
- protective clothing such as gloves (including latex-free), wet area clothing, face shields and lead gowns/aprons, wet weather clothing for community and air ambulance retrieval
- immunisation for protection against risks associated with providing care to patients or working in specific environments, eg. Hepatitis B, Ross River Vaccine, influenza
- screening necessary to work in particular areas, eg. radiation monitoring, urine and blood tests for those working with cytotoxic drugs
- duress alarms that are compatible with work done, other equipment and uniforms
- staff amenities at work, eg. potable water, fridge for staff food
- safety training, eg. training in WHS legislation, induction training, fire safety, patient handling, prevention of workplace bullying, and de-escalation of violence
- HSR training
- means of communication, including duress alarms where indicated by risk assessment, and
- secure, well designed premises.





## CASE STUDY

I am a Midwifery Unit Manager and have been advised that all unit staff have to attend training on WHS issues prior to accreditation. The sessions are being run at specific times, which means some staff will have to stay back and others come in early. Several staff have indicated that they will not be able to attend because they have other commitments, such as childcare. Can I insist staff attend?

Where possible, workers are required to cooperate with the PCBU and attend training. However, the PCBU needs to take account when scheduling training that most staff will have responsibilities outside work, so they should provide ample notice so that workers can make arrangements where possible to attend. Some flexibility is recommended in when, how and in what mode the training is provided.

The PCBU should explore alternative options for delivering training, such as e-learning or workbook format, which staff can do on their own at a convenient time during work hours.

Where workers are unable to attend scheduled WHS training, and that training is considered essential for them to work safely, then alternative options should be provided, eg. conducting training during shift rather than across shifts. The PCBU should also monitor to ensure that all workers receive essential training.

While attending WHS training, nurses are considered to be at work and entitled to be paid for this time. Some workplaces may allow shift times to be adjusted accordingly or may offer time in lieu as an alternative to overtime payment.

## Designers, suppliers, etc

Designers, manufacturers, importers and suppliers each have responsibility to ensure that their product, whether it is premises, furniture, equipment or chemicals, is designed to meet safety standards and will not pose a risk to workers or patients if used according to instructions (sections 22–25, WHS Act). Information for safe usage of furniture, equipment or chemicals should include:

- the intended use
- how to use
- safe working limits such as the safe working load (SWL) or weight restriction
- how the product should be stored, eg. chemicals requiring storage below 24°C
- specific handling, eg. incompatibilities such as the means for identifying slings for use with specific hoists, personal protective equipment to be worn
- maintenance including cleaning and servicing
- disposal of the product, eg. recycling, waste management
- product limitations and residual risks, if any, and
- any other precautions for safe use.

Installers and those who commission or repair equipment, furniture or buildings must ensure that these are installed, constructed, commissioned and repaired so that they do not pose a risk to anyone when used as intended. Similarly, when equipment is decommissioned, it should be rendered inactive and disposed of safely. Further, the PCBU performing the installation, commissioning, repair or decommissioning and disposal of equipment or structures must ensure that those in the vicinity are not exposed to risks while this work is done (section 26, WHS Act).

**Nurses and midwives should not design or modify any furniture or equipment themselves which is used in their workplace, otherwise you could be considered the designer. If you have an idea for a product that could make work safer, get professional advice before embarking on the project.**



## CASE STUDY

**I have been asked to participate in a design team for the refurbishment of our ward. Does this make me a designer?**

Involving workers in design projects is an important way that officers can demonstrate due diligence. As well, working with architects and designers is a valuable way of ensuring that the refurbishment takes into account factors for nurse/midwives, patient safety and clinical practicalities.

Your involvement in the design team is advisory and part of the consultation process, so you are not classed as a designer.

The Therapeutic Goods Administration (TGA) regulates medical devices for use in Australian health care facilities. Medical devices not only include the equipment used in the care of patients, but also beds and patient handling equipment, such as hoists and slide sheets.

Health care workers are encouraged to report any adverse event or problem associated with the use of a regulated device, such as defective components, performance failure, poor construction or design, or inadequate instructions for safe usage. The TGA has a form for reporting, available at <http://www.tga.gov.au/safety/problem-device-report-user.htm>.

Nurses are also encouraged to complete an incident form for any adverse event involving medical devices, whether injury has occurred or not. In certain circumstances the PCBU may also be required to notify WorkCover NSW (see glossary).

## IMPORTANT

**It is important to remember that the selection of products on government contract or registered by agencies such as the TGA is not a guarantee that the product is 'fit for purpose' – appropriate and safe for your specific application.**

Therefore, before purchasing any product it is important to consult with similar services using the product and trial the product in the workplace.

If the product is not properly evaluated prior to purchase, workers and patients are potentially at risk. There's potential that the equipment cannot be redeployed, resulting in delays, increased costs and wasted effort waiting for the appropriate product.

Most organisations have procedures which allow off-contract purchases, subject to justification. A risk assessment is an excellent means for providing this justification.

## Controller of premises, fixtures, fittings and equipment

Duties of controllers are contained in various sections of the WHS Act and WHS Regulation requiring any person with management or control of a workplace to ensure, as far as is reasonably practicable, that the workplace does not pose a risk to anyone. This can include:

- the integrity of the structure itself, ie. well constructed, 'fit for purpose' and well maintained
- the means of entering and exiting the workplace is safe
- the provision of adequate ventilation, lighting, fire safety requirements
- that products containing asbestos that cannot safely be removed are enclosed, made safe and logged in a register, and
- emergency plans are prepared, implemented and practised to ensure the safe and controlled evacuation of everyone should the need arise.

Similarly, fixtures, fittings, equipment and furniture must not pose a risk to anyone (Section 21).



## CASE STUDY

**I work in theatres and we use surgical loan sets supplied to us for specific operations. These loan sets can be very heavy and difficult to manoeuvre.**

This is a complex WHS issue because there are many PCBUs involved in the supply, transportation and use of these loan sets. A national project was coordinated by WorkCover NSW to address this issue, and in 2011 a guide was published to assist all involved to work safely with surgical loan sets. The guide is available from [www.hwsa.org.au](http://www.hwsa.org.au)



## CASE STUDY

**I work in aged care, coordinating aged care packages for clients in their home. Does the WHS Act apply to a client's own home?**

A residential home is only considered a workplace when it is being used as such, that is when nurses are attending to the client. Therefore, fixtures, fittings and equipment owned by the client needs to be safe if they are involved in the delivery of that care.

For example, a shower hob may restrict a client accessing the shower and necessitate the nurse assisting the client by lifting each leg over the hob. As such, this fixture is a WHS risk for the nurse because of the adverse posture associated with this task. However, if the client was able to step in and out of the shower unaided, then the hob is not a risk for the nurse at that time. Should the client's care needs change or their mobility become impaired, nurses should report this promptly so alternate procedures can be initiated, eg. shower aids, bathroom modification.

If the client was in premises leased by a health care provider, then any risks associated with the hob has to be looked at in broader context, which means it needs to be safe for all potential users, ie. all clients and all workers. This may result in a different outcome, with the hob being removed.

## Protection from discrimination

Section 104 of the WHS Act prohibits discriminatory conduct where a worker has exercised any right or duty, or refrained from exercising any power or function within the scope of this legislation, such as:

- raising any concern about WHS
- assisting in the resolution of any WHS issue
- nominating for, or being elected as a health and safety representative (HSR), or
- exercising any power or performing any function as a HSR.

Discriminatory conduct includes anything that disadvantages the worker such as dismissal of a worker, termination of a contract with a worker, altering the position to the worker's detriment, or failing to engage a prospective worker.



## CASE STUDY

**I am a Nursing Unit Manager and have been told by my manager that one of my staff is suspected of contacting WorkCover NSW about an ongoing safety issue that has not been resolved. As the staff appraisals are due, my manager has suggested that I use this as an opportunity to rate the nurse poorly, which could affect the nurse's future employment options. I am concerned if I don't follow this 'suggestion' I might find myself on the receiving end of similar treatment.**

Section 107 of the WHS Act prohibits anyone requesting another person to engage in discriminatory conduct for raising WHS concerns.

In the first instance you should speak with your manager expressing your concerns about linking an allegation to performance, as you understand this is contrary to the WHS legislation. Depending on the outcome, you could also speak with Human Resources. If you are a member of the NSWNMA, you should contact the Association immediately.

Under no circumstances should you be party to discriminating against any worker because of WHS.

## WHS Regulation

The WHS Regulation 2011 continues the approach adopted in NSW in 2001 of placing all the regulations pertaining to WHS in one, consolidated document. This makes it easier for everyone to know what is required to be done to comply with the various duties defined under the WHS Act.

A key component of the WHS Regulation is worker participation in WHS. While consultation has been a feature of legislation in NSW since 1984, from 2012 there is a shift away from a committee approach to health and safety representatives (HSRs) who represent work groups and play a more direct role in dealing with issues that affect the workers in their work group. More detail on worker participation and representation is provided in the next section.

The WHS Regulation also outlines the approach for how risks are to be managed. There is now greater emphasis on eliminating or controlling risks, with risk assessment being required only where controls are not obvious or part of established practice. This makes sense, particularly in health, where controls for many WHS risks have already been determined and work practices established. For example, we don't need to do a risk assessment to know we need to use a hoist for moving non-weight bearing

patients. However, we would still do a patient risk assessment to determine which sling and hoist are appropriate to move the particular patient. See the next section *Key elements for a safe workplace*.

The WHS Regulation also details the requirements for dealing with:

- general workplace issues such as WHS training, first aid, personal protective equipment, remote or isolated work, thermal comfort
- hazardous work, such as manual tasks, confined spaces, noise, falls from heights and electrical safety
- plant and structures safety, including registration of certain plant
- construction work
- chemicals, and
- asbestos.

Remember, the WHS Regulation applies to all workers working in any workplace, not just employees, eg. nurse venepuncturist working from a doctor’s surgery, nurse escort taking a patient to an external radiology practice, agency personnel, a student midwife on placement, as well as other medical, allied health, support and administrative personnel.

## Penalties

Penalties are imposed for breaches of duty under the WHS legislation – the Act or the Regulations.

There are three categories of penalties.

<b>CATEGORY 1</b>	For reckless conduct that exposes an individual to a risk of death or serious injury/illness and occurs without reasonable excuse.
<b>CATEGORY 2</b>	For failure to comply with a WHS duty and exposing an individual to a risk of death or serious injury/illness.
<b>CATEGORY 3</b>	For failure to comply with a WHS duty.

The penalty listed below is the maximum penalty for each type of duty holder and represents a substantial increase in penalties incurred under previous OHS legislation. These penalties are no longer based on penalty units, the formula used for previous penalties in NSW, which could be modified by the Minister. These penalties are determined nationally and apply across Australia in all jurisdictions that have adopted the model WHS Act and Regulations.

<b>CATEGORY 1</b>		
Reckless conduct	Corporation	\$3,000,000
	Individual as PCBU or Officer	\$600,000 and/or 5 years prison
	Other individual	\$300,000 and/or 5 years prison
<b>CATEGORY 2</b>		
Breach – high risk	Corporation	\$1,500,000
	Individual as PCBU or Officer	\$300,000
	Other individual	\$150,000
<b>CATEGORY 3</b>		
Breach of duty	Corporation	\$150,000
	Individual as PCBU or Officer	\$100,000
	Other individual	\$50,000

The WHS legislation falls within the criminal jurisdiction. For the majority of breaches, the prosecution has to prove beyond reasonable doubt that the offence has been committed. Refer to *WorkCover NSW Compliance Policy and Prosecution Guidelines* at [www.workcover.nsw.gov.au/compliance](http://www.workcover.nsw.gov.au/compliance).

Some offences, such as discriminatory conduct, fall within the civil jurisdiction which has a different standard of proof.

## Legislation at a glance

<b>Topic</b>	<b>Act</b>	<b>Regulation</b>
Accident notification	Part 3, ss 35–39	
Air quality		Chapter 3, cc 40, 49–52
Amenities/accommodation		Chapter 3, cc 40–41
Asbestos		Chapter 8
Carcinogenic substances		Chapter 7 Schedules 6–108
Cease performing unsafe work (right to)	ss 83–89	
Chemicals		Chapter 7
Codes of Practice	Part 14 s 274	
Consultation – representation and participation	Part 5 ss 46–79	Chapter 2
Construction work		Chapter 6
Definitions, important terms	ss 5–9	c 5
Designers, manufacturers, importers, suppliers and installers	Part 2, ss 20–26	Chapter 5 Plant Chapter 7 Chemicals
Discriminatory, coercive or misleading conduct	Part 6, ss 104–115	

<b>Topic</b>	<b>Act</b>	<b>Regulation</b>
Electrical safety		Chapter 4, cc 144–166
Emergencies		Chapter 3, c 43
Enforceable undertakings	ss 216–222	
Facilities		Chapter 3, cc 40–41
First aid		Chapter 3, c 42
Hazardous chemicals		Chapter 7
Health and safety duties – reasonably practicable – primary duty of care – PCBU – officers – workers – others – offences	s 18 s 19 ss 20–26 s 27 s 28 s 29 ss 30–34	
Health and safety representative – HSR	Part 5, ss 50–74	Chapter 2, cc 18–21
Health and safety committee – HSC	Part 5, ss 75–79	
Incident notification	Part 3 ss 35–39	
Issue resolution	Part 5 ss 80–82	Chapter 2, cc 22–23
Lighting		Chapter 2, c 40
Manual tasks (handling)		Chapter 4, cc 60–61
Noise		Chapter 4, cc 56–59
Penalties	ss 30–34	
Plant and structures		Chapter 5
Personal protective equipment (PPE)		Chapter 3, cc 44–47
Provisional Improvement Notices (PIN)	Part 5, ss 90–102	
Record keeping		See specific hazards
Remote or isolated work		Chapter 3, c 48
Risk management		Chapter 3, cc 32–38
Supervision		See specific hazards
Temperature – heat and cold		Chapter 3, c 40
Training, information and instruction	Part 2	Chapter 3, c 39 See specific hazards
WHS Entry Permits	Part 7, ss 116 – 151	Chapter 2, cc 25–31
WorkCover – role and powers of the regulator	Parts 8, 9, 10, 11, 12, and 13	
Work groups	Part 5, ss 51–59	Chapter 2, cc 16–23

Key: ss, refers to Sections of the WHS Act | cc, refers to Clauses of the WHS Regulations

The work health and safety legislation is available at:

- NSW Government: [www.legislation.nsw.gov.au](http://www.legislation.nsw.gov.au)
- AustLII: [www.austlii.edu.au](http://www.austlii.edu.au) (also available as Android, iPhone and iPad app).



A photograph of a woman in blue scrubs smiling and holding the hand of an elderly man in a grey sweater with glasses. The woman is on the left, looking down at the man's hand. The man is on the right, looking down at his hand. They are both smiling. The background is a blurred indoor setting, possibly a hospital or care home.

Work Health and Safety  
Essentials for Nurses and Midwives

Key elements for  
a safe workplace



# Key elements for a safe workplace

Every workplace needs to have a structured approach to managing WHS and preventing workplace injury. Key elements for a safe workplace should include:

- leadership
- policy development
- consultation
- training
- risk management, and
- maintain, review and improve.

Those of you familiar with quality management systems will recognise the similarity of this model, the aim of which is to achieve continuous improvement in WHS performance.



## WHS leadership

Leadership is the cornerstone of an effective WHS program. Leadership sets the bar and the safety culture in the organisation. This in turn determines how WHS is managed across the whole organisation. If WHS is perceived by senior management as a cost and distraction from core business, then the WHS culture tends to be reactive and 'blame focussed'. However, when WHS is perceived to be 'good business sense' and aligned to the organisation's goals, this filters through the organisation and embeds in how all decisions are made.

Executive and senior nurse/midwife administrators have a key role to play in shaping the safety culture in their organisation through:

- driving WHS
- determining goals
- recruiting, supporting and empowering personnel
- establishing clear communication processes

- guiding continuous improvement
- enabling WHS innovation
- establishing processes that work, and
- considering the WHS and patient safety implications of all decisions.

## Policy development

A WHS Policy is a general statement that outlines the organisation's commitment to a safe and healthy workplace.

A WHS Policy, and any other policies developed under this umbrella, should specify:

- the responsibilities and accountabilities of all people in the workplace to whom the policy applies, eg. PCBU, officers, supervisors, workers, others, and
- what the organisation will do to prevent injuries, eg. facility design, provision of appropriate equipment, training of employees, staffing and skill mix.

Examples of WHS policies a health care facility should have in place include:

- general WHS policy
- critical incident and emergency preparedness
- falls prevention (for working at height)
- hazard/incident/injury reporting
- hazardous manual tasks, including risks from occupational overuse
- infection control
- managing fatigue and shift work
- safe driving for employees who drive as part of work, including safe patient escorts
- safe patient handling
- security
- working remotely/isolated work, including duress alarms
- staff vaccinations
- use and testing of electrical appliances
- use of carcinogenic substances
- using chemicals safely
- violence, aggression
- bullying

- WHS and contractors
- WHS and procurement
- WHS and volunteers
- WHS consultation
- WHS induction and training
- work environment, facility design and management.

## Consultation and participation

Consultation continues to be central to health and safety legislation. However, the legislation has expanded the scope to address the WHEN, WHAT, HOW and WITH WHOM consultation is to occur.

Section 47 of the WHS Act requires that a PCBU must, so far as is reasonably practicable, consult with workers who carry out work for the PCBU and are, or are likely to be, directly affected by a health and safety matter.

### But first, why is consultation important?

Consultation and worker participation in WHS:

- provides for the possibility of better and more innovative solutions
- reduces the likelihood that decisions with WHS implication will be made by people who don't understand all the aspects of the work
- increases the likelihood that the solutions will work and be acceptable
- fosters positive working relationships – workers are more likely to understand how work impacts on others in the workplace
- engages workers in decision making
- fosters commitment to WHS at all levels, and
- raises awareness of WHS and the hazards associated with the workplace.

### When is consultation required?

Consultation is mandatory between PCBUs and workers and must occur when:

- identifying hazards and assessing risks
- making decisions about ways to eliminate or minimise risks
- making decisions about the facilities for the welfare of workers
- proposing changes that may affect the health or safety of workers, such as changes to premises, staffing and skill mix, model of care, systems of work, plant or substances used in the workplace

- making decisions about procedures on: how consultation is to occur; the resolution of WHS issues; monitoring the health of workers; and monitoring the environment
- developing a WHS training strategy – how and to whom training is provided, and
- as required by Regulation, or when directed by a WorkCover inspector.

It may also be appropriate for the PCBU to consult with workers in other circumstances, such as when conducting investigations into incidents.

### What does consultation involve?

The WHS Act is specific about what is required for consultation, namely that:

- all relevant information about the matter must be shared with workers
- workers must be given the opportunity to express their views, raise health and safety concerns and contribute to the decision-making process
- the views of workers must be taken into account
- workers must be advised of the outcome, and
- if workers have an elected representative (HSR), then that representative must be involved in the consultation.

It is also a requirement for the PCBU to consult with other PCBU's where work has the potential to impact on the safety of their workers, ie. where there is joint or shared responsibility for WHS. For example, private public partnerships, contractors working on site, etc.

### Do all workers have to be consulted?

No. The legislation requires consultation only between the PCBU and workers who are likely to be directly affected by a WHS issue. If there are elected HSRs then it is sufficient for consultation to involve the HSR/s representing the affected workers.

The broad definition of workers in the WHS Act means that anyone engaged to undertake work at the workplace is a worker. So, in some cases, consultation will need to involve workers employed by other businesses, such as agency staff or private/public partnership partners, because the WHS issue may also impact on the way they work at your workplace.

### Does consultation mean we all have to agree?

While an agreement is preferable, consultation does not require consensus or agreement be reached. The important consideration is that there was a genuine attempt to engage workers in the decision making process, that all consulted had adequate information to consult effectively and that the PCBU could demonstrate that they had taken the views and opinions of workers into account. However, it remains the responsibility of the PCBU to make and implement the decisions on how to eliminate or minimise workplace risks.



## What are the options for consultation?

Every workplace has to determine through consultation with workers how WHS consultation will best work.

There are three options:

- health and safety representatives (HSRs) representing work groups
- health and safety committees, HSCs, comprising worker and management representatives and the HSR, and
- other agreed arrangements.

These options are not exclusive. It is possible for one organisation to adopt any single consultation option, any combination of options, or indeed all of the options. It's about what will work best in your organisation and at individual workplaces.

This guide will provide a summary of some key issues on the options for consultation and how it could be applied to the work of nurses and midwives. However, nurses and midwives work in a variety of situations, and under a range of conditions, so it is recommended that those engaged in discussions on consultation also consider the following:

- *Code of Practice for Work Health and Safety Consultation, Cooperation and Coordination*
- *Worker Representation and Participation Guide.*

### IMPORTANT

NSWNMA supports the approach of work groups, represented by a HSR and at least one deputy, in combination with HSCs. This allows the HSR to focus on issues relevant to their work group as well as participating in the HSC on organisation-wide issues.

NSWNMA is available to assist workplaces and workers by:

- representing workers in negotiations on consultative arrangements – work groups, HSCs and agreed arrangements
- conducting the elections for HSRs, and
- supporting HSRs and HSC members through provision of information to assist them in resolving WHS matters.

## Work groups

One or more workers can request they be represented by a health and safety representative, HSR, when consulting with the PCBU on WHS matters. As each HSR represents a specific work group, if these are not yet determined, then negotiations to establish work groups must be initiated within 14 days following the request for HSR/s.

In negotiating the establishment of work groups, consideration must be given to:

- the number of workers
- the views of workers in relation to the determination and variation of work groups
- the nature of each type of work carried out by the workers
- the number and grouping of workers who carry out the same or similar types of work
- the areas or places where each type of work is carried out
- the extent to which any worker must move from place to place while at work
- the diversity of workers and their work
- the nature of any hazards and any risks to health and safety at the workplace(s)
- the nature of the engagement of each worker, eg. employee, contractor, volunteer, labour hire agency, short or long term appointments, full or part-time
- shifts, rotations and overtime, and
- any other factors specific to the workplace that may affect WHS.

This will assist in determining:

- the number and composition of work groups to be represented by HSRs
- the number of HSRs – there must be at least one per work group, however the NSWNMA recommends at least one deputy HSR to ensure a HSR is accessible whenever there are workers at work
- the workplaces where the work groups apply, and
- the PCBUs for which the work groups apply, ie. for workers carrying out work for more than one PCBU.

Once the negotiations for work groups have been completed, all workers need to be advised of the outcome – the composition of the work group, the number of HSR/s and deputy HSR/s to be elected and the process for the election.

Over time, factors affecting the composition of work groups may change and it may be necessary to renegotiate changes to the work group and representation.



Other important facts about work groups:

- There is no minimum or maximum number of workers who can be in a work group. However, the size and locations/s of the work group should be manageable for the HSR.
- Each work group must have at least one health and safety representative, although it's a good idea to have at least one deputy.
- Workers can belong to more than one work group, eg. an agency nurse working at multiple hospitals, a pool nurse who works across several areas within the one hospital.

### **IMPORTANT**

Importantly, for managers negotiating with workers about consultation arrangements, ensure your delegation entitles you to negotiate on behalf of the PCBU.

At any time in the process you can request assistance from NSWNMA or WorkCover.

## Examples of work group negotiations

### **CASE STUDY: Multiple sites**

#### **A pathology company with a chain of practices**

This organisation employs 120 nurses in 45 clinics across NSW. The nurses are all based full-time at their clinic, except for one clinic where the nurses also work off-site. Several nurses approached management requesting HSR representation. Management emailed all staff, including administration, laboratory, nurse and medical personnel asking for nominations to work on a working party to negotiate the procedures for consultation with the HSC. Four nurses nominated to be part of the working party – no other staff. Meetings were held by teleconference and a proposal developed to include all nurses in two work groups – one regional and one metropolitan, each represented by one HSR and a deputy. All staff were advised of the work group structure and nominations from nurses for each of the work groups were sought. With more applicants than positions for HSRs, an election was subsequently held using an online survey program. All nursing staff and clinic managers were advised of the outcome of the election. The HSC continues to represent all staff, and one of the metro HSRs is a member of this committee. The PCBU has also negotiated with the PCBU operating the off-site location to ensure nurses are also included in a work group when working at that site.



## CASE STUDY: Aged care

### A small stand-alone aged care facility

Following an initial briefing on the WHS legislation, workers indicated they were in favour of HSRs and work groups and were happy for the OHS Committee to negotiate on their behalf. The workplace was small and staff rotated through shifts, with no permanent night or weekend personnel. So it was agreed that the workplace would operate as one work group, but that there would be four HSRs to ensure there was sufficient cover for all shifts. There were four trained OHS Committee members. There was no need to hold an election as all four agreed to transition to HSRs.



## CASE STUDY: Hospital

### A large public hospital

This facility is a multi-union workplace and workers requested their respective unions, including the NSWNMA, be involved in negotiating work groups. After taking account of the many factors relevant to this workplace, the negotiating parties agreed that there be a number of work groups, including three for nurses and midwives – day, afternoon and night shift work groups. Each work group was to have one HSR and up to three deputies to cover the seven day roster so all nurses and midwives working any shift could liaise with the HSR rostered for their particular shift. The NSWNMA conducted the election of HSRs for the nursing/midwifery work groups for PCBU. All HSRs and deputies asked to be trained. All three HSRs opted to be members of the HSC for the hospital and one agreed to be a member of the Local Health District HSC.



## CASE STUDY: Department

### Obstetrics Department in a large teaching hospital

This department includes over 100 personnel including midwives, doctors, pharmacists, physiotherapists, research staff and other support professionals such as information and communications technology. Two midwives requested HSR representation in the department, indicating that they believed the work was sufficiently different to other workplaces in the hospital to warrant a unique work group. Staff in the department were contacted by email and replied in support of a separate work group for the department and agreed to have the staff who raised the issue represent them during negotiations with the PCBU to develop the consultation procedures for the work group. These procedures were put to the workers who agreed and supported the direct nomination of both midwives – one as the HSR, one as the deputy HSR. The HSR agreed to participate in the hospital HSC.

## Health and safety representatives

A health and safety representative (HSR) or deputy, is an elected representative of a work group. The HSR represents all the workers of that work group in WHS matters.



### CASE STUDY

**Some of my colleagues have asked me to be the health and safety representative for our work group. I'm not sure what this involves.**

First, you need to nominate for the position of HSR, or deputy, and then be elected. However, before nominating you need to understand what the role encompasses, which includes:

- representing the workers of the work group in relation to WHS issues
- monitoring what is being done in the workplace to eliminate or control WHS risks
- investigating complaints from work group members about WHS issues
- inspecting the workplace where the work group works (this needs to be arranged with management)
- inspecting after an incident or injury
- raising issues and negotiating with management about risk elimination and minimisation strategies
- referring issues that have not been resolved
- accompanying a WorkCover inspector visiting the workplace
- reporting back to the work group
- accessing workplace information on WHS issues, eg. minutes, emergency plans, and
- being present at an interview involving a work group member (subject to their agreement).

As a HSR, you can request assistance from any person, such as inhouse or external WHS professionals, eg. NSWNMA official who holds a WHS Entry Permit or WorkCover NSW.

After completing prescribed HSR training, you can:

- direct unsafe work to cease, and
- issue a *Provisional Improvement Notice*, or PIN, for a suspected breach of the legislation.

Importantly, these functions and powers relate specifically and exclusively to the workers and the work group you represent. In special circumstances, such as an emergency event after hours, or when requested by a worker from another work group at the workplace, the HSR from one work group can 'deputise' for another not present at the workplace.

**Continued next page**



## CASE STUDY (continued)

Training is available to persons elected as a HSR or alternate/deputy HSR to consolidate their understanding of scope and powers of the role. It is strongly recommended that all nurses and midwives undertaking a HSR role request and attend the training, which is five days in duration. Your employer is obligated to arrange the training within 3 months of your request and pay all reasonable expenses associated with attending this training.

Certain powers, such as directing unsafe work to cease and the issuing of PINs are only available to HSRs who complete the five day training program. *It is up to you as a HSR whether you choose to exercise these powers once trained.*

The activities and training you undertake as a HSR are regarded as part of your normal work and you must be paid the appropriate rate for your time.

Importantly, as a HSR under the WHS legislation you are *not personally liable* for your actions or any omission while exercising your duties in good faith.

The term of office for a HSR is three (3) years. If you resign or move to another work group, you cease to be the elected HSR for that work group.

### Transitional arrangements

WorkCover NSW has determined that an OHS Committee member elected between 1 January 2010 and 31 March 2012, and who completed the four day accredited training, be deemed a HSR if they agree, and their term of office will expire on 31 December 2014. However, to exercise full powers, from 1 January 2013, all HSRs will need to do the five days normally required – there is no gap training.



## IMPORTANT

It is the responsibility of the PCBU to register all HSRs through WorkCover NSW's on-line portal <http://hsr.workcovernsw.gov.au>.

 **DEFINITION****What is a PIN?**

A Provisional Improvement Notice, or PIN, is a notice issued to a person requiring them to address a WHS issue in the workplace.

When a HSR reasonably believes that any duty holder (PCBU, officer, worker or other) is contravening or has contravened provisions of the WHS Act, the HSR will consult with the person and give them adequate opportunity to correct the contravention. Where the issue is not corrected, the HSR can issue a PIN. The PIN must be complied with, unless the person to whom it is issued challenges the PIN within seven (7) days of issue. Then an inspector will review the PIN and make decisions with respect to upholding, cancelling or reissuing a Notice or other penalty.

The PIN must be displayed in a prominent place and cannot be removed while it is in force.

## Health and Safety Committees

Most health care facilities have well established health and safety committees (HSCs). The new legislation has changed the scope of these committees, considering them more as a support or complement to the work of the HSR. Under the WHS Act, the HSC provides a means for:

- cooperation between the PCBU and workers
- assisting in the development of health and safety policy and procedures, and
- monitoring WHS performance.

Two of the major functions of the HSC under the former legislation were to undertake workplace inspections and incident investigation. These tasks are now considered more appropriate for the HSRs as they are working in the work group and can respond in a more timely manner than a whole committee. However, if your workplace does not have HSRs, then these tasks will still need to be done. The HSC may still be an appropriate means for achieving this, provided it is part of the terms of reference, or agreed arrangements for the HSC.

Other important considerations are:

- at least fifty percent of committee members must be workers
- there is no prescribed training, although it is strongly recommended that committee members know what is expected of them, and, more generally, how WHS issues should be managed, so the PCBU should provide training
- members of the HSC who are HSRs are strongly encouraged to request HSR training

- WorkCover NSW will no longer maintain a register of committee members
- HSCs must meet at least quarterly, however there are no prescribed administrative requirements such as who is to chair the meeting, whether there is a quorum, the format for minutes and voting etc., and
- HSRs become members of a HSC relevant to their work group if they agree to do so.



## IMPORTANT

Also, in workplaces where no HSC exists, a HSC must be formed when requested by a HSR or five or more workers.

### What are other agreed arrangements?

The third option for workplaces to consider when setting up consultative arrangements is to have other agreed arrangements. These are any other arrangements between workers and the workplace that ensure workers have an opportunity to discuss, in an informed way, WHS issues and have their opinion considered.

For small workplaces, such as a clinic, there is often a less formal approach, and WHS issues are often discussed as part of regular team meetings. This may be sufficient and an effective way of ensuring WHS risks are identified and managed.

For larger workplaces, a more complex and structured approach, combining HSRs and HSCs, may be required. In some organisations, particularly those with many sites, there may need to be a pyramid approach with different layers moving information up and down the organisational structure, eg. facility HSRs and HSCs as well as Local Health District or organisation HSC.

So there are lots of options and each workplace will have different needs. The important thing is to ensure that workers get an opportunity to have a say in how consultation occurs, and the agreed arrangements should be documented, promoted and reviewed periodically to ensure that they still meet the needs of the workplace.

 **CASE STUDY**

I am the Nursing Unit Manager of a surgical unit. We have just received approval to purchase new beds. I would like to set up a working party to select the bed that most meets our needs for safety and patient comfort. What do I need to do to ensure that this meets our obligation for consultation and worker participation?

A working party is a great way to involve workers – it provides an opportunity for workers to discuss WHS concerns and be part of the problem solving process.

Ensure that all HSRs and/or HSC members relevant to the unit are involved in the working party.

Then consider which workers are involved with beds as they should form the basis for the working party:

- nurses – consider shifts as nurses on night duty may have different needs from nurses working in the day
- nurses working in recovery or operating theatres (if your patients go to theatre on their ward bed)
- other health professionals who may treat on the bed, eg. physiotherapist
- hospital porters if patients are moved on their bed
- infection control personnel
- cleaning personnel
- maintenance – inhouse servicing, and
- inhouse WHS and patient safety personnel.

Then consider what are the constraints in selecting the bed, such as the width or length of lifts, door widths, turning angles. What is the budget that you need to work within, and find out whether you are limited to beds on contract. Does the bed comply with AS/NZS 3200.2.38: 2007 *Medical electrical equipment – Particular requirements for safety – Electrically and manually operated beds for adult use?*

Conduct an initial meeting of the working party to determine the ‘wish list’ of design considerations for the bed. A proforma, such as the *Checklist for evaluating beds for the health industry* may provide a starting point ([www.workcover.nsw.gov.au](http://www.workcover.nsw.gov.au)). Consider whether your beds and bed accessories fit with existing patient handling equipment and fit through doors, in passageways and within lifts and whether you need to include a bariatric model.

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## CASE STUDY (continued)

Some members of the working party may be willing to take on some of the tasks to obtain the baseline data for consideration such as:

- obtaining specifications from the manufacturers and checking TGA compliance
- considering mattresses and other bed attachments
- checking the bed fits through doors, in passageways, within lifts, on ramps
- checking bed compatibility with other equipment or services, eg. liaise with NSW Ambulance, resuscitation committee, linen supply, and
- liaising with other locations where the trial beds are in use to gauge user feedback
- checking availability of post-purchase support from the supplier.

Once all the baseline data is obtained, it's time for the working party to determine the shortlist and arrange and conduct the trial. This is the time to get patients involved too. The working party will need to work out criteria for evaluation – refer to the *Checklist* for prompts such as positions, manoeuvrability, ease of cleaning, mattress comfort, pinch points etc. Your risk assessment should also include measuring push/pull forces on the various floor surfaces in your facility and, if the beds are to be moved on ramps, the forces to push and to restrain beds while on ramps (with mattress attachments and the patient in place).

Once the decision is made, the working party then needs to consider the logistics of the changeover and the impact this will have on the ward, specifically:

- how and when the changeover will occur
- who will physically do the changeover and ensuring adequate staffing for this process
- disposal of the old beds – refer to hospital policy on this issue, as on-selling may result in the hospital being subject to the supplier provisions under the WHS Act
- developing safe operating procedures for the beds
- training staff in the use of the new beds, and
- after a settling in period, a post installation evaluation to reflect on the process and outcome.

While documentation of the consultation process is not specifically mandated, it is generally the only way to prove that it did occur, which is important from both quality and WHS perspectives. It is also an important reference if the issue comes up again and saves 'reinventing the wheel'.

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## CASE STUDY (continued)

So, as a minimum, it is good practice to retain documentation for at least five (5) years on:

- description of the issue
- who was involved in the process
- what was considered
- what was decided and who was responsible for actioning, and
- when the matter was resolved.

Remember that the process for consultation needs to consider any local procedures already agreed with workers. If workers are part of a work group, then the HSR should always be involved. And finally, share your results with other wards and facilities that are part of your network or organisation, and with the HSC, if there is one at your workplace.

## Training

The provision of training is included as one of the PCBU's primary duties under the WHS Act 2011 (section 19) and further supported in the WHS Regulation 2011 (clause 39).

WHS training generally consists of both induction and ongoing training, related specifically to the work performed by workers. Induction training should address:

- how WHS functions at the workplace, including the process for WHS consultation
- how to report hazards and incidents
- health and safety policies and procedures relevant to the workers attending the training
- specific risks relevant to the workers and associated risk control strategies, eg. manual handling, and
- how to access health and safety information at work.

Training should also be provided on an ongoing basis to ensure workers remain up-to-date about the risks in the workplace and the strategies implemented to eliminate or control these risks. As such, training should be provided before:

- new equipment is introduced, eg. introducing a device to raise a patient from the floor, 'computer on wheels'
- new furniture is introduced, eg. electric beds, task chairs for the nurses' station

- a new chemical is introduced, eg. new bone cement used in operating theatres, new skin cleansing agent
- work procedures change, eg. computerisation of patient records, new patient assessment protocols such as falls risk
- a patient requires specific care, eg. particular, non-standard handling technique
- WHS policy or procedures are introduced or changed, eg. bullying and harassment, safe staffing.

WHS training should:

- be hazard specific, eg. cytotoxic drugs, violence prevention and management, manual handling, fire safety
- be based on the legislation and be consistent with best practice and local policies
- reflect the level of risk
- be developed and presented by persons qualified and experienced to provide such training
- consider language and literacy issues
- be workplace specific
- encourage active participation of all attending
- be compulsory
- be documented and the training records retained for a minimum of five (5) years, and
- be free of charge to workers and delivered during paid work time.

The WHS legislation does not mandate the type, or frequency, of WHS training required for health care workers. Rather, each organisation should determine the type and frequency of WHS training required for workers to perform work safely and then establish a system for ensuring that this policy is realised.

Workers may be required to participate in other safety-related training, such as fire safety. This training may be mandated through legislation (other than WHS legislation) or subject to requirements for accreditation or professional registration.

WHS training may count towards continuing professional development if it enhances your knowledge and contributes to your practice development. It may not count if it is the same or substantially similar to WHS training received previously, ie. same fire safety or safe handling lecture presented annually.

 **CASE STUDY**

**Part of my role as a Nursing Unit Manager is to investigate incidents that occur on my ward. Where can I get information on how to do this?**

Any nurse or midwife having to undertake any WHS function, including investigating incidents, should receive training. This training should be provided by your employer. It is not a skill developed in nursing or midwifery training and therefore it is not reasonable to expect you to know how to do this.

Nurses and midwives who are injured at work deserve to have the circumstances of their incident investigated by a competent person. Incident investigation is complex, and skills are necessary to recognise why the WHS system has failed and to determine solutions to remedy the problem. Nurses and midwives trained in incident investigation are more likely to consider and address all of the issues and make appropriate recommendations to prevent anyone else being injured.

Importantly you must involve the HSR representing nurses or midwives on your ward in any incident investigation.

Your organisation should have incident investigation guidelines and a form to lead you through the process.

A key outcome of the incident investigation is to determine what could be done to prevent recurrence of the incident, injury or illness. So, as well as training in the investigation process specific to your facility, you also need training in risk management.

You can request assistance with incident investigation from in-house WHS personnel or, if you are a member, contact NSWNMA for advice.

Further, some incidents and injuries are notifiable to WorkCover NSW immediately, and you need to know how to escalate these reports so that the organisation complies with its reporting obligations – see *notifiable incidents* in the glossary.

## Risk management

 **DEFINITION****Hazard**

Something with the potential to cause injury, illness, damage to property, damage to the environment or a combination of these.

**Hazardous task**

A work activity that involves exposure to a hazard.

**Risk**

The potential for harm from exposure to the hazard, eg. injury or illness.

Managing risks to health and safety is one of the primary duties of the PCBU under the WHS Act 2011 (section 19) and is further supported in Chapter 3 of the WHS Regulation 2011 (clauses 32-55).

Risk management is critical for ensuring that a workplace remains safe. It involves:

- *identifying* hazards
- where necessary, *assessing* the risks
- *eliminating* the hazards, and therefore the risk, or
- if this is not reasonably practicable, *controlling* the risk
- *maintaining* the controls, and
- *reviewing* the controls to ensure they are effective.

### Hazard identification

The WHS Regulation (clause 34) requires all duty holders (PCBU, officers, workers and others) to identify reasonably foreseeable hazards that can affect anyone at a workplace.

Hazards, and hazardous tasks, can include:

- the nature of work, eg. shift work, extended shifts, manual handling, bullying and harassment, violence, fatigue, working alone or remotely, bariatric care issues
- plant and equipment, eg. furniture such as beds, hoists, medical lasers, food hot boxes, computers, diathermy units, endoscope reprocessors
- hazardous substances (chemicals), eg. pharmaceutical products, disinfectants and sanitisers, latex, bone cements
- biological hazards, eg. organisms, blood and human tissue, waste
- the physical environment, eg. contaminants on the floor, electrical hazards, radiation, noise, heat and cold, low lighting, humidity, and
- the work premises, eg. layout of the ward, space, storage of equipment, security, construction work.



## CASE STUDY

I am a registered nurse working in an eighty-bed aged care facility. We have two main visiting doctors who both do their rounds each Wednesday, one in the morning and one in the afternoon. As the only RN on duty, I accompany the doctors on their rounds. Over the last few months the rounds have become longer and on several occasions I have worked the whole day without a break. Apart from being physically exhausting, I am concerned that this affects my concentration, which could lead to errors.

The work of the doctors, albeit for residents at your facility, is also directly related to the business of providing care. The current scheduling of their visits is having an impact on the safety of how you work.

Meal breaks are important to supply energy and prevent fatigue, a minimum consideration in preventing errors – for both you and the doctors.

Discuss with the doctors whether it is possible to reschedule to ensure a decent gap between their visits or to visit on different days. If their schedules don't permit this, suggestions include:

- liaise with medical officers to determine the frequency for routine resident consultation, ie. providing care is not compromised, is it necessary for each resident to be seen weekly or could some be seen fortnightly or monthly, thereby reducing the duration of each round?
- could technology assist in recording changes to progress notes and medication charts, eg. 'computers on wheels', electronic note taking, software for medication updates, digital voice recording for later download?
- increase RN coverage to include two RNs on round day so that the work could be shared
- incorporating a break into the round.

### Hazard versus risk

Contamination on the floor, such as a spill or food waste, is a slip hazard for anyone walking through the area. However, if an actual barrier (not a sign) is placed to prevent anyone walking through the contaminated area, then the risk of slipping is minimised. However, the hazard is still present and needs to be dealt with to eliminate any risk.

The internet has made it much easier to keep up to date on the hazards that have the potential to affect nurses and midwives and how the risks associated with these hazards can be controlled. The Resources section contains links to many helpful websites and resources.



## CASE STUDY

I work in the community on my own. My work involves communicating with doctors and other treatment providers related to the client. I also need to be able to communicate with the office on a range of issues including WHS and have asked my manager for a mobile phone. I have been told that a phone is not essential and to use the client's phone. However, the clients don't want me using their phone, especially if the issue has nothing to do with them. I kept pushing and now am told the health service doesn't provide phones because of the risk associated with use while driving. But, they don't seem to have a problem if I use my own phone. What should I do?

As a community worker you and your manager need to be able to communicate with each other while you are away from the office for reasons which include your safety. You are also entitled to be provided with tools and equipment necessary for you to perform your work. A mobile phone could be considered an essential tool for this purpose. Indeed, if you are dealing with clients who have the potential to become aggressive, or travel in remote or high risk areas, then other communication tools, such as remote duress alarms, emergency GPS beacons and/or satellite phones, should be considered.

You should put your concerns in writing and consider what options could be reasonable to allay concerns about secondary risks, such as only using communication tools when the vehicle is parked and not switched on, or installation of a hands free device.

Get your HSR involved – you may not be the only worker for whom this is an issue.

If you are working in the public health sector, the Award mandates provision of effective communication devices as does the NSW Health policy *Protecting People and Property* – see references.

If you can't get the problem solved through consultation, you can contact NSWNMA for assistance if you are a member. You or your HSR can also seek advice from WorkCover NSW.

## Risk assessment

Risk assessment is the systematic evaluation of:

- the hazard or hazardous task
- the environment in which the work is performed
- any equipment, chemicals, furniture, consumables or vehicles used
- the way work is organised
- the skills, experience and special needs of those performing the task
- the patients and others who may be involved, and
- what control measures are in place.

## Do all hazards have to be risk assessed?

No. Some of the hazards in workplaces are considered simple hazards, such as a loose floor tile, a sticking door or faulty bedrail. These can usually be controlled easily, either fixed on the spot or removed from service and taken away for repair.

For issues that can't be fixed immediately, some action is required to prevent harm. In the case of a loose tile, it might mean cordoning off the area where the tile is loose or taping it down. The hazard should always be documented in a maintenance log, even if it is fixed at the time, as this may be a recurring pattern that requires further investigation.

However, nurses, midwives and other health care workers are frequently exposed to hazards that are more complex and require some assessment before putting controls in place. As a guide, a hazard should be assessed if it:

- resulted in an incident or injury to workers, patients or visitors
- was revealed at a workplace inspection
- was raised through consultation with workers or others
- is a complex issue with many contributing factors
- presented as a safety alert from a supplier, the TGA or other industry source
- reveals uncertainty as to how best to eliminate or minimise the risk, or
- when requested by a HSR or directed by an inspector to undertake a risk assessment.

Risk assessment should also be done when something is about to change, such as:

- new work process, equipment, chemical or other product is being proposed
- new building work, refurbishment, or change to the work environment, such as furniture, fittings and fixtures
- new type of care delivery, such as a *Hospital in the Home* or *EACH* program is being considered, and
- different worker skill mix/experience, such as introducing a schools program.

Remember, that the purpose of risk assessment is to analyse the factors that contribute to the risk, which assists in determining appropriate and effective controls. Therefore, risk assessment remains a vital component of an organisation's WHS program.

Further, just because a hazard has not yet caused an incident or injury at your workplace, doesn't mean that it is not an issue.

While products on TGA, Government contract and PCBU/facility lists have been approved for purchase, this DOES NOT constitute a risk assessment. Risk assessment requires that this product be considered by the workers who will be using the product, in the environment in which it is to be used and in the circumstances of the planned use.

## Who should assess?

Firstly, risk assessment requires collaboration and therefore must involve representatives from the staff affected by the issue. It is not valid for only one person, or only managers, to undertake a risk assessment.

While most risk assessments can be worked through by consultation, sometimes it will be necessary to get expert help to determine the full extent of the risk and to help find the most appropriate solutions.

<p><b>In-house experts include</b></p> <ul style="list-style-type: none"> <li>• WHS personnel</li> <li>• patient safety personnel</li> <li>• patient handling coordinator</li> <li>• physiotherapists or occupational therapists</li> <li>• radiation medical specialist</li> <li>• building management or maintenance personnel</li> <li>• infection control officer</li> <li>• security manager.</li> </ul>
<p><b>External experts include</b></p> <p><b>NSWNMA Officers</b> Phone 1300 367 962   <a href="http://www.nswnma.asn.au">www.nswnma.asn.au</a>   <a href="mailto:gensec@nswnma.asn.au">gensec@nswnma.asn.au</a></p> <p><b>Ergonomists</b> Human factors professionals who help develop effective work systems, products and equipment that are matched to human capabilities. In health care facilities they are often involved in assessment of manual tasks, furniture and equipment, health information systems. <a href="http://www.ergonomics.org.au">www.ergonomics.org.au</a></p> <p><b>Occupational hygienists</b> Professionals who assess and monitor the work environment for chemicals, noise, air quality and vibration, eg. asbestos, glutaraldehyde, mould, temperature and humidity. <a href="http://www.aioh.org.au">www.aioh.org.au</a></p> <p><b>WHS Consultants</b> General WHS professionals, including safety advisors, engineers. <a href="http://www.sia.org.au">www.sia.org.au</a></p> <p><b>Occupational physicians</b> Medical doctors who specialise in preventing, diagnosing and treating injury and disease associated with work. <a href="http://www.racp.edu.au/afoem">www.racp.edu.au/afoem</a></p> <p><b>WorkCover NSW</b> Phone 13 10 50   <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a></p>





## CASE STUDY

I work in the Emergency Department of a city hospital. Many of the patients present intoxicated, under the influence of drugs, or experiencing psychotic episodes. These patients can be unpredictable and most staff working here have experienced assault, verbal abuse or injury while trying to attend to these patients or deal with their friends or family. Friday and Saturday nights have become unbearable and no-one wants to work these nights. How can risk assessment help?

You have already identified some key hazards. There is no question that this situation exposes workers and possibly others to risk. By looking at this problem systematically, through risk assessment, we seek to quantify the problem, and that helps in determining solutions. Importantly, risk assessment helps provide a business case or justification for requesting particular solutions which are then hard for the PCBU to ignore.

In the first instance, consult with the HSR/s. Then, to determine the extent and nature of the risk, the assessment would involve:

- consulting with workers, ie. nurses, doctors, administrative staff, X-ray personnel, security and other workers in this area
- obtaining incident/injury data – what has been reported and reviewing the circumstances, response and outcome of each incident, and what worked and didn't work
- data on patient throughput, particularly on Friday and Saturday nights, triage and diagnostic categories, and current processing times, ie. how long it takes for patients to be triaged, medically assessed, treated and discharged/admitted
- reviewing staff levels and skill mix, including use of agency personnel and the availability of security officers to assist
- reviewing facilities for families/friends while waiting and when consulting with medical personnel
- reviewing what strategies are in place for patient protection, eg. protocols, safe assessment room
- reviewing what strategies are in place for worker protection, eg. policy on bullying and violence, protocols, staff training, security, barriers and secure rooms, duress alarms and duress response team, patient alerts and associated management plans
- reviewing worker training strategies, including de-escalation skills, patient restraint methods and evasive self-defence techniques
- reviewing what support is available to workers who report incidents of assault to police
- reviewing the work environment, eg. safe assessment room, noise and stimulation, temperature, layout, perimeter security

Continued next page



## CASE STUDY (continued)

- reviewing information on how other emergency departments are dealing with this issue, eg. Australian and international experiences, Ministry of Health policies and guidelines
- reviewing the clinical protocols for diagnosis and treatment of clinical triggers for aggression, eg. drug and alcohol dependence, head injury, delirium, psychosis, hypoxia, hypoglycaemia, and
- reviewing information from external sources such as NSWNMA, WorkCover NSW and professional organisations.

The risk assessment will reveal where there are gaps in dealing with this issue and help target strategies that could be implemented, both in the short and long term.

### Risk control

Section 17 of the WHS Act 2011 requires risks to be eliminated. However, if it is not reasonably practicable, then the risks must be minimised. Reasonably practicable means doing what is effective and possible to ensure the health and safety of workers, taking into account:

- the seriousness of the risk
- what is known about the hazard and risk and the ways of eliminating or minimising the risk, and
- the availability and suitability of measures to eliminate or minimise the risk.

The cost can only be considered after all of the above have been taken into account to determine what is reasonably practicable to eliminate the risk, and whether that cost is grossly disproportionate to the risk. The process for minimising or controlling risk is known as the Hierarchy of Control. Usually, effective risk control requires a combination of strategies including the following.

## HIGH ORDER CONTROLS

**MUST BE IMPLEMENTED FIRST** as they generally achieve control by eliminating risk at its source and reducing reliance on human behaviour for compliance.

### Substitution

- Changing the equipment, eg. providing a range of patient handling aids, modifying wheels on trolleys to reduce pushing/pulling forces.
- Changing the furniture, eg. replacing mechanical hi-lo beds with electric beds, replacing standard showerchairs with tilt-in-space, height adjustable showerchairs.
- Changing products, eg. vinyl gloves instead of latex gloves, no-detergent hand cleansers.
- Installing shatter-proof glass instead of ordinary glass in high risk areas.
- Fitting automatic doors in place of heavy swing doors in operating theatres.

### Isolation

- Isolating the risk, eg. encasing dangerous or noisy parts of a machine such as the drive chain on a hoist, encasing medical lasers, shielding for X-rays, enclosed automatic endoscope reprocessors.

### Engineering

- Redesigning the environment, eg. refitting nurses' stations to accommodate computerisation, eliminating floor surface joints, installing medication cupboards in patient rooms.
- Installing duress and perimeter alarms, supplying holders at each patient's bedside for slidesheets, locating toilets away from the wall to facilitate the use of equipment and nurse access.
- Improving ventilation to reduce fumes or odours, eg. in the pan room, during procedures where chemicals are used such as anaesthetic gas scavenging, diathermy smoke capture.
- Improving lighting, eg. so nurses can safely get to and from transport or the carpark.
- Providing pressure sensors for patients who are assessed as high falls risk.
- Providing appropriate vehicles, eg. loading devices for patient transport, vehicles for nurses working in the community, powered tugs for moving equipment over distances or on ramps.

**IMPORTANT:** The WHS Act considers substitution, isolation or engineering controls of equal value, one is not preferable to the other. However effective control may involve a combination of two or more approaches, eg. changing chemicals and improving ventilation.

## LOW ORDER CONTROLS

These are secondary controls, applied to address residual risks that are not eliminated by implementation of the high order controls. Low order controls generally rely on individuals doing something to make the control effective, and include the following:

### Administrative

- Reviewing worker allocation to ensure adequate human resources for security and manual handling.
- Changing the way work is done, eg. scheduling heavy work across all shifts, improved patient assessment techniques to identify patients with particular needs.
- Developing safe work procedures, including remedial action, eg. not re-sheathing needles after injection, spill and mop up procedures after a chemical mishap, communication and check-back procedures for remote workers.
- Duress response teams.
- Post incident support such as counselling after a critical incident.

### Personal protective equipment (PPE)

- Providing equipment or clothing to reduce the likelihood of a worker being affected by a hazard, eg. lead gowns when working with radiation, gloves to protect against contaminants and body substances, glasses to prevent exposure to lasers during surgery, face shields to prevent splash contamination.



## IMPORTANT

1. If provided, the PPE should be fit for purpose and workers trained in correct usage. It should be issued to each person at risk, having regard to size, comfort, fit, and be maintained in a hygienic state (clause 44). PPE must also accommodate an individual worker's particular requirements, such as an allergy to latex. If PPE is to be shared, such as lead gowns or face shields in pan rooms, then there must be a system for checking the integrity of the PPE and maintaining it in a hygienic state. PPE should never be the ONLY control strategy as it does nothing to change the hazard at its source, only the potential for harm. No PPE can guarantee complete protection.
2. Training is no longer considered part of the Hierarchy of Control – it is a separate strategy that is required irrespective of the strategies adopted to control worker exposure to risks.
3. Some hazards, such as chemicals, manual handling, noise and construction require specific risk control strategies. Refer to the WHS legislation for these requirements.

More information on risk management can be obtained from the Code of Practice *How to manage work health and safety risks*.

### Implement and promote

Once control strategies have been determined, it is important to make these become a reality in the workplace. Part of the challenge is to promote what is to be done. There is no point in having safe work procedures if no-one knows about them. So, promotion should address:

- what the problem was and who it affected
- what strategies have been developed
- who was consulted to develop the strategy
- the benefit to nurses/midwives
- the benefit to patients, where applicable
- when and how the strategy will be introduced
- any training that will be provided, such as for using new pieces of equipment, or about a new procedure, and
- responsibilities, ie. managers, supervisors, workers, others.



## CASE STUDY

Over the last six months several of the most experienced nurses and midwives have sustained musculoskeletal injuries, including back, shoulder and wrist injuries. What's the best approach for preventing these type of injuries?

Musculoskeletal injuries are a common problem for nurses and midwives, but that doesn't mean they should expect to get injured. To minimise the risk to all nurses and midwives, the approach for eliminating or minimising the risk of musculoskeletal injury should include:

### **Preliminary**

- Set up a consultative group or working party to address hazardous manual tasks and involve the HSR/s.
- Review organisational policies and procedures relating to safe manual handling.
- Ensure that some of this working party have training and experience in risk assessment, including patient assessment if this is a component of the problem.
- Identify all nursing/midwifery tasks that are considered a problem. Review your injury statistics to determine any trends etc., ask nurses/midwives what tasks they find difficult or uncomfortable to do. Remember to consider all manual handling tasks, not just patient handling tasks.

### **Risk assessment**

- Assess each of the hazardous tasks. Consider postures, actions, forces, frequency and duration.
- Consider existing equipment. Is it adequate for the task, is it well maintained, are there any limitations, is a sufficient amount available when required.
- Examine the work environment. What factors may contribute to the risk, eg. floor coverings, width of corridors, ramp slopes, room size, floor joins and humps.
- Consider the furniture. Poorly designed and maintained beds, chairs etc. can increase the risk of injury. Is the furniture suitable for the type of floor coverings.
- If patient handling is a component of the problem, review patient assessment protocols to ensure they incorporate patient handling and falls risk considerations.
- Examine the way work is organised and resourced.
- Consider the uniform or clothing nurses wear. Clothing should not restrict movements such as squatting, shoes should be slip resistant and provide some impact protection against hard, concrete floors.
- Consider how work methods are communicated to workers and patient cooperation obtained.

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## CASE STUDY (continued)

### **Risk elimination or control**

- Eliminate risks through redesign of the work area, furniture or equipment, eg. electric beds, medication and other trolleys with appropriate castors for moving awkward or heavy loads, elimination of floor surface joins, access in patient bathrooms and toilets, automatic doors, equipment for bariatric patients, well designed and accessible storage areas, nurses' stations that are designed to accommodate computers, ramps with very low gradients.
- Eliminate risks through modifying the way work is organised, eg. eliminating unnecessary tasks or double handling such as moving patients on the hospital bed rather than transferring them to trolley, managing overtime to prevent worker fatigue.
- Ensure staffing is adequate and considers skill levels, the impact of nurses returning after injury, nurses away on leave or in training.
- Ensure adequate quantities of appropriate patient handling equipment and that equipment is readily accessible, eg. general hoists, stand-up hoist, range of sling types and sizes, slide sheets, transfer boards, transfer belts (also called gait belts or lifting belts), inflatable transfer devices such as the Hovermat, equipment to get patients up off the floor such as Hoverjack.
- Determine appropriate handling techniques for the type of patients/clients or residents based on best practice and match the environment, furniture and equipment.
- Ensure staff receive training in the use of all equipment and techniques, eg. coaching patients to move themselves.
- Provide means of communicating safe practices to patients and visitors, eg. hospital radio, brochures, patient handbook, local press, website.
- Importantly, ensure effective supervision of manual and patient handling practice across all shifts.

### **Promote, monitor and review for effectiveness**

- Keep workers informed.
- Establish performance criteria.
- Audit processes regularly against these criteria, and adjust where necessary.
- Provide feedback to the HSC and share with other wards or units.

## **IMPORTANT: Unsafe patient handling techniques**

There are a number of patient handling techniques still in use that are unsafe for the worker and for the patient. Nurses and midwives need to be aware that the following techniques are no longer acceptable:

- ‘top and tail lift’, also called the ‘fore and aft’
- shoulder lift
- cradle lift
- log lift
- pivot or ‘bear hug’ transfers
- any technique that involves hooking patients under or through their arms
- any manoeuvre involving the patient grabbing you around the neck– you **MUST** abort the manoeuvre to avoid serious neck injury
- any manoeuvre where your forehead contacts with the patient, and
- lifting patients manually from the floor, even in emergencies, except where a risk assessment has determined a manual lift is the safest method in the circumstances.

Nurses and midwives must be provided with the skills and the equipment to achieve the patient movement outcome without compromising either their or the patient’s safety.

It is important for anyone training or supervising nurses and midwives to be skilled in best practice patient handling, and the use of the patient handling equipment relevant to the care needs of the patients. Educators/trainers should also have training and assessment skills.

Patients who sustain injury because of the use of these unsafe and out-dated techniques may be able to take legal action. Additional care requirements associated with patient injury can also prolong their stay in hospital, along with their cost of care, investigations and treatment.

If you are unsure what techniques you should be using to move a patient, check the patient care plan, or ask your manager or the patient handling coordinator/educator.



## CASE STUDY

**I work with patients who receive cyclophosphamide for lupus and various cancers. We have a licence to use this drug until 2014, do we need to renew this and have there been any changes to the requirements?**

Cyclophosphamide is classified as a notifiable carcinogenic substance. The WHS Regulation 2011 continues the requirement for notification and approval to use this drug in a workplace. The approval continues to require renewal every five years.

Provided the circumstances for usage have not changed, and the approval was provided within the last five years, the transitional arrangements do not require the hospital to re-notify WorkCover NSW until the due date for renewal.

All workplaces where cyclophosphamide is used should have a policy. This should include who is responsible for notification to WorkCover NSW, safe work procedures, training, and waste management requirements. The PCBU is required to keep records forever of all workers exposed to this drug.

Of note is that cyclophosphamide must now be labelled in accordance with either:

- the Globally Harmonised System of Classification and Labelling of Chemicals, 3rd (revised) edition, published by the United Nations as modified under Schedule 6, or
- the Approved Criteria for Classifying Hazardous Substances [NOHSC: 1008(2004)].

## Maintain, review and improve

Embedded within your organisation's safety and quality system should be a process for monitoring the control measures that have been implemented to ensure they remain effective.

**MAINTAIN**ing an effective WHS system requires that:

- managers and supervisors have authority and resources to implement and maintain safe systems of work for nurses and midwives
- there is a process for obtaining, storing and retrieving up-to-date information on hazards, risks and control measures pertinent to nursing and midwifery
- personnel with leadership roles in WHS, such as nursing and midwifery managers, receive the training necessary to fulfil their roles, eg. incident investigation, risk management
- all nurses and midwives receive training relevant to their role, responsibilities and the risks of their work
- the work environment and the equipment used by nurses and midwives are safe, and that nurses, midwives and their HSRs are consulted regularly on WHS matters.



**REVIEW**ing risk control measures involves assessing whether:

- the strategy has been implemented as planned
- any compliance problems have emerged, ie. staff not following procedure and why
- conditions have changed since the introduction of the strategy which could impact on the effectiveness of the strategy, eg. new legislation, shift changes, change to patient demographics, change to the type of service offered to patients or clients
- any other problems have arisen as a result of the strategy, and
- the strategy has had any impact on incidents or injuries. Remember that for some strategies, an increase in reporting may actually indicate a positive outcome, and rare but potentially serious incidents are unlikely to be revealed in statistics, especially in the short term.

Periodically, all work systems need to be reviewed, and adjusted as required, as part of your organisation's continuous **IMPROVE**ment process.

### Issue resolution

Issue resolution is a process for dealing with issues that pose significant or immediate threat to the safety or health of workers or others in the workplace, or issues that, for whatever reason, have remained unresolved and continue to pose a threat.

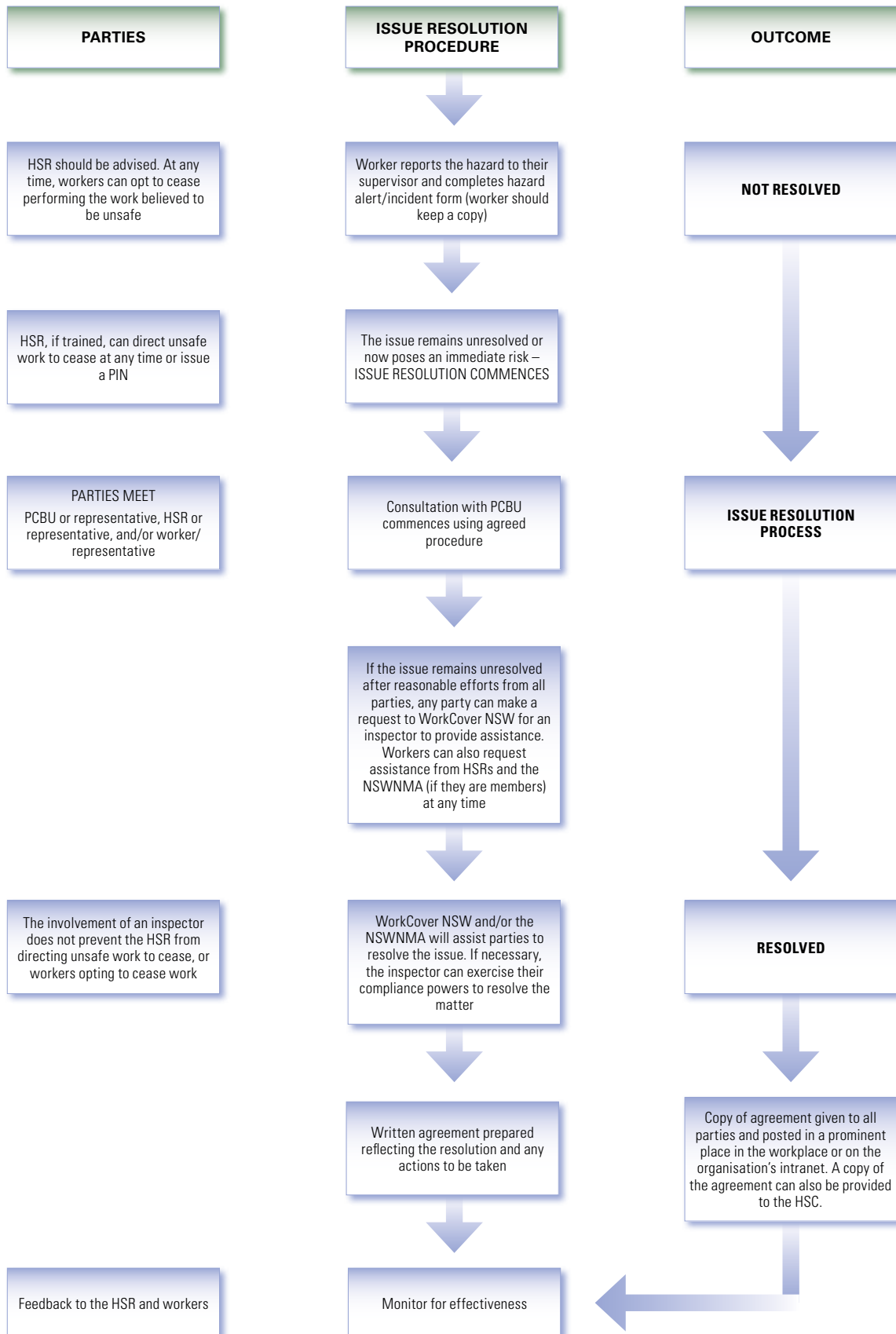
The WHS Regulation 2011 (clause 22) requires an agreed, written procedure for resolution of WHS issues. This procedure must meet the minimum requirements outlined in clause 23, which is known as the default issues resolution procedure. All officers and workers should be aware of this procedure.

Further, the WHS Act (section 81) requires all parties to make reasonable efforts to achieve timely and effective resolution of the issue and to follow the agreed procedure.

So, who are the parties? The PCBU must be represented by someone with sufficient delegation and authority to negotiate on its behalf. The PCBU cannot be represented by a HSR, even if that person is a manager.

If the affected workers are in a work group, the HSR/s, or their nominated representative (eg. NSWNMA) must be involved. Alternatively, if the workers are not part of a work group, the workers themselves can be party to resolving the issue, or may nominate a representative, such as NSWNMA, if workers are members of the NSWNMA.

If the organisation has a specific issue resolution procedure, this should be used. Alternatively, a suggested approach is outlined on the following page.





Work Health and Safety  
Essentials for Nurses and Midwives

## Resources



# Resources

Please note that the list of resources includes documents from a variety of sources including those developed to comply with previous NSW OHS legislation, other Australian and international jurisdictional requirements, as well as general guidance documents. The advice contained within these documents may not be consistent with current legislative requirements in NSW, therefore some caution is advised and users should always reference against current legislation.

All weblinks are correct at time of publication however they are subject to change by the controlling organisation.

KEY INFORMATION	
WorkCover NSW	13 10 50 <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>
NSWNMA	1300 367 962 <a href="http://www.nswnma.asn.au">www.nswnma.asn.au</a>
NSW Health	02 9391 9000 <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a>
Safe Work Australia	1300 551 832 <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>
SAI Global – Standards	<a href="http://www.saiglobal.com">www.saiglobal.com</a>
LEGISLATION	
Work health and safety	<a href="http://www.legislation.nsw.gov.au">www.legislation.nsw.gov.au</a> OR <a href="http://www.austlii.edu.au">www.austlii.edu.au</a>
Guideline	Compliance policy and prosecution guidelines 2012 <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>
On-line portal	Work health and safety <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>
BULLYING, AGGRESSION AND WORKPLACE VIOLENCE	
Policy	NSW Health – Protecting people and property: NSW Health Policy and guidelines for security risk management in health facilities: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a>
	NSW Health – Bullying – prevention and management of workplace bullying in NSW Health: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a>
	NSW Health – Zero tolerance response to violence in the NSW Health Workplace: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a>

<p><b>Australian</b></p>	<p><a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Preventing and responding to bullying at work</li> <li>• Bullying prevention kit</li> <li>• Bullying improvement tool</li> </ul> <hr/> <p>WA – Prevention and management of aggression in health services: <a href="http://www.commerce.wa.gov.au">www.commerce.wa.gov.au</a></p> <hr/> <p>Comcare bullying resources: <a href="http://www.comcare.gov.au">www.comcare.gov.au</a></p> <hr/> <p>Preventing workplace bullying. Carlo Caponecchia and Annie Wyatt: <a href="http://www.beyondbullying.com.au">www.beyondbullying.com.au</a></p> <hr/> <p>Distinguishing between bullying, harassment and violence. Carlo Caponecchia and Annie Wyatt: <a href="http://www.beyondbullying.com.au">www.beyondbullying.com.au</a></p> <hr/> <p>Preventing violence against health workers. Clare Mayhew: <a href="http://www.worksafe.vic.gov.au">www.worksafe.vic.gov.au</a></p>
<p><b>International</b></p>	<p>NZ – Managing the risk of workplace violence to health care and community service providers: <a href="http://www.osh.dol.govt.nz">www.osh.dol.govt.nz</a></p> <hr/> <p>UK – Preventing workplace harassment and violence: <a href="http://www.hse.gov.uk">www.hse.gov.uk</a></p> <hr/> <p>Canada: <a href="http://www.ccohs.ca">www.ccohs.ca</a></p>
<p><b>CONSULTATION</b></p>	
<p><b>Code of practice</b></p>	<p>Work health and safety consultation, cooperation and coordination: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>
<p><b>Guideline</b></p>	<p>Worker representation and participation guide: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>
<p><b>On-line notification of HSRs</b></p>	<p><a href="https://hsr.workcover.nsw.gov.au">https://hsr.workcover.nsw.gov.au</a></p>
<p><b>ENVIRONMENT, DESIGN, EQUIPMENT AND SECURITY</b></p>	
<p><b>Code of practice</b></p>	<p><a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Managing the work environment and facilities</li> <li>• Safe design of structures</li> <li>• How to manage and control asbestos in the workplace</li> <li>• Managing noise and preventing hearing loss at work</li> <li>• Confined spaces</li> <li>• Managing electrical risks in the workplace</li> <li>• Managing risks of plant in the workplace</li> <li>• Construction work</li> <li>• Demolition work</li> </ul>
<p><b>Policy</b></p>	<p>NSW Health – Protecting people and property: NSW Health Policy and guidelines for security risk management in health facilities: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p>
<p><b>Standards</b></p>	<p>AS 1428.1-2009 Design for access and mobility – general requirements for access – New building work: <a href="http://infostore.saiglobal.com">http://infostore.saiglobal.com</a></p> <hr/> <p>AS 4485-1997 Security for health care facilities: <a href="http://infostore.saiglobal.com">http://infostore.saiglobal.com</a></p> <hr/> <p>Building Code of Australia: <a href="http://infostore.saiglobal.com">http://infostore.saiglobal.com</a></p> <hr/> <p>AS/NZS 3200.2.38: 2007 Medical electrical equipment – Particular requirements for safety – Electrically and manually operated beds for adult use</p>

<b>Guidelines</b>	<p>Australasian health facility guidelines:  <a href="http://www.healthfacilityguidelines.com.au">www.healthfacilityguidelines.com.au</a></p> <p>A guide to designing workplaces for safer handling of people:  <a href="http://www.worksafe.vic.gov.au">www.worksafe.vic.gov.au</a></p>
<b>Fact sheet</b>	Emergency plans: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>
<b>Aged care</b>	<p>Design guidelines for aged care facilities (NSW Health):  <a href="http://www.fallssa.com.au">www.fallssa.com.au</a></p> <p>SA – Guide to the safe design of aged care facilities:  <a href="http://www.safework.sa.gov.au">www.safework.sa.gov.au</a></p>
<b>Medical device incidents</b>	Therapeutic Goods Administration: Notifications of reports and investigations – safety alerts: <a href="http://www.tga.gov.au">www.tga.gov.au</a>
<b>Medical Device Program</b>	USA – Safety culture – Stop Sticks program – Designing, implementing and evaluating a sharps injury prevention program: <a href="http://www.cdc.gov">www.cdc.gov</a>
<b>FALLS PREVENTION</b>	
<b>Code of practice</b>	Managing the risk of falls at workplaces (relates to falls from heights): <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>
<b>Australian</b>	Preventing slips, trips and falls: <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>
<b>FATIGUE</b>	
<b>Policy</b>	<p>NSW Health – Fatigue – preventing and managing work related fatigue: Guidelines for the NSW Public Health System:  <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p> <p>QLD Health – Fatigue risk management system resource pack:  <a href="http://www.health.qld.gov.au">www.health.qld.gov.au</a></p>
<b>Australian</b>	<p><a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Fatigue prevention in the workplace</li> <li>• Shift work: How to devise an effective roster</li> </ul> <p>Work-related fatigue – summary of recent indicative research, 2006:  <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>
<b>International</b>	<p>CANADA – Scientific symposium on the health effects of shift work:  <a href="http://www.iwh.on.ca">www.iwh.on.ca</a></p> <p>NZ – Shift work: reducing its effect on health and safety:  <a href="http://www.osh.dol.govt.nz">www.osh.dol.govt.nz</a></p> <p>UK – Managing shift work: health and safety guidance:  <a href="http://www.hse.gov.uk">www.hse.gov.uk</a></p>
<b>FIRST AID</b>	
<b>Code of practice</b>	First aid in the workplace: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>
<b>HAZARDOUS CHEMICALS</b>	
<b>Code of practice</b>	<p><a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Managing risks of hazardous chemicals in the workplace</li> <li>• Labelling of workplace hazardous chemicals</li> <li>• Preparation of safety data sheets for hazardous chemicals</li> </ul>
<b>Guide</b>	Cytotoxic Drugs and Related Waste – Risk Management Guide 2008: <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>

<b>Fact sheet</b>	<p><a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Guidance on the classification of hazardous chemicals under the WHS regulations</li> <li>• Guidance on the interpretation of workplace exposure standards for airborne contaminants</li> </ul>
<b>Policy</b>	<p>NSW Health – Cytotoxic drugs and related waste – safe handling in the NSW Public Health System: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p> <p>NSWNMA – Protection from toxic drugs: <a href="http://www.nswnma.asn.au">www.nswnma.asn.au</a></p> <p>Glutaraldehyde in NSW Public Health Care Facilities: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p>
<b>Australian</b>	<p>Pest management and fumigation evidence of training guidance <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a></p>
<b>LABOUR HIRE</b>	
<b>Fact sheet</b>	<p>Labour hire duties of persons conducting a business or undertaking – legislative fact sheet series: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>
<b>Policy</b>	<p>NSW Health – Contractors – Better Practice Guidelines Including Health/Safety in Engagement/Management/Evaluation: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p>
<b>MANUAL HANDLING</b>	
<b>Code of practice</b>	<p>Hazardous manual tasks: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>
<b>International standard</b>	<p>ISO/TR 12296:2012 Ergonomics – Manual handling of people in the health care sector: <a href="http://infostore.saiglobal.com">http://infostore.saiglobal.com</a></p>
<b>Policy</b>	<p>NSWNMA: Policy on Manual Handling: <a href="http://www.nswnma.asn.au">www.nswnma.asn.au</a></p> <p>NSW Health: Manual handling incidents – NSW Public health services – Policy/best practice guidelines prevention (2005): <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p> <p>ADHC NSW: Best practice guidelines for manual handling risk management in disability and community care: <a href="http://www.haccohs.adhc.nsw.gov.au">www.haccohs.adhc.nsw.gov.au</a></p>
<b>Australian – general manual handling guides</b>	<p><a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Manual handling guide for nurses</li> <li>• Manual handling competencies for nurses</li> <li>• Smart move toolkit</li> <li>• Manual handling resource</li> <li>• Design and handling of surgical instrument transport cases</li> </ul> <p>Workplace Health and Safety QLD. Participative ergonomics for manual tasks: <a href="http://www.justice.qld.gov.au">www.justice.qld.gov.au</a></p>
<b>Australian – patient handling guides</b>	<p>NSW – Implementing a safer patient handling program: <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a></p> <p>VIC – Transferring people safely: <a href="http://www.worksafe.vic.gov.au">www.worksafe.vic.gov.au</a></p> <p>QLD – Manual tasks involving the handling of people Code of Practice 2001: <a href="http://www.justice.qld.gov.au">www.justice.qld.gov.au</a></p> <p>Safe Work Australia – Manual handling risks associated with the care, treatment and transportation of bariatric (severely obese) patients in Australia: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>



<b>NSW Training programs</b>	<p>Manual handling for nurses – a series of four programs.  <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a></p> <ul style="list-style-type: none"> <li>• Program A: Essentials</li> <li>• Program B1: Patient risk assessment</li> <li>• Program B2: Managing risk</li> <li>• Program C: Leadership and change</li> <li>• Resources</li> </ul>
<b>Other patient handling resources</b>	<p>UK – Handling home care: achieving safe, efficient and positive outcomes for care workers and clients: <a href="http://www.hse.gov.uk">www.hse.gov.uk</a></p> <p>UK – The Guide to the Handling of People, 6th Edition, Smith J (ed), Backcare: <a href="http://www.backcaretrading.org.uk">www.backcaretrading.org.uk</a></p> <p>USA – Safe patient handling training for schools of nursing: <a href="http://www.cdc.gov/niosh">www.cdc.gov/niosh</a></p> <p>NZ – The New Zealand patient handling guidelines: <a href="http://www.acc.co.nz">www.acc.co.nz</a></p>
<b>Associations for health care professionals</b>	<p>Australian Bariatrics Innovations Group: <a href="http://www.ausbig.com.au">www.ausbig.com.au</a></p> <p>Australian Association for the Manual Handling of People: <a href="http://www.aamhp.org.au">www.aamhp.org.au</a></p> <p>Health Care Ergonomics Special Interest Group, Human Factors and Ergonomics Society of Australia: <a href="http://www.ergonomics.org.au">www.ergonomics.org.au</a></p>
<b>RISK MANAGEMENT</b>	
<b>Code of practice</b>	<p>How to manage work health and safety risks: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p>
<b>Policy</b>	<p>NSW Health – Work health and safety: better practice procedures: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p> <p>NSW Health – Occupational health and safety and injury management profile: <a href="http://www.health.nsw.gov.au">www.health.nsw.gov.au</a></p>
<b>VOLUNTEERS</b>	
<b>General</b>	<p>Resource kit: <a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a></p> <p>WorkCover NSW: <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a></p>
<b>WORKPLACE CULTURE</b>	
<b>General</b>	<p>Safety culture survey (with questionnaire and tools): <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a></p> <p><a href="http://www.safeworkaustralia.gov.au">www.safeworkaustralia.gov.au</a>:</p> <ul style="list-style-type: none"> <li>• Motivations, attitudes, perceptions and skills: pathways to safe work</li> <li>• Something to think about – motivations, attitudes, perceptions and skills in work health and safety</li> </ul> <p>CEO/Agency head – leadership, health and safety culture: <a href="http://www.comcare.gov.au">www.comcare.gov.au</a></p>
<b>International</b>	<p>UK – HSE Briefing note – safety culture: <a href="http://www.hse.gov.uk">www.hse.gov.uk</a></p> <p>UK – A review of safety culture and safety climate literature for the development of the safety culture inspection toolkit: <a href="http://www.hse.gov.uk">www.hse.gov.uk</a></p>

## OTHER GENERAL WHS PUBLICATIONS

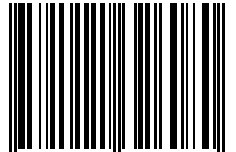
<b>Aged care</b>	The Guide: Implementing occupational health and safety in residential aged care: <a href="http://www.health.gov.au">www.health.gov.au</a> Accreditation standards – Physical environment and safe systems: <a href="http://www.accreditation.org.au">www.accreditation.org.au</a>
<b>Community services</b>	Community services safety pack: <a href="http://www.workcover.nsw.gov.au">www.workcover.nsw.gov.au</a>
<b>Disability services</b>	Manual handling resources: <a href="http://www.hacchohs.adhc.nsw.gov.au">www.hacchohs.adhc.nsw.gov.au</a>
<b>International</b>	European Agency for Safety and Health at Work: <a href="https://osha.europa.eu/en">https://osha.europa.eu/en</a>





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