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Industrial Relations



# HWSA FINAL REPORT

## Safe Steps – Manual Tasks, Slips & Trips in Hospitals

### National Intervention & Compliance Campaign

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# 1 PROJECT OVERVIEW

## 1.1 Executive Project Summary

This campaign was initiated by the Heads of Workplace Safety Authorities (HWSA) as manual tasks and slips/trips continue to be a major cause of injury and disease within the health and community services industry. During 2004-05 muscular stress accounted for 51% of claims, while slips/trips accounted for 16% of all claims.

The following workplace safety authorities worked together to successfully complete this campaign of inspector visits, evaluation survey and the provision of advice and information to hospitals across Australia:

- ACT WorkCover
- SafeWork SA
- WorkCover NSW
- WorkSafe Victoria
- WorkSafe WA
- Workplace Health & Safety Queensland
- Workplace Standards Tasmania
- WorkCover Tasmania
- Office of the Australian Safety and Compensation Council (ASCC)

A total of 203 audits were undertaken. Two prohibition notices and 103 improvement notices were issued, and in 300 instances formal advice was provided. Most of these actions (approximately 70%) were associated with manual task activities and the majority of improvement notices issued were associated with Central Sterilisation and Supply Department (CSSD) work area.

Most hospitals (approximately 70%) were rated as 'above compliant' for hazard identification, risk assessment, risk control, purchasing, training and management commitment. Less than 4% of all hospitals were assessed as below compliant for these key audit issues; that is, 96% of workplaces had a compliant risk assessment and control process. Although not directly comparable because the measures were different, this indicates improvement since the Design 4 Health campaign was performed in 2004.

Generally, there were no excessively 'significant barriers' to controlling risks identified; however, inadequate time, budget and staffing resources were recognised as hindering optimum approaches to risk management.

The audit assessment survey indicated that participating inspectors found the audit tool and process 'average to good':

- **audit tool:** in terms of format, ease of completion, effectiveness, timing
- **audit process:** in terms of training, usefulness of audit supplement, workplace response to visit and actions.

To assist with the evaluation of the campaign, the Office of the ASCC conducted a survey (Appendix C) of occupational health and safety (OHS) managers and staff in the non-clinical areas of hospitals to collect baseline information on OHS practices and attitudes. This survey found that most of the time OHS managers use appropriate ways of controlling manual task and slip/trip hazards; however, there are some areas for improvement, including in CSSD areas and in the provision of bariatric equipment.

The Office of the ASCC will conduct a follow-up survey of a sample of hospitals in approximately March 2009 to re-measure OHS manager perceptions and attitudes about health and safety in non-clinical areas, and to determine if any changes have occurred since the campaign was conducted.

## 1.2 Introduction

HWSA initiates national campaigns targeted at specific industries across all jurisdictions. These campaign activities support the National OHS Strategy 2002-2012, and facilitate the development of consistent approaches to nationally recognised priorities.

The National OHS Strategy identifies health and community services among its seven priority industries as well as body stressing as an injury mechanism for national attention. Manual handling in the health and community services industry sector was the focus of the 'Design 4 Health, National Manual Handling Campaign 2004'. In June 2007, HWSA decided once again to focus on manual handling in the health services sector with an additional focal area of slips/trips.

In determining the direction of this project, reference was made to the major findings of the Design 4 Health National Manual Handling Campaign 2004 as follows:

- dramatic improvements had occurred in the standard of manual handling risk management within the industry sector (hospitals, nursing homes and accommodation for the aged) in the five years prior to the 2004 campaign
- industry sub-sectors, including hospitals, met the minimum criteria for manual handling management systems
- workplaces appeared to have controlled patient-handling risks reasonably well; however, risks remain uncontrolled in other general manual handling areas such as kitchens, food services and laundries
- design issues relating to the design of buildings, furniture and equipment were identified as common sources of uncontrolled manual handling risks.

### 1.3 Project Objectives

The project developed information that can be used by HWSA members, each jurisdiction and by hospitals to reduce high incidence/severity manual handling and slips/trips risks in their non-clinical areas. The purpose of this project was to educate the hospital sector through a balance of information, assistance and enforcement activity.

The key objectives of this initiative were to:

- assess the level of compliance and the control of manual handling and slips/trips risks in specific areas of selected hospitals and compare this level of risk control against relevant state guidance materials
- improve awareness and knowledge of manual handling and slips/trips in specific areas of selected hospitals through providing reference information and relevant State guidance materials
- identify opportunities for improvement that lead to 'good practice' approaches to manual handling and slips/trips in specific areas of selected hospitals.

The project included:

- hospitals (excluding psychiatric hospitals and nursing homes)
- workplaces with 20 or more workers
- workplaces in the public and private sectors
- workplaces in regional and metropolitan areas.

Specifically the project focused on:

- manual tasks in non-clinical work areas (nominated tasks in kitchen, laundrette and CSSD areas)
- slips/trips – audit of environment in nominated high-risk work areas
- barriers and enablers to use of control measures in non-clinical areas (kitchen, laundrette and CSSD areas)
- bariatric care (data from survey only - not to be incorporated into audit).

## 1.4 Methodology and Process

The project approach included the following key components:

- development of a Communication Plan to provide strategic direction for communications activity in support of the 'Safe Steps' campaign
- development and distribution of letters to hospital CEOs and national and state media releases
- development of an audit tool to facilitate a uniform assessment process, referencing relevant guidance material as required
- completion of a national audit to assess the level of compliance and control of manual handling, slips/trips risk in hospital non-clinical work areas
- delivery of reference information to promote 'good practice' approaches to reduce risks associated with manual handling and slips/trips
- survey conducted pre-workplace audit/reference information to evaluate the level of knowledge and compliance before the audit process. This survey was funded by the Office of the ASCC and conducted in conjunction with the participating State authorities
- completion of an audit tool/process survey to evaluate inspectorate views of the campaign activities
- post-campaign follow-up survey to evaluate workplace changes (practices and/or attitudes) following the campaign. This survey will be funded by the Office of the ASCC, conducted in March 2009 in conjunction with the participating State authorities and reported separately to HWSA members.

### ***The Audit***

The audit tool and inspector supplement were developed and trialled over a six week period between January and February 2008. An information brochure to promote good practice and reduce risks associated with manual tasks and slips/trips was also developed. Training/briefings were provided to inspectors participating in the audits between March and May 2008. Jurisdictional inspectorates completed audits between April and August 2008.

Two hundred and three audits of hospitals were undertaken including eight pilot audits. Considerable variability existed in the size of hospitals. The number of staff reported ranged from 5 to 7,000 full-time equivalent employees and the number of beds from 3 to 952.

Laundry services were at least partially outsourced by 79% of the hospitals. Food services were outsourced by 20% and CSSD (sterilisation) by only 8%.

### ***The Office of the ASCC Survey – Pre Audit***

Separate surveys were designed for OHS managers and for non-clinical workers in kitchens, laundries and CSSD areas. The surveys were funded and developed by the Office of the ASCC and approved by the participating jurisdictions. Jurisdictions provided contact details for 409 hospitals.

The Office of the ASCC engaged Sweeney Research in Melbourne to administer the survey. Telephone calls were made to OHS managers asking for their cooperation to complete a survey and to distribute surveys and reply paid envelopes to workers in the non-clinical areas for which they had a duty of care (that is, surveys would not be distributed to those non-clinical areas which had been contracted out). Survey packs were mailed to OHS managers who had agreed to participate progressively between 13 March and 23 June 2008. Follow-up reminder postcards were sent out to OHS managers approximately two to three weeks after the initial mail-out. As well, the Office of the ASCC mailed surveys and reply paid envelopes to jurisdictions so that inspectors could distribute extra surveys to workers at the time of their inspection.

### ***Survey of Inspectorate views on audit tool/process***

A post campaign survey of inspectors was conducted to obtain feedback about the audit tool and process and identify opportunities for improvement for future campaigns (see Appendix B).

Each participating inspectorate was asked to comment on aspects of the audit tool and the audit process.

## **1.5 Reports**

The following reports/documents are attached:

- Safe Steps – manual tasks, slips/trips in hospital campaign – evaluation results (Appendix A)
- Inspectorate audit tool/process assessment survey (Appendix B)
- Office of the ASCC pre-audit survey (Appendix C)
- Audit Tool (Appendix D)
- Audit reference information (Appendix E).

## 1.6 Project Results

### 1.6.1 The Audit Findings – National Results (Appendix A)

#### *Hazard Identification*

**Table 1: Hospital Hazard Identification Rating: Manual Tasks & Slips/Trips N=195**

	Improvement Required		Compliant		Good Practice
	1	2	3	4	5
Manual Tasks		4%	21%	46%	29%
Slips/Trips		2%	25%	40%	33%

Hazard identification strategies for manual tasks were judged to be better than compliant in 75% of hospitals and 71% for slips/trips hazard identification.

Fewer than 5% of hospitals were judged not to have satisfactory hazard identification procedures for manual tasks and slip/trip hazards.

Reactive hazard identification systems were commonly mentioned; however proactive identification of potentially hazardous manual tasks appears less common. This was also identified in the survey findings.

#### *Risk Assessment*

**Table 2: Hospital Risk Assessment Rating: Manual Tasks & Slips/Trips N=195**

	Improvement Required		Compliant		Good Practice
	1	2	3	4	5
<b>Manual Tasks</b>		9%	20%	42%	29%
<b>Slips/Trips</b>		6%	27%	36%	31%

Risk assessment was assessed as being above compliance in 71% of hospitals for manual tasks and 67% for slip/trip hazards.

Fewer than 10% of hospitals in all jurisdictions were judged not to have adequate risk assessment in place for manual tasks and slip/trip hazards, with the exception of one jurisdiction (19% and 13% respectively). See Appendix A, Figure 8.

Generic risk management software is commonly used by hospitals for both manual tasks and slips/trips. The assessment procedures very rarely incorporated assessment of the direct manual tasks risk factors and interactions. Inspector comments indicated that the focus of risk assessments was on 'manual handling' rather than the more encompassing 'manual tasks'.

### ***Risk Control – Laundry Services***

**Table 3: Laundry Services Risk Control Rating: Manual Tasks (N= 377) & Slips/Trips**

	Improvement Required		Compliant		Good Practice
	1	2	3	4	5
<b>Manual Tasks</b>	4%	11%	28%	33%	24%
<b>Slips/Trips</b>	1%	4%	42%	30%	23%

Manual task risk control was judged to be less than compliant for 15% of the laundry tasks rated, and more than adequate for 57% of tasks observed. Less than 10% of laundry tasks were assessed to be non-compliant.

Inspectors issued improvement notices for 20 of the manual tasks rated and gave advice in a further 71 instances.

For many of these tasks the design of trolleys provided is a key concern, as is their proactive maintenance. This conclusion is supported by the Office of the ASCC survey findings. It was noted that many hospitals had replaced larger size linen bags with smaller size bags thus reducing the amount of linen that can be placed in them and the amount of force required to handle them. However, the relevant Australian Standard still calls for the larger bags.

Slips/trips risk control was rated as less than compliant for 5% of instances in which a rating was provided, and more than adequate for 53% of instances.

Six improvement notices were written for slip/trip hazards, and formal advice was provided in a further 29 instances. Examples of control measures implemented to control slips/trips risks included adequate lighting, non-slip flooring, non-slip footwear, ramps and lifts, good housekeeping and immediate clean-up of spillages. The use of such controls was reported by hospital staff in the Office of the ASCC survey.

### ***Risk Control – Food Services***

**Table 4: Food Services Risk Control Rating: Manual Tasks (N= 475) & Slips/Trips**

	Improvement Required		Compliant		Good Practice
	1	2	3	4	5
<b>Manual Tasks</b>	3%	10%	23%	36%	28%
<b>Slips/Trips</b>	1%	7%	32%	30%	30%

Manual task risk control ratings were recorded for 475 tasks related to food services. Inadequate risk control measures were identified in 13% of cases, and better than compliant ratings provided for 64% of tasks.

One prohibition notice, 32 improvement notices and 78 instances of formal advice were issued. Potentially hazardous tasks observed by inspectors associated with food services included putting away stock, emptying deep fryer oil and setting up meal trays. Issues for which controls were not in place or which resulted in compliance action included tasks associated with washing dishes, storage, handling heavy items, and lack of work area specific training.

Slips/trips control was rated as inadequate in 8% of instances, and as better than adequate in 60% of cases.

Seven improvement notices and 44 instances of formal advice were given for slip/trip hazards in food services. Enforcement actions were typically taken for issues such as damaged tiles, raised lino edges, inappropriate or poorly designed steps, or spills observed during inspection.

**Risk Control – CSSD Services**

**Table 5: CSSD Services Risk Control Rating: Manual Tasks (N= 475) & Slips/Trips**

	Improvement Required		Compliant		Good Practice
	1	2	3	4	5
<b>Manual Tasks</b>	3%	12%	24%	28%	33%
<b>Slips/Trips</b>	1%	2%	31%	33%	33%

Manual task risk control ratings were recorded for 475 manual tasks related to CSSD. Inadequate risk control measures were identified in 15% of cases and a better than compliant rating provided for 61% of tasks.

Thirty five improvement notices and 55 instances of formal advice were issued. Potentially hazardous tasks observed by inspectors mainly involved handling loan sets – unloading and loading for washing and sterilising and from theatre trolleys. This finding is supported by CSSD workers who reported difficulty in performing such tasks in the Office of the ASCC survey. Issues which resulted in compliance action included unloading and sorting loan kits, tasks associated with sterilising, and handling trays.

Slips/trips risk control was rated as better than compliant in 66% of cases and inadequate in just 3% of cases.

One prohibition notice, three improvement notices and 23 instances of formal advice were given for slip/trip hazards in CSSD. Some issues identified were wet floors and slip hazards when removing sterile equipment from washers/dryers. CSSD workers also identified these issues in the Office of the ASCC survey.

**Purchasing/Training/Management Commitment**

**Table 6: Purchasing/Training/ Management Commitment N=195**

	1	2	3	4	5
	Improvement Required		Compliant		Good Practice
<b>Purchasing</b>	4%		36%		60%
<b>Training Manual Tasks</b>	<4%		25%		71%
<b>Training Slips/Trips</b>	<4%		34%		62%
<b>Management Commitment</b>	<3%		~26%		~71%

Purchasing procedures were rated as less than adequate in 4% of hospitals, while 60% or ratings were better than compliant.

For manual task training, 71% of hospitals were rated as better than compliant and 62% for slips/trips. Less than 4% of hospitals were deemed to provide less than adequate training for both hazards. However, training was rarely noted to include training in manual tasks hazard identification and risk assessment; slip/trip hazards were commonly included as part of manual handling; and the emphasis continued to be on ‘manual handling’ rather than the more general ‘manual tasks’.

Management commitment was rated as being above compliance in approximately 71% of hospitals. Only 3% of ratings for management commitment were less than compliant.

**1.6.2 Survey of Inspectorate Views on Audit Tool/Process (Appendix B)**

Overall, the length, format and ease of completing the audit tool was assessed as ‘average’. Timing of the audit and its ability to identify reasons for inadequate control measures were also assessed as ‘average’; however, the tool’s ability to prompt during the assessment was rated as ‘good’.

Elements of the audit process were also rated. Training and audit material provided to support the process were rated as ‘good’. Workplace response in terms of initial reception and actions resulting from advice and notices given were also rated ‘good’. The distribution (to inspectors prior to the audit) of the Office of the ASCC survey was rated ‘average’. The value of HWSA compliance campaigns was also given an ‘average’ rating.

It should be noted that the response rate from the inspector surveys was low.

**1.6.3 Office of the ASCC Survey (Appendix C)**

In summary, the survey highlighted that most of the time managers (OHS and/or line managers) use appropriate ways of controlling manual task and slip/trip hazards in the non-clinical areas of hospitals.

### ***Hazard Identification – Manual Tasks***

Non-clinical workers reported that their work was far more physically demanding than OHS managers thought it was. This may indicate the need for more consultation between OHS managers and non clinical workers about biomechanical demands. However, OHS managers and non-clinical workers had similar views about what the top hazardous manual tasks were:

- in kitchens, both OHS managers (30%) and workers (17%) thought pushing and/or pulling trolleys was the most hazardous task. There was also agreement that the second most hazardous task was heavy lifting/heavy loads (16% and 14%)
- in laundries, OHS managers (19%) thought pushing and/or pulling trolleys was the most hazardous task, while workers (24%) thought it was moving/sorting dirty linen. Both OHS managers (17%) and workers (16%) thought heavy lifting/ heavy loads was the next most hazardous task
- in the CSSD areas, OHS managers (27%) and workers (26%) agreed that heavy lifting/heavy loads was the top most hazardous task. Their views about the second most hazardous manual task differed: 13% of managers nominated loan kits, and 15% of workers stated pushing/pulling trolleys.

### ***Hazard Identification – Slips/Trips***

In all three non-clinical areas, wet/greasy/slippery/soapy areas were nominated by both OHS managers and workers as the main hazard. However, workers in laundry and sterilisation and supply areas thought this was more of a hazard than OHS managers did:

- kitchens – OHS manager 44% and worker 48%
- laundries – OHS manager 15% and worker 44%
- sterilisation and supply areas – OHS manager 28% and worker 66%.

Slip/trip hazards were less frequently nominated by OHS managers compared with manual task hazards.

### ***Risk Assessment***

Overall, the survey highlighted that most of the time OHS managers reported using appropriate ways of controlling manual task, and slip/trip hazards. OHS managers (94%) were more likely than non-clinical workers (88%) to think that most of the time or always they/the hospital took particular prevention measures.

Ninety four percent of OHS managers reported that they had a policy on risk management, assessment and control of manual handling hazards. However, when asked about the strategies used to prevent workers from injuring their backs, or from developing aches and pains in hands, arms or shoulders, 23% of OHS managers stated that regular assessment and review of the way employees work is conducted only sometimes or never.

### ***Risk Control***

Overall, the findings suggest that for both manual handling, and slip/trip hazards in the non-clinical areas of hospitals, controls are being used most of the time or always. However, there were differences in OHS manager and non-clinical worker perceptions that most of the time or always:

- supervision is provided (OHS manager 79% and worker 50%)
- the frequency and length of time lifting/carrying tasks are done is reduced (66% and 44%)
- duties are rotated (70% and 51%)
- new, safe and appropriate equipment is provided (76% and 57%)
- extra employees/workers are provided in busy times (51% and 35%).

### ***Risk Control - Manual Tasks***

OHS managers reported that the hospital used the following strategies to prevent injuries from manual tasks in non-clinical areas:

- investigating incidents/complaints and making changes (92%)
- putting effective controls in place (89%)
- providing training on risk management policies and procedures (86%).

OHS managers were more likely than non-clinical workers to state that the following controls were used to prevent injuries from manual tasks in non-clinical areas:

- manual handling training/instruction is provided (OHS manager 92% and worker 78%)
- manual handling information/guidance material is provided (91% and 77%)
- potential manual handling hazards are actively identified (89% and 77%)
- the right manual handling tools and equipment is provided (91% and 75%).

The major strategies nominated by both OHS managers and non-clinical workers which are used to prevent injury from manual handling were:

- a policy on risk management, assessment and control of manual handling hazards (OHS manager 94% and worker 88%)
- maintenance and repair equipment as needed (94% and 83%)
- reviewing incident reports and statistics (95% and 82%)

- providing regular breaks (92% and 81%).

### ***Risk Control – Slips/Trips***

There was very little difference between each of the non-clinical areas in the use of controls. Both OHS managers and non-clinical workers stated that the main controls used most of the time or always for slip/trip hazards were:

- cleaning floors using the correct method for the floor surface (OHS manager 100% and worker 94%) and as often as necessary (100% and 92%)
- using signs to warn people if floors were slippery (97% and 94%)
- cleaning up spills quickly (97% and 93%)
- providing handrails (93% and 93%)
- good lighting on stairs (96% and 93%)
- using flooring appropriate to the type of work being done (99% and 90%).

OHS managers reported that for the major slip/trip hazards they had identified, the following occurred:

- incidents involving these hazards were investigated and recorded routinely on the register of injuries (97%)
- effective controls were put in place for these hazards (93%)
- employees/workers in the non-clinical areas participated in a discussion about the risk assessment of these hazards (86%)
- risk assessments were conducted and recorded for tasks identified as contributing to these hazards (85%)
- employee/worker training highlighted the risk management policies and procedures for these hazards (84%).

### ***Attitudes Towards Health and Safety Management***

Both OHS managers and non-clinical workers had positive and very similar attitudes towards health and safety. Both groups highlighted that most of the time or always it is important that there is a continuing emphasis on health and safety, that management knows what to do when a health and safety problem is raised, and that non-clinical workers are strongly encouraged to report unsafe conditions.

Nevertheless, there were some attitudes where OHS managers and non-clinical workers were in less agreement. These included: worker involvement in health and safety issues at the workplace (OHS managers 94% and workers 75%); management considers health and safety to be more important than getting the work done (OHS managers 89% and workers 69%); and worker involvement in

informing managers about important health and safety issues (OHS managers 94% and workers 78%).

### ***Bariatrics***

The majority (79%) of hospitals surveyed have management plans or policies for the manual handling of bariatric/obese patients. Seventy-seven percent of hospitals have operational procedures for the manual handling of bariatric/obese patients. Public rather than private hospitals are somewhat more likely to have these policies and procedures in place. However, less than one third of the hospitals surveyed (31%) have evaluated the effectiveness of their policies and procedures. While most hospitals (89%) consider manual handling needs when purchasing bariatric equipment, most do not have enough bariatric equipment, particularly birthing beds (22% have enough), mortuary equipment such as trolleys and fridges (21%), and carry chairs (17%).

### ***Issues to Highlight***

Based on the survey findings, the CSSD areas appear to be of concern. These workers reported experiencing low control over how they do their work and high workplace demands (high job strain) compared with laundry and kitchen workers. This means they are potentially at a higher risk of becoming stressed which, if not addressed, places these workers at a higher likelihood of developing psychological and physical injuries. Evidence of job strain is illustrated by worker reports in Appendix C.

Overall, the survey highlighted that future areas of focus in the non-clinical areas of hospitals might be:

- risk assessment
- training
- guidance material
- equipment
- staff supervision and numbers
- task allocation.

The survey results suggested the need for a greater focus on the use of all controls in the hierarchy, and a particular focus on elimination through the purchase of better equipment and improved design. Lower level administrative controls such as rotation of duties, monitoring of worker health, and providing regular breaks for staff were also limited in their use.

## **1.7 Project Outcomes and Recommendations**

The findings from the audits and the Office of the ASCC survey of the non-clinical areas of hospitals were reasonably well aligned. That is, most of the time hospitals are controlling their manual tasks, and slips/trips risks. However, it appears that there is some room for improvement for controlling risks in the non-clinical areas assessed, especially CSSDs.

The Safe Steps campaign outcomes outlined in the concept plan were:

- improvement in the level of manual task and slips/trips risk control in specific areas of selected hospitals receiving intervention
- identification of barriers and enablers to the use of control measures for manual tasks and slips/trips in specific areas of selected hospitals
- greater knowledge regarding the issues impacting on bariatric care
- in the longer term, this intervention will contribute to a reduction in injuries and deaths resulting from unsafe manual task practices and slips/trips in hospitals
- reporting against the evaluation design.

Although the audit approach does not allow direct data comparison with the Design 4 Health campaign, risk identification and control in non-clinical areas were found to be better controlled in 2008 than 2004, and these findings suggest improvement has been made since the last campaign.

Notices (105) and formal advice (300 instances) were provided with the objective of achieving improvement in control of manual task and slips/trips risks. The post-audit survey to be performed by the Office of the ASCC will help to evaluate the extent of any improvement made by hospitals since the audit.

Barriers to controlling risks such as inadequate time, budget, and staffing resources were reported by employees; however these did not significantly hinder implementation processes in the hospitals audited. Other barriers reported by non-clinical workers were heavy workload, stress, limited space and poor design.

The Office of the ASCC survey reported that 79% of hospitals surveyed have management plans or policies for the manual handling of bariatric patients. However, less than a third have evaluated their effectiveness. While 87% of hospitals surveyed consider manual task needs when purchasing equipment for bariatric patients, most do not have enough bariatric equipment.

Various evaluation points were highlighted in the Concept Plan. Letters to stakeholders and media releases were developed and distributed within the planned time-frames. The pre-audit survey was successfully completed with acceptable response rates. Audits and provision of reference materials were performed and finalised in the specified time-frame.

Both the audits and the Office of the ASCC survey found issues for concern in the CSSD areas. More improvement notices were written for this area than the other non-clinical areas, and CSSDI workers reported greater concern about manual tasks, slips/trips, pain, work demands, and lack of control over their work than workers in the other non-clinical areas. These findings suggest this is an area for future focus.

Risk assessment in non clinical areas generally might be another area for future focus. 23% of OHS managers reported that regular assessment and review of the way employees work was conducted only sometimes or never. This could be

interpreted to mean that while risk assessment procedures are in place, they may not consistently be conducted and/or that assessments might be a reactive measure following injury or incident, rather than being done on a routine basis as a proactive measure to determine if and where hazards exist. However, it should be noted that inspectors concluded that only 10% of hospitals did not have adequate risk assessment processes in place.

This suggests two possible measures:

- hospitals/OHS managers could place more emphasis on proactive hazard identification and risk assessment, monitoring and reviewing, consulting more with non clinical workers and providing more encouragement to workers to report problems
- different and more innovative approaches to auditing workplaces may be needed to establish that assessment procedures are actually taking place to ensure meaningful compliance for risk reduction.

The survey results indicate the need for a greater focus on the use of all controls in the hierarchy, and a particular focus on elimination through purchasing better equipment and workplace design.

### 1.7.1 Recommendations

- Best practice findings of this campaign should be communicated to the hospital sector and acknowledgment of the improvements made by hospitals since the Design 4 Health campaign.
- A national focus is required for CSSD areas to ensure implementation of control measures to reduce the risks associated with manual tasks. It is recommended that particular attention be paid to the design of containers, handling of loan sets, use of lifting equipment, work area design and psychosocial issues and liaison with equipment suppliers and building designers.
- The scope of bariatric care has enormous implications for a range of workplaces including hospitals, nursing homes, community health services, ambulance services, fire services, police services, mortuary services, and funeral homes. It is recommended that the initial baseline data obtained through this SafeSteps campaign be built upon in future projects, either at a state/jurisdictional level or in a future HWSA project, so that this issue is better understood with the ultimate goal of better control of the associated risks through research, auditing, enforcement and education. Hospitals are encouraged to evaluate their bariatric programs and to review equipment needs.
- The Office of the ASCC survey should be considered in all HWSA campaigns as a means to evaluate the effectiveness of the audit process and to measure possible changes in OHS attitudes and behaviours a result of the campaign.
- It is recommended that the national campaign reference group liaise with:

- Australian Standards regarding the linen bag size requirements
- trolley suppliers and manufacturers regarding trolley design
- hospital building designers regarding dishwashing, storage and CSSD work areas.
- Hospitals should:
  - ensure manual tasks and slips/trips training includes hazard identification and risk assessment
  - ensure consultation with workers during all phases of the risk management process
  - implement proactive maintenance programs
  - conduct proactive hazard identification and risk assessments
  - use risk assessment tools that specifically assess the manual tasks and slips/trips risk factors.
- An assessment of inspectorate views/opinions should be conducted as standard approach of all HWSA campaigns.
- A repeated number of national and jurisdictional audits and campaigns in hospitals and community services have occurred over the past five years and it is essential that acknowledgement of this level of intervention be taken into account when planning any future campaigns in this sector.

## **2 APPENDICES**

## **2.1 Appendix A – Safe Steps Campaign – Evaluation Results**

## **2.2 Appendix B – Inspectorate Audit Tool/Process Assessment Survey Report**

## **2.3 Appendix C – Office of the Australian Safety Compensation Council – Pre-Audit Survey**

## **2.4 Appendix D – Audit Tool**

**2.5 Appendix E – Audit Reference Information**