Occupational Health and Safety in Residential Aged Care

First Steps

October 1999

Department of Health and Aged Care

Disclaimer

OHS in Residential Aged Care: First Steps (First Steps) has been developed to provide information to assist small aged care facilities to develop their own occupational health and safety program.

The material takes into account the special circumstances of aged care facilities and must be considered with the relevant State OHS Legislation.

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Development of First Steps

OHS in Residential Aged Care: First Steps was produced by Marion Pocock Consultancy, under contract to the South Australian WorkCover Corporation and the Commonwealth Department of Health and Aged Care. Marion Pocock wishes to acknowledge the input of Christine Aickin of Workability (Self-Assessment and 4.2), Carla Baron, N&C Baron & Associates and Verna Blewett, New Horizon Consulting Pty Ltd, the Flexible Learning Centre of the University of South Australia, the support of the Steering Committee for the project and the contribution of each person and organisation who gave feedback during the consultation phases.

Contents

Using *First Steps*

1.1 Introduction

Occupational Health and Safety in Residential Aged Care: First Steps has been designed to assist you, as staff working in small aged care facilities, to improve your management of Occupational Health and Safety, and to meet the OHS requirements for the accreditation of your facility.

Under the Federal Government's Aged Care Act 1997 all residential aged care facilities in Australia will need to become accredited by 1 January 2001, if they wish to continue to receive residential care subsidies. The requirements and processes for gaining accreditation are set out in the *Standards and Guidelines for Residential Aged Care Services,* the *Aged Care Standards Agency Accreditation Guide for Residential Aged Care Service,* and the *Application Kit for Accreditation.*

Of the 44 Expected Outcomes specified in the Standards and Guidelines which facilities are required to meet to gain accreditation, seven relate to OHS. Expected Outcome 4.5 – Occupational Health and Safety is the major one, but Expected Outcomes 4.1 to 4.7 all have OHS requirements.

To help you meet the OHS requirements for accreditation we have cross referenced *First Steps* with these documents. In particular, if you complete the self-assessment checklist contained in *First Steps* this will assist you to complete the OHS related criteria in the worksheets of the *Application Kit for Accreditation.*

Throughout *First Steps* the relevant Expected Outcomes from the *Standards and Guidelines* have been quoted to provide you with the links between OHS and the *Standards and Guidelines*. Section 5 pays particular attention to accreditaion.

(Of course there are many other requirements for accreditation besides the OHS ones. You will still need to be working with the *Standards and Guidelines* to make sure you meet all those other requirements as well.)

In summary, *First Steps* can help you:
- implement priority Occupational Health and Safety (OHS) management systems
- address the major hazards facing aged care facilities
- reduce work related injuries and illness (and associated costs)
- meet the OHS requirements of accreditation

1.2 Who should use the *First Steps*?

First Steps is designed as a management guide for owners, employers, directors, managers and employees of small aged care facilities who are involved in the process of reviewing and improving OHS. *First Steps* also aims to assist you to reduce accidents and the human and economic costs of work related injuries or illness.

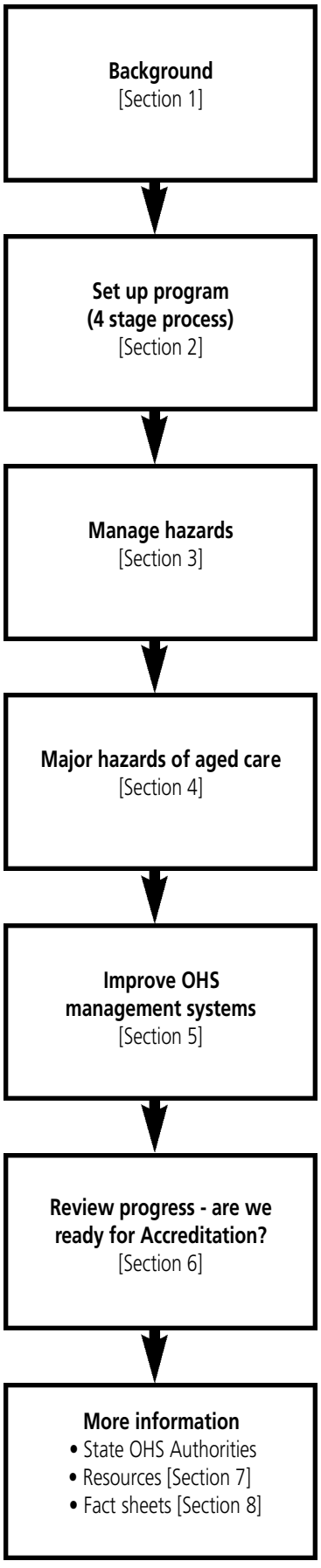
1.3 What's in *First Steps*?

First Steps outlines simple steps you can follow to improve the management of OHS and prepare your facility to meet the OHS requirements for accreditation. **Flowcharts** are used to summarise the major steps required, with more information included in the text. You may also use the flowcharts to develop your facility's OHS procedures (if required).

First Steps also includes a number of **sample tools** (i.e. checklists and forms). They may be used in their current form or adapted to meet the needs of your facility. They occur throughout *First Steps* immediately after the section in which they are discussed. The development and systematic use of well designed checklists and forms is a central element in an effective OHS program.

In the final sections of *First Steps* you will also find contacts for further information and a range of **Fact Sheets** which may be used to inform staff or further develop OHS.

Section 1 sets out a summary of the content of *First Steps* (summarised in flowchart 1.1), and describes the five major principles necessary for an effective OHS program, as background information for the remainder of *First Steps*.



Flowchart 1.1 – Using *First Steps*

1.4 Factors affecting effective OHS

To be effective OHS must be integrated into the day-to-day operations of your facility. Its success will depend on 5 major principles:[1]

- leadership demonstrated by managers
- employee participation
- designing better environments
- training and communication
- continuous improvement

Let's consider each of these in turn.

1.4.1 Leadership

Leadership and commitment from senior management must be visible.

This requires managers to:
- allocate resources
- allocate responsibility, authority and accountability
- plan and follow through decisions
- assess performance and implement continuous improvement
- regularly review OHS
- integrate OHS into all decision making
- consult with employees
- develop written policies and procedures

1.4.2 Employee participation

Consultation with employees/health and safety representatives is a requirement of each State's OHS Legislation. Employee participation is crucial for you to achieve a successful and effective OHS program.

Some reasons why consultation and participation are likely to lead to a successful program are:
- people are more likely to change if they are involved in the process
- common goals can be identified when working together
- participation can provide a more fulfilling role for employees
- employees have detailed knowledge of any hazards in their work and often have ideas of how problems can be solved

Details of the legal requirements for consultation methods are included in *Fact Sheet 3* in Section 8.

[1] WorkSafe Australia, (1995), "OHS Good for Business", AGPS, Canberra.
'Commonwealth of Australia, copyright reproduced by permission'.

1.4.3 Designing better environments

To design better environments you need to consider OHS:
- prior to designing new facilities or redesigning current facilities
- when making decisions to purchase new equipment
- restructuring your staffing arrangements
- when identifying, assessing and controlling risks

This process is described further in Section 3.

1.4.4 Training and communication

OHS should be part of all training. When training new staff you should include workplace OHS policies and procedures, quality expectations, and similar OHS issues.

Communication with employees on OHS issues is crucial to:
- raise awareness of OHS
- ensure people know what they are required to do
- encourage the exchange of ideas
- update people on changes and procedures

More detail of training requirements is included in Section 5.

1.4.5 Continuous improvement

Continuous improvement is an essential component of an effective OHS program. This involves you and your staff constantly asking the questions 'Are we doing it right?' and 'How can we do this better?'.

The continuous improvement requirements of the relevant *Standards and Guidelines for Residential Aged Care Services are* included in Section 5.

1.5 Summary

In this opening section we have described the purpose and content of *First Steps*, and also provided an overview of the 5 major principles on which any effective OHS program needs to be based. In the next section we will look at the practical steps required to set up or improve such a program.

Getting started

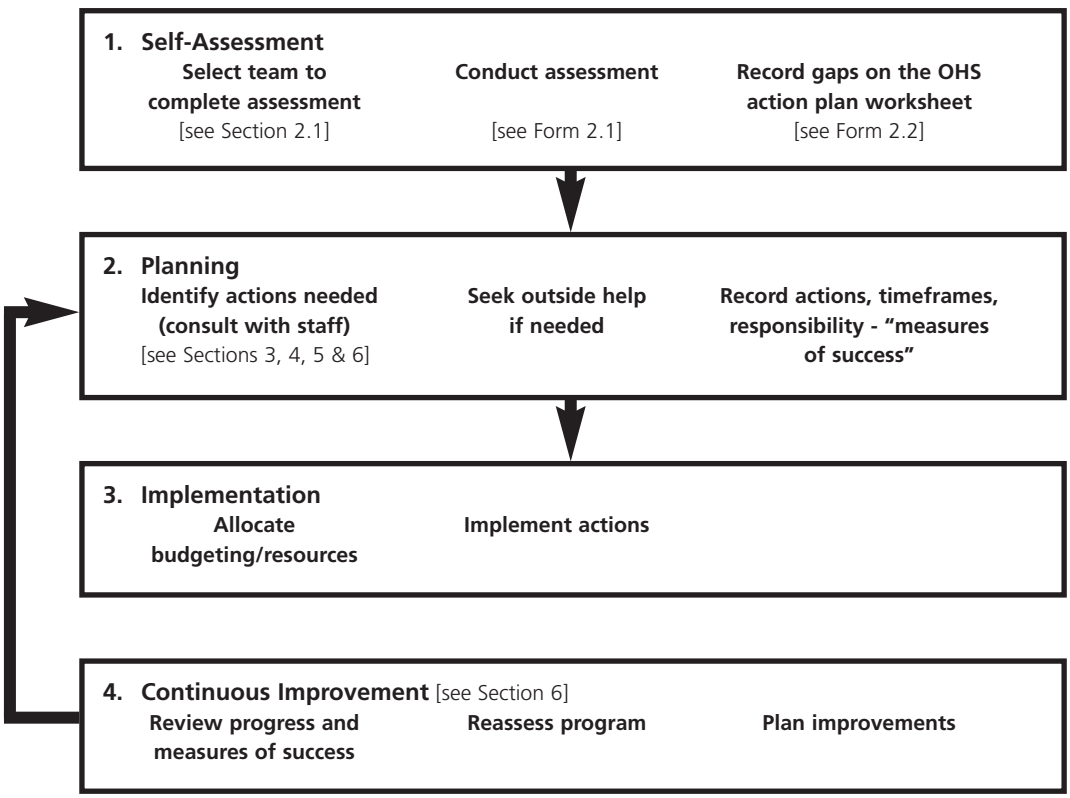
2.1 Introduction

Effective OHS requires 4 major steps. These steps are common to many projects, and you will recognise them from other activities at work and home.

These steps can be summarised as:

1. Self-assessment
2. Planning
3. Implementation
4. Continuous improvement

More detail about each of these steps is included in flowchart 2.1.



Flowchart 2.1 Planning for effective OHS

2.2 Where are we now? (self-assessment)

The first step is to select a team to review your facility's current performance in OHS to identify achievements and any gaps.

The team may include the Director and Health and Safety Representative [HSR] if one is elected, or the OHS Committee [if one is in place] or with one or more employees.

Once your team is selected, it should inform all staff about the review prior to commencing and invite them to be involved. As we have seen, employee participation is a major principle of effective OHS.

Form 2.1-The Self Assessment checklist on the next page will guide your team through the process of assessing OHS. The form includes the major OHS requirements, but you will need to review your State OHS legislation to make sure you comply with all requirements.

Answering the questions in Form 2.1 will require you to review physical locations, policies and procedures, meeting minutes, incidents and hazard reports and any other documentation to provide evidence for your answers. Record relevant information in the comments section of the checklist.

Form 2.1 Sample Checklist for Self Assessment against OHS related Expected Outcomes of the *Standards and Guidelines for Residential Aged Care Services*

	Yes	*No*	*Comments*
1. Continuous improvement (expected outcome 4.1)			
a) Does your facility have an OHS plan?	❑	❑	
b) Is OHS information (such as hazard/incident reports, maintenance reports and minutes) collected and used as the basis of review/planning?	❑	❑	
c) Is there a budget allocation for OHS?	❑	❑	
d) Does your facility have a written OHS policy?	❑	❑	
e) Does the policy include responsibilities of employees and managers?	❑	❑	
f) Is there a written rehabilitation policy?	❑	❑	
g) Are OHS policies and procedures reviewed regularly?	❑	❑	
2. OHS legislation (expected outcome 4.2)			
a) Is your facility aware of State OHS legislative requirements?	❑	❑	
3. Consultation/participation (expected outcome 4.5)			
a) Are there effective means of consultation/ participation of employees in OHS decision making that meets State legislative requirements?	❑	❑	
b) Is OHS a regular agenda item at management, board, staff and resident information meetings?	❑	❑	
c) Where applicable, are the language needs of employees and residents considered when consulting on OHS?	❑	❑	

Form 2.1 – Sample Checklist for Self Assessment [cont]

4. Education and staff development (expected outcome 4.3)	*Yes*	*No*	*Comments*
a) Do all new employees, contractors (agency staff, trades people) and volunteers receive OHS induction?	❑	❑	
b) Has OHS training been provided for the following			
• Owners/board (OHS obligations)?	❑	❑	
• Managers, supervisors, employee representatives (legislation and hazard management)?	❑	❑	
• Employees (hazard specific)?	❑	❑	
• OHS committee training (if one is in place)?	❑	❑	
• First aiders?	❑	❑	
• Rehabilitation co-ordinator (in injury management)?	❑	❑	
c) Are records kept of OHS training covering course topic aims and outcomes, attendance, date, presenter (including induction)?	❑	❑	
5. Managing hazards (expected outcome 4.5)			
a) Are inspections of the whole workplace conducted regularly using purpose designed checklists?	❑	❑	
b) Does your facility have a system for reporting hazards?	❑	❑	
c) Are there planned proactive programs to address:			
• Manual handling?	❑	❑	
• Slips, trips and falls?	❑	❑	
• Client aggression?	❑	❑	
• Hazardous substances?	❑	❑	
• Plant and equipment?	❑	❑	
• Fire security and other emergencies? (expected outcome 4.6)	❑	❑	
• Living environment? (expected outcome 4.4)	❑	❑	
• Infection control? (expected outcome 4.7)	❑	❑	
d) Have risk assessments been carried out on all identified hazards and hazardous tasks?	❑	❑	
e) Are reports/hazards followed up and actioned (controlled)?	❑	❑	

Form 2.1 – Sample Checklist for Self Assessment [cont]

	Yes	*No*	*Comments*
f) Is the action taken reviewed to ensure effectiveness?	❑	❑	
g) Are staff and residents considered when managing risks and developing safe work procedures?	❑	❑	
h) Are OHS implications considered when purchasing or hiring equipment/ furniture etc?	❑	❑	
6. Incident reporting/investigation (expected outcome 4.5)			
a) Does the facility have a standard form for reporting/investigating incidents/ injuries that complies with relevant State Legislation and Codes of Practice?	❑	❑	
b) Are staff aware of the reporting procedure?	❑	❑	
c) Are incidents investigated and documented?	❑	❑	
7. Injury management (no cross reference to standards)			
a) Is there a procedure to manage workers compensation claims?	❑	❑	
b) Is there a process to manage early and effective return to work following an injury?	❑	❑	

2.3 What to do with the self-assessment results (planning)

Any 'no' answers recorded when filling in your Self-assessment checklist (Form 2.1) demonstrate a gap in the OHS system and the need for improvement. Record these on Form 2.2-Action plan worksheet (see next page). This worksheet is based on those in the *Application Kit for Accreditation*. You will need to document the actions required, what your outcome (or improved result) will be, who is responsible for the actions and the timeframe. The remainder of *First Steps* will help you decide on the actions required.

It is vital to involve staff in the planning process in order to achieve successful outcomes (and meet the legal requirements for consultation). Discuss the required actions with employees and their representatives. Record the actions on the OHS action plan worksheet (Form 2.2) (or your own action plan if you already have one).

Next you will need to decide who will be responsible for the tasks, and timeframes. Record these also on Form 2.2. Obtain outside help for carrying out tasks, if needed.

Refer to the relevant State OHS Legislation while developing the action plan to ensure legislative compliance and to meet Expected Outcome 4.2 of the *Standards and Guidelines for Residential Aged Care Services*.

You may need to include short and long term objectives in the plan. Some may be completed within one month while others require one or even two years.

Next you will need to decide what resources are needed to implement the plan.

Determine how you will measure the success of the plan; for example, through better reporting of hazards, regular maintenance of equipment, reduction in injuries. This will require the development of 'measures of success' such as '90% of equipment checked by the due date'. Record these measures of success in the 'What will be the improved result?' column of the action plan (Form 2.2).

You will also need to prioritise activities recorded on your action plan, so that you start by addressing priority hazards first.

For effective prioritisation you will need to take into account:
- the particular needs of your facility
- your major hazards (see Section 4)
- legislative compliance
- resource/budget requirements
- training and staff development needs

Form 2.2 – Sample OHS Action Plan Worksheet

Actions Required	What will be the improved result?	Relating to expected outcome No:	Person or team responsible	Date action to be completed	Actual date action completed	What was the improved result?
1						
2						
3						
5						
5						
6						
7						
8						

Source: Adapted from Aged Care Accreditation Agency Guide for Residential Aged Care

2.4 Implementation

Now you have an action plan in place the next step is to make it happen.

- arrange any resource/budgeting needs for implementing the action plan
- implement the required actions (if additional information is needed to implement the improvements, contact your employer association, union or State OHS Authority)
- provide any required training (Expected Outcome 4.3)
- record the "improved result" on the action plan worksheet

2.5 Continuous improvement

(Expected Outcome 4.1)

To achieve continuous improvement you and your team will need to:

- review progress against the action plan at the OHS committee or staff meetings at regular intervals, for example monthly, to ensure timeframes are being met, that the changes made have been effective and to identify any difficulties in implementing the plan
- reassess your OHS program on a regular basis (e.g. annually), using the self-assessment checklist (Form 2.1) and your 'measures of success' entries in the 'What will be improved result?' column of your action plan
- use the findings to develop an annual OHS plan (continuous improvement) and to complete the worksheets in the *Application Kit for Accreditation*

2.6 Summary

Completion of the self assessment sheet and recording the required tasks on the action plan has started you and your team on the path to continuously improve OHS within your facility.

The next section of *First Steps* will provide you with more detail on how to manage your hazards by firstly identifying them, then assessing and eliminating or minimising the risks.

Managing hazards

3.1 Introduction

A key element in any effective OHS program is the management of hazards.

Managing hazards involves 4 major steps:
- hazard identification
- risk assessment
- risk control
- monitoring and review

In this Section we will go through each of these steps in turn, outlining a range of strategies and tools to assist in the management process. Sample forms related to each step are included immediately after the relevant discussion.

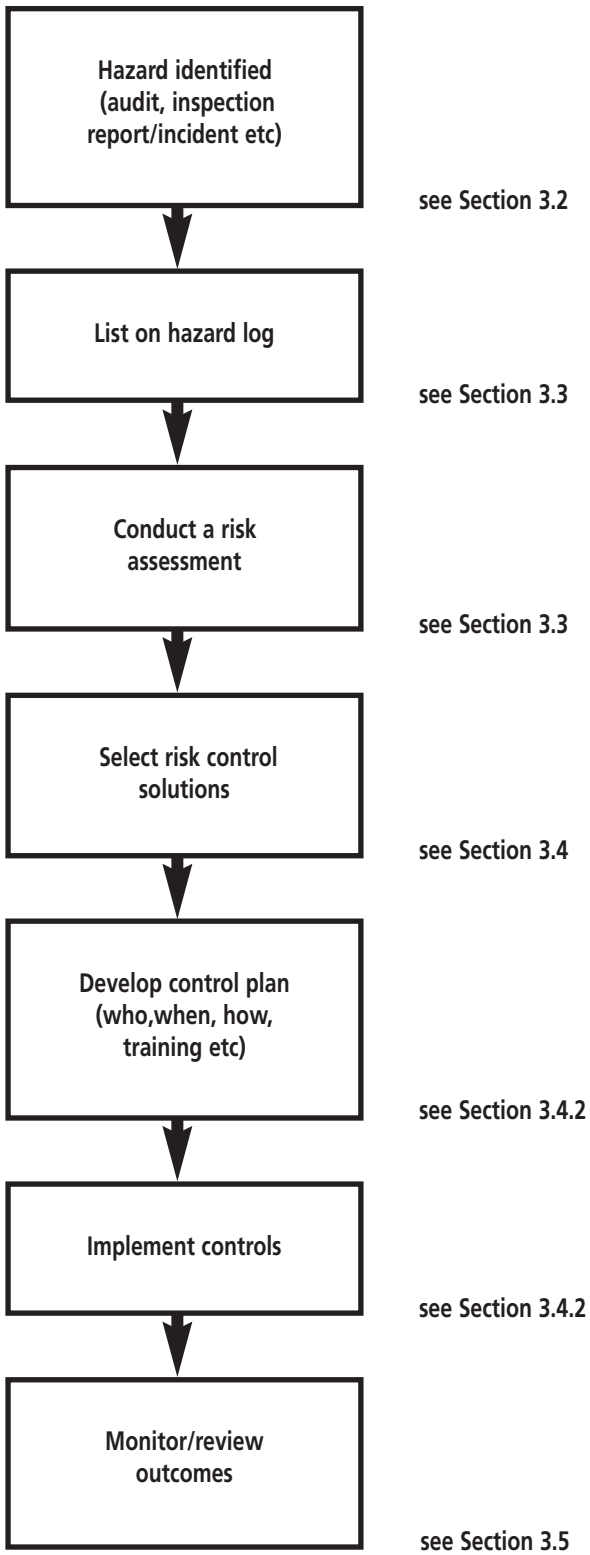
Using these strategies and tools will also assist you to meet Expected Outcome 4.5 of the *Standards and Guidelines for Residential Aged Care Services,* which requires 'Management to actively work to provide a safe working environment that meets regulatory requirements'.

There must be policies and practices which provide:
- for the management of hazards identified in the workplace
- for management and staff involvement in identifying and resolving OHS issues
- incident report mechanisms that are present, functional and acted upon
- equipment that is fit for the purpose intended, is well maintained, and which staff are trained to use

Hazards are defined as anything that has the potential to cause injury or illness, such as:
- physical hazards, for example, sharp edges, slippery floors
- chemicals
- work practices such as repetitive jobs, including manual handling
- aspects of workplace design, for example restricted access to toilets, poor lighting, steep stairs

Risk is defined as the likelihood (probability) that injury/illness will occur and the potential severity (consequences).

The steps involved in managing hazards are shown in the following flowchart (Flowchart 3.1).



Each step must include consultation with staff and feedback

Flowchart 3.1 Hazard Management Process

3.2 Hazard identification

The first step in managing hazards is to identify your hazards. It is important to involve everyone in this task.

Tools that can assist you to identify and address hazards are a hazard log (Form 3.1), hazard or incident reports (Form 3.2), and a structured workplace inspection using a workplace inspection sheet (Form 3.3).

Strategies for identifying hazards may be continuous, that is integrated into day to day activities, or specifically planned for the purpose. Examples of each are listed below.

Continuous strategies

- hazard reports completed by staff
- incident reports and investigation
- informal observations
- OHS discussion at staff meetings/OHS committee
- 'breakdown' maintenance records

Planned strategies

- regular workplace inspections
- monthly review of data
- conducting a hazard audit, for example, brain-storming to consider all aspects of the facility and the things which could cause injury/illness
- considering potential hazards prior to purchasing new equipment or chemicals
- use of industry information from employer organisations and unions to highlight issues which have not been considered

3.2.1 Hazard audits

One useful planned activity to identify hazards is to conduct a hazard audit ('hunting for hazards'). This can be done in a number of ways. Use a small group of staff from a range of positions to conduct the survey but involve everyone. One way to organise the survey is to draw a map of the site and then to look at and discuss the potential hazards within each area, for example, kitchen, storeroom, resident rooms, office, maintenance shed, garden, delivery area.

Consider: [2]

- substances used - for example, cleaning and laundry products, photocopier toner
- equipment used - suitability of hoists, maintenance tools, ovens, washing machines, dryers, irons, lawnmowers etc and any hazards associated with the way they are used or maintained
- moveable items - vehicles, store boxes, linen and food trolleys, shower chairs, wheelchairs (manual and electric), lifters
- people - do they have the skills, information, training and equipment necessary to perform tasks safely? Do they comply with the procedures? Are there potential hazards for staff who are new and/or inexperienced? How could they be affected?

Record all the hazards identified in a hazard log. A sample hazard log has been included (Form 3.1 – see next page). A hazard log should include a summary of hazards including the level of risk, actions taken, responsibility, completion date and follow-up date.

The next step is to decide which hazards present the greatest risk in order to prioritise which hazards to address first. Hazards which are simple to fix (and at small, or no cost) should be rectified at the time or soon after the audit.

Keep a record of the actions and consider whether the same or a similar problem may exist in other areas of the facility.

2 Victorian Occupational Health and Safety Authority, "An Accident at Work Hurts Everyone Around You – Making OHS Matter", October 1994, pp 7-8

Form 3.1 – Sample Hazard Log

Date of report	Nature of hazard (risk identification)	Priority (risk assess-ment)	Action required (risk control)	By whom	By when	Date action completed	Follow up date

3.3 Risk assessment

Risk assessment is the second major step you need to take in managing hazards, once you have identified hazards by any of the continuous or planned methods listed above, and entered them in your hazard log (Form 3.1).

Risk assessment is the process in which you and your staff consider two things:
- the degree of seriousness of injury or illness which could be caused by a hazard
- the likelihood of such injury or illness occurring.

There are a number of tools which you could use to assist in conducting risk assessments. One example is the risk table[3] on the next page.

3.3.1 Using a risk table

Consider the following:

What might be the consequences of the hazard?

- fatality
- major injuries (normally irreversible injury or damage to health)
- minor injuries (could require several days off work)
- negligible injuries (first aid)

How likely is it the hazard will cause an injury or illness?

- very likely – could happen frequently
- likely – could happen occasionally
- unlikely – could happen but only rarely
- highly unlikely – could happen but probably never will

3 National Occupational Health and Safety Commission (1995), "Plant in the Work Place - Making it Safe", Australian Goverment Publishing Service, Canberra

The risk table matrix is used to determine the level of risk based on the assessment of likelihood and consequence. For example, a frequently used slippery bathroom floor could be assessed as very likely to result in a major injury. Using the risk table this would be assessed as high risk.

Consequence	**Likelihood**			
	Very likely	***Likely***	**Unlikely**	***Highly Unlikely***
Fatality	High	*High*	High	*Medium*
Major Injury	High	*Medium*	Medium	*Low*
Minor injury	High	*Medium*	Medium	*Low*
Negligible	Medium	*Medium*	Low	*Low*

Table 3.1 Risk Table

Conduct a risk assessment on each of the hazards listed in the hazard log and record the results. This will then help to prioritise which hazards should be addressed first.

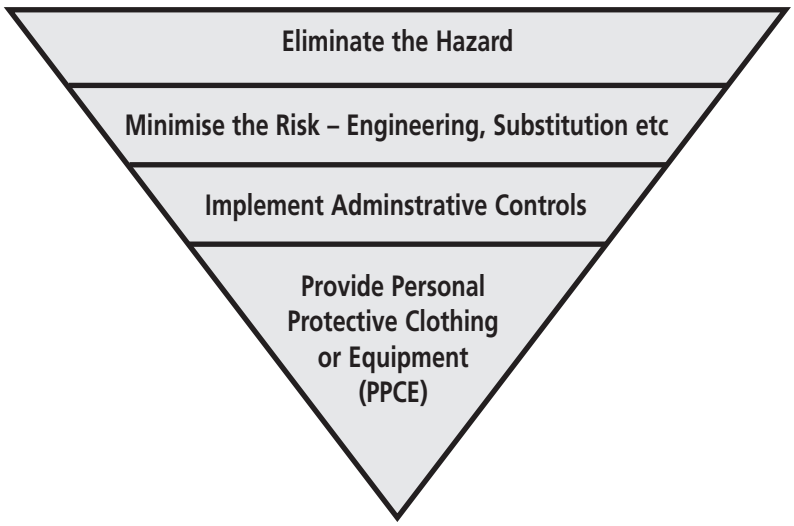
3.4 Risk control

After hazard identification and risk assessment, the third major step in managing hazards is risk control. This requires you to plan actions to eliminate or reduce the risks of injury or illness starting with the high priority hazards.

The recognised method for controlling risks is to apply the 'Hierarchy of controls.'

3.4.1 Hierarchy of controls

The hierarchy of controls is a graded list of four strategies:



The first of these, eliminating the hazard completely, is the most desirable, but if this is not possible the second can be applied, and so on down the hierarchy to the least satisfactory option, the use of personal protective clothing or equipment. In practice, if it is not possible to eliminate the hazard completely, it is often necessary to use some combination of the remaining three controls.

Methods used should be in compliance with the relevant State OHS *Regulations* and *Codes of Practice*.

Elimination

Examples of elimination are:

- repairing or replacing faulty equipment
- redesigning the workplace or work practices, for example, not doing unnecessary high risk tasks or designing new facilities (or redesigning old ones) to allow sufficient space for manual handling tasks

If the hazard can't be eliminated the next option is to minimise the risk of injury.

Minimise the risk of injury

There are a number of options you may be able to use alone or in combination to minimise the risks of injury and illness.

Substitution

Substitution requires replacing hazardous substances or procedures with those which are safer, for example by:

- replacing a hazardous cleaning product with one which is non-hazardous and environmentally friendly
- replacing tiles in the bathroom with non slip tiles

Modification

You may be able to modify the workplace or work practices to minimise risk, for example by:

- rearranging the layout of a resident's room to allow free access with a hoist
- improving drainage in bathrooms

Isolation

You may be able to isolate hazards to minimise the risk, for example by:

- moving a photocopier away from the desk area
- locking up chemicals to prevent access by residents or visitors

Engineering controls

Engineering controls include the use of:

- hoists and trolleys
- spring loaded bases in linen baskets
- electric or manually raising beds

If risks can't be minimised the next option is to consider implementing administrative controls.

Administrative controls

Administrative controls include:

- changing the way the work is done
- implementing Safe Work Practices or Standard Operating Procedures (SOPs)
- training
- increasing the supervision of staff

Examples include:

- written procedures for higher risk tasks
- safe procedures to be followed during maintenance
- signs warning of hazards
- rest breaks for people like computer operators doing repetitive tasks
- job rotation
- regular training on, for example, manual handling

Personal Protective Clothing and Equipment (PPCE)

PPCE is a means of protecting the worker's body from the hazard, and may include:

- gloves (for example vinyl, rubber, mesh)
- respirators/masks
- safety glasses/goggles
- hearing protection
- non-slip shoes, rubber boots
- aprons

PPCE must be:

- carefully selected to be suitable for the task
- correctly fitted
- comfortable to wear
- always worn where indicated

You must train staff in the use and maintenance of PPCE and they must be supervised to ensure they do wear/use and maintain it.

3.4.2 Implementing controls

When you have considered options for controlling risks and chosen a solution, your next step is to document it on the hazard log (Form 3.1) and develop an implementation plan, including who is responsible for tasks and the time frames.

Employees and their representatives must be involved in the process of selecting controls and trained in any new procedures required.

3.5 Monitoring and review

(Expected Outcome 4.1)

You have now *identified* your hazards, and *assessed* and *controlled* the risks they present. The fourth step in managing hazards is, in consultation with your staff, to *monitor and review* the changes made to control the hazard to ensure they have been effective, and have not introduced additional hazards.

The hazard log (Form 3.1) is a key tool for monitoring and review. Record the action completed and follow up dates on the hazard log. During review you may identify further improvement strategies which need to be implemented. These should be recorded as a new item on the hazard log.

3.6 Tools for identifying hazards

3.6.1 Hazard reports

Effective hazard reporting is essential for successful hazard management and to meet Expected Outcome 4.5. Implementing the use of hazard report forms (Form 3.2 on the next page) will encourage your staff to identify and report hazards. You can then implement controls before an injury occurs.

Encourage staff to complete hazard report forms for any situation which requires actions beyond simple maintenance. For example, a maintenance request may be completed for a wheel sticking on one shower chair. Repeated occasions of wheels sticking on a number of shower chairs has identified a hazard and a hazard report form should be completed.

Hazard report forms should be:

- completed by anyone-employees, managers, contractors, volunteers or residents/families
- investigated and improvements planned and implemented by the director/supervisor (in consultation with staff)
- signed by the health and safety or employee representative (if there is one)
- discussed at an OHS committee/staff meeting

After discussion at a meeting you should include comments on the effectiveness of action taken on the hazard report form and hazard log. Provide feedback to the staff member who reported the hazard.

The steps for resolving hazards are summarised in Flowchart

Form 3.2 - Sample Hazard Report form

To be completed by person identifying hazard

Name (optional): **Date:**

Description of hazard
(include area and task involved, and any equipment, tools, people involved.
Use sketches if necessary):

Suggested actions
(list any suggestions you have for reducing or eliminating the problem e.g. redesign, use of mechanical devices, training etc):

Report to (Name) . . . . . **Position** . . . . .
Give this report to Manager/Supervisor

To be completed by management

Action taken
(to be completed by a Manager/Supervisor in consultation with employees and include action at local level):

Risk Rating (See Risk Table)

Supervisor . . . . . **Date** . . . . .

Outcome evaluation: Hazard eliminated ❑ Risk controlled ❑

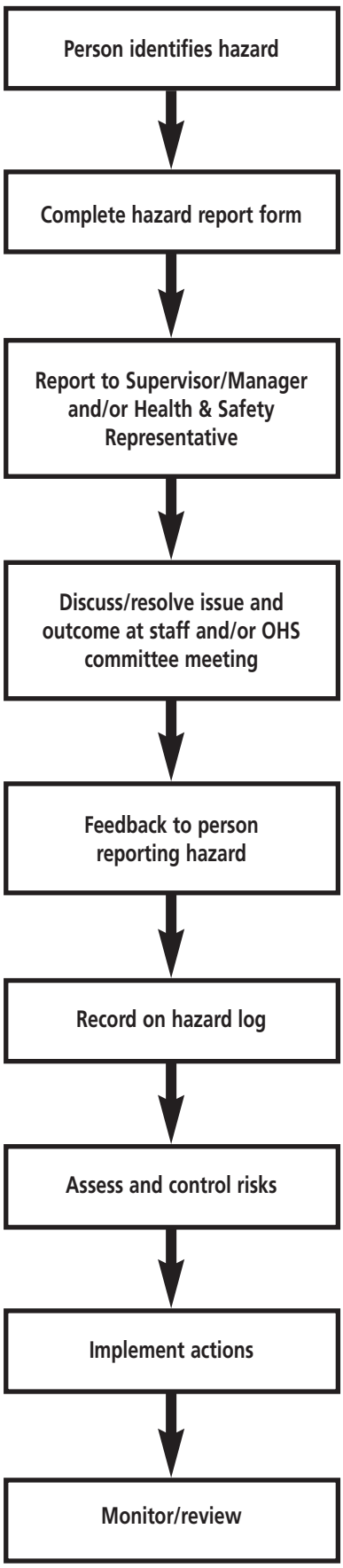
Further actions, by who, when?

❑ Response to person reporting
Date of response . . . . .

❑ Response to staff meeting/ OHS Committee
Date of response . . . . .

Director . . . . . **Date** . . . . .

Employee representative . . . . . **Date** . . . . .



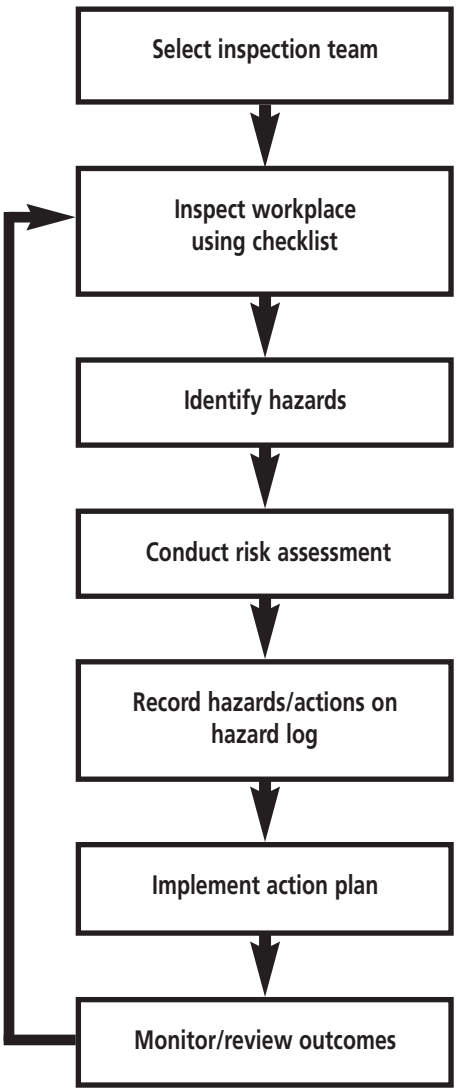
Flowchart 3.2 Steps in resolving hazards

3.6.2 Workplace inspections

Regular workplace inspections using a checklist provide you with a chance to identify hazards not noticed on a day-to-day basis.

The objective is to identify hazards, monitor OHS standards and ensure that corrective action is taken within an agreed time frame.

Inspections should be conducted by a manager and an employee representative or OHS committee member. It is a good idea to rotate the people conducting the inspections and bring in people from different areas as they may see different hazards. This also helps to encourage participation by all staff in the facility. A flowchart of the process is shown in Flowchart 3.3.



Flowchart 3.3 Workplace inspections

You should decide how often to conduct inspections in consultation with employees, considering how quickly hazards could arise, for example, every two months.

Inspections should include a wide range of issues such as housekeeping, emergency equipment, lighting, equipment, storage and hazardous substances, and should involve staff working in the area.

A sample Workplace Inspection sheet or checklist is included (see Form 3.3 on the next page). You will need to adapt this to suit your facility. A small facility may only need to have one checklist, or it may be more practical to have more than one and complete them at staggered regular intervals, for example, kitchen/dining areas, laundry, offices, resident rooms, garden and maintenance areas.

Following workplace inspections you must take action to address identified hazards or issues. Document the actions on the checklist, along with who is to take action and the timeframe. Rectify anything which can be immediately fixed but still record it on the checklist as it may indicate a trend, for example, blocked fire exits.

Once actions have been completed record the completion date on the checklist. You may wish to record major hazards on the hazard log, to keep all information in one place (see Form 3.3).

Long term actions should be included in the OHS Action Plan worksheet (Form 2.2).

Form 3.3 – Sample Workplace Inspection Sheet

Work area:
Date of inspection:
Person/s inspecting:

Rating 1=poor 5=excellent

Area	Rating	Actions required	By Whom	By When	Action Completed
Corridors/Stairs e.g. No blind corners					
Hand rails accessible					
Anti-slip tread on stairs					
Stairs in good condition					
Floors Even/visible steps etc.					
In good condition (no trip hazards)					
No spills					
Work Areas Clean and tidy					
Equipment/paperwork put away					
Storage Items stored correctly					
Storage designed to minimise lifting problems					
Walking area clear					
Electrical Residual Current Devices (RCDs) fitted for moveable equipment and RCDs checked					
Equipment checked and has current inspection tag					
No damaged appliances, points, plugs, cords					
No cords on floors or across walkways					
Equipment In good condition (if unsafe taken out of service)					

Form 3.3 – Sample Workplace Inspection Sheet [cont]

Rating 1 = poor, 5 = excellent

Area	Rating	Actions required	By Whom	By When	Action Completed
Equipment (cont) In use or stored appropriately					
Suitable for purpose used					
Maintenance checks/ records up to date					
Ventilation Air vents, filters, extraction fans clean					
Servicing records kept up to date					
Gas Cylinders Cylinders secured					
Stored outside (minimum inside)					
Cylinders in use secured on trolley					
Hazardous Substances Material Safety Data Sheets (MSDS) available for allsubstances					
All containers clearly labelled					
Stored appropriately					
Manual Handling Unnescessary manual handling eliminated					
Staff trained in manual handling					
Staff trained in use of mechanical aids					
Lighting Light fittings clean/working					
Work areas well lit					
Night lighting adequate					
Security lights working					

Form 3.3 – Sample Workplace Inspection Sheet [cont]

Rating 1 = poor, 5 = excellent

Area	Rating	Actions required	By Whom	By When	Action Completed
Employee amenities Toilets/handbasins clean/ soap available					
Lunch room clean					
Safety signs OHS policy dispalyed					
First Aid, Protective and Fire Equipment, signs etc posted					
Waste disposal Bin regularly emptied/cleaned					
Food scraps in vermin proof bins					
Infectious waste disposal Sharps containers available (close to area of use)					
Infectious waste disposed of appropriately					
Fire/Emergencies Extinguishers in place, serviced/not blocked					
Exits clearly marked/clear					
Exit/Emergency lighting works					
Action cards/emergency numbers displayed					
Smoke detectors tested					
Fire blanket accessible					
Employees know procedures (ask a sample of staff)					
First aid kit available, well stocked and clean					
Records kept of first aid provided					

Form 3.3 – Sample Workplace Inspection Sheet [cont]

Rating 1 = poor, 5 = excellent

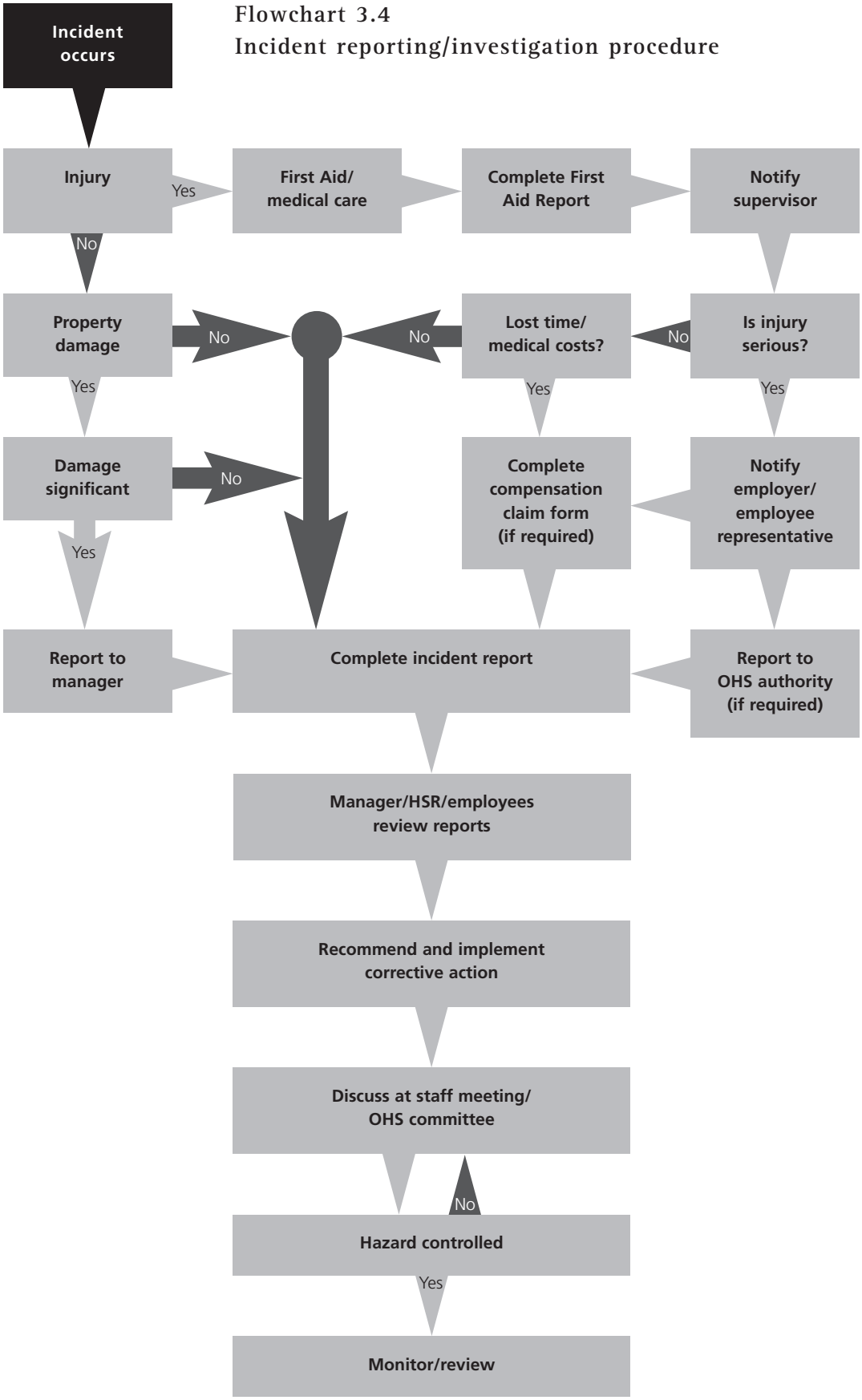
Area	Rating	Actions required	By Whom	By When	Action Completed
Grounds Paths even/ obstruction free					
Garden sheds locked					
Easy access to grounds for residents/staff					

- On completion of the inspection, allocate and record actions.
- Forward the Checklist to the facility manager/OHS Co-ordinator.
- Sign the sheet once tasks have been completed.
- Record identified hazards on the Hazard Log (including a review date).
- Record long-term actions on the OHS Action plan.
- Monitor Checklist to ensure all actions have been implemented.

3.6.3 Incident reports/investigation

OHS Legislation in all States requires incidents resulting in injury to be recorded. Serious injuries must be reported to the appropriate authority. The requirements differ from State to State so you must refer to the State Legislation or State OHS authority to check specific requirements. The process for incident investigation is summarised in Flowchart 3.4 on the opposite page.

Flowchart 3.4
Incident reporting/investigation procedure



Reporting and investigating 'near miss' incidents where no injury occurred will also assist you to identify hazards. Where an injury results in lost time or medical costs, workers compensation claim forms must be completed.

Incident report forms are legal documents and must be completed thoroughly and objectively. An example form is included on the next page (Form 3.4).

You will need to adapt this to suit your facility and your State legislation. Investigating incidents is essential for identifying and addressing hazards. This requires investigators (a manager and health and safety/employee representative) to be trained in the task. A detailed approach must be used, particularly for long-term incidents or symptoms where underlying causes may be hard to identify.

Things you should consider include:

- who was involved?
- where and when did the incident occur?
- what task or work was being performed?
- how did the incident occur, for example, was a chemical, client, process or equipment involved?
- what were the events leading up to the incident?

Look for problems related to equipment, the task, work environment or procedures (not just what a person did wrong).

You can use this information to identify the underlying causes (hazards). You will then need to conduct a risk assessment on each hazard.

Next, develop a plan for controlling the hazards identified, including time frames and responsibilities and record the outcomes on the incident report form (Form 3.4) and the hazard log (Form 3.1).

Discuss the injury statistics and actions taken at the OHS committee/staff meetings. Document the discussion in the minutes, including a review of the effectiveness of the actions taken.

You may choose to use separate incident report forms for staff and residents or to use the same form. Where the same form is used, confidentiality of resident records must be protected. Staff reports must also be kept confidential with incidents discussed at meetings but without individuals involved being identified.

For more information about the management of employee injuries see Section 5.6.

Form 3.4 – Sample Incident/Injury Report

Status:

Employee ❑ Visitor ❑ Contractor ❑ Volunteer ❑ Student ❑ Resident ❑

1. Details of injured person

Surname: Phone: (h) (w)

First name: Sex: M ❑ F ❑

Address: Date of birth:

1st Language:

Experience in job:

❑ 0-3 months ❑ 3-5 years

❑ 4-12 months ❑ 5 years plus

❑ 1-2 years

Work arrangement:

❑ Casual ❑ Full time

❑ Permanent P/T ❑ Other

2. Details of witnesses:

Name: Phone: (h) (w)

Address:

Name: Phone: (h) (w)

Address:

3. Details of incident or accident:

Date: Time of Injury:

Activity engaged in:

Location of incident/accident:

Describe how and what happened:

4. Details of injury (the assistance of a supervisor may be required to complete this section):

Nature of injury/illness (eg burn, sprain, cut etc):

Mechanism (eg fall, grabbed by person, muscular stress):

Location on body (eg back, right thumb, left arm etc):

Agency (eg furniture, another person, hot water):

5. Treatment administered:

First Aid Administered Yes ❑ No ❑

Treatment:

Referred to:

First Aid Attendant (Print name): (Signature):

Form 3.4 – Sample Incident/Injury Report [cont]

Sections 6-9 must be completed by Supervisor

6. Did the injured person stop work:

Yes ❑ No ❑ If yes, state date: Time:

Outcome:

- ❑ Treated by doctor
- ❑ OHS Authority notified
- ❑ Hospitalised
- ❑ Lodged Workers Comp Claim
- ❑ Returned to normal duties
- ❑ Returned to alternative duties
- ❑ Referred to Rehab Co-ord
- ❑ Referred to OHS Officer and/or OHS Committee

7. Incident or accident investigation

(comments to include identified causal factors):

Name and Signature *(supervisor)*: Date:

8. Remedial actions:

- ❑ Conduct task analysis
- ❑ Conduct hazard systems audit
- ❑ Develop/review tasks/procedures
- ❑ Improve work environment
- ❑ Review OHS policy/programs
- ❑ Replace equipment/tools
- ❑ Improve work organisation
- ❑ Develop and/or provide training
- ❑ Reinstruct persons involved
- ❑ Improve resident /staff skills mix
- ❑ Provide debriefing and/or counselling
- ❑ Request maintenance
- ❑ Improve personal protection
- ❑ Improve work congestion/ housekeeping
- ❑ Investigate safer alternatives
- ❑ Request Material Safety Data Sheets (MSDS)
- ❑ Improve design/ construction/guarding
- ❑ Add to inspection program
- ❑ Improve communication/ reporting procedures
- ❑ Improve security
- ❑ Temporarily relocate employees involved
- ❑ Other (specify)

What, in your own words, has been implemented or planned to prevent recurrence:

9. Remedial actions completed:

Signed (supervisor): Title: Date:

10. Review comments

(OHS Committee/staff meeting):

Reviewed by DON/Director/Site Manager (Signed) (Date)

Source: Adapted from WorkCover NSW/Baptist Community Services, "Managing Resident Aggression in Aged Care Facilities" - 1st Edition, November 1998.

Major hazards of the aged care industry

4.1 Introduction

What are the hazards most commonly encountered in aged care facilities which must be eliminated or minimised to prevent or reduce the occurrence and severity of staff injuries or illness?

Seven major hazards which have been identified are:

- manual handling
- slips, trips and falls
- resident aggression
- plant and equipment
- the living environment
- fire, security and other emergencies
- infection control

The first three of these hazards make up more than 80% of all claims for workers compensation, according to statistics from the National Occupational Health and Safety Commission [NOHSC] for aged care in 1996-1997. The latter four reflect major hazards referred to in the *Standards and Guidelines for Aged Care Services.*

However, these are not the only hazards in aged care and other examples are detailed in the *Practical Guide to OHS in Residential Aged Care.*

In this section the information, strategies and tools that were introduced in the preceding sections will be applied to each of these seven major hazards in turn, using the appropriate hazard management approaches.

4.2 Manual handling

Manual handling is the most common cause of injuries for employees working in aged care facilities, accounting for 58% of all injuries. Nurses, carers, cleaners, laundry, maintenance, administration and kitchen staff have all been injured during manual handling.

Statistics from the National Occupational Health and Safety Commission [NOHSC] for aged care in 1996-1997 showed strains and sprains made up three quarters of all the workers compensation injuries that occurred.

It is important to remember that manual handling injuries can be the result of lots of stresses and strains over time. Often the immediate cause is only part of the picture.

The most commonly injured part of the body is the back, followed by the shoulder, arm, hand and neck.

The following steps are required to reduce the number of injuries.

4.2.1 Identify the hazards

Identify manual handling hazards by:

- reviewing injury and near miss data
- reviewing potential manual handling problem areas and tasks during workplace inspections
- talking to staff to find out what the difficult manual handling jobs are
- observing tasks, for example, pushing a linen trolley or shower chair with poorly maintained wheels, getting a non-weight bearing resident out of bed, moving beds around, lifting and carrying a pot of soup in the kitchen, leaning over for long periods while feeding residents in bed or at a low table, mopping floors for prolonged periods

4.2.2 Assess the risks

In consultation with Health and Safety Representatives and employees assess the risk of each task. You can use a manual handling task risk assessment (Form 4.1) or resident risk assessment (Form 4.2). Refer to your State *Code of Manual Handling Practice* for more details.

4.2.3 Control the risks

Based on the risk assessment, consider options to control the risks (using the four step 'hierarchy of controls' we looked at in Section 3.4, eliminate, minimise, administrative strategies, personal protective clothing and equipment (PPCE)).

Some examples include:

- ensure that bathroom design allows sufficient space for shower trolleys, hoists and commodes
- install overhead railing, hoists in rooms used for heavy or non weight bearing residents
- purchase height adjustable electric beds
- maintain all wheels on linen trolleys, commodes, hoists etc
- ensure that the wheels on trolleys are compatible with the floor coverings
- implement a No Lifting policy
  (see Form 4.3 for an implementation checklist)
- select the appropriate lifting aid for the resident and the task (see Table 4.1 for a selection table of aids for non-weight bearing and weight bearing residents)
- provide height adjustable trolleys in kitchens
- reduce the size and weight of pots used in kitchens
- ensure washing machines and dryers are at a suitable height

4.2.4 Record actions

Record actions on the hazard log (Form 3.1) and/or OHS action plan worksheet (Form 2.2) (longer term items).

4.2.5 Monitor/evaluate

Monitor and evaluate the controls selected. This should occur both before, during and after implementing controls.

You can:

- re-do the task risk assessment with the control measure in place
- trial new equipment prior to purchase (for example beds, trolleys)

After controls have been implemented you can:

- monitor hazard reports, inspection reports and incident investigations to see if the number reduces
- monitor Workers' Compensation payments to see if they reduce

4.2.6 Case studies

Kitchen case study

A member of the kitchen staff working in an aged care facility noticed that it was difficult to move bulk dry food and flour containers around the kitchen. The bulk dry food and flour containers were very heavy and because there was a shortage of storage space they had to be pushed around the kitchen from time to time. The staff member let the chef know that the containers were awkward to move and presented a manual handling hazard.

The chef assessed the risk with the help of the staff member and decided to take immediate action. She bought dolleys for the base of the containers to make them easier to move around. The risk was reduced. [4]

In this case study the chef used the manual handling risk assessment checklist (Form 4.1). She went through every question with the employee who had to move the containers. Where the employee answered 'yes', they knew they had a risk. In this case, it was lifting over 16 kg and pushing an object which had an awkward shape in a restricted space. They worked out a way to reduce the risk. By putting wheels on the containers they eliminated the need to lift and made it easier to push. They still had the space problem but the job was much improved. (In the longer term extra storage space was planned to eliminate that problem).

No lifting approach case study

Cyril Jewell House is an aged care facility which introduced a 'no lifting approach' as a result of staff, management and resident consultation. The key to the success of the program is that all residents are assessed on admittance by the physiotherapist and carers and a plan established for minimising manual handling. The emphasis is on the use of appropriate equipment for each resident taking into account risk factors, resident condition and resident/family wishes. Daily care requirements are detailed in the care plans. There is also a written handover that highlights any changes in care plans.

As a result of the program, overhead lifting systems have been installed in a number of rooms and others are planned. Overhead systems are installed in the bathrooms and toilets while lifting and standing machines and pivot boards are also available. All beds are now of the adjustable height hydraulic type.

Induction and ongoing training in safe manual handling techniques and use of equipment is provided for all staff.

The OHS objectives relating to the no lifting approach have been incorporated into the centre's quality improvement plan objectives. [5]

[4&5] Hesta Better Health and Safety Case Studies, 1997, pp10-11

Form 4.1 – Sample Manual Handling Risk Assessment and Control Action Plan

Part A. Task: **Date:**

Name:

(person(s) carrying out identification/assessment)

Position:

Part B. Description of activity and location

Include the way the activity fits in with the overall work process eg. getting residents out of bed as part of the process of taking them to the bathroom or lifting heavy kitchen supplies as part of preparing meals

.

Part C. How was the task identified?

Hazard report	❑	Direct observation	❑
Incident records	❑	Resident assessment	❑
Consultation	❑		

Part D. Movements and posture during Manual Handling

	YES
1. Is there frequent or prolonged bending down where the hands pass below mid thigh level of the employee?	❑
2. Is there frequent or prolonged reaching above the head?	❑
3. Is there frequent or prolonged bending due to extended reach forwards?	❑
4. Is there frequent or prolonged twisting of the back?	❑
5. Are awkward postures adopted that are not forward facing and upright?	❑

Part E. Task and load

	YES
6. Is the manual handling performed frequently or for long periods of time by the employee?	❑
7. Are the loads moved or carried over long distances?	❑
8. Is the weight of the load:	
a) more than 4.5 kg handled from the seated position?	❑
b) more than 16 kg and handled in a posture other than seated?	❑
c) more than 55 kg?	❑
9. Are large pushing or pulling forces required?	❑
10. Is the load difficult or awkward to handle due to?	❑
a) size?	❑
b) shape?	❑
c) temperature?	❑
d) instability?	❑
e) unpredictability?	❑
f) restricted vision?	❑
11. Is it difficult or unsafe to obtain adequate grip?	❑

Form 4.1 – Sample Manual Handling Risk Assessment and Control Action Plan [cont]

Part F. Work environment

	YES
12. Is the activity performed in a restricted space (eg bathroom, hallway access)?	❑
13. Is the lighting inadequate?	❑
14. Is the climate hot or cold (eg is manual handling affected by bulky clothes, cold stiff hands or slippery perspiring hands)?	❑
15. Are the floor surfaces cluttered, uneven, slippery or otherwise unsafe (eg obstacles, electrical cords, rugs, ridges, carpeted making pushing/steering difficult, steps)?	❑

Part G. Individual factors

	YES
16. Is the employee new to the work or returning from extended period away?	❑
17. Are there age-related factors, disabilities, pregnancy factors?	❑
18. Does the employee's clothing, or lack of waterproof clothing, footwear or personal protective equipment interfere with manual handling performance?	❑

Part H. Equipment

	YES
19. Is equipment incompatible with furniture or other equipment?	❑
20. Is equipment unsuitable for the task it is being used for?	❑
21. Is equipment inefficient and slow to use?	❑
22. Is equipment poor quality?	❑
23. Is equipment difficult to use or understand how to use?	❑
24. Is equipment poorly maintained?	❑
25. Is equipment unavailable or difficult to obtain when needed?	❑

Part I. Work organisation

	YES
26. Are there bottlenecks, deadlines or periods of peak activity?	❑
27. Is the work affected by insufficient staff numbers to complete tasks within deadline?	❑
28. Are there inefficiencies in the systems of work and/or double handling?	❑

Part J. Skills and experience

	YES
29. Are employees untrained in manual handling?	❑
30. Are employees untrained in recognition and reporting of risks?	❑
31 Are employees untrained in how to perform specific tasks?	❑
32. Has there been a failure to provide employees with an induction into work practices and safety requirements?	❑
33. Are employees inexperienced in manual handling?	❑
34. Are work demands beyond the physical capacity of employees?	❑

Form 4.1 – Sample Manual Handling Risk Assessment and Control Action Plan [cont]

Part K. Risk control options

Consider short, medium and long-term solutions and record options.

Part L. Control strategy details and action plan

Record the control measures to be implemented, timeframe and person responsible.

Source: Adapted from Manual Handling Guide for Nurses, WorkCover NSW, 1998, p 12-15.

Form 4.2 – Sample Resident Manual Handling Risk Assessment Checklist

Physical function

- ❑ Control of arms and legs
- ❑ Weight
- ❑ Height
- ❑ Subluxed shoulder
- ❑ Balance
- ❑ Tone
- ❑ Sensation
- ❑ Vision
- ❑ Body awareness
- ❑ Hearing
- ❑ Range of movement

Mental status and cognition

- ❑ Aggression
- ❑ Unpredictable
- ❑ Resisting
- ❑ Confused
- ❑ Agitated
- ❑ Judgement
- ❑ Memory
- ❑ Concentration

Medical Condition

- ❑ Pain
- ❑ Fractures
- ❑ Medication
- ❑ Recent change
- ❑ Fatigue
- ❑ Delicate skin

Communication

- ❑ Ability to speak
- ❑ Ability to understand
- ❑ Language barriers
- ❑ Body language
- ❑ Confidence

Summary of factors affecting manual handling

Source: Adapted from the Queensland Nurses Union Back Pain Prevention Package & Manual Handling Guide for Nurses, WorkCover NSW, 1998, p 38

Form 4.3 – Sample No Lifting Policy Implementation Checklist

'No lifting' is a new approach to resident handling. Rather than manual lifting and moving of residents being improved through optimising manual handling skills, manual handling of residents is minimised or eliminated wherever possible. Any handling which involves manually lifting the whole or substantial part of the resident's weight is avoided. This is a much broader approach to resident handling than has been taken in the past.

A no lifting approach involves:

- provision of mechanical lifting aids and equipment to assist carers to move/transfer residents
- assessment of residents for their manual handling needs
- encouragement of resident mobility and independence
- education and training of staff in the correct use of aids and equipment and in manual handling techniques (and ongoing assessment of staff manual handling skills)
- consultation with staff in the trialling and purchase of equipment
- adequate levels of appropriately skilled staff
- workplace assessments and modifications to the workplace

Checklist for the implementation of the no lifting policy

	YES	*NO*
Consultation		
1. Have nurses and other relevant staff been consulted about the policy?	❑	❑
Senior management commitment		
2. Has senior management commitment been obtained to the establishment of the no lifting policy?	❑	❑
3. Has budgetary commitment to the policy been obtained for equipment, training etc?	❑	❑
4. Has an audit been completed to establish the injury rates and related workers compensation costs?	❑	❑
External advice/assistance		
5. Is it necessary to engage external assistance to establish/implement the policy or provide advice?	❑	❑
Workplace structures, roles and responsibilities		
6. Has someone been nominated to coordinate the approach and have roles of staff members been defined?	❑	❑
7. Has a committee consisting of management and staff representatives been established to develop policies and procedures and to oversee the implementation of the approach?	❑	❑

Form 4.3 – Sample No Lifting Policy Implementation Checklist [cont]

	YES	*NO*
Equipment		
8. Has an audit of manual handling equipment been conducted to determine equipment needs?	❑	❑
9. Have suppliers been contacted to provide advice and to arrange demonstrations of equipment?	❑	❑
10. Has equipment been trialled?	❑	❑
11. Has equipment been selected and purchased in consultation with staff?	❑	❑
12. Is there a maintenance program for equipment?	❑	❑
13. Is there adequate appropriate storage space for equipment?	❑	❑
14. Is equipment easily accessible to staff?	❑	❑
Staff training		
15. Have staff been educated in the policy and procedures of the no lifting approach?	❑	❑
16. Have staff been trained in the correct use of equipment and manual handling techniques based on the no lifting approach? Has training been provided to all staff including casual and agency staff?	❑	❑
17. Does an appropriate trainer/educator need to be engaged to provide the training?	❑	❑
18. Is the training competency based and does it include the no lifting approach?	❑	❑
Resident/advocate information and education		
19. Have residents and their families been informed of the approach and their co-operation gained?	❑	❑
Worksite assessment		
20. Has a worksite assessment of the work areas and the physical environment been conducted to determine whether workplace modifications are required?	❑	❑
Staffing levels		
21. Is there an adequate number of appropriately skilled staff to enable the no lifting policy to be properly implemented?	❑	❑
Risk assessment of manual handling tasks		
22. Have risk assessments of manual handling tasks been conducted and control measures implemented?	❑	❑
23. Are the manual handling needs of residents assessed and are they incorporated into individual resident care plans?	❑	❑
Cultural change		
24. Have policies and procedures been established to ensure full compliance and cooperation by staff with the no lifting procedures and manual handling methods taught in training?	❑	❑
Policy monitoring and evaluation		
25. Have procedures been established for the evaluation of the policy?	❑	❑

Source: Adapted from the ANF (Vic Branch) No Lifting Implementation Guide & Checklist, 1998.

Table 4.1 – Resident handling using hoists and non-mechanical aids

The following information provides practical assistance to help with the selection of appropriate equipment for lifting and moving residents. Hoists are obviously very useful for handling people, but they are not always available. The following tables provide assistance in selecting hoists and non-mechanical aids that can assist carers to handle residents more safely.

1. Choosing a hoist for resident handling

Task	Stand up hoist	General purpose hoist	"Process hoist" with chair attachment etc
Lying in bed to chair commode, wheelchair	use full harness applied in lying to pull resident up to sitting in bed	useful for this task	commode chair placed in bed
Bed to toilet	with toilet seat attachment	useful	useful
Dressing	useful		
Off the floor	some hoists only; use four point sling	sling or Jordan frame attachment	boom attachment for sling or Jordan frame
Into waterchair	long booms only	useful	
Walking	with fold up footboard		
Complete bed to bath, shower or toilet in hoist			chair attachment, no slings needed

2. Non-mechanical aids for weight bearing resident

Transfer type	Buckle Belt	Velcro Belt	Blue Sling	PAT slide	Slide sheet
Chair to bed	★★★	★★★	★		
Toiletting/commode	★★★	★★★	★		
Repositioning in bed	★★				★★★
Helping up from floor	★★★				
Bed to trolley				★★★	

★★★ Best available choice

★ Can be done but requires advanced skills

★★ Can be done but involves some risk

No symbol indicates that the aid is not applicable for this task.

Table 4.1 – Resident handling using hoists and non-mechanical aids [cont]

3. Non-mechanical aids and hoists for non-weight bearing resident

Transfer type	Hoist	PAT slide	Slide sheet
Chair to bed	★★★		
Toiletting/commode	★★★		
Repositioning in bed	✜		★★★
Helping up from the floor	★★★		
Bed to trolley		★★★	

★★★ Best available choice

✜ Good for high dependency residents who require continuous repositioning. Need to ensure that the sling is comfortable for continuous use.

Adapted from: Lifting and moving people: Choosing the right equipment, (1998) WorkCover NSW, Catalogue no. 752

4.3 Slips, trips and falls

Slips, trips and falls are a common cause of injury for employees working in aged care facilities.

Statistics from the National Occupational Health and Safety Commission (NOHSC) showed slips, trips and falls as a cause of injury increased from 10.8% of all injuries in 1992-1993[6] to 15% in 1996-1997[7].

The 1992-1993 statistics showed that over 80% of falls were on the same level caused by slips on wet or oily internal floor surfaces. The other 20% were classed as falls from a height, such as down steps or stairs.

In order to reduce the number of injuries it is necessary to:

Identify the hazards

Identify potential slip, trip or fall hazards, for example, water on bathroom floors and near outer doors, freezer rooms, or bedrooms where residents may be incontinent when standing, worn or slippery steps or stairs. (Outside paths should also be checked.)

Review injury/near miss data, talk to staff (to identify unreported near misses) and review potential problem areas during workplace inspections. Record potential hazards on a hazard report form (Form 3.2).

Assess the risks

Assess the risks of each potential hazard using the risk assessment table (Table 3.1)

Control the risks

Control the risks using the 'hierarchy of controls' (Section 3.4). For example:

- apply a non slip surface in bathrooms and kitchens
- ensure spills and wet floors are sign-posted and dried quickly
- clean vinyl corridors/floors in a way to allow a dry surface for walking
- mark the edges of steps and ramps (where needed)
- use non-slip mats (at doors and beside beds)
- prevent the use of talcum powder in bathrooms
- mop bathroom floors after use
- use non-slip shoes, rubber boots in bathrooms

Record actions required in the hazard log (Form 3.1)

[6] WorkSafe Australia, "Occupational Health and Safety Performance Overviews, Selected Industries", Issue No.7. Hospitals, Nursing Homes and Related Industries, July 1995, AGPS, Canberra.

[7] Ellis N and Stiller L, "Evaluation of the National OHS Strategy for Residential Aged Care". Draft report for the Commonwealth Department of Health and Aged Care, December 1998.

Monitor and evaluate

Monitor and evaluate the outcomes of the controls, for example, during reviews of monthly data and workplace inspections

It may be necessary to implement short-term solutions while more expensive long-term solutions are planned, for example, mopping the bathroom floor after each use until non-slip tiles can be fitted.

4.4 Resident aggression

The National Occupational Health and Safety Commission injury statistics for the Aged Care Industry showed 7.2% (1992-1993) and 8% (1996-1997) of injuries were as a result of being "hit by moving objects". Over a third of the injuries within the 1992-1993 group were as a result of being hit by another person, either accidentally or deliberately. It was believed there might be significant under-reporting, further demonstrating that resident aggression is a major hazard within aged care facilities.

Reducing the risk of injuries requires a systematic approach including a number of strategies. The strategies that need to be developed, in consultation with staff, include:[8]

- identifying the causes of aggressive behaviour
- assessment of risks
- developing and implementing risk controls
- monitoring, evaluating and improving the strategies

4.4.1 Identify the causes of aggressive behaviour

Identifying the causes of aggression requires:

- a regular review of incident reporting (which depends on the use of effective aggression incident report forms) to determine the time and details of incidents, possible triggers and the severity of incidents (Form 4.4)
- ongoing review of the physical, personal and social needs of all residents
- review of the way work is organised, for example, are residents woken, showered, toileted and fed rapidly, causing confusion and frustration?

4.4.2 Assess the risks

Following identification of the causes the next step is to assess the level of risk, considering how severe the aggression is and how often staff are exposed to the aggression. This will assist to prioritise the most serious risks.

[8] Baptist Community Services and WorkCover NSW. "Managing Resident Aggression in Aged Care Facilities". First edition, November 1998.

4.4.3 Develop and implement risk controls

Some examples of control strategies are outlined below:

Staff

- train managers in record keeping, analysing reports and hazard management
- employee discussions and problem solving
- work in pairs/teams and avoid rotating employees between residents
- don't wake residents suddenly and always approach them from the front
- provide training in identifying areas of work where aggression may occur, actions to minimise risk, what to do during and after incidents and how to prevent them
- train employees to protect themselves by defusing situations using negotiation and anger management skills
- be aware of burnout and reducing fatigue or stress
- establish policies and procedures for emergency situations including effective communication systems
- deal with the effects of aggression
- provide team and management support, for example, via team discussions
- provide access to debriefing and counselling services
- carry out ongoing monitoring and review of aggressive incidents

Residents

- find out resident likes and dislikes and plan care with their family
- plan activities to meet their needs and preferences
- review resident health – pain, effects of medication
- don't rush or hurry residents

Environment

- use aromatherapy, music, pastel colours, pleasant pictures
- reduce potential weapons where possible, for example, sticks, frames, furniture and fittings
- ensure clothing and footwear can be put on and removed easily
- provide a secure garden or walking area including points of interest
- keep the atmosphere as calm as possible, avoiding large gatherings
- minimise noise levels (for example, radios)

Case study

St Catherines, a small aged care facility, identified resident aggression as a significant OHS issue. Using a proactive approach they have created a calm environment for residents and staff using aromatherapy with vapourisers and scented oils, sensory boards and doll therapy. They play nature videos, calming music and monitor the television to avoid loud game shows. They have also painted the exit doorways to create scenic images.

Changes to resident routines are documented and short-term problem sheets are read at the beginning of each shift.

These simple, cost effective initiatives have resulted in increased productivity with happier staff and residents. There have been no staff injuries from resident aggression in the last 12 months. [9]

4.4.4 Monitor, evaluate and improve the strategies

It is also important that you monitor and evaluate the strategies used, and look for ways to improve.

This requires:

- ensuring incidents are reported
- ongoing review and updating of systems/procedures
- team review of all aggressive incidents
- regular case reviews of all residents with challenging behaviour, focusing on incidents and preventative measures
- ongoing review of training

[9] SA WorkCover Corporation SAfer Industries Aged Care Industry Newsletter. Issue 2, April 1999, p2.

Form 4.4 – Sample Aggression Incident Report

To assist management to prevent resident aggression it is important that employees record incident details on this form. It is vital that all employees' concerns are addressed.

Your name:

Resident's name:

Residential care facility/wing:

Date	Time of incident	Your sex	Resident's sex	Has resident been aggressive to you before?
/ /	am/pm	F ❑ M ❑	F ❑ M ❑	Yes ❑ No ❑

Tick what activity you were engaged in when the aggression occurred.

- ❑ Feeding
- ❑ Lifting
- ❑ Turning
- ❑ Dressing/changing
- ❑ Transporting
- ❑ Bathing
- ❑ Grooming
- ❑ Awaking from sleep
- ❑ Toileting
- ❑ Redirecting
- ❑ Other activities

Did the aggression come from the resident you were attending? ❑ Yes ❑ No

Tick the type of aggression involved.

- ❑ Hit
- ❑ Punch
- ❑ Scratch
- ❑ Kick
- ❑ Spit
- ❑ Sexual harassment
- ❑ Sexual comments
- ❑ Unwelcomed touching
- ❑ Trip
- ❑ Yell (insult)
- ❑ Yell (noise)
- ❑ Abusive comments
- ❑ Offensive comments
- ❑ Racial abuse
- ❑ Hair pulling
- ❑ Pushing
- ❑ Bent fingers back
- ❑ Bite
- ❑ Throwing object
- ❑ Grabbing
- ❑ Other

Were you injured? ❑ Yes ❑ No

If yes, please fill out an Incident/Injury Report.

In your opinion was there a "trigger" to this incident? ❑ Yes ❑ No

What was the "trigger" e.g. pain, other person, personal care?

Indicate the seriousness of the incident from your perspective by circling the appropriate number.

0 1 2 3 4 5

Not at all serious — Extremely serious

Would you like to talk about this incident? ❑ Yes ❑ No

Source: WorkCover NSW/Baptist Community Services, "Managing Resident Aggression in Aged Care Facilities", 1st edition, November 1998.

4.5 Plant and equipment hazards

Expected Outcome 4.5 (Criteria d) requires that equipment used is fit for the purpose intended and well maintained and that staff are trained in its use. Examples of equipment are hoists, wheelchairs, trolleys, vacuum cleaners, stoves, lawn mowers and workshop tools.

Maintenance

You must have a maintenance system in place to ensure routine and preventative maintenance is undertaken and recorded.

Your maintenance system should include:
- documentation of breakdown maintenance
- a documented program for routine preventative maintenance
- documentation of completed preventative maintenance including the date and signature of the person who performed the task (including external maintenance programs)
- records of work needed as a result of routine inspection and maintenance and breakdowns for each item of equipment

Routine inspections and maintenance must be conducted by competent personnel, and in line with suppliers' recommendations and relevant State Standards and Regulations.

Some equipment may not have a specified frequency of maintenance. You should review relevant maintenance records and decide on a reasonable frequency period for maintenance to make sure breakdowns are prevented, for example, servicing of shower chair wheels.

'Flagging' dates for routine maintenance can be managed by a manual diary or card system or on a computerised database.

Maintenance records must be reviewed regularly to ensure the maintenance has been conducted and to identify a need for more frequent preventative maintenance or replacement of equipment. This information will also be useful to guide you when selecting new equipment.

Fit for purpose

Ensuring equipment is fit for the purpose requires you to use a number of approaches including:
- purchase of suitable equipment
- assessment of the equipment and the task prior to use, for example, hoists
- training staff in the skills required to select the correct equipment

Purchase of suitable equipment requires a pre-purchase assessment to ensure it is suitable for the task, the area in which it will be used and stored and for the people who will use it.

A sample checklist has been included for you to adapt for this purpose (Form 4.5-Selecting equipment-pre-purchase assessment, on the next page). Other more detailed checklists are available from WorkCover NSW, for example for selecting hoists or beds[10]. Australian Standards may also apply.

New equipment must be checked for safety on arrival and there must be a system for the safe disposal of replaced equipment.

[10] WorkCover NSW, Checklist for Evaluating Mobile Hoists (Catalogue Number 741)

Form 4.5 – Sample Selecting Equipment – Pre-purchase Assessment

Item: **Date of Assessment/Trial:**

Design

- ❑ Meets relevant Australian Standards?
- ❑ Durable and reliable?
- ❑ Easily cleaned and maintained?
- ❑ Compatible with existing environment/equipment e.g. hoists fit under beds, through doorways etc.?
- ❑ Easily manoeuvrable and adjustable (if applicable)?
- ❑ Controls and displays visible, legible, easily operable?
- ❑ Facilitates good postures/safe use in handling?
- ❑ Safe design e.g. no "pinch points"?

Performance

- ❑ Does it perform the required functions?
- ❑ What training is needed for correct use?
- ❑ Is training provided by the supplier?
- ❑ Does the item suit the residents e.g. weight, height, fragile skin etc?
- ❑ Does it provide enough support?

Usability

- ❑ What accessories are available?
- ❑ Can it be operated by one person?
- ❑ Is there adequate storage space?
- ❑ Is an emergency repair and maintenance service agreement available?
- ❑ Is a "user friendly" instruction manual provided?
- ❑ Is a trial period available?
- ❑ Brakes fitted (where necessary)?

Risk assessment

- ❑ All associated risks with equipment and parts identified and assessed?
- ❑ Would any alternative product be better?

Other Comments:

Checked by Maintenance Personnel:

Signature (Manager):

Signature (Employee Representative):

Adapted from QNU BackPain Prevention Package, 1990.

4.6 Living environment

Expected Outcome 4.4 of the *Standards and Guidelines for Residential Aged Care Services* requires managers to actively work to provide a safe and comfortable environment consistent with resident care needs, and to have the following policies and practices in place (only those directly affecting OHS are included):

- grounds of the service are safe, well maintained and easily accessible to residents, staff and visitors
- consideration of resident and staff needs in the management of environmental risks and the development of safe work procedures
- a restraint free environment whenever possible
- any restraints be the least restrictive type possible and used only after all reasonable alternatives are explored
- decisions to restrain made in partnership between the resident and/or representative and the health care team

To achieve safe grounds you will need to identify any potential hazards, conduct risk assessments and control the risks.

Potential hazards may include:
- uneven paths or ground surfaces
- low overhanging bushes or trees obstructing paths
- contents of garden or workshop sheds (which may contain tools and chemicals)
- poor lighting in carpark areas

Assessing the risks, as described earlier, will assist to prioritise required actions.

Risk controls may include:
- repair of uneven paths or ground surfaces
- regular trimming of bushes and trees
- keeping sheds locked to prevent access by residents or visitors
- improved lighting
- sitting areas (for residents to sit if tired)
- secure areas within the garden (if required)

When developing safe work practices and managing environmental risks you must consider both resident and staff needs. For example, when setting up resident rooms to ensure safety of staff and residents, or if fitting a keypad within secure areas to prevent egress by residents, you need to consider and meet the egress needs of independent residents, staff and visitors.

Making decisions to use resident restraints must, like other potential hazards, be based on an assessment of risk to residents and staff.

Use the most effective, safest alternative based on the "hierarchy of control" (Section 3.4) following agreed procedures and guidelines.

You must monitor and review the outcomes of the risk control strategies and improve them if required.

4.7 Fire, security and other emergencies

Expected Outcome 4.6 of the *Standards and Guidelines for Residential Aged Care Services* requires management to provide an environment and safe systems of work that minimise fire, security and emergency risks, and to have the following policies and practices:

Tick those you have in place

- ❑ clear instructions related to fire safety, security and other emergencies
- ❑ staff induction in fire safety and the use of security and emergency equipment
- ❑ training linked to legislative requirements and internal policies
- ❑ regular testing of fire and other emergency equipment
- ❑ evidence of regular fire, evacuation and other emergency drills
- ❑ participation of management, staff and residents in identifying and addressing fire, security and other emergency situations
- ❑ management and staff involvement in identifying and resolving security risks
- ❑ chemicals and dangerous goods identified, stored and used correctly

If you don't have any of the above practices in place improvements must be made. These improvements and the actions, timeframes and responsibilities should be included in the OHS action plan worksheet (Form 2.2).

More detailed considerations based on the *Standards and Guidelines for Residential Aged Care Services* are included in Fact Sheet 8.4 in Section 8.

4.8 Infection control

Expected Outcome 4.7 of the *Standards and Guidelines for Residential Aged Care Services* requires facilities to have an effective infection control program in place including policies and practices which provide for:

- incident reporting mechanisms which are used and acted upon
- equipment fit for the purpose intended, well maintained and staff trained in its use
- management and staff involvement in identifying and resolving infection control risks
- the identification of sources of infectious waste and appropriate disposal methods
- surveillance programs

Infection control strategies must be integrated into your general OHS management systems (section 5) and included in induction and ongoing training.

You will need to consider all possible sources of infection to identify potential hazards including:

- resident equipment such as nebulizers, glucometers, dosettes
- wound and skin care
- continence management
- management of 'sharps'
- food storage and handling
- laundry procedures
- infectious and general waste disposal

Conduct a risk assessment on any hazards you identify and implement controls to minimise the risk of infection.

You will also need to monitor infections and use the information to identify the root causes and the need for changing practices. For example, an increased number of urinary tract infections may indicate a need to change care practices or to increase the fluid intake of residents. Monitor and review the actions you take to address infection control hazards to ensure they are effective.

You will need to develop policies and guidelines (in consultation with staff) to make sure standard precautions are always met when:

- treating and caring for residents
- handling food
- cleaning and laundry tasks
- managing sharps and needle stick injuries

Additional precautions are recommended when a resident is infected and standard precautions may not prevent transmission of infection.

You must also take steps to prevent infections by the appropriate handling of waste such as soiled linen, food waste, clinical (medical) waste including sharps, containers of blood or body fluid.

You must identify infectious waste, isolate it if necessary, place it in safe containers and dispose of it appropriately in order to prevent infection.

More detailed information resources on infection control are listed in the resource section (Section 7).

4.9 Summary

Section 4 has provided the information, strategies and tools needed to apply the hazard management process in a practical way to address a number of hazards.

There are a large number of other hazards present in aged care facilities which must also be addressed using the hazard management approach. Several of these are included in the *Practical Guide to OHS in Residential Aged Care*.

Managing hazards is just one of the major factors which make up an effective OHS management system.

Other factors include consideration of legislative compliance, education and staff development, record keeping, injury management and continuous improvement. These are discussed in Section 5.

Occupational Health & Safety management systems

5.1 Introduction

This section of First Steps provides information about the relevant Expected Outcomes of the *Standards and Guidelines for Residential Aged Care Services*, and how they relate to OHS. It also provides strategies and tools for assisting you to meet these requirements for accreditation.

It includes a description of:
- the relevant Expected Outcomes
- requirements for continuous improvement
- the need for compliance with OHS legislation
- education and staff development requirements and a checklist
- OHS record keeping requirements

Section 5 also includes a brief outline of some of the basic requirements for Occupational Injury Management. While this is not a direct requirement of the *Standards and Guidelines* it forms a crucial part of the management systems related to OHS.

Managing OHS within small aged care facilities should be integrated into the systems used for managing other aspects of the facility.

Standard 4 of the *Standards and Guidelines for Residential Aged Care Services* outlines the requirements of the 'physical environment and safe systems'. Standard 4 sets the framework for managing OHS in aged care facilities including the need for:
- a process of continuous improvement in managing OHS (Expected Outcome 4.1-see Section 5.2)
- compliance with the legislation (Expected Outcome 4.2-see Section 5.3)
- education and staff development (Expected Outcome 4.3-see Section 5.4)
- ensuring that the living and working environment is safe and comfortable for residents (Expected Outcome 4.4-see Section 4.6)

- managing hazards (Expected Outcome 4.5-see Section 3)
- involving managers and staff in identifying and resolving OHS issues (Expected Outcome 4.5-see Section 3)
- ensuring that incident reporting mechanisms are present, functional and acted upon (Expected Outcome 4.5-see Section 3.6.3)
- consideration of OHS during the purchase of goods and equipment and developing preventative maintenance programs (Expected Outcome 4.5-see Section 4.5)
- minimising risks of fire, security and other emergencies (Expected Outcome 4.6-see Section 4.7)
- ensuring that an effective infection control program is in place (Expected Outcome 4.7-see Section 4.8)

5.2 Continuous improvement

The *Accreditation Guide for Residential Aged Care Services* (Appendix 1) defines continuous improvement as 'continuous review by managers, staff, residents and carers of policies, practices and service outcomes to identify and implement improvements for better outcomes'.

It defines the Continuous Improvement Cycle as 'where a service demonstrates what it is doing now to meet an expected outcome and what it is going to do to continuously improve on its current practice and process'.

Diagram 1: Continuous improvement cycle[11]

[11] "Standards and Guidelines for Residential Aged Care Services". Commonwealth Department of Health and Family Services, May 1998.

The *Accreditation Guide for Residential Aged Services* (p. B1) describes a quality service in the aged care industry as one which:

- reflects the needs of participants (residents, relatives and staff)
- is planned and documented appropriately
- provides staff development so each part of the work is understood and practised
- recognises the need for possible cultural change to improve quality
- is structured and operating as a total concept rather than ad hoc
- is continuously reviewing its operations on the basis of customer feedback

Continuous quality improvement in OHS in your facility is demonstrated if you can show that you review what you currently do and what you are going to do to improve on current practices and processes.

When reviewing what you currently do consider the following (this is not a comprehensive list but examples only):

- ❑ are staff involved in OHS?
- ❑ are lines and forms of communication for OHS identified?
- ❑ does staff induction include OHS?
- ❑ are mechanisms in place for reporting or providing feedback on OHS hazards?
- ❑ are steps documented for reporting OHS hazards?
- ❑ are actions taken when OHS hazards are raised and is feedback provided?
- ❑ is OHS data collected?
- ❑ do staff know the reason for data collection and the process for collection?
- ❑ are quality improvement activities in place, including a review of documents, surveys and/or questionnaires, observation and checklists (workplace inspections) and suggestion boxes?
- ❑ is the OHS plan resourced and regularly reviewed to ensure objectives are met (and updated if needed)?
- ❑ are OHS policies and procedures reviewed and updated regularly?
- ❑ are OHS achievements recorded and reported to proprietors and boards e.g. via newsletters, annual reports?
- ❑ is an effective injury management program in place?

If your facility doesn't have these initiatives in place you should discuss them with staff, develop possible actions to improve on the current practices and processes and include them into the action plan worksheet in order to continuously improve.

The following chart describes some possible strategies.

Continuous Improvement of OHS [12]		
Improvement required	**What could we do?**	**Possible ways to do it?**
Increase staff involvement with OHS	Include OHS on the Agenda of staff meetings/quality meetings.	Report OHS to staff, seek input e.g. to policies, procedures.
Identify lines/forms of communication for OHS	Increase staff awareness of how to report OHS issues.	Develop flowchart of communication channels. Display on OHS noticeboard.
Include OHS in induction	Restructure induction to include OHS.	Use checklist of OHS issues to be included (from the *Practical Guide*.)
Implement mechanisms for reporting/feedback on hazards	Develop a hazard report form including the need for feedback.	Use sample Form 3.2 *First Steps*. Discuss, adapt, implement. Develop flowchart.
OHS data collection	Define data to be collected. Inform relevant staff e.g. collect, collate MSDS, monthly incidents.	Adapt form 5.1 Use MSDS Register from the *Practical Guide*.
Implement Quality Improvement (QI) activities	Define OHS QI activities eg: • document reviews • surveys, questionnaires • checklists • suggestions.	Include required activities in OHS action plan.
OHS plan resourced, reviewed	Identify resources required for each step of plan. Set dates for review of plan e.g. monthly at staff meeting.	Obtain costs for training etc. Include in budget preparation. Discuss progress, delays, priority changes and document.
OHS Policy and Procedures reviews	Develop a list of policy/ procedure review dates.	Adapt form 6.2 to seek staff input into Policy/ Procedures reviews.
Record OHS achievements - feedback to "stakeholders"	Define information to describe achievements eg: • purchase of new equipment • changes to work areas etc.	Include in reports and/ or Resident/Staff Newsletters.

[12] Adapted from *NOHSC Small Business Management Training: Integrating Occupational Health and Safety Competencies*, Commonwealth of Australia, 1999

5.3 Compliance with OHS legislation

The *Standards and Guidelines for Residential Aged Care Services* require facilities to comply with all legislation including OHS Acts and Regulations (Expected Outcome 4.2). Each State has its own OHS Act and Regulations which specifically state the mandatory requirements for OHS in that State, and a number of Codes of Practice which provide guidance on how to achieve the required standards. These should be followed when developing and implementing hazard controls unless a solution is found which is 'equal to' or 'better than' the Standard set within the Code of Practice.

Specific OHS Legislation is listed in Section 7 (with telephone numbers if you require copies of the relevant legislation). Summaries of some of the major requirements of the OHS Acts and Regulations, that is, responsibilities and roles of OHS committees and health and safety representatives are included in Fact Sheets in Section 8. These may be used as reference and/or displayed on staff notice boards.

In addition to OHS Legislation the facility must comply with the relevant State Workers Compensation and Rehabilitation Acts and Regulations (available from the State Authorities listed in Section 7).

5.4 Education and staff development

Expected Outcome 4.3 and its criteria requires your facility to:

- identify and document the knowledge and skills required by your staff to perform their jobs
- regularly assess staff to identify development needs
- monitor staff development activities and outcomes

OHS training should be integrated into the overall training program for professional development and included in the business and/or OHS plan for your facility.

Individual State OHS legislation requires specific OHS training for health and safety representatives, health and safety committees, managers, supervisors, first aiders, those who undertake manual handling, those working with hazardous substances and plant and others. Check the requirements with State Authorities.

The following checklist includes OHS issues which should be considered when planning training. Any items which you don't currently have in place should be included in the OHS action workplan.

OHS Training Considerations

Tick those you have in place

- ❑ do job descriptions and specifications include OHS?
- ❑ is information about OHS available to staff?
- ❑ is a staff induction program incorporating OHS been developed and implemented?
- ❑ is a staff appraisal which identifies OHS educational needs in place?
- ❑ are the skills and knowledge of staff including OHS assessed?
- ❑ are resources allocated for staff development (including OHS)?
- ❑ is the internal education program based on training needs, for example changes to processes, new equipment, OHS Legislation, future needs, manual handling and accreditation standards?
- ❑ is there regular review of the education program, including OHS components?
- ❑ is there encouragement of external education?

Steps in developing a training program are as follows

5.5 OHS records

(Cross-references to Standard 1, Expected Outcome 1.8 - Information Systems)

Records must be kept for a range of OHS issues including those specified in the legislation:

- *injury/incident reports and investigation
- *workers compensation and rehabilitation records
- *first aid records
- hazardous substances register
- material safety data sheets (MSDS)
- instruction/training records
- certificates and licenses
- major accident/incident notifications (to the OHS authority)
- health surveillance, atmospheric monitoring
- manufacturers and suppliers of OHS information (operating manuals etc)
- hazard report forms (and actions taken)
- workplace inspection/audit reports
- hazard log
- maintenance and testing results
- risk assessment reports
- evacuation exercise results

**These must be kept confidential with access only to authorised personnel*

You should review and analyse the records regularly in consultation with staff to assess the effectiveness of the OHS system and identify areas for improvement.

In addition, some records such as incident reports, types of injuries, first aid, hazard reports and the hazard log should be reviewed regularly (for example monthly) at OHS committee meetings or staff meetings. See Form 5.1 for a sample recording sheet.

Other records would be monitored less frequently (for example, three to six monthly) to ensure they are up-to-date, for example, that maintenance has been completed as planned.

An overall review should be conducted on an annual basis to assess the suitability of the records, to check compliance and identify areas for improvement.

Form 5.1 – Sample monthly OHS statistics

Staff	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
Number of incidents reported													
Number of medical costs only incidents													
Number of lost time incidents													
Number of near misses reported													
Number of incidents investigated													
Number of actions taken to prevent further incidents													
Number of actions reviewed													
Hazards	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
Number reported (total)													
Number of new hazards													
Number of hazards repeated													
Number actioned													
Workplace inspections conducted													
Number of meetings re: hazards													
Maintenance	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
Number of planned checks													
% of scheduled checks completed													
Number of breakdown calls													
Number of repeated breakdowns													
Number of reviews of repeated breakdowns													
Training	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
Number of OHS training sessions/briefings													
Number of staff who attended OHS training													
Resident Incidents / Injuries	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Total**
Number of incidents reported													
Number of injuries													
Number of incidents investigated													
Actions taken to prevent incidents													
Actions reviewed													

5.6 Occupational injury management

While the major focus of *First Steps* is to assist facilities to prevent injuries occurring, it is also important to have an effective system in place to manage injuries if they do occur.

The detailed legal requirements for claims management and rehabilitation vary between States, so it is essential to contact your local regulatory authority, claims agent or insurer for more information (see Section 7).

An injury management program aims to achieve a timely, safe and durable return to work for injured employees. It needs to be tailored to the facility and integrate all aspects of injury management including:

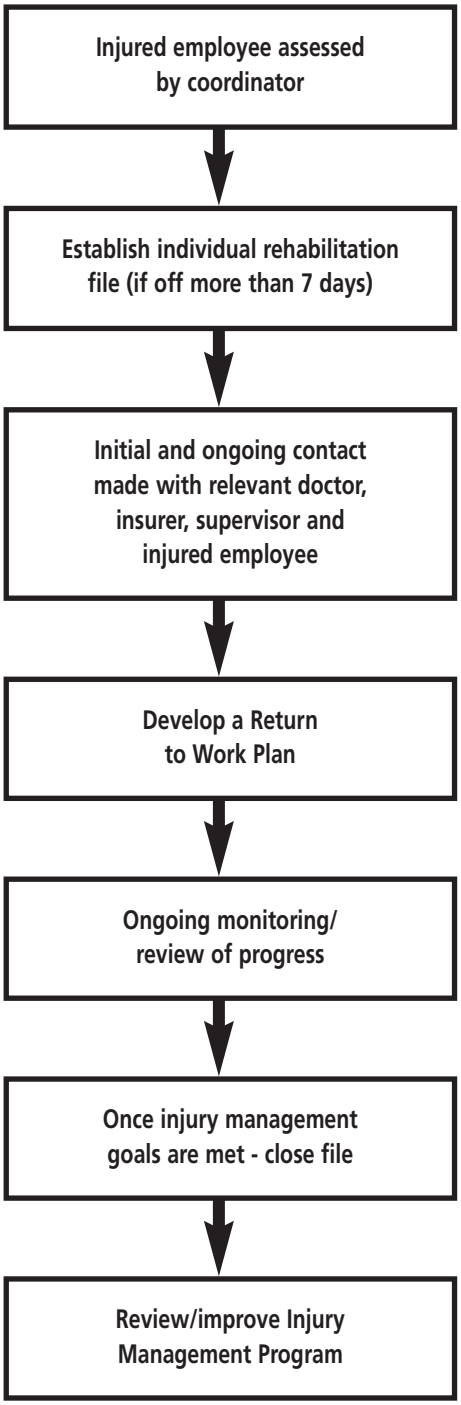
- treatment of the injury
- claims management
- rehabilitation
- return to work programs
- retraining

Generally one person will manage the rehabilitation process (this is a legal requirement in some States). This may be an injury management or rehabilitation co-ordinator or the director of care/facility manager.

Injury management should commence immediately after an injury occurs and be an active process, aiming for early return to work. Effective injury management depends on well informed employees, managers, treating doctors and other professionals and insurers. To achieve this it is important to have:

- an injury management policy and procedures
- an employee information sheet
- authority for release of information between the people involved in rehabilitation
- a letter to the treating doctor providing information about the employee's normal position and duties and information about suitable alternative duties available at the facility

The steps in injury management (following immediate treatment and accident reporting/investigation) are as follows in Flowchart 5.1 on the next page.



Flowchart 5.1 Injury management process

Specific details of the process and examples of documentation are included in the *Practical Guide and the Occupational Injury Management in Aged Care Facilities Manual (Department of Health and Aged Care) 1999.*

5.7 Summary

Section 5 has provided some information, strategies and tools to assist you to set up, review and/or improve OHS management systems within your facility.

Implementing or improving these systems will assist you to take further steps towards meeting the requirements of accreditation.

Section 6 will assist you to consider the actions you have taken or planned as a basis to prepare you to complete the OHS related information in the *Application Kit for Accreditation*.

Occupational Health and Safety review – preparing for accreditation

6.1 Introduction

First Steps has provided you with information on how to:

- assess where your facility is in terms of OHS
- develop goals of where it wishes to be
- develop action steps for 'how to get there' and what needs to be done
- develop performance measures to assist in measuring success

If you have worked through the process of addressing the gaps identified in the self-assessment checklist, it is now time to review performance and prepare for completing Worksheet 4.5 in the *Application Kit for Accreditation.*

Section 6 provides the strategies and tools to lead you through the process of reviewing your progress to date and using the information to prepare for accreditation.

6.2 Reviewing progress

The first step is to repeat the self-assessment checklist (Form 2.2) from Section 2 of *First Steps*. You should now be able to answer 'yes' to a greater number of questions.

6.3 Preparing for accreditation

In preparation for completion of the *Application Kit for Accreditation* the next step is to review in more detail 'what we say we do' and 'what we do' to achieve Expected Outcome 4.5, to review the results and determine how to improve. The outcomes may be recorded on the Standards Review form (Form 6.1 on the next page).

Form 6.1 - Sample Standards Review Form - Preparing for Accreditation

Expected Outcome

(Description as per Accreditation Manual):

1. What do we say we do to achieve this outcome?

- What policies are in place to address the criteria of this outcome?

List	*Date of Release/Review*

- Is each policy clear and understandable? Yes ❑ No ❑
- Is each policy current and correct? Yes ❑ No ❑
- Is each policy practical? (can be followed in the daily course of events). Yes ❑ No ❑
- What other written materials address this outcome? (e.g. staff and resident handbooks, procedures, orientation information, standard operating procedures etc).

List	*Date of Release/Review*

Do these agree with or conflict with the policies on this issue?

❑ Agree

❑ Conflict-Initiate a continuous improvement form with suggestions to remedy the conflict. Record actions required in the OHS action plan.

Form 6.1 - Sample Standards Review Form – Preparing for Accreditation [cont]

2. What do we do to address this outcome?

- What evidence shows we do these things?

  List with dates:

  - minutes of meetings
  - memos
  - audits, surveys, inspections
  - suggestions e.g. hazard forms, follow-ups
  - anything else

List	*Date*

- Is what we do consistent with what we say (see question 1)?

❑ Yes

❑ No - Initiate a continuous improvement form advising of problems and suggestions to bring policies and practices into agreement. Record actions required in the OHS action plan.

3. What are the results of what we say and do?

4. How can we improve on what we say and do to achieve this outcome?

Source: Carla Baron, N&C Baron & Associates

Expected Outcome 4.5 requires management to actively work to provide a safe working environment that meets regulatory requirements.

Reviewing and improving OHS requires consideration of:

- management of hazards
- involvement of management and staff in resolving OHS issues
- incident reporting (and actions taken)
- equipment fit for purpose

Each of these key requirements have been described within *First Steps*, and strategies and sample tools provided to assist you to improve the management of OHS within your facility.

You may have implemented some of these strategies or plan to do so and these activities will assist you to complete Worksheet 4.5 in the *Application Kit for Accreditation* and to consider steps required to achieve continuous improvement. The improvements may require a staged approach.

Suggestions for how you may consider these stages and complete Worksheet 4.5 follow.

These are not a complete list and you will need to consider the specific needs of your facility to complete the worksheet.

6.3.1 Criteria (a) – Managing the Risks – 1st Stage

This assumes risk management is currently ad hoc.

Objective

To put in place a planned program to fix urgent problems which present a risk.

How will we improve 'what we say we do'?

- Develop a procedure for identifying hazards
- Implement a risk assessment tool
- Develop a hazard log
- Document the process for eliminating or minimising risk

How will we improve 'what we do'?

- Conduct a hazard audit to identify all hazards
- Ask employees about their hazards
- Make a list and assess the risk, to rank in order of importance
- Brainstorm ideas for fixing them
- Document and implement the urgent and/or easy things
- Develop an action plan for the longer term issues

Measures of success (the improved results)

- Most urgent hazards have been addressed
- Number of hazards addressed i.e. risks eliminated or minimised
- Number of solutions implemented to plan i.e. within timeframes
- Level of interest/involvement of staff
- Level of resources provided by managers

Continuously improving

- Check the changes are made according to the action plan worksheet (and that they fixed the problem)
- Understand why solutions didn't work - develop an alternative solution

Once these improvements are made you can plan a second stage of improvement to move to a more systematic approach to managing risks (this may take 3-6 months or more depending on the size and complexity of your facility).

6.3.1 Criteria (a) – Managing the Risks – 2nd Stage

Moving to more Systematic Approach.

Objective

To implement a program to address high risk issues and establish a systematic approach to identifying and addressing hazards.

How will we improve 'what we say we do'?

- Develop a procedure to conduct regular workplace inspections
- Develop a checklist for the inspections

How will we improve 'what we do'?

- Train staff in conducting inspections
- Conduct regular inspections, identify new hazards and ensure controls are in place for previously identified hazards
- Regularly adjust and extend the list of hazards in the hazard log based on the inspections
- Build a plan that addresses the risks (high risk items first)

Measures of success (the improved results)

- List of hazards regularly being amended
- Level of OHS expertise increasing
- Manager provides necessary resources
- Number of successful solutions implemented
- Documented inspection system
- Increased employee involvement in regular inspections

Continuously improving

- Quarterly review of the inspection system and documentation to see if it can be improved
- Implement action plan and check that the changes are made according to the plan and actually fix the problems identified
- Quarterly review/update of the action plan

Once the second stage requirements are met you can then move onto the third stage of systematically addressing the major risks.

6.3.1 Criteria (a) – Managing the Risks – 3rd Stage

Objective

To systematically address all major hazards.

How will we improve 'what we say we do'?

- Develop/adopt hazard specific policies and procedures e.g. manual handling, hazardous substances, UV radiation (outdoor workers), resident aggression, occupational stress etc

How will we improve 'what we do'?

- Implement a 'No Lifting' policy
- Implement a program to address challenging behaviour etc

Measures of success (the improved results)

- Reduction in manual handling injuries/incidents
- Implementation of 'No Lifting' strategy
- Reduction in resident aggression incidents

Continuously improving

- Monitor compliance with 'No Lifting' policy and address reasons for non-compliance
- Review suitability of hoists and identify need for additional equipment
- Review outcomes of resident aggression prevention strategies

See *First Steps* Section 4 and the *Practical Guide* for further assistance.

6.3.2 Criterion (b) – Involving Employees – 1st Stage

Assuming employee involvement in OHS is ad hoc.

Objective

To develop a structure to involve employees in OHS.

How will we improve 'what we say we do'?

- Include employee involvement in OHS procedures, for example, risk assessment and control etc

How will we improve 'what we do'?

- Add OHS to agenda of staff meetings, discuss OHS issues and record outcomes
- Involve employees in workplace inspections
- Encourage employees to report hazards

Measures of success (the improved results)

- Most urgent hazards have been addressed
- Increased number of hazards reported
- Employees involved in all workplace inspections
- Increased employee input into solutions for hazards
- Increased level of interest/involvement of staff

Continuously improving

- Check OHS has been discussed at all staff meetings
- Check whether employee input into risk controls has been recorded

Once employee involvement is set up you can plan to move to a second stage, more systematic approach to employee involvement.

6.3.2 Criterion (b) – Involving Employees – 2nd Stage

Moving to a more systematic approach.

Objective

To implement a structure for employee involvement in OHS.

How will we improve 'what we say we do'?

- Develop a procedure and flowchart for the process of consultation, for example regarding changes to the workplace, work processes, equipment (see the *Practical Guide* for an example)

How will we improve 'what we do'?

- Consider the need to implement an OHS committee or elect a health and safety representative/employee representative (see the *Practical Guide* and relevant OHS legislation for more details)

Measures of success (the improved results)

- Employee involvement in OHS initiatives documented
- OHS discussed regularly (and input sought from employees) e.g. at staff meetings, via OHS committee etc
- Increased level of interest/involvement of staff

Continuously improving

- Review whether involvement strategies have been successful e.g. increased hazard reporting, OHS suggestions, input into procedures etc

6.3.3 Criterion (c) – Reporting and Acting on Incidents

Assuming there is under-reporting of incidents, for example, serious injuries only reported.

How will we improve 'what we say we do'?

- Review the current incident report form and any procedure e.g. is it readily available, user friendly, provides the required information?
- Review the incident investigation procedure (if available)
- Adapt the form/s and procedures to be more user friendly
- Include incident reporting in the induction program (see the *Practical Guide*)

How will we improve 'what we do'?

- Make the incident report form more accessible/simple to use
- Train employees in how to complete the form and when
- Investigate all incidents
- Discuss incidents (maintaining confidentiality) at staff meetings and address outstanding issues

Measures of success (the improved results)

- Number of incidents reported
- % of incidents investigated and actions taken
- % of incidents discussed at staff meetings/OHS committee
- All new staff receive instructions on incident reporting
- Most urgent hazards addressed

Continuously improving

- Regularly review the suitability of the incident report form
- Review incidents and trends at staff meeting/OHS committee and develop strategies to address hazards

6.3.4 Criterion (d) – Equipment Fit for Purpose – 1st Stage

Assuming equipment management is ad hoc.

Objective

To put in place a planned program to fix urgent problems with equipment which may present a risk.

How will we improve 'what we say we do'?

- Develop a procedure for regular checking of equipment
- Develop an equipment inspection log (see the *Practical Guide*)

How will we improve 'what we do'?

- Commence a regular equipment inspection/service schedule (by competent persons)
- Keep and review records to ensure compliance
- Train staff in the selection of appropriate equipment for the task

Measures of success (the improved results)

- Equipment log developed
- Inspection/service schedule commenced
- Improved selection of equipment for tasks
- % of checks conducted (of those planned)

Continuously improving

- Check the equipment is in good order e.g. are checks frequent enough?
- Quarterly checks of schedule
- Review of training provided/required

Once these basic systems are implemented to ensure equipment is fit for the purpose, you may plan to move to a second stage with a more systematic approach.

6.3.4 Criterion (d) – Equipment Fit for Purpose – 2nd Stage

Moving to a more systematic approach.

Objective

To implement a systematic program to ensure that all equipment is fit for the purpose, well maintained and that staff are trained in its use.

How will we improve 'what we say we do'?

- Develop a procedure to be followed when purchasing new equipment (including consultation and pre-purchase reviews)
- Include specific details of equipment to be used in care plans e.g. manual handling equipment or in Standard Operating Procedures for laundry, kitchen, garden equipment
- Write a procedure to be followed for faulty equipment
- Develop a training record matrix for specific equipment

How will we improve 'what we do'?

- Trial new equipment before purchase
- Select and use appropriate equipment day-to-day
- Train staff in equipment hazard identification, risk assessment and control

Measures of success (the improved results)

- Equipment used as per care plans/Standard Operating Procedures
- Equipment checked/serviced as per schedule
- % repairs/modifications of equipment recorded

Continuously improving

- Quarterly checks of schedule
- Adapt frequency of checks if indicated e.g. if frequent breakdown maintenance is required between checks

The process described above could be followed for each worksheet within the *Application Kit for Accreditation*. As OHS is integrated into a number of other activities within the facility, OHS will be referenced in a number of the worksheets.

6.4 Continuous improvement

Ongoing reviews of OHS are essential to achieve continuous improvement. This will include regular review of the components of OHS, for example:

- monthly reviews of hazard reports, incident report forms, types of injuries
- annual review of the overall system using the self-assessment checklist
- review of compliance with OHS legislation
- regular review of OHS policies and procedures, for example, annually.

A sample review form is included (see Form 6.2 on the next page) which can be used to obtain staff input.

This information then feeds into the review form (Form 6.1) which will assist you to prepare for completion of the *Application Kit for Accreditation*. A separate review may be completed for each Expected Outcome during preparation for accreditation.

The outcomes of these reviews will then form the basis of your annual OHS plan which may be a separate plan or be incorporated into the overall business plan for the facility.

As you progress beyond the steps included in *First Steps*, further assistance for continuously improving can be found in the *Practical Guide*.

If you require specific OHS information contact your employer organisation, union or the OHS Authorities listed in Section 7 or refer to the additional resources listed in Section 7.2.

Networking with other small facilities (and larger ones) will also provide a valuable source of information and possibly allow for joint problem solving.

Form 6.2 - Sample OHS Policy/Procedure Document Review

Name of Policy: _____

You are asked to review the attached Policy and complete the following:

	Yes	No
Do you believe the Policy is clear and understandable?	❑	❑
Is the Policy current and correct?	❑	❑
Is the Policy practical - that is can it be followed in daily practice?	❑	❑

Comments/Suggestions: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name (optional) _____

Source: Carla Baron, N&C Baron & Associates

Resources

7.1 Legislation

Australian Capital Territory
Occupational Health and Safety Act 1989

New South Wales
Occupational Health and Safety Act 1983

Northern Territory
Work Health Act 1986
Work Health (Occupational Health and Safety) Regulations 1992

Queensland
Workplace Health and Safety Act 1995
Workplace Health and Safety Regulations 1997

South Australia
Occupational Health Safety and Welfare Act 1986
Occupational Health Safety and Welfare Regulations 1995

Tasmania
Workplace Health and Safety Act 1995
Workplace Health and Safety Regulations 1998

Victoria
Occupational Health and Safety Act 1985
Occupational Health and Safety Regulations (contact information Victoria Phone: 1300 366 356 for the full list of Regulations)

Western Australia
Occupational Safety and Health Act 1984
Occupational Safety and Health Regulations 1996

- Each State also has a range of Codes of Practice and Guidelines. Contact your OHS Authority to obtain a list of those which are relevant to your facility.

7.2 OHS authorities/contacts

Commonwealth Statutory Body

National Occupational Heath and Safety Commission
92 Parramatta Road
Camperdown NSW 2050
Switch: (02) 9577 9555
1800 252 226 (outside Sydney)
Fax: (02) 9577 9202
http://www.worksafe.gov.au

Australian Public Service OHS Agency

COMCARE Australia
CFM Building, 12 Moore Street
Canberra ACT 2601
Switch: (02) 6275 0000
1300 366 979
Fax: (02) 6257 5634
http://www.comcare.gov.au

State & Territory Government OHS Agencies

New South Wales

WorkCover Authority of NSW
400 Kent Street
Sydney NSW 2000
Switch: (02) 9370 5000
1800 451 462
Fax: (02) 9370 6120
http://www.workcover.nsw.gov.au

Western Australia

WorkSafe Western Australia
1260 Hay Street
West Perth WA 6005
Switch: (08) 9327 8777
Fax: (08) 9321 8973
http://www.safetyline.wa.gov.au

Victoria

Victorian WorkCover Authority
222 Exhibition Street
Melbourne VIC 3000
Switch: (03) 9641 1555
1800 136 089 (Vic only)
Fax: (03) 9641 1222
http://www.workcover.vic.gov.au

Australian Capital Territory

ACT WorkCover
3rd Floor
FAI House
197 London Court
Civic ACT 2601
Switch: (02) 6205 0200
Fax: (02) 6205 0797
http://www.act.gov.au

South Australia

WorkCover Corporation
100 Waymouth Street
Adelaide SA 5000
Switch: (08) 8233 2222
1800 888 508 (all States)
1800 188 000 (SA only)
Fax: (08) 8233 2466
http://www.workcover.sa.gov.au

Workplace Services
Department for Administrative and Information Services
Level 3, 1 Richmond Road
Keswick SA 5035
Switch: (08) 8303 0400
1800 777 209 (a/h emergency)
Fax: (08) 8303 0400
http://www.eric.sa.gov.au

7.2 OHS authorities/contacts [cont]

Tasmania

Workplace Standards Tasmania
Department of Infrastructure,
Energy & Resources
30 Gordons Hill Road
Rosny Park TAS 7018
Switch: (03) 6233 7657
1300 366 322 (TAS only)
Fax: (03) 6233 8338
http://www.wsa.tas.gov.au

Queensland

Division of Workplace Health
and Safety, Department of Training
and Industrial Relations
75 William Street
Brisbane QLD 4000
Switch: (07) 3247 4711
1800 177 717
Fax: (07) 3220 0143
http://www.detir.qld.gov.au

Northern Territory

Work Health Group
Minerals House
66 The Esplanade
Darwin NT 0800
Switch: (08) 8999 5010
1800 019 115
Fax: (08) 8999 5141
http://www.detir.gov.au/wha

Standards Australia

Head Office
1 The Crescent
Homebush NSW 2140
Information Centre (02) 9746 4748
Sales: (02) 9746 4600
Office in each State

7.3 Hazard specific information

The following is not an exhaustive list of available resources but rather a guide to assistance available in relation to the identified subject areas.

Infection control

Infection Control in the Health Care Setting. Guidelines for the prevention of transmission of infectious diseases. National Health and Medical Research Council. Government Info Shop, 10 Mort Street, Canberra ACT 2600. Ph: (02) 6247 7211, Fax: (02) 6257 1797.

NSW Health Training and Information: Infection Control Resource Kit. Ellis and Associates for NSW Health. September 1996. Ph: (02) 9332 1090.

Residential Aged Care Guidelines for Infection Control. Leaver M (ed). Kimberly Clark Corporation. January 1999. For orders Ph: (02) 9963 8061.

Resident aggression

Management of Aggression Training Manual. Management of Client Aggression in Aged Care. Port Adelaide Central Mission Inc, WorkCover Corporation South Australia, GPO Box 2668, Adelaide SA 5001. Ph: (02) 8233 2222.

Managing Resident Aggression in Aged Care Facilities. Baptist Community Service/WorkCover NSW. 1st ed November 1998. Ph: (02) 9370 5000.

Guidelines for Reducing the Risk of Violence at Work – includes a brochure "Managing the Risks of Violence in Aged Care Facilities". WorkCover Corporation South Australia, GPO Box 2668, Adelaide SA 5001. Ph: (02) 8233 2222.

Manual handling

Manual Handling Codes of Practice (Contact State WorkCover).

Strategies to Reduce the Risk of Back Strain in Nursing Homes. WorkSafe WA, 1993. (See http://www.safetyline.wa.gov.au)

Manual Handling Guide for Nurses. NSW Nurses Association, WorkCover NSW. September 1998. Ph: (02) 9550 3244.

Manual Handling Competencies for Nurses. NSW Nurses Association, WorkCover NSW. September 1998. Ph: (02) 9550 3244.

No Lifting Implementation Guide and Checklist. Australian Nursing Federation (ANF) (Victorian Branch) 1998. Ph: (03) 9275 9333.

Guidelines for Implementing No Lifting. Australian Nursing Federation (ANF) (SA Branch) 1999. Ph: (08) 8363 1948.

No Lifting by the Year 2000 – Health and Safety Yearbook 1998. Queensland Nurses Union, 1998. Ph: (07) 3840 1444.

Lifting and Moving People: Choosing the Right Equipment. WorkCover New South Wales November 1998, Catalogue No. 752. Ph: (02) 9370 5000.

Designing Workplaces for Safer Handling of Patients/Residents – Guidelines for the Design of Health and Aged Care Facilities. Victorian WorkCover Authority, August 1999. Ph: (03) 9641 1555 (Publications).

Prepurchase Criteria to use in the Selection of Equipment and Furniture – Health and Aged Care. Victorian WorkCover Authority, November 1998. See http://www.workcover.vic.gov.au. Look under special projects- Aged Care and Health.

Criteria for Evaluating the Core Elements that Support a Best Practice Patient/Resident Handling Training Program in the Health and Aged Care Sector. Victorian WorkCover Authority, December 1998. See http://www.workcover.vic.gov.au. Look under special projects - Aged Care and Health.

Checklist for evaluating beds for the health industry. WorkCover NSW 1998, catalogue No. 742. Ph (02) 9370 5000

Checklist for evaluating mobile hoists. WorkCover NSW 1997, catalogue No. 741. Ph (02) 9370 5000

Lifting and moving people: choosing the right equipment. WorkCover NSW 1998, catalogue No. 752. Ph (02) 9370 5000

Other resources

Guidelines for the Management of Loss and Grief in the Aged Care Industry (Draft). WorkCover NSW, June 1999. Ph: (02) 9370 5000.

OHS Fact Sheets

8.1 OHS legal requirements

OHS Acts

Occupational Health and Safety Acts in each State of Australia (see *Section 7* for a complete list) place a general duty of care on the employer and employees in the workplace and also on anyone who designs, manufactures, imports or supplies any plant or substances to a workplace.

The Acts (which differ slightly between States) also cover issues such as how to resolve OHS issues and the roles of (and election process where applicable) for health and safety committees and representatives.

OHS regulations

OHS Regulations in each State set out specific requirements and standards, which must be met. They relate to physical hazards, systems of work and/or administrative matters.

Codes of Practice

Codes of Practice provide practical guidance that should be followed unless there is another way to get an equal or better outcome. There is a varied number of Codes of Practice in each State covering a range of issues e.g. Manual Handling Code of Practice.

Guidelines

A range of Guidelines are published by State OHS Authorities and the National Occupational Health and Safety Commission. These generally address specific hazards and provide assistance to meet the requirements of the Acts, Regulations and Codes of Practice.

Australian Standards

Australian Standards also provide direction about a range of OHS issues. They must be followed if they are referenced in the Regulations. They may also be referenced as a Code of Practice.

8.2 OHS responsibilities

Employer responsibilities

The wording of employer responsibilities within the Acts of each State varies but in summary employers are required to:

- provide and maintain a safe working environment
- provide safe systems of work
- provide information, instruction and supervision of employees to ensure safety
- ensure the safe use, storage and handling of plant, equipment and substances
- provide adequate facilities for staff
- consult with employees/Health and Safety Representatives about OHS
- identify, assess and control hazards

Employee responsibilities

Employee responsibilities defined in the OHS Acts vary slightly between States but in summary they are to:

- take reasonable care to ensure their own safety
- not place others at risk by any act or omission
- follow safe work procedures
- use and care for equipment as instructed
- not wilfully or recklessly interfere with safety equipment
- report hazards and injuries
- co-operate with the employer to meet OHS obligations

Managers and supervisors OHS responsibilities

Managers and supervisors have responsibilities on behalf of the employer, but must also comply with their requirements as employees. It is their responsibility to:

- act as role models
- ensure employees have the information, instruction, training and supervision they need to work safely
- consult with employees (and representatives) on proposed changes
- identify, assess and control hazards
- maintain a safe working environment

8.2 OHS responsibilities (cont)

OHS coordinator role

Some aged care facilities may nominate an OHS Coordinator to assist in implementing OHS. The coordinator does not take on the management role or responsibilities for OHS. They must be allocated time for the role. They also need appropriate OHS training.

Their role may be to:

- assist in developing preventative strategies e.g. policies, procedures, action plans
- assist the OHS committee (if one is elected)
- assist in identifying, assessing and controlling hazards
- assist in workplace inspections, audits and incident investigation
- coordinate the collection, recording and analysis of OHS data
- coordinate training programs

Proprietors/Boards of Management responsibilities

Proprietors and boards of management have a legal responsibility for OHS. These include:

- nominate a responsible officer (where applicable)
- ensure the legal obligations of the facility are met

OHS responsibilities of residents and their families

Residents and their families have rights within the facility, but they also have a responsibility to ensure their actions do not put staff at risk.

Contractors

Contractors also have OHS obligations. They are to ensure their own safety and not put others at risk. Employers have responsibility for the OHS of contractors in relation to issues where they have control, for example, for safe access and egress, no tripping hazards etc. Contractors including agency staff and tradespeople, must be inducted to the site and included in training.

8.3 Consultation

Health and Safety committee roles

The requirements for setting up OHS committees vary between States. Generally small facilities would not be required to have a committee, but where they are set up, their roles are to:

- provide a forum for management and employees to meet and discuss OHS issues in the workplace
- bring together the employees' practical knowledge of the job and the management overview of the facility and work organisation
- assist to develop, monitor and review OHS policies, procedures and plans
- assist to resolve OHS issues
- develop and monitor a program for hazard identification, risk assessment and control
- consider proposed changes which may affect OHS (for example, purchase of new equipment, workplace changes, policy, procedure changes)
- develop and monitor an injury reporting system
- review incident reports and follow up actions
- assist to develop and evaluate training programs
- review external and internal OHS reports
- oversee the overall approach to OHS within the facility to encourage integration of OHS into the overall management system and to promote continuous improvement

Health and Safety Representatives' role

The role of Health and Safety Representatives (where elected), in line with State legislation is to:

- represent employees on OHS matters in meetings with managers, supervisors and OHS inspectors
- participate in appropriate OHS training
- discuss OHS issues with employees within their workgroup
- participate in hazard identification, risk assessments and controlling risks
- assist to develop, implement, monitor and review agreed procedures
- participate in workplace inspections and incident investigation
- may issue Default Notices/Provisional Improvement Notices (in some States)

8.4 Fire, security and other emergencies

(Expected Outcome 4.6)

Ensure the following policies and practices are in place:

- procedures for staff, residents and visitors to follow for fire, safety, security and other emergencies, including evacuation and emergency drills which can be understood by everyone
- emergency procedures and plan clearly displayed
- emergency contact phone numbers clearly displayed
- regular review of procedures
- staff education covers emergency procedures (and legislation)
- training data, including attendance records collated
- regular training program reviews documented
- orientation program documented and program reviewed
- qualified personnel conduct orientation and ongoing refresher programs
- alarm system operation demonstrated to staff
- identification system for staff and residents
- security measures developed
- service agreements with accredited equipment service providers and fire and safety instructors (where necessary)
- access for staff to external programs and information, for example, videos
- program documented for planned, preventative and corrective maintenance of fire, security and emergency equipment
- equipment testing documented and audited (and reviewed regularly)
- documented evidence of regular practice of emergency procedures (including evacuation exercises)
- risk reporting system for staff, residents and visitors
- regular inspection of the facility to assess potential areas of risk
- quality improvement systems to identify and address deficiencies

8.5 Hazardous substances & dangerous goods

(Expected Outcome 4.6)

Hazardous substances are those substances which may harm health and are listed on the National Occupational Health and Safety Commission's *List of Designated Hazardous Substances [NOHSC:10005]* or have been classified as a hazardous substance by the manufacturer or importer in accordance with the *Approved Criteria for Classifying Hazardous Substance [NOHSC:1008(1004)]*.

Dangerous substances means any substance (solid, liquid or gaseous) that is toxic, corrosive, flammable or otherwise dangerous in accordance with the *Australian Dangerous Goods Code (ADG Code) 6th edition, 1998*.

Ensure the following policies and practices are in place:

- procedures for the use and storage of hazardous substances (chemicals) and dangerous goods
- hazardous substances and dangerous goods are clearly and correctly labelled (including decanted products)
- information and safety documentation, for example, material safety data sheets (MSDS) obtained from suppliers
- instructions for use and dispensing of dangerous goods kept in storage area
- secure storage of hazardous substances and dangerous goods
- staff education program includes the use and storage of hazardous substances/ dangerous goods (and is documented)
- hazards of substances identified, risks addressed and controlled
- personal protective clothing and equipment (PPCE) provided (with instructions for use)
- provision for first aid and medical attention if required

Project Steering Committee - Small Business Project

Jenny Hefford
Director Quality Assurance Workgroup
Commonwealth Department Health & Aged Care

Laurie Stiller
Manager
Sydney Operations
Niki Ellis & Associates

Mardi Webber
OHS Consultant
WorkCover Corporation

Angela Halsey
State Manager SA & NT
The Aged Care Standards Agency

ALHMW Union Representative
Sue Balde
OHS Representative
Helping Hand Aged Care

Aged Care Organisation Association Representative
Chris Racar
OHS Coordinator
Masonic Homes

Megan Williams
Senior Grants Project Officer
WorkCover Corporation

George Karlis
OHS Consultant
WorkCover Corporation

Consultant to Committee
Marion Pocock
Marion Pocock Consulting

As part of the evaluation of *First Steps*, we would appreciate your feedback on the contents.

Please complete the details below.

If you have additional comments and wish to attach them we would appreciate them too.

Please return your comments 3 months after receiving *First Steps* (or sooner if you wish).

Please send it to:

George Karlis
Executive Officer
Aged Care OHS Working Party
GPO Box 2668
Adelaide 5000

Name of Person completing the form (optional): _____

Facility _____

How long have you had *First Steps*? _____

What was your overall impression of *First Steps*?

(circle your response) 1 2 3 4 5 6

Poor Excellent

Comments: _____

Was *First Steps* easy to follow? 1 2 3 4 5 6

Poor Excellent

Comments: _____

Was the language easy to understand? 1 2 3 4 5 6

Poor Excellent

Comments: _____

Were the flowcharts easy to understand and follow? 1 2 3 4 5 6

Poor Excellent

Comments:

Have you used any of the sample forms? (if yes, which ones)

Were the forms useful and easy to use? 1 2 3 4 5 6

Poor Excellent

Comments:

Which parts of *First Steps* have you used?

Which sections did you find the most useful?

Which sections did you find the least useful?

How could *First Steps* be improved?

Have you completed the Self Assessment Checklist?

How useful was it? 1 2 3 4 5 6

Poor Excellent

Have you developed an OHS Action plan using *First Steps*?

What OHS improvements have resulted?

Was *First Steps* helpful in the accreditation process? 1 2 3 4 5 6

Poor Excellent

Comments:

Individual results collated from the questionnaires will remain confidential but will be used collectively to evaluate the effectiveness of the *First Steps* guide and make any improvements required.