Government of South Australia

SafeWork SA

Community Workers

Work health and safety guidelines

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safe, fair, productive working lives

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Community Workers
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Introduction

The trend for people requiring care, basic maintenance, support or assistance in their own homes instead of in residential settings continues to increase at a rapid rate. As the number of people ageing or with a disability increases, there is a greater demand for services that allow them to stay in their own homes within the community. The range of providers, including carers, nurses, cleaners, housekeepers, property maintenance personnel and pharmacy services, highlights an increased need for guidance in managing work health and safety (WHS) challenges that arise when providing a service within homes or community settings.

Challenges include not only the many and varied WHS and other hazards faced by workers, but also the corresponding WHS responsibilities of employers, workers, contractors and clients. Sometimes these responsibilities may seem difficult to clearly define. For example, how do managers weigh up their duty of care to clients versus staff? Or, when services are contracted or brokered, who is responsible for ensuring a safe working environment?

These *Community Workers – Work health and safety guidelines* (the Guidelines) are intended to help you as an employer, manager or co-ordinator to address these dilemmas and manage hazards that you and your workers may face.

The Guidelines provide case studies illustrating solutions that have proven successful elsewhere, and include tools such as checklists and forms that you can adapt to your own workplace.

Section 3, WHS Management Systems, provides a guide for setting up and reviewing systems that will ensure effective management and good information and communication about WHS. All of the information provided is for guidance only and should be adapted to suit your own organisation's needs and situations.

The ultimate aim of the Guidelines is to prevent injury or illness to people working in the community. The costs of injury are high, not only the personal suffering and loss, but also the disruption to the client and the organisation.

1. Legislative requirements

WHS laws apply to all workplaces in South Australia and are defined in the *Work Health and Safety Act 2012* (SA) (the WHS Act) and the *Work Health and Safety Regulations 2012* (SA) (the WHS Regulations), and are supported by Codes of Practice. The Guidelines support that legislation and, where appropriate, refer to it.

The WHS legislation defines responsibilities of persons conducting a business or undertaking (PCBUs), workers, the self-employed, building owners and occupiers, and others. It is important to note that the definition of 'worker' includes 'a volunteer or a student gaining work experience' [WHS Act – Sections 7(1)(g) and 7 (1)(h)].

The WHS Act, the WHS Regulations and relevant Codes of Practice are available on the SafeWork SA website at safework.sa.gov.au.

PCBU responsibilities

As an employer you are a PCBU and you have a duty to ensure each worker, as far as reasonably practicable, is safe from injury and risks to health while at work and to:

- provide and maintain:
  - a safe working environment e.g. safe floors and access
  - safe systems (methods) of work e.g. safe manual handling methods and procedures for personal security
  - safe plant, equipment and substances e.g. safe electrical equipment and cleaning products
- provide adequate facilities e.g. toilets, hand washing facilities, drinking water etc
- provide information, instruction, training and supervision to ensure safety in an understandable language and form
- monitor working conditions e.g. by conducting home safety assessments
- monitor the health and safety of workers e.g. review injury records
- keep records of work-related incidents and injuries
- identify hazards, conduct risk assessments and control risks (i.e. see, assess and fix hazards, and evaluate and review outcomes – sometimes called the SAFER approach)
- develop, implement and review WHS policies and procedures
- consult workers and their representatives about WHS issues.

For further information, refer to WHS Act – Sections 19, 20 and 21, and WHS Regulations – Chapter 3.

Note that the definition of 'health' in the WHS Act includes 'psychological health' (WHS Act – Section 4).

Officer duties

Officers of a PCBU must exercise due diligence to ensure that the PCBU complies with its duty to ensure the health and safety of workers and others at the workplace (WHS Act – Section 24).

An 'Officer' is anyone who is involved in the higher level decision making of a business or organisation (WHS Act – Section 4). Due diligence is defined at Section 27 (5).

Coordinator/manager responsibilities

Coordinators/managers are to:

- ensure WHS policies and procedures are in place and followed
- ensure WHS risks are identified, assessed and controlled (and controls monitored and maintained)
- provide workers with the information, instruction, training and supervision required to safely carry out their jobs
- provide contractors with relevant information required to safely carry out their work and comply with their WHS responsibilities.

Worker responsibilities

All workers must:

- take reasonable care to protect their own health and safety
- not adversely affect the health and safety of others including clients and other workers
- use the equipment provided by the employer to protect their health and safety
- follow reasonable instructions on health and safety.

For further information, refer to WHS Act Section 28, and WHS Regulation 46.

Volunteer responsibilities

Volunteers are to:

- take reasonable care to protect their own health and safety
- not adversely affect the health and safety of others including clients and other workers
- use the equipment provided by the employer to protect their health and safety
- follow reasonable instructions on health and safety.

Refer to WHS Act Section 28, and WHS Regulation 46, for further information.

Contractor responsibilities

Companies that contract staff are PCBUs and will have a duty to ensure the work health and safety of the contract staff they place. Contract staff will have duties as workers.

Contractors are to:

- take reasonable care to protect their own health and safety
- not put clients or other workers at risk
- develop and implement WHS systems, policies and procedures for their own workers
- assess the workplace for hazards and develop safe work practices
- report any hazards/incidents to the broker/case manager.

More infformation on contracting community care services is provided on pages 9-10.

Client responsibilities

As the client's home is a workplace, clients must provide, as far as is reasonable, a safe working environment for workers coming into their home. Clients may be asked to:

- secure their pets to avoid harm to the worker
- allow reasonable modifications to be made to ensure the safety of workers e.g. move mats which may cause a fall
- leave an outside light on for after-dark visits
- not smoke while the worker is present
- provide appropriate and safe equipment (if required)
- treat workers with courtesy and respect (non-abusive and non-threatening).

This information should be provided to clients in simple information sheets/booklets.

Tobacco Products Regulation Act requirements

Employers must ensure that workers are not exposed to smoke in the workplace, including client homes.

Procedures must be implemented to ensure workers are not exposed to cigarette smoke e.g. agreement for the client to refrain from smoking while the worker is present.

Duty of care to client vs duty to worker

Generally it is possible for community organisations to meet their duty of care to clients while maintaining their obligation to protect the health and safety of workers. Where this is in doubt and the safety of workers appears at risk, it will be necessary to conduct a risk assessment (refer page 21) and develop a plan to manage the risk.

Solutions must ensure the safety of both the worker and the client, and wherever possible should not disadvantage either party. The client should, wherever possible, be involved in conducting risk assessments and developing solutions. In some situations it may be necessary to develop contracts with clients in order to provide a safe working environment.

Some situations require effective negotiation skills to enable a positive outcome for both the client and the service provider. Whether you approach this yourself or you engage the services of an external consultant, it may assist you to follow these steps:

- identify and define the problem
- gather information from the client and the worker
- analyse the information
- develop alternative solutions or controls
- select the most practical, effective and economic solution to resolve the problem
- evaluate the effectiveness of the situation – have you achieved your objective/desired outcome? If not, revisit the steps until a positive outcome is achieved.

Confidentiality/client privacy

Community care organisations and contracted agencies need to collect information about clients to enable them to provide an appropriate and effective service, without putting the client or workers at risk of injury or illness.

Permission to share the information should be obtained from the client or their legal representative and recorded with an explanation that the information is required to safely provide their services.

Details should include:

- to whom the information is to be released
- the purpose for which the information is to be released
- the period of time their permission is valid e.g. for the term of service delivery.

All relevant information needs to be obtained and shared (as appropriate) with workers who are involved in service delivery. This assists in ensuring that the appropriate personnel, equipment and service are provided and that the client and workers are safe from any injury or harm.

Organisations and workers obtaining client information need to ensure that this information is made available to other workers providing a service, where it is necessary to ensure their health and safety. The information must not be made available to others who are not involved in service delivery.

The *Privacy Act 1988* imposes restrictions on an organisation's ability to gather and disclose personal information. Disclosure of information to another agency or organisation is permitted with consent, but should be restricted to information that is necessary for the ongoing care needs of a client.

While client's wishes should be respected, a federal Privacy Act exemption applies where the WHS of workers is at risk and sharing information can reduce this risk. The employer's duty of care takes precedence over privacy issues, and criminal liability penalties may apply for failing to disclose information that results in injury.

Summary

The WHS legislation describes the roles and responsibilities of people working in any environment, including the home of a client, a vehicle or a community venue.

This section of the Guidelines has provided a brief summary of the WHS legal requirements and supporting legislation. Particular examples of how these may be implemented in the home and community sector are included in the following sections.

Further information

For more information regarding privacy requirements and smoking see:

- Federal *Privacy Act 1988*
  http://www.privacy.gov.au/act/privacyact/
- Federal Privacy Law, National Privacy Principles, see Principle 2.1(e)
  http://www.privacy.gov.au/act/
- *Tobacco Products Regulation Act 1997*
  http://www.austlii.edu.au/au/legis/sa/consol_act/tpra1997293/

2. Contracting community care services

A wide range of contractual agreements is in place in the community sector. While these vary in structure, WHS responsibilities should be clearly defined in all contractual agreements.

Selecting contractors

When selecting contractors, request that they outline how they will meet their WHS and injury management responsibilities. Ask for documentation to support what they have said they will do and the procedures they have in place to protect the health and safety of themselves, their workers (if relevant) and clients.

If the community care organisation conducts a telephone assessment rather than a risk assessment within the client's home, the contract needs to clearly outline the expectation that the contractor is responsible for conducting an in-home risk assessment. Any known hazards must be communicated to contractors.

Independent self-employed contractor responsibilities

Self-employed contractors are PCBUs and are responsible for their own WHS and the safety of their client.

Self-employed contractors are not covered by the workers rehabilitation and compensation system and must have their own personal injury insurance. They must also have public liability insurance to cover any injuries they cause to their clients and the public.

Community care organisations (the Principal) remain responsible for any WHS matters over which they have control (refer to WHS Act Section 16). They must ensure contractors are aware of their responsibilities and direct them to where they can obtain extra information and guidance. Arrangements for WHS must be clearly addressed in contracts and information provided to contractors. For example, contractors should be advised to report hazards or incidents to the Principal organisation if they cannot be readily addressed.

Service delivery should be regularly reviewed and monitored by the Principal for compliance with the WHS requirements of the contract. If additional hazards are identified by the Principal during the ongoing service provision, then these hazards need to be made known to the contractor to ensure that appropriate and effective controls are put in place.

A number of sections of these Guidelines are relevant to contractors. Contractors should be encouraged to use the Guidelines to develop their own systems for ensuring their safety and that of their clients.

Principal agency/relationship

The Principal organisation may contract to an agency that provides services by employing their own workers. In this situation the agency contracted is responsible for the WHS of their workers and the safety of the workplace. The agency will direct when and how the work will be done, and provide the necessary equipment. The agency must provide workers compensation coverage for their workers and public liability insurance. However, the Principal retains a duty for those WHS matters it can control or influence.

To meet this duty, the Principal should keep copies of the agency's WorkCover registration, public liability insurance and relevant WHS policies, procedures and processes on file. The Principal must conduct regular checks of compliance with WHS systems of the agency/contractor or obtain copies of the contractor's regular audits of their workers/sub-contractors and the outcomes of these audits. The Principal must also review the contractor's services annually, evaluating effectiveness and quality of the service.

The agency providing the workers may require the referring organisation (the Principal) to conduct a risk assessment and report hazards. The agency providing the service (not the Principal organisation) needs to verify the information, as it has legal responsibility for its workers.

There also needs to be agreement included within the contractual agreement about how identified hazards will be addressed.

For example, the case manager from the Principal organisation may be responsible for negotiating with the client to have changes made. In this case the agency providing the service still has a responsibility to ensure the safety of its workers, by implementing a plan to address the issue until the Principal takes action.

CASE STUDY

Sunrise Community Care, who organise services for clients in their own homes, contracted Handy Andy Gutter Cleaning service. Andy started the business seven years ago and had learned largely through his own mistakes.

As he worked alone, with a casual assistant during busy times, Andy had never bothered to document safety procedures or risk assessments until Sunrise made it mandatory if his contract was to be renewed. As they were generally satisfied with his performance and safety record, they suggested he approach SafeWork SA for some advice about the systems and documentation required.

Although paperwork was not Andy's strong point, once in place it was relatively easy to maintain, and he found it enabled him to gain additional work through government contracts. Sunrise then audited Andy's work on an annual basis as part of their internal audit system and found he complied with all requirements.

3. WHS management systems

Introduction

As an employer, manager or coordinator you are required to develop, implement and review an overall system for effectively managing WHS to ensure the safety of your workers.

Some of the activities that make up the WHS management system include:

- policies and procedures
- WHS planning
- hazard management
- induction and ongoing training for all staff
- consultation with workers and their representatives
- incident reporting and investigation
- injury management
- emergency planning
- record keeping, monitoring, analysis and review.

The complexity and formality of these activities will depend on the nature and size of your organisation.

Policies and procedures

Your WHS policy is a written statement of your commitment to WHS.

The policy should be developed in consultation with workers and include:

- the responsibilities of management and workers (including volunteers and contractors)
- accountabilities for WHS.

The policy should also:

- encourage cooperation and consultation between managers and workers
- outline how WHS will be managed using a planned continuous improvement approach with an emphasis on hazard management
- outline roles and responsibilities for injury management
- be available to workers (and understood by them).

Procedures should be developed to outline how the requirements of the policy will be met, so there may be procedures for:

- hazard management
- conducting client home assessments
- manual handling
- personal security
- hazardous substances
- accident reporting and investigation
- injury management
- any other areas of concern.

WHS planning

WHS management systems should be continuously improving with managers and workers always seeking to improve outcomes. Strategies for improvement should be included in a WHS plan.

Developing a plan requires you and your workers to:

- consider where you are now
- set goals or objectives for where you wish to be
- prioritise goals
- for each goal identify steps or actions needed to achieve it
- for each action, state who is responsible for doing it, the timeframe and date for review of progress
- review goals and the WHS plan regularly.

WHS Action Plan Flowchart

When reviewing current performance you will need to consider:

- the legislation (are you meeting your legal obligations?)
- incident, injury and near miss data
- feedback from workers about their hazards and concerns.

An example WHS Management Review Checklist is included on as **FORM 1** to assist you to measure your current performance.

When setting goals you will need to be realistic and set goals which can be achieved e.g. to reduce manual task injuries by 20% over the next two years (compared with last year).

Next, set priorities for which goals should be addressed first and which can be part of longer-term planning. You will need to consider:

- the particular needs of your organisation
- your major hazards
- compliance with the legislation
- resource and budget requirements
- training needs.

Once priorities have been decided you will be able to set timeframes for your plan. Include dates to review progress and the outcomes of completed tasks.

Next, identify what actions will be required to meet the goals and who will be responsible for the actions. Record this on an WHS action plan (an example is included as **FORM 2**).

Reassess your plan on a regular basis. You should do this in consultation with workers either formally or informally e.g. at each WHS committee meeting or staff meeting.

During the review of the plan you will be able to remove tasks that have been completed, add any new goals and tasks, and review the priority of those still underway.

WHS training

All management, staff and workers must receive regular WHS training. In particular, those meeting the definition of Officer should keep up to date with current WHS issues that may affect their workplace.

Manager, supervisor and coordinator WHS training should include:

- their roles and responsibilities
- legislation
- hazards and hazard management
- conducting audits and incident investigation
- resolution of WHS issues and the role of WHS inspectors
- roles, responsibilities and rights of workers
- injury management.

Worker (including volunteer) WHS training should include whatever knowledge and skills are needed for them to work safely. They should receive training:

- during induction (an example Induction Checklist is included as **FORM 4**)
- prior to commencing hazardous tasks they have not previously done
- regularly as updates.

Training should include:

- worker and management responsibilities
- specific hazards e.g. manual tasks, electrical safety, hazardous substances
- use of internal systems (hazard reporting, home safety checks, risk assessments and incident reporting).

In addition, specific training must be provided for Health and Safety Representatives (HSRs), WHS committee members, first aid officers, emergency control staff, WHS Co-ordinators and the Rehabilitation and Return-to-Work Coordinators (RRTWC).

The training needs to take into account the literacy levels of workers and volunteers, and the special needs of people whose first language is not English.

Planning training

An effective training programme requires planning. This means assessing training needs, setting objectives, working on the best methods to provide the training and evaluating the results. WHS training should be a component of the organisation's overall training plan.

Consultation

As employers and managers you are required to consult with workers before making changes to the workplace or work practices, policies and procedures that could affect the WHS of workers e.g. if you wished to extend service hours to provide after-hours services.

Since workers in the community do not work in a single workplace, consultation presents a challenge. The formality of the consultation process will depend on the size of the organisation. Larger organisations may have WHS committees and/or HSRs. WHS should be a regular agenda item at staff meetings of both large and small organisations.

WHS issues discussed at regular meetings may include:

- proposed changes to work procedures
- incident/hazard reporting
- feedback on issues previously reported
- WHS performance e.g. assessments conducted or improvements in injury statistics
- training needs
- review of the WHS plan (refer to part 5 of the WHS Act for more information on your consultation obligations).

Health and Safety Representatives

HSRs are elected by their work groups. These work groups are set up in consultation between PCBUs and interested workers. HSRs have a vital role to play in assisting workers in their workgroup to have health and safety issues raised and addressed. Through their own experience in the workplace, HSRs have a practical understanding of the health and safety problems that workers experience and can contribute suggestions about ways to resolve these problems.

HSRs are elected for a period of three years and in their role they may:

- inspect the workplace
- investigate incidents or injuries (along with management)
- represent the work group or individuals to management
- issue a provisional improvement notice (PIN) requiring a hazard to be corrected (where it is not resolved by consultation)
- direct that work ceases where there is an immediate risk to workers' WHS.

HSRs must be consulted by the PCBU about proposed changes that may affect worker health or safety.

They are entitled to facilities, time and resources to enable them to perform their duties, and five days paid training leave to attend approved WHS training (5 days in the first year, 3 days in the second year and 2 days in the third year).

For further information, refer to the WHS Act Part 5, Division 3, and WHS Regulations, Chapter 2.

Health and safety committees

Health and safety committees provide a forum for management and workers to meet regularly to discuss workplace health and safety issues. They are an important way to bring together workers' practical knowledge of jobs, and management's overview of the workplace and work organisation.

An employer may introduce a health and safety committee. If one is not in place, an HSR or five or more workers may request it and the employer must introduce one. An employer may also be instructed to introduce a committee by SafeWork SA. The committee's role is to provide for formal consultation and assist in the:

- development of policies and procedures
- development, implementation and review of WHS plans and set priorities
- resolution of WHS disputes
- review of WHS resources
- development and maintenance of effective injury and hazard management systems
- development of processes to ensure legal obligations are met
- review of rehabilitation and the needs of workers with disabilities.

Elected committees must meet at least quarterly. Committee members should be appropriately trained. At least half the members on a committee must be workers who represent a cross-section of the organisation.

For further information, refer to the WHS Act Part 5, Division 4.

Incident notification

All notifiable incidents involving workers or volunteers are to be reported to the PCBU immediately.

The PCBU must ensure that SafeWork SA is notified immediately after becoming aware of an incident by telephone on 1300 365 255 or 1800 777 209 (emergency number 24 hours/7days a week), or by fax on 8204 9200.

Refer to Sections 35-39 of the WHS Act for more details on incident notification).

A PCBU must keep a record of each notifiable incident for at least five (5) years from the day notice is given to the regulator [refer to the WHS Act, Section 38 (7)].

A notifiable incident which is immediately notifiable includes those which:

- result in death
- cause acute symptoms after exposure to a substance
- require treatment as an inpatient in a hospital immediately following the incident e.g. vehicle accidents.

SafeWork SA must be notified as soon as practicable after the injury occurs. The site must not be altered without permission of the Inspector, except to rescue an injured or deceased person or to prevent risk to other workers.

Notifiable Dangerous Incidents which result in an immediate and significant risk to a person (even if not resulting in injury) must also be reported immediately. Although dangerous occurrences are unlikely to occur in the community sector, they may include:

- collapse of a hoist e.g. lifter or scaffold
- damage to/or malfunction of major plant
- collapse of a trench or a building floor, wall or ceiling in a workplace
- explosion, fire or gas leak
- electric shock
- electrical short circuit malfunction or explosion
- flood, rock fall or ground collapse
- any other unintended or uncontrolled incident resulting from operations at a workplace.

If unsure whether an incident should be reported, telephone SafeWork SA on 1300 365 255 (refer to Section 37 of thew WHS Act for more details on what constitutes a dangerous incident).It is recommended that all incidents that have a work health and safety outcome or possible outcome are reported to the PCBU to ensure legal requirements are met.

Incident investigation

All incidents must be investigated to identify contributing hazards with the aim of preventing similar incidents. It will usually be a simple procedure but will, on occasions, require a more formal investigation. The investigation should involve the manager, the injured worker and HSR (if elected).

Things to consider in an investigation include:

- who was involved in the incident?
- where and when did it occur?
- what task was being performed?
- how did the incident occur?
- what were the events leading up to the incident?

The contributing factors may include one or more of the following:

- the task itself e.g. cleaning high shelves or lights
- equipment e.g. electrical fault, floor obstructions
- procedures (or other organisational factors)
- human error e.g. when the worker did not follow procedures.

For each identified hazard you should conduct a risk assessment and take steps to remove or reduce the risk of the incident recurring.

Injury management

While the major focus of the Guidelines is to assist you to prevent injuries or illness occurring, it is important to have an effective system in place to manage injuries when they do occur.

An injury management programme aims to achieve a safe return to work for injured workers in the shortest time possible. It needs to include all aspects of injury management including:

- treatment of the injury/illness
- rehabilitation
- return-to-work programs (or retraining where this is not possible)
- claims management.

In each organisation with more than 30 employees, a Rehabilitation and Return-to-Work Coordinator (RRTWC) must manage the rehabilitation process. The RRTWC must receive approved training in their role.

Injury management should start immediately after an injury occurs. It should be an active process involving the injured worker and aiming for an early return to work.

Effective injury management requires:

- open communication between the manager, injured worker, treating doctors, RRTWC, other professionals and the claims agent (where applicable)
- an injury management policy (this may be included in the WHS policy)
- procedures for claims management and rehabilitation
- a worker information sheet (including their rights and responsibilities and the employer's responsibilities) – an example is included as **FORM 14**)
- authority for exchange of information between the people involved in rehabilitation
- a letter to the treating doctor outlining the worker's normal roles and information about any suitable alternative duties available e.g. job dictionary
- ongoing contact between the manager/co-ordinator and the injured worker.

All records related to workers rehabilitation and compensation must be kept confidential (in a locked cabinet).

Emergency planning

It is essential that you and your workers have a plan in place for addressing foreseeable emergencies. This will include the office area, client homes and community venues visited. You will need to consider issues such as:

- fires (including bushfires, if relevant)
- security breaches
- medical emergencies
- motor vehicle accidents
- electrical shocks.

Factors to be considered include:

- prevention of fires e.g. report obvious electrical faults or inappropriately positioned heaters in client homes
- checking that workers and clients can safely exit from the office, home or venue e.g. is the exit from the home blocked by security doors or roller shutters?
- checking that a fire detection system is in place e.g. smoke alarms (but consider that workers should not depend on them to work as they may be faulty)
- a procedure to ensure workers report obvious electrical faults
- access to first aid and other emergency equipment e.g. in vehicles
- who to report to and how to seek help in the event of an emergency. This may include the need to use international colour coding for emergencies e.g. code red means fire, code black means personal threat, etc
- reporting and recording after the event (particularly for after-hours emergencies)
- debriefing after emergency events
- having procedures in place to address emergencies where there is no mobile phone coverage (e.g. using the client's phone). If using a mobile phone dial 000 or 112. This will obtain emergency services even if there is no SIM card in the phone or may get help if there is no service via your carrier.

It is essential to include emergency procedures in the staff induction process. Potential emergency procedures include those listed above and others that may be identified by your organisation. Ongoing training should then be provided to ensure all workers and contractors are familiar with those procedures.

WHS record keeping

There are legal requirements for you to maintain a range of WHS records, including those specified in the WHS Regulations.

These requirements include:

- injury/incident reports and investigations*
- workers rehabilitation and compensation records*
- first aid records
- chemical register identifying those which are classified as hazardous substances and including Material Safety Data Sheets (MSDS)
- risk assessments and controls
- training records
- certificates and licences
- maintenance and testing records (e.g. Residual Current Device [RCD] tests)
- hazard report forms (and actions taken)
- workplace inspection/safety check forms
- major incident/dangerous occurrence reports to SafeWork SA.

** These records must be kept confidential and access only allowed to authorised personnel.*

The records should be reviewed regularly (e.g. at staff meetings) to ensure the WHS system is effective and to identify areas for improvement.

The record keeping methods should also be reviewed regularly to ensure compliance and suitability, and to identify areas for improvement.

WHS monitoring and review

To achieve continuous improvement, it is essential that you and your workers regularly monitor and review what you currently do in relation to WHS. You can then plan how to improve your current practices and procedures.

This will require a review (or internal audit) of each of the components of WHS, including:

- monthly reviews of incidents and hazards
- annual overall system review (using a WHS Management Review Checklist – an example is included as **FORM 1**)
- review of WHS legislative compliance e.g. as per your internal audit schedule
- regular review of the suitability of, and compliance with, policies and procedures e.g. every two years.

The review may identify areas of practice requiring improvement or areas within the policies and procedures that need updating to reflect improved practice.

The outcomes of these reviews will then form the basis for your annual WHS plan, which may be a separate plan or included in the organisation's overall business plan.

During the process of review and improvement, if you find you need help to address specific WHS issues, assistance may be obtained from your employer organisation or SafeWork SA. Employers Mutual Limited or WorkCover*SA* provide information regarding workers rehabilitation and compensation.

Networking with other organisations providing care in clients' homes and/or the community will also provide a valuable source of information.

Further information

- Workers Rehabilitation and Compensation Act 1986
  http://www.austlii.edu.au/au/legis/sa/consol_act/wraca1986400/

4. Managing hazards

Introduction

Effective hazard management is the key to preventing or minimising workplace illness and injury. Hazard management is most effective when it is managed on a systems basis rather than ad hoc. An essential role you have as a PCBU, officer or coordinator is to effectively manage hazards. This involves five steps (often referred to as the **SAFER** approach):

- **SEE** (identify) the hazards
- **ASSESS** the risks (decide how serious they are)
- **FIX** (control) the risks
- **EVALUATE** the outcomes
- **REVIEW** the controls and monitor compliance.

The full legal requirements are included in WHS Regulations Chapter 3, Part 1.

This section provides you with some strategies and tools to help you manage hazards in a home or community setting. It is essential to reinforce with workers that their safety is paramount.

The major goal of managing hazards in the community is worker safety. They must be made aware that, if their personal safety is threatened, it is better to leave than remain in an at-risk environment.

Hazard identification

A hazard is something that has the potential to cause injury or illness. Examples of hazards in the community are heavy loads, worn steps, heavy gates, loose mats, faulty electrical equipment, hot items such as removing food from a microwave or oven, hazardous substances (such as cleaning products) and potential client and/or pet hazards.

To identify hazards you should:

- conduct a safety check before the worker starts work in a new client's home (an example Client Home WHS Assessment is included as **FORM 6**) or accompanies a client to a community venue such as a swimming centre for the first time
- seek information about hazards from referring agencies (an example Client Referral is included as **FORM 5**)
- encourage workers to report hazards using hazard forms or direct reporting (an example Hazard Report is included as **FORM 7**)
- discuss WHS at staff meetings (while maintaining client confidentiality)
- check records of incidents, injuries or near misses (an example Incident/Injury Report is included as **FORM 3**).

Some hazards will be more obvious than others. When you are conducting an inspection include both the outside of a home and the inside. Review the environment (lighting, access, dust and noise), security, housekeeping, work tasks, equipment and hazardous substances.

Although you are not required to do a written hazard assessment for every hazard, it may be useful for you to record any hazards you identify on a hazard form or hazard log (an example Hazard Log is included as **FORM 8**).

It is important to consult with the client when conducting a safety check and to involve them as much as possible, informing them of any issues identified which may affect their personal safety (see the example Client Home WHS Assessment, included as **FORM 6**, to record issues discussed with clients).

Risk assessment

Risk assessment is deciding the level of risk associated with a hazard in order to plan what to do about it. Risk assessment is best done in consultation with the people working in the area. To estimate the level of risk, you and your workers should consider:

- **Likelihood:** How likely is it that an injury or illness will result from the hazard?
- **Consequences:** How severe the injury or illness resulting from the hazard might be.

You may need to consider:

- the nature of the hazard e.g. heavy load or chemicals
- how it might affect health and safety e.g. back injury
- how workers are exposed to the hazard e.g. skin contact or inhaling shower cleaning chemicals
- how much, how often and how long workers are exposed e.g. 6 times per day for hours or 2 minutes per month
- the location of the hazard e.g. home, garden, shopping centre, clinic, office.

The following Risk Assessment Matrix is a useful tool for prioritising hazards by rating the level of risk. For example, a hazard that is likely to cause a major injury is rated as high risk, while one that is unlikely but could cause a minor injury is rated as medium risk.

Draw lines from your estimate of likelihood and consequence on the matrix – where they intersect indicates the level of risk.

Those hazards with the highest risk should be dealt with first. Those that present a lower risk, but can be easily addressed, should be fixed immediately.

It is useful to record the outcome of each risk assessment.

Risk Assessment Matrix

		LIKELIHOOD			
		Very likely	Likely	Unlikely	Highly unlikely
CONSEQUENCE	Fatality	Extreme	High	High	Medium
	Major injuries	High	High	Medium	Medium
	Minor injuries	High	Medium	Medium	Low
	Negligible injuries	Medium	Medium	Low	Low

Risk control

Once hazards have been identified and assessed as presenting a risk, action must be taken to eliminate the hazard or reduce the risk. The best option is to eliminate the hazard but this is not always possible. When choosing methods for reducing the risk, options should be selected from the 'hierarchy of control' (refer diagram below).

Control measures from the top of the hierarchy are the most effective and should be the first choice wherever possible. Those at the bottom of the hierarchy are less reliable and more difficult to maintain.

Once solutions have been selected, plan any action needed, who will do it and when, and set a suitable review date to check all actions are taken. You will also need to follow up the change to make sure it worked, that the risk is now removed or reduced and that it did not create any new hazards. It may be useful to document each step in the process e.g. on a Hazard Log (see example provided as **FORM 8**).

Hierarchy of Control

Example used: hazard identified - a caustic substance was used for cleaning the shower.

1. Eliminate the hazard	e.g. clean the shower without chemicals
If this is not practical then	
2. Substitute the hazard with something of lesser risk	e.g. use a safer cleaning product
If this is not practical then	
3. Use engineering controls e.g. redesign, ventilation, isolation	e.g. open the bathroom window and/or use an exhaust fan to increase ventilation when cleaning the shower
If this is not practical then	
4. Use administrative controls	e.g. write a safe work procedure on how to clean the shower safely by wiping the product on, not spraying it
If this is not practical then	
5. Use personal protective clothing or equipment	e.g. wear gloves and a respirator to clean the shower

CASE STUDY 1

Anne, a co-ordinator, doing an initial visit to Bill, a new client, found the front passage floor of his house was badly damaged by white ants. A risk assessment identified this as high risk (likely to cause a major injury).

As it was not possible to eliminate the problem (this would have been very costly to Bill) the hierarchy of control was considered.

Agreement was reached for Bill to receive his treatment in the rear sunroom, which had a concrete floor (a substitution control).

Bill's worker, Jill, was informed of this and it was recorded in his care folder.

When the solution was reviewed, it was found that to enter the rear door to the sunroom Jill had to walk through tall grass. As the weather was getting hot this presented a further hazard (assessed as high risk/unlikely but could cause a fatality from a snake bite).

Anne then arranged for Bill's son to cut the grass regularly.

These simple solutions allowed Jill to be safe while providing Bill's treatment.

Some of the major hazards within the community are in the areas of manual tasks, slips, trips and fall hazards, hazardous substances, electrical and equipment safety, personal security and isolated work, vehicle and driving safety, challenging or aggressive behaviour from clients or others and infection control.

Separate sections are included in these Guidelines to address these issues.

These hazards, however, are not the only hazards encountered in the community, so it is essential to use the methods outlined above to identify, assess and control the hazards specific to the individual homes or community venues where your workers do their work.

5. Hazardous manual tasks

Hazardous manual tasks are defined (see WHS Regulation 5) as any activity that requires a person to use their body (musculoskeletal system) to perform work. This includes lifting, lowering, pushing, pulling, carrying, holding or restraining something, and tasks which require repetitive actions, sustained postures and exposure to vibration.

Manual handling is a major cause of injury in the community sector. These injuries may result from:

- moving clients e.g. in and out of bed, chairs, vehicles or the shower
- lifting and carrying equipment or shopping e.g. from vehicles
- repetitive movements e.g. vacuuming/sweeping indoors or outdoor paths
- pushing clients in wheelchairs
- lack of space in homes
- moving heavy furniture (should not be done without the right equipment)
- stooping to low work surfaces e.g. beds or low sinks
- extended reaching e.g. up to high cupboards, high dusting, gutter maintenance.

Manual task hazards should be identified during the initial home safety check, but workers may also identify these when the tasks are being done:

- think about the tasks to be performed e.g. vacuuming, showering
- observe the work area e.g. bed height, space around the bed
- review the equipment e.g. the length of the vacuum cleaner tube/pipe.

When manual task hazards are identified, assessing the risk requires you to consider a number of factors. These include:

- actions, postures and movements e.g. bending, twisting, over-stretching
- workplace layout e.g. cramped work space, low work surface
- weights and forces (worker shouldn't lift more than 16-20kg)
- characteristics of the load e.g. unstable or unpredictable load, difficult to slide, push, pull or turn, difficult to handle, sharp edges, slippery
- location of load and distances moved e.g. storage above shoulder or below knee or load carried a long distance
- frequent and prolonged movements e.g. repetitive tasks, prolonged exertion
- job organisation e.g. heavy workload, too many clients in one day, lack of staff, unrealistic deadlines, bottlenecks of work
- work environment e.g. uneven or slippery floor surfaces, lighting, extremes of hot or cold
- individual factors e.g. worker skills and training, worker hampered by illness, disability or restrictive clothing
- vibration e.g. using power tools.

An example Hazardous Manual Task Risk Assessment is provided as **FORM 9** – use this for recording the assessment.

Possible solutions

Possible solutions may include:

- eliminate unnecessary manual handling tasks wherever possible e.g. encourage clients to move themselves
- develop and implement a 'No Lifting of People' policy, and a minimal lifting approach for other tasks
- provide mechanical aids e.g. laundry trolleys, client hoists or slide boards
- carry smaller loads of supplies
- raise the bed to a suitable height using bed blocks
- relocate the bed or furniture to allow enough space
- use a hand-held shower to prevent over-stretching
- store equipment within easy reach e.g. between shoulder and mid-thigh height rather than on the floor
- use two workers when using hoists, slide sheets or to carry heavy supplies, nominating one as the leader
- ensure enough workers are available to move large clients (bariatric clients often classified as those more than 30% over Body Mass Index [BMI] with a medical problem)
- provide competency-based manual task training, including hazard identification, risk assessment and control (specific to the community setting)
- provide and maintain suitable aids for outdoor tasks such as wheelbarrows, sack-trucks or trolleys to move loads
- use a long-handled squeegee to wash windows
- change work flows. Change tasks regularly e.g. vacuum two rooms, wash dishes, return to vacuuming
- provide extender wands for vacuum cleaners
- provide extender handles for dusters etc
- allow sufficient rest breaks
- review manual handling needs of clients if their condition changes (by suitably trained professionals when necessary)
- match the skills and abilities of workers with clients
- empower staff to refuse client requests which may present a risk.

CASE STUDY 1

John is a young man with Cerebral Palsy. He uses an electric wheelchair for mobility.

John lives alone in a home that he rents from a housing association. He receives support around the home and in community settings from support workers. John directs the workers in the specific services he receives which allow him to live as independently as possible.

John is conscious of all the latest trends and expressed a desire to purchase a futon. Workers who support John were concerned at the safety implications of this, as part of their role was to assist John in and out of bed and to and from his wheelchair. The low futon meant that workers would be required to bend excessively and use unsafe practices to perform this transfer.

John had reasonable mobility. Through negotiation between John, the workers and the service manager, arrangements were made for John to raise the futon and move himself into a position where he could be more easily transferred by staff. Eventually John became able to complete the transfer to and from his wheelchair all by himself.

In this case negotiation allowed for a win-win situation. John could still have his futon i.e. his rights had not been impeded. Likewise, workers were not required to perform an unsafe transfer thus preserving their right to a safe working environment. In addition the negotiations resulted in increased independence, mobility and fitness for John. It also became possible for John to choose the time he got in and out of bed rather than this being dictated by staff availability and rosters.

Ongoing monitoring of these arrangements ensures they still meet both the client's and the workers' safety needs.

CASE STUDY 2

Sam and Adam, who work for Acres Community Care (ACC), were required to transfer a client from the wheelchair to the bed in the evening using a lifting machine. Sam and Adam found this task difficult due to the space restrictions caused by furniture within the client's bedroom.

ACC negotiated with the client but were unable to come to a mutually agreed resolution. An external consultant was engaged to assist. An assessment of the tasks and the area in which the task was performed identified that the difficulty evolved from the placement of a heavy bedside table next to the bed, which prevented the wheelchair and lifter from being placed appropriately to enable a safe transfer.

The recommendation from the consultant was to place castors on the bedside table with wheel locks. This enabled Sam and Adam to easily move the bedside table out of the room prior to transfer of the client. The bedside table was then able to be placed back in the room after the transfer and be stabilised with the wheel locks, which met the needs of both the client and workers.

CASE STUDY 3

A worker regularly accompanied clients to a community swimming centre. A major manual task hazard identified was the lowering and lifting of clients to and from the pool. This required bending, twisting, over-stretching and moving a heavy load.

Clients were often not able to help with the move. The provider discussed the issue with pool management and then assisted in development of a funding proposal to a local service club for the installation of a hoist suitable for lowering and raising people from the pool. After suitable training, the risk of injury to the workers and clients, and also to other people who used the pool, was significantly reduced.

Further information

For more information see:

- *WHS Regulations,* Regulation 60

  http://www.legislation.sa.gov.au/LZ/C/R/OCCUPATIONAL%20HEALTH%20SAFETY%20AND%20WELFARE%20REGULATIONS%201995.aspx

- *Code of Practice – Hazardous Manual Tasks*

  http://www.safework.sa.gov.au/uploaded_files/resCOPManualHandling.pdf

- Transferring People Safely, WorkSafe Victoria 2006

  http://www.worksafe.vic.gov.au/wps/wcm/connect/WorkSafe/Home/Forms+and+Publications/Publications/import_Transferring+people+safely

- Manual Handling Guidelines Version 2, Department of Health (available to borrow from the SafeWork SA library)

- Occupational Job Dictionary, Aged Care Industry, SafeWork SA

  http://www.safework.sa.gov.au/contentPages/docs/ac_jd-01.pdf

6. Slips, trips and falls

Slips, trips and falls result in many injuries to workers and clients in the community setting.

Major slip, trip and fall hazards include:

- uneven or damaged floor surfaces e.g. ridges between carpet and tiles, damaged carpets, rotted floorboards
- loose mats and rugs, especially on polished floors, towels on the bathroom floor or bedding (including quilts) on the bedroom floor
- wet or oily floors e.g. bathrooms, recently washed floors or spills
- obstructions e.g. pets, excess furniture, electrical cords, boxes or newspapers
- working at heights e.g. to clean light fittings or to remove cobwebs, gutter cleaning, pruning
- inappropriate footwear
- carrying loads which obstruct the view
- poor lighting in client homes
- uneven steps, stairs or paths
- leaf litter, seed pods, slippery vegetation such as moss.

Assessment of the risk of these hazards requires you to consider the location of the hazard, how often workers (and clients) are exposed and the potential severity of an injury. For example, a fall from a height such as a ladder may result in a more severe injury than a fall on the same level. A risk assessment should be conducted and controls implemented before any work at height is conducted.

Possible solutions

Possible solutions may include:

- prevent entry to rooms with damaged floorboards
- remove loose mats (this may only be temporary while the worker is in the home) or stick them down
- negotiate the repair of damaged floor surfaces e.g. covering torn carpet with tape
- secure cords with tape
- remove storage from main walkways (at least making a wide-enough path to safely walk and push a wheelchair if required)
- negotiate the application of non-slip surfacing to bathroom floors (or fit non-slip mats)
- discourage the use of talcum powder in bathrooms
- minimise work at heights, provide long-handled extender dusters if needed, provide ‘feet on floor’ instruction with assessments made of high work
- train workers to reduce size of loads carried and to use trolleys where possible
- improve lighting e.g. replace globes or increase wattage
- negotiate the repair of broken steps, stairs and paths
- store items within easy reach
- wear non-slip footwear (may require a footwear policy)
- maintain good housekeeping e.g. wipe up spills, keep walkways free of storage and cables, monitor floor condition
- have safe work procedures and training in place for the use of ladders/step stools where high work cannot be avoided

- conduct risk assessments of all outdoor work at heights e.g. can ladders be secured, are there safe footings for the ladder, what is the condition of the roof, are ladders and equipment in good condition, weather conditions, height from exposed edge to ground level.

Further information

- Safeguards Information Sheet 'Ladders', SafeWork SA
  http://www.safework.sa.gov.au/uploaded_files/gs57i.pdf

7. Isolated or remote work

Community workers at times find themselves alone in situations where their access to support/help is limited. The WHS Regulations, Regulation 48, requires PCBUs to maintain effective communication with workers who work alone and/or in remote areas.

When assessing the risks to workers, employers need to consider how likely the threat is and how severe the outcome may be. You and your workers should consider the following:

- location of the workplace (is it isolated geographically?)
- if the worker had an incident, what is the likelihood of the client or their family being able to contact help on the worker's behalf?
- are workers working alone?
- is work carried out after dark?
- distances travelled, road surfaces and condition
- distances from help (where workers are in isolated areas)
- any neighbourhood security hazards
- mobile phone coverage.

Where the potential for a problem is identified, solutions must aim to eliminate or reduce the risk. In most situations, planning and technology will assist this. An example Home Visit Security Checklist is included as **FORM 10**

Possible solutions

Possible solutions may include:

- relocating the service to another location
- use two workers rather than one
- mobile phones or other electronic methods to obtain assistance, with emergency numbers keyed in to speed dial
- monitoring the location of staff e.g. staff to ring a central point within half an hour of the last job (not always possible)
- obtaining permission from the client to use their telephone for work-related calls
- ensuring workers carry ID badges specifying the organisation they work for
- ensuring workers have reliable vehicles (particularly for work at night) and roadside assistance coverage (see Section 10, 'Vehicle and Driver Safety', for more information)
- procedures and training for workers in reporting and recording incidents
- mapping emergency coordinates of remote properties/houses
- mapping areas where there is generally no mobile phone coverage and developing communication systems for these areas
- ensuring that a worker's family and friends have the relevant office contact details and can advise the workplace if the worker does not arrive home at their usual time
- providing the on-call coordinator with work time and location details to assist tracking workers who do not arrive home on time.

CASE STUDY 1

The Distant Country Care Service recognised that mobile phone coverage was a problem at many of their country sites. They plotted GPS and fire map locations for each client so that, if a situation did arise where help was required, they could speed up emergency response times.

CASE STUDY 2

Green's Community Care WHS Co-ordinator identified personal security as a major WHS risk, particularly for their workers who worked alone at night.

After researching options, the organisation purchased 30 mobile phones and provided them to each worker. A cost-effective plan was negotiated for call costs.

They identified a worker at their residential care site who would be available for workers to report to at the end of their shift. Each fortnight a roster of community workers is sent to the central point, listing finishing times for each after-hours worker. Each worker must ring the central point within half an hour of completion of work. Emergency numbers, including office contacts, were pre-entered into the speed dial section of each phone. If a call is not received, the co-ordinator is notified and takes action as outlined in their written procedures.

CASE STUDY 3

At West's Community Care, where 300 workers work 9am-5pm, the procedures in case study 2 would not be possible. Workers are encouraged to carry their mobile phones and enter the emergency numbers into speed dial.

Here, workers are required to tell their family of their expected time of return. Each worker is provided with a sticker listing the office number, which family members may ring if the worker does not arrive home within half an hour of the expected time. The agency will then ring the last client and take necessary steps.

This procedure can be made more formal in high risk situations, where two workers attend or the lone worker contacts the office directly on arrival at home (particularly where workers live alone).

Where indicated, and there is no mobile phone coverage, the office staff ring the 'at risk' client's home landline number to check the welfare of the worker. A code word is used to report any risks.

CASE STUDY 4

Eastern Community Care Service assessed the security risk for their workers as low, so their system involved notifying each client of the worker's arrival time, with instructions to ring the co-ordinator if they didn't arrive within 15 minutes of the set time. The co-ordinator could then 'back track' to locate the worker.

8. Challenging or aggressive behaviour

Workplace violence is defined as 'any incident where an employer or worker is abused, threatened or assaulted in situations relating to their work' and includes issues such as sexual harassment, bullying and challenging client behaviours.

Threats to the personal safety of community workers may arise from interaction with clients, client's family members or friends, or members of the general public. This issue presents a particular problem, as community workers often work alone and after dark. The work is conducted within another person's environment and workers can be confronted with values, attitudes and belief systems at odds with their specific training and experience.

It is sometimes difficult to anticipate who else may be in the house at the time workers visit or to control the behaviour of visitors. As a result, workers may be at risk of experiencing challenging, aggressive and/or violent behaviour from a client or a client's relative or visitor/s.

In most situations, planning and good interpersonal skills will significantly reduce the likelihood of situations deteriorating to the point where workers are threatened. Workers should be trained to always be aware of their surroundings and how to de-escalate tense situations.

Challenging behaviour may include:

- verbal abuse
- inappropriate sexual behaviour
- difficult personalities
- those with unrealistic expectations or who repeatedly refuse services
- aggressive or threatening behaviours directed at themselves, property or others.

These behaviours can put the physical or psychological health of workers at risk. There may also be an accumulative effect, that is, while a one-off incident may not cause psychological harm; repeated incidents may result in harm. Further, psychological harm from the incident will vary in degree from worker to worker depending on their past experiences, values and beliefs.

Factors that may contribute to clients displaying challenging behaviour include:

- pain (physical or psychological)
- a feeling of loss of control
- depression, anxiety, loss or grief
- frustration from not being understood due to language barriers or speech impediments, or from misunderstanding/misinterpreting information or situations
- lack of self worth, loneliness, feeling powerless, feeling ignored, having unmet needs or rejection
- confused states caused by dementia, hypoglycaemia or epilepsy
- mental illness or personality disorders
- brain injury or physical and neurological disability
- medication – either incorrect or omitted doses.

When facing the risk of challenging behaviour, you and your workers should consider whether the client exhibiting challenging behaviours has control of their behaviour or is without control e.g. due to brain injury, dementia, mental illness etc. Those who do have control should be made aware of the natural consequences of their behaviour e.g. changes to the services provided.

Where clients do not have control, it is essential to identify triggers and to prevent these occurring or to minimise the risk of hazardous outcomes. Details relating to the client's capacity to control behaviours, triggers, risk assessment, strategies to address specific behaviours and any actions taken must be recorded and communicated to relevant workers.

The worker's perception of aggressive behaviour is important. Not all expressed anger is a problem to workers, but if 'it hurts your feelings' or 'makes you feel uncomfortable' it is an incident and should be reported.

Policies and procedures

When there is the potential for workers to experience incidents of challenging behaviour, it is important for employers to ensure there are policies and procedures in place to minimise this potential. For example:

- policies and procedures relating to violence at work and working with clients who exhibit challenging behaviour
- communication strategies to ensure risks and safe work strategies are communicated to all workers involved
- close working relationships with other agencies
- emergency procedures and contingency plans are communicated to all workers and kept on hand during all visits e.g. prompt cards to remind workers not to park in driveways, to know exit points from homes and reminders about how to de-escalate threatening situations
- training/education about working with challenging behaviour including understanding warning signs, identifying risks, how to diffuse situations, permission to leave a situation if uncomfortable and how to establish systems and controls to minimise risks.

When developing a Prevention of Workplace Violence Policy include:

- acknowledgement of occupational violence hazards
- potential risk factors
- management commitment to preventing and managing workplace violence risks
- statement that occupational violence is unacceptable and will not be tolerated
- statement that appropriate action by workers will be supported. All incidents and near misses will be investigated and action taken to prevent or reduce risks.

When developing Challenging Behaviour Procedures consider:

- what is the scope of the definition of challenging behaviour?
- what is the potential impact on workers and what are their perceptions of factors which present risks?
- how frequently does challenging behaviour occur?
- what risks are associated with the challenging behaviour?
- what strategies can be used to identify and resolve aggressive or violent behaviour?
- what emergency procedures can be put in place?
- what support is available following incidents?

Management factors

Management factors to consider may include:

- policies and procedures are in place to address threatened or actual violence
- inter-agency referrals with little information are followed up for more information
- care plans flag potential risks and relevant workers are informed of flagged clients
- education is provided for workers who face challenging behaviours e.g. using a consistent approach and ensuring they are aware to withdraw immediately if they feel unsafe and to report any behaviour which may offend, so that other workers are forewarned
- visit times are controlled in a policy on after-hours work
- system in place to monitor visits e.g. contact with worker prior to and following visits
- ensure services are suspended following an aggressive/violent incident until it has been fully investigated and strategies to manage behaviour are implemented
- mobile phone coverage/duress alarm or security firm monitoring in place
- systems of hazard identification, risk assessment, incident reporting and investigation are in place
- known risks and control strategies are communicated to relevant workers
- systems are in place to support workers after incidents such as defusing, debriefing, counselling, Employee Assistance Programmes, monitoring and review
- a checklist outlining everything a worker needs to do to adequately prepare for a home visit is developed and used.

Client factors

Client factors to consider may include:

- medical conditions and capacity to control behaviour
- recent history of violence/aggression or criminal record
- behaviour of carers/significant others/visitors
- support available from carers and significant others
- client specific triggers for challenging behaviour
- frequency and predictability of challenging behaviours
- history of drug or alcohol abuse
- client capacity to present a physical threat or an infection control threat e.g. spitting, throwing bodily fluids, not disposing of sharps appropriately
- behaviours preventing completion of tasks
- client willingness to accept service
- gender/cultural expectations.

Safe working tips

Safe working tips for workers include:

- ensure pre-visit assessment and all other relevant information has been obtained
- if there is any suspicion of risk, arrange with your employer to have another worker accompany you
- obtain a list of emergency numbers and key the emergency number 000 or 112 into the quick-dial section of your mobile phone
- check that you have the correct location details for the client, a street directory and a first aid kit in your vehicle
- ensure you have any appropriate safety equipment with you including gloves, mask, antiseptic gels, torch and batteries (if lighting is poor or after dark)
- ensure your whereabouts are communicated to your employer and to your family if appropriate e.g. visiting client on the way home
- utilise any previous knowledge you, or other workers, have about the client, relatives, carers, visitors, neighbours etc
- dress appropriately e.g. business-like, non-provocative
- listen for conflict prior to entry
- respect that you are entering another person's environment
- stand back and to the side of the door after knocking
- keep mobile phone and keys on your person e.g. on a key ring on your belt
- know where the exit doors are and keep them clear and unlocked
- park vehicle in a safe, well-lit area with easy egress (not in the driveway)
- be aware of how your interpersonal skills may affect the situation. Be aware of your own limitations e.g. response to conflict, values, commitment to safety vs risk taking etc
- have a good understanding of emergency procedures (including vehicle break downs, car-jacking, road rage etc)
- be willing to participate in post-incident debriefing/counselling/worker assistance programmes
- advise clients of expected time of arrival and ask them to restrain pets away from the visit area
- never assume the environment is 100% safe or the client 100% safe. Always be prepared for the unexpected.

South Australia Police offer the following advice on dealing with aggressive behaviour:

- maintain a distance of safety and/or place a barrier between you and the client
- if two workers are present, one worker should do the talking while the other worker observes
- read body language to predict aggressive behaviour e.g. red face, clenched jaw or fists, sweating, exaggerated gestures, rapid breathing, crossed arms and legs, previous behaviour
- stay calm and calm the aggressor – speak slowly, clearly and quietly
- while self-defence training is usually not necessary, simple actions to de-escalate aggressive behaviour can be appropriate e.g. keep hands down (below shoulder level), lower your voice (don't try and reason with the person), slowly back away
- listen carefully and nod in agreement, rephrase
- be confident – stay on the same eye level
- keep silent and patient
- explore what the real issues are

- take an active role, make notes
- use good interpersonal skills to gain information and take time to consider your options
- don't be lulled into a false sense of security, convey threatening gestures, make tasteless comments, take sides, become defensive or make promises you can't keep.

Source: South Australia Police presentation to HACC funded service providers, Personal Safety in the Workplace, 2008

CASE STUDY 1

Mary visited a man each week to clean his house. One week when she visited, his son was there. He told Mary he was recently out of jail for abusing his wife. He went on to say all women were trouble and deserved what they got. At the time Mary was in a room and the man stood between her and the door. She felt extremely vulnerable and left the house as soon as she could. Mary immediately contacted her Manager.

The Manager visited the client when the son was out. The client said his son was staying with him until he found a place to stay. The client could not guarantee his son would not be present during worker's visits. The service (which was not an essential health service) was withdrawn until the son moved out.

CASE STUDY 2

A client touched a worker on the buttock and made inappropriate comments about her breasts as she was tending to his medication. The worker was frightened and left the client's home immediately, following the organisational security procedure.

The coordinator conducted an investigation of this incident. The client was very apologetic. It was made very clear to him that his behaviour was inappropriate and in breach of his responsibilities. A risk assessment indicated that services to this client could continue on the condition that two people visit the client and that any further inappropriate behaviour would lead to withdrawal of service.

CASE STUDY 3

A worker was providing care to a client when the client's relative, who was exhibiting violent and erratic behaviour, confronted her. The worker managed to defuse the situation by utilising skills gained through conflict resolution and negotiation training, and by staying calm and in control.

She then phoned the Police using the mobile phone provided by her organisation. The Police promptly attended the scene.

To ensure the client could continue receiving a service while workers remained safe, a procedure was developed whereby workers attending the home called the client first to ensure the client's relative was not there. This worked well and the client continued to receive the service.

CASE STUDY 4

Jane visited Fred each week. While he used language she would describe as 'better in a bar', smelled like a brewery and often made lewd jokes, she did not mind as she 'grew up with brothers and this wasn't new'. Unfortunately, Jane described Fred to other team members as having a great sense of humour!

When Jane went on holidays, Angela filled in for her and went to visit Fred. Angela didn't think being called 'bitch' was funny, and when she challenged Fred he became angry and used a range of other colourful adjectives to describe her. Angela felt threatened and violated, and left the house.

During debriefing, Angela revealed that she had grown up with an alcoholic father and felt very uncomfortable around people on whom she could smell alcohol (in her experience these people could become violent). She told management that, had she been prepared, she would not have been so shocked and the situation might not have deteriorated as it did. Angela was traumatised and management did not ask her to go back to see Fred.

Fred missed his services until someone else could be found. That worker was told about his behaviours in advance. So when Fred called her a name, she used her sense of humour and asked that he call her something else instead, which he did. Since that time Fred always calls workers 'Boss'; not perfect, but not rude either.

CASE STUDY 5

A male client made reference to and asked about a worker's intimate life. Recognising it as sexual harassment, she explained to the client that this was an inappropriate question and that she felt uncomfortable and asked him to stop. He apologised.

The situation was reported to the coordinator on an incident report. The client was monitored for a period of two weeks, with no further incidents. Another worker who also visited the client was informed.

CASE STUDY 6

As an additional step to ensure security, Southern Services only provide clients with the worker's first name. Workers are encouraged not to ring clients from their own phones and to apply for a silent number or to block the numbers showing on caller ID on the client's phone. This can be done by dialling 1831 before the number from a landline or #31# if using their mobile phone.

This information is recorded in a procedure and included in induction training.

CASE STUDY 7

Western Community Care covers Challenging Behaviour and Mental Health in induction training, including how to recognise and defuse a potentially violent situation.

New workers work in a 'buddy' system for the first visit to clients who may present challenging behaviours. A 'flagging system' is used to inform staff of issues and clear procedures are in place to deal with challenging behaviours. An Employee Assistance Programme is offered to workers, which provides debriefing and/or counselling following incidents. The co-ordinator encourages all workers to contact her if they have concerns.

A team approach is used to problem-solve specific issues. For example, how to address situations where the client's behaviour prevents completion of tasks or they prevent entry; how to maintain personal barriers where clients are very lonely or isolated and have unrealistic expectations of workers. Emergency numbers are entered into the speed dial of new worker's mobile phones and code words are used to identify risk situations.

Further information

- Preventing and Responding to Work-Related Violence, SafeWork SA, 2014
- Managing the Risks of Violence at Work in Home and Community Based Care, SafeWork SA, 2006
  http://www.safework.sa.gov.au/uploaded_files/resViolenceHomeCare.pdf
- Preventing Workplace Violence: Toward a Best Practice Model for Work in the Community, RDNS Research Unit (Koch and Hudson), 2000
  http://www.safework.sa.gov.au/contentPages/docs/agedViolenceBestPractice.pdf

9. Psychological health

Psychological ill health may result from ongoing work-related stress, where workers are subjected to demands and expectations that are out of keeping with their needs, abilities, skills and coping strategies [Comcare 2007].

To ensure the psychological health of workers is maintained, community care organisations must identify potential psychological hazards, assess the likelihood and potential consequences of harm and control risks.

Factors which may contribute to psychological injury include:

- unrealistic timeframes for completion of work and travel to the next client
- workloads which are too great
- unrealistic expectations by clients and/or their family/carers
- lack of skills and training for the job
- experiencing grief or loss following the illness or death of a client
- conflict with clients
- inability to discuss issues or problems e.g. challenging behaviours
- poor relationships with supervisors and/or other workers
- lack of counselling and support following a critical incident
- complaints which are not taken seriously
- co-workers/managers/clients being over-critical or the worker being highly sensitive to criticism
- repeated absences from work which are not followed up (suggesting the employer is not concerned about the worker's health)
- feeling undervalued
- working in isolation which prevents the opportunity to debrief after difficult situations
- low job satisfaction.

To assess the level of risk, discuss these psychological health issues with workers:

- what stressors do they face?
- how do they manage them?
- have they experienced symptoms of stress/psychological illness e.g. headaches, rashes, digestive problems, drowsiness (particularly when driving), hypertension or difficulty sleeping?
- how do they rate the level of support at work e.g. communication channels, peer support, access to counselling, training in addressing stressful situations at work?

Controlling risks

To control psychological health risks:

- provide workers with a job description statement and make them aware of their roles, responsibilities and rights
- hold regular staff meetings to provide an opportunity for debriefing and problem solving (while maintaining client confidentiality)
- provide training in procedures to ensure workers are competent to perform their roles
- reassign clients to other workers where stress is reported due to personality clashes (where appropriate)
- reduce opportunities for fatigue related to work e.g. from long distance travel or long hours, heavy workloads

- provide workers with knowledge of how to prepare for, and deal with, grief and loss.
- provide additional support for workers in high risk situations e.g. peer support or professional Employee Assistance Programmes
- monitor work absences and discuss with workers
- implement procedures for early identification, reporting and management of psychological injury
- implement critical incident debriefing procedures and review them following serious incidents
- ensure all workers know and follow procedures for critical incidents
- create a work culture of management and team support
- demonstrate zero tolerance of workplace bullying
- develop ways to demonstrate that workers are valued e.g. celebrating the achievement of corporate and personal milestones
- adopt flexible, family-friendly work arrangements, as stress can come from family pressures, especially if caring for children and/or parents.

CASE STUDY 1

Rural Home Services decided to ask workers, at their monthly staff meeting, to share the best and worst moment they had experienced since they last met. This generated discussion about the good and difficult times faced by workers on a daily basis. It also created an environment where team members could empathise with each other, offer support and exchange ideas about how to deal with the different situations.

The session was so successful that 'Best and Worst' became a permanent agenda item.

Another session trialled at the staff meeting was a segment to improve understanding between team members. As the team was made up of administrators, maintenance workers, assessment officers, volunteer co-ordinators etc, the team leader asked the group to suggest what might be the most difficult aspect of each worker's role e.g. the most difficult part of the maintenance worker's role. The maintenance workers would then comment on whether the group had identified the same things that they themselves found most difficult about the job. They would also describe what they liked most about the work.

At the end of the session, each member of the group was asked to write down what they appreciated most about the other workers. This was written on separate cards with each worker's name on it. The cards were then given to the worker to remind them what they brought to the team and why they were valued.

CASE STUDY 2

Eastern Community Care recognised that a number of workers expressed concern on how to answer client questions about death.

In the previous six months, three long-term clients had died, one suddenly and two following long illnesses. Two workers, Jo and Anne, mentioned at a staff meeting that they were having trouble getting over the deaths.

The coordinator, Bill, organised a workshop on loss and grief with a presenter from a local funeral director. In addition, Bill discussed the effects of grief and stress and the steps for managing them. These include peer group support, exercise, relaxation techniques, taking time out, counselling and valuing the role played by individuals. He also provided a copy of the SafeWork SA publication *Coping with Loss and Grief in the Aged Care Industry*.

Jo, Anne and a number of other workers expressed that they now felt much better knowing their feelings were a normal part of grief. They also acknowledged that the role they played in supporting clients and their families was a very positive one.

Bill decided to run grief and loss training annually, and added it to the training calendar.

Further information

- Dealing with Workplace Bullying: A Worker's Guide, Safe Work Australia, 2013
- Guide for Preventing and Responding to Workplace Bullying, Safe Work Australia, 2013
- Managing Loss and Grief, Guidelines to Assist in the Management of Loss and Grief in Residential Aged Care Facilities and Community Care, SafeWork SA 2004
  http://www.safework.sa.gov.au/contentPages/docs/agedLossGriefGuidelines.pdf
- Coping With Loss and Grief in the Aged Care Industry, SafeWork SA 2004
  http://www.safework.sa.gov.au/contentPages/docs/agedLossGriefBrochure.pdf
- Psychological Injury, Comcare website
  http://www.comcare.gov.au/safety__and__prevention/health_and_safety_topics/psychological_injury

10. Vehicle and driver safety

Travelling between clients' homes and/or community venues presents a number of hazards for workers in community settings. Vehicles may belong to the organisation or the workers may use their own car. Where workers/volunteers use their own vehicle for work, they must demonstrate that it is in safe, acceptable working condition (an example Vehicle Inspection Checklist is included as **FORM 11**).

Issues you may need to consider include:

- design of the vehicle (ergonomics) e.g. hatchbacks may limit head space in rear doorways, reducing mobility
- maintenance of vehicle safety e.g. tyres, brakes, lights, seatbelts
- road safety issues e.g. poor weather, dirt roads, high traffic levels, driving at night, road rage, car-jacking
- getting in/out of the vehicle and accessing the boot
- entering and leaving roadways
- driver fatigue and/or stress due to tight schedules
- assisting clients in and out of vehicles
- distractions within the car
- unsecured loads, storage and loading/unloading of equipment/shopping etc
- procedures following motor vehicle accidents
- insurance cover for transporting clients in either workers' own cars or the organisation's cars
- driver competency and driving record
- legislative requirements e.g. driver accreditation for community buses etc
- clients with medical clearance allowing them to travel without wearing seat belts.

Once you have identified hazards, you then need to assess the level of risk and implement controls.

Possible solutions

Possible solutions you may consider include the following:

- Identify and assess risks prior to purchase of the organisation's vehicles. Develop a checklist of requirements and trial a number of cars to select the most suitable e.g. seat height and adjustability, boot access and size, the need for a station wagon if equipment must be moved.
- Train workers in driving new vehicles.
- Develop safe driving procedures e.g. allow suitable time between clients to prevent speeding, regular breaks when travelling long distances, safe storage of loose items, access to a mobile phone and a hands-free kit.
- Ensure every organisation-owned vehicle has emergency procedure documents (e.g. accident, breakdown, road rage etc) with contact numbers and a first aid kit which includes a travel sickness clean-up kit.
- Conduct regular safety and roadworthy vehicle checks using a checklist (organisation and private cars), and training in how to do safety checks (an example Vehicle Inspection Checklist is included as **FORM 11**)
- Regular checks (e.g. annual) of drivers' licences, vehicle insurance and registration, plus evidence of an annual mechanical service.
- Put procedures in place for reporting changes in driver status e.g. loss of licence or medications which may cause drowsiness.

- Put procedures in place for reporting accidents which include identifying contributing factors and an analysis of driver competency, if appropriate.
- Provide defensive driving courses, including driving on dirt roads.
- Require workers, including volunteers, to sign a 'conditions of use' form if they use their private cars for work (an example Conditions for Use of Private Vehicles form is included as **FORM 12**).
- Safe driving lectures which include safe driving tips, strategies for dealing with road rage (these may be delivered free by SA Police) and worker safety information e.g. keeping doors locked, always lock vehicle and remove keys when exiting vehicle etc.
- Risk assessment of manual handling hazards associated with transporting clients, mobility aids, shopping and shopping trolleys.
- Training for moving clients and equipment (e.g. wheelchairs) in and out of vehicles.
- Prevent workers using client cars.
- If there is a risk that a client will try to get out of the car, ensure they are accompanied by a second person. Seat the client in the rear passenger side seat with the child lock on and seat belt securely fastened.
- Use of hoists/slide boards/slide sheet for moving dependent clients and heavy equipment.
- Fitting cargo barriers in station wagons.
- Assessment of client safety needs e.g. clients who have seizures should sit in the rear seat and have a carer to accompany them, or use alternative transport such as access cabs.
- When a client requires oxygen, secure the cylinder behind the client's seat (if possible). Additional cylinders should be transported in the boot of sedans. They may be placed horizontally, but must be firmly secured to prevent rolling. Leave the window slightly open when travelling. Prohibit smoking in the vehicle when transporting or using oxygen. If transporting concentrators, remove the humidifier and firmly secure in the boot.
- Ensure that clients who cannot wear seat belts carry the letter from their doctor. Seat the client in the back passenger side seat.

CASE STUDY 1

Following the training session on how to complete a safety check, Cherie completed her car inspection and found that her seatbelt did not retract correctly. She had the seatbelt replaced.

One week later Cherie was involved in a serious accident. The ambulance officer on the scene assured her the new seatbelt had, without a doubt, saved her life.

CASE STUDY 2

Adam, a worker at Eastern Community Care, was asked to take Mrs Green to a medical appointment. When he arrived to pick her up, Mrs Green's daughter and two small children were waiting to accompany her, but there were no child restraint seats available.

Adam assessed the risk and informed Mrs Green he would have to ring his coordinator, Sandy. Sandy spoke to Mrs Green and advised that the program's policy did not include taking family members with clients, for safety and insurance reasons.

CASE STUDY 3

Enid, aged 80 years, has been a volunteer driver with Blue Hills Council for over 20 years. Her dedicated service was rewarded with a certificate and celebration at the local community centre last year.

In the last six months Enid has had a series of minor accidents. After examining Enid's recent driving record, Pamela, the Volunteer Coordinator, spoke with Enid over a coffee asking how the recent accidents had affected her. Enid admitted she was beginning to lose her confidence, and that she was worried she was not as sharp as she used to be and could be placing clients at risk. However, she loved volunteering and having this purpose in her life.

After discussing Enid's interests, Pamela found Enid an alternative voluntary position as a helper on the community bus. Enid later expressed relief that she no longer has the responsibility of driving frail clients in busy traffic.

11. Hazardous chemicals

There are a number of chemicals used in client homes, particularly for cleaning, laundry and gardening tasks.

Some chemicals are classed as hazardous based on criteria set by Safe Work Australia. The risk of being affected by chemicals may be increased in areas of poor ventilation, such as shower alcoves, ovens or small gardening sheds.

The health effects of these substances may vary from minor skin irritations to severe asthma attacks if a worker becomes sensitised to a product.

It is essential that you and your workers identify the hazardous chemicals that are to be used in the home and/or garden, and assess and control any risks.

There is a legal requirement to maintain a Register listing hazardous chemicals used, handled or stored at a workplace. Safety Data Sheets (SDS) are to be obtained from the suppliers for all hazardous chemicals used. SDS detail the chemical's ingredients, its effect on health, first aid instructions, information on safe storage, handling and disposal, and an emergency contact number. SDS must be less than five years old. These are also kept in the Register, with workers able to access them when necessary.

A risk assessment must be conducted on the use of each hazardous chemical and controls put in place. Wherever possible non-hazardous chemicals should be used in place of those classed as hazardous.

This may present you with a challenge. You need to decide how this can be achieved most effectively for your organisation.

CASE STUDY 1

Northern Community Care's WHS Committee considered how they could most simply address the issues of hazardous chemicals, by conducting a risk assessment.

The workers listed the chemicals they used in their clients' homes and the most common household cleaning products they thought might be used for cleaning showers, toilets and ovens. The coordinator obtained the SDS for each product. The committee then reviewed them, the areas in which the chemicals were used and how they were used. They decided the tasks of greatest risk were cleaning the shower and oven.

The SDS for products used for these two activities are now kept in the clients' homes for ready access, as well as at the office.

In addition, clients were invited to attend an information session on home safety, including the use of chemicals, and were encouraged to purchase the safest alternatives when workers took them shopping.

Clients have been extremely supportive and often ask for advice on which products to buy.

Workers always open a window and turn on any exhaust fans when cleaning the shower or oven, and wear gloves if required by the label or SDS of the cleaning product. They only use chemicals that display the manufacturer's labels.

Possible solutions

Possible solutions may include:

- preventing the mixing of any chemicals
- keeping all chemicals clearly labelled with the full name and any health or safety warnings e.g. 'flammable' or 'gloves to be worn'
- never using chemicals in unlabelled containers
- only using chemicals for their correct purpose
- following instructions for safe use on labels and SDS
- training/instructing workers in the safe use of chemicals and how to read and interpret an SDS
- informing workers if they are affected by chemicals to move away from the area and notify the co-ordinator immediately
- using the safest alternative non-hazardous chemicals
- using exhaust fans or open windows to increase ventilation
- using bleaches with care, as they may cause burns to skin, eyes and the mouth in high concentrations
- when using detergents and other substances, wearing gloves to prevent dermatitis
- informing workers of the risks of latex allergies and the need to report any reactions from wearing latex gloves
- providing cleaning substances for workers, rather than using the clients'
- following storage instructions, as some chemicals may react with others and/or may be flammable e.g. mower fuel.

CASE STUDY 2

Jack was called to replace a washer in the toilet of Mrs Biggs, a client of Rural Home Care. The job was relatively simple, although the toilet cistern was old and the parts somewhat rusty. A day after completing the job, Jack noticed a red itchy rash on his left hand and believed it to be a result of chemicals placed in Mrs Biggs's toilet cistern.

The incident was reported and investigations confirmed that the rash had resulted from an allergy to chemicals within the cistern. Safe work procedures were then altered to include the wearing of rubber gloves when working on toilets.

After a month the new procedure was reviewed. Workers were ignoring the procedure because the gloves made it extremely difficult to undertake the replacement of washers, due to the necessity of handling small parts.

After discussions with the workers and the local health clinics, a barrier cream was distributed to all workers with instructions to apply prior to placing hands in toilet cisterns. This procedure was found to be immediately accepted and utilised by workers, and no further reactions to chemicals were reported.

CASE STUDY 3

Eastern Aged Care decided that the most effective way to ensure their community workers used safe cchemicals in people's homes was to provide them.

Each worker was provided with a lidded bucket containing the chemicals they needed, with the relevant SDS and safety equipment. Workers were then trained in the safe use of the products and safety equipment.

At each monthly staff meeting workers brought their containers for refilling. This ensured workers' safety, saved clients the cost of purchasing cleaning products and proved to be cost effective (after the initial purchase).

Further information

- WHS Regulations – Chapter 7, Hazardous Chemicals
- Code of Practice – Managing the Risks of Hazardous Chemicals in the Workplace

12. Electrical safety

Electrical hazards may cause a fatality. The most frequent electrical hazards are:

- frayed electrical cords
- over-loaded power points e.g. double adaptors
- damaged or cracked equipment
- electricity near water, such as bar heaters or hairdryers in bathrooms (an increased risk with hand-held showers)
- damaged or incorrectly wired electrical switches.

All workers and contractors working with moveable electrical equipment (e.g. vacuum cleaners, polishers, irons, toasters, and kettles, power tools etc) in client homes must first plug a portable Residual Current Device (RCD) into the wall socket.

Portable RCDs must be electrically checked regularly as per Australian Standard AS/NZS 3760 or as recommended by the manufacturer, and physically tested before each use by the built-in push-button tester.

Some organisations also choose to test polarity. This will detect a wiring fault behind a power point, which could prevent an RCD working (this is not a legal requirement).

It is important for workers to visually check all electrical cords and appliances before using them, as RCDs do not provide 100% protection. Any electrical installation work must be carried out by a licensed electrical worker.

Possible solutions

Possible solutions may include:

- conduct a risk assessment prior to commencing work in a new location
- ensure all workers use their RCDs and conduct a push-button test prior to each use, and that these instructions are included in safe work procedures
- instruct workers and contractors not to use the client's equipment if it appears old and has not recently been used, unless it is electrically checked
- encourage clients to install RCDs on their fuse board
- discourage the use of floor heaters or portable fans in bathrooms
- encourage the installation of wall or ceiling heaters in bathrooms
- prevent the use of or replace faulty cords/switches
- use power boards with overload switches rather than double adaptors which may overheat
- examine and test electrical cords and equipment owned by the organisation regularly, in line with AS/NZS 3760
- provide training on the safe use of electricity including:
  - correct use of equipment e.g. RCDs
  - emergency procedures in the event of fire or shock
  - identifying faulty or damaged cords/equipment
- ensure the requirement to use RCDs is included in contractor WHS agreements
- conduct regular, random safety audits of workers and contractors
- prior to drilling walls, use a stud finder to locate hidden electrical wiring. Turn off the electricity before drilling and use a cordless drill.

CASE STUDY 1

Jane, a cleaner with Big Heart Agency, casually reported to her manager 'I was almost electrocuted yesterday'. When Amy, her manager, asked whether her RCD 'tripped', Jane replied she had left it at home. Amy checked that safe work procedures included instruction about the use of RCDs and notified all workers of the incident, reinforcing the requirement to always use an RCD. She then planned for additional electrical safety training to be provided for all workers at a briefing session later in the year.

CASE STUDY 2

Peter, a care worker, was employed by an agency and provided in-home personal care to people including cooking, cleaning and showering. As part of providing care, Peter was required to use a number of electrical appliances belonging to both the agency and, in some cases, the home owner. Peter used a power board as, in most cases, he plugged a few appliances in at the same time.

Once, a homeowner commented that he could smell burning coming from somewhere. Peter noticed smoke coming from the power board. As he went to turn it off, it caught fire. Peter turned the power off at the power point and unplugged the power board. He told his employer what had happened. The employer investigated this and subsequently replaced all workers' power boards with ones that have overload protection, and also provided a portable safety switch (RCD) for them to use whenever they use electrical appliances.

CASE STUDY 3

Jamie, a gardener and general maintenance worker, had recently started a new job. As part of her induction the need to carry out a brief assessment of every workplace to identify hazards was explained. The induction also covered the use of portable safety switches (RCDs) as well as the importance of not using the client's equipment if it was old and had not been used for a while.

At the time, Jamie thought this was all a bit 'over the top'. A month later, at one of her workplaces, she carried out the assessment and used her portable safety switch. While working, her drill broke and she asked if she could use the client's drill, an old metal type. After she plugged it in and turned the power on, the safety switch tripped out. She tried it again twice and the safety switch tripped each time.

She told the client, who had the drill checked by an electrician. It turned out that the drill had a problem and probably would have resulted in someone receiving an electric shock. Jamie gained a great deal of respect from this experience, not only for electricity but also why taking a few minutes to conduct an assessment is worth the trouble.

Further information

- WHS Regulations – Chapter 4, Part 7
- Code of Practice – Managing Electrical Risks in the Workplace
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13. Infection control

Within the community sector, infectious diseases may be a hazard for both workers and clients. There are many types of infections, spread in many ways.

Some infectious diseases, such as hepatitis B and C, or HIV/AIDS, can be transmitted when infected blood comes into contact with the bloodstream of another person e.g. from a cut or needle-stick injury. Others, such as gastroenteritis and hepatitis A, are spread when faecal contamination of hands, food or other objects enters the mouth and digestive tract of another person.

Infections such as influenza can be inhaled from an infected person's sneeze or cough.

Mosquitoes, flies, rats and other vermin can also spread infectious diseases e.g. Ross River virus or gastroenteritis. There are also other infectious diseases not mentioned above which may be a hazard in a community setting.

The PCBU has a duty of care to protect workers and clients from infectious diseases. Clients have a duty of care to protect workers. Workers also have a duty to inform their supervisor if they have a heightened risk of infection or have an infection that could be spread.

Managers must negotiate client permission to disclose increased infection risk information to workers. If permission is not granted, managers are to make a decision on whether the service commences or continues, based on a risk assessment.

Possible solutions

The major approaches to minimising risks of infection include:

- immunisation e.g. hepatitis B
- training for workers in infection control procedures, including Standard Precautions.

Standard Precautions are the work practices required to achieve a basic level of infection control. They include good hygiene practices such as hand washing and protective barriers (e.g. gloves, masks, plastic aprons and goggles etc), and appropriate handling and disposal of infectious waste, laundry and sharps.

Standard Precautions are to be used for the treatment of all clients and in the handling of all blood and other body fluids (regardless of the client's perceived infectious status).

Hand washing should occur:

- on arrival at each client's home
- prior to food preparation
- after cleaning
- after touching animals
- whenever body fluid contamination may occur e.g. toileting, giving medications, before and after wound care, handling soiled linen
- before and after going to the toilet
- before and after eating or smoking
- before leaving each client's home.

Other possible solutions you may consider include:

- procedures for addressing handling and spills of blood and body fluids
- procedures for the use and disposal of sharps
- use of suitable sharps containers
- supply and use of gloves – gloves should be worn to prevent contact with blood or body fluids e.g. when changing or laundering wet or soiled linen or clothing, changing dressings or bandages, cleaning objects which may be contaminated such as toilets
- develop safe food handling procedures and provide mandatory food handling training
- when hand washing facilities are not available, provide workers with a supply of antiseptic gels which are to be used with a hand washing motion for at least 15 seconds – hands are to still be washed as soon as possible (especially if they are soiled).

Further information

- Infection Control Guidelines, Department of Health and Ageing, 2004
  www.health.gov.au/internet/main/publishing.nsf/Content/2804E9F9B95357F7CA256F190003B4DA/$File/howto.pdf
- 'You've got what? (3rd edition, 2005), Department of Health
  www.dh.sa.gov.au/pehs/Youve-got-what.htm
- *Food Regulations (SA) 2002*
  http://www.austlii.edu.au/au/legis/sa/consol_reg/fr2002166/
- Food Safety Programs (see Aged Care Food Safety Program), Department of Health
  www.health.sa.gov.au/pehs/Food/food-safety-programs.htm
- For safe food handling requirements, contact your local Council's Environmental Health Officer (EHO)

14. Domestic squalor

Workers are sometimes required to provide services to clients who live in domestic squalor. Severe domestic squalor includes extreme household uncleanliness and hoarding, where the accumulation of materials has led to the living environment being unclean, unsanitary, dangerous or a fire risk.

Where clients live in severe domestic squalor, circumstances are usually so complex that a multi-agency approach is the best way to achieve positive outcomes e.g. local council, Housing SA, Mental Health Unit, local aged care providers, general practitioner (GP), Aged Care Assessment Team, and even the RSPCA, with one organisation to manage the case. The different agencies can provide different types of expertise, as well as share the associated costs related to service provision in these situations.

Quite often a client will refuse assistance, due to a wide range of reasons. Their refusal may be related to a lack of insight about the squalid condition of their home and the risk it presents. Community organisations have a duty of care to persevere, however, if the client's health and safety is at risk or their neighbours' health and safety is impacted. Success is more likely if time is taken to build a relationship of trust before proceeding with services.

It is critical that the underlying reason for the squalor is determined if an ongoing solution is to be found. This can be obtained with a comprehensive assessment by a geriatrician through the Aged Care Assessment Team or the client's GP. The aim is to identify any existing conditions, such as dementia, malnutrition, infection, psychiatric condition, substance abuse etc, which may be contributing to the situation.

Once the cause is identified, the best approach can be determined. Clients with hoarding disorders will need support from mental health professionals, as any clean-up will cause significant stress.

Where the squalor does not present a risk to the person, neighbours or the fabric of the building, intervention does not need to be immediate, but a plan of support does need to be developed to prevent further deterioration causing problems in the future.

When sending workers into a home where there is squalor or unsanitary conditions, the actual risk to workers must be considered along with what controls could be put in place. An example 'Squalor' Health and Safety Checklist (prior to service provision) is included as **FORM 13**.

The actions required to ensure the health and safety of workers entering a client's home where there is squalor will depend on the work being conducted. For example, taking a client shopping presents no risk to workers and should not stop the client getting help.Risk assessments of the tasks, considering the environment, must be made and controls implemented.

Possible controls

Each situation is unique, but the following control approaches have proved effective in some situations:

- Perform the required tasks in one less cluttered room.
- Provide gloves, tissues/masks infused with small amounts of essential oils, and antiseptic hand wipes or gels.
- Visit on a regular basis to develop a relationship before gradually incorporating services such as help with shopping and garden clean-ups. This can lead to eventual agreement from the client to have excess hoarded materials removed.
- Engage the assistance of Council EHOs if assistance is refused. EHOs can place an order on the property, but this approach is more likely to be successful if performed with a case manager or social worker in place to support the client to meet their compliance obligations.

- Take the client shopping without entering the house (if appropriate).
- Enlist the help and support of family where possible.
- Involve the client with setting achievable goals, such as cleaning small areas within a set timeframe and assisting them to identify the benefits in their life if the squalor is resolved.
- If cleaning is agreed to, forensic cleaners should have the necessary expertise to work safely in severe domestic squalor. The cost can sometimes be placed against the client's property by Council, if they own their home, or shared between agencies and the public housing authority if appropriate.
- If the client has been determined to have diminished capacity and has no suitable guardian or advocate, an application can be made for a Guardianship Order appointing a Public Advocate.
- If no information is available about the client, it is prudent not to conduct the initial visit alone.
- If there are large numbers of pets contributing to the unsanitary conditions or pets in poor condition, a reduction in numbers and desexing of remaining pets may be accepted before the destruction or rehousing of all animals is considered. The Council and RSPCA may assist with this.

Professional home organisers now exist who work with clients to sort material into piles e.g. recycle, throw out, sell or keep.

CASE STUDY

Joan, who lived in public rental accommodation, was hospitalised with an episode of mental illness. A review of the home by the occupational therapist and Joan prior to discharge found hoarding, poor disposal of excreta, large amounts of rotten food and infestation by vermin. Her gas and electricity had been disconnected.

Joan expressed dismay at the condition of her flat and she agreed to forensic cleaning being conducted. This was provided with special funding. Joan was discharged with follow-up support from Community Mental Health and a Community Care Provider to assist her to prevent the situation arising again in the future.

(Adapted from the Partnership Against Homelessness [PAH] Guidelines)

Further information

- Guidelines for Field Staff to Assist People Living in Severe Domestic Squalor, Partnership Against Homelessness, August 2007

  http://www.housing.nsw.gov.au/NR/rdonlyres/F9EAEB32-C0AC-4C1F-8D2B-60DCA951D98A/0/FinalSqualorGuidelinesSeptember2007PDF.pdf

15. Useful contacts

Government and other

Aged Care Assessment Team
Department of Health and Ageing
www.health.gov.au

Aged & Community Services SA & NT Inc.
www.agedcommunity.asn.au

Employers Mutual Limited
www.employersmutual.com.au

Housing SA
www.dfc.sa.gov.au

Local Councils
Find your local Council by searching
www.lga.sa.gov.au

Mental Health Unit
The unit is part of the SA Health Department.
www.health.sa.gov.au/mentalhealth

RSPCA
www.rspcasa.asn.au

SA Police
Home Assist and State Crime Prevention Branch
www.police.sa.gov.au

WorkCoverSA
www.workcover.com

Community organisations

The following organisations are prepared to provide assistance and/or advice if required (ask for the WHS Manager).

Anglicare SA Inc.
www.anglicare-sa.org.au

Eldercare Inc.
www.eldercare.net.au

Helping Hand Aged Care
www.helpinghand.org.au

Resthaven Inc.
www.resthaven.asn.au

Southern Cross Care (SA) Inc.
www.southerncrosscare.com.au

16. Acknowledgements

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- Murray Mallee Aged Care Group
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- South Australia Police
- Tenison Woods Aged Care Services
- Uniting Care Wesley
- Western Linkages.

APPENDIX A: GLOSSARY

These definitions have been created within the context of the Guidelines and may have slightly different meanings in other contexts.

Client

Person receiving a service. Clients may also be known as care recipients or consumers.

Contractor

A person or firm who conducts a service or task on behalf of an organisation for an agreed fee, but who is not employed directly by the organisation.

Hazard

Something with the potential to cause an injury or illness.

Health and Safety Representative (HSR)

Worker/s elected by their work group to represent them to management on WHS issues.

SDS

Safety Data Sheet.

WHS

Work Health and Safety.

PPE

Personal protective equipment (includes gloves, rubber boots, masks, safety glasses).

Risk assessment

The process of assessing risk of injury or illness occurring from a hazard. It involves considering the likelihood of injury or illness and the possible severity.

Risk control

Strategies to eliminate or minimise the risks of an injury or illness resulting from a hazard.

Worker

Person employed directly by an organisation to provide a service. Includes personal care attendants, nurses, therapists, consultants, co-ordinators, cleaners, drivers, companions etc, as well as volunteers, contractors, a worrrker from a labour hire company, an apprentice or trainee, a student gaining work experience.

Workplace

Any place where a worker or contractor works or any place where a worker goes while at work. Includes offices, vehicles, clients' homes and community venues.

APPENDIX B: EXAMPLE FORMS

The following forms are provided as examples. They will need to be adapted to suit your organisation.

FORM 1: WHS Management Review Checklist

FORM 2: WHS Action Plan

FORM 3: Incident/Injury Report

FORM 4: Induction Checklist

FORM 5: Client Referral

FORM 6: Client Home WHS Assessment

FORM 7: Hazard Report

FORM 8: Hazard Log

FORM 9: Hazardous Manual Task Risk Assessment

FORM 10: Home Visit Security Checklist

FORM 11: Vehicle Inspection Checklist

FORM 12: Conditions for Use of Private Vehicles

FORM 13: 'Squalor' Health and Safety Checklist (prior to service provision)

FORM 14: Return to Work Information

FORM 1: WHS Management Review Checklist

	Yes	No	Comments
WHS Policies/Plan			
1. WHS policy developed (written)	☐	☐	.....
2. Policy includes responsibilities of managers and workers	☐	☐	.....
3. Policies and procedures reviewed regularly	☐	☐	.....
4. Workers aware of WHS policies and procedures	☐	☐	.....
5. WHS plan developed	☐	☐	.....
6. WHS plan reviewed regularly	☐	☐	.....
7. Officers identified	☐	☐	.....
Consultation			
1. WHS Committee elected (if required)	☐	☐	.....
2. Health and Safety Representatives (HSRs) elected (if requested)	☐	☐	.....
3. WHS discussed at staff meetings	☐	☐	.....
4. WHS discussed at contractor meetings	☐	☐	.....
WHS Training			
1. All new workers receive WHS induction training	☐	☐	.....
2. Workers receive regular ongoing WHS training	☐	☐	.....
3. Managers/coordinators receive WHS training and updates	☐	☐	.....
4. HSR and WHS Committee members trained	☐	☐	.....
5. Records kept of WHS training (aims, attendance, date, presenter)	☐	☐	.....

	Yes	No	Comments
Managing Hazards			
1. Pre-service checks of homes conducted	☐	☐	.....
2. Checks reviewed regularly	☐	☐	.....
3. Regular community venues checked before use (access etc)	☐	☐	.....
4. Offices inspected regularly	☐	☐	.....
5. System in place for reporting hazards (e.g. hazard forms)	☐	☐	.....
6. Hazards reported by workers	☐	☐	.....
7. Processes in place to address:			
▪ hazardous manual tasks	☐	☐	.....
▪ remote and isolated work	☐	☐	.....
▪ slips, trips and falls	☐	☐	.....
▪ staff security	☐	☐	.....
▪ electrical hazards	☐	☐	.....
▪ hazardous chemicals	☐	☐	.....
▪ infection control	☐	☐	.....
▪ pet issues	☐	☐	.....
▪ challenging behaviours	☐	☐	.....
▪ bullying	☐	☐	.....
▪ other hazards	☐	☐	.....
8. Risk assessments carried out on hazards	☐	☐	.....
9. Hazards/reports followed up and controlled	☐	☐	.....
10. Controls reviewed for effectiveness	☐	☐	.....
11. Client needs considered when addressing hazards	☐	☐	.....
12. WHS considered when purchasing new equipment (e.g. for office, vehicles)	☐	☐	.....

	Yes	No	Comments
Incident Reporting/Investigation			
1. Form available for reporting incidents and injuries	☐	☐	.....
2. Workers (including contractors and volunteers) aware of the reporting procedure	☐	☐	.....
3. Incidents investigated and documented	☐	☐	.....
Injury Management			
1. Procedure in place for claims management	☐	☐	.....
2. Process in place to manage rehabilitation and return to work following injury	☐	☐	.....

Name of person completing form: .....

Date checklist completed: .....

FORM 2: WHS Action Plan

Goal/objective	Actions required	By whom	By when	Outcomes	Review/ completion date

FORM 3: Incident/Injury Report

Position:	☐Worker	☐Volunteer	☐Contractor
Outcome:	☐Near miss	☐Injury	☐Property damage

1. Details of person involved

Name: ..... Phone: (h) (w)

Address: ..... Sex: ☐M ☐F

..... Date of birth: .....

..... Position: .....

Experience in the job: ..... (years/months)

Start time: ..... am/pm

Work arrangement: ☐Casual ☐Full-time ☐Part-time ☐Other

2. Details of incident

Date: ..... Time: ..... Location: .....

Describe what happened and how: .....

.....

.....

3. Details of witnesses

Name: ..... Phone: (h) (w)

Address: .....

4. Details of injury

Nature of injury (e.g. burn, cut, sprain) .....

Cause of injury (e.g. fall, grabbed by person) .....

Location on body (e.g. back, left forearm) .....

Agency/initial contact (e.g. lounge chair, another person, hot water) .....

5. Treatment administered

First aid given ☐Yes ☐No

First Aider name: .....

Treatment: .....

Referred to: .....

Sections 6-9 must be completed by Coordinator/Manager

6. Did the injured person stop work ☐Yes ☐No

If yes, state date: ..... Time: ..... Time lost (days): .....

Outcome

☐ Treated by doctor ☐ Hospitalised ☐ Workers compensation claim

☐ Returned to normal work ☐ Alternative duties ☐ Rehabilitation

7. Incident investigation (comments to include causal factors – add extra sheets if needed)

.....

.....

.....

.....

8. Risk assessment

Likelihood of recurrence: .....

Severity of outcome: .....

Level of risk: .....

	Likelihood			
Consequence	Very likely	Likely	Unlikely	Highly unlikely
Fatality	Extreme	High	High	Medium
Major injuries	High	High	Medium	Medium
Minor injuries	High	Medium	Medium	Low
Negligible injuries	Medium	Medium	Low	Low

9. Actions to prevent recurrence

Action	By whom	By when	Date completed

10. Actions completed

Signed (Manager): ..... Title: ..... Date: .....

☐ Feedback to person involved Date: .....

11. Review comments

WHS committee/staff meeting: .....

Reviewed by Manager (signed): ..... Date: .....

Reviewed by HSR (signed): ..... Date: .....

FORM 4: Induction Checklist

Worker Name: ..... **Employment Date:** .....

Position/Job: ..... **Manager/Supervisor:** .....

GENERAL INDUCTION

Introduction (explain)

☐ Nature and structure of the organisation

Employment conditions (explain)

☐ Job description and responsibilities
☐ Work times and meal breaks
☐ Time recording procedures
☐ Leave entitlements
☐ Notification of sick leave or absences
☐ Out-of-hours enquiries and emergency procedures

Meet key people (introduce)

☐ Health and Safety Representatives
☐ Payroll officers/human resources staff
☐ Co-workers

Other issues

☐ Quality management policy and procedures
☐ Environmental management policy and procedures
☐ Equal employment opportunity
☐ Sexual harassment
☐ View driver's licence

Security

☐ Car parking
☐ Client home security
☐ Personal / personal belongings
☐ Cash/drugs
☐ Emergency procedures

Payroll (explain)

☐ Rates of pay and allowances
☐ Pay arrangements
☐ Taxation (including completing the required forms)
☐ Superannuation and any other deductions
☐ Union (membership) and award conditions

Health and safety (explain and show)

☐ WHS policy and procedures
☐ Roles and responsibilities for health and safety
☐ Information on hazards present in client homes and controls
☐ Role and names of Health and Safety Representative/Health and Safety Committee
☐ Health and safety communication processes
☐ Incident reporting procedures, including the location of forms that need to be completed
☐ Emergency procedures, including emergency exits and equipment, and first aid
☐ Safe use and storage of hazardous chemicals, including Safety Data Sheets

Review

☐ Review work practices and procedures with the worker
☐ Answer and ask questions
☐ Repeat any training required or provide additional training if needed

Conducted by (name): ..... (sign): ..... Date: .....

Worker's signature: ..... Date: .....

FORM 5: Client Referral

REFERRAL		
Referred by:	Contact details:	
Agency:		Date:
Referral request:		
☐ Transport ☐ Carer Support ☐ Home Assist (internal) ☐ Social/Shopping ☐ Community Bus ☐ Community Centre ☐ Home Assist (external) ☐ Other (describe)		

CLIENT INFORMATION			
Mr/Mrs/Ms/Miss Surname:		Given names:	
Preferred name:	Date of birth:	☐ Estimated age	M / F
Address:			
Telephone:			
Country of birth:	Indigenous status:		
Language:	English ability:	Interpreter: ☐ Yes ☐ No	
Income:	Veterans' Affairs:	☐ Gold Card ☐ White Card ☐ N/A	
Living arrangements:		Housing type:	
EMERGENCY CONTACT Name:			
Relationship:		Phone:	
GP: Name:		Clinic:	
Address:		Phone:	
Medical Conditions:			
		Eligibility/Target group:	
Other people living at home:			

PRIMARY CARER INFORMATION (if relevant):			
Mr/Mrs/Ms/Miss Surname:		Given names:	
Preferred name:	Date of birth:	☐ Estimated age	M / F
Address:			
Telephone:		Carer relationship:	
Country of birth:	Indigenous status:		
Language:	English ability:	Interpreter: ☐ Yes ☐ No	
Income:	Veteran's Affairs:	☐ Gold Card ☐ White Card ☐ N/A	
Living arrangements:		Housing type:	
GP:	Clinic:	Ph:	
Medical conditions:			
		Eligibility/Target group:	
Does carer live with the care recipient?: ☐ Yes ☐ No	Relationship to care recipient:		
Number of people this carer cares for:			

RISK ASSESSMENT PRIOR TO HOME VISIT

Find out as much as possible about the following points from the referral source. If this is too intrusive (i.e. referral source is self) then tick 'unknown'.

Risk factors	Comment	Level of Risk	
1. History of violence/aggression		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown
2. Substance abuse		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown
3. Psychiatric illness		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown
4. Threatening/argumentative behaviour		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown
5. Aggressive animals		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown
6. Accommodation/ household issues		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown
7. Other		☐ Very Likely ☐ Likely ☐ Unlikely	☐ Highly Unlikely ☐ Unknown

Where there are ticks indicating risk is 'Very Likely' or 'Likely,' more than one co-ordinator must be recommended to attend home visit, and it must be discussed with the team leader prior to visit.

Recommendation:	☐ 1 Co-ordinator ☐ 2 Co-ordinators ☐ 1 Co-ordinator and other health professional ☐ Unsure (discuss with team leader)

FORM 6: Client Home WHS Assessment

Client name: ..... **File number:** .....

Address: ..... Phone: .....

..... Date: .....

Person completing checklist: ..... Signature .....

Client informed of need for inspection: ☐Y ☐N Client signature .....

Location of door to enter: front ☐ side ☐ back ☐ other ☐

	Visually safe	Visually unsafe	Hazards identified and actions required	Action completed (date)
Outside/front of house				
1. Parking and access				
2. Gates (easy to open)				
3. Pathway/garden				
4. Steps/stairs				
5. Verandah/porch surface				
6. Pets				
7. Lighting at night				
8. Door clear of obstruction/ easy to open				
9. Neighbourhood security risks				
Inside house				
1. Floor surfaces				
2. Lighting				
3. Freedom of movement				
4. Pests (wasps/vermin)				
5. Tasks involving height				
6. Emergency exit clear/in good working order				
7. Smoke detector present				

	Visually safe	Visually unsafe	Hazards identified and actions required	Action completed (date)
Electrical/gas				
1. RCD at mains				
2. RCD protection for portable equipment				
3. Electrical leads/extension cords				
4. Switches/plugs				
5. Power points near water				
6. Gas cylinders (cooking, heating, oxygen)				
Equipment				
1. Vacuum cleaner				
2. Carpet sweeper				
3. Broom (e.g. handle length)				
4. Mop/bucket				
5. Step ladder				
Bathroom/toilet				
1. Access to bathroom facilities appropriate				
2. Access to bath/non-slip surface				
3. Toilet accessible for cleaning				
4. Drainage adequate				
5. Floor surface level, in good condition, no trip hazards				
6. Ventilation adequate				
7. Electrical leads in good condition, easy to access, away from water				

	Visually safe	Visually unsafe	Hazards identified and actions required	Action completed (date)
Kitchen/dining				
1. Adequate workspace				
2. Stove in good working order				
3. Electrical equipment in good condition				
4. Bench/table adequate height for work				
5. Table/chairs stable				
Laundry				
1. Adequate workspace				
2. Washing machine in good order, no moving parts exposed				
3. Drainage adequate				
4. Clothes line easy to access, working				
5. Iron, ironing board suitable and working				
6. Dryer in good condition				
Bedrooms				
1. Sufficient space around bed				
2. Bed suitable height				
3. Floor surface appropriate				
4. Heaters present				
5. Electrical cords/power points				
Lounge/dining room				
1. Adequate work space				
2. Furniture stable				

	Visually safe	Visually unsafe	Hazards identified and actions required	Action completed (date)
Other issues				
1. History of aggression or violence/threat to staff				
2. Resistance to care				
3. Infection control issues				
4. Weapons present (guns/knives/stun gun)				
5. Hazardous manual tasks assessment required? (if yes, complete and attach)				
Outside, rear/side of house				
1. Pathway – level surface, uncluttered, adequate width				
2. Entry steps/stairs non-slip, level surface, solid				
3. Verandah – level surface, non-slip, uncluttered				
4. Door/s easy to open, unobstructed				
Garage/shed (if used by worker)				
1. Door – easy to open, clear of obstruction				
2. Adequate work space				
3. Lawnmower suitable and working				
4. Gardening equipment suitable and working				
5. Floor surface level, no trip hazards				
6. Electrical leads/power points in good condition				
7. Lighting adequate				
8. Other				

	Visually safe	Visually unsafe	Hazards identified and actions required	Action completed (date)
Hazardous chemicals				
1. Health effects/emergency procedures known				
2. Safety Data Sheets (SDS) available				
3. Suitable for purpose				
4. Stored in safe position (as per SDS)				
5. Gloves/other personal protective equipment (PPE) available				
6. Ventilation fan/window adequate				
7. Substances in original container and labelled				
8. Worker allergies				

Issues found

Hazard forms initiated ☐Yes ☐No

Assessor's signature: ..... Date: .....

FORM 7: Hazard Report

Worker to complete

Location: Date:

Name of worker: Reported to:

Description of hazard

Corrective action taken ☐ required ☐

Co-ordinator/team leader to complete

Action taken

☐ Discussed at staff meeting/WHS committee Date: .....

Further action required

Co-ordinator ..... Date .....

Health and Safety Representative ..... Date .....

Manager ..... Date .....

☐ Feedback to person reporting Date .....

I agree/disagree with action taken (person reporting) .....

FORM 8: Hazard Log

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

FORM 9: Hazardous Manual Task Risk Assessment

Task ..... Date ……..

Location ..... Form completed by ……..... …

actions and posture	loads	job design
☐ bending, twisting, stretching or over-reaching	☐ heavy weight (more than 16-20kg)	☐ repetitive movements
☐ pulling, pushing or lifting	☐ awkward to lift or handle	☐ prolonged task
☐ carrying or holding	☐ large force	☐ lack of people
☐ sudden or jerky movements	☐ object greasy or dirty	☐ load carried a long way
☐ awkward or cramped	☐ can't be held close to body	☐ not enough time
☐ other	☐ other	☐ vibration .....

workplace	equipment	people
☐ unsuitable height	☐ aids not available	☐ not trained
☐ clutter/trip hazards	☐ aids hard to use	☐ old/young worker
☐ lack of space	☐ clothing restricts movement	☐ task too demanding
☐ slippery/uneven surface	☐ protective gear unsuitable	☐ special needs (e.g. pregnant)
☐ poor lighting	☐ other	☐ other .....
☐ other		**RISK RATING .....**

Issues identified	Possible solutions
.....	.....
.....	.....
.....	.....

Action plan

action needed	by whom	by when	review date
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Review (did the solution work?) ……

.....

FORM 10: Home Visit Security Checklist

Client name	**File number** .....
Address:	Phone: .....
.....	Date of assessment: .....
.....	

	Yes	No	Actions required
Are there any pets in the house?			
Are pets aggressive?			
Does the house have deadlocks?			
Is there a security alarm?			
Are there window locks?			
Are there security screens?			
Is there a key hide?			
Is external lighting adequate?			
Does the layout of the house allow workers to leave easily?			
Are there possible hiding spots in the garden between house and vehicle?			
Does the client have any cognitive issues (e.g. dementia)?			
Is there any known history of aggression (verbal or physical)?			
Is there any history of issues with family members?			
Is the worker working alone?			
Is the site remote or isolated?			
Is there mobile phone coverage?			
Are there known 'safe houses' or help in the area?			
Does the worker have a screamer and torch?			
Is there a need for the worker to carry cash or drugs?			
Are there any security hazards in the neighbourhood?			
Are road surfaces in good condition?			
Is roadside assistance available to the worker?			
What are visit times (am, pm, night)?			

FORM 11: Vehicle Inspection Checklist

Vehicle description .....

Vehicle registration: ..... Vehicle plant number: .....

Date of inspection: ..... Driver's name: .....

What should I check before operating the vehicle?	Yes	No
Oil level		
Brake fluid level		
Water level		
Windscreen washer level		
Adjust seat and controls		
Seat belts – check for operation (all)		
Parking brake – hold against slight acceleration		
Foot brake – holds, stops vehicle smoothly		
Clutch and gearshift – shifts smoothly without jumping or jerking		
Mirrors clean and adjusted		
Doors and door locks operate correctly		
Steering – moves smoothly		
Lights – clearance, headlights, tail, licence plate, brake, indicator turn signals, hazard, reverse		
Dash control panel – all lights and gauges are operational		
Horn – operational		
Vehicle reverse alarm (if fitted)		
Hydraulic systems – no evidence of leaks and systems operate smoothly		
Check spare tyre		
Wheelchair hoist operational		
Check tow bar (where fitted)		
Emergency equipment		
First aid kit		
Blankets		

Name of worker undertaking vehicle inspection: .....

Signature: .....

Vehicle faults to be reported immediately: .....

.....

.....

REMEMBER – What should I do before vehicle operation?

- Initially read, understand and follow the manufacturer's operating manual. This will provide a wide range of information relative to the vehicle.
- Know how to operate the vehicle and use any related equipment or attachments safely.
- Be familiar with the location and function of all the controls.
- Develop a routine method of inspecting the vehicle.
- Before moving off adjust the seat and mirrors, and fasten seat belt/s.

FORM 12: Conditions for Use of Private Vehicles

I ..... agree to the following conditions in regard to the use of my private vehicle for Community Care business.

1. I will maintain the vehicle in a roadworthy condition.

2. When transporting clients in my car, I will ensure my vehicle is clean and tidy.

3. I will provide/have provided for the Manager's perusal:
   - my Drivers Licence
   - Registration and Compulsory Third Party Insurance
   - Third Party Property Insurance or Comprehensive Insurance.

4. I have checked with my insurer that I can use the vehicle for volunteer/work purposes, including carrying clients, and have complied with any requirements in this regard.

5. I have read and understood the organisation's procedures regarding vehicle accidents and personal injury.

6. I agree to advise my supervisor immediately if I become unable to safely drive my vehicle due to any reason including:
   - loss of licence
   - loss of insurance
   - being under the influence of drugs or alcohol
   - taking medication which may impact on my driving ability
   - having a medical condition which impacts on my driving ability.

7. I am aware that the organisation may at any time audit for compliance with the above.

Worker's signature ..... Date .....

Manager's signature ..... Date .....

FORM 13: 'Squalor' Health and Safety Checklist (prior to service provision)

	Yes	No	Comments
1. Is the building safe and secure?	☐	☐	.....
2. Are floorboards/ceilings safe?	☐	☐	.....
3. Are electricity, gas and water connected?	☐	☐	.....
4. Are there damaged powerlines that could cause electric shock?	☐	☐	.....
5. Are there animals on the premises?	☐	☐	.....
6. Is there a fire hazard?	☐	☐	.....
7. Is protective clothing/special equipment required?	☐	☐	.....
8. Is there a health risk?	☐	☐	.....
9. Are there weapons or explosive materials on the premises?	☐	☐	.....
10. Are there booby traps?	☐	☐	.....
11. Are there slip hazards because of faeces?	☐	☐	.....
12. Are there fall hazards from climbing over barricades?	☐	☐	.....
13. Is there a likelihood or probability of physical attack from occupants?	☐	☐	.....

Adapted from PAH Guidelines

FORM 14: Return to Work Information

INJURED WORKER INFORMATION SHEET

There are a number of people involved in helping you return to work after your injury in the workplace. These include your employer and the doctor/s treating you. It is important that you report your injury immediately or as soon as possible. Don't wait until the next day hoping that it will get better in the meantime.

Your employer may have an arrangement with a doctor/group of doctors who specialise in managing work-related injuries and who will see you immediately to arrange a treatment plan. Your supervisor will assist in arranging transport to the doctor in the safest manner. If you have a regular doctor, you may wish to choose them to treat you when you have experienced a workplace injury.

Injury management will assist you to return to work as soon as possible. You should be actively involved with decisions regarding your return-to-work program. Your supervisor, or the rehabilitation and return-to-work coordinator, may give you a copy of the Job Dictionary related to your position and a list of duties that you would normally undertake.

This will enable your doctor to choose duties that will not increase your injury, and these will be recorded on your medical certificate. Your employer can then develop a return-to work-strategy – in consultation with you, your supervisor and the rehabilitation and return-to-work coordinator – that can be implemented in stages to safely get you back to work.

It is important for you to keep in touch with your employer, the rehabilitation and return-to-work coordinator, your doctor and other treatment providers. You must submit medical certificates to your employer as soon as possible (within 24 hours of receipt) to help keep your employer informed of your medical condition and level of fitness for work.

Once your treating doctor finds that you are partially fit to return to work in some capacity, a written return-to-work program will be established and your input is encouraged. For example:

- when developing alternate or different duties that are meaningful to both you and your employer
- modifying existing duties
- obtaining different equipment to help you undertake these duties.

The return-to-work program should include:

- your doctor's name and your name
- a description of the goal of the return-to-work program
- the actions to be taken and who is to take them.

All parties will sign the plan to indicate agreement with the strategies documented.

Any changes to your return-to-work program as a result of advice from your treating doctor must be made with your agreement and in writing. Your employer must give you and the treating doctor a copy of the changed program.

The Case Manager at Employers Mutual Limited (the claims agent) or the rehabilitation and return-to-work coordinator may recommend using a vocational rehabilitation service to help you return to work sooner.

SafeWork SA
safe, fair, productive working lives

1300 365 255
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