

Healthcare and social assistance industry

Code of practice

February 2026

NSW Editorial note

1. This code is based on a national model code of practice developed by Safe Work Australia under the harmonisation of national work health and safety legislation and has been approved under section 274 of the *NSW Work Health and Safety Act 2011* (the NSW WHS Act). Notice of that approval was published in the NSW Government Gazette referring to this code of practice as Healthcare and social assistance industry on Friday 20 February 2026. This code of practice commenced on 20 February 2026.
2. When reading this Code, please be aware that any reference to:
 - the 'Work Health and Safety Act' refers to the *Work Health and Safety Act 2011* (NSW), or any successor legislation,
 - the 'Work Health and Safety Regulation' refers to the *Work Health and Safety Regulation 2025* (NSW), or any successor regulation,
 - a code of practice refers to the relevant NSW Code of practice, or any successor code of practice.

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Foreword

What is an approved Code of Practice?

This Code of Practice on managing work health and safety (WHS) in the healthcare and social assistance industry is an approved code of practice under section 274 of the *Work Health and Safety Act* (the WHS Act).

An approved code of practice provides practical guidance on how to achieve the standards of work health and safety required under the WHS Act and the *Work Health and Safety Regulation* (the WHS Regulation) and effective ways to identify and manage risks.

A code of practice can help anyone who has a legal duty in the circumstances described in the code of practice. Following an approved code of practice will help you comply with the health and safety duties in the WHS Act and WHS Regulation. Like regulations, codes of practice deal with particular issues and may not cover all relevant hazards or risks. WHS laws require duty holders to consider all risks associated with work, not only those for which regulations and codes of practice exist.

Codes of practice are admissible in court proceedings under the WHS Act and WHS Regulation. Courts may regard a code of practice as evidence of what is known about a hazard, risk, risk assessment or risk control and may rely on the code in determining what is reasonably practicable in the circumstances the code of practice relates to. For further information see Safe Work Australia's *Interpretive Guideline: The meaning of 'reasonably practicable'*.

Compliance with the WHS Act and WHS Regulation may be achieved by following another method if it provides an equivalent or higher standard of WHS than the code of practice.

An inspector may also refer to an approved code of practice when issuing an improvement or prohibition notice.

Scope and application

This Code is intended to be read by a person conducting a business or undertaking (PCBU) (for example employers) in the healthcare or social assistance industry. It provides practical guidance to PCBUs on how to manage health and safety risks associated with work in the healthcare and social assistance industry. However, due to the size and diversity of the industry, the examples and case studies provided are focused on hospitals, aged care services and disability support services.

This Code may be a useful reference for other persons interested in the duties under the WHS Act and WHS Regulation and how they relate to the healthcare and social assistance industry.

How to use this Code of Practice

This Code includes references to legal requirements under the WHS Act and WHS Regulation. These are included for convenience only and should not be relied upon in place of the full text of the WHS Act or WHS Regulation.

The words 'must', 'requires' or 'mandatory' indicate a legal requirement that must be complied with.

The word 'should' is used in this Code to indicate a recommended course of action, while 'may' is used to indicate an optional course of action.

What is a workplace?

A workplace includes any place where a worker goes or is likely to be while at work.

This includes places like a private home where someone is being cared for or supported by a worker, a community location a worker is visiting with a client, or an ambulance on its way to the hospital.

Interaction with other laws and regulations

This Code is focused on WHS requirements. There are a range of other laws, regulations and standards that apply to the healthcare and social assistance industry (for example, the NDIS Code of Conduct, the Aged Care Quality and Safety Standards, or professional standards for medical practitioners). Complying with these laws, regulations and standards does not guarantee compliance with WHS laws, and vice versa.

1. Who has WHS legal responsibilities

The following people have WHS legal responsibilities.

- PCBUs, such as employers, platforms, sole-traders or contractors
- Workers
- Officers
- Designers, suppliers and installers
- Others

1.1 Person Conducting a Business or Undertaking (PCBU)

PCBU is a broad term that captures different kinds of working arrangements.

This Code's main target audience is PCBUs. The Code uses the word 'you' throughout to refer to PCBUs. Information on who a PCBU is can be found below.

PCBUs may include:

- employers, sole traders, contractors and other businesses
- hospitals, aged care facilities and disability support service providers (including government and privately owned entities)
- government departments and authorities (e.g. state and territory health departments)
- platforms that provide care or support workers under 'gig' arrangements
- training providers (e.g. specialist medical colleges)
- Intermediaries (e.g. support coordinators, navigators) and labour hire firms
- designers, importers, suppliers or manufacturers
- people who manage or control facilities (e.g. facilities managers), and
- sole traders and self-employed people, such as owners of a general practice, people offering allied services within a hospital, or support workers providing in-home care.

If it is not clear who the PCBU is in your workplace, you should seek legal advice or contact SafeWork NSW.

Sole traders or self-employed people (including gig workers)

Sole traders or self-employed people can be both PCBUs and workers at the same time. A sole trader or self-employed person is a PCBU if they are conducting a business or undertaking.

At the same time a sole trader or self-employed person is a worker if they do any type of work for a PCBU.

As a PCBU they have a range of WHS legal responsibilities, including the **primary duty**.

For example, a self-employed surgeon must eliminate or minimise WHS risks for their workers and other people affected by the work as much as they reasonably can. The surgeon also owes a **primary duty** to any workers or subcontractors they engage, direct or influence (e.g. medical receptionists at surgery suites).

For more information, see Safe Work Australia's guidance *WHS duties in a contractual chain*.

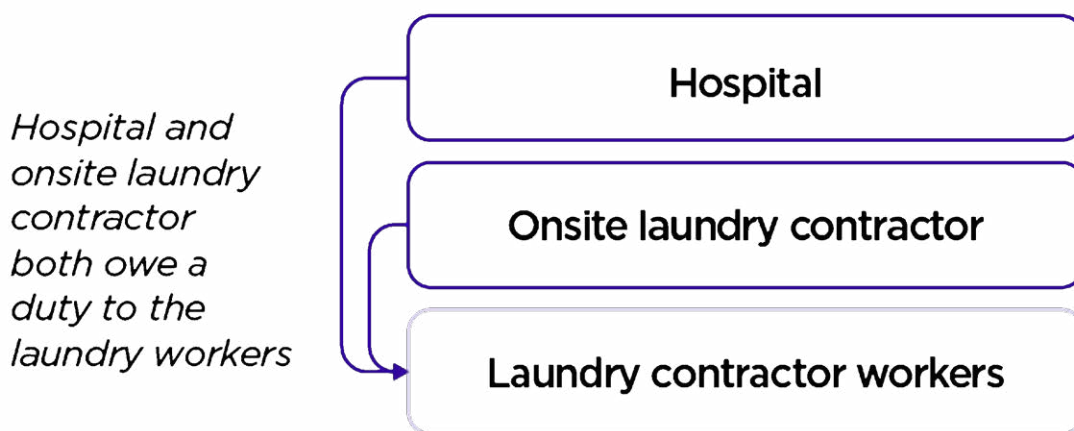
Who is a worker of a PCBU?

Workers that PCBUs owe a duty to include people they directly employ or engage (e.g. employees, contractors, students on placement or gaining work experience and volunteers).

However, there does not need to be a direct contractual relationship between a PCBU and the workers for the PCBU's legal responsibilities to apply. A PCBU's workers may also include people doing work for them through subcontracting, labour hire, platforms or similar arrangements.

For example, if a hospital (as a PCBU) contracts an on-site laundry service, the laundry service's workers are also the hospital's workers. The hospital has WHS legal responsibilities for these workers, as it caused the workers to be engaged when it contracted the laundry service to perform the laundry work. In this case, both the hospital and the laundry service have WHS legal responsibilities to the workers, and these responsibilities are shared.

Figure 1: Example of how WHS duties can be shared



Primary duty

Under WHS laws, a PCBU has the main legal responsibility for keeping people safe in a workplace. This responsibility is known as the 'primary duty'.

Under the primary duty, if you are a PCBU, you must:

- ensure the health and safety of **workers** when they are at work, and
- ensure the health and safety of **others** who may be at risk from the work (such as patients, clients or visitors).¹

The primary duty applies 'so far as is reasonably practicable'. This means doing as much as **you** reasonably can to keep people safe.

To meet the primary duty, you must eliminate health and safety risks at work. If you are not reasonably able to eliminate risks, you must minimise these risks as much as you reasonably can.²

For further information refer to Safe Work Australia's *Duties of a PCBU* and *How to determine what is reasonably practicable to meet a health and safety duty*.

1. Work Health and Safety Act s 19.
2. Work Health and Safety Act s 17.

Worker safety vs patient or client care

Patient or client care, support or preferences do not take priority over worker safety. WHS legal requirements exist to protect workers and others from WHS risks, and these requirements cannot be ignored because of an actual or perceived conflict with patient or client care.

Because their job is to care for others, it is common for people in the healthcare and social assistance industry and their managers to prioritise patient or client care. This sometimes even includes putting the preferences of patients, clients or family members above the safety of workers. For example, a patient may prefer to be carried by a worker and not moved with lifting equipment. This may pose a risk to the worker and the patient.

You must fulfill your WHS legal obligations. **You** should also communicate with workers, patients, clients and their families about the importance of protecting workers' health and safety.

For example, nurses sometimes must care for patients living with dementia who are behaving violently and may not be able to control their behaviour. This behaviour represents a WHS risk to the nurse. In some circumstances, it may be appropriate to refuse care to the patient. In other cases, the nurse's employer may not reasonably be able to *eliminate* the nurse's exposure to WHS risk, because the patient still requires care. However, the nurse's employer must still *minimise* WHS risks as much as they reasonably can by providing controls that prevent the nurse from being injured, such as caring for the patient in a specialised ward, rostering on enough staff to care for the patient safely, arranging a medical review, providing training in de escalation techniques or time to debrief to review practice or incidents.

Consultation duties

You have a duty to consult with workers, and their Health and Safety Representatives (HSRs) if they have them, on health and safety matters. You also have a duty to consult with people who share a duty for the same matter (e.g. a security guard working for a private security company but contracted to work in a hospital may be owed a duty by both the security company and the hospital). For more information see the [consultation section](#) of this Code and the *Code of Practice: How to manage work health and safety risks*.

Note references to consultation with workers in this Code includes consultation with any HSRs.

1.2 Workers

Under WHS laws, workers have a duty to take reasonable care of their own health and safety. They must also take reasonable care of the health and safety of others.

Workers must also comply with reasonable health and safety instructions, as much as they reasonably can, and cooperate with reasonable health and safety policies or procedures that have been communicated to them.

Who is a worker in the healthcare and social assistance industry?

The term 'worker' includes anyone who does work for a **PCBU**, including employees, contractors, subcontractors, agency staff, managers, apprentices, 'gig' workers, trainees, students on placement and volunteers.

The WHS duties listed above apply to all workers. Every worker in healthcare and social assistance is covered by WHS laws no matter how they are engaged or their visa status. As you read this Code think about all the workers at your workplace. You may have clinical staff such as general practitioners, surgeons, nurses, midwives, medical assistants, ambulance workers, allied health workers, disability support workers, and students on placement; and non-clinical staff such as security guards, frontline support staff, receptionists, kitchen and laundry workers, and maintenance workers.

Workers can take an active role in managing WHS risks in the workplace, including by helping you identify hazards, understand and assess risks, and design appropriate controls. However, you retain the primary responsibility for managing WHS risks.

For some workers, the health and safety instructions they must comply with might be as simple as not entering certain areas, or only operating equipment they have been trained to.

Other workers may have more significant and broader-ranging responsibilities for WHS. For example, executives and managers may be instructed to develop health and safety processes for their unit, or for identifying and responding to new and emerging hazards on behalf of their employer. They may be responsible for handling high risk situations, according to their level of experience and training. In these cases, you still retain your WHS legal responsibilities, but the worker may have a significant role in supporting their organisation to meet them.

1.3 Officers

Officers have specific duties under WHS laws.³

The role and influence a person has in an organisation determines if they are an officer under the WHS laws. This may be different for each organisation.

A person may be an officer if they:

- are the owner or operator of a small business or organisation
- make big decisions about all or part of the business or organisation, or
- can affect the business or organisation's financial standing.

Who is an officer in the healthcare and social assistance industry?

Officers may include owners and operators of facilities, hospital directors, senior executive board members, and other members of the senior leadership team.

Officers have a duty to exercise due diligence to ensure the employer or organisation complies with its duties. Due diligence includes taking reasonable steps to:

- acquire and keep up-to-date knowledge of the WHS matters of the organisation, such as an understanding of the nature of the employer or organisation's work and common hazards and risks
- ensure the organisation has enough resources and processes to eliminate or minimise risks to health and safety and verify those resources are being used, and
- ensure the organisation has appropriate processes for receiving and considering information regarding incidents, hazards and risks to health and safety, verify those processes are effective and respond in a timely way to that information.

For information on officers and their duties see Safe Work Australia's *Interpretive Guideline: The health and safety duty of an officer* and guidance on *Officer duties*.

Note: Just because a person's job title has 'officer' in the name, this does not necessarily mean they are an 'officer' under WHS laws.

3. Work Health and Safety Act 2011 s 27.

1.4 Designers, suppliers, manufacturers, importers and installers

Designers, suppliers, manufacturers, importers and installers must ensure, as much as they reasonably can, that buildings, equipment and technology used as or at a workplace do not create WHS risks.

Designers, suppliers, manufacturers, importers, installers and their clients must consult each other on the risks and work together on appropriate design solutions, for example:

- manufacturers to consult with designers of equipment
- importers to consult with designers and manufacturers of equipment, and
- the person who commissions construction work to consult with the designer of the structure such as a hospital building.

Designers have a very important role in preventing WHS risks. This is because addressing risks in the design phase is often the most effective way of eliminating risks to health and safety.

For more information see the *Code of Practice: Safe design of structures* and the *Code of Practice: How to manage work health and safety risks*.

Case study – Designer duty

An architect is asked to design a new aged care home. Their client asks them to create a 'facility that will make residents feel like they are at home' while ensuring it has suitable equipment for people handling tasks. In consulting on the design, the architect realises that many residents of the facility have health conditions that reduce their mobility as they age, requiring staff at the facility to help them get around. Following a risk assessment and considering the facility design, the architect and aged care provider agree to install ceiling hoists into the aged care home, which ultimately prevents many injuries among staff at the facility that would otherwise have been caused by manual people handling. While some residents prefer not to have ceiling hoists as these make them feel less 'at home', both the architects and the aged care provider have a duty to prevent worker injuries.

1.5 Others

Other people at the workplace, such as patients, clients, their families and visitors, must take reasonable care for their own health and safety and the health and safety of others.

Others at the workplace must also comply with reasonable health and safety instructions **you** give them as much as they reasonably can. This includes following any verbal instructions given at the workplace or following written instructions such as signs.

Case study – Others in the workplace

A disability support worker attends a client's home to assist them with self-care tasks. The client wants to be moved from their bed to a lounge so they can watch television. Lifting equipment is usually used when transferring the client from the bed to the chair. On this visit, the lifting equipment is unavailable as it is being repaired.

The father of the client suggests that he will help the worker to lift his daughter. However, the support provider has a policy of not conducting manual lifts because of the risk of injury to workers. The father insists his daughter be moved and encourages the worker to ignore their policy in this instance. The worker calls their supervisor, who explains to the father that manually lifting the client will create a risk for both the worker and the father.

2. Managing WHS risks

This section explains how a good risk management process can help prevent work-related fatalities, injuries and illnesses in the workplace.

A good risk management process involves:

- **identifying hazards and assessing risks**
- using risk controls to eliminate or minimise risk
- monitoring and reviewing the effectiveness of controls, and
- genuine and thorough **consultation** at each stage of the process.

Before **you** start the risk management process you should:

- know about your legal obligation to **consult** with your workers and their HSRs (if they have them) throughout the process
- identify who needs to be involved, for example managers, workers, human resources staff, HSRs, subject matter experts
- explain the process to everyone involved, and
- decide how the process and its outcomes will be recorded and communicated.

2.1 Identifying hazards and assessing risks

To determine if there is a risk in the workplace, **you** need to think about the chance that something bad could happen (likelihood), and how serious the potential harm could be (consequence).

Identifying hazards and assessing risks involves:

- identifying things that could potentially cause physical or psychological harm
- consulting with workers and other people with WHS duties
- finding out more about how the harm might occur, and
- looking at hazards and risks together to understand how they might interact or combine.

You must seek knowledge about ways to eliminate or manage risks. Ignorance of WHS issues in your workplace is not a defence. You should consult with workers and reach out to other organisations (e.g. equipment manufacturers) for information on effective controls to manage risks. In managing risks relating to individual patients or clients, you may need to seek information from other medical services or the patient's family or carers.

How to identify hazards

You will need to use a range of methods and a variety of sources to identify hazards in your workplace. This includes reviewing data and reports (e.g. injury records, workers' compensation claims), looking for trends, undertaking inspections, talking to workers and their representatives (through meetings or surveys) and thinking about the hazards associated with different **aspects of work**.

Some hazards may always be present in the workplace. Others may arise because of specific activities, or the nature of the work or services being provided. Some hazards may be present only when something goes wrong.

Make sure you have appropriate ways for workers to report hazards, risks, incidents and near misses, and actively encourage them to do so. Reporting gives you information that you can use to improve safety in your workplace. Just because workers have not reported hazards does not mean they are not present in the workplace.

Workers might not report hazards if they:

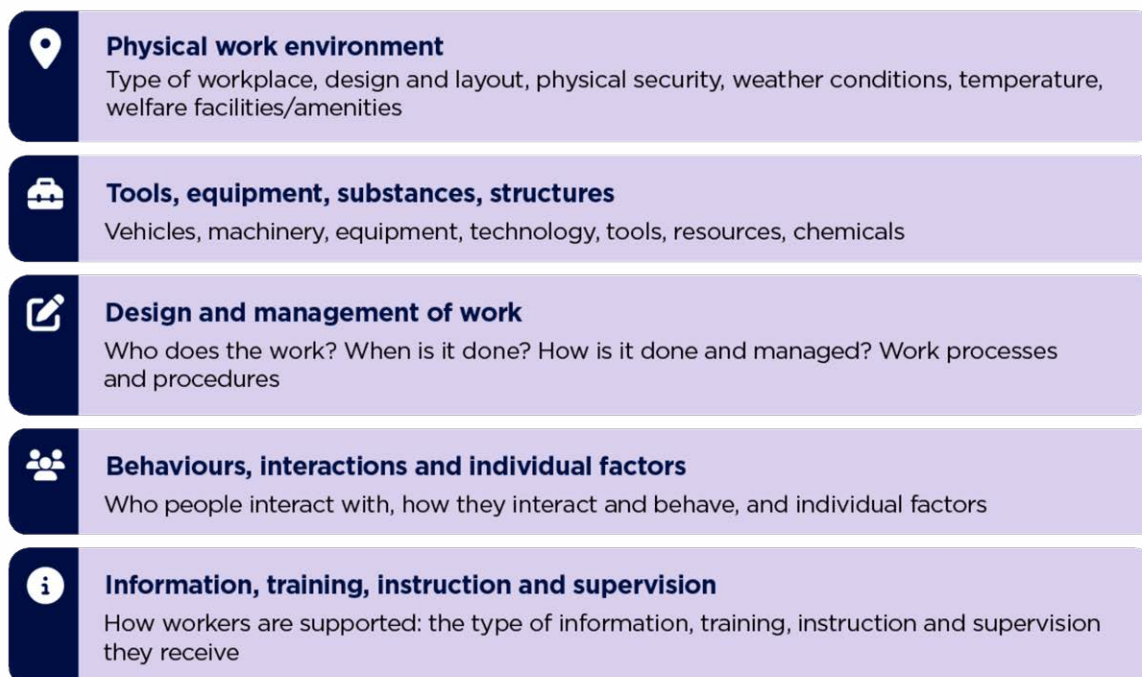
- see them as just part of the job
- believe they are not serious enough to report
- feel they do not have time to report them
- do not think safety is being treated as a priority in the workplace
- think their reports will be ignored, or not handled respectfully or confidentially
- fear they will be blamed or that reporting will disadvantage them in some way (e.g. disciplinary procedures, loss of work)
- do not know how to report a hazard or raise concerns
- think someone else will or should report it, or
- do not have a good understanding of health and safety or do not turn their minds to it.

You should promote a positive safety and reporting culture and make workers feel supported to speak up. You should also consider factors that may discourage workers from speaking up and address these (e.g. casual work arrangements, workers with low levels of English literacy or other communication barriers, cultural factors, newly arrived migrants or younger workers). These factors can be addressed by providing appropriate inductions and training, translated resources, adequate support and supervision, ongoing consultation and by creating a safe environment to raise concerns.

Aspects of work

It is important to consider all aspects of work and assess how they may cause or contribute to risks in the workplace. This review should be ongoing, as safety is not a 'set-and-forget' exercise.

Figure 2: Aspects of work



2.2 Understand and assess the risks

It is not enough to identify hazards in a general sense. To understand and assess the risks to the health and safety of workers, you need to know:

- the source(s) of the hazard and how workers could be exposed,
- when and where the hazard is present - for which workers and doing what tasks,
- the type and seriousness of harm the hazard could cause (**consequence**), and
- how likely the harm is, or (in instances where harm builds over time) how frequently and for how long workers might be exposed (**likelihood**).

Work out what could happen if someone is exposed to a hazard – consequence and likelihood

Harm can be caused immediately by a single incident. For example, a fall could cause a sprained ankle or exposure to a traumatic incident could result in immediate psychological harm.

Immediate harm: Where immediate harm is a possibility, organisations should consider:

- **consequence:** the type of harm it would cause and how serious it might be. The type of harm might range from a minor injury to a worker being killed.
- **likelihood:** This can be estimated by considering how often people are exposed to the hazard and how effective current risk controls are.

Harm occurring over time: Harm can also occur over time with repeated or prolonged exposure to a hazard. For example, exposure to fatigue in the workplace can build up over time and result in psychological and physical harm. Undertaking repetitive physical tasks without effective controls in place can result in musculoskeletal disorders.

Where harm could occur over time you should consider:

- **duration:** How long is the worker exposed to the hazard?
- **frequency:** How often is the worker exposed to the hazard?
- **severity:** How serious would the consequence of exposure be?

Consider the hazards and risks both individually and together

Individual hazards and risks should not only be considered in isolation. Workers and others may be exposed to more than one physical or psychosocial hazard at any time. Hazards can interact or combine (including both psychosocial and physical hazards) to create or increase risks.

For example, exposure to workplace stress and work overload can increase the risks of workers developing musculoskeletal disorders.

Fatigue can make workers more likely to make mistakes when following infection prevention controls, exposing them to biological hazards.

Assessing risks in changing or unknown environments

In some work situations, the risk of harm may be difficult to plan for and control. For example, disability support workers may work in other peoples' homes and not have advance knowledge of the work environment before they arrive. Other work environments may change rapidly, such as when a lot of different types of patients enter a hospital, or during an emergency.

For work in other peoples' homes, a pre-visit risk assessment should be conducted and discussed with the worker prior to the visit. This can then be updated as required by the worker.

If the work environment changes after the initial assessment, **you** should consider doing a dynamic risk assessment. A dynamic risk assessment allows the worker to quickly assess the risks in a situation and respond appropriately. You must ensure the worker is properly trained to do a dynamic risk assessment. The dynamic risk assessment should also be recorded and reviewed as part of your overall risk management process.

Dynamic risk assessments are useful for dealing with uncertainty or emergency situations, but they do not replace the need for you to fulfill your WHS legal obligations.

Case study – Dynamic risk assessments

An organisation providing home nursing services has controls in place to manage the potential risk of violence during home visits, including a pre-visit risk assessment. The organisation has a care plan for each patient. The plan documents known triggers and strategies that have worked well in the past to minimise any risks. This includes having workers work in pairs where there is a history of violence, providing equipment for communication, and logging and sharing a detailed history of interactions on previous visits. The organisation also trains workers to continually observe and assess each visit for potential changes in risk, and to terminate the visit if there is a threat of violence without escalating or putting themselves in danger.

Half an hour after entering a patient's home, a worker notices evidence of drug and alcohol consumption. The patient's behaviour then becomes aggressive. The worker assesses that the risk to their safety has escalated and following established procedures, terminates the home visit due to the risk of violence.

The risk assessment and care plan are updated, and the provider negotiates with the patient that future visits will be conducted in a community care clinic as this is a safer environment.

2.3 Control the risks

Once you know about the hazards and risks in the workplace, you need to control them as much as you reasonably can.

You must eliminate risks if you reasonably can. The most effective way to control risks is to eliminate them completely. For example, stop doing a task or remove the hazard from the workplace.

You may be able to eliminate certain risks for some workers, in some areas of the workplace or for specific tasks.

If it is not reasonable to eliminate risks, **you must minimise them as much as you reasonably can.** This means applying controls until the risk is minimised as much as it reasonably can be.

Brainstorm ways to control the risks

Brainstorm all possible things that can be done to manage the risk.

Talk to your workers about possible controls and what might work best. Workers will have good ideas or insights based on their knowledge and experience.

Consider whether the work environment or systems of work can be **re-designed** to eliminate or minimise the risk arising from exposure to the hazard.

You should also think about measures you can take to make controls more effective, or as a backup if processes and procedures are not followed properly (e.g. a wheel maintenance program that ensures all wheeled equipment works smoothly).

Consider which controls are the most effective and reliable

From the possible controls you have talked about, use the hierarchy of controls and consider which control or combination of controls will be most effective and reliable.

What if the risk is already known and controls are already well-established?

A full assessment of the hazard and its risk may not be required if there are well-known and effective controls available. If this is the case, you can simply implement the known controls.

You must first eliminate the risks if you are reasonably able to. The best way to do this is to identify controls that eliminate the hazard completely. For example, the use of automated dispensing technology (e.g. in-pharmacy robotics and automated dispensing cabinets) in hospital pharmacy departments.

Not all elimination measures will be reasonable. For example, it may not always be reasonable to eliminate exposure to harmful behaviours from patients or members of the public if this means care cannot be delivered. However, risks resulting from these behaviours must still be minimised as much as you reasonably can.

Case study – Considering controls

An aged care provider identifies that there is a risk of a resident being exposed to burns when making their own cups of tea or coffee. The risk could be eliminated by removing access to tea and coffee making facilities. However, the Aged Care Quality Standards include the ‘dignity of risk’ principle (‘people in aged care have the right to live the life they choose even if it involves some risk to themselves’). This means it may not be reasonable for the provider to eliminate the risk of burns. However, consistent with both the WHS and Aged Care legislative frameworks, the risk must still be minimised by implementing other controls. For example, alternative equipment could be provided to reduce the risk, such as an insulated urn (so residents do not have to lift a heavy kettle) or two-handled mugs which are less likely to be spilled.

Hierarchy of controls

You should select controls (or combinations of controls) based on their effectiveness.

The hierarchy of controls helps rank controls from the highest level of protection and reliability to the lowest. It will help you to think about why a risk exists in the first place and consider whether you can redesign a given task to make work safer. It will also help you select the most appropriate control, or combination of controls for the risk.

Figure 3: The hierarchy of controls



Using the hierarchy of controls

First, **you** must consider whether a risk can be completely eliminated from the workplace. For example, use automated floor cleaning devices that eliminate the need for workers to clean floor surfaces.

If there is not a reasonable way to eliminate risks, you must minimise risks as much as you reasonably can by doing 1 or more of the following:

- **substituting** hazards or risks with something safer (e.g. replacing a hazardous chemical with a non-hazardous one)
- **isolating** hazards or risks from people, including physically separating a person from a hazard (e.g. by keeping infectious patients in a separate ward), and
- using **engineering** controls such as a mechanical device or process (e.g. needle-free connection systems to prevent needle-stick injuries).

After you have applied all reasonable substitution, isolation and engineering controls, consider if risks remain.

If so, use administrative controls, such as training, supervision, work methods or procedures, or warning signs.

If you have applied all reasonable administrative controls, consider if risks still remain.

If so, use personal protective equipment (PPE).

Administrative controls and PPE are the least effective controls as they rely on human behaviour or supervision to work.

For example, policies and procedures to manage hazardous tasks only remain effective if workers consistently follow procedures and do not make mistakes.

It is okay to use administrative controls and PPE when they are combined with other more effective controls (as a back-up). For example, patients suspected of having an infectious disease may need to be isolated from others, and workers caring for them may need to wear a fit-tested face mask, gloves and gown.

If not used in combination with other controls, administrative controls and PPE should only be used:

- as a short-term interim measure until a more effective way of controlling the risk can be used, or
- when there are no other controls available (as a last resort).

You should make sure the controls you use do not introduce any additional hazards or risks. For example, a robot vacuum cleaner may reduce risks related to cleaning by people but may pose a trip hazard.

What is reasonably practicable?

‘Reasonably practicable’ is a legal requirement under WHS laws. It means doing everything **you** reasonably can to keep workers and others in the workplace safe.

When you are using controls to manage WHS risk, the control (or combination of controls) must:

- provide the highest level of protection for people and be the most effective and reliable (i.e. controls located towards the top of the **hierarchy of controls**)
- be available to use in the workplace, and
- be suitable for your workplace and your workers.

The cost of eliminating or minimising risk is relevant in determining what is reasonably practicable. However, there is a clear presumption in favour of safety over cost. Choosing a low-cost option that provides less protection simply because it is cheaper is unlikely to be considered a reasonably practicable way of eliminating or minimising risk. The cost of eliminating or minimising risk must only be taken into account after **identifying and assessing the risk** and the available ways of **eliminating or minimising the risk**.

If your organisation faces resourcing pressures this does not remove your legal responsibilities to manage WHS risks.

You should also consider other legislative requirements or standards that may influence or contain information about how to manage risks. Sometimes, how you manage risks may need to comply with both WHS laws and other legal frameworks at the same time.

Good work design

Designing the workplace and the work itself so that it is free from WHS hazards is the best way to prevent work-related fatalities, injuries and illnesses. This process is known as 'good work design'.

Good work design can address the root causes that contribute to risk, meaning you do not need to rely on less effective controls (such as influencing human behaviour).

To be most effective, good work design should begin at the earliest possible opportunity (e.g. when designing a new work task or a new building). It should also be considered whenever there are changes to work or the work environment.

Things to consider for good work design

The work: how work is performed, including the physical, mental and emotional demands of tasks and activities, the duration, frequency and complexity of tasks, and the context and systems of work.

Physical environment: the workplace itself, the equipment, materials and substances used, and the vehicles, buildings and structures.

Systems and processes: including information technology, business management, products and services, supply chains, and human interaction, including with patients or customers.

Workers: their physical, emotional and mental capacities, preferences and needs

Essentially good work design requires you to consider all aspects of work and how they are designed and interact with each other.

For more information, see the following resources:

- Safe Work Australia's resources on *Good work design*
- the *Code of Practice: Safe design of structures*, and
- the *Code of Practice: How to manage work health and safety risks*.

2.4 Review controls

Safety is not a 'set-and-forget' exercise. **You** must closely monitor and regularly review controls to ensure they are working as planned, are not creating new risks and to account for changes that happen in the workplace. Consider if there is something more or different you need to do to keep workers and others safe.

Reviewing controls should be done regularly and must be done:

- when the control does not work effectively
- when more could reasonably be done to eliminate or minimise risks
- before changes at the workplace that might result in new or different WHS risks
- when new hazards or risks are identified
- if the results of consultation indicate a review is necessary, or
- if an HSR requests a review for one of the reasons stated above, or if they believe **your** review of control measures was inadequate.

Reports, incidents, complaints (including informal complaints) or grievances from workers may identify new hazards or risks and should trigger a review. These do not have to be raised in a WHS context to be seen as a WHS issue. For example, a worker raising concerns about excessive work hours may indicate that the risk of fatigue is not being managed well in the workplace.

Questions to consider may include:

- Are controls working effectively, without creating new risks?
- Have risks changed or are they different to what you previously assessed?
- Are workers (and their representatives if they have them) actively involved in and consulted on the risk management process?
- Are workers open to raising WHS concerns and reporting problems promptly?
- Are workers trained to identify and report WHS concerns?
- Are there any upcoming changes that might result in a worker being exposed to new or different risks?
- Are new controls available that might better control the risks?
- Have risks been eliminated or minimised as much as they reasonably can be?

If the effectiveness of the controls is in doubt, go back through the risk management steps, review your information and make further decisions about controls in consultation with workers.

Information, training, instruction and supervision

You must ensure, as much as you reasonably can, that workers receive any information, training, instruction or supervision needed to protect everyone in the workplace from WHS risks. Information, training or instruction provided to a worker must be suitable, taking into account:

- the nature of the work
- the nature of the risks associated with the work, and
- the controls being used.

You must also ensure (as much as you reasonably can) that information, training and instruction are provided in a way that workers can easily understand.

Many workers in the healthcare and social assistance industry are from culturally and linguistically diverse backgrounds.

You have a legal responsibility to make sure the information, training and instruction they receive about WHS is easy for them to understand.

If your workers do not speak or understand English well or are new to the workforce, you could consider using translated materials, pictures or diagrams to demonstrate certain procedures, or additional supervision and training to ensure they understand how to perform their work safely.

Training programs should be reviewed regularly, including when there is change to:

- work processes (e.g. fatigue management, risk management), and
- controls (e.g. if using new equipment, ensure workers are trained in how to use it safely).

You should keep records of the training given to your workers.

Since supervisors and managers are workers, they must also be provided training relevant to their role.

Supervision

The level of supervision provided to workers depends on different factors, including the level of risk associated with a task, and the experience of the worker performing the task. For example, higher levels of supervision may be needed for workers who are new to the workforce, or who haven't done a particular task before.

Leadership commitment

Genuine commitment by **you** and your leaders is essential to managing WHS risks effectively. Leadership plays a crucial role in creating safe, respectful workplaces. Leaders, through their governance arrangements, actions and resourcing decisions, actively shape the organisation and the way work is undertaken. These decisions will, directly and indirectly, impact how effectively an organisation manages WHS risks.

Leadership can drive cultural change within organisations. You and your leaders need to:

- understand WHS risks in your organisation, and your legal responsibilities to address them
- **consult** genuinely with workers (and their representatives) about how to improve WHS in the workplace
- take WHS risks seriously by matching words with real action (e.g. make it easy and accessible for workers to report WHS risks and incidents)
- allocate enough staff and resources to eliminate or minimise WHS risks as much as you reasonably can
- model safe working behaviours, and challenge behaviour that does not align with good WHS practice (e.g. not following safety procedures or engaging in bullying or harassment), and
- communicate clearly about actions being taken to address WHS risks.

Positive engagement with HSRs and unions demonstrates a commitment to preventing WHS hazards. Encouraging workers to become leaders themselves by supporting active HSRs can also make a positive difference to a health and safety culture at work.

2.5 Consultation when managing WHS risks

Consulting with workers

You must consult with workers (and any HSRs if they have them) who are (or are likely to be) directly affected by a WHS matter.⁴ Consultation requires sharing information, giving workers a reasonable opportunity to express views and taking those views into account before making decisions.⁵

Note: Consultation is a legal WHS requirement and is separate to other consultation requirements, such as those under modern awards or enterprise agreements.

When must workers be consulted?

Workers must be consulted when you are identifying hazards and assessing WHS risks, and when you are making decisions about risk controls. All consultation must include any HSRs representing your workers. Note references to consultation with workers in this Code includes consultation with any HSRs. They must also be consulted on changes that could affect WHS, including:

- new policies, procedures and systems of work
- organisational restructures, changes to staffing levels, new reporting arrangements and work locations
- changes to tasks, workloads, duties and working arrangements, including rosters
- new technology, tools, plant, equipment, substances, structures and production processes
- the redesign of existing workplaces, and
- changes to the way information, training, instruction and supervision are provided.⁶

If you and your workers have agreed procedures for consultation, the consultation must be done in accordance with those procedures.

Different workers may be exposed to different risks and you should consult with a range of different workers to ensure you do not miss something. For example, you should consult with workers on different shifts, clinical and non-clinical staff, and staff who may be more exposed to particular hazards (e.g. women are more likely to experience sexual harassment).

You should ensure the way you consult is accessible, including by providing information in multiple languages where required.

For more information, see the *Code of Practice: Work health and safety consultation, cooperation and coordination*.

2.6 Consulting, cooperating and coordinating activities with other employers or organisations

WHS responsibilities can be shared between you and other employers, contractors or organisations, and more than one organisation can have the same legal WHS responsibilities at the same time. This could be because they are involved in:

- the same activities
- share the same workplace, or
- owe a duty towards the same set of people (e.g. a security guard working for a private security company but contracted to work in a hospital may be owed a duty by both the security company and the hospital).

4. Work Health and Safety Act s 47.

5. Work Health and Safety Act) s 48.

6. Work Health and Safety Act s 49.

Where more than one person shares a duty with someone else, each person retains responsibility to meet their duty. They must do so to the extent to which they can influence and control the matter.

You must consult, cooperate and coordinate with each other on WHS risk management when you share a duty, as much as you reasonably can.⁷ This will help each employer or contractor more easily and effectively control risks, and assist them to meet their duties.

It is best to sort out how risks will be managed between different employers and contractors before work begins. You can build WHS risks management arrangements into contractual agreements (although each organisation still retains its **primary duty** to ensure health and safety).

Further guidance is available in Safe Work Australia's *Principles that apply to work health and safety duties* and in the *Code of Practice: Work health and safety consultation, cooperation and coordination*.

Case study – Consulting, cooperating and coordinating activities in aged care

An aged care facility engages a catering company to provide resident meals. The facility has some influence over the type of food prepared for residents and owns and maintains the equipment in the kitchen. However, the facility does not control the everyday work activities of the catering company.

The facility consults with the catering company to satisfy themselves that the catering company has adequate systems in place to ensure the health and safety of workers. The catering company cooperates by verifying that its workers have been trained in food preparation, that food is kept at a safe eating temperature, workers are not exposed to manual handling risks when loading/unloading food trolleys or doing washing up, and that workers are provided with personal protective equipment (PPE).

Workers of the catering company will deliver food to the aged care facility at various times, including in the early morning and late at night. The catering company cooperates with the facility to make sure its workers are aware of and follow security processes. For example, the facility ensures that catering workers have access to the facility's carpark after hours, which is secured with good lighting and easy access to the goods lift. They also coordinate to ensure catering workers are provided with security passes, appropriately vaccinated to reduce risks to residents, and trained in security protocols and emergency procedures.

Case study – Consulting, cooperating and coordinating activities in disability support

A disability services provider offers support by allied health and support workers to clients in their homes. Workers are allocated a case load and expected to deliver services at a frequency set out in each client's care plan. Workers attending client's homes often feel pressured to deliver additional services requested by the clients, who they have developed relationships with. Clients with more complex needs, who require additional attention, are not allocated additional time.

The service provider's management team consult with staff to understand their workload and other factors impacting their health and safety. They develop clear service standards and provide these to all clients. These state that services cannot be provided that are out of scope, and clients with more complex needs must be given more time for visits. Caseloads are regularly reviewed to ensure that clients with complex needs are allocated fairly among workers, so that workers do not have more complex clients than they can safely support.

7. Work Health and Safety Act 2011 s46.

2.7 Interim or emergency control measures

Some types of controls take time to get right (e.g. controls that involve designing work processes, or physical changes to the work environment requiring planning and approval). In these circumstances, and when you are not reasonably able to eliminate the risk, you may need to put short-term, interim controls in place in the meantime to minimise the risk. However, you should not let these short-term controls stay in place as a permanent fix.

If you identify a hazard that poses an immediate or significant danger to people, then immediate action is required. This may require you to stop the unsafe work until appropriate controls are put in place, isolate the hazard or put temporary controls in place until the hazard can be addressed permanently.

2.8 Incident notification

Some WHS incidents are 'notifiable incidents' which **you** must report to SafeWork NSW. Notifying SafeWork NSW of 'notifiable incidents' can help identify causes of incidents and prevent similar incidents at your workplace and other workplaces.

A 'notifiable incident' is:

- if someone dies
- a serious injury or illness, or
- a dangerous incident that exposes someone to a serious risk (even if is a 'near miss' or if no one is injured).

An incident is only a notifiable incident if it happens as a result of work. For example, if an elderly patient dies of natural causes in a hospital, this is not a notifiable incident. However, if a patient dies due to a medication mix-up, this is a notifiable incident.

If a notifiable incident occurs, you must:

- report it to SafeWork NSW immediately after you become aware it has happened, and
- preserve the incident site until an inspector arrives or directs you otherwise. This doesn't prevent you helping an injured person, removing a deceased person, making the site safer, or assisting with a police investigation.

Call 000 if there is an immediate risk to life.

Contact SafeWork NSW for advice on how to make a notification.

You can find more information on incident notification in Safe Work Australia's *Incident notification information sheet*.

3. Hazards, risks and controls

This section outlines common hazards and risks in the healthcare and social assistance industry, and considers how to eliminate or minimise them, including by providing examples and case studies.

It covers the following topics:

- hazardous manual tasks
- fatigue
- psychosocial hazards
- work-related violence, aggression and harassment
- biological hazards
- hazardous chemicals
- work environment hazards
- slips, trips and falls
- equipment hazards
- vehicle hazards
- electrical hazards

3.1 Hazardous manual tasks

Key messages

Many workers in the healthcare and social assistance industry are required to do jobs that involve manual tasks (using the body to move or hold objects or people). Hazardous manual tasks can cause different types of musculoskeletal disorders (MSDs), a broad term that refers to any injury to, or disease of, the musculoskeletal system.

MSDs are preventable, but they do not always have a single cause. Their causes can be complex and relate to a range of different factors in the workplace, including both physical and **psychosocial factors**. These hazards can interact or work together to increase risks, so they should not be considered or controlled in isolation.

People handling is one of the most common causes of MSDs in the healthcare and social assistance industry.

What is a hazardous manual task?

A hazardous manual task is a task that requires a person to use their body in a way that involves one or more of the following:

- a repetitive or sustained force (e.g. a nurse pushing a bed across a carpeted area)
- high or sudden force (e.g. a support worker moving a client up a bed)
- repetitive movement (e.g. an aged care worker folding sheets)
- sustained or awkward posture (e.g. a radiographer twisting when positioning a person for an X-ray), or
- exposure to vibration (e.g. a dentist using a drill).

Common hazardous manual tasks in the healthcare and social assistance industry include:

- people handling
- laundering linen
- catering or cooking activities, and
- medical and diagnostic tasks (e.g. ultrasounds, surgery, or laboratory processing).

These hazards can put stress on the body and either directly cause, or contribute to, an injury.

MSDs can be caused by sudden damage (e.g. when a load being handled changes position causing a wrist sprain) or through gradual wear and tear (e.g. through repeated stress on the same part of the body). For more information, see the *Code of Practice: Hazardous manual tasks*.

What is ‘people handling’?

People handling is a hazardous manual task. It refers to any workplace activity where a person is physically moved, supported or restrained.

These tasks may expose workers to risk factors including:

- awkward or sustained postures
- high or sudden force, or
- sudden movements of the person being handled.

Examples of people handling tasks include:

- a security guard restraining a person behaving violently.
- a nursing assistant transferring a person from a bed to a chair without assistance in an aged care facility.
- a nurse supporting the leg of a patient with bariatric needs while dressing a wound.
- a community support worker helping a client to shower at home.

Most people handling activities have a high potential to cause injuries to workers if suitable control measures are not used.

WHS duties for hazardous manual tasks

You have specific responsibilities under WHS laws to manage MSD risks from hazardous manual tasks.

When deciding on controls, you must consider anything that could cause or contribute to an MSD, including:

- postures, movements, forces and vibration
- how long and how often a task happens
- workplace environmental conditions (such as temperature, lighting or noise) and how they might affect the task or the worker
- design of the work area (e.g. a nurse’s workstation or utility room in a hospital, or the home of someone receiving disability support)
- layout of the workplace (e.g. Is there enough space to use equipment such as hoists, walking aids, or larger chairs for patients with bariatric needs? Is the equipment appropriate? Does the facility need updating?)

- systems of work used (e.g. Are there enough workers for the task and have they been trained? Are there enough workers rostered on? Are there strategies to manage high job demands during busy periods? Are risk assessments conducted before providing service and before workers visit clients' homes? Is there a requirement for a care plan for patients with bariatric needs?), and
- the nature, size, weight or number of persons, animals or things involved in a hazardous manual task (e.g. How often does people handling occur? How many objects need to be moved? Is the person being moved likely to be aggressive? Do they have any medical conditions impacting the task?)

Designers, manufacturers, importers and installers of equipment also have WHS responsibilities to reduce the exposure of workers to MSD risks from hazardous manual tasks.

For more information see [Who has WHS legal responsibilities](#), [Managing WHS risks](#), and *Code of Practice: Hazardous manual tasks*.

Managing the risks of hazardous manual tasks

Risks related to hazardous manual tasks can be managed through **good work design**, and must follow the **hierarchy of controls** and involve effective **consultation**.

When managing the risks of people handling, **you** must consider the characteristics of the person being handled, and (where appropriate) consult with them, their family members or other carers or service providers to determine the best way to manage risks.

If handling a person creates WHS risks, you must eliminate or minimise risks as much as you reasonably can. MSD risks are not 'part of the job' for healthcare and social assistance workers and must be prevented wherever possible.

No worker should lift or restrain a person (other than a small infant) by themselves. You should provide appropriate transfer devices (such as hoists, raising aids, slides, or electric hospital beds) and ensure these are well-maintained. You should also provide enough workers to assist with people handling, and ensure they are trained to use and maintain equipment safely.

For more information see [Consultation when managing WHS risks](#) and *Code of Practice: Work health and safety consultation, cooperation and coordination*.

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**

Examples of when a risk assessment should be carried out:

- Before a hazardous manual task is carried out (e.g. person is handled).
- At regular intervals or when change is identified (e.g. following changes in a person's medical condition, or when changing from a 'one-person assist' to 'two-person assist' with tasks).
- When developing a hazardous manual task register or safe work procedures with your workers.
- When worker consultation has identified difficult tasks, or where there are ineffective, broken equipment or equipment not available for use. When consultation with workers has identified difficult tasks
- When equipment is ineffective, broken or unavailable.
- When identified by a HSR or others, such as a family member.

Identify if the manual task is hazardous and what risk factors directly stress the body:

- repetitive or sustained force (e.g. sustained hand force during surgery)
- high or sudden force (e.g. loading a wheelchair into the back of a vehicle)
- repetitive movement (e.g. washing pots in a kitchen)
- sustained or awkward posture (e.g. working at a fume hood in a laboratory), or
- exposure to vibration (e.g. cutting open a cast).

What is the risk of MSD?

- How often and how long are specific postures, movements or forces performed/held?
- How long is the task?
- Does the task involve high or sudden force?
- Does the task involve vibration?

Examples of things to consider when understanding the risks (noting these can combine):

- Nature of the task (e.g. working in an awkward position for sustained periods).
- Design and layout of work areas (e.g. unable to use equipment because the equipment does not fit through the door, bending and reaching are needed because items are placed too far from the worker).
- Nature of items, equipment or tools (e.g. hoists are not fit-for-purpose for the task or are poorly maintained meaning they may break when lifting a patient).
- Accessibility of equipment (e.g. if workers need to go searching for equipment, or batteries are not charged, they are unlikely to use it).
- Characteristics of the person being handled (physical) (e.g. the person's weight and girth, types of injuries the person may have, or if the person has an infectious disease).
- Characteristics of the person being handled (non-physical) (e.g. unpredictable behaviours, their willingness to assist with the handling process or ability to communicate).
- Location of load and distances moved (e.g. storage above shoulder or below knee height, or load required to be carried a long distance).
- Systems of work (e.g. working alone, inadequate breaks or task variety, unreasonable timeframes, high workload, insufficient staff numbers, hours worked, communication between organisations or disciplines, maintenance schedules, procurement processes).
- Work environment (e.g. poor housekeeping or storage practices may lead to awkward postures from reaching and bending over, cold temperatures may increase the risk of muscle injuries).
- Individual factors (e.g. the worker's training, skills and experience, pre-existing injuries, types of clothing worn, footwear and PPE used).

Summary: How you should control risks

Consult with workers and **others** to design **controls**.

If risks cannot be eliminated, minimise risks as much as you reasonably can using the **hierarchy of controls**. The following are examples of controls for hazardous manual tasks:

- **Eliminate** the risks of MSDs where possible, including through **good work design** (e.g. design building with enough space for automated systems such as medication dispensers or sterile trolley washers).
- **Substitute** the hazard with a safer alternative (e.g. use microfibre mops instead of string mops, install a dishwasher to reduce the number of plates that need to be washed by hand, replace heavy wheelchairs with lighter ones, buy pre-sliced vegetables).
- **Isolate** the hazard from any person exposed to it (e.g. set up a physical barrier around a machine that produces harmful vibration or noise).
- **Engineering controls** (e.g. hoists, automatic beds, auto-pipettes in laboratories, wheelchairs and other assistive devices that reduce the need for patient handling, motorised trolleys).
- **Administrative controls** (e.g. develop a regular procedure for inspecting and maintaining equipment to ensure it remains safe to use, train workers in how to use equipment safely, improve rosters to reduce physical fatigue).
- **Provide PPE** (e.g. shoes with a good grip that will prevent workers from slipping when doing manual tasks)
- Use a combination of control measures to effectively eliminate or minimise risks.
- Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

For more information see the SafeWork NSW website.

Case study – People handling in aged care

A nursing assistant works in an aged care facility and their daily tasks involve people handling, performing care tasks, and using equipment. The aged care facility has a high number of residents with limited mobility, increasing the risk of injury to workers when performing people handling tasks.

The nursing assistant recently reported some shoulder pain to their supervisor. The management team was concerned and investigated by talking to workers, observing tasks, considering other hazards and risks in the workplace, and reviewing mobility assessments and various reports.

They found many of the facility's hoists had not been maintained and could no longer be used safely. Staff had reported this but not all the equipment had been fixed or replaced. Due to staff shortages and work demands in providing prompt care for residents, workers felt they lacked the time to wait to use the limited number of working hoists, and so had been manually lifting people.

After consulting with their staff, the facility established a system and budget for inspecting, maintaining and replacing equipment. They reviewed the staff roster, which was found to be not properly accounting for routine staff absences. More staff were rostered on around times when residents were found to need more mobility support, such as mealtimes. They also formed a health and safety committee to ensure future WHS problems in the workplace were identified and acted upon.

Case study – Patient in home-based care

A newly qualified disability support worker was employed by a labour hire company to provide in-home support to a client. The worker, who had limited English language skills, was given a Support Plan for the client that included over 50 pages of detailed information related to their medical history and support needs. When they arrived at the home, the worker saw that assistive equipment was available, but they had not been trained to use it. The worker was unable to find the information they needed in the Support Plan. When the client needed to be moved, the worker attempted to use a hoist which had not been set up properly, and the client was injured.

A subsequent investigation found the worker had not been given adequate training, instruction and support, creating WHS risks. Following a risk assessment and worker consultation, the company developed safe work procedures requiring that new workers be paired with more experienced workers until they could demonstrate the required competencies in practice. The company designed a new template (with a two-page summary) for reporting the client's support needs, which includes pictures for workers with lower levels of English.

3.2 Fatigue

Key messages

Fatigue can be both a direct health risk to workers by itself and can also cause or contribute to other WHS risks when workers become fatigued. Fatigue is often seen as 'part of the job' in the healthcare and social assistance industry. However, this is not the case, and **you** have a legal responsibility to eliminate or minimise the risk to health and safety from fatigue as much as you reasonably can.

In some industries, such as aviation, the risks of fatigue are well-recognised. Most people understand that a pilot must not fly a plane when they are too fatigued to do so safely. This same principle applies in the healthcare and social assistance industry. Workers, patients, and others in the workplace must not be put at risk of harm because a worker's judgment or reaction times are impaired by fatigue. Likewise, **your** duty to manage the risks of fatigue are not removed by the need to care for patients, a worker's preference for certain shift patterns, their willingness to work extra hours or to come to work when fatigued.

What is fatigue?

Fatigue is an acute and/or ongoing state that leads to physical, mental or emotional exhaustion.

Fatigue can cause health and safety risks. It can directly harm workers (e.g. fatigue can cause heart conditions, musculoskeletal disorders, diabetes, high blood pressure and other health conditions). Fatigue can also impair judgment and slow reaction times, which may increase the risk of injuries, unless safety systems are in place.

For example, fatigue increases the risk of sharps injuries and medication errors.

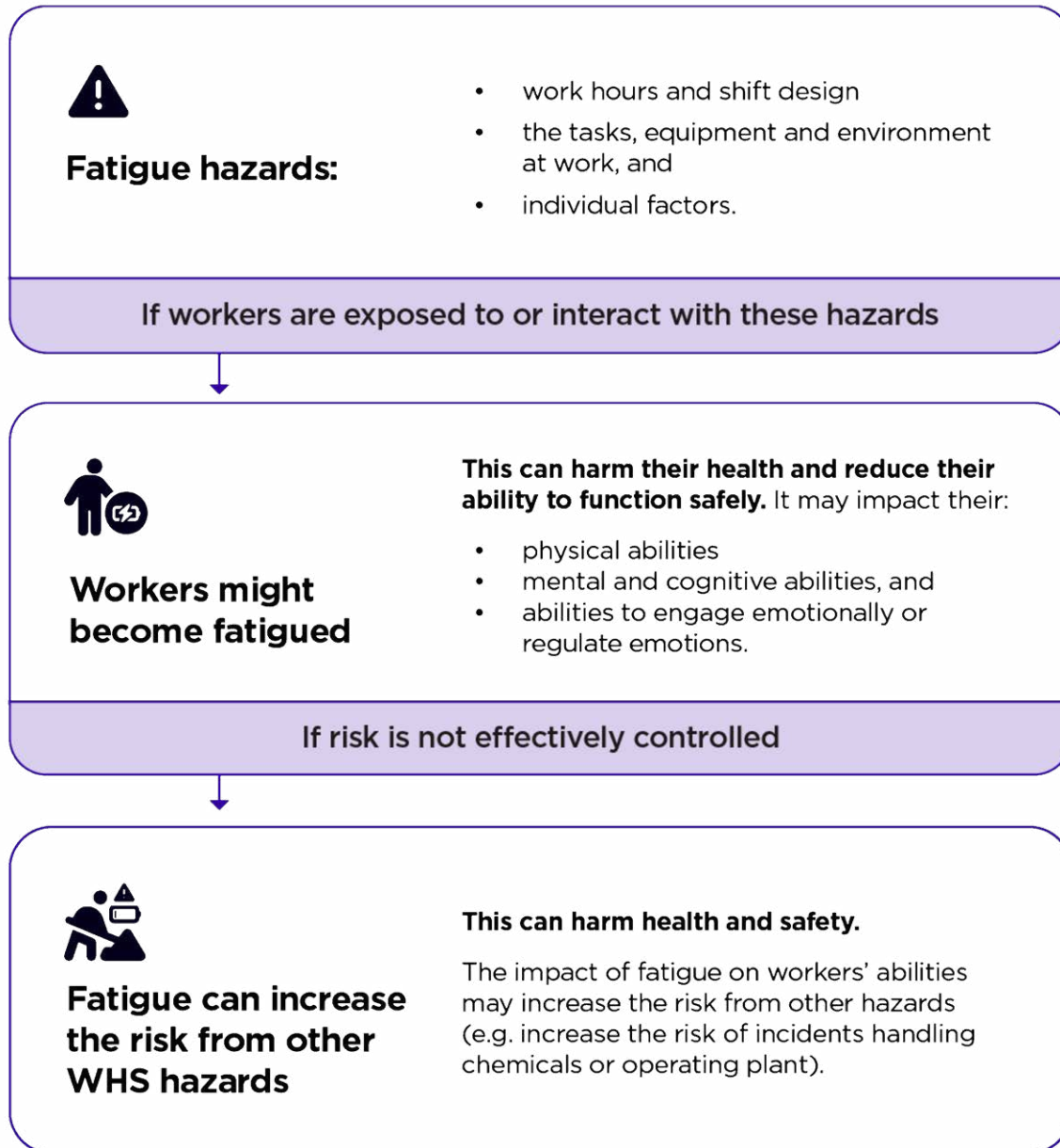
Fatigue is more than feeling tired or drowsy. It can be:

- physical – pronounced physical exhaustion and a reduced ability to engage in physical activities (e.g. manual tasks or long or irregular working hours)
- mental – pronounced mental exhaustion and a reduced ability to engage in mental or cognitive activities (e.g. making complex decisions about patient care)
- emotional – pronounced emotional exhaustion and a reduced ability to engage in emotional activities (e.g. empathising with or caring for patients), or
- a combination of any of these.

Workers can become fatigued because of things that happen at work, outside of work (e.g. long hours of physically demanding domestic tasks) or because of a combination of work and non-work fatigue hazards. The way work is rostered and changed (e.g. constant and repetitive sleepover shifts, changes from night to day work) can also impact life outside of work for workers.

You must identify, understand and control fatigue hazards to prevent WHS risks.

Figure 5: How fatigue causes harm



WHS duties for fatigue

You must manage fatigue hazards at work by eliminating or minimising the risk of fatigue as much as you reasonably can. For example, you must:

- provide a safe work environment (e.g. install adjustable, low-vibration seats in vehicles, foster a culture where workers feel comfortable reporting fatigue)
- implement safe systems of work (e.g. by not allowing workers to work shifts that are too long, providing adequate breaks between shifts and rostering on enough people to do the work), and
- monitor workers' health and the conditions at the workplace (e.g. by reviewing time sheets).

Your duties are not removed by a worker's, or client's, preference for certain shift patterns, their willingness to work extra hours or to come to work when fatigued. You have a duty to ensure workers, patients, clients or members of the public are not put at risk because a worker's judgement or reaction times are impaired by fatigue (e.g. while performing surgery, checking medications or driving).

WHS responsibilities to manage the risks of fatigue do not mean workers can never work extra hours or multiple jobs. However, they should talk to their manager or supervisor about the risk of fatigue and avoid working arrangements that result in WHS risks.

Managing risks of fatigue

Some fatigue hazards are common in the healthcare and social assistance industry (e.g. double shifts, being on call, frequent travel between clients or locations and doing physically, emotionally or mentally demanding work). Workers are more likely to become fatigued when exposed to a combination of fatigue hazards. Fatigue can be caused by a single instance of exposure to hazards, or over time with repeated or long-term exposure. Fatigue risks can be separated into:

- the risk of workers becoming fatigued which can directly cause health problems, and
- health and safety risk from fatigue-related incidents.

Rostering and staffing levels can significantly impact the risk of fatigue to workers. In the healthcare and social assistance industry, these factors may be determined by a client's Support Plan. You may need to liaise with a client, their family, advocate, planner, navigator or guardian to ensure they have appropriate funding and support for workers to be rostered safely.

For more information, see the [Managing WHS risks](#) section.

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**

Examples of factors to consider when identifying fatigue risks:

- Work hours and shift design
 - working long hours (e.g. 'double shifts', excessive overtime)
 - working irregular hours (e.g. 'on call' work)
 - working during normal sleep times (e.g. night shifts)
 - regular sleepover shifts or disturbed sleep
 - backwards rotating shifts (night-evening-day)
 - breaks during shifts insufficient or tightly scheduled
 - extended travel times that reduce sleep opportunity.

- Tasks, equipment and environments
 - physically demanding, challenging or tiring work (e.g. **lifting or moving patients**)
 - responding to distressing or traumatic situations (e.g. providing emergency care)
 - providing emotional support (e.g. breaking difficult news to patients or families)
 - vicarious trauma
 - tasks requiring concentration where errors have a high risk (e.g. performing surgery)
 - workplace culture (e.g. are workers supported to report fatigue?)
 - exposure to other **psychosocial hazards**, and
 - exposure to repetitive or loud noises (e.g. noise from medical equipment).
- Individual factors (both work and non-work)
 - significant time since last sleep (e.g. a worker at the end of a 'double shift')
 - limited work experience (e.g. new workers needing to concentrate harder on tasks)
 - workers with additional domestic or caring responsibilities
 - barriers to understanding WHS information (e.g. due to literacy or language skills)
 - barriers to raising WHS issues (e.g. power imbalances, fear of impact on registration)
 - working multiple jobs (e.g. labour hire workers, platform workers or contractors).

Health and safety risks from fatigue are greatest where:

- workers are doing hazardous work (e.g. driving, working with hazardous chemicals including cytotoxic drugs, working with biological hazards (including infectious diseases), performing surgery, administering medication, performing hazardous manual tasks, or operating equipment)
- there are insufficient risk controls for harmful behaviours (e.g. **harassment**, violence and aggression)
- there are insufficient systems to prevent fatigue-related errors (e.g. workers are required to memorise patient information, or manually calculate medicine doses without checks, switches on machines are not labelled and critical switches guarded to prevent accidental activation, or PPE is not provided).

Summary: How **you** should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks as much as you reasonably can by preventing workers from becoming fatigued, including through **good work design**.

If risks cannot be eliminated, minimise risks as much as you reasonably can. Consider the following example controls:

- Work hours and shift design – example controls
 - Monitor actual time worked against the roster and identify real work hours
 - Provide enough workers, time and resources to do the job safely
 - Ensure workers have adequate and regular breaks to rest, eat and rehydrate
 - Ensure sleepover shifts are appropriately rostered and workers can wake rested
 - Use forward rotation roster systems (day-evening-night)
 - Schedule hazardous work requiring high concentration outside low body clock periods (i.e. between 2 am and 6 am).
 - Allocate shift and night workers consecutive days off to allow for at least 2 full nights' rest, including some weekends.

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- Task, equipment and work environment –example controls
 - Rotate workers through physically, cognitively or emotionally demanding tasks (e.g. rotate workers through tasks such as providing bad news)
 - Plan tasks and select equipment to remove unnecessary work
 - Ensure the workplace and surroundings are well lit, safe and secure
 - Implement safeguards for hazardous tasks requiring concentration (e.g. provide PPE, implement safety switches on equipment, provide appropriate signage to warn workers of hazards).
 - Select equipment which minimises hazards from noise and vibration.
 - Provide suitable rest areas for workers where appropriate (e.g. so they can rest before driving home in remote areas or when working long shifts or overtime)
 - Individual worker –example controls
 - Recognise workers have both work and personal commitments, and design shift rosters that enable them to meet both
 - Develop a clear policy for managing fatigue, with procedures for monitoring WHS risks
 - Give additional support or supervision to workers who are new or returning to work after a period of extended absence
 - Provide information to workers about how to manage fatigue (e.g. how to transition on and off the night shift)
 - Give notice of shifts –particularly any long, irregular or night shifts to allow workers to plan their sleep and other responsibilities

Many of the control measures to prevent fatigue can also help workers recover. For example, providing adequate time between shifts, increasing breaks and minimising job demands.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Fatigue in healthcare

After a medication administration error, a large city hospital conducted an investigation. The investigation found the nurse who made the error had worked more than 240 hours that month, including many long shifts of 10 hours at night and 12 hours in the day. The nurse had also worked night shifts at short notice to fill in for absent staff. The unit manager had not been able to call in replacement staff because of budget constraints. The nurse had also often worked shifts on backward rotation, and did not have 2 days off in a row for the entire month.

The investigation revealed there was no monitoring of the actual hours worked by staff, or consideration of whether they were too fatigued to do their job safely. Following the investigation report, the hospital developed a ‘safe hours’ policy with clear guidelines to minimise the risk of fatigue, including:

- a forward-rotating roster system
- a maximum number of night shifts that could be worked in a roster cycle
- a minimum number of days off in a roster cycle
- minimum break times between shifts
- escalation options for requesting replacement staff in certain situations
- monitoring and recording of actual hours worked, and
- monitoring of staff fatigue, and procedures for reporting this.

3.3 Psychosocial hazards

Key messages

Psychosocial hazards are common in the healthcare and social assistance industry and can cause psychological harm. The specific psychosocial hazards workers are exposed to, and how they are exposed, varies between workplaces and roles. Psychosocial hazards may interact or combine to create new, changed, or higher risks, so they need to be considered together when managing risks.


Just because psychosocial risks are common at your workplace, it does not mean they can be treated as ‘part of the job’ and ignored. **You** must identify, assess and control the risks caused by psychosocial hazards. You must eliminate or minimise these risks as much as you reasonably can.

The best way to do this is to prevent psychological harm from happening in the first place. Initiatives aimed at improving worker well-being, such as counselling or EAP services, are aimed at responding to psychological harm that has already occurred, instead of preventing it. These do not meet your duty to eliminate or minimise psychosocial risks to workers.

See the *Code of Practice: Managing psychosocial hazards at work* for more information.

What is a psychosocial hazard?

Psychosocial hazards are work-related hazards that can cause psychological (as well as physical) harm.



Psychosocial hazards that may arise at work:

- High or low job demands
- Low job control
- Poor support
- Violence and aggression
- Bullying
- Harassment including sexual harassment
- Traumatic events or material
- Lack of role clarity
- Poor organisation change management
- Remote or isolated work
- Poor physical environment
- Conflict or poor workplace relationships and interactions
- Inadequate reward and recognition
- Poor organisational justice

Table 1 below sets out common psychosocial hazards in the healthcare and social assistance industry.

Psychosocial hazards may be described and grouped differently. The language is not as important as ensuring you identify what could cause harm and manage the risks.

Table 1: Common psychosocial hazards in the healthcare and social assistance industry

Type of psychosocial hazard	Examples
<p>High job demands</p> <p>Sustained or intense high levels of physical, mental or emotional effort that creates stress.</p> <ul style="list-style-type: none"> • The risk is higher when the demands: <ul style="list-style-type: none"> • exceed the workers' skills • are unachievable • last a long time • are frequent • are significant. <p>A job can include periods of high and low job demands and a combination of mental, emotional and physical demands.</p>	<p>Physical demands</p> <p>Inadequate worker to patient ratios or client pressure to work faster or not take breaks.</p> <p>Inadequate time, resources and staffing allocated to tasks.</p> <p>Being discouraged by managers, or through a personal sense of duty, from taking time off due to limited staffing.</p> <p>Being under pressure to deliver care to each patient within a strict time limit leading to tasks being done too fast and causing risk of physical injury.</p> <p>Insufficient staff for safe patient handling or to respond to aggression.</p> <p>Mental demands</p> <p>Having too much to remember, without systems in place to help record information and provide reminders at the right time.</p> <p>Not having sufficient time to think about how to approach a difficult, complex or high-risk situation or how to prioritise competing tasks.</p> <p>Providing care to multiple people with complex needs and comorbidities, creating a high-stakes fear of error, particularly when combined with a lack of support or guidance from supervisors.</p> <p>Emotional demands</p> <p>Responding to distressing and emotional situations or providing support and empathy to people in need (e.g. communicating a difficult diagnosis).</p> <p>Exposure to traumatic events or material (e.g. providing care to victims of abuse or violence, or patients with a short life expectancy).</p> <p>Being concerned about being blamed if things go wrong.</p> <p>Having to rapidly switch between emotional situations (e.g. a midwife working with a woman in labour, a woman losing a planned pregnancy, and a planned termination around the same time).</p>
<p>Low job control</p> <p>Workers having limited control over the work, including how and when it is done.</p>	<p>Micromanaging work, including intense oversight, surveillance and control over how work is done, particularly in absence of strong reasons for this or when levels of autonomy do not match a workers' abilities.</p> <p>Workers have limited ability to adapt the way they work or apply their judgement.</p> <p>Lack of consultation about changes that impact work.</p> <p>Workers feel unable to advocate for patients or clients at due to fear of reprisal.</p>

Type of psychosocial hazard	Examples
<p>Poor support</p> <p>Not being given enough support, including from supervisors or other workers, or not having the tools or resources to do the job.</p>	<p>Not being able to ask for help or discuss issues at work. Having a supervisor who is too busy or stressed to assist you or answer questions.</p> <p>Not having enough support or workers to meet responsibilities</p> <p>Having faulty, outdated, or dangerous equipment, such as mobility equipment that needs repairs and is crucial to patient care.</p> <p>Incomplete, inconsistent or confused patient information. (e.g. not having clear records or instructions, lack of information sharing between services).</p> <p>Remote or isolated work where access to support is limited.</p> <p>Lack of fairness in decision-making and interactions. For example, providing critical feedback in front of others, or allocating shifts unfairly.</p> <p>Lack of managerial support for reporting WHS concerns and the prospect of reprisal action.</p> <p>Not having enough workers to do the work safely.</p>
<p>Harmful behaviours from other workers</p> <p>This includes:</p> <ul style="list-style-type: none"> • violence and aggression • bullying • harassment and discrimination, including sexual harassment or gender-based harassment, racism, ablism, agism, and • conflict or poor workplace relationships and interactions. <p>Note: Harmful behaviours from others in the workplace (e.g. patients, clients) are covered in the next section.</p> <p>See also the <i>Code of Practice: Sexual and gender-based harassment</i></p>	<p>Abusive, humiliating comments and conduct (e.g. making offensive comments about personal life in a work setting, isolating and ignoring, name calling, rumours, practical jokes).</p> <p>Undermining someone’s work, unreasonable performance expectations, unjustified criticisms or complaints.</p> <p>Inappropriate work scheduling or withholding of information.</p> <p>Unwelcome conduct including unwelcome touching, inappropriate staring and intrusive questions.</p> <p>Frequent rudeness, incivility and hostility (e.g. not acknowledging others, facial expressions and eye rolling, impatience and ‘snappy’ responses).</p>

Type of psychosocial hazard	Examples
<p>Traumatic events or material</p> <p>Reading, hearing or seeing traumatic events or material, including abuse or neglect. Experiencing fear or extreme risks to the health or safety of themselves or others.</p> <p>Note: A person is more likely to experience an event as traumatic when it is unexpected, is perceived as uncontrollable or is the result of intentional cruelty. This includes vicarious (e.g. second-hand accounts) exposure and cumulative (e.g. repeated) trauma.</p>	<p>Providing care to victims of abuse or violence or communicating with their families.</p> <p>Providing care to patients with a short life expectancy or communicating with their families.</p> <p>Witnessing the death of a patient, especially when unexpected.</p> <p>Being exposed to violence or threats of violence. This could be from patients or other people (e.g. family members) at work.</p> <p>Inexperienced workers providing care or treatment to seriously injured or ill patients for the first time or where their usual duties involve minor injuries or illnesses.</p>
<p>Remote or isolated work:</p> <p>Working in locations with long travel times, or where access to help, resources or communications is difficult or limited.</p>	<p>Providing home-based care away from a supervisor and without support from other workers.</p> <p>Performing work alone and not being given a means to reliably communicate with other workers when support is needed.</p> <p>Driving long distances to work from different locations including clients' homes.</p> <p>Working in a location far away from supplies or resources needed, including in a large facility or hospital.</p>

Workers may use different language to describe psychosocial hazards. For example, they might say they feel:

- stressed, burnt-out⁸ or emotionally exhausted about their workload
- anxious or scared about talking to or dealing with an aggressive person
- humiliated, degraded or undermined by sexual harassment or discrimination
- angry about policies being applied unfairly
- confused about what their role involves, torn between competing priorities or 'feeling like a failure' for not being able to meet unrealistic expectations, or
- distressed, unable to sleep, or upset by exposure to traumatic situations.

8. WHO (World Health Organization), 'Burn-out an "occupational phenomenon": International Classification of Diseases', WHO, 28 May 2019, accessed 24 March 2025.

WHS duties for psychosocial hazards

You must manage the risks of psychosocial hazards in the workplace by eliminating them as much as you reasonably can. If you are not reasonably able to eliminate risks, you must minimise them as much as you reasonably can.

When deciding on controls for psychosocial risks, you have a specific legal duty to consider:

- how long, how often and how severely workers are exposed to psychosocial hazards
- how psychosocial hazards interact or combine with each other
- the design of work, including job demands and tasks
- systems of work, including how work is managed, organised and supported
- the design, layout, and environmental conditions of the workplace and workers' accommodation, including safe entry and exit and facilities (e.g. bathrooms) for the welfare of workers
- the equipment, substances and structures at the workplace
- workplace interactions or behaviours, and
- information, training, instruction and supervision provided to workers.

These factors will impact the risks in your workplace and will therefore assist you to find the best controls.

Managing psychosocial risks

When considering the matters above, you might think about how you can improve systems of work (deciding when and where specific tasks are done, which workers do tasks and with who), management of work (ensuring clear reporting structures and risk management plans in place) and support for workers (what equipment they need, working in pairs, providing backup in high-risk situations, and establishing post-incident de-briefings).

You might also think about how other hazards in the workplace, such as high job demands, are increasing the risk to workers when combined with the risks from harmful behaviours, such as bullying and harassment.

Information, training, instruction and supervision may be necessary to implement controls effectively. They may also assist in controlling some psychosocial risks, for example where low role clarity is creating a risk, information and training on the worker's role will help.

You will often need to use a combination of controls to effectively eliminate or minimise risks.

You must continually monitor and review controls to make sure they are working effectively and reliably. Some control measures may introduce new risks which must also be managed as much as possible. New hazards and risks might arise which means control measures may need to change to ensure WHS risks are prevented.

Short versus long-term controls

In the short term, you may implement controls such as adjusting rosters, extending shifts, redeploying staff internally, and deferring and delaying tasks until they have the resources.

However, over the longer term, you will have a broader range of actions you can take to meet your WHS duties – and you must take those actions if you reasonably can.

For example, while extended hours for existing staff or closing beds may be reasonable in the short term, over the longer-term there are a range of other options that can be used to further minimise risks, such as employing additional staff. And, if the risks to workers and others increases when exposure to psychosocial hazards is prolonged, it will be reasonable to do more to control the risk.

Summary: How you should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**

Examples of common psychosocial hazards:

- high job demands (e.g. too much to do in a period of time, not enough workers, exposure to traumatic situations)
- low job control (e.g. workers have limited say on how the job is done)
- poor support (e.g. poor organisational change management, poor organisational justice, poor physical environment, remote or isolated work)
- harmful behaviours (e.g. violence, aggression, bullying, harassment, sexual harassment, conflict and poor workplace relationships or interactions), including internally from colleagues or externally from others in the workplace such as patients.

Summary: How you should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks as much as you reasonably can by preventing psychosocial risks, including through **good work design**.

If risks cannot be eliminated, minimise risks as much as you reasonably can.

You must consider:

- how long, how often and how severely workers are exposed to psychosocial hazards
- how psychosocial hazards interact or combine with each other
- the design of work, including job demands and tasks
- systems of work, including how work is managed, organised and supported
- the design, layout, and environmental conditions of the workplace and workers' accommodation, including safe entry and exit and facilities (e.g. bathrooms) for the welfare of workers
- the equipment, substances and structures at the workplace
- workplace interactions or behaviours, and
- information, training, instruction and supervision provided to workers.

Example controls for reducing the risk of psychosocial hazards include:

Duration, frequency, severity and interaction with other hazards

- Rotate staff between roles so there are breaks with no traumatic or upsetting exposures. This could mean doing administrative work away from patients/residents/families.
- Limit overtime and extra shifts or reduce intensity of work for those working long hours.
- Consider how hazards may combine to increase the risk – for example if you cannot further reduce high work demands, make sure workers have greater support.

Physical work environment

- Design the workplace to minimise the need for physically demanding tasks or jobs. For example, locate storerooms and equipment in accessible areas close to where they are needed, and ensure walkways are suitable for the equipment being used.
- Provide appropriate spaces for:
 - tasks that require concentration without distraction
 - difficult conversations with patients and families, to allow privacy and reduce others' exposure to distressing information
 - workers to retreat away from patients and families following difficult and emotional situations, both for breaks, but also while continuing work on other tasks.
- Ensure good visibility where people work, including good internal and external lighting
- Ensure workers have access to safe areas to retreat to during an aggressive incident
- Providing separate facilities and amenities for workers which give privacy and security
- Provide access control to staff only areas (e.g. electronic swipe access)
- Good line of sight to prevent workers working in isolation.

Tools, equipment, substances, structures

- Provide tools and equipment that reduces human error, mental loads and exposure to distressing content (e.g. intuitive IT systems to capture patient information).
- Provide tools and equipment that help plan work safety. (e.g. shift scheduling software that identifies resourcing issues and prevents harmful schedules)
- Ensure tools and equipment is readily accessible in the location and at the time needed to reduce demands on staff (e.g. locate equipment next to or near where it will be used considering how urgently it may be needed; have sufficient equipment so workers do not need to compete for its use).
- Provide, maintain and test equipment that supports workers to seek assistance when needed (e.g. duress alarms for violence; call buttons or alarms for medical emergencies).

Design and management of work

- Plan and schedule resources to match the requirements of the task, considering:
 - staff leave, rest and recovery needs
 - staff expertise, training and supervision requirements
 - peak periods, ad hoc or unplanned tasks likely to add to workloads, and
 - retention and turnover rates
 - patient or client needs.
- Reduce the amount of work done each day using scheduling, work planning, delegation, and prioritisation of the most urgent tasks.
- Where you have a shortage of workers with particular skills and expertise, redesign tasks so other workers provide support (e.g. other workers do administrative parts of their role).
- Schedule regular reviews of workloads and worker to patient ratios to manage demands.
- Increase breaks and recovery time after exposure to a traumatic event.

-
- Share information about patients that present known risks to workers, especially where multiple workers or providers may be caring for the same patient.
 - Increase autonomy and flexibility in how workers prioritise and plan work tasks.
 - Allow workers flexibility to adapt their approach when dealing with high emotional demands or distressing situations.
 - Reduce frustrations between workers (e.g. avoid competition, be transparent about promotion decisions, minimise uncertainty about tasks or priorities).
 - Address power imbalances. Workplaces with low diversity (e.g. the workforce is dominated by one gender, age or cultural group) and some workforce characteristics (e.g. new and young workers, casual, workers from minority groups) are more likely to experience harmful behaviours.
 - Create accessible and user-friendly ways to report harmful behaviour informally, formally, anonymously and confidentially, and prevent retaliation against those who report.
 - Implement reporting systems for exposure to trauma and bullying and harassment (e.g. trigger a review of the incident and whether control measures are working as planned).
 - Provide support after traumatic events (e.g. support by supervisors, counselling and professional support).
 - Monitor the health of your workers following traumatic events (e.g. are there any changes to behaviour or increased absenteeism?).

Information, training, instruction and supervision

- Ensure supervisors and other relevant roles (e.g. HR) have the skills, experience and training to perform their role and support workers (e.g. provide development programs to improve skills, train supervisors to be empathetic leaders, including taking workers' concerns seriously, sensitively managing problems and helping when workers are struggling).
- Increase the number of specially trained / skilled workers (e.g. people handling or dementia care).
- Ensure new workers have additional support and supervision (e.g. not having them work alone, providing inductions, training and mentoring (i.e. buddy) programs).
- Provide information and training on behaviour expectations (e.g. sexual harassment), when and how to report, and policies on how harmful behaviours will be addressed.
- Ensure workers know what to do if they experience or see harmful behaviours at work.

Harmful behaviours from colleagues

- In some circumstances, poor internal workplace behaviours (including from supervisors, managers, or other workers) may be an inappropriate response to psychosocial hazards in the workplace, such as high job demands, lack of role clarity and inadequate support. (e.g. stress and fatigue among staff contribute to tension and a poor workplace culture. The first step in improving culture is to manage other psychosocial risks such as high job demands).
- Consider whether the workplace culture supports, tolerates, or ignores harmful behaviours, including lower level (but still harmful) behaviours like eye-rolling, name calling, teasing, sexual or gendered jokes, comments about a person's appearance, questions about a person's private life, and crude language.
- Address inappropriate or harmful behaviours early, even if workers 'seem ok with it' or no one raises a concern.
- Set, model and enforce acceptable behaviour standards for all people in the workplace, including through having clear policies.

- Encourage workers to report behaviours of concern and address barriers to reporting.
- Address all types of harmful behaviours (e.g. bullying, aggression, harassment, discrimination and incivility or disrespect) early and appropriately. This not only prevents behaviours escalating but workers will be less likely to report behaviours like sexual harassment if other harmful behaviours are not being addressed.

See the *Code of Practice: Sexual and gender-based harassment*.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

For more information on managing psychosocial hazards see the *Code of Practice: Managing psychosocial hazards at work*.

Case study – Harmful behaviours: in-home disability support services

A disability support service employs workers to provide in-home support to clients.

Among themselves, workers often discuss problems including:

- clients not having adequate equipment for support (e.g. mobility equipment), and
- workers having to attend clients' homes alone without knowing what tasks and support will be needed, or who else will be at the home.

The employer has a duty to work with both clients and support workers to ensure there is a **safe environment** for workers. The employer has a good understanding of risks present in their office but has not identified or assessed risks related to working in clients' homes or with clients. They have also failed to consult with workers on concerns they have about safety in the workplace.

Staff turnover has been increasing due to the “stress of dealing with clients' behaviour”. Most workers have sustained some kind of physical injury like bruising, and a worker recently required hospital admission after being attacked by a client's pet, with the psychological harm having a big impact on their life.

As a first step to improving the situation, the employer decides to hold an all-staff meeting to discuss WHS. At the meeting, carers raise a range of WHS issues, and the employer discovers that many of the same issues are shared by workers. In consultation with workers, the employer decides to:

- establish an ongoing WHS assessment and risk identification process, with a review of incidents and a dedicated budget for WHS improvements
- create a process for electing HSRs, and holding regular health and safety committee meetings so staff concerns can be raised and addressed
- implement a pre-visit WHS risk assessment process
- involve behaviour support practitioners to support positive client behaviours
- implement a system to report incidents to SafeWork NSW
- roster on an experienced manager to do inspections and provide support to workers, and
- develop clear policies and processes to manage common hazards like harmful behaviours by clients and aggressive animals.

Case study example – Day surgery clinic in a private hospital

The employer responsible for a day surgery clinic in a private hospital has seen a rise in passive-aggressive interactions between staff. Doctors in the practice have been communicating with administrative staff using a rude tone and complaining about having to constantly rebook appointments.

The employer considers all the relevant matters as follows:

- **How long, how often and how severely workers are exposed to psychosocial hazards:** Poor communication has been observed almost daily for several weeks. The interactions have not escalated to the point of extreme behaviour (e.g. yelling) however things will likely get worse if nothing is done.
- **How psychosocial hazards interact or combine with each other:** Other psychosocial hazards in the workplace are increasing risks. Unfilled vacancies in the administrative team are leading to high job demands. Doctor interactions with patients place a high mental and emotional demand on them.
- **The design of work, including job demands and tasks:** During busy periods the demand on workers can mean they are rushed and pressured to get tasks done. Administrative staff often need to leave people on hold on the phone due to high numbers of calls and inquiries.
- **Systems of work, including how work is managed, organised and supported:** Each doctor works different hours over different days, including over the weekend. Some doctors do not work weekends at all. While some of the doctors have marked in their shared calendar when they are working, others have not shared this with administrative staff.
- **The design, layout, and environmental conditions of the workplace and workers' accommodation, including safe entry and exit, and facilities for the welfare of workers:** The design of the workplace is appropriate to the tasks being completed, with facilities and enough space for staff available. The employer notes that workers accommodation is not required or provided at the workplace.
- **The equipment, substances and structures at the workplace:** All staff have access to required IT equipment and medical equipment as required. The employer recently did an asset review and ensured equipment was up to date.
- **Workplace interactions or behaviours:** Interactions between doctors and administrative staff are frequently negative. However, interactions within each group are positive when they are by themselves.
- **Information, training, instruction and supervision provided to workers:** There are clear and strict processes for training and qualification of doctors. Administrative staff rely on an ad hoc approach to training and instruction.

Based on this consideration, the employer concludes the poor workplace interactions are being caused by a lack of support for administrative staff and workplace systems causing tension and confusion.

The following controls are put in place:

- A central scheduling system is made accessible to all staff online with doctors displaying their office hours and upcoming leave. The employer sends regular reminders to staff to update the schedule.
- A clear policy for training and supervising administrative staff is developed and put into practice.
- Training for administrative staff includes a consistent and efficient approach to scheduling doctor appointments, with enough time for doctors to debrief and have breaks after seeing patients, and
- The employer begins recruitment to fill vacancies in the administrative team to address job demands.
- The employer continues to consult with workers and observe interactions to ensure the controls are working and harmful interactions are no longer occurring.

3.4 Work-related violence, aggression, and harassment

Key messages

Workers in the healthcare and social assistance industry often work with people who are injured, unwell, experiencing mental illness or dementia, or experiencing other difficulties, such as the death of a loved one.

When people experience these things, they sometimes may behave aggressively. In some cases, this behaviour can be prevented from escalating through reducing stress and frustration in the workplace. In other cases, the person's clinical condition may be contributing to this behaviour. This can become a hazard for workers and creates WHS risks.

Workers in the healthcare and social assistance industry sometimes have to work with people who are behaving aggressively or displaying behaviours of concern. However, workers should never be harmed because of this.

As part of your primary duty to ensure the health and safety of workers at the workplace, **you** must do everything you reasonably can to protect workers from being harmed by violence, aggression and harassment at work. It may not always be possible for you to eliminate the risk of aggressive behaviour to workers. However, you must minimise the risk of people being injured by this as much as you can.

What is work-related violence, aggression and harassment?

Work-related violence, aggression and harassment are psychosocial hazards and fall into the group broadly termed 'harmful behaviours'. They create risks of both physical and psychological harm to workers.

Note: Violence and aggression may happen between workers or come from other people at the workplace such as patients, clients, family members or the public.

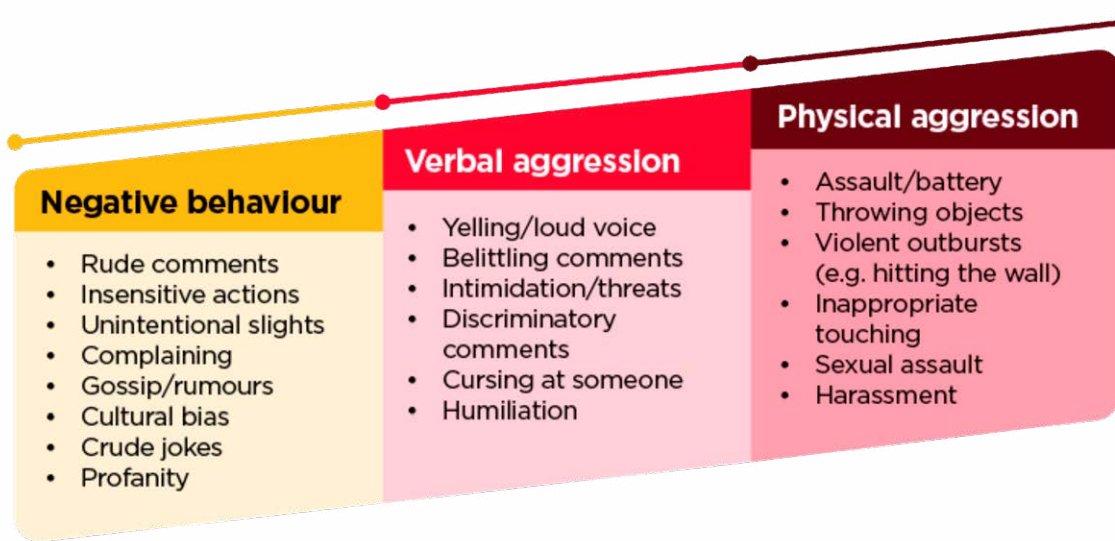
Violence, aggression and harassment occurring between workers is covered in the section on **psychosocial hazards**.

This section is focused on work-related violence, aggression and harassment (including sexual harassment) from other people in the workplace, such as patients, consumers, clients, residents, family members or the public.

Healthcare and social assistance workers are particularly vulnerable to harmful behaviours due to high pressure, complex work environments and frequent interactions with people. When compared to other industries, the healthcare and social assistance workforce also has a higher proportion of female workers and workers from culturally and linguistically diverse backgrounds. This may increase the risk of some kinds of harmful behaviours, such as gender-based sexual harassment or racism. For more information, see the *Code of Practice: Sexual and gender-based harassment*.

Subtle forms of violence, such as tensions between people, incivility, and rudeness, often lead to more extreme harmful behaviours when the causes of stress are not controlled. These subtle forms of violence can still be harmful, especially when they occur regularly or over a long time. The diagram below shows how behaviour can worsen over time if hazards are not controlled.

Figure 6: How harmful behaviours can worsen if not addressed early



WHS duties for work-related violence, aggression, and harassment

You are responsible for protecting workers and others in the workplace from work-related violence, aggression and harassment (including sexual and gender-based harassment). You must **eliminate risks if you reasonably can**.

If that is not possible, you must minimise risks as much as you reasonably can.

For example, some consumers with psychiatric conditions may behave violently towards workers but still require medical treatment. In this situation, it may not be possible for an employer to eliminate the risk of violence to their workers. However, employers must still minimise risks as much as they can (e.g. through effective medical management, placement in a specialised ward, having enough workers with the right mix of skills, having workers trained in de-escalation, having ‘code black’ arrangements, and, where required, the use of restrictive practices such as seclusion if risk cannot be effectively managed in another way).

Managing work-related violence, aggression, and harassment

The first step **you** must take is to do a risk assessment to work out what kind of risks their workers could be exposed to. The risk assessment should consider things like:

- if the work requires workers to deal directly with people
- how likely the violent behaviour is (e.g. do people being treated have medical conditions that may increase the chance of violence? Does the person have a previous history of violence? Could they be affected by drugs or alcohol?)
- the type of facilities available at a workplace (e.g. is there a safe place for workers to go if someone is behaving violently? Is there a lot of light and noise which may agitate people with certain conditions?)

These factors will help you understand the risk to workers. They must then use controls to prevent risks wherever they can.

To control the risks from harmful behaviours, you need to look at the underlying causes of the behaviour as well as addressing the behaviour itself. For example, harmful behaviours can be an inappropriate response to high levels of stress. While the behaviour itself should be addressed, if the cause of the stress is also not addressed, the risk will not be controlled.

For example, harmful behaviours from family members might result from:

- stress caused by long wait times without access to resources or information (e.g. updates on wait times and patient progress, lack of resources or amenities while waiting), or
- anger due to a perceived lack of fairness or concern and distress from thinking that their family member is not receiving the care they need.

Harmful behaviours may result from stress caused by:

- changes in work systems (e.g. sudden or unexplained shifts in daily routine, different personnel due to funding changes, work scheduling and staffing)
- anger due to a perception they are not being listened to or understood, or their needs not being addressed
- frustration (e.g. due to inattention or lack of active support, living arrangements or conflict with other residents)
- ability, or lack of ability, to make their own choices or have control
- withdrawal from medication, alcohol or other drugs, and
- use of restrictive practices as a last resort to prevent harm to a client or patient.

While you might not always be able to eliminate the sources of stress, there are a range of things you can do to minimise them, and therefore reduce the potential for violence, harassment, and aggression. Awareness of the sources will also help you to recognise early signs of an escalating situation and safely intervene.

In some cases, behaviour that is harmful to workers may not result from intentional aggression. Even when the harmful behaviour is not intentional, the WHS risks from the behaviour must still be managed by employers and contractors.

Work related violence is common to human services and care occupations in the healthcare and social assistance industry but has different causes and expressions in different types of workplaces. WHS controls should be sensitive to this (e.g. behaviours related to an intellectual disability are different to those related to dementia).

In some cases, it may be appropriate to remove the person displaying harmful behaviours, so they no longer pose a risk to workers. For example, a visitor who behaves aggressively may be:

- given a warning about the need to treat staff with respect
- issued with a barring notice limiting the times they can attend the facility (e.g. to times where there are additional workers or managers available, or when a particular worker is not on shift), or
- banned from the facility altogether.

Summary: How you should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

To identify hazards at the workplace, it may be useful to:

- Walk through and inspect the workplace (including for low visibility in service areas, entries and exits for workers after hours, long patient queues and wait times).
- Identify situations and areas of the workplace where patients, residents and others may experience heightened negative emotions such as stress, distress, frustration, communication difficulties, anger, a sense of unfairness or have unreasonable expectations of the services that can or should be provided.
- Observe interaction between workers and others in the workplace (e.g. rudeness and incivility, poor relationships, racism, or workers avoiding being around certain people).

- Conduct confidential worker surveys about incidents or behaviours that have caused discomfort and situations that had the potential to become more violent.
- Identify factors external to the workplace which may lead to violence or aggressive behaviour (e.g. patients affected by drugs or alcohol).
- Talk to patients or clients about their support needs, including any unmet needs.
- Consider the mix of patients or clients and what 'triggers' they may have.
- Consider varying communication abilities (e.g. clients with an intellectual disability).
- Consider the different impacts on workers depending on their role (e.g. are workers in a role that is more likely to expose them to aggressive people?)
- Consider the types of services offered at the facility and the different types and levels of risk involved (e.g. emergency departments, mental health, drug and alcohol, brain injury, aged care, neurology, midwifery and early childhood are often higher risk environments for aggression).

Hazards that can increase the likelihood of work-related violence or aggression include:

- providing care or services to people who are distressed, confused, afraid, ill, impacted by mental health, an intellectual disability or dementia, or affected by drugs and alcohol
- handling valuable or restricted items (e.g. cash or medicines)
- working offsite or alone (e.g. a patient's home, without supervision)
- working in unpredictable environments (e.g. where family members may pose a risk to workers' safety)
- inappropriate placement (e.g. younger clients placed in residential aged care)
- service and care methods, policies or communication that causes or escalates frustration (e.g. low staffing levels, unclear policies, insecure employment, high staff turnover, setting unachievable expectations of the services an organisation or workers can provide, not sharing information about patient progress)
- poor quality behavioural support plans
- untrained staff being directed to perform complex care work
- low worker diversity and a workplace culture that accepts or tolerates gendered violence.

Hazards that can increase the likelihood of harassment include:

- acceptance of inappropriate behaviour (e.g. racially or sexually crude conversations, innuendo or offensive jokes are part of work culture or not challenged when they occur)
- power imbalances along gendered lines (e.g. workplaces where one gender holds most of the management and decision-making positions)
- treatment of workers as disposable or replaceable, or promotion of the idea that care and support work is unskilled work that "anyone can do"
- working in isolation in restrictive spaces with limited supervision or access to support (e.g. vehicles such as ambulances, remote locations, wards late at night, patient's homes)
- poor understanding among workplace leaders of the nature, causes and impacts of sexual harassment. While anyone can experience harassment, there are certain groups who are more likely to experience it. Some workers may be at greater risk because of their age, gender, sexuality, migration status, disability and literacy skills.

Summary: How you should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks of violence, aggression and harassment, including sexual harassment, as much as you reasonably can, including through **good work design**. Use the **hierarchy of controls**, particularly when seeking to reduce the risk of assaults.

Physical work environment

Prevent harmful behaviours and escalation

- Arrange rooms to minimise agitation. For example, avoid cluttered rooms and allow enough space to move and use equipment.
- Promote comfort including by reducing noise and other stimuli, controlling temperature, allowing access to food, drink, entertainment and other items that may reduce stress or boredom (e.g. provide mobile phone charging points and other distractions).
- Provide security cameras to monitor risks and deter harmful behaviours.
- Roster on additional workers and have supervisors perform more regular check-ins to monitor potential causes of escalation.
- Ensure workplace design and lighting provides good visibility, including in car parks.

Reduce harm

- Separate workers from the public with fixed or removable barriers (e.g. high counters, furniture, screens on counters or screens between a driver and passenger).
- Provide two exits in all interview and treatment rooms.
- Provide both fixed and portable duress alarms.
- Arrange the workplace (e.g. furniture and partitions, observation mirrors) to ensure good visibility of areas accessible to patients/families where appropriate. Improve natural surveillance and avoid restrictive movement.
- Ensure there are no areas where workers could become trapped, such as rooms with keyed locks.
- Provide secure areas where workers can retreat.
- If patients need to be restrained, provide access to quiet, private and secure areas to minimise distress to others.
- Home visits should not be undertaken by workers without police or security when there is a high risk of violence.

Tools, equipment, substances, structures

- Secure any objects that could be thrown or used to injure someone.
- Use face shields where spitting or intentionally coughing is a risk. However, consider how this may impact communication and potentially increase frustration.
- Ensure communication systems (e.g. phones, intercoms, panic buttons and duress alarms) are provided, maintained and tested.
 - Ensure community workers have access to duress alarms. These should work in all locations and be able to be responded to quickly.

- Provide suitable PPE (e.g. stab-proof vests and protective clothing for security guards).
- Ensure vehicles are fit-for-purpose (e.g. have central locking devices, GPS tracking devices to allow drivers in distress to be located, lighting to allow the driver to monitor passenger behaviour, are well maintained so they do not break down at unsafe locations or times).

Design and management of work

Prevent harmful behaviours

- Communicate regularly and transparently to reduce distress. For example, provide family and friends with information about patient progress and location.
- Provide enough workers to both care for and support clients and patients, and to keep workers safe. Staff should not work alone where there is a risk of violence.
 - In some workplaces and only where appropriate, this may include security guards or staff trained in restraint, mediation or de-escalation techniques.
- Consider the gender mix of workers (e.g. roster male workers to provide care where there is a known risk of harassment towards female workers).
- Identify rostering practices that minimise escalation and ensure continuity of supports for the patient or client.
- Alternate tasks in the workplace where possible (particularly tasks requiring high levels of interaction) and ensure workers have regular breaks if aggression or incivility is likely.
- Use barring notices that limit or prevent access to the facility for visitors who display aggressive behaviour.

Prevent escalation and reduce harm

- Ensure there are enough workers to identify escalating behaviour early to give the best chance of de-escalation.
- Establish a system for screening patients, clients and visitors for risk of violence, and ensure the right worker cares or supports them. (e.g. where possible, triage and prioritise care for patients with acute mental health conditions or under the influence of drugs or alcohol, ensure staff rostered for patients or clients have sufficient training).
- Match staffing levels and supervision to patient or client needs.
- Provide 'buddy' shifts for workers delivering supports to complex clients for the first time.
- Establish risk management and behavioural plans that can be clearly understood by any worker using them and ensure workers have access to them, especially for in-home care and higher risk patients. Plans should consider:
 - Who should be providing care? (e.g. gender, skill mix, violence prevention training)
 - How many staff are required to provide care safely? (e.g. pairs for personal care, 3 to shower an elderly person who is resisting)
 - Is a 1 to 1 'patient special' required? Should this be a clinical or a security special?
 - Where will the patient be located?
 - Access to duress devices and response times.
 - Has the area been cleared of anything that can be used as an improvised weapon?
 - Medical management (e.g. PRN medications charted)
 - Escalation pathway where controls are ineffective, and
 - The risk of violence from family members.

- Use behavioural contracts that set expectations about behaviours that will not be tolerated and consequences (e.g. stop treatment, stop providing support or care in-home, treatment or support only provided in a particular facility).
- Establish procedures for working in isolation and uncontrolled environments (e.g. risk assessments to determine the safety of a patient's home at the beginning of each visit).
- Establish systems for immediate medical attention where needed, reporting, debriefing and support after an incident, and consideration of paid leave for impacted staff).
- Report criminal behaviour to police.

Information, training, instruction and supervision

- Establish pre-shift team briefings to share information on potential risks.
- Provide training for staff in:
 - identifying early warning signs of violent behaviours from patients and visitors
 - de-escalation techniques
 - personal safety (e.g. understanding the physical environment, breakaway techniques, using evasive measures)
 - specific care and support needs (e.g. dementia, mental health conditions, other medical and health-related supports as required)
- Establish a dedicated, trained, regularly drilled, multi-disciplinary team to respond to high risk situations (e.g. code black team).
- Provide additional supervision and support for new, young and inexperienced workers.
- Encourage workers to keep records and screenshots if harmful behaviour occurs online or through phone communication and report the behaviour to their supervisor.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Gender-related violence in a hospital ward

A 45-year-old male patient has just been admitted to a general ward with suspected early-onset dementia, as there were not enough spaces in the dementia ward to accommodate him. Throughout the day shift, nurses complain that he has been making frequent unwelcome comments, including sexual innuendo. The head nurse speaks to him about this behaviour, but the comments continue and escalate.

At the end of the day shift, this information is noted in the handover notes, but the shift handover is disrupted by a life-threatening emergency elsewhere on the ward, and ultimately not adequately discussed. A male nurse originally moved to the ward is diverted elsewhere due to competing patient needs.

At 3:00 am the next morning, a younger female nurse is asked to do rounds alone and the man assaults her.

The hospital investigates the incident and identifies multiple failures, including a lack of adequate staffing and worker training, a lack of consideration of the risk of escalation and violence, a failure to consider the gender mix of staff where there was an identified risk of sexual harassment, poor systems for information sharing and handover, and a lack of security systems and distress alarms for nurses.

The hospital puts in place a range of changes to address these issues, which reduce the risk of a similar incident occurring in the future.

3.5 Biological hazards

Key messages

When compared to other industries, workers in the healthcare and social assistance industry are at a much greater risk of exposure to biological hazards because of the nature of their work providing care to people who may be unwell, providing support to people with complex conditions, and handling of potentially infectious materials.

However, the risk of biological hazards can be effectively managed in the workplace with preventative controls.

What are biological hazards?

The most likely biological hazards that workers will be exposed to in the healthcare and social assistance industry are viruses, bacteria and parasites from contact with unwell people or with items containing or contaminated with their bodily fluids (e.g. blood, faeces, vomit, urine, saliva, fluid from coughs, sneezes or wounds).

Other biological hazards may also be present in the workplace, such as mould and allergens (e.g. animal dander). Exposure to a biological hazard can result in illness or disease in a worker or other person at the workplace.

Examples of how a worker or other person at the workplace may be exposed to a biological hazard in the healthcare and social assistance industry include:

- Direct contact with a person who has an infectious disease
- During clean-up of vomit, faeces, urine, blood or other fluid from wounds
- Handling contaminated items (e.g. soiled clothing and bedding, contaminated utensils and personal effects, food, waste items, surfaces)
- Breathing in air containing infectious particles or contact with droplets from coughs or sneezes on eyes, mouth or nose.
- Surgical plume containing a mix of hazardous components (e.g. ultra-fine particulates, bacteria, viruses)
- Sharps injury causing exposure to blood or other bodily fluids
- Breathing in air containing mould spores
- Breathing in air containing animal dander

Note: Some biological hazards (e.g. influenza, COVID-19 and gastro) have the potential to spread rapidly between people.

WHS duties for biological hazards

You must ensure that workers and others in the workplace are not exposed to WHS risks from biological hazards. **You must eliminate risks as much as you reasonably can.** If elimination is not possible, you must minimise risks as much as you reasonably can.

You have a range of other WHS responsibilities that may be relevant to preventing risks from biological hazards, including providing adequate and accessible facilities (e.g. for handwashing), and providing adequate training and information to safely perform tasks and appropriate PPE.

In addition to WHS laws, there are other requirements and standards for managing the risks of biological hazards that apply in the healthcare and social assistance industry, such as the *National Safety and Quality Health Standards 2021 Preventing and Controlling Infections Standard*. Complying with these standards does not guarantee compliance with WHS laws, and vice versa.

More information on managing the risks of biological hazards can be found in:

- **Who has WHS legal responsibilities?**
- *Code of Practice: How to manage work health and safety risks.*

Managing biological hazards

In addition to the **general risk management process**, there are additional considerations to consider when managing the risks of biological hazards.

Personal protective equipment for infectious diseases

PPE is an important control for managing the risks of biological hazards. **You** must provide PPE free of charge to workers (unless it has already been provided by someone else). It must fit the person using it and be comfortable for them to wear.

You must also ensure the PPE stays in good condition (e.g. clean and hygienic, repaired or replaced when damaged) so that it continues to be effective in managing WHS risks. You must train workers in how to use PPE properly (e.g. how to store and maintain, how to put on and take off safely).

Different WHS risks will require you to provide different PPE. Not all PPE protects the wearer from exposure to biological hazards. Protection from airborne diseases requires the use of tight-fitting respirators (e.g. N95/P2 masks). Tight-fitting respirators need to be fit tested to the worker to ensure they provide suitable protection and fit checked by the worker each time they are put on. Workers wearing tight-fitting respirators will require regular breaks to avoid injuries or discomfort.

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Identifying the different sources of biological hazards (where they can be found) and how they can affect people (including whether they can spread to others) is the first step of your risk assessment.

When identifying the hazards and potential infection sources consider the following factors which may increase risks:

Work environment

- Type of workplace (e.g. working in a client's home may not be as frequently cleaned or disinfected as other workplaces like a hospital. However, working in a client's home there may be contact with fewer people)
- Likelihood of hazardous materials and substances (e.g. more likely during seasonal virus outbreaks, such as influenza and gastro)
- Ventilation (e.g. airflow can influence exposure to biological hazards in the air)
- Crowded environments (where infectious diseases may spread more easily between people)
- Design of the workplace (e.g. poor design may result in hard to clean surfaces or inadequate air exchanges).

Work tasks and practices

- Working with bodily fluids (e.g. pathology, patient/client care, cleaning)
- Working with sharps
- Working around animals

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- Working with food
 - Tasks involving dust or aerosols that may contain biological material (e.g. cleaning, dusting)
 - Working with shared equipment.

Possible exposures

- Direct contact with a biological hazard (e.g. person to person)
- Cleaning up vomit, faeces, urine, blood or other fluid from wounds
- Breathing in air contaminated with a biological hazard
- Contact with droplets or sprays (e.g. from coughs, sneezes, droplets on surfaces)
- Contact with blood (e.g. needle stick/sharps injuries)
- Contact with contaminated items (e.g. handling contaminated items like bedding or food waste).

Summary: How you should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks of biological hazards as much as you reasonably can, including through **good work design**. The **hierarchy of controls** can assist you in managing risks.

In some settings, relatively simple control measures may effectively minimise the risk (e.g. PPE suitable to the risk, ventilation, good hygiene practices, regular cleaning).

Additional control measures may be required in settings where risks are higher (e.g. infectious disease wards, aged care homes where residents are especially vulnerable to disease, during outbreaks).

In these circumstances, consider:

- increased hand hygiene
- more frequent cleaning and disinfection
- improved ventilation (e.g. surgical plume evacuator system, HEPA filters)
- use of negative pressure rooms
- signage on patient or client rooms
- greater physical distancing
- testing of visitors
- isolation of infected people from others (e.g. use an isolation room or cohort infectious patients together), and
- use of portable medical tents.

It is important that you seek and monitor information and advice from authoritative sources relevant to your workplace to help you identify the most effective and reliable control measures, particularly if there are outbreaks or emerging hazards.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

In addition to the general advice on when to review risk controls, you should also consider reviewing controls when you receive new information about a biological hazard (e.g. a new virus or strain of an existing virus) or ways to control risks (e.g. a new vaccine developed).

Case study – Norovirus outbreak in an aged care home

A resident in an aged care home reports they have been unwell for over a day with diarrhoea and that they have been in the communal dining room as well as some group activities. A swab later reveals that the resident has a norovirus infection. The aged care home's policy requires the immediate use of additional control measures during infectious disease outbreaks to limit the spread between people.

The aged care home's policies require additional contact measures to be put in place right away, with workers practicing more frequent hand hygiene and using masks, gloves and gowns.

Unfortunately, the aged care home cannot confine all residents to their rooms as there are not enough staff to monitor them all or manage restriction zones. After checking all the residents, 2 more report diarrhoea and vomiting. The residents with symptoms are provided with appropriate care and support in their rooms, which have ensuite, to prevent interaction with other residents while they are infectious.

While workers have increased handwashing and use of PPE, other staff at the home (including cleaning staff and cooks) are not given additional training or access to equipment. Investigation also reveals low levels of hand hygiene among residents and a lack of routine cleaning in dining areas. The virus spreads to 6 more people, including 3 workers, before it is finally contained.

An education program is developed to assist in preventing further infections. In future outbreaks, cleaning staff and cooks are given training in hand washing, issued with PPE, and asked to report symptoms promptly. Procedures are also updated to increase cleaning of frequently touched surfaces to reduce the risks of environmental contamination and transmission.

3.6 Hazardous chemicals

Key messages

Workplaces in the healthcare and social assistance industry contain and use a range of hazardous chemicals, including cleaning products, drugs, and anaesthetic gases. Depending on their type and use, these chemicals can pose WHS risks, including in ways workers may not be aware of, or that can build up over time.

Some healthcare and social assistance workplaces, such as hospitals, may already have well-developed procedures for managing the risks of hazardous chemicals. However, in other workplaces (such as in a person's home) hazardous chemicals may be less obvious and may be used in ways that are unsafe. **You** must eliminate or minimise the risks related to hazardous chemicals as much as you reasonably can, regardless of the workplace.

What are hazardous chemicals?

Hazardous chemicals are chemicals that pose a physical or health hazard.

Some chemicals can create physical hazards like fires, explosions or corrosion. Other chemicals may produce health effects shortly after contact (like skin, respiratory or eye irritation) or cause long-term health conditions (like cancer or organ damage). Some chemicals may become more harmful when mixed with another chemical. Some chemicals cause both physical and health hazards. As such, exposure to these chemicals can be harmful to workers and others in the workplace.

Common forms of hazardous chemicals in the healthcare and social assistance industry

Common types of hazardous chemicals used in the healthcare and social assistance industry include:

- cleaning products (e.g. bleach, peracetic acid)
- disinfectants and hand sanitisers (e.g. sanitisers with ethanol or isopropyl alcohol)

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- chemicals used to preserve specimens in theatres and pathology (e.g. formaldehyde)
 - anaesthetics
 - by-products of treatments (e.g. acrylonitrile and hydrogen cyanide from surgical smoke)
 - noxious airborne contaminants and gases generated from lasers (e.g. carbon, benzene, toluene, carbon monoxide)
 - medications in solution or powder form which may cause irritation if used or stored incorrectly, and
 - cytotoxic drugs (e.g. anthracyclines used to treat cancer), and
 - fumes from diathermy.

WHS duties for hazardous chemicals

You must keep your workers and others safe from the risks of using, handling, generating, and storing hazardous chemicals in the workplace. You must eliminate risks as much as you reasonably can. If this is not possible, you must minimise risks as much as reasonably can by using the hierarchy of controls.

In addition to this primary duty, you also have other legal responsibilities under WHS laws if there are hazardous chemicals in the workplace. These include:

- ensuring all containers of hazardous chemicals are correctly labelled
- storing hazardous chemicals safely and informing your workers about them
- maintaining an up-to-date hazardous chemical register that is easy to access, and that includes a copy of the current **safety data sheet** for each hazardous chemical on the register
- displaying safety signs (if identified as a control) at the workplace to warn people about the hazardous chemical, or state any responsibilities people at the workplace may have because of it
- ensuring no one is exposed to a hazardous chemical in an airborne concentration above its **exposure standard**, and
- **monitoring the health of workers** who handle, generate or store hazardous chemicals where there is a significant risk of exposure.

Safety data sheets and hazardous chemical registers

Safety data sheets (SDS) are an important source of information about hazards, safe handling and storage when working with the hazardous chemical. Information found in a SDS includes:

- the chemical identity and ingredients
- the dangers it can pose, such as health and physical hazards
- how to safely handle, store and clean up the chemical
- first aid and emergency procedures, and
- disposal considerations.

Manufacturers or importers of a hazardous chemical must prepare the SDS. The manufacturer, importer or supplier must provide the SDS when a hazardous chemical is first supplied to a workplace, or in future supplies if the SDS has been updated.

You must request a copy of the SDS if you do not have one and must always do so before the chemical is used in the workplace.

You must ensure the SDS is current and easily accessible to anyone working with or around hazardous chemicals (e.g. printed out and displayed close to where the chemical is used). This includes emergency services workers or anyone else who may be exposed.

You must also keep an up-to-date hazardous chemical register, listing the hazardous chemicals used, handled or stored at the workplace. The register must include a copy of the current SDS for each hazardous chemical. It should be regularly updated as new hazardous chemicals are introduced or if particular hazardous chemicals are no longer being used.

You may not need to obtain a SDS or include the hazardous chemical on the workplace's hazardous chemical register if the hazardous chemical is a consumer good:

- used in small amounts in a way that is consistent with household use, and
- is incidental to the nature of work carried out by a worker using the hazardous chemical.

For example, a disability support worker using a common household cleaner to clean a client's home is unlikely to need an SDS. However, if they use the chemical for a different purpose than its intended use, or in greater amounts than what is normal for household use, an SDS is likely to be required.

You can choose to request a SDS from the manufacturer, importer or supplier if you are unsure and want to find out more.

Comprehensive information on SDS, including duties and responsibilities, is available in the following resources:

- *Code of Practice: Preparation of safety data sheets for hazardous chemicals*
- Safe Work Australia's *Using safety data sheets*.

Other duties

These are just some of the duties and responsibilities for businesses or organisations working with hazardous chemicals. The [managing risks section](#) outlines additional duties that apply for hazardous chemicals relating to the work environment. It is important that you read the relevant WHS laws and other legislative frameworks applicable in NSW and consult with the relevant people involved at your workplace (e.g. workers handling hazardous chemicals).

Comprehensive information about duties and responsibilities when working with hazardous chemicals is available in the following resources:

- *Code of Practice: Managing risks of hazardous chemicals in the workplace*
- *Code of Practice: Labelling of workplace hazardous chemicals*
- *Code of Practice: Preparation of safety data sheets for hazardous chemicals*
- Safe Work Australia's *Health monitoring*
- Safe Work Australia's *WHS duties related to hazardous chemicals*
- Safe Work Australia's *Workplace exposure standards for airborne contaminants (2024)*

Managing the risks of hazardous chemicals

In addition to the general risk management process, there are also additional considerations you should think about if your workplace uses hazardous chemicals.

Know the hazardous chemicals in your workplace

Products containing hazardous chemicals often go unnoticed. You should take all reasonable steps to find out what chemicals are being used by all workers you **are responsible for**.

Workplace exposure to airborne contaminants, including airborne hazardous chemicals

Work processes can release contaminants in the form of dusts, gases, fumes, vapours, or mists into the air, which may be harmful to health or safety. These are known as airborne contaminants and may be invisible. People that breathe in airborne contaminants at work may be at risk of adverse health effects.

You must eliminate or minimise risks from airborne contaminants in the workplace as much as you reasonably can, and ensure that workers and others are not exposed to levels of airborne contaminants above their workplace exposure standard (WES).

Australia is transitioning to the Workplace exposure limits – airborne contaminants (WEL list). Until 1 December 2026, you must still comply with the Workplace exposure standards for airborne contaminants. Contact SafeWork NSW for further information.

For further information refer to Safe Work Australia's *Workplace exposure standards for airborne contaminants (2025)* and *Workplace exposure limits for airborne contaminants*.

Health monitoring

For hazardous chemicals, you must provide health monitoring to workers if there is a significant risk to a worker's health because of exposure to particular hazardous chemicals, and if there is a valid way to determine the effect on health or biological exposure.

Health monitoring must be done by a doctor with experience in health monitoring. If health monitoring indicates a worker may be being harmed by chemical exposure, this must be reported to SafeWork NSW.

Health monitoring is not an alternative to using **effective controls to manage risks**, including using the **hierarchy of controls**. Health monitoring provides information about the controls used in the workplace and if they are working. If a worker's health is still being affected by exposure to hazardous chemicals, health monitoring lets you know so you can do more to protect the workers' health and safety.

Further information on health monitoring, including health monitoring guides, is available on the Safe Work Australia website.

Work environment

The work environment where hazardous chemicals are used and stored is important to consider in a risk assessment. If your workplace contains hazardous chemicals, you must:

- manage any WHS risks associated with ignition sources
- ensure that flammable and combustible substances are kept to a minimum
- provide a spill containment system if there is a risk of hazardous chemicals spilling or leaking
- provide fire protection or firefighting equipment:
 - designed and built for the hazardous chemicals and conditions in their workplace
 - compatible with the equipment used by the main emergency service organisation in their area, and
 - that is properly installed, tested and maintained.
- provide other emergency equipment that may be needed in the workplace.

If a hazardous chemical storage and handling system no longer needs to be used, you must ensure, as much as you reasonably can, that the system is free from hazardous chemicals when the system is no longer used or is disposed of. If that is not possible, you must ensure that the handling system is correctly labelled.

You must also use proper signage when large or bulk quantities of certain hazardous chemicals are stored in the workplace and notify SafeWork NSW where required.

More information about maintaining a safe work environment in the [Work environment hazards](#) section below and in the following resources:

- *Code of Practice: Managing risks of hazardous chemicals in the workplace*
- *Code of Practice: Managing the work environment and facilities*
- *Safe Work Australia's Guidance on the interpretation of Workplace exposure standards for airborne contaminants.*

Cytotoxic drugs

Cytotoxic drugs are common hazardous chemicals used in the healthcare and social assistance industry to treat cancer and other medical conditions. Workers may be exposed to cytotoxic drugs through handling them directly, or through contact with bodily fluids (including waste like faeces or urine) from a patient who has been treated with them. Contact with cytotoxic drugs or related waste that is not properly controlled can pose serious WHS risks to workers.

Cytotoxic drugs can be highly toxic to non-target cells, mainly through their action on cell reproduction. Even at low exposure levels, cytotoxic drugs can cause cancer, affect foetal development, affect fertility, damage DNA, and cause organ toxicity. Some have also been shown to cause secondary cancers in cancer patients.

Cytotoxic substances can generally be identified by the following purple symbol:

Figure 8: Symbol for cytotoxic drugs



Managing risks associated with cytotoxic drugs

When working with cytotoxic drugs, you should follow the general risk management process of identifying hazards, assessing risks and controlling risks, while also keeping in mind any additional considerations when working with hazardous chemicals.

The following table outlines some considerations that you should consider when managing the risk of worker exposure to cytotoxic drugs in the healthcare and social assistance industry. These considerations can also be applied when managing the risk of other hazardous chemicals in the workplace.

Workers who are pregnant, breast-feeding or planning parenthood and are involved in the preparation or administration of cytotoxic drugs or exposure to cytotoxic waste should be informed of the reproductive risks and possible effects on foetal development. Those required to perform these duties may elect not to do so and appropriate and suitable alternative duties must be provided.

Settings	Considerations when managing risks
Preparing cytotoxic drugs	<p>What safe standard operating procedures for handling cytotoxic drugs exist or are needed in the workplace?</p> <p>Are cytotoxic drugs correctly labelled?</p> <p>Are there proper facilities and equipment to prepare the cytotoxic drugs?</p> <p>Do workers need to be rotated to reduce the risk of exposure?</p>
Administering cytotoxic drugs	<p>How are cytotoxic drugs administered (e.g. injection or tablet/capsule)?</p> <p>If the patient or client has difficulty swallowing, can the crushing of cytotoxic capsules or tablets be prevented by administering it in an alternative form (e.g. injection)?</p> <p>What is the effect of cytotoxic drugs on patients (e.g. unpredictable behaviours)?</p> <p>What training and procedures are provided for workers administering cytotoxic drugs?</p> <p>What facilities and equipment are required to safely administer cytotoxic drugs?</p> <p>Are cytotoxic drugs correctly labelled?</p> <p>Do workers need to be rotated to reduce the risk of fatigue?</p>
Cytotoxic contaminated laundry	<p>What are the sources of contaminated laundry?</p> <p>Who is involved with handling contaminated laundry?</p> <p>How is the contaminated laundry moved?</p> <p>What identification and warning signs (e.g. labels and special bagging) are required?</p> <p>What training and information is provided to workers who may be exposed?</p> <p>What facilities and equipment are needed?</p>
Cytotoxic contaminated waste	<p>What are the sources of contaminated waste? (e.g. Providing care to patients? Waste from packaging?)</p> <p>Who is involved with handling contaminated waste?</p> <p>How is the contaminated waste moved, sorted, stored and disposed of at the workplace?</p> <p>What facilities and equipment are required to safely handle contaminated waste?</p> <p>What training and information is provided to workers?</p>
Spilling cytotoxic drugs and contaminated waste	<p>Is there anything in the work environment that could cause a cytotoxic drug or contaminated waste to spill (e.g. trip hazards, bedpans, urinary catheter bags)?</p> <p>What are the likely causes of spills (e.g. leaks from syringe when administering drugs, spilled bedpan)?</p> <p>Who might be exposed if the cytotoxic drug or contaminated waste is spilled (e.g. workers handling drugs, other patients in the ward, visitors)?</p> <p>What reporting and notification procedures are in place for incidents?</p> <p>What training and information on spill containment and decontamination procedures are provided to workers?</p>

You can refer to the following guidance below for more comprehensive information about what to consider when working with cytotoxic drugs:

- SafeWork NSW guide *Cytotoxic drugs and related waste – risk management*.

Summary: How you should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Identify and assess the risks by:

Finding out what hazardous chemicals are in use

- Check the hazardous chemical's **SDS** and label for hazard properties
- Check if there is an **exposure standard** for the chemical in the *Workplace exposure standard for airborne contaminants* (WES list), available on Safe Work Australia's website
- Consider all possible ways a worker could be exposed to the chemical (e.g. breathing in, or physically contacting).

Considering the work involved

- Observe the work tasks involved and practices
- Check the conditions where the tasks are being carried out
- Consider what could go wrong in a work task (e.g. accidental spillage)
- Review any available incident information involving the hazardous chemical.

Assessing the risks

- Evaluate how long and how often workers are exposed to chemicals
- Review controls to see if they align with information on labels and SDS
- Consider if the worker has pre-existing medical conditions that put them at greater risk
- Monitor the health of workers

Summary: How you should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks of hazardous chemicals as much as you reasonably can, including through **good work design**. Use the **hierarchy of controls**.

Example controls for hazardous chemicals include:

- negative pressure rooms
- good ventilation (e.g. use of extractors, fume hoods, surgical plume evacuator systems)
- storing hazardous chemicals safely and informing your workers about them
- this may include storing certain chemicals in dedicated areas, and specialised storage for explosive or flammable gases (e.g. compressed gas cylinders should be stored outdoors, preferably in a secure cage protected from sunlight. Indoor storage is not recommended unless the building has been designed for that purpose with appropriate fire-rated walls and ventilation).
- following **exposure standards** for airborne contaminants
- **health monitoring**
- maintaining a hazardous chemical register with **SDS**
- monitoring for chemicals with a WES (including in storage areas in case of leaks)

- closed systems for cleaning scopes using peracetic acid
- displaying safety signs
- labelling hazardous chemicals' correctly
- rotating staff through work involving hazardous chemicals to reduce exposure, and
- providing appropriate PPE and making sure it fits properly (e.g. fit-tested P2/N95 masks).

Note: Hazardous chemicals can react with each other to create a more harmful effect. Consider this when storing and mixing hazardous chemicals with each other. Read the SDS and label carefully, as it may inform you what types of hazardous chemicals should be separated.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Cleaning with hazardous chemicals

An in-home disability support provider wanted to manage the WHS risks of hazardous chemicals to their workers.

They started by surveying workers to find out if they were using any chemicals not listed on the provider's hazardous chemical register. The workers identified they were using several common household cleaning products for cleaning showers, toilets and ovens.

The provider requested and obtained SDS for each of these products. The provider's WHS committee then did a risk assessment, reviewing the chemicals' safety information, and how they were used by workers. They identified tasks that posed WHS risks, including cleaning showers and ovens.

Copies of the SDS for these products were provided to workers and are now kept in the clients' homes for easy access, as well as at the provider's office. Workers were asked to make small changes to how they did their cleaning tasks when using these chemicals, including by opening windows, turning on any exhaust fans and wearing gloves when cleaning a shower or oven. Any product that did not display the manufacturer or importer's label was no longer used and removed from the client's home.

3.7 Work environment hazards

Key messages

Healthcare and social assistance work happens in a huge range of different work environments. Workers have the right to a safe work environment wherever they work. **You** must consult with workers and others in the workplace to provide a safe environment for workers, wherever they may work.

The best way to manage the risks of hazards in the work environment is through **good work design**, which allows you to eliminate WHS risks from the work environment altogether. Where this is not possible, you must minimise risks as much as you reasonably can.

What are physical work environment hazards?

Indoor and outdoor work environment hazards are physical features of the workplace that can harm a worker.

Some of the most common work environment hazards in the healthcare and social assistance industry include:

- poorly designed workplaces (e.g. not enough space for tasks or emergencies, no ability for staff to escape an area)
- poor lighting
- poor line of sight

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- poorly designed floors and surfaces (e.g. carpet that is not suitable for pushing wheeled equipment, poorly designed stairs or ramps)
 - clutter
 - lack of access control for worker only areas, and
 - remote or isolated workplaces.

WHS duties for work environment hazards

In addition to the **primary duty**, you must eliminate or minimise WHS risks in the work environment as much as you reasonably can by:

- ensuring the layout of the workplace allows people to enter, exit and move around safely, under normal working conditions and in an emergency
- ensuring work areas have enough space for the work to be done safely
- ensuring there is adequate lighting for workers to work, move around and evacuate in an emergency safely
- ensuring floors and other surfaces are designed, installed and maintained so work can be done safely
- ensuring there is enough **ventilation** to avoid WHS risks
- ensuring workers who work in extreme temperatures avoid WHS risk.

Providing adequate facilities and systems of work

First aid

You must provide access to first aid equipment and facilities in the workplace. You must also ensure enough workers or other people are trained to administer first aid.

The type and extent of equipment and facilities provided, and the number of people trained, will depend on the risks in the workplace (e.g. type of work and hazards, number of people in the workplace, location of workplace).

For example, hospitals and aged care facilities will usually have many people trained in first aid. However, their facilities may not always be set up for the types of injuries workers experience.

For workers delivering care or support in peoples' homes, first aid facilities may not be readily available. You must provide access to first aid for these workers based on a risk assessment (for example, a first aid kit).

Facilities

You must provide facilities for workers, including toilets, drinking water, washing and eating facilities. These facilities must be in good working order, clean, safe and accessible and should be separated from work areas. Information on what to consider when providing facilities for workers is provided in the section on **adequate and accessible facilities**.

Emergency plans

You must ensure that an emergency plan is prepared and maintained for the workplace. It must include procedures:

- that provide an effective response to emergencies
- for evacuating the workplace
- for notifying emergency service organisations as soon as possible
- for getting medical help

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- for communicating with workers during an emergency
 - for training workers in what to do in an emergency, and
 - for testing the emergency response.

What is included in the emergency plan will depend on the risks in the workplace (e.g. type of work and hazards, number of people in the workplace, location of workplace). Emergency plans must be developed for all workplaces, even when workers are working from peoples' homes.

Further guidance on emergency plans and procedures is available in the *Code of Practice: Managing the work environment and facilities* and Safe Work Australia's *Emergency plans fact sheet*.

Remote or isolated work

You must manage WHS risks for workers working in remote or isolated locations by eliminating or minimising WHS risks as much as you reasonably can. You must also provide a method for effective communication with the worker.

Remote or isolated locations could mean, for example, a worker who is alone on a ward late at night in a city hospital, or a worker driving to a remote rural property to deliver care.

More information on [managing the risks of remote or isolated work](#) is provided in the next section.

Managing risks in the physical work environment

Entries and exits

Healthcare facilities such as hospitals and aged care homes are places with high foot traffic. Workers, patients, carers and visitors are constantly entering and exiting. This means the entry and exit must be safe and allow workers, patients and visitors (including those with special needs or disabilities) to enter and exit safely, both under normal conditions and in emergencies.

Design of aisles, walkways, staircases and ramps

Aisles, walkways and staircases should be wide enough to accommodate any tasks and equipment they will be used for (including in emergencies) and kept free of furniture or other obstructions. They should comply with all relevant Australian Standards, Building Codes, and Construction Codes. Open sides of staircases should be guarded with an upper rail and a lower rail. A handrail should be provided on at least one side of every staircase. Extra handrails may be needed down the centre of wide staircases. The surface of steps and the caps of stairs should be differentiated with contrasting colours. Ramps should have a slope that is gentle enough for anyone using it to navigate safely.

Separate entries and exits for equipment, vehicles and pedestrians, should be provided to minimise the risk of persons being hit by moving vehicles. If people and vehicles must share a traffic route, use kerbs, barriers or clear markings to designate a safe walkway. Doors and gates should be fitted with safety devices if necessary. Doors on main traffic routes should have a transparent viewing panel, unless they are fire-rated doors.

The location of exits should be clearly marked, and signs should be posted to show the direction of exit in an emergency evacuation. **You** should also consider installing observation mirrors (also known as 'traffic mirrors' or 'convex mirrors') to eliminate blind spots and prevent people at the workplace from running into each other. When work occurs in a person's home or other new location, workers should familiarise themselves with exit points or emergency support.

Carpeting should be avoided in clinical areas where patient care occurs, or in areas where:

- spills are likely to occur (e.g. around sinks or dining areas)
- people may have direct contact with contaminated carpets (e.g. children or babies crawling on the floor)

- patients are at greater risk of airborne infections
- the carpet may make it difficult for workers to push patient beds, wheelchairs or other wheeled equipment like food and medication trolleys.

Floors and surfaces should also be routinely cleaned for infection control. For more information on infection control, see **biological hazards**.

Lighting

Lighting must be provided, whether it is from a natural or artificial source, to allow safe movement around the workplace and to allow workers to perform their job without having to adopt awkward postures or strain their eyes to see.

Entry and exit routes, stairs and walkways, wards, operating theatres, waiting areas and all areas of the workplace (including private homes) should be well lit.

Adequate lighting after dark may be required for outdoor paths around the workplace and in carparks. Outdoor lighting should allow workers to move about easily without the risk of falling.

Emergency lighting must be provided for the safe evacuation of people in the event of an emergency.

Lighting for work areas should be sufficient to prevent WHS risks. In most cases, this will mean ensuring the workplace is well-lit, including in areas such as carparks. In areas where lower levels of lighting are required (e.g. to reduce stimulus that may cause agitation, or where patients or clients are sleeping), lighting should still be adequate to protect against risks (e.g. trips or collisions).

For more information on lighting in the workplace, see *Code of Practice: Managing the work environment and facilities*.

Access to adequate and accessible facilities

Providing adequate and accessible facilities for workers is an important part of ensuring the workplace is free from WHS risks. In determining the kind of facilities to provide, you must consider:

- the nature of the work and hazards at the workplace
- the size, location and type of workplace, and
- the number and type of workers (e.g. gender, work roles) at the workplace.

Table 3 below further outlines key considerations when designing facilities.

Table 3: Key considerations for designing facilities

Facility	Key considerations
General considerations for all work areas	<p>Designed so they are free from WHS risks.</p> <p>Suitable for all tasks and equipment used in them.</p> <p>Suitable for use by all people who may use them (e.g. bariatric rooms will require a larger design, aged care bathrooms may need additional handrails, lifting equipment and space for additional staff).</p> <p>Ensure flooring is non-slip, level, clean and free of trip hazards.</p> <p>Suitable for emergencies (e.g. large enough to accommodate a crash cart and code blue or code black teams).</p>

Facility	Key considerations
Free, clean drinking water	<p>The temperature of drinking water should be at or below 24 degrees.</p> <p>Sometimes direct connection to a water supply is not possible. For example, workers on the road should have access to public drinking water or bottled water.</p>
Eating facilities	<p>Workers must be provided with clean facilities for eating, preparing and storing food.</p> <p>For residential care and supported accommodation, break rooms should be separate from the client's living spaces.</p> <p>Eating facilities should be separate from work areas to avoid contamination, and to allow workers a break away from patients or clients.</p> <p>Where possible, work should be scheduled to allow workers travelling or working in remote areas access to suitable eating facilities. Where access to eating facilities for workers isn't possible, the only enclosed facility available to them may be their vehicle. In this instance, portable food storage facilities may be required, such as a car fridge or insulated lunch box.</p>
Handwashing	<p>Hand hygiene facilities, like alcohol-based handrub dispensers or sinks with soap and water, should be provided in all examination and treatment areas, procedure rooms and near toilets (i.e. not in an adjacent room). They should also be in places where hygiene is important (e.g. kitchens, laundries, pharmacies, surgery rooms, laboratories, bathrooms and change rooms).</p> <p>Alcohol-based handrub should be provided in disposable cartridges with disposable nozzles, designed for hands-free dispensing. Refillable dispensers should not be used due to the risk of contamination.</p> <p>Alcohol-based handrub should contain at least 60% alcohol. Dispensers should be placed at the point of care and in all areas of the workplace including at reception, to encourage use by administrative staff, patients, visitors and workers.</p> <p>Alcohol-based handrub dispensers need to be suitably located out of the reach of children, at a height that avoids splashing in eyes, or in supervised locations. These dispensers should also not be placed near heat sources and electric motors, or near a sink. Use of alcohol-free sanitisers may be required in some settings (e.g. mental health facilities, alcohol withdrawal units).</p> <p>For workplaces where there are no hand washing facilities, workers should have access to alternative hand hygiene facilities (e.g. alcohol-based hand sanitiser, hospital-grade wipes, or a portable water container with soap and paper towels).</p>
Toilets	<p>All workers must have access to clean toilets at work, including workers with a disability and workers who do not identify as male or female.</p> <p>Toilets should be located inside a building or as close as possible to the workplace. In multistorey buildings, toilets should be located on at least every second floor.</p> <p>Toilets should be supplied with toilet paper, handwashing facilities, including a sink and liquid hand soap, rubbish bins, and sanitary bins. Air dryers may also be fitted in toilets.</p> <p>For mobile, temporary or remote workplaces, workers must have planned access to other toilets, such as public toilets or toilets at a client's home. Information should be provided on where the toilets are located. Toilets in a client's home should be lockable and allow for privacy.</p>

Facility	Key considerations
Housekeeping facilities	<p>Housekeeping in the workplace involves designating and keeping work areas, accessways, delivery areas, storage areas, waste management areas, vehicle parking areas clean and clear for safe movement.</p> <p>Provide enough storage spaces (e.g. closets) for workers doing housekeeping duties.</p> <p>All housekeeping rooms should:</p> <ul style="list-style-type: none"> • have appropriate PPE available • have an appropriate water supply and sink or floor drain • be big enough for the task and well ventilated, with suitable lighting and locks fitted to all doors • have safe chemical storage facilities, if required • be available as close as possible to the location needing housekeeping work, and • not be used to store other items or equipment not needed for housekeeping. <p>For more guidance on housekeeping, please refer to Safe Work Australia's <i>Slips and trips at the workplace fact sheet</i>.</p>
Change rooms	<p>Change rooms should be available to workers, depending on the nature of work.</p> <p>It may not always be possible for workers to have access to change rooms (e.g. when working in people's homes). For these workers, consider how workers can safely and hygienically handle used PPE and equipment.</p> <p>If provided, change rooms should include access to secure storage for personal belongings.</p> <p>Separate change rooms should be provided for each gender.</p> <p>The change room should allow a clear space of at least 0.5 square metres for each worker changing at any time.</p>
Personal storage	<p>Accessible and secure storage should be provided for personal items belonging to workers, like bags, jewellery, medication, or hygiene supplies. This storage should be separate from that provided for personal protective clothing and equipment to avoid contamination.</p> <p>In temporary or mobile workplaces, lockable containers kept in a safe place should be provided.</p>
Shower facilities	<p>At least one shower cubicle for every ten workers who may need to shower should be provided. These should be available for workers of all genders and should provide a suitable level of privacy.</p> <p>Safety showers and eye wash facilities may be required in some areas (e.g. pathology, pharmacy, engineering, cancer therapy) as required by relevant standards or a risk assessment.</p> <p>Accessible shower facilities should be provided for workers with disabilities.</p>
Rest and quiet areas	<p>Rest and quiet areas may be provided for workers on extended shifts or working longer hours (e.g. staff on call, medical officers who work overtime). These rooms can also be used to recover after stressful shifts (e.g. after traumatic events).</p> <p>Workers on sleepover shifts should be provided a separate space to sleep in, as well as linen and a bed to ensure they wake rested.</p>

Ventilation

Healthcare facilities are places where workers are more likely to be exposed to airborne biological hazards (e.g. bacteria and viruses). Ensuring adequate ventilation can reduce the concentration of airborne biological hazards in an indoor space. It is important to ensure ventilation and air cleaning mechanisms are suited to the type of work and level of risk.

Natural ventilation (e.g. opening windows and doors) may not be appropriate in high-risk settings, as it may spread the biological hazard to other areas. In these situations, heating ventilation and air conditioning (HVAC) systems fitted with HEPA filters may be necessary to remove biological hazards from the air. Fans may also be used to improve airflow. However, for all ventilation types, the direction of airflow must be from 'clean' to less clean areas, to avoid dispersing contaminated air.

HVAC systems should be well maintained and regularly serviced in accordance with manufacturers' instructions, to an agreed maintenance plan, and accurately documented in a maintenance record.

You should also consult a ventilation engineer or an occupational hygienist for advice on optimal ventilation when designing or refitting an area, or during an airborne-transmitted outbreak.

Additional guidance can be found in the *Code of Practice: Managing the work environment and facilities* and the *Australasian Health Facility Guidelines*.

Remote or isolated work

Remote or isolated work is work that is isolated from the assistance of other people because of the location, time or nature of the work being done. Assistance from other people includes support, rescue, medical assistance and emergency services.

Healthcare and social assistance services are often carried out in remote and isolated locations. For example, a residential care worker may work alone on a night shift, or a flying doctor service may visit a remote community.

Working alone or remotely increases the risk of any job. Exposure to **work-related violence** (which can come from clients, patients and members of the public or from other workers and providers) and poor access to emergency assistance are the main hazards that increase the risk of remote or isolated work. Working alone can also increase the severity of workplace injuries.

Remote and isolated work may carry other types of risk. For example, it can increase the likelihood of workers being exposed to psychosocial hazards. These hazards include:

- Lack of support (e.g. workers cannot easily ask questions, access resources or get help from supervisors or other workers)
- Work-related violence (e.g. security officers may be at greater risk of exposure to violence and aggression when working alone without back-up)
- Sexual and gender-based harassment (e.g. female workers may be at greater risk of sexual and gender-based harassment)
- Low role clarity (e.g. workers may not be able to easily discuss and clarify tasks)
- High job demands (e.g. a worker working alone cannot share or divide tasks when there are competing demands, such as when moving a patient or lifting and carrying heavy loads).

For more information see **Psychosocial hazards** and *Code of Practice: Managing psychosocial hazards at work*.

Working in private homes

Many healthcare and social assistance workers may deliver care and support in private homes (e.g. residential care facilities, and residential homes in the community). These homes are a private home for the client and a workplace for the worker. **You** have a duty to manage WHS risks and provide a safe working environment extends to private homes.

Working together with homeowners, clients, their families and others is important to minimising any WHS risks. Before visiting someone's home, a risk assessment should be conducted and suitable controls to manage risks must be put in place.

In some cases, the rights of a client in their home (e.g. the right to smoke cigarettes) may conflict with the rights of workers to a safe workplace (e.g. not being exposed to harmful carcinogens). You must eliminate or minimise WHS risks in private homes as much as you reasonably can. To do this, you must consult with homeowners or clients and do all you reasonably can to protect workers from WHS risks.

Workers also have the right to stop or refuse work they reasonably believe is unsafe.

Smoking

Smoke from cigarettes, vapes and similar products can cause cancer. Workers should never be exposed to this smoke. Where a workplace is also a person's home, smoking should not occur near or around workers.

When WHS hazards and risks are identified in a private home, you must share this information with workers, and with other employers or contractors who may deliver services at the home (e.g. presence of a dangerous pet). Ensure a pre-visit risk assessment is conducted for home visits. Where the risks of a home visit are high, care or support may need to be provided in another location, such as a facility where risks to WHS are lower.

Table 4 below includes example control measures **you** can use to control WHS risks in private homes.

Table 4: Example control measures for private homes

Duty	Examples of control measures
Ensuring safe access and movement	<ul style="list-style-type: none">• Ensure gates and doors to the home are easy to open• Pathway leading to the door is free of obstructions• Repair any broken steps• Grass is regularly mowed / kept short• Growth is cleared away (e.g. moss and slime)• Leaf litter from outdoor pathways is cleared away• Pets are restrained• Adequate lighting provided• Grab rails and a shower hose are installed in the shower• Changes in the floor surface level are indicated clearly in split-level homes (e.g. by using stair nosings of a different colour)• Ensure home is not cluttered

Duty	Examples of control measures
Ensuring the home is safe to work in	<ul style="list-style-type: none"> • Allow an adequate workspace to carry out tasks in a comfortable posture • Use mechanical aids or assistive devices such as hoists to minimise lifting and carrying • Ensure loose rugs or floor coverings do not pose a trip hazard or restrict the movement of wheeled devices • Provide suitable, clearly labelled cleaning products • Ensure exits are clear of obstacles • Ensure locks are functional • Ensure the house is not damp or mouldy • Laundry has adequate drainage • The clothesline is easy to reach. Beds are at a suitable height to minimise bending (e.g. by using bed blocks under the legs of the bed to increase the bed's height or bed and mattress lifters). • Stored equipment or objects are within easy reach. Heavy or frequently used items are stored between knee and shoulder height. • Workers are not exposed to hazards such as drug paraphernalia, vermin, rotten floorboards, etc.
Ensuring utilities are in good working order	<ul style="list-style-type: none"> • Provide and maintain smoke alarms • Electrical equipment is safe to use • Stove tops, washing machines, dryers, air-conditioners, heaters and internal and external lighting are well-maintained and in good working order.

Summary: How you should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Identify risks in the work environment by considering:

- the layout of the workplace (e.g. does it allow workers to move safely?)
- space provided for the work (e.g. is there enough space to work safely?)
- lighting (e.g. is the lighting enough or work area well-lit to keep them safe?)
- floors and surfaces (e.g. are floors even and well-maintained? Are ramps and stairs safe to use?)
- **ventilation** (e.g. are all work areas well-ventilated? Are risks of airborne contaminants well controlled?)
- temperature (e.g. is the workplace at a comfortable temperature?)
- first aid facilities (e.g. do first aid facilities cater for hazards in the workplace? Does the worker have a suitable first aid kit if working in a person's home?)
- other facilities for staff, such as water, food, bathrooms and toilets (e.g. are they in good working order, clean, safe and accessible?)
- emergency plans and procedures (e.g. has consideration been given to the types of emergencies that may be experienced at the workplace? Has the risk been assessed for a client's home?)
- remote or isolated work (e.g. do workers have access to communications?)

For work in people's homes, you should also consider:

- animals (e.g. Are there pets that may be aggressive? Does the house contain insects or rodents?), and
- other signs of increased risks in the workplace (e.g. presence of weapons or drug paraphernalia, home very poorly maintained).

Summary: How you should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks of the hazard as much as you reasonably can, including through **good work design**.

Use the **hierarchy of controls**. Example controls for work environment hazards include:

- **Eliminating** the need to enter a hazardous private home by delivering a healthcare consultation remotely via video call, instead of going in person or having the person attend a clinic or hospital.
- **Substituting** hazardous cleaning products available in a client's home with non-toxic alternatives.
- **Isolating** the risk posed by a dangerous dog by ensuring it is always locked away in the garage whenever workers visit the home.
- **Engineering** controls, such as patient lifting devices, to reduce manual handling risks.
- **Administrative** controls. For example:
 - Send more than one worker to the home, especially where there is a risk of violence or aggression.
 - Ensure workers have access to communication, such as a suitable duress alarm.
 - Provide a system that allows you to know the whereabouts of your workers (e.g. workers notify you when they arrive at and leave a private home).
 - Providing training to your workers on effective de-escalation techniques in case they experience violence or aggression.
- **Provide PPE** (e.g. gloves and masks for cleaning)
- Use a combination of control measures to effectively eliminate or minimise risks.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Smoking at an aged care home

A residential aged care home allows residents to smoke cigarettes outside in a designated smoking area, on the basis that the facility is their home. However, HSRs for workers at the facility are concerned that workers are being exposed to the risk of lung cancer through second-hand smoke, as workers are often asked to supervise residents while they smoke.

The facility considers the issue through a risk assessment and determines that the risk to workers outweighs the need for residents to smoke. The facility develops a plan to be smoke-free with a phasing out of all smoking in the facility. The facility also provides residents with access to a 'quit smoking' program. Many residents oppose the initiative and some even move to another facility. However, the majority eventually come to understand their need to cooperate in providing a safe work environment, and the benefits for their own health.

3.8 Slips, trips and falls

Key messages

Slips, trips and falls are one of the largest causes of injuries in the healthcare and social assistance industry. Many slips, trips and falls involve falling on the same level, and falls on stairs and ramps. Slips, trips and falls indoors and outdoors and often result in serious injuries including fractures, musculoskeletal injuries, cuts and bruises.

Workers are sometimes blamed for slips, trips and falls (e.g. “You should have been more careful!”) when the cause is usually due to the way work is organised or an unsafe work environment. **You** can reduce the risk of slips, trips and falls through **good work design** (e.g. designing the work environment to be free from trip hazards), good maintenance of the work environment (e.g. keeping walkways clear), and systems of work that reduce risks (e.g. not creating high work demands that make workers feel they have to rush or take shortcuts).

What are slips, trips and falls?

Slips occur when there is not enough traction (i.e. there is insufficient contact, grip or friction between a person’s foot or shoe and a walking surface), leading to a loss of balance. Contaminants on surfaces that lead to slips include both wet (e.g. water, oil) or dry (e.g. talcum powder) substances. For example, grease on the floor of an aged care home’s kitchen could cause a worker’s shoe to slide and them to slip over. Slips may also cause a secondary injury (e.g. the worker who slips then hits their head on a bench).

Trips occur when a person’s foot or lower leg gets caught on an object while walking and throws them off balance. Tripping is often due to an obstacle or item the worker has not noticed (e.g. electrical cords from medical equipment, loose mats or carpet tiles, or changes in floor surface levels). For example, a disability support worker visiting a new client’s home may trip on a loose mat in a dark part of the house, causing them to lose balance and fall.

Falls at level often occur when a person unexpectedly falls from a higher surface to a lower surface, such as when a person loses balance or misses a step. Due to the speed and sudden forces involved, injuries can still occur even if no fall results. For example, while carrying an empty stretcher down a flight of stairs, a paramedic mis-stepped causing her to lose balance. She did not fall but strained her back muscles while trying to regain balance.

Common slips, trips and falls hazards in the healthcare and social assistance industry include:

- work demands that cause workers to rush or take shortcuts
- poorly designed tasks, such as requiring workers to carry objects that restrict their vision
- uneven steps, stairs or paths
- uneven or damaged floor surfaces (e.g. ridges between carpet and tiles, damaged carpets, loose mats and carpet tiles, rotted floorboards)
- wet or oily floors (e.g. bathrooms, recently washed floors or spills)
- obstructions or obstacles (e.g. rugs, towels on the bathroom floor, pets, excess furniture, electrical cords)
- inappropriate footwear
- carrying loads which obstruct a worker’s view
- poor lighting, and
- leaf litter, seed pods or slippery vegetation (e.g. moss on pathways or steps).

WHS duties associated with slips, trips and falls

You must do as much as you reasonably can to prevent slips, trips and falls.

You must eliminate risks as much as you reasonably can. If this is not possible, you must minimise risks as much as you reasonably can.

For more information, see:

- the *Code of Practice: Managing the work environment and facilities*
- Safe Work Australia's *Slips and trips at the workplace fact sheet*
- the SafeWork NSW website.

Managing risks of slips, trips and falls

Floors and surfaces

A wide range of floor covering materials are used in healthcare and social assistance workplaces.

When selecting floor coverings for the workplace, the following needs to be given consideration:

- How much foot traffic will the surface have?
- Does the flooring provide adequate grip or friction for safe walking when dry?
- For flooring that is walked on when wet, does it have enough grip to be safe when wet?
- What kind of work will happen? (e.g. carpet provides good slip resistance but may cause too much friction if workers need to push heavy patient beds or food trolleys.)
- How often, and in what way, will the surface be cleaned?

Floors should be inspected regularly and maintained to eliminate or minimise slip, trip and fall hazards. Floor surfaces should have enough grip to prevent slipping, especially in areas that are likely to become wet or contaminated. Surface treatments may also be used to improve slip resistance if required. Floors at different levels should be differentiated with contrasting colours.

The slip resistance of floors should be maintained by using the correct cleaning methods. Some cleaning methods may increase the risk of slips (e.g. through build-up that can reduce grip).

Carpeting should be avoided in clinical areas where patient care occurs, or in areas where:

- the carpet may make it difficult for workers to push patient beds
- wheelchairs or other wheeled equipment like food and medication trolleys are used, or
- unsecured carpets or floor mats should generally not be used unless they can be fixed in place, as they pose a trip hazard.

Floors and surfaces should also be routinely cleaned for infection control. For more information on infection control, see [biological hazards](#).

Lighting

Lighting must be provided, whether it is from a natural or artificial source, to allow safe movement around the workplace and to allow workers to perform their job without having to adopt awkward postures or strain their eyes to see.

Entry and exit routes, stairs and walkways, wards, operating theatres, waiting areas and all areas of the workplace (including private homes) should be well lit.

Adequate lighting after dark may be required for outdoor paths around the workplace and in carparks. Outdoor lighting should allow workers to move about easily without the risk of falling.

Emergency lighting must be provided for the safe evacuation of people in the event of an emergency.

For more information on lighting in the workplace, see *Code of Practice: Managing the work environment and facilities*.

Housekeeping

An untidy workplace can create slip, trip and fall risks. Therefore, good housekeeping practices are essential for all workplaces.

You should put systems in place to ensure:

- the source of any leaks is found and fixed before slips occur
- spills on floors are cleaned up as soon as possible
- walkways are kept clear of obstructions
- work materials and equipment are stored away safely
- waste is disposed of and removed from the workplace promptly, and
- workers are trained in housekeeping procedures and cooperate to maintain a clean and tidy workplace.

While it may be reasonable to expect workers to keep their immediate work area clean and tidy at the end of the working day, other options for carrying out general cleaning of the workplace should be considered, including having the workplace professionally cleaned.

Additional guidance on managing risks associated with slips, trips and falls is available in Safe Work Australia's *Slips and trips at the workplace fact sheet*.

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Examples of ways to identify hazards:

- Consult with relevant people like workers and residents
- Inspect the workplace regularly
- Review injury data.
- Mark on a map of the work area where slips, trips and falls incidents have occurred.

Examples of things to consider when understanding the risks (Note: More than one thing can interact to increase the level of risk):

- **Planning and design:** Poor planning will result in risks even if the environment is well-maintained. Work planning and design includes considering:
 - design of work tasks (Can the task be designed differently, for example, by positioning key work areas closer together? Are workers rushing due to too much work, or time-critical tasks? Can equipment be provided to assist?)
 - manual handling (e.g. Are workers expected to carry objects that are too heavy or that restrict their vision? Can equipment such as a trolley be used?)
 - attentional demands (e.g. Is a worker's attention split between lots of different tasks and people? Are there flashing lights or loud noises in the workplace?).

- **Workplace layout** (e.g. consider current and future work tasks, how workers will move around, and the equipment required).
- **Floor surfaces** (e.g. flooring should be suitable for all expected work activities, possible contaminants, expected environmental conditions, and the characteristics of people using the area, such as people with poor mobility. Consider floor materials, finishes, and maintenance, and suitability of stairs and ramps).
- **Poor maintenance** (e.g. loose or curling floor matting, torn carpet, uneven or broken concrete footpaths, lack of cleaning).
- **Lack of storage** (e.g. accessways or walkways are obstructed by items, not enough power points within range resulting in trailing cables, no suitable location for patient lifters).
- **Housekeeping** (e.g. messy work environment creating limited space for safe walking or using equipment safely, not having enough waste bins so waste is left on the ground, poor or non-existent housekeeping procedures).
- **Lighting** (e.g. not enough light particularly in areas of low natural light such as underground levels and stairwells, glare, reflections or shadowing).
- **PPE** (e.g. Ensure workers have shoes with good grip. Workers wearing goggles, face masks or helmets can reduce vision and increase the risk of a fall).

A detailed list of questions to consider when preventing slips, trips or falls can be found in the SafeWork NSW *Guide to preventing slips, trips and falls at work*.

Summary: How you should control risks

Consult with workers and others to design controls.

Eliminate or minimise the risks of the hazard as much as you reasonably can, including through good work design.

Example controls using the hierarchy of controls for slips, trips and falls include:

- **Eliminate** the risks of slips, trips and falls (e.g. fix a broken paver)
- **Substitute** the hazard with a safer alternative (e.g. replace old, worn flooring with a newer, slip-resistant surface)
- **Isolate** the hazard from a person exposed to it (e.g. prevent access to a staircase with a broken step and provide an alternative route until it is fixed).
- **Engineering controls** (e.g. install rails and non-slip surfaces to bathrooms, improve lighting, provide adequate drainage, use equipment to avoid having to reach high places)
- **Administrative controls** (e.g. implement housekeeping procedures, regularly inspect the workplace for trip hazards)
- **Provide PPE** (e.g. slip-resistant footwear).

Use a combination of controls to effectively eliminate or minimise risks.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Alternative route

A disability support provider was contacted by a client asking for in-home care services. An initial house inspection identified that the front stairs were damaged and posed a significant tripping risk. As repairs would be costly, the provider and client agreed that workers would enter the house through the back door, which was well-lit and had stable concrete flooring. The provider informed workers of this approach, and the client was able to receive their in-home care while mitigating the trip hazard for the workers.

3.9 Equipment hazards

Key messages

Equipment in the healthcare and social assistance industry is used for a range of purposes, including to manage WHS risks. For example, hoists can reduce the risks associated with people handling and face masks can reduce the risk of infectious diseases. However, equipment can also introduce risks that need to be managed in the workplace. Thinking about what equipment to use, and ensuring it is well-maintained, and reduces the risk of injuries or illnesses.

What are equipment hazards?

Note: WHS laws use the technical term 'plant', a term used to cover any machinery, equipment, appliance, software, container, attachment, tool, substance and structure, or any component or thing fitted or connected to any of those things.

This Code uses the term 'equipment' instead but covers the same things and the same legal requirements that relate to plant.

Equipment in the healthcare and social assistance industry is wide-ranging and can include X-ray and MRI machines and CT scanners, ventilators, dialysis machines, surgical equipment, hospital beds, examination tables, lifting equipment and vehicles. It can also include computers, monitors and other equipment used for communication and record-keeping.

The level of risk can change or increase if equipment is not well maintained, not fit-for-purpose for the task or not used properly (e.g. a hoist is not well maintained causing its lifting arm to disconnect from the lifting column). Other risks include hearing loss due to noisy equipment, and musculoskeletal disorders caused by manually lifting a patient or client or using poorly designed equipment.

WHS duties associated with equipment

Under WHS laws, there are specific duties that apply for equipment. These are outlined in Table 5. Note that equipment that relies only on manual power for its operation and is designed to be mainly supported by hand (e.g. a syringe) is not covered by the specific duties relating to equipment.

For more information see [Who has WHS legal responsibilities](#) and the *Code of Practice: Managing the risks of plant in the workplace*.

Table 5: WHS duties relating to equipment

Duty holder	WHS duties
Employer or contractor with management or control of fixtures, fittings or equipment	<ul style="list-style-type: none"> • Must ensure the health and safety of workers is not put at risk when working with equipment, as much as you reasonably can. This includes workers involved in installing, commissioning, operating, inspecting, maintaining, repairing, transporting, storing, and dismantling the equipment. Employers and contractors must identify and manage the risks associated with equipment. • Must take reasonable steps to ensure the equipment is only used to do what it is designed to, unless the proposed use does not increase the risk to health and safety. For example, an employer must ensure that a patient hoist is only used to lift patients (and not, for example, furniture). • Must review the manufacturer's and supplier's instructions for safe set-up, installation, use, and maintenance of equipment and any other relevant safety information. • Must inspect each item of equipment in the workplace and observe how it is used. • Must ensure that maintenance, inspection and, if necessary, testing of equipment is carried out by a competent person. Maintenance and repair must be done in accordance with the manufacturer's specifications.
Designers, manufacturers, importers and suppliers of equipment, substances or structures	<ul style="list-style-type: none"> • Must ensure that equipment, substances or structures designed, manufactured, imported or supplied are without risks to health and safety, as much as you reasonably can. • This duty includes testing and analysis and providing specific information about the equipment or substance. • In most cases, the supplier will be responsible for inspecting and maintaining the equipment.
Installers	<ul style="list-style-type: none"> • Must ensure equipment is erected or installed in accordance with the manufacturer's instructions and with regard to any relevant Australian Standard (e.g. AS/NZS 3000 Electrical installations, also known as the Wiring Rules). • Should notify the designer, manufacturer, supplier and person with management or control of equipment of new risks identified during the equipment installation.
Workers	<ul style="list-style-type: none"> • Workers who operate equipment should be competent or suitably supervised during training, so they do not put themselves or others at risk.

Managing risks of equipment

Radiology

Machines that use radiation for medical purposes pose risks to health and safety for workers. All Australian jurisdictions have annual limits for occupational exposure to radiation.

Key controls for managing risks of radiation include:

- rotating workers through tasks to ensure their exposure to radiation is as low as possible
- avoiding radiation exposure by pregnant or breastfeeding workers
- monitoring the health of workers, including through regular health monitoring
- use of dosimeters, with adequate systems and training in place to ensure that multiple workers are not using the same dosimeter

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- using appropriate PPE including lead-lined aprons
 - ensuring workers are suitably trained
 - controlling access to radiology areas, and
 - using signage to warn people in the workplace about areas where radiation exposure may occur.

You should ensure that risks to workers' health from radiation are managed in accordance with the Australian Radiation Protection and Nuclear Safety Agency's *Code for Radiation Protection in Medical Exposure*. More detailed information is provided in that code.

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Examples of ways to identify hazards:

- Observe how work is carried out and what equipment is used
- Talk to workers, HSRs, manufacturers, suppliers and other relevant people.
- Review manufacturer's instructions, records and incident reports related to equipment.

Examples of things to consider when assessing risks:

- **suitability of equipment:** is it being used for its intended purpose? Has it been modified from its intended use?
- **location of equipment:** does it have an impact on the design and layout of the workplace? Are workers able to access the equipment without risks?
- **abnormal conditions:** are there any abnormal situations, misuse or fluctuation in operating conditions you can foresee?
 - You should think about all the activities that may be carried out during the life of the equipment (e.g. installation, commission, operation, inspection, maintenance, repair, transport, storage and dismantling.)

Summary: How **you** should control risks

Consult with workers and **others** to design **controls**.

Eliminate the risks of equipment hazards as much as you reasonably can, including through **good work design**.

If risks cannot be eliminated, use the **hierarchy of controls**. The following are example controls for managing the risks of equipment:

- **Substitute** the hazard with a safer alternative (e.g. replace castors or improve handles on trolleys to make them easier to push or use)
- **Isolate** the hazard from any person exposed to it (e.g. install screens to minimise radiation from equipment such as X-Ray and MRI machines).
- **Engineering controls** (e.g. equipment guarding)
- **Administrative controls** (e.g. implement a tag-out system to ensure the equipment is isolated from its power source and not operated while maintenance or cleaning work is being done, train workers to operate equipment safely).
- **Provide PPE** (e.g. lead-lined aprons for workers using X-Ray machines, protective eyewear).
- Use a combination of control measures to effectively eliminate or minimise risks.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Mobile workstations

Nurses in a busy regional hospital have been using mobile workstations with laptops to take clinical notes and manage patient information. Since the workstations were rolled out, there has been an increased incidence among nurses of wrist injuries, which the hospital suspects may be due to the ergonomic set-up of the workstations. On reviewing the manufacturer's instructions for both the laptop and the mobile workstation, the hospital discovers they have been set up incorrectly and are not being used as intended.

The hospital consults with nurses who share that the mobile workstations have increased both physical and psychosocial risks, as nurses also have less time away from patients and feel they are expected to be 'always on the go'. The hospital redesigns work processes, rotating nurses through shared, static workstations away from patients for administrative work. The workstations are ergonomically designed and reduce the incidence of wrist injuries.

3.10 Vehicle hazards

Key messages

Many workers in the healthcare and social assistance industry perform jobs that require the use of a vehicle. In Australia, vehicle-related incidents are the single biggest cause of work-related fatalities and can also pose significant injury risks for both workers and others.

Vehicles may belong to an organisation, or workers may use their own car. Either way, a vehicle being used for a work purpose is a workplace, and **your** responsibilities for managing WHS risks apply.

What are vehicle hazards?

Vehicle-related hazards in the healthcare and social assistance industry do not just occur while driving on public roads. Other risks include patient handling in and out of vehicles, violence and aggression from patients within vehicles (including while driving), and vehicle roll-aways.

WHS duties for vehicle hazards

When using a vehicle for work, the vehicle becomes a workplace. This means the same WHS legal responsibilities that you have in other workplaces apply in a vehicle.

When is a vehicle a workplace?

- When the vehicle is owned, leased or hired by the employer or organisation.
- When the vehicle being operated is owned by another organisation where a worker is the passenger.
- When a worker uses their own vehicle for work.
- When a worker travels on public transport such as taxis, buses, ride share and trains as part of their work.

You must ensure that vehicles used for work are suitable, safe and properly maintained. Like any vehicle, vehicles used for work should comply with road rules and safety standards. Workers must take reasonable care of their own safety when driving by following policies, procedures and road rules.

Managing the risks of vehicle hazards

You must manage risks to the health and safety of workers associated with vehicles, such as during the transport of people between facilities and activities.

Road safety should not rely only on individual driving behaviour. You must put suitable and adequate control measures in place to manage the risks associated with driving. It is important to maintain an ongoing risk management process to prevent harm to the worker, patients or clients, and any other people in the workplace.

Risks when transporting patients or clients

When transporting patients or clients, you should consider the following risks:

Duty holder	Description
Patient or client-related risks	<p>When transporting patients or clients, you should assess any risks that relate to their characteristics, such as medical conditions, known instances of aggression, mobility, and care needs. A care plan can help assess each patient or client's unique needs, by including recommended medical aids, listing known cultural practices, and outlining safe handling practices (e.g. listing lifts and hoists required to move them, organising interpreting services to ensure informed consent, the number of workers required for safe lifting).</p> <p>For example, if workers are transporting a client with bariatric needs, ensure that a suitable vehicle is used with proper restraints and equipment is available to safely transport, handle and lift the client into the vehicle. This includes having specific bariatric-rated lifting equipment and a wheelchair. Also ensure there is enough space in the vehicle to accommodate the workers, client and equipment needed to perform tasks safely.</p>
Suitability of the vehicle	<p>When transporting patients or clients, it is important to select an appropriate vehicle for the task. Consider whether the vehicle can safely transport the patient or client, caters to their condition or bodily characteristics, the distance to be travelled and the road conditions of the planned route. Vehicles should be well-maintained and equipped with necessary safety features, and able to accommodate the required medical equipment. Employers and organisations must schedule regular vehicle inspections and maintenance to prevent breakdowns or other mechanical issues during travel.</p> <p>Vehicles with wheelchairs should include loading ramps and the ability to restrain wheelchairs safely during transit.</p> <p>Vehicles should also be suitably equipped, including with emergency communication devices, spare tyres and adequate water in remote areas.</p> <p>For example, if a client requires oxygen, secure the cylinder behind the client's seat (if possible). Additional cylinders should be transported in the boot of vehicles, placed horizontally and firmly secured to prevent rolling. Leave the window slightly open when transporting or using oxygen.</p>
Worker's suitability to carry out transport tasks	<p>You must ensure workers have enough information, training, instruction or supervision, to prevent WHS risks as much as you reasonably can. This should include a valid driving licence and could also include training on risk management, road safety, patient or client care on the road, safe equipment use, driving in dangerous conditions (e.g. floodwaters or bushfire areas) and relevant policies and procedures such as incident reporting.</p> <p>Workers should not be required to drive through floodwaters or bushfire areas, including if an area is still dangerous after a flood or fire has passed (e.g. fallen powerlines after a disaster).</p> <p>Workers should also not be required to drive when fatigued, as this can greatly increase the risk of a crash.</p>

Duty holder	Description
Emergency response related risks	<p>Emergency transport introduces increased risks due to the urgent nature of care required, time constraints, high-stress situations and the unique road rules that apply to emergency vehicles. This pressure to act quickly can lead to potential compromises in safety, due to factors such as increased driving speed, rapid decision-making and stressful interactions with patients or family members. In such scenarios, both patients and emergency transport workers may face additional risks that must be considered and managed by employers or contractors.</p> <p>For example, two paramedics responded to a rapidly deteriorating patient experiencing severe chest pain late at night. Since the patient's outcome was heavily dependent on timely medical intervention, the paramedics had to drive at higher speeds and move through intersections while traffic lights were red. The patient lived on the second floor of a townhouse. Navigating the staircase without a patient lift resulted in an injury to one paramedic.</p> <p>Following the incident, the ambulance operator reviewed the equipment it provides in ambulances and increased the number containing patient hoists. The type of equipment available was noted in the dispatch system, and procedures changed to ask 000 callers if a building has stairs - allowing the right equipment to be sent.</p>

For more information see:

- the Transport for NSW *Road safety and your work: A guide for employers*.

Vehicle roll-aways

Vehicles that are not immobilised properly can pose serious risks to workers and others. Vehicle roll-aways result in a significant number of serious injuries and fatalities in Australia each year. Roll-aways can occur with any type of vehicle, including ambulances or private cars.

Roll-away incidents can be caused by:

- vehicles parked on an incline or unstable ground with brakes not engaged properly
- equipment failure or inadequate maintenance of the braking system
- starting a vehicle while it is in gear
- accidental use of the vehicle controls
- wheels not correctly immobilised, and
- a lack of training for workers on how to correctly immobilise vehicles.

More information on managing the risk of vehicle roll-aways is provided in Safe Work Australia's *Fact sheet: Prevention of vehicle roll-aways*.

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Examples of ways to identify hazards:

- Regularly inspecting vehicles, equipment and parking areas (e.g. worn-out tyres, brakes, lifting equipment in ambulances, adequate lighting in parking areas).
- Monitor daily transport activities and look at weather reports.
- Understand the client's behaviour when travelling in a car (e.g. does travelling in a vehicle increase their agitation? Do they require supervision beyond the driver?)

Examples of things to consider when understanding the risks:

- How likely is the risk of injury? (e.g. How often must the worker drive between clients? Are there hazardous road conditions like rain or traffic?)
- How might risks occur? (e.g. location of patient or client in the vehicle, use of mobile phone while driving, driver fatigue or stress, unsafe entering and exiting of vehicle, inadequate securing of patients or equipment, inadequate vehicle maintenance, sudden patient behaviour changes during transport)
- How serious could the harm be? (e.g. potential injuries from vehicle accidents, musculoskeletal injuries from lifting patients, infection risks when transporting patients with communicable diseases).

Summary: How you should control risks

Consult with workers and others to design controls.

Eliminate the risks of the hazard as much as you reasonably can, including through good work design.

Use the hierarchy of controls. The following are example controls for managing vehicle risks:

- **Eliminate** the risk (e.g. cancel non-essential trips especially during extreme weather, use video conferencing software instead).
- **Substitute** the hazard with a safer alternative (e.g. use a professional patient transport service instead of a worker's car to drive clients).
- **Isolate** the hazard from people (e.g. use designated pick-up and drop off zones to separate vehicles from workers and pedestrians).
- **Engineering controls** (e.g. ramps, lifting equipment, reverse cameras, parking sensors, vehicle tracking systems).
- **Administrative controls** (e.g. schedule enough time between visits to avoid rushing, limit consecutive shifts to prevent fatigue, provide training on safe driving and vehicle inspection).
- **Provide PPE** (e.g. masks and gloves to prevent the spread of infections in an enclosed vehicle, high-visibility vests when working in areas with traffic).
- Use a combination of control measures to effectively eliminate or minimise risks.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Resident transport

An aged care worker is tasked with transporting a resident with a history of mental health conditions. Every fortnight, he drives the resident from his care facility to the local medical centre for a routine appointment.

The resident has exhibited aggressive behaviour in the past, but no incidents were expected during this trip.

However, mid-journey he suddenly becomes agitated and aggressive. The behaviour escalates from kicking the back of the worker's seat to reaching forward from behind and attempting to choke and shove the worker, who struggles to maintain control of the vehicle.

Luckily, on this occasion the worker manages to pull over safely and calm the resident down before returning to the aged care home. The worker immediately reports the incident to her supervisor.

A review of the incident identified that the incident was a serious one which put the lives of the worker, the resident and other road users at risk. The facility decided to:

- monitor patients before transport for signs of potential behaviour risks.
- install a physical barrier to separate the driver from passengers, where appropriate.
- arrange for some medical visits to occur at the aged care facility.
- avoid seating patients with known behavioural issues directly behind the driver.
- roster on additional staff members when required.
- safely pull over on the road at the first signs of aggressive behaviour.
- review incidents where aggressive behaviour has been recorded and evaluate whether these patients require a second support worker during transport.

3.11 Electrical hazards

Key messages

Many workers in the healthcare and social assistance industry regularly use electrical equipment as part of their duties, creating potential WHS risks to workers and others in the workplace. Electrical hazards can arise from a variety of factors such as damaged cords, old devices and improper use of fixed or portable medical devices.

Larger facilities such as hospitals and aged care homes may have well-established procedures for managing electrical risks. However, workers providing care and support in private homes may be more likely to encounter hazardous electrical equipment that has not been inspected by an electrician. **You** should ensure all workers are aware of the risk of electrical hazards, and do not attempt to fix electrical issues yourselves. This must only be done by a qualified electrician.

What are electrical risks?

Electrical risks are the risks of death or other injury caused directly or indirectly by electricity. The most common causes of electrical deaths or injuries are:

Electric shocks: The human body conducts electricity. If any part of the body touches live electricity, it can cause an electric shock. Injuries caused by electric shock can include burns to the skin, burns to internal tissues, damage to the heart or death.

Electrical fires resulting from an electrical fault, arcing or explosion, which can cause death or burns.

WHS duties for electrical hazards

You must manage electrical risks at the workplace. When managing electrical risks, risks must be eliminated as much as reasonably possible. If this is not possible, the risks must be minimised as much as reasonably possible.

You must ensure that electrical equipment is suitable, safe and properly maintained regardless of who owns or supplies the device and where it is located (e.g. hospitals or private homes). This includes ensuring that:

- residual current devices (RCDs, sometimes known as ‘safety switches’) are installed. RCDs are a personal protection device that disconnect electricity in case of electrical fault and can be both fixed or portable. Fixed RCDs are usually installed at either the switchboard or a fixed socket outlet. Portable RCDs are usually plugged into a socket outlet fitted to a power cable.
 - Workers providing care or support in private homes should be provided with a portable RCD to protect their safety when using any electrical devices in the home.

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- You must ensure RCDs are tested regularly and working effectively. This includes daily push button tests by the user and tripping time tests by a suitably qualified person every 6 months.
 - any malfunctioning equipment is disconnected, isolated from electricity supply and removed from use if safe to do so.
 - only competent persons (e.g. a qualified electrician) routinely test and tag electrical equipment prior to use or after a suspected malfunction.
 - reporting arrangements are made to let supervisors and other workers know about electrical equipment taken out of service, especially for safety reasons.
 - workers do not use electrical equipment in hostile conditions (e.g. wet or dusty areas, outdoors) unless the equipment is made for those conditions.

Workers have a responsibility to ensure they are safe while using any electrical equipment by following workplace policies and procedures.

Managing risks from electrical hazards

Some equipment involves greater risk than others. The healthcare and social assistance industry often relies on portable medical devices that use electricity like ventilators, patient monitoring equipment, power-assisted beds and domestic appliances like vacuum cleaners and hair dryers. Regular movement of plug-in equipment can cause damage to plugs and socket outlets, electrical connections, and electrical cables. Electrical cables can also become damaged if caught in bed mechanisms. Cables should be positioned to avoid this.

Workers exposed to electrical risks are not the only ones at risk. Faulty electrical equipment can also lead to fires and damage to property which can cause widespread death or injuries.

Employers and contractors must manage WHS risks to workers associated with electrical hazards. It is important to maintain an ongoing risk management process to prevent harm to the worker and any other people in the workplace.

For more information see:

- *Code of Practice: Managing electrical risks in the workplace*
- Safe Work Australia's *Electrical risks at the workplace fact sheet*
- **Managing WHS Risks**

Summary: How **you** should identify and assess hazards and risks

Consult with workers and **others** to **identify and assess hazards and risks**.

Examples of ways to identify hazards:

- Consider injury and safety data related to electrical hazards.
- Train workers to recognise warning signs like hot outlets or switches and tripping circuit breakers.
- Test and tag electrical equipment regularly, especially in hostile environments.

Examples of things to consider when understanding the risks:

- How likely is it? (e.g. Do workers need to use untested electrical equipment in private homes? How often do workers use equipment near a water source? How often do workers mention warning signs like hot outlets?).
- How might the hazard occur? (e.g. frequent movement of 'plug in' electrical equipment causing wear and tear to the electrical cord, plug and socket outlet, use of older electrical equipment with fewer safety features, or no RCD protection provided in private home).

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- How serious can the harm be? (e.g. electrocution causing death, electric shock causing injury or fire leading to burns).

Summary: How you should control risks

With electrical hazards, you should ensure:

- RCDs are installed and portable RCDs provided for private homes,
- malfunctioning equipment is disconnected, isolated and removed from use,
- only qualified electricians test and tag electrical equipment and test RCDs
- reporting of electrical equipment that is taken out of service, especially for safety reasons, and
- workers do not use unsuitable electrical equipment in hostile conditions (e.g. wet or dusty areas, outdoors).

Consult with workers and others to design controls.

Eliminate the risks of the hazard as much as you reasonably can, including through good work design.

Use the hierarchy of controls. The following are example controls for electrical hazards:

- **Eliminate the hazard** (e.g. turn off electricity to isolate hazardous equipment).
- **Substitute** the hazard with a safer alternative (e.g. use a battery operated device instead of one connected to mains power).
- **Isolate the hazard** (e.g. lock-out tag-out of circuit protective device and apply a danger tag).
- **Engineering controls** (e.g. RCDs, cable protection covers to prevent damage to electrical cables, provide enough socket outlets to prevent overloading)
- **Administrative control measures** (e.g. schedule regular inspections, set protocols for workers to unplug equipment when not in use, train workers to identify and report faulty equipment, have a licensed electrician test and tag electrical equipment and RCDs, use permits and warning signs).
- **Provide PPE** e.g. wear insulated gloves when working with electrical switchboards, use protective footwear to prevent electric shocks, wear, arc rated full face shield when working in high current and arcing.
- Use a combination of control measures to effectively eliminate or minimise risks.

Maintain and review controls to ensure they are being used and are effective, especially after any changes to the task or workplace.

Case study – Electrical risks in a patient’s home

A home care support worker is visiting an 82-year-old with mobility issues and early-stage dementia at his home to assist with daily activities. During her visit, the worker notices that an electric heater has a frayed power cord, and multiple appliances are plugged into a single power outlet. As she begins preparing lunch in the kitchen, she hears a popping sound from the living room and sees sparks coming from the heater.

Luckily, there is no open fire, but the sparks and smoke indicate an electrical fault that needs professional attention. The worker turns off the power, checks her patient is ok, and reports the incident to her employer who calls out an electrician.

Following the incident, the worker was issued with a portable RCD which she now uses at all client’s homes. She was also given a fire blanket and fire extinguisher in case a fire begins while she is working. The worker also now begins each visit with a quick inspection of the workplace for hazards, using a checklist which includes checking for damaged or faulty electrical equipment. The employer recognises its failure to assess WHS risks and improves this with a comprehensive overhaul of its risk management practices.

4. Resources

Police

The Police Assistance Line operates 24 hours a day, 7 days a week and allows the reporting of crime over the phone with the information being made immediately available to your local police.

Phone: 131 444 (In cases of emergency, please call 000). Website: www.aic.gov.au/contact-us/report-crime

Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission is the national regulator of Commonwealth funded aged care services. They have various functions, including resolving complaints about aged care services and undertaking compliance and enforcement actions. Website: agedcarequality.gov.au

National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission

The NDIS Commission is an independent Australian Government regulator. They have various functions, including regulating and registering NDIS providers and monitoring NDIS providers and their compliance with the NDIS Code of Conduct. Website: ndiscommission.gov.au

Dementia Behaviour Management Advisory Services (DBMAS)

The DBMAS helps staff and carers to support people living with dementia experiencing changes to their behaviour by providing assessment, clinical support, care planning, mentoring, linking to current research and a 24-hour help line. Website: dementia.com.au/dbmas

Human rights agencies

Human rights agencies can investigate reports about human rights breaches and discrimination, including workplace sexual harassment:

National: The Australian Human Rights Commission

New South Wales: Anti-Discrimination New South Wales

Fair Work Commission

If you are a worker and have been treated unfairly or punished by your employer because you reported a WHS incident, you may be able to make a complaint to the Fair Work Commission.

Phone: 1300 799 675. Website: fwc.gov.au

Fair Work Ombudsman

The Fair Work Ombudsman is Australia's national workplace relations regulator. It provides employees and employers with information and advice about workplace entitlements and obligations.

Phone: 13 13 94. Website: fairwork.gov.au

Workers' compensation

If a worker sustains a physical or psychological injury requiring medical attention or time off work, they may be able to access worker's compensation.

NSW State Insurance Regulatory Authority

Mental health support

There are a range of mental health bodies that can provide individual support to workers.

The National Mental Health Commission provides a list of organisations providing mental health support.

Website: www.mentalhealthcommission.gov.au/find-support

Domestic, family and sexual violence counselling

1800RESPECT is the national domestic, family and sexual violence counselling, information and support service. It can be contacted on 1800 737 732 or via online chat at www.1800respect.org.au

Disclaimer

This publication may contain information about the regulation and enforcement of work health and safety in NSW. It may include some of your obligations under some of the legislation that SafeWork NSW administers. To ensure you comply with your legal obligations you must refer to the appropriate legislation.

Information on the latest laws can be checked by visiting the NSW legislation website www.legislation.nsw.gov.au

This publication does not represent a comprehensive statement of the law as it applies to particular problems or to individuals or as a substitute for legal advice. You should seek independent legal advice if you need assistance on the application of the law to your situation.

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