

A handbook
for workplaces

Working safely in visiting health services

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INTRODUCTION

For many years Victorian health professionals, such as nurses, occupational therapists, physiotherapists and medical practitioners, have been providing assessment and treatment services in clients' homes. In recent years there has been an increase in the provision of healthcare services in clients' homes, particularly with the development of Hospital in the Home (HITH) programs and Hospital Admission Risk Programs (HARP).

Working Safely in Visiting Health Services is aimed at employers or duty holders, and employees whom provide health services in an environment external to a purpose built workplace. It does not include the home care industry or community based services.

This publication refers to all healthcare services that provide assessment and treatment services in clients' homes and other community settings as 'visiting health services'. Some examples of visiting health services are HITH, district nursing, community mental health services, visiting pathology services and general practitioners (GPs). These services are delivered in a variety of locations, including private homes, rooming or boarding houses, supported accommodation residential services, crisis accommodation, community residential units, and hotels.

Under occupational health and safety (OHS) legislation, employers have a duty to control risks associated with visiting health services. This Guide sets out practical ways to prevent the two principal hazards associated with visiting health services - occupational violence and musculoskeletal disorders. It provides advice for employers, employees, health and safety representatives (HSRs) and other people involved in visiting health services.

1

MANAGING OHS IN YOUR WORKPLACE



Effective management of OHS risks enables safer delivery of services to clients as well as providing better protection to employees and others. An important part of risk management is consulting with employees, HSRs and clients regarding health and safety issues.

1.1. OHS LEGISLATION

The *Occupational Health and Safety Act 2004* (OHS Act) requires employers to provide a workplace that is safe and without risks to health. The OHS Act also imposes a number of other duties on employers, employees and others.

In the OHS Act, a 'workplace' is defined as 'a place, whether or not in a building or structure, where employees or self employed persons work'. The obligations of employers under the OHS Act apply to all places where work is carried out, such as private homes and other community settings and transport.

A healthcare service organisation must, so far as is reasonably practicable, ensure the safety of both the worker and the client. Evaluation of the physical workplace environment, as well as an appropriate clinical assessment of clients, are fundamental steps in the identification and control of any risk issues related to delivering care to clients.

For more information on the OHS Act, refer to the WorkSafe publication, *Summary of the Occupational Health and Safety Act 2004*.

1.2. DEVELOPING A SYSTEMATIC APPROACH TO OHS MANAGEMENT

Systems and processes for the management of health and safety hazards in the workplace should be built into the day-to-day running of a business. They should be viewed as part of normal operations. A systematic risk management approach is necessary to manage OHS in order to eliminate or reduce the risk of work-related injury and illness.

A risk management approach requires a process of hazard identification, risk assessment, risk control, and evaluation and review of control measures.

What is a hazard? A hazard is something with the potential to cause harm.

What is a risk? A risk is the likelihood of harm arising from the exposure to a hazard and the consequences of that harm.

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1.2.1. Hazard identification

This is the process of identifying all situations or events that could give rise to the potential of injury or illness.

Hazard identification should be undertaken when:

- identification has not previously been undertaken;
- client care needs have changed;
- designing a new job or task;
- changing a job or task;
- introducing new equipment or substances to the workplace;
- reviewing a procedure when problems have been identified, e.g. after an incident;
- preparing a submission for service funding; and
- planning ongoing tasks as part of continuous improvement.

Hazards can be identified by:

- consulting with employees;
- completing pre-visit checklists;
- conducting workplace inspections;
- reviewing incident and injury records;
- investigating incidents and near-misses; and
- obtaining relevant clinical information.

1.2.2. Risk assessment

This process determines whether there are any risks associated with the hazards identified.

What to consider when assessing risk:

- the likelihood of the exposure leading to injury or disease;
- the frequency and duration of exposure to the hazard;
- the adequacy of existing risk control measures; and
- who may be affected by a particular hazard.

1.2.3. Risk control

The objective of the OHS Act is the **elimination**, at the source, of risks to the health, safety and welfare of persons at work.

If risks cannot be eliminated, OHS legislation requires that they be reduced so far as is reasonably practicable, using one or more of the following methods (in order from most effective to least):

- **substitution** of the hazard with something posing a lesser risk;
- **isolation** – for example, enclosing the hazard; and/or
- **engineering control** – for example, a mechanical aid.

If a risk to health and safety remains after the methods described above have been used, **administrative** controls, for example work procedures and training, should be applied and **personal protective equipment** (PPE) worn, as required. Always consider the hierarchy of control when controlling risks.

MANAGING OHS IN YOUR WORKPLACE

Elimination

Redesigning the job to design out risks altogether is the most effective method of controlling risk, including the physical environment, so far as is reasonably practicable. Try this approach first.

EXAMPLE

John, who has a history of substance and alcohol abuse, had threatened visiting health services employees on a number of occasions. He attempted to assault one employee who was providing in-home treatment services on the last visit. The employer suspended the provision of in-home treatment services while John's care needs were reviewed. Ultimately, John was required to attend a more controlled environment (the local hospital) for treatment.

Substitution

If a risk cannot be eliminated then steps should be taken to reduce the risk so far as is reasonably practicable by replacing materials, equipment or processes with less hazardous ones.

EXAMPLE

Occupational therapy staff reported experiencing lower back pain after reaching into the boot of their work vehicle – a sedan - to unload equipment to be used during home visits. The employer substituted the use of these vehicles with station wagons from the hospital's fleet pool to ensure that equipment was easily accessible and presented at a more appropriate height. Employees reported no incidence of lower back pain after the implementation of this control.

Isolation

If the equipment or materials cannot be changed or substituted, it may be possible to enclose or isolate the hazard from employees - eliminating or reducing the risk of injury or illness.

EXAMPLE

A GP had previously been confronted by an aggressive dog at the door of a client's home. On the return visit, prior to entering the premises, the dog was moved into the laundry by the owner to isolate the pet during the GP's visit.

Engineering

If the hazard cannot be isolated, the surroundings or the equipment may be redesigned to minimise the risks.

EXAMPLE

To reduce the risk of needle stick injuries occurring, a district nursing service implemented the use of self-blunting or retractable 'safety' cannulae.

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Administrative

A combination of controls may be needed to reduce risks, such as establishing policies, procedures and work practices designed to reduce an employee's exposure to risk. Such administrative controls require the provision of specific training and supervisory practices.

Information, instruction and training should only be used to control risks when it is not reasonably practicable to implement higher level controls. However, staff must receive training on the management of all risks to which they are exposed.

EXAMPLE ONE

To reduce the risk of musculoskeletal disorders, a HITH program implemented a systematic approach to identify and assess hazardous manual handling tasks based on 'no lifting' principles. As a result, a comprehensive 'no lifting' training program was provided for full-time, part-time and casual employees, along with the provision of higher level controls such as hoists and slide sheets.

EXAMPLE TWO

A major hospital implemented procedures for conducting home visits. Procedures included the hospital conducting a pre-visit assessment audit using a checklist. When planning visits, employees were required to notify the employer of the clients' addresses and their expected arrival/return times. Mobile phones and duress alarms were provided. Supervisors were required to call the offsite employees at a specified time during the visits.

Personal protective equipment (PPE)

If no other measures will reduce the risk so far as is reasonably practicable, then PPE may help to reduce the risk. PPE should not be relied on solely and should be used in conjunction with higher level controls.

EXAMPLE

If there is potential for exposure to bodily fluids, PPE such as gloves, goggles and a mask should be provided and worn. There should be replacement protective clothing for situations where it becomes contaminated. Slip-proof boots and protective aprons can be used in wet work environments, such as when showering clients.

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1.2.4. Evaluating and reviewing control measures

Controls should be evaluated and regularly reviewed to check they are having the desired effect and remain effective. Evaluating control measures may involve the modification of the process of hazard identification, risk assessment, risk control and further evaluation of control measures.

Satisfactory control of risk is often a continuous process, involving ongoing consultation, trialling and refining of risk control measures in response to employee feedback, new technology and changes in knowledge over time. Employees and their HSRs should be asked the following types of questions.

- Did the risk control work? Did the risk control adequately address the identified hazard and likelihood of it occurring?
- Did it create another hazard? The risk control may have addressed the initial hazard, but did it create another one?

1.3. TRAINING

The OHS Act requires employers to ensure that employees are provided with information, instruction and training which will enable them to perform their work in a way that is safe and without risks to health.

Any training programs provided by the employer should be:

- compulsory for all employees including casuals/part-time staff, volunteers and students;
- provided during paid time; and
- provided on commencement of employment with regular refresher training provided.

It is important that any training program should address the following:

- the policies and procedures of the workplace;
- non-acceptance of occupational violence and actions that will be taken to prevent it from occurring;
- legal issues and legislative framework;
- predicting, preventing and managing aggression and potential assault situations;
- systems of emergency response and availability of emergency services;
- training of managers on their obligations and in emergency response;
- prevention and management of risks from manual handling;
- comprehensive clinical assessment skills; and
- incident reporting.

2

PREVENTING OCCUPATIONAL VIOLENCE



2.1. WHAT IS OCCUPATIONAL VIOLENCE?

Occupational violence and aggression is defined as any incident where an employee is abused, threatened or physically assaulted in the workplace. Within this definition:

- **'threat'** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked, and may involve an actual or implied threat to safety, health or wellbeing; and
- **'physical attack'** means the direct or indirect application of force by a person to the body of, or to clothing or equipment worn by, another person, where that application creates a risk to health and safety. Physical attack is defined without consideration of the attacker's intent or ability.

The term 'occupational violence' applies to all forms of physical attacks on employees, including:

- striking, kicking, scratching, biting, spitting or any other type of direct physical contact;
- throwing objects;
- attacking with knives, guns, clubs or any other type of weapon;
- pushing, shoving, tripping and grabbing; and
- any form of indecent physical contact.

Aggression can include sexual harassment or assault or where an employee is abused or threatened.

Visiting health services may experience forms of occupational violence while undertaking their tasks. Risks may arise from the actions of clients, their carers or others at the home or where services are provided, during travel to or from a service, in vehicles, or while parking or accessing buildings.

In healthcare, clients may exhibit challenging behaviour because of their condition or disability. Regardless of the intent of the perpetrator, or whether the behaviour is a result of clinical symptoms, violence to workers is unacceptable. It is important to identify the reasons behind such behavioural issues in order to control the risks posed to visiting health workers.

2.2. HAZARD IDENTIFICATION

The employer's duty under the OHS Act is to provide the highest level of protection that is reasonably practicable in the circumstances to employees, other persons at work, and members of the public, against risks to their health and safety.

As with any workplace hazard, employers are required to be proactive in the management of the risk of occupational violence. Management begins with the identification of potential sources of occupational violence, assessment of the likelihood and consequence, followed by implementation of controls. Priority must be given to eliminating the risk or reducing the risk so far as is reasonably practicable.

PREVENTING OCCUPATIONAL VIOLENCE

In visiting health services there is the potential for occupational violence when working:

- with clients who are in distress or who are likely to be affected by drugs or intoxicated;
- with people who have mental illness or other conditions that may result in violent behaviour;
- with clients who have a history of violent and aggressive behaviour;
- with people (children, adults, elderly) who display challenging behaviours;
- where drugs are handled (administration of medication);
- where someone is denied a service or when dealing with frustrated people;
- with expensive equipment;
- alone; and/or
- at night.

There may be a greater potential for occupational violence to occur when there are a combination of these factors, e.g. working alone at night.

Visiting home services should not handle cash. A service that is known to receive cash payments may become a target for burglary. Suitable alternative payment options should be put in place.

2.2.1. Hazard identification methods

There are a number of common methods for the identification of occupational violence hazards. Some of these hazard identification methods are summarised below.

Referral checklists and initial audits of the proposed workplace

These involve the use of a checklist on referral or an initial audit of the proposed working environment prior to the service being provided, where reasonably practicable. This is of particular importance in cases where the client is previously unknown to the service. The aims of such checklists and audits are to identify potential hazards related to security, access, lighting, visibility, means of communication, physical layout and any other factors that may affect the safety of the employee delivering the service. The checklists and audits may identify that the environment is inappropriate for the safe delivery of services and indicate a need to develop alternative management of the situation.

For an example of a referral checklist refer to section 5.

Review of client risk information

This may involve a review of the client's medical history, diagnosis, medication or behavioural history to identify any potential triggers or controls that may need to be implemented. Further reviews should be conducted over time to monitor any changing conditions. Any serious incidents or threats of harm should result in withdrawal of the worker and a review of the way in which services can be safely provided.

Consultation with employees

Consultation with the people delivering the service may alert the employer to potential problem situations, behaviours or triggers.

Review of incident and injury reports

A review of reported incidents or near-misses is important as it allows employers to:

- accurately identify the nature and extent of the occupational violence;
- act quickly on issues being reported;
- assess if risk control measures are making a difference; and
- ensure employees involved in an incident receive prompt assistance.

Employers also need to identify if there are any factors in their workplaces that may make employees reluctant to report actual or potential incidents of occupational violence. Employers need to address these issues through consultation with employees and their HSRs, and implement suitable controls.

PREVENTING OCCUPATIONAL VIOLENCE

Reporting may be inhibited if employees believe that:

- violence and aggression from clients is part of the job;
- other staff do not share the perception that there is a threat to safety;
- nothing will be done if incidents are reported;
- the person who makes a report will be seen as the cause of the incident;
- others (including management) will think they do not have the skills to handle difficult situations;
- the person who makes the report will be punished; and/or
- de-briefing, back-up and support for workers is unavailable.

Advice from relevant industry groups

Other employers within the industry or employee associations may have experienced similar occupational violence issues and have advice on implementing systems to eliminate or reduce the risks from violence. This is particularly useful to smaller visiting home service operators.

2.2.2. Risk assessment

When assessing the risk of occupational violence in visiting home services, employers need to consider:

- the likelihood of violence occurring;
- the possible severity of the violence;
- information on previous incidents or aggression in the workplace;
- what controls are currently in place; and
- whether these controls adequately protect the health and safety of employees.

2.3. ISSUES TO CONSIDER WHEN CONTROLLING THE RISK

Management of risks begins with identification of hazards, assessment of risks and information flows that alert workers to understanding the behaviours they may be confronted with. Training in identifying warning signs and ways of managing the situation should be provided to staff.

The following issues need to be considered when attempting to control the risk of occupational violence.

Limited control

Visiting health services have limited control over the environment in which their services are delivered, particularly within a client's home. There are often risks associated with the activities that may be undertaken at these premises such as drug use, the availability of potential weapons, aggressive animals and unknown people being present during a visit.

EXAMPLE

A social worker dealing with a 22 year-old male with a history of drug abuse had felt uncomfortable on a previous visit when four young males were at the client's house drinking alcohol.

Solution: The social worker contacted the client just before departing for the next visit and ascertained who was going to be present during the visit. His employer also provided training in how to make an assessment of the risk prior to entry and let him know that he had his support if he made the decision to postpone the visit due to a perceived threat from other people being present.

PREVENTING OCCUPATIONAL VIOLENCE

Communication

Appropriate systems for communicating with employees delivering services off-site are essential. Mobile phone service coverage, equipment function and office business hours may present problems, particularly in an emergency where there is a need to communicate with management or authorities. A reliance on clients' telephones or staff members' personal mobile phones may not be adequate.

EXAMPLE

A district nurse delivering a service in the outer suburbs was frequently out of range on her mobile phone.

Solution: Her employer issued staff with mobile phones which had a service carrier that provided greater geographical coverage. A global system for mobiles (GSM) phone was also made available for visits to outer areas where coverage was limited. The employer also implemented a procedure where visits were to be completed prior to 4.30pm as the office closed at 5pm. Phones were also programmed with three additional emergency contact numbers if staff were unable to contact the office.

Access and egress

Working at clients' residences and in community settings may present a risk particularly if employees are unfamiliar with the layout of the premises and safe access and egress routes. Aggressive animals in paths of travel, location of parking and incidence of violent crime all need to be considered for the safe delivery of services.

EXAMPLE

Employees in an inner-city HITH service had reported being concerned for their safety when visiting an unfamiliar area.

Solution: In consultation with employees, the hospital implemented a system where an initial audit was conducted prior to the discharge of clients, to identify suitable access/egress points at their residences and safe well lit locations to park vehicles. No visits were conducted until such audits had been completed and staff had been provided with relevant information.

Working in isolation

Working alone or in isolation presents a hazard for visiting health services, particularly when working in rural areas which may be some distance from assistance in an emergency.

Visits with an additional employee or accompanying security officer may assist to reduce the risk of occupational violence occurring but in certain situations this may end up putting more people at risk. If this risk is identified, the visit should be cancelled and other options explored.

EXAMPLE

Employees in a rural district nursing service typically worked alone and routinely visited properties over 45 minutes away from the nearest point of assistance, i.e. a police station.

Solution: After consulting with employees, the employer implemented a system which involved initial audits to identify if additional staff or security officers needed to attend. The employer also provided mobile phones and duress alarms with long-range coverage. Employees were required to provide a list of the locations they were to visit and an estimated finish time. The supervisor was required to make phone contact with employees during each visit. The supervisor would use 'yes/no' questions when calling to ascertain if there were any issues.

PREVENTING OCCUPATIONAL VIOLENCE

Close contact with the public

The nature of delivering assessment and treatment services requires people to work in close proximity to members of the public, without controls such as security access to staff areas, or physical barriers such as counters, to prevent occupational violence against staff. Visiting staff may face a greater degree of risk due to their increased exposure to clients, carers and others.

EXAMPLE

A male doctor visiting a client's home had been grabbed by the tie and threatened by an agitated family member when the doctor stated that the client needed to be readmitted to hospital rather than continuing care at home

Solution: After applying a 'zero tolerance' policy, the health service ensured that all visiting employees had received training on identifying warning signs and techniques for calming and defusing problem situations. The health service also implemented a procedure where visiting employees did not wear any neckties or identification on a lanyard around their neck, unless it was a quick release type.

Procedures being performed

The types of procedures being performed by visiting health services employees can increase the risk of occupational violence. Invasive procedures that cause pain and distress to the client, such as inserting IV-lines, increase the risk, particularly when dealing with people who have limited understanding of what is taking place or have limited capacity to control their behaviour, e.g. people with dementia.

EXAMPLE

There had been reports of a number of phlebotomists working for a pathology service being assaulted on home visits whilst collecting blood from elderly clients with dementia.

Solution: After implementing a prevention of occupational violence policy, the pathology service reviewed their current practices in consultation with employees and HSRs. They implemented a process to identify clients who may be likely to respond aggressively to phlebotomists. This allowed them to deliver the service in an environment where the client felt less threatened and where people they felt comfortable with were present, e.g. their local GP's practice. Employees were also provided with additional training on how to identify warning signs of a distressed client and minimise potential distress to the client.

2.4. SPECIFIC TASKS/CONTROLS

This section explores a variety of tasks undertaken by visiting health services employees, as well as risk controls. A red, amber and green (or 'traffic light') colour coding system has been used to help identify work practices which involve high risk and provide examples of safer work practices. Where organisations have work practices falling within the red, high risk category, they may be in breach of the legislation if it is reasonably practicable to implement controls described in the amber or green columns of the table.

As previously stated, employers should focus on *eliminating* the risk so far as is reasonably practicable or if this is not possible then *reducing* the risk so far as is reasonably practicable.

In some situations a combination of work practices may assist in reducing the risk to a greater degree than by using the solutions from one section in isolation.

PREVENTING OCCUPATIONAL VIOLENCE

Below is a more detailed explanation of the 'traffic light' colour coding system which is used through the following sections.

RED SOLUTION (HIGH RISK)	AMBER SOLUTION (REDUCED RISK, LESS EFFECTIVE)	GREEN SOLUTION (LOW RISK)
The practices in the red column are high risk and should not be used in workplaces. An employer who allows these practices to be used may be in breach of OHS legislation unless it is not reasonably practicable to implement controls outlined in the amber or green sections.	The solutions in the amber column reduce risk, but are less effective in reducing risk than those outlined in the green column.	The solutions in the green column are the most effective at reducing risk, and should be regarded as the target for all workplaces, so far as reasonably practicable.

PREVENTING OCCUPATIONAL VIOLENCE

2.4.1. Visit preparation

The table below refers to activities conducted prior to a visit.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • No assessment of risk prior to delivery of the service. • No policies and procedures in place for delivery of service offsite. • No processes in place for dealing with aggressive or threatening persons. • No requirement for employees to provide information to their employer regarding location of visit or arrival and departure times. • No handover provided to employees regarding risk of occupational violence involving a client or others at premises. • No consequences for, or reassessment of, people who threaten or act violently towards employees. • No training provided to employees regarding relevant policies and procedures. 	<ul style="list-style-type: none"> • Limited process in place for dealing with aggressive or threatening persons. • Limited handover provided to employees regarding risk of occupational violence involving a client or others at premises. • Limited training provided to employees regarding relevant policies and procedures. 	<ul style="list-style-type: none"> • Assessment of client's suitability for provision of home services conducted prior to visit. • Assessment conducted in a controlled environment. • No visits conducted until risk assessment completed. • Policies and procedures in place for conducting visits and delivering service offsite. • System is in place for collecting data from staff prior to visit which may include: <ul style="list-style-type: none"> • address/phone number of destination; • departure time; • expected time of return; • vehicle type, colour and registration details; and • mobile phone number. • Written and verbal handover provided to employees regarding risk of occupational violence from a client or others at premises to be visited. • System in place to monitor visits and ensure staff members return safely, including after hours and weekends. • The employer's policy and procedures to prevent and manage occupational violence is communicated on referral and prior to delivery of service, with actions to be taken against perpetrators of occupational violence also outlined. (Refer to section 2.5 for examples.) • Treatment contract in place for client prior to service being provided. • Procedures established with police regarding best methods of contacting them in an emergency. • All employees providing visiting health services are appropriately trained and aware of policies and procedures relating to visits.

PREVENTING OCCUPATIONAL VIOLENCE

2.4.2. Travelling to and from visits

The table below refers to car travel, vehicle breakdowns, parking and property access/egress.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • No initial assessment conducted, or initial assessment does not identify suitable parking areas or access and egress points. • No adequate communications equipment. • No procedures in place for travelling to and from visits. • No training provided to employees regarding policies, procedures and what to do in the event of a vehicle breakdown. • Employees use personal vehicle. 	<ul style="list-style-type: none"> • Employees are provided with some communications equipment. • Limited procedures in place for travelling to and from visits. • Limited training provided to employees regarding policies, procedures and what to do in the event of a vehicle breakdown. 	<ul style="list-style-type: none"> • Initial assessment identifies suitable (i.e. well lit) areas to park vehicles and suitable access/egress points from the property to be visited. • Employees park in an accessible position on the street (not in the driveway) where they can easily drive out in an emergency. • Employees keep car keys on them at all times. • Mobile phones provided to employees with adequate coverage, emergency numbers programmed into phones (including automotive breakdown assistance) and personal duress alarms provided. • Employees do not enter enclosed properties with a dog in the front yard, until the pet is secured by owner. • Employees listen for any conflict that may be occurring at a premises before entering. • Employees able to cancel visit if they consider a risk of occupational violence exists. • Training provided to employees regarding policies and procedures, and what to do in the event of a vehicle breakdown. • Employer vehicles used (i.e. fleet vehicles) with automotive breakdown assistance.

PREVENTING OCCUPATIONAL VIOLENCE

2.4.3. Working alone

The table below refers to working alone and also includes working in isolated/rural areas.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> Working alone without adequate communications equipment. Reliance on employees or clients communication equipment (i.e. personal mobile phones). No procedures in place to keep track of employee locations. No or limited training provided to employees regarding the assessment of risk and relevant policies and procedures. 	<p>Working alone with the following controls in place.</p> <ul style="list-style-type: none"> Procedures in place to ensure employees advise the employer of the clients address and their expected arrival and return times. Supervisors contact employees performing visits within 30 minutes of them arriving at a client's home, using 'yes/no' questions to determine if any issues exist. Code words established to alert the employer if employee is in a threatening situation or under duress. Person available (i.e. office staffed) to respond appropriately if the employee does not return or make contact at the end of their visit. No visits conducted after a set time, e.g. 4:30pm. Duress alarms provided with appropriate coverage and appropriate response system in place. Mobile phones with appropriate coverage and programmed emergency numbers provided and taken on visits. Employees authorised to contact emergency services directly if required. Employees able to conduct a situational risk assessment and end a visit if they consider a risk of occupational violence exists. Training provided to employees regarding the assessment of risk and relevant policies and procedures. 	<ul style="list-style-type: none"> Employees do not deliver the services alone. Visits conducted with two persons or a security officer or police officer if visit is essential (additional controls from the 'reduced risk solution' column also implemented).

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2.4.4. Working at night

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • Employees conduct visits alone at night or after hours. • Reliance on employees' or clients' communication equipment (i.e. personal mobile phones). • No persons available to respond in emergency situations (i.e. office not staffed after hours). • No or limited training provided to employees regarding the assessment of risk and relevant policies and procedures. 	<ul style="list-style-type: none"> • Visits conducted with two persons, or with security officer, or one person with telephone backup, based on risk assessment. • Procedures in place to ensure employees advise the employer of the client's address and their expected arrival and return times. • Supervisors contact employees performing visits within 30 minutes of them arriving at a client's home, with 'yes/no' questions used to determine if any issues exist. • Code words established to alert the employer if employees are in a threatening situation or under duress. • Person available (i.e. office staffed) to respond appropriately if the employee does not return or make contact at the end of their visit. • Duress alarms provided with appropriate coverage and appropriate response system in place. • Torch and batteries provided. • Mobile phones with appropriate coverage and programmed with emergency numbers provided and taken on visits. • Employees authorised to contact emergency services directly if required. • Employees able to conduct a situational risk assessment and end visit if they consider a risk of occupational violence exists. • Training provided to employees regarding the assessment of risk and relevant policies and procedures. 	<ul style="list-style-type: none"> • Visits not conducted at night or after hours.

PREVENTING OCCUPATIONAL VIOLENCE

2.4.5. Working with clients (and their carers and/or family members)

The table below focuses on situations where people are in distress or are likely to be affected by drugs or intoxicated or who have a history of aggression or threatening behaviours.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • Limited assessment of risk of occupational violence from client. • Visits conducted when client behaviour assessed as high risk and no or ineffective controls are implemented. • Employees conduct visits alone. • No processes in place to deal with aggressive or threatening people. • No consequences for, or reassessment of, people who threaten or act violently towards employees. • Reliance on employees' or clients' communication equipment (i.e. personal mobile phones or home telephones). • Visits conducted at locations where people are under the influence of alcohol or drugs. • Treatment and rehabilitation procedures that may cause client to become distressed and agitated are performed on visits. • Employees are not informed of specific client triggers or actions taken to manage specific clinical behaviours. • No or limited training provided to employees regarding the assessment of risk, identification of early warning signs and techniques for defusing a situation before it escalates. • Visiting employees wear items of clothing that may present a strangulation hazard, i.e. neckties, identification cards on lanyards around neck. 	<ul style="list-style-type: none"> • Visits still conducted if client's behaviour assessed as high risk, but with controls implemented to reduce the risk. • Visits conducted with two appropriately trained employees or security officer if client has a history of violence or aggression. • Procedures in place for dealing with aggressive or threatening people. • Code words established to alert the employer if employees are in a threatening situation or under duress. • Duress alarms with appropriate geographic coverage provided. • Mobile phones with appropriate geographic coverage provided and to be taken on visits, with emergency numbers programmed into phones. • Employees authorised to contact emergency services directly if required. • Employees able to conduct situational risk assessment and end visit if they consider a risk of occupational violence exists. • Employees informed of specific client triggers and actions taken to manage specific clinical behaviours which are documented in treatment plan. • Training provided to employees regarding the assessment of risk, identification of early warning signs and techniques for defusing a situation before it escalates. • Visiting employees wear items of clothing that do not present a strangulation hazard, i.e. elastic neckties, identification cards on quick release lanyards. 	<ul style="list-style-type: none"> • Visits not conducted if behaviour assessed as being high risk (i.e. adversely affected by drugs or alcohol). • A framework to manage occupational violence is implemented and appropriate actions taken following situations involving occupational violence. (Refer to section 2.5 for examples.) • Appropriateness of service and client symptom management are reviewed, which may result in withdrawal of visiting service and treatment being provided elsewhere (e.g. at hospital for clients who have a history of aggression or threatening behaviours). • Treatment/rehabilitation services are provided at a more suitable location to minimise the client's distress or agitation.

PREVENTING OCCUPATIONAL VIOLENCE

2.4.6. Handling drugs, cash and valuable equipment

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • Large quantities of drugs are carried by employees during visits; and contents of drug containers are easily identified by others. • Valuables, equipment and personal belongings left in view inside vehicles. • Employees take personal valuables on visits, i.e. prominent or excessive amounts of jewellery worn. • Employees collect payment from clients during visits for delivering treatment and rehabilitation services. • No procedures in place regarding handling of drugs or valuables. • Employees not trained in procedures and precautions for handling drugs and valuable equipment. 	<ul style="list-style-type: none"> • Only necessary quantities of drugs are carried on visits and these are transported in containers that do not identify their contents. • Procedures in place regarding handling of drugs and valuable equipment. • Employees trained in these procedures. • Employees wear minimal jewellery during visits. 	<ul style="list-style-type: none"> • Clients prescribed with the relevant medication prior to visit, eliminating the need for employees to carry drugs on visits. • Drugs and other valuables are not carried on visits. • Valuables not left in view inside vehicles. • All accounts paid centrally. Employees do not collect payment for treatment or rehabilitation services during visits. • Employees wear no jewellery during visits.

PREVENTING OCCUPATIONAL VIOLENCE

2.5. DEVELOPING A WORKPLACE CULTURE OF NOT TOLERATING OCCUPATIONAL VIOLENCE

Violence and aggression against staff are unacceptable. It is important for employees to understand that violence or aggression against them is not part of their job and should not be tolerated. Employers should have policies and procedures in place to support non-tolerance of occupational violence by implementing a 'prevention of occupational violence' or 'zero tolerance' approach.

Such approaches see appropriate steps taken to protect employees, clients and other people from the effects of occupational violence. Any serious incidents or threats of harm should result in a review of the way in which the service can be safely provided and may result in a withdrawal of service until suitable controls are put in place.

Management commitment, particularly from the Chief Executive Officer, directors and senior management, is essential to the underlying success of any OHS initiative.

However, in addition, all levels of management need to be aware that:

- occupational violence is unacceptable, and will not be tolerated;
- policies and procedures on occupational violence will be actively supported;
- incidents of occupational violence will be taken seriously;
- staff must be appropriately trained to know the workplace procedures, including emergency responses in a situation involving occupational violence;
- staff should be encouraged and supported to use the workplace procedures; and
- all incidents and potential incidents involving occupational violence are to be reported and investigated.

All employees should be aware:

- that occupational violence is unacceptable and will not be tolerated;
- that workplace procedures are in place, including emergency responses when confronted by occupational violence, and be able to exercise them consistently;
- that their employer will support employees in complying with these procedures;
- that a process for reporting incidents and near-misses is in place;
- that all incidents and potential incidents involving occupational violence are to be reported;
- that their employer will respond appropriately after any incident or near-miss;
- that all reported incidents or potential incidents of occupational violence will be investigated in order to eliminate or reduce the risk of occupational violence in the workplace; and
- that certain factors may contribute to the risk of occupational violence.

Responses to occupational violence

It is important that there are clear policies and procedures to describe actions to be taken if occupational violence against employees takes place. It is equally important for a communication strategy to be implemented for informing offenders and affected employees of the actions taken. These actions may include:

- clinical review and management strategies;
- formal meeting with client and carer;
- liaison with and/or referral to other services;
- warnings;
- conditional treatment contract for client, which may include restrictions on access and other persons being present;
- withdrawal of service and future provision of service in a more secure location, i.e. treatment at hospital rather than at home as violence may be an indication of a deterioration in the client's mental state;
- exclusions; and
- police involvement.

PREVENTING OCCUPATIONAL VIOLENCE

2.6. PREVENTION OF OCCUPATIONAL VIOLENCE POLICY

In addition to the information contained in a general policy, a prevention of occupational violence policy should contain the following:

- acknowledgement of occupational violence hazards;
- risk factors associated with occupational violence;
- stated employer commitment to preventing and managing risks associated with occupational violence and ensuring a safe working environment;
- statement that occupational violence is unacceptable and will not be tolerated;
- commitment from senior management;
- statement that appropriate actions taken by employees in situations involving occupational violence will be supported (e.g. termination of visit if staff perceive risk of occupational violence occurring, leading to a reassessment of the situation);
- statement that all reported incidents and near misses will be investigated; and
- statement that action will be taken following any report of occupational violence to prevent or reduce the risk to employee health and safety.

3

PREVENTING MUSCULOSKELETAL DISORDERS



3.1. WHAT ARE MUSCULOSKELETAL DISORDERS?

Musculoskeletal disorders (MSDs) are defined in the *Occupational Health and Safety (Manual Handling) Regulations 1999* as injury, illness or disease that arises in whole or in part from manual handling in the workplace, whether occurring suddenly or over a prolonged period of time. MSDs, particularly of the back, neck and shoulders, are the most common injuries sustained by health workers.

3.2. WHAT IS MANUAL HANDLING?

Manual handling covers a wide range of activities including: lifting; lowering; pushing; pulling; holding; throwing; carrying; and repetitive tasks, such as typing, sorting, assembling and operating equipment. In healthcare, client handling makes up a large proportion of manual handling and causes many MSDs. Healthcare staff can be exposed to high force while lifting, holding, restraining or assisting clients, or pushing, pulling and lifting equipment and furniture. Awkward postures and movements, such as bending and twisting the back, or repetitive and sustained poor postures of the shoulders, arms and hands, can be involved when treating clients and assisting them to move and walk.

3.3. HAZARD IDENTIFICATION, RISK ASSESSMENT AND CONTROL

In healthcare some tasks are known to be hazardous, such as lifting people and physically transferring dependent clients from bed to a chair. Employees also perform tasks which often require them to adopt sustained awkward postures, particularly bending and twisting to perform bathing, feeding, and other tasks. Work practices should be based on 'no lifting' principles, where staff do not manually lift clients. Equipment and aids should be used to transfer clients who require assistance to be moved, to minimise the use of sustained awkward postures when performing tasks. The environment and furniture should be designed as far as is reasonably practicable to reduce risks from bending, twisting and exerting force, e.g. pushing, pulling and lifting (see also section 4). Clients should also be encouraged to assist wherever possible to minimise risks to staff and enhance client mobility.

The WorkSafe publication, *Transferring People Safely* gives guidance on assessing risks associated with handling people and has examples of client risk assessment tools. WorkSafe's *Designing Workplaces for Safer Handling of Patients and Residents* contains information about design issues for health services.

PREVENTING MUSCULOSKELETAL DISORDERS

3.4. ISSUES TO CONSIDER WHEN CONTROLLING THE RISKS

Environment

The environment in which manual handling is undertaken can influence the risk to employees and clients. Poor lighting, lack of heating, clutter, slippery or uneven floor surfaces and difficult access and egress across rough ground or staircases can all contribute to risk. Health workers need to be trained to identify risk and supported in their assessment of the situation.

EXAMPLE

Cathy had motor neurone disease and received daily dressings and chest physiotherapy with a ventilator. Cathy's bedroom and bathroom had been adapted and fitted with ceiling mounted hoists for transferring Cathy to her chair and for toileting and showering. Cathy lived with her elderly mother in a house on a high slope and access was from the back veranda, which had a wooden barrier gate to keep the dog in. Nurses carried their equipment up a steep overgrown drive and lifted it over the barrier twice a day. The house was very cold and Cathy's mother refused to use the central heating because of the cost.

Solution: The hospital agreed to loan Cathy a ventilator and store dressing materials in her room. Cathy's mother agreed to open the front door after identification by the visiting nurse. She also agreed to use a fan heater in Cathy's room and bathroom during treatment.

Design

Design issues in houses, units and supported residential facilities may include:

- lack of adequate corridor width and space for turning corners;
- narrow doorways and inadequate space in bedrooms, bathrooms and toilets for moving clients and using equipment safely;
- poor floor surfaces, leading to high push forces for wheeled equipment or risk of slips, trips and falls;
- difficult access to showers;
- lack of hand rails; and
- different levels or steps between areas inside and outside the dwelling.

These issues can lead to the inability to use mechanical equipment to move people, and therefore put workers at risk when attempting to manually lift, pull or push their clients.

When long term treatment requires manual handling of the client, modifications to the home should be undertaken where practicable to reduce risks from manual handling. These may include small scale, relatively non-intrusive changes or structural changes, such as the modification of a bathroom to allow a flat surface in the shower without barriers to access.

PREVENTING MUSCULOSKELETAL DISORDERS

EXAMPLE

Bert returned home to his wife and their ground floor flat, three weeks after he had suffered a stroke. He could stand and transfer into a chair, but not walk. The occupational therapist from the rehabilitation unit visited the home with the community nurse to assess Bert's activities of daily living at home. Bert had been given a wheelchair which barely fitted around the corners in the flat and could not get near the shower or into the toilet. There was one small step down from the front door to the balcony and Bert's wife could not push the wheelchair down the step.

Solution: The occupational therapist ordered a narrow commode chair which would push into the toilet and shower as well as a slatted base with an access ramp and a hand rail for the shower. Until the equipment was delivered, the nurse assisted Bert's wife with washing and toileting Bert in bed. A portable ramp with a rail was ordered initially to go over the access step to allow staff and Bert's wife to push him outside to transport him to attend rehabilitation until a permanent ramp could be installed. Bert's condition was reassessed in a few weeks and plans were made for changes to the bathroom to install a flat accessible shower for his long term management.

Equipment and furniture

Home furniture may not provide a good base for staff to work from. For example, beds and couches that are low, soft or wide, and chairs that are low or lumpy, create difficulties for visiting healthcare staff. Assisting people to move may involve bending, twisting and reaching and high force. Treatments such as dressing a wound or inserting an intravenous line need accuracy and precision and may require extended periods of awkward postures.

The time required to gain approval for funding of hire or purchase of equipment needs to be considered prior to delivery of services in a client's home. The design of vehicles and a lack of appropriate lifting or wheeled equipment can pose manual handling risks to staff undertaking client home visits. Examples of furniture, fittings and equipment which can be loaned, hired or purchased for clients requiring treatment at home are listed in section 4.

EXAMPLE

Jan had dialysis at home three times a week. She was quite frail and depended on her son to assist her around the house. Jan's son got her into a comfortable low lounge chair in front of the television before he went to work. The visiting nurse had to bend over or kneel on the floor and twist to administer the dialysis.

Solution: A patient service contract including the hospital's policy on manual handling using 'no lifting' principles was developed and presented to all clients. Funding was provided for a supportive but high armchair with wide arms and tilt capacity. Jan could then sit in front of the television during her treatment and the nurse was able to administer the treatment while sitting on a kitchen chair next to Jan.

PREVENTING MUSCULOSKELETAL DISORDERS

Resources

Managing staff numbers and timing of visits has to be considered in order to deliver service in the safest way. Assistance from family members may not be possible or desirable.

EXAMPLE

A district nursing service covered a wide area, with staff not easily available to help others in circumstances requiring extra assistance.

Solution: The service put in place a mandatory assessment visit before any services were offered. The assessor had a checklist to assess the environment, the client's condition and treatment requirements, including equipment, staff numbers and skills needed. There was a regular review of the assessment process to update service provision requirements.

Policies, procedures and training

A service provider must have clear policies on: what services will be provided; what is expected of clients; and what issues constitute grounds for withdrawal or change of the service. The policy must include an assessment of the environment to be performed before treatment is undertaken. Staff procedures need to be clearly stated and all staff trained and competent in the procedures.

EXAMPLE

A hospital did not have specific policies related to their visiting health services.

Solution: The hospital developed a policy that includes its position on client and other manual handling tasks. The policy also reinforces the hospital's commitment to work practices to manage risks from manual handling, and procedures for hire or loan of lifting and wheeled equipment, and modifications to home environments, furniture and access. All visiting staff were trained in the procedures. Simplified copies of the policy were prepared and given to all clients at the assessment visit. The home visit assessor attended in-hospital case conferences to get an up-to-date assessment of the clients' conditions and abilities, and to indicate whether the clients were appropriate to receive treatment in the home or required further hospital or rehabilitation care.

Expectations of clients

The client may expect levels of assistance that may pose a risk to staff (e.g. a client with chronic illness who wants to be treated in their low and soft queen size bed). Clear policies on what is an appropriate level of safety for staff should be communicated to clients at the start of a service, to avoid clients wanting staff members to perform tasks which are not considered safe. The client may be asked to sign a service contract or care plan agreeing to the need for staff to work in a safe and healthy environment. This agreement can contain specific issues which must be controlled, such as harassment of staff, smoking and manual handling, and the conditions under which the service will be provided.

EXAMPLE ONE

Jim's wife wanted to have Jim at home for the last few weeks of his life, with assistance from the local palliative care group. Jim was bed-bound and receiving increasing medication, skin care, ventilation and bathing. The assessor for the palliative care group visited Jim's home and found his bedroom was upstairs, with a queen size bed situated against the wall.

Solutions: The assessor discussed his concerns with the current set-up with Jim's wife who agreed to hire an adjustable height hospital bed with a flow mattress, and convert the lounge room downstairs into his bedroom. A slide sheet was purchased to move and turn Jim in bed. Jim was able to return home and have daily treatment and support until his death, with less discomfort for him and minimal hazardous manual handling for the nursing staff.

PREVENTING MUSCULOSKELETAL DISORDERS

EXAMPLE TWO

Five year-old Brad had a high level of physical disability from cerebral palsy. He began receiving treatment at home from the local community health centre (CHC) team members. Brad's mother had a back injury and wanted team members to lift Brad up and down from his wheelchair to a beanbag on the floor and provide treatment to him there.

Solutions: The team members assessed the home environment and gave Brad's mother a copy of their 'no lifting' policy (client version). They assisted Brad's mother to obtain an appropriate mobile hoist, a wheeled adjustable height support trolley and commode chair with supports for Brad through his case manager. In the interim, they provided child care at the CHC for Brad's younger siblings while treating Brad at the CHC. They assisted the family to plan and obtain some funding for modifications to their shower to allow commode access and for overhead tracking and a hoist to be installed in Brad's bedroom and the bathroom. The long term solutions eliminated the manual handling tasks for the health service staff, other helpers and the family.

PREVENTING MUSCULOSKELETAL DISORDERS

3.5. SPECIFIC TASKS/CONTROLS

This section identifies specific manual handling tasks that visiting practitioners are likely to experience, as well as appropriate risk controls. The same 'traffic light' colour coding system which was used in section 2.4 is applied to categorise controls.

3.5.1. In-bed treatment tasks

The table below relates to in-bed treatment tasks, e.g. personal care, dressings, intravenous line insertion, injections, therapeutic exercises and catheter management.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; and jerky movements.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • Client on low bed for treatment. • Client has to be manually pulled and/or lifted into position because of soft bed surface. • Client needs assistance with removing clothing and/or pressure stockings. • Sustained holding or gripping movements to perform leg exercises, insert intravenous line or dress wound for uncooperative or poorly positioned client. • No storage location, therefore, equipment stored on floor. • Staff not trained in manual handling risk assessment and work practices. • One staff member. 	<ul style="list-style-type: none"> • Bed raised on bed raiser frame with lockable castors. • Board placed under mattress. • One slide sheet for moving client. • Staff have received some training in manual handling risk assessment and work practices. • Clear access to both sides of the bed. 	<ul style="list-style-type: none"> • Electric adjustable height hospital bed. • Two slide sheets. • Client or partner assists with dressing and undressing. • Client's clothing easy to remove or put on. • Clear access to both sides of the bed. • Appropriate storage room for equipment and clear work area. • Staff trained and competent in manual handling risk assessment and work practices. • Two staff members when moving people in bed.

3.5.2. In-chair treatment tasks

The table below focuses on in-chair treatment tasks, e.g. podiatry treatment, intravenous line insertion, dressings and exercise therapies.

Typical risk factors include: sustained awkward postures, such as: bending, twisting and gripping; exerting high force; and jerky movements.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> • Client on low, deep or soft chair or couch for treatment. • Client has to be manually assisted into position because of soft or deep surface. • Client needs assistance with removing clothing and/or pressure stockings. • Sustained small movements to insert intravenous line, treat feet, exercise arms or dress wound for uncooperative or poorly positioned client. • No storage surface, therefore equipment on floor. • Staff not trained in manual handling risk assessment and work practices. • One staff member. 	<ul style="list-style-type: none"> • Client in hard chair with feet up on another chair for treatments such as dressings or podiatry. • Chair available for treating practitioner. • Staff have received some training in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> • Adjustable height, lift and recline client treatment chair. • Height of treatment chair adjusted with leg or seat raisers. • Mobile treatment stool. • Client's clothing easy to remove or put on. • Equipment surface next to chair. • Staff trained and competent in manual handling risk assessment and work practices. • One or two staff members depending on risk assessment.

PREVENTING MUSCULOSKELETAL DISORDERS

3.5.3. Bed-to-chair and chair-to-bed transfers

The table below assesses bed transfers including assisting clients, moving them for treatment, transferring to commode and teaching clients to transfer themselves.

Typical risk factors include: awkward postures, such as bending and twisting; exerting high force uneven movements; and reaching.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<p>Client not able to assist</p> <ul style="list-style-type: none"> Lifting dependent client from bed to chair by top and tail lift or hook arm lift. Bending and twisting over low bed and chair. Standing pivot (lift) of dependent client. Lifting client's legs up onto bed*. Manually repositioning client*. 	<p>Client not able to assist</p> <ul style="list-style-type: none"> Bed raised on bed raiser frame with lockable castors and with firm mattress. Wheelchair or mobile commode chair with removable arm. Use of slide board with slide sheet. Client or staff lift legs up using aid e.g. towel or slide sheet.¹ 	<p>Client not able to assist</p> <ul style="list-style-type: none"> Adjustable height bed. One or two slide sheets to position client in bed ready for transfer. Mobile or overhead tracking lifting hoist with appropriate/recommended slings. Access to bed from both sides. Wheelchair or mobile commode chair with removable arm. Slide sheet to reposition client in bed if necessary*. Adequate space to manoeuvre mobile hoist. Hard floor surface enabling wheeled equipment to be used without exerting high push and pull forces.
<p>Client able to assist</p> <ul style="list-style-type: none"> Lifting and pulling client into sitting. Supporting client from sitting to standing. Swivelling client and lowering into chair. Clutter and furniture around bed. Repositioning client in bed*. 	<p>Client able to assist</p> <ul style="list-style-type: none"> Bed raised on bed raiser frame with lockable castors. Bed rope to assist client from lying to sitting. Standing transfer with walk belt and mobility aid.² Client assists to lift legs using aid if necessary.¹ 	<p>Client able to assist</p> <ul style="list-style-type: none"> Adjustable height bed. Monkey bar or bed stick for client to initiate transfer. Free space on both sides of bed for staff. Space to transfer across to chair or for equipment to be rotated at 90°. Slide board, or slide board and slide sheet, to allow client to reach across and slide from bed to chair with assistance from carer. Chair or commode with removable arm at slightly lower level than bed. Mobile standing hoist for clients who can bear weight but require minimal assistance. Standing transfer with mobility aid for high functioning client. Client assists to lift legs using aid if necessary*.
<ul style="list-style-type: none"> One staff member. Staff not trained in manual handling risk assessment and work practices. <p>* Note: Chair-to-bed transfers only.</p>	<ul style="list-style-type: none"> Staff have received some training in manual handling risk assessment and work practices. <p>* Note: 1. Chair-to-bed transfers only. 2. Walk belts should not be used to lift clients out of chairs or off beds.</p>	<ul style="list-style-type: none"> Two staff members. Staff trained and competent in manual handling risk assessment and work practice. <p>* Note: Chair-to-bed transfers only.</p>

PREVENTING MUSCULOSKELETAL DISORDERS

3.5.4. Showering

The table below focuses on patient showering tasks, e.g. transferring clients to shower chair/commode, manoeuvring wheelchairs, entering and exiting the shower, and assisting showering.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; handling slippery and awkward objects; working on slippery surfaces; and pushing and pulling.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
Client not able to assist	Client not able to assist	Client not able to assist
<ul style="list-style-type: none"> Lifting client from bed to chair and chair to bed as described in section 3.5.3. Pushing and pulling commode chair with small wheels over carpet or around sharp and narrow corners and doorways. Inadequate shower access – lifting and pivoting client from commode chair to plastic seat in shower. Bending and twisting into a confined shower area to wash client. Lifting client from commode chair to seat in or over bath and out of bath. Bathing client. 	<ul style="list-style-type: none"> Assisting client from bed to chair and chair to bed as described in section 3.5.3. Pushing wheeled commode chair over temporary ramp into shower cubicle. Slatted raised floor and ramp entry. Using slide sheet to move client in bed and bathing client in bed as an alternative or interim measure. Towel or other covering on floor to prevent slips. 	<ul style="list-style-type: none"> Assisting client from bed to chair and chair to bed as described in section 3.5.3. Pushing and pulling commode chair with large wheels over hard surface floors. Adequate space in doorways and corridors. Adequate access to shower cubicle <ul style="list-style-type: none"> Shower base at floor level Wide entry or remove glass doors. Using hand-held hose to wash client. Carer wearing protective apron/ boots to allow closer access. In larger areas, transfer from bed to shower/bath trolley and bathing with hand-held shower, drying and dressing client on trolley. Non-slip flooring.
	Client able to assist	Client able to assist
	In addition to above: <ul style="list-style-type: none"> using slide sheet to assist client to move in bed; 	In addition to above: <ul style="list-style-type: none"> handrail in shower for client to assist standing; dressing client in chair or transfer back to bed for dressing;
<ul style="list-style-type: none"> One staff member. Staff not trained in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> one or two staff members depending on risk assessment; and staff have received some training in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> one or two staff members depending on risk assessment; and staff trained and competent in manual handling risk assessment and work practices.

PREVENTING MUSCULOSKELETAL DISORDERS

3.5.5. Toileting

The table below focuses on tasks associated with toileting of clients, e.g. transferring client to chair/commode, pushing chair, entering and exiting the toilet cubicle, assisting transfer to toilet or toileting in bed.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; handling awkward objects; and pushing and pulling.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
	Client not able to assist	Client not able to assist
<ul style="list-style-type: none"> Lifting client from bed to chair and chair to bed as described in section 3.5.3. Pushing and pulling commode chair with small wheels over carpet and around sharp and narrow corners and doorways. Inadequate access to toilet cubicle or over toilet for commode - lifting and pivoting client from commode chair to toilet. Bending and twisting to assist with personal hygiene. 	<ul style="list-style-type: none"> Assisting client from bed to chair and chair to bed as described in section 3.5.3. Pushing wheeled commode chair into cubicle and over toilet. 	<ul style="list-style-type: none"> Assisting client from bed to chair and chair to bed as described in section 3.5.3. Pushing and pulling commode chair with large wheels over hard surface floors. Adequate space in doorways and corridors. Adequate space to push wheeled commode chair over toilet. Access space from side to assist with personal hygiene.
	Client able to assist	Client able to assist
	<ul style="list-style-type: none"> As above. 	In addition to above: <ul style="list-style-type: none"> handrail next to toilet for client to assist standing; use of slide board for client to transfer from commode/wheelchair to toilet;
<ul style="list-style-type: none"> One staff member. Staff not trained in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> One or two staff members depending on risk assessment. Staff have received some training in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> one or two staff members depending on risk assessment; and staff trained and competent in manual handling risk assessment and work practices.

PREVENTING MUSCULOSKELETAL DISORDERS

3.5.6. Mobilising

The table below refers to mobilising, including assisting clients to transfer from chair or bed to standing, or assisting with walking.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; handling awkward objects; and restraining.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<p>Standing</p> <ul style="list-style-type: none"> Client in low soft bed or low chair. Client has to be manually pulled and lifted because of low soft surface. 	<p>Standing</p> <ul style="list-style-type: none"> Bed raised on bed raiser frame with lockable castors and with firm mattress. Access to both sides of the bed. Chair raised and with arms to push up on. Wheelchair with arms and removable foot plates. Use of walk belt* to assist client into standing. Client walking aid e.g. stick, frame. 	<p>Standing</p> <ul style="list-style-type: none"> Adjustable height bed. High chair or ejector chair with arms. Wheelchair with arms and removable foot plates. Mobile standing/walking frame.
<p>Walking</p> <ul style="list-style-type: none"> Propping up client while walking. Bending and twisting to assist client to move lower limbs. Inappropriate floor surfaces, e.g. thick carpet or slippery. Client walks in inappropriate shoes, e.g. slippers. 	<p>Walking</p> <ul style="list-style-type: none"> Client uses stick or frame or pushes wheelchair. Appropriate walking surface and shoes. Use of walk belt* to assist and balance client while walking. 	<p>Walking</p> <ul style="list-style-type: none"> Client uses mobile standing/walking frame or appropriate walking aid. Appropriate walking surface and shoes.
<ul style="list-style-type: none"> One staff member. Staff not trained in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> One or two staff members depending on risk assessment. Staff have received some training in manual handling risk assessment and work practices. <p>* Note: Walk belts should not be used to lift clients out of chairs or off beds.</p>	<ul style="list-style-type: none"> One or two staff members depending on risk assessment. Staff trained and competent in manual handling risk assessment and work practices.

PREVENTING MUSCULOSKELETAL DISORDERS

3.5.7. Transferring client into and out of cars or other transport

The table below refers to vehicle transfers including assisting clients to transfer from their wheelchair or standing position into a vehicle.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; handling awkward objects; and restraining.

HIGH RISK	LOW RISK SOLUTION
Client not able to assist	Client not able to assist
<ul style="list-style-type: none"> • Pivot/lift transfer from wheelchair into car passenger seat or from seat to wheelchair. • Two person lift from wheelchair into passenger seat. 	<ul style="list-style-type: none"> • Mobile car accessible hoist. • Wheelchair accessible taxi or adapted car. • Bus with wheelchair hoist.
Client able to assist	Client able to assist
<ul style="list-style-type: none"> • Pivot/lift transfer from wheelchair into or out of car passenger seat. • Assisted pushing/pulling client up steps into bus/van. 	<ul style="list-style-type: none"> • Standing transfer using walking aid, e.g. frame. • Slide board between wheelchair and vehicle seat. • Client pivots from wheelchair to rotating passenger seat or disk on seat that rotates. • Client lifts legs using towel or leg lifter. • Client uses bus wheelchair hoist and transfers into bus seat.
<ul style="list-style-type: none"> • One staff member. • Staff not trained in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> • One or two staff members depending on risk assessment. • Staff trained and competent in manual handling risk assessment and work practices.

PREVENTING MUSCULOSKELETAL DISORDERS

3.5.8. Transferring equipment into and out of cars or other transport

The table below refers to transferring medical equipment and walking or other aids.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; handling awkward objects; and restraining.

HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
<ul style="list-style-type: none"> Bending and twisting to lift heavy equipment, such as hoists and respirators out of back seat or boot of a car or from the side sliding door of a van. Carrying heavy equipment into homes with difficult access or layout, e.g. up steep driveways or steps. 	<ul style="list-style-type: none"> Use of station wagon. Equipment is light, foldable and transportable. One or two staff depending on risk assessment. Objects secured in vehicle to prevent injury to occupants. 	<ul style="list-style-type: none"> Use of suppliers or furniture removalist vans to deliver all large and awkward equipment, e.g. electric beds, mobile hoists and pumps. Use of station wagon with slide out carrying surface. Use of appropriate trolley, e.g. adjustable height trolley or fold-up, portable and wheeled equipment case. Hire out of equipment to leave at client's home. Client hires or buys relevant equipment or furniture. One or two staff depending on risk assessment.
<ul style="list-style-type: none"> Staff not trained in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> Staff have received some training in manual handling risk assessment and work practices. 	<ul style="list-style-type: none"> Staff trained and competent in manual handling risk assessment and work practices.

3.5.9. Managing falls and emergencies

The table below addresses falls and emergencies, e.g. client falls, collapses over toilet, arrests or resistance to treatment.

Typical risk factors include: sustained awkward postures, such as bending, twisting, reaching and gripping; exerting high force; handling awkward objects; and restraining.

HIGH RISK	LOW RISK SOLUTION
<ul style="list-style-type: none"> Lifting or dragging client from floor (with one or two people). Lifting slumped client from toilet/commode to bed/chair. Lifting client to floor to apply resuscitation. Lifting client into standing or walking while client resists. 	<ul style="list-style-type: none"> Assessment of immediate risks to client and staff. Making client comfortable and safe on floor until further medical attention is available. Use of mobile hoist to lift client from floor/toilet. Use of slide sheet to slide client out of awkward positions or into sitting position. Use of inflatable chair to raise client into high sitting. Providing chair for client to use to assist self from floor, assisting client to roll/kneel to access chair.

5.1. EXAMPLE CHECKLIST: REFERRAL INFORMATION

This checklist can be used when referring clients to other health services in order to identify any potential occupational violence risks. It covers the minimum information which should be gathered at referral, particularly for short visits or one-

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MANUAL HANDLING AIDS AND EQUIPMENT



Examples are given here of the types of equipment and furniture appropriate for use in home environments. Specific brands and designs can be found through contact with suppliers, on supplier web sites, through your OHS or occupational therapy department or through contact with specialist services, such as the independent living centre.

THREE IMPORTANT THINGS TO REMEMBER

1. Choosing the correct equipment

Equipment choice should be based on assessment of the individual client's needs, the environment in which the service is provided and the risk to visiting health employees and other carers and the client. A health professional, such as an occupational therapist, can assist in evaluating the equipment needs. Risk is also dependent on the short or long term nature of the health service provision. The source of funding or provision of loan equipment or furniture is an important factor which may impact on the timing of the equipment provision.

2. Consultation

Equipment has two aims: to maximise the client's independence; and to reduce risks to staff from manual handling. Consultation on appropriate equipment should occur with OHS staff, such as 'no lift' coordinators, HSRs and health service staff. Consultation with the client and others involved, such as case managers and family carers, should be undertaken before choosing equipment. A collaborative approach will lead to the optimum outcome for employees while having regard for the rights of the client.

3. Safety of equipment

Equipment such as hoists and slings need to be safe and used according to the manufacturer's instructions, e.g. safe working loads. Equipment must be sufficiently strong and stable for the proposed use, and inspected before being put into a new service. There must be regular maintenance and the equipment should be used by competent, trained people. Specific equipment can be obtained which meets the needs of very large or heavy clients or those with specific physical needs which require individualised design.

Installation and dismantling of equipment such as overhead tracking, bed raiser frames, and other equipment which requires installation should be undertaken in the home by appropriately skilled and qualified tradespersons and service providers. There is potential legal liability for employers if such equipment is not installed properly and causes injury to staff or clients.

MANUAL HANDLING AIDS AND EQUIPMENT

EQUIPMENT AND FURNITURE

Equipment and furniture may include the following.

Beds

- Electrically adjustable height and back rest height hospital type beds - can also provide multiple other adjustments, including down to floor height and tilt.
- Adjustable height or fixed bed raisers, e.g. frames.
- Electrically operated mattress elevators or inflatable 'bed sits'.
- Pressure-relieving or foam mattress overlays and raisers.
- Flat board under mattress to give firm surface.

Transferring, moving and lifting equipment

- Electrically operated lifting, moving and transferring hoists attached to overhead tracking in ceiling or a frame.
- Electrically operated mobile lifting and transferring hoists.
- Electrically operated raising, standing and transferring hoists.
- Slings - hoists come with a variety of slings to support the client. These can include full body slings (if necessary with head support), personal care slings which allow access for dressing, toileting and personal hygiene, padded slings, mesh for bathing and standing slings or harnesses for standing and walking hoists.
- Bed sticks, or adjustable width holds, or swing out sitting and standing aids.
- Free standing bed poles or 'monkey bars'.
- Bed ropes or ladders.
- Slide sheets.
- Slide boards with slide sheets.
- Inflatable leg-lift aids.

Bathing equipment

- Bath/shower rails – can be fixed diagonally, vertically or horizontally to the wall, floor or other fixed surfaces to allow clients to push down on them to assist standing or sitting.
- Mobile commode chairs with rubber wheels, brakes, removable arms and foot plates and a seat with a front or central space to allow toileting and washing. Some can be padded or specifically designed with support for a client who has limited sitting balance.
- Shower chairs – can be commodes which are pushed into the shower space or a variety of fixed chairs, stools or wall mounted seats or slatted benches.
- Hand-held shower hoses with flexible tubing to allow washing of all parts of the body.
- Adjustable height bath trolleys which can be used to transfer the person to the bathroom, bathe the person, be emptied and used as a drying and change surface.
- Shower bases with entrance ramps, slatted wood or other material to fill the gap between the floor and the ledge at the entrance to the shower.
- Overhead bathroom tracking, usually multidirectional, to allow client to be lifted to and from commode or wheelchair, change table, bath or toilet.
- Mesh slings – hoist slings which can be left under a client while they are immersed in water or showered.

Bathing is not recommended practice. Bathing aids and adjustable baths may be used by some clients who are able to assist and may be necessary for some clients with high level disabilities, but visiting health staff should not be bathing clients as an alternative to showering.

MANUAL HANDLING AIDS AND EQUIPMENT

- Bath seats – come in various forms, such as slide across benches which sit over the bath and battery operated seats which can be lowered into the bath and raised again.
- Adjustable baths, electrically operated, which can be raised and lowered. Some baths have a half door and raised seat to allow access from the side.
- Adjustable height change tables with wheels and brakes, and adjustable side rails if required, used with a mobile or overhead hoist.
- Bath stretchers or shower and changing benches, usually of mesh, which lie horizontally over the bath and are used with a hoist or are height adjustable for clients who can not support themselves.

Toileting equipment

- Toilet or commode chairs.
- Toilet back supports.
- Raised toilet seats.

Walking aids

- Standing/walking hoists with support slings for clients who can bear weight but need considerable support, either mobile or supported from overhead tracking.
- Walking aids – mobile walkers with a variety of height adjustments, arm rests and hand holds, and trunk or pelvis supports or sling seats.
- Walking frames, either with legs or wheels or both.
- Walking sticks – from four-point to single canes or adjustable height crutches.
- Adjustable height step sets with rails.
- Portable or fixed access ramps with or without rails.

Lifting clients

- A variety of mobile floor hoists with a range of height adjustments to match the tasks for which they are used, e.g. floor to bed height adjustment to allow picking someone up from the floor.
- Hoists attached to overhead tracking devices, with a range of adjustment to meet the needs of the client.
- Inflatable chairs, with or without backs, to lift clients from the floor to sitting up high.

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REFERRAL AND ASSESSMENT CHECKLISTS

REFERRAL AND ASSESSMENT CHECKLISTS

5.1. EXAMPLE CHECKLIST: REFERRAL INFORMATION

This checklist can be used when referring clients to other health services in order to identify any potential occupational violence risks. It covers the minimum information which should be gathered at referral, particularly for short visits or one-off visits (i.e. by a GP, maternal and child health nurse or pathology service collecting blood samples from client at their home) where it may not be reasonably practicable to conduct a more in-depth assessment.

Note: this is an example only - it identifies the issues that may be addressed and incorporated into the agency's own documentation. This information may be incorporated into referral forms or gathered verbally at the point of referral.

Name:		
Address:	Suburb:	
Client's phone numbers:	(h)	(w)
Nominated contact person's phone details:	(h)	(m)
	Yes	No
Is the client or others known to be potentially aggressive, violent or disturbed?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a risk of the client or others at the premises using a weapon?	<input type="checkbox"/>	<input type="checkbox"/>
Is there evidence that client or others at the premises may be under the influence of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Is the service to be provided at night or outside of normal working hours?	<input type="checkbox"/>	<input type="checkbox"/>
If answer was 'yes' to any of the above questions, visits should not be conducted until the risk is assessed further and appropriate controls implemented.		
Has relevant medical history been communicated including potential risk situations?	<input type="checkbox"/>	<input type="checkbox"/>
Does the client have any animals?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are they securely locked away?	<input type="checkbox"/>	<input type="checkbox"/>
Is the client/carers aware of the proposed visit?	<input type="checkbox"/>	<input type="checkbox"/>
Have they consented to the proposed visit?	<input type="checkbox"/>	<input type="checkbox"/>
Are the premises easily accessible from the street?	<input type="checkbox"/>	<input type="checkbox"/>
Accommodation type:	House <input type="checkbox"/>	Flat/unit <input type="checkbox"/>
	Aged care facility <input type="checkbox"/>	
	Supported accommodation residential services <input type="checkbox"/>	
	High rise complex <input type="checkbox"/>	Floor: _____
	Lift access <input type="checkbox"/>	Stair access <input type="checkbox"/>

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RESOURCES AND LINKS

6.1. WHERE TO GO FOR MORE INFORMATION

WorkSafe Victoria

WorkSafe Victoria offers a complete range of OHS services, including: emergency response; advice; information and education; inspections and audits; licensing and certification; publications; and on-line guidance. WorkSafe Victoria publications can be downloaded from the WorkSafe Victoria website (at www.worksafe.vic.gov.au).

Advisory service

222 Exhibition Street
Melbourne VIC 3000

Phone: 03 9641 1444
Toll-free: 1800 136 089

Email: info@worksafe.vic.gov.au

WorkSafe incident notification
Phone: 13 23 60

6.2. FURTHER READING AND RESOURCES

Consultation

Talking Safety Together, WorkSafe Victoria, 2005.

Consultation: A User's Guide, WorkSafe Victoria, 2005.

Information for Employees, WorkSafe Victoria, 2005.

Prevention of occupational violence

Prevention of Bullying and Occupational Violence at Work Guidance Note, WorkSafe Victoria, 2003.

Zero Tolerance; Response to violence in the NSW Health Workplace: Policy and Framework Guidelines, NSW Department of Health, 2003.

Personal Safety and Privacy for Doctors, Australian Medical Association (AMA) Position Statement, November 2005.

Zero Tolerance (OH&S Violence and Aggression) Resource Kit, ANF (Victorian Branch), 2002

Australian Standard Security for Health Care Facilities (AS4485.2-1997), Part 2: Procedure guide Section 6: Security for external services.

Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services, Department of Human Services, September 2004.

Staff Safety in the Workplace: Guidelines for the prevention and management of occupational violence for Victorian child protection and community-based juvenile justice staff, Department of Human Services, June 2005.

Victorian Taskforce on Violence in Nursing – Final Report, Nurse Policy Branch, Department of Human Services (Victoria), November 2005.

Manual handling

Designing Workplaces for Safer Handling of Patients and Residents, WorkSafe Victoria, 2002.

Transferring People Safely, WorkSafe Victoria, 2002

No Lifting Policy, ANF (Victorian Branch), April 2006.

No Lifting Implementation Guide and Checklist, ANF (Victorian Branch), 1998.

Ballarat District Nursing and Healthcare Inc Safety Development Fund Project Final Report – Musculo-skeletal Injury Prevention Program for District Nurses, Ballarat District Nursing and Healthcare Inc, January 2003.

Victorian Nurses Back Injury Prevention Project Evaluation Report, Department of Human Services (Victoria), 2004.

General OHS

Summary of the Occupational Health and Safety Act 2004, WorkSafe Victoria, 2005.

Guide to the OHS Act 2004, WorkSafe Victoria, 2005.

Home and community services

Victorian Home Care Industry, Occupational Health and Safety Guide, Department of Human Services (Victoria) and WorkSafe Victoria, 2005.

Working Safely in Community Services, WorkSafe Victoria, 2005.

Casual workers and labour hire

Placing Workers in Safe Workplaces, WorkSafe Victoria, 2005.

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Healthscope Limited

Health and Community Services Union

Health Services Union

OT Australia (Australian Association of Occupational Therapists)

Royal District Nursing Service

St Vincent's Hospital

The Department of Human Services (Victoria)

Victoria Police Crime Prevention Unit

Victorian Health Industry Association

The information presented in *Working Safely in Visiting Health Services* is intended for general use only. It should not be viewed as a definitive guide to the law, and should be read in conjunction with the *Occupational Health and Safety Act 2004*.

Whilst every effort has been made to ensure the accuracy and completeness of *Working Safely in Visiting Health Services*, the advice contained herein may not apply in every circumstance. Accordingly, the Victorian WorkCover Authority cannot be held responsible, and extends no warranties as to:

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(628 Bourke Street).....03 9941 0558

Mildura.....03 5021 4001

Mulgrave.....03 9565 9444

Preston.....03 9485 4555

Shepparton.....03 5831 8260

Traralgon.....03 5174 8900

Wangaratta.....03 5721 8588

Warrnambool.....03 5564 3200