

HEALTH AND SAFETY GUIDELINES FOR

Home-Based Health Care Services



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Foreword

This guideline arose in response to the death of a home-based caregiver in 1995. One of the coroner's recommendations was that OSH complete, publish and widely circulate guidance material for employers, employees and others involved in the home-based health care industry. It should be noted that while that guideline has been through a thorough and appropriate consultation process, the recommended health and safety practices represent minimum standards. Good employers will aim for best practice models which exceed these guidelines.

These *Health and Safety Guidelines for Home-Based Health Services* have been produced as a joint initiative between the New Zealand Home Health Association (NZHHA) and the Occupational Safety and Health Service (OSH) of the Department of Labour.

In recognition of the need for health and safety guidelines for the home-based care industry, a joint NZHHA and OSH working party developed draft health and safety guidelines and distributed these for comment to a wide range of groups and individuals with knowledge of home-based health care issues.

This document incorporates earlier drafts and any comments made. The contributions of members of the working party and all those who commented are gratefully acknowledged.

Introduction

Purpose

These guidelines provide information on managing hazards in home-based health care settings. Employers in the home care industry should use the guidelines as a resource to assist in the development of policies and procedures in order to protect staff and to meet their responsibilities under the Health and Safety in Employment Act 1992 (HSE Act).

Effective communication of information about the client, the care to be provided and the potential risks faced by home health care providers is an essential part of hazard management. Of most concern for health providers, and a catalyst for this document, has been an historical lack of disclosure of client information to home health care providers, resulting in risk to the safety of staff, clients and others. One factor contributing to a lack of disclosure has been a concern to protect the privacy of personal health information. For this reason, the requirements of the Privacy Act and the Health Information Privacy Code are included in these guidelines.

These guidelines are primarily aimed at employers, but information has also been included that will be of value to employees, principals, contractors and others in home-based health care settings.

The guidelines do not provide specific solutions to specific issues. It is intended that employers use these guidelines as a resource to assist in the development of policies and programmes most appropriate to their particular organisational, staff and client characteristics.

The objective of these guidelines is to assist employers with the management of hazards encountered in the home health care industry, enabling them, their principals and their employees to meet their duties and responsibilities under the Health and Safety in Employment Act.

Scope

What is Meant by Home-Based Health Care?

Home-based health care is care or support provided in a person's home to improve or maintain the person's health status and wellbeing. It includes the provision of equipment or services.

For the purpose of this document, home-based health care *does not* include non-healthcare-related services provided in the home, such as domestic work, child care. The exception, however, is where that care is provided as part of a health and disability service provider's contract of care for a client.

Home-based health care may be provided by (but is not limited to) the following:

- doctors, nurses, midwives, medical social workers, psychologists;
- home health aides, personal care assistants;

- physical, occupational and speech therapists, audiologists, optometrists;
- pharmacists, dentists, podiatrists, nutritionists, dieticians;
- phlebotomists, laboratory technicians, respiratory therapists;
- vocational and educational rehabilitation personnel;
- meals on wheels deliverers, drivers of home-based health care vehicles;
- befriending or companionship visitors, elder abuse service co-ordinators.

Home-based health care settings include care of a client in the client's home and also care of a client in the caregiver's home, e.g. respite care.

For the purposes of this document, home-based health care settings *do not* include care settings that are owned and managed by a care provider, such as:

- group homes or accommodation;
- residential care settings such as rest homes;
- children's homes.

Though they may share a number of common health and safety hazards with home-based health care settings, care settings that are owned and managed by the care provider have a range of management, legal and resource issues not considered in these guidelines.

Volunteer Care Giving in the Home

Persons other than employees who may provide health care at home include volunteers or family, whanau and friends. Volunteers and other caregivers who are not employees are excluded from liability and have only limited protection under the HSE Act, (see Section One, Requirements and Management of Health and Safety, Sections 15-19 of the HSE Act).

Despite this limited protection, it would be good practice for employers to take all practicable steps to ensure the health and safety of their voluntary workers.

In addition, in some situations persons are deemed to be employees for the purposes of the HSE Act — for example under the Modern Apprenticeship Training Act 2000.

Application of the HSE Act to Work Done in the Home

"Place of work" for the purposes of the HSE Act means a place where a person works, which includes the home-based health care setting where the caregiver is working.

Employers, employees, principals, contractors, contractor's employees, and the self-employed working in the home care industry each have duties under the HSE Act, and these guidelines outline those duties.

The duties of an employer under the HSE Act do *not* apply to occupiers of a home who engage or hire persons to perform residential work (as defined by the Act — see definition on p.11) in their own home. This means that homeowners and occupiers who contract, for example, a cleaner or builder to work in their home do not have the status of an employer and are not liable under the HSE Act.

A client who is able to arrange their own care may also be deemed an employer or principal (the latter should they work through an agency that provides health care services). The client

may be provided with funding by an agency. Through the client's actions of carrying out all the processes to maintain a person's service, they may be considered an employer or principal.

Overview

Similar Hazards to other Health Care Workers

Health care workers providing care in a client's home face hazards similar to those experienced in hospital and other institutional health care settings. However, the home-based work environment is likely to be less controllable, visible, standardised and predictable.

Special Features that may Increase the Risk

In addition, the home environment can be isolated, and care workers are frequently working alone and at any time of the day or night. Because they are often working on their own, caregivers may be more inclined to perform additional or hazardous activities when requested, such as lifting clients or other loads unaided, moving furniture, climbing ladders, or standing on unsafe stools.

"Difficult" Behaviours"

Similarly, home care workers often "make allowances" for their client's behaviour and can gradually come to accept increasingly dangerous behaviours as "normal" or "ones they can manage". Supervision of work may be from a distance, and there may be delays responding to calls for assistance due to distance or isolation. Each of these factors can create additional health and safety risks for workers.

Working in a Client's Home

The home-based working environment imposes limits on the employer's ability to control the place of work. The home in which the care is provided can be in a state of disrepair, conditions may be unhygienic, or lack of maintenance may create hazards — for example, faulty appliances or equipment, and surfaces or electrical wiring in poor condition.

In addition, the clients have a greater degree of autonomy in their own home which caregivers and employers must respect. When evaluating the practicable steps for the control of identified hazards, caregivers and their employers need to take into account the client's beliefs and right to make personal choices about how they manage their home setting. However, these beliefs and rights should not be considered to override the employee's right to a safe place of work.

Training or the Lack Thereof

A further influence on health and safety in home-based care is that a significant proportion of caregivers are aides or attendants without qualifications or with limited training, who are often employed for short periods only. This situation challenges the employer to ensure adequate orientation, on-the-job training and supervision so as to be able to deliver a quality service safely.

Hazard Identification

Categories of hazards associated with home health care include:

- **Biological hazards** such as exposure to blood-borne diseases including the hepatitis (Hepatitis A, Hepatitis B and Hepatitis C) and HIV/AIDS. Other infectious conditions may pose a risk to the health care worker. Exposure to biological hazards may occur through exposure to blood or body fluids, sharps (used needles), contaminated laundry or waste, specimens, used medical equipment, or poor home hygiene.
- **Behavioural (psychosocial) hazards** such as challenging or aggressive behaviour from the intellectually impaired or brain-damaged client. Client behaviour may be hazardous when they are stressed, angry, hostile, or under the influence of drugs or alcohol. Some have behaviour or mental health conditions that can contribute to threatening or violent behaviour. Workplace stressors from physical or emotional demands, including the effects of shift work, may play a part. Caregiver stress can also be a factor in incidents of client aggression, abuse or violence. Similarly, travel-related hazards such as a vehicle accident, breakdown or security issues when home care workers are nursing their clients alone at night can expose these people to risk.
- **Manual handling hazards** arising from physical labour in the home. Manual handling can place a caregiver at risk of sprain or strain injuries, including back injuries. Many such hazards are worsened by the non-purpose-designed environment that home care takes place in. This includes unsafe flooring, surfaces, spatial constraints, or other conditions, furniture or equipment in the home that might result in strains, falls, burns, cuts or other injuries. Electrical, gas or fire hazards resulting from conditions in the home, from biomedical equipment or oxygen use may also be considered as environmental hazards.
- **Chemical hazards** through leakage, unsafe handling, storage, labelling or mixing of chemicals including domestic cleaners, drugs, or medications. Fumes may also result from chemicals such as solvents or disinfectants.

What Sort of Accidents/Incidents are Reported?

Evidence suggests under-reporting of critical incidents, accidents and injuries. Of those injuries that are reported, musculoskeletal disorders and, in particular, back injuries are the most common.

Violence to home-based caregivers is one of the major occupational health and safety issues facing the home-based health care industry. Exposure to actual or threatened physical harm may arise from interactions with the client, their family or whanau, visitors, or unrelated members of the public who are encountered while the caregiver is performing work, or while travelling to work. Threatening or aggressive behaviour may expose the worker and/or their client to significant risk due to the isolated settings in which home-based health care may be provided. Information on the prevention and management of violence is included in these guidelines.

It is this situation that has caused OSH most concern and, in its view, is the most likely to give rise to further fatalities or “serious harm” to employees. Employers must take “all practicable steps” to ensure that this type of risk to their employees is adequately minimised.

About these Guidelines

These guidelines outline the duties imposed by the HSE Act and provide information on a number of specific hazards in the home-based care industry.

Section One provides information on legal responsibilities under the Health and Safety in Employment Act 1992 and other relevant Acts. It also provides guidance for managers on the essential components of workplace health and safety and outlines the process of hazard management.

Section Two provides guidance on the management of health information, including the requirements of the Privacy Act and the Health Information Privacy Code.

Section Three contains guidelines on the prevention and management of workplace violence in home-based health care settings.

Section Four contains guidelines on the prevention of infection and the management of blood-borne biological hazards in home-based health care settings.

Section Five contains guidance on the prevention of sprain and strain injuries and the management of manual handling hazards in home-based health care settings.

The appendices include sample checklists to assist the employer, manager, supervisor and/or employee to assess hazards and evaluate workplace health and safety management.

Definitions

Blood refers to human blood, human blood components, and products made from human blood.

Body fluids refer to human body fluids apart from blood that are considered potentially infectious from blood-borne diseases. These are urine; faecal discharges; semen; cerebrospinal fluid; amniotic fluid; menstrual discharge; pleural, peritoneal, or pericardial fluid; inflammatory exudates; any other body fluid or tissue.

Caregiver refers to individuals who provide home health care.

Challenging behaviours are those that put caregivers, clients or others at risk due to the inability of a client to protect themselves from harm, or to control behaviours that are likely to cause serious offence or injury or damage.

Client is used in this document to refer generically to anyone who is the focus of care or the user of the home-based health care service. Where appropriate, this may include the family or group/whanau or significant others who are deemed to be the guardian or nominated representatives of the client.

Contractor means a person engaged by any person (other than an employee) to do any work for gain or reward.

Current accepted good practice is the provision of services to achieve quality outcomes for the client, in line with the normally accepted range of practice within the relevant service group, and reflective of current guidelines for that service provision where these exist. This may include codes of practice, research/evidence/experience-based practice, professional standards, guidelines, benchmarking.

De-escalation is a complex interactive process in which the highly aroused client is redirected from an unsafe course of action towards a supported and calmer emotional state through timely, appropriate and effective communication.

Disability services means goods, services or facilities which are provided by those holding themselves out to be providing a service whether or not a charge for service is made and which are: (a) provided to people with disabilities for their care or support or to promote their independence; or (b) provided for the purposes related or incidental to the care or support of people with disabilities, or to the promotion of the independence of such people

Domestic assistance means help with housework, domestic duties, e.g. vacuuming, cleaning, cooking.

Employee means a person employed by any other person to do any work (other than residential work) for hire or reward; and in relation to any employer, means an employee of the employer.

Employer means a person who or that employs any other person to do any work for hire or reward; and, in relation to any employee, means an employer or the employee.

Hazard means an activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm; and **hazardous** has a corresponding meaning.

Health agencies those organisations who provide a health service, whether or not a charge for service is made.

Health professional means any registered medical practitioner, nurse, psychologist, pharmacist, dietician, physiotherapist, or other registered qualified health practitioner recognised by the Health and Disability Commissioner Act 1994.

Health services means goods, services or facilities which are provided by health agencies and which are (a) provided to individuals for the purpose of improving or maintaining a person's health status; or (b) provided for the purposes of related or incidental to improving or maintaining a person's health status.

Home-based health care refers to home-based services provided from a variety of sources, required to realise the aims of supporting a person to remain living at home, and traditionally associated with home help, attendant care, district nursing and respite care. It includes services for people with disabilities and people with personal health needs. An indicative list of health and disability services includes categories of personal care/ assistance with activities of daily living, health care services, domestic help with household tasks, social support and respite care.

Personal care means help with personal care, e.g. bathing, showering, dressing (also known as attendant care).

Preventable harm means harm caused by action or inaction rather than by an underlying disease or disability, which could have been reasonably foreseeable and prevented given the state of technology and knowledge at the time the harm occurred.

Principal means a person who engages any person (other than an employee) to do any work for gain or reward.

Provider refers to any public, private or voluntary sector group, agency or organisation that provides home-based health care. Service provider refers to the person who performs for, or on behalf of the organisation, group or agency. This includes the provision of direct and indirect care or support service to the client. It includes employed, self-employed, visiting,

session, contracted, and volunteer service providers, or anyone who has a formal relationship with the organisation, group or agency to provide a service to the client. It excludes the informal/unpaid carer/family/whanau network.

Purchasers are those agencies who buy health and disability services on behalf of consumers. They include hospitals, ACC and health insurance companies.

Residential work, in relation to the occupier of a home, means domestic work done or to be done in the home; or work done or to be done in respect of the home; by a person employed or engaged by the occupier solely to do work of one or both of those kinds in relation to the home.

Safe, in relation to a person, means not exposed to any hazards; in every other case, means free from hazards; “unsafe” and “safety” have corresponding meanings.

Serious harm is defined under the Health and Safety in Employment Act 1992, (HSE Act). It includes death and permanent or temporary severe loss of bodily function. See the First Schedule to the Act for a full definition.

Significant hazard — as set out in the HSE Act, a significant hazard can be an actual or potential cause or source of:

(a) **serious harm**; this includes death, serious injury or disease (see above for definition of serious harm);

(b) **harm** the severity of which depends on how often or how long a person is exposed to the hazard (for example, exposure to noise over a long period causes gradual and permanent deafness; the risk of occupational overuse syndrome will increase where an employee is exposed to repetitive movements more often and for long periods of time);

(c) **harm** that can't be detected until a significant time after exposure has occurred (for example, exposure to certain chemicals may cause health problems years later).

Standard precautions refer to infection control procedures designed to reduce the risk of spreading organisms from both recognised and unrecognised sources of infection. Standard precautions: apply to all clients; are designed to protect employees; ensure protective attire and equipment is provided and used when in contact with potentially infectious body fluids; are used in conjunction with transmission-based precautions for specific pathogens.

Transmission-based precautions refer to infection control isolation precautions required to manage clients with infectious, communicable diseases and the management of those pathogens of clinical significance, e.g. multi-resistant organisms. Transmission-based precautions should consider: admission; placement; transfer; discharge; notification requirements, e.g. diseases that are required to be notified under Section 74 of the Health Act 1956.

Language and Terminology

These guidelines, which are aimed at home-based health care workers, (a group that is extremely diverse within itself), also have applicability to a wide range of sectors where similar hazards exist, e.g. hospitals, rest homes, etc. The language and terminology of these guidelines are designed to meet the needs of this wide range of sectors.

Section One: Legal Requirements and Management of Health and Safety

Legal Requirements for Health and Safety

Legal Framework

The principal objectives of the Health and Safety in Employment Act 1992 (HSE Act) are to encourage excellence in health and safety management and to prevent harm to employees at work.

To do this, the HSE Act imposes duties on employers as well as employees and others in the workplace. The Act also provides for regulations and codes of practice that set more detailed minimum standards.

This following information provides a brief overview of the HSE Act 1992 as it specifically applies to home-based caregivers. For further advice, it is recommended that the reader contact their nearest OSH office or visit the OSH web site www.osh.dol.govt.nz.

If you engage the services of a caregiver who is working for hire or reward then you will have duties under the HSE Act as an employer or a principal, even if the caregiver is family, whanau or friend.

If you are a client at home receiving care from a caregiver who is contracted to provide that care by a provider, then it is the provider who has duties under the HSE Act.

General Duties of Employers (Section 6 of the Act)

You may be an employer for the purposes of the HSE Act. If you engage the services of a caregiver to provide home-based health care (even if they are family, whanau or a friend) and you pay them, or if an agency pays them on your behalf, then you may have duties under the HSE Act as an employer.

The Act requires that you must take all practicable steps to ensure the safety of employees at work including:

- providing and maintaining a safe working environment for employees;
- providing and maintaining facilities for the safety and health of employees while at work;
- ensuring that machinery and equipment is safe for employees to use;
- ensuring that working arrangements are not hazardous to employees;
- providing procedures to deal with emergencies that may arise while employees are at work.

Hazard Management (Section 7-10 of the Act)

A hazard management programme must consider safety of employees, clients, their family and the people who may be on the premises whilst it is considered a workplace.

There are three steps to follow to manage hazards in the workplace, which should be completed before work commences:

- identify situations where employees and visitors may be at risk from hazards;
- assess and prioritise the hazards;
- take action to prevent harm.

Step One: Identify Hazards (Section 7 of the Act)

A system needs to be in place to ensure that all existing hazards and any new hazards to employees at work can be identified.

Systems of Hazard Identification

There are a variety of methods that employers can use to identify actual or potential hazards. These include:

- **Information Gathering and Analysis:** Through analysis of incidents, surveys of employees, and research of information in similar settings. Analysis of information may be assisted by a health and safety advisor, project team, or health and safety committee.
- **Physical Inspections:** This is the common method of identifying environmental hazards. It is usual for an employer to develop a checklist, which is used during an assessment of the working environment. Checklists need to be reviewed regularly and amended to ensure that they reflect the findings of the review of the hazard management plan which may occur as a consequence of new hazards arising.
- **Task Analysis:** In some instances it is appropriate for tasks employees have to carry out to be viewed and analysed to identify associated hazards. This approach is particularly useful in identifying hazards associated with manual handling, which is a major part of client care.
- **Process Analysis:** An approach similar to task analysis, where a process is observed from start to finish to identify the hazards. This method is of value for examining a process such as assisting with a shower or bath. When an activity such as this takes place in the client's own home, the hazards are generally greater, as private homes may not be designed appropriately for assisted hygiene care.

Collecting Information about Hazards Pertaining to the Care of the Client

In the home-based care setting, and particularly where employees carry out their work alone or in isolated environments, it is advisable that as much information about the client and the home setting is collected *prior to the first visit*. A checklist of questions to be asked prior to the first visit or when accepting referrals is a useful tool.

Hazards relating to client care may be identified:

- by inquiry on the telephone;
- from case notes;

- from the client, their family/whanau;
- by request from the referral agency;
- from the GP;
- from other relevant community agencies including, where appropriate, the community police;
- at the first visit.

An effective means of obtaining all relevant information on the client is required. The intended use of that information must be given.

Further information may need to be collected when gaps are identified and information should be sought from more than one source. Information may be gathered from the client, their family or whanau, the client's previous caregivers, and other relevant agencies such as ACC.

See Section Two for guidelines on the collection and use of information and requirements for protection of the privacy of information.

Responsibilities for Collection and Dissemination of Information

- Principals, purchasers (such as ACC) and providers have a responsibility to access and provide all relevant information to the agency being contracted, to ensure information on hazards is communicated.
- Contractors (such as the health care agency) accepting clients have a responsibility to identify any gaps in information received, and to request and seek additional information.
- Employers must ensure all relevant information is available, is in a form and manner that can be understood by the employee, and has been provided to those caregivers who need to know in order to protect the safety of themselves and their client.
- Employees (such as the supervisor and the caregiver) must ensure they have read and understood all relevant information, identified any gaps and requested additional information needed to provide safe care.

Employee Information

Hazards may also be related to the status or condition of an employee. Pre-employment screening questionnaires should be designed to encourage disclosure of situations whereby employment of the individual in the home care setting will pose a further risk to their personal safety or the safety of others.

For example, home care workers with pre-existing health conditions may be placed in an "unsafe" environment by their employment within specific domestic or personal care roles. An example would be a home care worker with a history of recurrent back injuries being placed in a cramped work environment, which may result in the potential for a manual handling injury.

In situations where applicants disclose a current or intermittent injury of this nature, methods of managing the hazard would need to be considered in conjunction with the provisions of the Human Rights Act 1993. (See the reference to other Acts at the end of this section.)

Additional Sources of Information on Hazards

- manufacturer's information with equipment;
- chemical Material Safety Data Sheets (MSDS);
- surveys, complaints, reports;

- case notes, referral information, client needs assessment;
- other agencies including OSH and ACC, health and safety consultants.

Keeping a Hazard Register

Recording identified hazards and the progress made to managing those hazards in a hazard register is a useful means of demonstrating that the employer meets the requirements of the HSE Act.

Note that hazards that relate to health information of an identifiable individual will need to be recorded and communicated in a manner which takes into account the Health Information Privacy Code.

Step Two: Assess Hazards

You need to assess which hazards are likely to cause the most harm to people.

If the hazard is significant, the Act sets out the process you must go through to control the hazard.

How to Assess Hazards

Identified hazards must be assessed with the aim of identifying significant hazards, that is those that may result in serious harm. The assessment needs to consider what risk is posed by the hazard, to whom and in what circumstances.

The HSE Act requires all significant hazards to be eliminated or controlled. However, during hazard identification there are likely to be additional hazards identified that, while not “significant”, will still need to be managed.

Significant hazards that may cause serious harm will have highest priority. If there is high risk, do something about it immediately. If there is a low probability of risk occurring (frequency) *and* a low risk of severe injury (severity), it will have lesser priority. However, where it is possible to easily adopt immediate measures to eliminate or control a nonsignificant hazard, then it would be prudent to do so.

Consider:

- Who is most at risk, when and where, and from whom/what?
- What are the actual and potential contributing factors?
- What are the actual and potential consequences?
- Could serious harm result from the hazard?

Step Three: Control Hazards (Sections 8, 9, 10)

Following identification of significant hazards, a range of possible control measures must be identified. This step of hazard management also requires identification of effectiveness of controls and the resources required in determining whether controls are practicable. The setting of time frames is also necessary.

A hierarchy of hazard control must be followed (see the flow chart on p. 21). Eliminate the hazard where practicable. If elimination is not practicable, isolate the hazard. If isolation is not practicable, minimise the hazard and protect employees with clothing and equipment, monitor

their exposure to the hazard, and with their consent, monitor their health in relation to the hazard.

1. If practicable, you must eliminate the hazard so that people can't be harmed. (Section 8)

The key word is *practicable*. It's not practicable to eliminate many hazards outright – obviously you can't eliminate all chemicals, medical equipment, or blood and body fluids from every home care setting.

But you may be able to use a less harmful chemical in place of a highly toxic one, replace old equipment, and use safer alternatives where they are available and practicable, for example needleless systems for injections.

2. If it's not practicable to eliminate the hazard, you must isolate it. (Section 9)

This means putting a barrier between, or separating the hazards and the person. For example, access to drugs or medications can be limited through the implementation of various security measures.

3. If it's not practicable to eliminate or isolate the hazard, then you must minimise the chance it will cause harm. (Section 10 (1)(2))

Minimising hazards includes following safe and accepted work practices, maintaining equipment properly, training employees in safe work methods, and supervising employees.

So if you use medical equipment such as needles, you must provide training, ensure safe work practice is followed, provide equipment for safe disposal of needles and inform employees of safe work practice.

In addition to minimising the hazards, you *must ensure that the appropriate protective clothing and equipment is provided and used*. For example, gloves can be used to protect an employee from harsh chemical products and from blood and body fluids.

When a minimisation strategy is used you are required to:

- monitor your employees' exposure to the hazard;
- with your employees' consent, monitor their health.

Section 11 of the HSE Act requires that employees be given the results of any monitoring that is performed.

Examples of this could be where employees are exposed to infection, or to excessive noise, repetitive movements or heavy lifting, or to chemicals such as glutaraldehyde (CAidal Plus).

Further Information on Hazard Control

Minimisation strategies are generally considered less effective as they require people to remember to work in a certain way or use certain equipment, etc. It is fundamentally the reliance on the "human factor" that reduces the effectiveness of controls, hence the hierarchy of elimination, isolation and minimisation. However, minimisation strategies are commonly used to prevent illness and injury. A combination of these controls may be used to create a robust hazard control system.

Engineering Controls

Eliminate or reduce an employee's exposure through the design, purchase and use of equipment, machinery, or forms of protection or guarding to change the duration, frequency, and/or severity of exposure. Examples of engineering controls include the use of a hoist to lift a

person in and out of a bath, or the use of a needleless system for intravenous drug administration.

Modifying the Environment

This may include removal of hazards, modifying the workspace, installing barriers, controlling for physical conditions such as temperature and air quality, layout. The type of modification will depend on the nature of the hazard.

Modifying the Task

This may include making changes to the way the task is performed, or the timing or frequency of a task.

Administrative Controls

Eliminate or reduce an employee's exposure to a hazard by changing the duration, frequency, and/or severity of exposure. Examples of administrative controls include client/carer matching, rotating of employees to jobs free of a specific hazard, adjusting work schedules, and providing adequate staffing when the work output is increased.

Signage, Labelling and Safe Storage and Transport of Hazardous Materials

Procedures for the control of hazards include ensuring that hazards are identifiable through labelling and/or signage, and that safe handling of hazardous substances occurs to prevent exposure to the hazard. Signage can be used to indicate the presence of hazards and the need for any restrictions to avoid exposure. Storage considerations may include, for example, the height items are stored at, the temperature, or the security of storage. Transport issues include ensuring drivers are aware of the hazards they are carrying and what to do in the event of an accident or spillage.

The order of this list itself provides some useful insight into the control of hazards. For example, engineering controls such as lifting devices are generally more effective than administrative controls such as applying correct lifting technique, with the proviso that the employee is trained in how to use the lifting device safely.

Use of Personal Protective Clothing and Equipment (Section 10(2)(b))

Where no other methods are available to eliminate a hazard, protective clothing and equipment can provide personal protection. This may include gloves, masks, gowns, aprons, goggles, and boots. Containers for the safe disposal of hazardous substances and sharps may also be considered protective equipment.

It may also include personal security devices such as alarms and means of communicating from a distance such as cell phones.

Equipment must be suitable for the hazard concerned. There needs to be a system in place to ensure that personal protective equipment is worn, maintained and replaced if damaged.

Monitoring Employee Exposure to Hazards (Section 10 (2)(c)(d)(e))

You may also, if necessary, need to monitor your employee's exposure to the hazard and, with your employees' consent, monitor their health.

Examples of this could be where employees are exposed to infection, such as following a blood/body fluid exposure, when blood tests may be required to establish immunity or whether infection has occurred.

Monitoring employees' health may also be required where there is exposure to certain chemicals such as glutaraldehyde (CAidal Plus) or to excessive noise.

Developing Emergency Procedures (Section 6(e) and 12(a))

Fire safety and civil defence preparedness are common emergency items. However, through development of the hazard management procedures, you will find that emergencies specific to the type of work will be identified. Having customised emergency procedures in place will assist in the control of hazards and prevention of harm in that workplace; in the case of this document, those that may arise as a consequence of working in the home care environment. The policy on management of actual or potential violence may also include an emergency procedure, such as emergency numbers to call, how to obtain urgent assistance, crisis team intervention, and involvement of police. Procedures to be followed in the event of a motor vehicle accident may also fall into this category.

Controlling Hazards in the Home Care Setting

It may not be practicable to eliminate or isolate certain hazards in the home care setting, which may be beyond the control of the caregiver and their employer. For example, caregivers may encounter conditions in the home such as poor condition of flooring, presence of rubbish or rodents, broken materials or faulty appliances.

However, you can request that clients repair or remove unsafe equipment or conditions. For example, you may require as a condition of care that clients:

- replace old or faulty equipment (e.g. broken vacuum cleaner attachments);
- repair electrical equipment (e.g. frayed cords);
- repair physical hazards (e.g. rotten floorboards);
- tie up or shut away animals with potential to be aggressive, e.g. dogs.

Interim measures for client care may be able to be put in place so that the client's care is not compromised whilst health and safety matters are addressed. For example, a client agrees to having care administered at an alternative venue whilst health and safety matters at the client's home are addressed to the satisfaction of both parties.

Withdrawal of Service as a Means of Hazard Control

If hazards cannot be eliminated, isolated or minimised and the risk posed is significant, home care providers should consider withdrawal of service. Withdrawal of service may mean care is limited, provided in certain settings or under certain conditions, or withdrawn entirely.

The risk to the employee or to others as a result of service being provided may need to be balanced against the risk resulting from the service being withdrawn. Withdrawal of service would normally be considered where significant harm might result if service is provided and only after all other methods of eliminating or controlling the risk have been considered and assessed to be ineffective. The employer should ensure there are procedures outlining the conditions under which withdrawal of service is to be considered, and detailing the responsibilities of employees, supervisors, and management if withdrawal of service occurs.

Communication with the principal of the contract under which the care was being provided should aim to ensure that clients are not abandoned, and that alternative care and protection of the client (and others directly affected by the client's condition) commences.

Service providers who take over responsibility for care should have the required higher level of skills, knowledge and/or resources to enable the hazard to be eliminated or controlled.

Summary of Hazard Management

Step One: Identify Potential and Actual Hazards

- Analyse incidents;
- Survey employees;
- Research information in similar settings;
- Form a project team or health and safety committee to analyse issues;
- Involve employees in analysis;
- Gather information on client;
- Gather information on employees.

Consider:

- In what settings may hazards exist?
- In what circumstances may a hazard develop?
- Who may be exposed to a hazard?
- When are incidents occurring?
- Are there actual or potential hazards related to tasks?
- Are there hazards related to client or employee condition?

Step Two: Assess the Hazard

- Who is most at risk, when and where and from whom/what?
- What are the actual and potential contributing factors?
- What are the actual and potential consequences?
- Could serious harm result from the hazard?

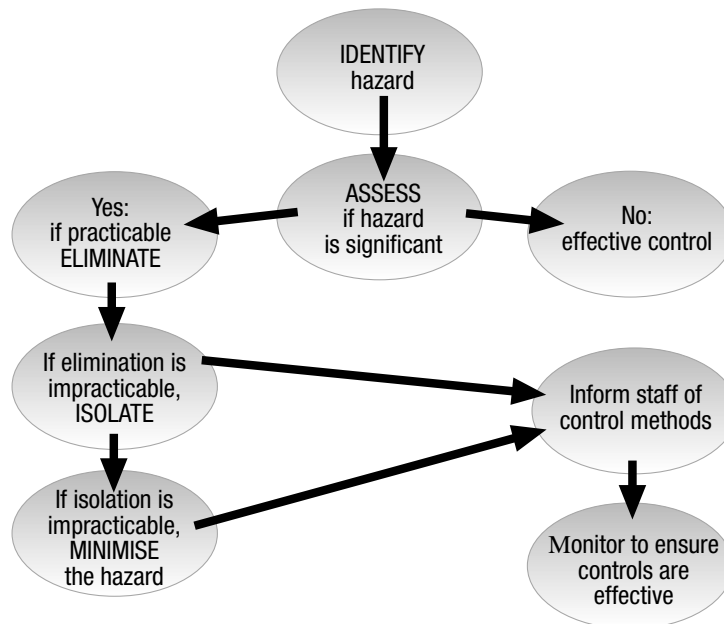
Step Three: Control the Hazard

- What controls are currently in place?
- How effective are existing control methods?
- What might be done to reduce the risk of harm?
- Can the hazard be eliminated?
- Can contributing factors be eliminated or isolated?
- Can the risk be reduced by changing work process?
- Can rules and procedures be developed to reduce risk?
- Can the number of workers exposed to the hazard be reduced?
- Can protective clothing or equipment reduce exposure?
- Are procedures in place for monitoring exposure?

- Are hazards identifiable and is there sufficient information for workers?
- Are procedures in place to limit consequences of emergencies?
- Are procedures in place for adequate training and supervision?
- Are procedures in place for review of the effectiveness of controls?

Hazard Management Flowchart

The following flowchart provides an outline for the hazard management process:



Regularly assess and review the hazard management plan. The frequency of such a review will depend on the nature of the environment and the regularity with which it changes. It could be audited annually. Hazard management programmes should also be reviewed when there is a change in activity, a new piece of equipment, or an accident. Accidents often occur when a hazard is not being properly managed or not identified initially.

Duty to Inform Employees (Section 12)

You must inform your employees about:

- what to do if an emergency arises while they are working;
- the hazards they may be exposed to or create while at work;
- where the necessary safety equipment and protective clothing is kept.

You must also give your employees the results of any monitoring of their health, or of the workplace, as described above.

Duties to Train and Supervise Employees (Section 13)

You have specific responsibilities for training and supervising anyone you employ:

- you must ensure the employee has, or is supervised by a person with the knowledge and experience to ensure that they and others are not harmed;
- you must ensure that employees are adequately trained in the safe use of all equipment, machinery, substances and protective clothing provided.

Employers must ensure employees are adequately trained and/or have knowledge and experience before undertaking work.

Health and safety training needs can be identified from:

- employee training needs analysis;
- performance appraisals;
- identified hazards and methods of control;
- analysis of incidents and accident reports;
- client needs assessments.

The training programmes and methods will be appropriate to the employees' role and level of knowledge. Training should be documented and evaluated to ensure employees have received the information and understood the issues.

When identifying training needs, cultural factors also need to be considered. Caregivers need to be able to appropriately assess and have an understanding of the cultural needs of the client (and their family or whanau) in order to provide safe care. For example, for Maori clients, value systems, belief systems, practices, protocols and expectations need to be communicated during orientation of caregivers. Cultural factors can also be relevant to health and safety matters as part of training supervisors in the management of incidents and accidents. For example, a tohunga can perform a "lifting of the tapu" ceremony at an accident scene.

A health and safety induction checklist incorporating training procedures specific to each position and/or work setting is an effective way to ensure orientation is comprehensive.

Ongoing education needs should also be identified. Retraining or refresher courses will assist in ensuring work practices do not deteriorate and become unsafe.

Training will also be required when change is introduced, including new systems of work and new equipment.

Evaluation of the training will need to ensure training objectives have been met, including cultural training objectives.

NOTE: any reference in Section 15, 16, 17 and 19 of the HSE Act to "others", or "any other person" may include volunteers, members of the public, students.

Responsibilities to the Public (Section 15, 16, 17 & 19)

The Act places duties on employers, principals, self-employed and employees to ensure that their work activities do not harm other people.

For home-based workers, this would include clients receiving care and any others in the home who could be exposed to a hazard as a result of work being done. For example, a wet floor

caused by an activity of your care, such as assisting a client with showering, is a hazard that needs to be identified to others. Similarly, a change in treatment or medication that could be predicted to result in behavioural changes in a client would require evaluation and management of potential risk to others.

Duties of Persons with Control over a Place of Work (Section 16)

Any person who is in control of a place of work must take all practicable steps to ensure that no hazard harms:

- people in the vicinity of the place;
- people at work there (as employees, contractors, subcontractors or employees of contractors/subcontractors);
- people who pay to be at the place of work;
- people who come onto the place of work to buy or inspect goods offered for sale and have consent to be there.

If you engage a caregiver to provide home-based health care in your home, you will not have duties as a “controller of a place of work” under the HSE Act, but you will have duties as an employer or principal.

A place of work would include a car provided to a caregiver to use when travelling to or between homes where care is provided, and an office from which the caregiver works. It would also include the part of a home where a person is performing work or through which the person must pass to do their work.

When considering all practicable steps that must be taken to prevent harm from hazards, an employer may face some restrictions on options when that place of work is within a client’s home. For example, it may not be practicable or appropriate to do repairs or maintenance in the home, such as fixing broken floorboards or repairing electrical wiring. However, an employer may request that hazardous wiring or other significant hazards be fixed as a condition of care. They might also restrict the use of certain equipment, or specify certain areas of the home where care may or may not be provided. A further example would be requiring the client to restrain dogs as a condition of care.

If you are Self-Employed (Section 17)

The previous sections cover the responsibilities of employers and employees. If you are a self-employed care worker, you must take all practicable steps to ensure that no action you take while at work (or inaction) harms either yourself or another person.

Duties of Principals (Section 18)

A principal is defined in section 2 of the HSE Act 1992 as “a person who or that engages any person (otherwise than as an employee) to do any work for gain or reward”.

Under the HSE Act, you may have duties as a principal. You may be a principal for the purposes of the HSE Act if you engage the services of a caregiver to provide home-based health care (that may include family, whanau or a friend) and you pay the caregiver, or an agency pays them on your behalf.

If you engage a service provider, or hire a contractor or subcontractor, you must take all practicable steps to ensure that they, and their employees, are not harmed while carrying out the work they are engaged to do.

Note that a person can be one or more entities under the Act – for example they may be both a principal and an employer.

For their part, the service provider/contractor must carry out all the requirements under the Act including identifying and managing hazards. For example, where they are employers of employees, they will be responsible for ensuring their employees know how to do their work safely. A principal must take steps to ensure that a job is done safely. The principal's duties may vary in any given situation. In some cases, the only duty on a principal may be to engage a competent contractor such as those who are specialised in caring for people with hearing impairment. In other cases, the principal may have to stipulate in advance the safety requirements to do the work safely, such as using specialised mobility aids for personal care such as showering.

Duties of Employees (Section 19)

While at work, all employees also have duties under the Act. They must take all practicable steps to ensure their own safety and that no action or inaction causes harm to others.

Codes of Practice and Regulations (Sections 20 and 21)

The Act refers to Codes of Practice, which may be either approved or voluntary. Codes of practice are statements of preferred work practices or arrangements, which provide guidance on managing health and safety. Employers and others may use other arrangements to achieve the desired outcome relating to safety and health. Approved codes of practice are those given government approval, and voluntary codes relate to those developed by industry groups which may have that group's endorsement but have not been processed through official government channels.

The Health and Safety in Employment Regulations (1995) impose mandatory requirements. Employers must take all practicable steps to ensure that suitable and sufficient facilities are provided at every place of work under the control of the employer. They must be suitable to be used for their purpose, be maintained in good order and condition, and employees must have access to them.

Such facilities are:

- toilets, hand washing facilities;
- means of leaving the place in an emergency;
- first aid facilities;
- safe levels of lighting and ventilation providing fresh or purified air;
- means for controlling humidity arising from work process or activity;
- means for controlling atmospheric conditions including air velocity, radiant heat and temperature, and the control, treating or carrying off any harmful atmospheric contaminants;
- a separate place to have meals protected from atmospheric contaminants, dirt, noise or other work hazard;

- facilities and procedures for indisposed employees;
- drinking water.

Where the work is of such a nature where the following is required, employees must also be provided with facilities for:

- washing, changing, and a place to store clothing;
- seating where work may be performed sitting, or rest opportunities where sitting while working is not reasonable;
- drainage or other measures to ensure dry floors.

Recording, Investigating and Notifying Accidents (Sections 7(2), 25,26)

The Act requires you to keep a register of work-related accidents and serious harm. You must record every accident that harmed or might have harmed (near-miss accident):

- any employee at work;
- any person in a place of work under your control.

Employers will need to ensure that systems are in place that will encourage prompt reporting and documentation of accidents and near-misses, and need to allocate responsibilities for accident notification and investigation.

The purpose of recording near-misses is to prevent serious harm or death occurring in the future. When considering what a near-miss accident is, employers should consider the actual event that occurred, the potential for serious harm or death that was only just avoided, and the ability to prevent it from happening again.

A near-miss might include a carer who was threatened with violence, or a person nearly tripping over due to a faulty surface that could have resulted in a dangerous fall, or a blown tyre that didn't result in an vehicle accident but had the potential to. Investigation of near-miss incidents will allow the identification of hazards and subsequent preventative measures.

A Workplace Accident Register is available from OSH (and selected bookstores) for recording and reporting accidents. Details relating to accidents that cause serious harm must be gathered in the format prescribed by the HSE Act. Information in the accident register will assist with analysis of accident types/causes and review of health and safety management systems.

In addition, you must report *serious harm* to employees while at work to the Occupational Safety and Health Service as soon as possible and give written notice, in the prescribed format, within 7 days.

In the event of a "serious harm" accident, the accident site must not be altered unless authorised by an OSH inspector, except to the extent necessary:

- to save the life, prevent further harm or relieve suffering of a person; or
- to maintain the access of the general public to an essential service or utility; or
- to prevent serious damage to or serious loss of property.

Penalties for Offences (Sections 49-56)

There are penalties for certain offences which apply to breaches of the HSE Act committed by employers, principals, self-employed, employees and controllers of places of work.

If you knowingly:

- take an action which is contrary to the Act, knowing it is reasonably likely to cause serious harm to a person; or
- fail to take an action you are required to take under the Act, and you know that failing to act is reasonably likely to cause serious harm;

you could be liable for a fine of up to \$100,000 and/or one year in prison.

If your breach of the Act or regulations results in serious harm to someone, you could be fined up to \$50,000. For any other failure, you could be fined up to \$25,000.

Role of OSH Field Staff

OSH health and safety inspectors help employers to realise a safe and healthy work environment by providing information, advice and education. They work with employers to find safety and health solutions and will respond promptly to investigate situations where people's health and safety is at risk.

Health and safety inspectors are responsible for checking that people are complying with the law. They have the legal power to enter any place of work at a reasonable time. They may also remove samples.

If a health and safety inspector believes you are not complying with the law, he or she can issue an improvement notice. It will tell you how you are not complying and may specify what you must do to comply and when.

Where the failure to comply with the law may cause serious harm to someone, the inspector can issue a prohibition notice. These notices suspend the particular work activity until the legal requirements are met.

Management of Health and Safety

Principles of Effective Health and Safety Management

Management commitment and employee involvement is essential in the development of an effective health and safety plan. Section 14 of the HSE Act requires that employers involve employees in the development of health and safety procedures.

Organisational features need to be taken into account when developing measures to promote a safe working environment. Salient points to note are:

- (a) organisational culture is an essential characteristic in the achievement of a safe and healthy workplace;
- (b) the style of leadership will influence the organisation and its effectiveness;
- (c) open communication is a vital factor in an effective organisational culture;

- (d) encouragement of initiative, innovation and involvement of employees should occur;
- (e) education is of paramount importance in creating a safe working environment;
- (f) legislative requirements must be complied with;
- (g) appropriate equipment and other resources must be provided;
- (h) safety refers to all other people in the workplace, which includes the client/family/visitors and others in the place of work.

Management Commitment

In order for health and safety to be effectively managed, it is imperative that managers support the process.

Excellence in management commitment can be achieved through the following:

- an organisational climate which recognises employees as its most valuable resource;
- management is seen to drive new projects and initiatives;
- management recognises and rewards good safety records;
- management provides assistance and resources to staff at all levels;
- organisational structure is planned and communicated to ensure health and safety accountabilities and responsibilities are clear and achievable.

Employee Involvement

Management of health and safety will be enhanced where employees have demonstrated means to bring about any safety concerns, and where they are involved in hazard management and in the development of health and safety policies.

Employee representation on a health and safety committee is also an effective method of employee involvement.

Health and Safety Policy

An organisation-wide health and safety policy should be developed following communication with employees at all levels of the organisation. By involving employees in this process, greater ownership of this policy is likely to be achieved. Ongoing communication will also be required for effective implementation and evaluation of the policy.

An organisation-wide health and safety policy should indicate management and employee responsibilities and incorporate a philosophy or goal.

Some organisations choose to display their health and safety policy, signed by key management individuals, as a visual reminder of the importance and value placed on health and safety.

Health and Safety Procedures

Health and safety procedures should meet the objectives set out in the policy and will be relevant to specific work setting/s. Procedures may include (but are not limited to):

Hazard Management

- hazard identification, reporting and hazard inventory/register;
- hazard assessment and monitoring;
- control of (specific) hazards by elimination, isolation or minimising risk;
- provision and maintenance of protective clothing and equipment.

Emergency Preparedness

- disaster, civil defence and emergency preparedness;
- fire safety, drills and evacuation;
- emergencies arising from the nature of the work, e.g. a breach of personal security when working alone.

Health and Safety Training and Education

- first aid equipment and procedures;
- health and safety orientation, training and supervision.

Employee Health Management

- employee health monitoring;
- pre-employment screening;
- employee vaccination;
- management of blood/body fluid exposures and needle stick injuries;
- employee counselling and employee assistance programmes;
- critical incident debriefing;
- injury management, rehabilitation and return to work.

Accident Reporting and Investigation

- injury and/or near-miss reporting;
- notification of serious harm;
- accident investigation.

Contract Management

Employers may refer to best practice standards and to policies and procedures developed in similar workplaces for guidance.

Client Health and Safety and Standards of Client Care

Although the main focus of the Health and Safety in Employment Act is on employers and employees, the HSE Act also outlines duties to ensure that work activities do not harm other people. This would include ensuring no harm comes to clients. In this regard, there are overlaps between the HSE Act and other significant pieces of legislation. Employers will need to refer to all relevant legislation when developing, implementing and reviewing client health and safety.

Legal responsibility for the safety and quality of care provided to clients is governed by the Health and Disability Services Act 1993 (and the Health and Disability Services (Safety) Bill) and by Health and Disability Sector Standards.

Employers and service providers should refer to the Health and Disability Sector Standards (NZS 8134–8138) for further information on measures of quality and safety of client care. For example, the standards include criteria to ensure the quality of:

- procedures on access and entry to the service to ensure client risks are assessed;
- reassessment of risk when change in client need occurs;
- management of immediate client safety needs when access to the service is declined;
- prompt assessment where entry to the service is urgent/acute;
- planning for exit, discharge or transfer of care;
- documentation of all client care procedures and decision-making;
- management of suitably qualified service providers and caregivers;
- individualised, written and up-to-date service delivery/care plans;
- first aid and emergency equipment and procedures for client care;
- clinical and environmental infection control management;
- safe storage of harmful substances;
- management of hazardous substances including waste and biological substances;
- safe food management where providing meals for clients;
- documentation of adverse, unplanned or untoward events.

Each of these and other client-focused procedures (the above list is not exhaustive) will have an impact on health and safety and need to be taken into account when developing and reviewing health and safety management for home-based health care.

Other Relevant Legislation

Accident Rehabilitation and Compensation Insurance Act 1992

Continues the scheme to rehabilitate and compensate individuals who suffer personal injury. It assists individuals who have had an accident to rehabilitate themselves and maximise their independence. The scheme may include contracting for services to other agencies.

The Health Act 1956

Sets up the Ministry of Health and covers a whole range of health-related matters. It has a

number of provisions covering sharing of health information between health service providers, in particular Section 22.

Health and Disability Services (Safety) Bill

Currently a Bill, this Act will focus on systems for preventing harm caused by providers of health and disability services and licensing requirements of service providers. Home-based health care is currently not included in the Bill; however, indications are that future amendments may add home-based health care to the Act. The Bill provides for the Minister of Health to issue service standards which providers must comply with.

Health and Disability Sector Standards NZS 8134:2000

These draft standards contain generic provisions across the whole of the health and disability sector, including home-based health care service providers. The standards include issues of quality and safe practice.

A number of other standards contain information that is relevant to health and safety in home-based care. These include the *Infection Control Standard NZS 8142:2000*, the *National Mental Health Standard NZS 8143*, and the *Restraint Minimisation and Safe Practice Standard NZS 8141:2000*.

Health and Disability Commissioner Act 1994

The Health and Disability Commissioner Act 1994 sets out the rights of consumers and provides mechanisms for addressing complaints. The Code of Health and Disability Consumers' Rights includes a duty on health and disability service providers to provide services of an approved standard.

Human Rights Act 1993

Protects people with disabilities from discrimination. Disability is defined in the Act and includes physical impairment, physical or psychiatric illness, intellectual or psychological impairment, and other forms of disability or impairment.

Occupational Legislation

Occupational legislation such as the Nurses Act, the Physiotherapy Act and the Dental Act includes requirements for registering of practitioners, ongoing competency assessment and other measures to ensure safe practice.

Official Information Act 1982

Outlines the rights relating to and access to official information.

Privacy Act 1993

The Privacy Act 1993 is designed to promote and protect individual privacy and sets out rules for the manner, in which personal information may be collected, held and used. (See Section Two for further information.)

Section Two: Managing Information

Legal Framework

The Privacy Act 1993 and the Health Information Privacy Code 1994

Information on hazards relating to the care of clients needs to be effectively communicated. Personal information may need to be exchanged between referral agencies, care providers, managers/supervisors, employees, clients and their families or whanau or other persons. The privacy of an individual's personal information also needs to be protected.

The Privacy Act, the Health Information Privacy Code and the Health Act each contain provisions relevant to the manner in which personal information including health information may be communicated.

This section examines the requirements of the Privacy Act and the Health Information Privacy Code. This information is of a general nature only, and is intended as a guide to situations of relevance to health and safety concerns. Employers wanting to ensure they comply with all matters relating to privacy need to refer to the relevant Acts and other sources of information on those Acts.

The Privacy Act 1993 is designed to promote and protect individual privacy and sets out rules for the manner in which personal information may be collected, held and used. Your organisation may hold and collect personal information (that is information about an identifiable individual) about its members, employees, volunteers and the individuals to whom the organisation gives assistance.

The Health Information Privacy Code 1994, issued by the Privacy Commissioner under the Privacy Act, relates specifically to health information about identifiable individuals.

Health information is any one of the following types of information about an identifiable individual:

- information about health or medical history;
- information about disabilities;
- information about health services or disability services that are (or have been) provided;
- information about the donation, testing or examination of any body part or bodily substance; and
- information that is collected in the course of the provision of any health service or disability service.

Organisations must designate a person to be the organisation's privacy officer. Employers and principals need to be familiar with the Privacy Act and the Health Information Privacy Code and ensure that workplace policies and procedures meet the limits set out. The Privacy Act and the Health Information Privacy Code set out 12 Privacy Principles or Rules relating to the collection, storage, security, access, use and disclosure of personal information, as well as an individual's right to access and correct personal information.

Privacy Officers

Organisations must designate a person to be the organisation's privacy officer. Employers and principals need to be familiar with the Privacy Act and the Health Information Privacy Code and ensure that workplace policies and procedures meet the limits set out.

The privacy officer plays an important role in ensuring compliance with the legislation. All requests for access to, or correction of, information should be referred to the privacy officer.

Comment on Management of Health Information

The rules relating to the collection, use and disclosure of information are discussed in more detail below.

Rule 1: Purpose of collection of health information. This entitles your organisation to collect health information for a lawful purpose connected with your organisation's activities, providing the information is necessary for that purpose.

Health agencies must consider, when collecting information, whether it is necessary for a lawful purpose. The main purpose for which health information is collected by health agencies is obviously for care and treatment. Linked purposes include administration, training and education and monitoring.

The collection of unnecessary information is prohibited. Different users may not require the same depth and breadth of health information. For example, information needed for treatment purposes would be greater than that needed for administration purposes; and health funders, purchasers and providers may have no need to collect the same depth as providers of care and treatment.

The individual (or their representative) should be made aware of the fact information is being collected, the purpose and intended recipients of that information, how the information will be held, any consequences of not providing the information, rights of access to and correction of information, and if mandatory collection is authorised by law. There are some exceptions to these requirements, which are set out in the Health Information Privacy Code (and commentary).

Information must not be collected by unlawful means or by means that are unfair or intrude to an unreasonable extent upon the personal affairs of the individual concerned. Unreasonable intrusion may include asking personal or sensitive questions within hearing of others or in a culturally insensitive form or context.

Collecting Information on Clients for Health and Safety Purposes

It is essential for agencies to ensure they access all relevant information about the person to whom care is to be provided prior to care commencing. Without adequate knowledge of the client, both the client and the employee could be put at risk of harm.

For example, an employer will need to inform a caregiver about their client's history of challenging or violent behaviour, and any recognised contributing factors and techniques to manage it. The provisions of the Health Information Privacy Code relating to collection and disclosure of information must be met.

The employer needs to pursue the collection of information until they are satisfied that they have all relevant information, and communicate appropriate information to those who require it, and provide the best possible resources in terms of personnel, equipment and back-up to ensure that work is safe.

Implementing these processes effectively will also ensure that the requirements of the HSE Act are met. That is, for example, any challenging behaviour that could potentially occur and that may be “hazardous” to the client themselves and/or the caregiver is known. With this knowledge, precipitous events are more likely to be avoided.

Rule 2: Source of health information. This requires your organisation to collect health information directly from the individual concerned. Exceptions are limited and must be justifiable.

Information should be collected directly from the individual concerned except in certain circumstances. Exceptions include (but are not limited to):

- where the individual has authorised collection from someone else, or if the person is unable to provide authorisation, their representative’s authorisation;
- where compliance prejudices the individual’s interests, purpose of collection or individual safety;
- where compliance is not reasonably practicable (such as the mentally incompetent or brain-damaged client); and
- where information is publicly available.

Information may need to be collected from:

- the client;
- other sources authorised by the client;
- other sources where it is not reasonably practicable to obtain the information from the client, for example, when the client is unconscious;
- other sources where collecting the information from the client would prejudice their interests, prejudice the collection, or prejudice the safety of any person. For example, the client may not be honest with the agency, so that accurate information about their health may not be obtained.

Rule 3: Collection of health information from the individual. This requires that when your organisation collects health information directly from an individual, the individual must be given certain details including why the information is being collected and what will happen to it.

The individual (or their representative) should be made aware of the fact information is being collected, the purpose and intended recipients of that information, how the information will be held, any consequences of not providing the information, rights of access to and correction of information, and if mandatory collection is authorised by law. There are some exceptions to these requirements, which are set out in the Health Information Privacy Code (and commentary).

Types of Information to be Collected

The employer needs to consider *whether there is anything relating to the condition, care and treatment of the client that may place an employee or other person at risk of harm while or as a result of care being provided.*

When collecting information, the following questions may be considered where relevant to the type of care being requested/provided. The following are examples only, and will require modification depending on the nature of care to be provided:

Has the client any condition that may expose the caregiver to a risk of infection?

Yes / No / information declined

(If Yes, state nature of infection and/or mode of transmission, e.g. blood/body fluid contact, relevant treatment details, any details on degree of risk to caregivers, source for further information).

(If declined, give reason for decline and relevant section of legislation.)

In the case of information being declined, the person making the enquiry, (who may be for example, the employer), must determine whether care can be provided without compromising the health and safety of the employee. (Further, it may be necessary to follow the guidance of the earlier section on withdrawal of service.) This rationale should be applied to the following questions where any information is declined.

Does the client have any condition that may predispose them to challenging behaviour?

Yes / No / information declined

(If Yes, provide all relevant information.)

(If declined, give reason for decline and relevant section of legislation.)

Has the client any history of actual or potential challenging behaviour?

(If Yes, provide further information on predisposing factors, care, treatment and any other relevant factors.)

(If declined, give reason for decline and relevant section of legislation.)

Are you aware of any hazards relating to the client's home environment?

- biological;
- environmental;
- electrical;
- ergonomic;
- chemical;
- social;
- other.

(If Yes, provide all relevant information.)

(If declined, give reason for decline and relevant section of legislation.)

Rule 4: Manner of collection of health information. This prevents your organisation from collecting personal health information by unlawful or unfair means, or by a means which would intrude to an unreasonable extent upon the privacy of the individual concerned.

Unreasonable intrusion may include asking personal or sensitive questions within hearing of others, or in a culturally insensitive form or context.

Rule 5: Storage and security of health information. Health information your organisation holds must be kept secure against loss or unauthorised use, modification, or disclosure.

Rule 6: Access to personal health information. Any health information about an individual held by your organisation must be made available to that individual on request. This right is subject to limited reasons for refusing a request.

If Access to Information is Refused

If agencies are asked to disclose and they are not required to do so by law, they cannot be compelled to do so. A reason for refusal must be given.

If an access or correction request is refused, the requester may complain to the agency and ask to have the complaint considered as part of internal complaints procedure. Otherwise the requester may refer the refusal directly to the Privacy Commissioner's Office.

Rule 7: Correction of health information. This entitles an individual to request that any personal information held by your organisation be corrected.

Rule 8: Accuracy of health information to be checked before use. This requires your organisation to ensure that any health information which your organisation proposes to use is accurate, up-to-date, complete, relevant and not misleading.

Rule 9: Retention of health information. Health information must not be kept for longer than is required for the purposes for which the information must be lawfully used. Note: This rule must be read subject to the Health (Retention Of Health Information) Regulations 1996, which provide that health information must be retained for a minimum period of 10 years which runs from the day after the most recent date on which the individual received health or disabilities services.

Rule 10: Limits of use of health information. This restricts your organisation to using health information only for the purpose for which it was obtained (with some exceptions).

Rule 10 limits the uses to which health information can be put. This rule means that information collected for one purpose must not be used for another purpose unless an exception applies. Individual authorisation is always preferable to relying on an exception to the rule.

Exceptions that apply allow information to be used for other purposes include where:

- an individual has authorised use for other purposes;
- use is directly related to the first purpose; or
- the information will not identify the individual concerned.

Agencies that have complied with Rule 1 will have clear purposes for having information and Rule 10 allows them to use the information for those purposes.

Before using information, agencies must ensure it is accurate, up-to-date, complete, relevant and not misleading.

Rule 11: Limits on disclosure of health information. Health information about an individual cannot be disclosed to any other person (unless covered by the exceptions set out).

Rule 11 of the Code places limits on the disclosure of health information. Disclosure is permitted (but not required):

- where disclosure is for one of the purposes for which the information was collected;
- where the disclosure is made to or authorised by the individual, or the individual's representative (where that individual is unable to exercise their rights under the Code);
- the information is general (as set out in the Code) and the disclosure is not contrary to an express request of the individual or their representative; or
- one of the further exceptions under Rule 11 (2) applies.

The further exceptions allow disclosure in certain circumstances where it is not desirable or practicable to obtain individual authorisation. One of these exceptions is where information is needed to prevent or lessen a *serious and imminent* threat to public health or safety, or the life or health of the individual or another individual. This exception should not be treated as an overriding provision, however. The agency would need to believe on reasonable grounds that it is not necessary or desirable to obtain individual authorisation, the threat must be serious and imminent and the disclosure of information must be limited to that needed to prevent or lessen the threat.

Communication and Confidentiality of Information

Rule 11 of the Health Information Privacy Code allows disclosure where that was a purpose for obtaining the information. These disclosures may be a part of regular procedures, commonly made or reasonably justified. For example passing on information to other members of the care team or making a referral. The transfer of relevant information to employees would fall under this rule.

These purposes should be discussed with the client when the information is collected. There is no need then to subsequently approach the client for authorisation to disclose for those purposes. Only the information necessary to achieve the purpose should be disclosed.

Professionals must also ensure that any disclosure they make complies with their code of ethics. Many codes will allow disclosure if the law requires it. In most cases, there will be nothing to prevent the agency from telling the client that the disclosure has to be made.

Responding to Requests for Information and Obtaining Consent

When considering the release of information in response to a request by another agency or individual, a health or disability agency or care worker can only disclose health information if permitted to do so by one of the exceptions to Rule 11 or under the provisions of some other statute.

Other statutory provisions, which may apply when a health agency receives a request for health information, are:

1. Section 22F of the Health Act 1956 provides that every person who holds health information must disclose that information on the request of:

- the individual concerned;
- the individual's representative or the provider of health or disability services to that individual.

A request can be refused if the holder has reasonable grounds for believing that the individual does not want the information disclosed (s 22F(2) Health Act 1956).

2. Under Section 22c of the Health Act 1956 (as amended by the Health Amendment Act (No.2) 1993), agencies that provide health or disability services may disclose health information about an identifiable individual:

- if permitted under the Privacy Act's Health Information Privacy Code of the Privacy Act; or
- if it is required by *specified persons for certain purposes*.

These persons and the purposes include (s 22c (2), Health Act 1956):

- any medical officer of a penal institution, for the purposes of exercising that person's powers, duties or functions;
- any probation officer, for the purposes of exercising that person's powers, duties or functions;
- a social worker or a care and protection co-ordinator, for the purposes of exercising that person's powers, duties or functions;
- any member of the police, for the purposes of exercising that person's powers, duties or functions;
- any employee of the Ministry of Health, for the purpose of administering the Health Act 1956, or the Hospitals Act 1957, or compiling statistics for health purposes;
- any employee of a funding agency, e.g. a Regional Authority, where the requested health information is for the purposes of exercising or performing the funding agency's powers, duties or functions under the Health and Disabilities Services Act 1993.

3. The Official Information Act 1982 applies to public health agencies, e.g. public hospitals. Where a public sector agency receives a request for information, the request must be dealt with under the provisions of that Act. There is an underlying obligation to disclose the information but information may be withheld to protect the privacy of an individual or a deceased individual. If an agency is considering withholding information on those grounds, the agency must also consider whether there is any public interest reason for disclosing which may outweigh the privacy interests. Where the information requested is health information, there would need to be a stronger public interest in disclosure in order to outweigh the privacy interest.

Note: In all cases where an agency receives a request for information, it is prudent for such request to be referred to the agency's Privacy Officer where possible.

Sometimes clients may not want information passed on. Their concerns may be dealt with in a number of ways. These are discussed in detail in *On the Record: A Practical Guide to Health Information Privacy*. For example, one way that this might be managed is to formulate a policy that requires disclosure of information to future caregivers.

Rule 12: Unique identifiers. This places limits on the use of identification numbers for individuals, and restricts your organisation's right to require an individual to disclose any identification number which may have been given to him or her by another agency.

Complaints of Breach of Code

Every health agency must designate a person or persons to deal with complaints alleging a breach of the Health Information Privacy Code. The agency must have a complaints procedure in place, which includes provisions as contained in clause 7 of the Code.

Further Information

The Health Information Privacy Code 1994 (incorporating amendments and revised commentary.) Reprinted June 2000, Office of the Privacy Commissioner.

On the Record: A Practical Guide to Health Information Privacy. 2nd Edition, July 2000. Office of the Privacy Commissioner.

A Guide to Employers on the Privacy Act 1993. The Employers' Association.

Guidelines for Clinical Risk Assessment and Management in Mental Health Services. Ministry of Health and Health funding Authority, July 1998.

Mental Health Professionals and Patient Information: Guidance Notes for Agencies in the Mental Health Sector. Office of the Privacy Commissioner, September 1997.

Section Three: Prevention and Management of Workplace Violence and Aggression

Overview

Violence is a serious occupational health and safety concern facing care workers in the home care industry, and employers are encouraged to develop a workplace philosophy and culture that clearly states that violence in any form is unacceptable. Violence includes verbal and emotional threats, and physical attack to an individual's person or property. It can lead to injury, stress and trauma. Violence has potential to occur inside or outside premises, or on callouts, and can be highly unpredictable.

There are a number of potential sources of work-related violent or aggressive behaviour in the home care setting, including the client, their family or whanau, other people known to the client, co-workers, other individuals in the community encountered while working, and dogs.

Violent behaviour can escalate from intimidating body language, to verbal threats, physical threats and assault. Verbal abuse can occur in person or over the phone.

Violence may include:

- threats of physical harm;
- threats of a sexual nature;
- “ganging up” by a group over an individual;
- physical or sexual assault.

Common causes of aggression include:

- situational factors such as fear of new people, excessive threat, noise, pain, mood state, etc.;
- belief that one has been wronged;
- low impulse control;
- difficulty in verbalising problems;
- medical illness such as delirium;
- mental illness such as psychotic disorders, substance abuse, organic mental disease and personality disorders.

Agitation can lead to violence if it is not attended to very quickly. Recognise that anger can trigger aggressive outbursts and destructive behaviour.

Reactions to workplace violence can continue for a long time after the incident. If the incident and employee's reactions are not actively managed, the impact of the incident can be very damaging.

The reactions of individual employees will vary according to the nature of the incident and the

extent to which the person was involved. The level of fear an individual feels and the way they respond during and after a violent act relates to their own experiences, skills and personality. Common reactions include immediate body reactions associated with distress and feelings of anger, protest, frustration, anxiety, shock, powerlessness, guilt and embarrassment. Irritability and loss of concentration, sleeplessness and nightmares can continue for some time after the incident and the employee may fear returning to work.

The most important aspect of the management of workplace violence is prevention.

Managing Workplace Violence

There are three steps to follow to reduce the risk of workplace violence. These steps should be completed prior to work commencing in areas where workplace violence is a hazard.

- *Identify* situations where employees and visitors may be subjected to workplace violence.
- *Assess* which violent hazards are more likely to cause injury or harm to the health of employees or others in the place of work, and how serious the risk of harm may be. Identify significant hazards as per the Health and Safety in Employment Act. Assess existing and potential controls. List all reasonable and practicable steps that may be taken.
- *Take action* to prevent violence and harm.

The responsibility for completing the three steps rests with any person who is an employer, main contractor (principal), self-employed person or person with control over the workplace.

Specialist advice may be needed but people in the workplace can complete many of the activities such as identifying situations where violence may occur. Employees can be involved in the process of gathering information and working out the best ways to prevent workplace violence. Let employees know there should be special emphasis on prevention and talk to them about any changes before they are introduced.

It is useful to break the management of workplace violence down into three phases using a before, during and after approach.

Before: Planning and Implementation

Planning to identify, eliminate or control and reduce the impact of workplace violence, and introducing measures to reduce risk.

Training to provide employees with the skills to recognise and defuse a potentially violent incident and to know the measures to take.

During: Immediate Response

Following the plans and procedures that are in place and containing the violent incidents.

After: Recovery and Review

Restarting the work process, returning things to normal as soon as possible and providing support and counselling to employees to minimise the impact of the incident.

Reviewing violent incidents to identify areas in need of improvement.

Before: Planning and Implementation

A systematic approach is needed to establish safe systems of work so workplace violence is well controlled. Where workplace violence cannot be prevented, planning should focus on reducing the impact. Employees need to be prepared and confident that they will know what to do if a violent incident occurs.

Employers are required to take “all practicable steps” to control the hazard of workplace violence and take action to reduce the risk of injury or harm. In determining the most appropriate health and safety management, the employer must consider what practicable steps can be taken to ensure the safety of employees and others.

The “practicable steps” will include, for example:

- In the community mental health setting, the degree of injury that might be suffered if the person does not receive the correct medication and/or it is not administered at the correct time.
- The likelihood or otherwise that a mentally ill person will become suddenly aggressive if drug treatment and therapy is not provided, and what is known about their history of violence or aggression.
- Whether an alarm system will be effective enough following placement of a mentally ill person in the community in an isolated region where support and emergency response may take time to arrive.
- The cost of providing two trained personnel around the clock against the risk of serious assault on a lone employee.

See the definition of “all practicable steps” in Appendix 1 of this document (p.71).

Identify Situations with the Potential for Violence or Aggression

Identify the possible situations where employees and other people may be subjected to workplace violence. If the reason for violence can be identified, and it is something that can be altered, there is a greater chance that the amount of violent and aggressive behaviour can be reduced.

Identification of Hazards

Identification of hazards should be performed organisation-wide (for example, through workplace security analysis) as well as for each health care setting and/or each client and carer situation.

A systematic organisation-wide process of hazard identification, assessment and management will mean that a range of control methods are identified. Appropriate and “practicable” control methods can then be applied to hazards identified in each individual care setting.

A. Workplace Security Analysis

Workplace analysis involves a step-by-step assessment of the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop.

A comprehensive plan for maintaining security in the workplace may include establishing liaison with other agencies such as security advisors, police, OSH, or others who can help

identify ways to improve security and prevent and mitigate workplace violence.

The recommended programme for workplace security analysis includes, but is not limited to, analysing and tracking records, monitoring trends and analysing incidents, screening surveys and analysing workplace security.

Analysis of security should aim to evaluate the effectiveness of existing security measures, determine if risk factors have been reduced or eliminated, and identify appropriate action to eliminate or control risks.

When assessing the potential for violence in the work environment, a number of different sources should be used to identify situations where violence may occur. For example:

- talk to people who have experienced violence in the workplace;
- talk to employees and allow them to communicate their concerns about violence in the workplace;
- survey employees in confidence — ask about incidents that have caused them discomfort and situations that had the potential to become more violent (near-misses);
- collect information about the different situations where violence may occur in workplaces similar to yours;
- check accident and incident reports to find out about people who may have been injured in the past;
- where appropriate, inspect parts of your workplace where violence may be a problem;
- set up a system to encourage employees to report incidents, for example individual recognition for bringing a safety concern to the attention of managers.

Hazard Worksheet

A hazard identification worksheet may be useful to make notes as you talk to people or inspect workplaces. Information to be included is:

- task and location;
- description of the hazard;
- people affected;
- how often, e.g. daily, from time to time, at any time, during particular procedure;
- additional comments.

B. Identifying Client-Related Risks

With the benefit of knowledge of potential situations where violence may occur, the employer and caregiver can assess specific care giving situations in order to identify the potential for violence. The employer can also assess the level of risk in each situation and practicable steps that may be taken to reduce risk and to manage incidents.

Gathering information about the client and their home setting *prior to* care commencing is a critical factor in the management of risk. The skills and training of the caregiver are other critical factors.

Factors to be assessed include:

- needs assessment of the client;

- obtaining and reviewing client history;
- assessing the home environment;
- assessing level of care required and skills of caregivers, including competency to manage situations where violence or challenging behaviours may occur;
- appropriate matching of client and caregiver;
- communicating relevant information to all caregivers and supervisors;
- planning care for the client according to needs assessment and history;
- adequate supervision of care and regular review of progress;
- prompt review of needs and care where condition changes;
- medication management, review, security, record keeping.

When identifying hazards in specific client care situations, managers, supervisors and the carer will need to ask:

Do I have the information I need to provide safe care to this client?

Questions should include:

- is there a history of aggressive behaviour and in what circumstances?
- what factors have been identified as contributing to an escalation or reduction in violence for this client?
- are there factors in the client's home environment that may affect the risk of violence, such as the physical environment, location and isolation, family or whanau, friends, neighbours, dogs?
- are there cultural factors or gender issues that may affect care and choice of caregiver?
- what communication and support systems are available?
- how often will care be reviewed and by whom?

For more guidance on assessment, refer to Appendix 2: Factors Relating to Violence in the Home Care Health Setting, (p. 72).

Assessing Risk

The Act requires that employers assess each hazard to determine whether it is significant or not. Therefore, each situation should now be considered in terms of how likely it is to cause harm. These situations can be rated in a number of ways, for example "high, medium or low.

To determine the overall significance, employers need to ask:

- What is the likelihood of employees recognising the hazard and understanding the action needed to eliminate or reduce the risk?
- What factors would affect the situation? For example: staffing arrangements, experience, knowledge and skills, level of training, security arrangements, client history and nature of reason for the visit or care being provided.
- How likely is it that someone will be injured or harmed if they are involved in a violent incident?

- How serious would the injury or harm be if something did happen?
- Who would be affected and how often would these people be exposed to the risk of injury or harm from workplace violence?

In work settings where people are at risk of significant physical or psychological trauma, risk reduction must have a high priority for implementing control strategies.

Controlling the Hazard (Sections 8-10 of the HSE Act)

Take action to prevent injuries and psychological harm that may result from workplace violence. Eliminate the situation that may result in violence wherever practicable. If elimination is not practicable, isolate or minimise the hazard and protect the employee. Ways to do this include, but are not limited to, substituting a hazardous procedure with a less hazardous one, reorganising the work environment, and providing protective equipment and emergency support.

1. Eliminate the hazard.

Change the system of work to eliminate the hazard and contributing factors. Sometimes the exact reason or trigger for workplace violence can be identified and work procedures altered accordingly, for example, eliminating the need to openly carry large amounts of cash, or removing or eliminating something that is known to contribute to hostile behaviour.

However, in the home care setting, and in the community mental health setting in particular, factors contributing to violence are likely to be multiple and/or difficult to predict and elimination may not be possible.

Sometimes, refusal to accept a client for care or withdrawal of service may be the only way to eliminate the risk of violence in a given case.

2. Where the hazard cannot be eliminated, isolate the hazard.

Isolating the hazard by separation with space, time or barriers might include:

- removing potential violent weapons such as paper spikes, scissors or knives in areas where they present an opportunity for violence to worsen and their removal is practicable;
- job rotation may be used to reduce the amount of time employees are in stressful work situations, especially when they are new to the job;
- rostering can also be used as a method to reduce the period of exposure to aggressive situations.

3. Where the hazard cannot be eliminated or isolated, minimise the hazard and protect employees.

- introduce team care or buddying where practicable in situations where the risk of violent behaviour is high or the situation is unknown, such as a first visit;
- ensure every effort is made to match the needs of the client with the skills and experience of the caregiver;
- ensure an escape route is always planned and kept open — always aim to avoid dead ends where you may be unable to retreat to a safer place when necessary.
- ensure new employees are not required to work without full supervision until they have the competencies to do so and buddy with more experienced staff when needed;

- ensure ongoing analysis of reported incidents to assess any need for additional training or information;
- proactively monitor the employees' stress and fatigue levels (refer to the OSH guide *Stress and Fatigue: Their Impact on Health and Safety in the Workplace*).

4. Set up effective systems for transfer of information.

Where employees interact with people who may be violent, the transfer of information from one care provider to another will allow each person to be prepared for a potentially violent incident. The disclosure of health information needs to be in accordance with the Privacy Act and the Health Information Privacy Code.

Those who are providing care need to have access to information relevant to their ability to provide and maintain safe care of the client. Policies need to be in place to determine who has access to records so that privacy of health information is maintained. (See Section Two for more information on transfer of information.) Health professionals need to ask themselves the questions:

- Who will get the information?
- Why will they get the information?
- Why is that necessary?
- What is the likely impact on privacy and confidentiality?

5. Set up effective communication systems to be used in an emergency.

- Have relevant numbers available.
- Have a means of communicating.
- Have a means of indicating alarm.
- Ensure all employees know their role in the event of an emergency.

6. Provide training and supervision.

Section 13 of the HSE Act requires that employers specifically train and supervise employees. Training needs to be appropriate to the client group, and will need to take into account the level of care provided and the existing training and knowledge base of the participant.

Training should be evidence-based and in accordance with current accepted best practice and related health and disability sector standards.

Two types of training in workplace violence are needed: general training and task-specific training.

General Training

When should training in workplace violence take place?

- during induction training; and
- as part of a regular violence prevention programme.

The training should meet national standards where they exist. In the absence of such standards, individual or groups of providers may develop such standards.

Who should attend?

Everyone involved in managing and providing care where workplace violence has been identified as an actual or potential hazard.

The level of training provided should be comparable to the risk involved. Any training should focus on the specific problems identified in the hazard assessment process.

Training should aim to:

- equip employers and employees with the ability to assess the level of risk in a particular situation and choose the most appropriate procedure, including when to withdraw from a situation to seek assistance; and
- equip employees to make reasonable decisions in the circumstances and to balance the need for actions needed to maintain their own safety and the safety of others who may be in their care.

Depending on the degree of risk, participants should have an understanding of some or all of the following:

- the role and responsibilities of the employer, employees and others in the prevention and management of workplace violence;
- the hazard management approach to workplace violence;
- consultation which should take place between employer and employees in order to identify the potential for workplace violence, and to assess and control risks;
- types of workplace violence and a range of influencing factors in home-based health care settings;
- application of relevant prevention and control strategies;
- safety procedures that are in place to reduce the risk of workplace violence and consequences if they are not followed;
- emergency procedures.

Task-Specific Training

When should task-specific training take place?

- (a) during induction to the task;
- (b) as part of refresher training; and
- (c) when work tasks are about to be changed or introduced.

Instructions need to be specific to the work situation, appropriate to the client group, and according to the level of skill and responsibility expected from the worker.

Training should aim to:

- inform employees of their role and responsibilities;
- improve the employees' ability to communicate, defuse and manage situations where there is a potential for violence;
- provide guidance on how to prevent the occurrence of harm to self or others.

Training components may include some or all of the following, as relevant:

- verbal and nonverbal communication techniques;
- responding to challenging behaviour, aggression or violence;
- skills in defusing hostile situations;
- de-escalation techniques;
- safe management of restraint techniques where appropriate;
- how to access help in an emergency.

Training in self-defence is an important element of any violence prevention programme, however, it needs to be presented as a last line of defence, suitable when all other measures are attempted but fail to contain the violent behaviour.

Supervision should be provided on the job to reinforce the new skills learned in training and to ensure they are put in place. It is not sufficient to train employees in how to behave if a violent incident occurs and hope the employees apply it when they return to their workplaces.

7. Establish clear policies.

Create and disseminate a clear policy of non-tolerance for workplace violence, verbal and nonverbal threats, and related situations. Managers, supervisors, employees, clients and visitors must be advised of this policy.

The policy may include a commitment to:

- maintain a supportive environment that places as much importance on employee safety and health as on serving the patient or client;
- identify risk of violence or aggression and take all practicable steps to prevent them from occurring;
- encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks;
- ensure that there are adequate resources available to prevent incidents from occurring;
- require records of incidents to assess risks and to measure progress;
- support any employee who reports or experiences workplace violence and ensure that no harm comes to them as a result of reporting incidents;
- assign responsibility and authority to individuals or teams with appropriate training and skills and experience;
- support and implement appropriate recommendations from health and safety committees and accident/incident investigations.

8. Develop and implement a violence prevention programme.

A violence prevention programme is a written programme for workplace safety and security, incorporated into the organisation's overall health and safety programme.

The programme should have clear goals and objectives to prevent workplace violence, suitable for the size and complexity of the organisation, and adaptable to specific situations in the working environment. Training of employees will be a key part of the programme. The programme should also outline support for affected employees and a programme of rehabilitation to facilitate recovery. This includes counselling and debriefing for employees experiencing assaults and other violent incidents.

The team or individuals responsible for the programme should be provided with the opportunity to develop expertise on workplace violence prevention in home-based health care.

The programme should allow employee involvement in the design, implementation and evaluation of the programme.

Immediate Response

The aim is to have an effective response that controls and defuses the situation and reduces the risk of long-term harm to employees at all levels. The specific nature of the response will vary from one workplace setting to another and needs to be developed appropriate to the needs of the setting, the support available, the skills of the employees and the nature of the client group.

Back-up procedures must be in place to ensure that support can be provided quickly in the case of an emergency. Involvement of the police will be a decision for those involved in the incident but needs to be considered as a means of accessing urgent assistance, as well as for follow-up.

There needs to be an identified person who has authority to take charge when a violent incident occurs. They require training in how to co-ordinate the response, including taking care of employees who may be in shock, injured or affected in some way. Allocation of a safe place to retreat to, control of media access to employees, providing communication to families and arranging transport home are important to relieve pressure on employees.

Immediate counselling and support should be available. Those involved should be encouraged to take part in a formal debriefing programme.

Recovery and Review

The recovery phase is about providing ongoing support for affected employees and a programme of rehabilitation to facilitate recovery. This includes facilitating counselling and medical or other health professional support and advice for employees experiencing violent incidents, and assisting employees to return to normal duties as quickly as possible after the disruptive incident.

On return to work, the employee may find that returning to the scene of the violent incident brings back memories of the distress that occurred, and the employee may be overwhelmed by fear. It is important for employees to feel safe as well as be safe so as to prevent an adverse reaction to an incident where no threat actually exists.

The following actions should be part of the recovery and review:

- provide clear information to all employees;
- provide ongoing professional counselling and support services for employees and their families;
- allow time to recover but encourage early but gradual return to work as part of the process;
- provide advice on legal matters and ACC arrangements as appropriate;
- investigate the incident and review safety management to reduce the risk of injury or harm in the future.

Guidelines for Employers, Managers and Supervisors on Prevention and Management of Workplace Violence

Health and safety policies and procedures should ensure that:

- information is collected in order to identify actual or potential hazards relating to violence, including client history and needs assessment, and any known contributing factors and management techniques used;
- effective systems are in place for transfer of information on hazards;
- risk of harm from challenging or aggressive behaviour is assessed, significant hazards are identified and all practicable steps are taken to eliminate, isolate or minimise the risk of violence and to protect employees from harm;
- general information on violent behaviour, its prevention and management is communicated to employees;
- caregivers who may be exposed to violence are informed of the risk (within the limits imposed by the Privacy Act) and all practicable steps taken to prevent exposure;
- employees have access to, are trained in and are supervised in the use of personal security equipment;
- appropriate matching of client and caregiver occurs to minimise risk of harm from behavioural conditions;
- relevant training of employees in violence prevention and management occurs;
- supervision of employees in safe work practice occurs at a level that ensures exposure risk of exposure to aggression is minimised and monitored;
- prompt review of client care occurs when needs or behaviour changes;
- provision, training in use of and maintenance of communication devices occurs;
- near-miss accidents, threats, harassment or assaults are reported and followed up;
- debriefing, support, counselling and rehabilitation is offered following exposure to violence and planned return to work to promote rehabilitation.

Guidelines for Employees on Prevention and Management of Workplace Violence

In order to provide safe care and to reduce the risk of harm from exposure to aggressive or violent behaviour, employees need to consider the following:

1. Do I have the information I need to provide safe care to this client?

Information required includes:

- any history of aggressive behaviour and in what circumstances;
- factors identified as contributing to an escalation or reduction in violence for this client;
- any contributing factors in the client's home environment that may affect the risk of violence, such as the physical environment, location and isolation, family or whanau, friends, neighbours, dogs;

- employer's policy and procedures on prevention and management of violence;
 - what communication and support systems are available;
 - how often will care be reviewed and by whom.
2. *Do I have the knowledge and skills required to provide safe care to this client?*
- Do I have knowledge of contributing factors and preventive techniques?
 - Do I have training in management techniques, such as de-escalation, defusing hostile situations, management of challenging behaviour or calming and restraint techniques?
 - Do I have training in what to do if attacked, such as how to call for help, self-defence?
 - Do I have knowledge of when and how to seek assistance in an emergency?
3. *Do I have the support and equipment needed to provide safe care to this client?*
- Is personal security equipment available?
 - Is there a means of calling for help and is there emergency assistance available?
 - Is advice or information available on management of violence or challenging behaviour?
4. *If hazards are not controlled, and care cannot be provided without significant risk of injury, what steps can be taken?*
- report threatening or challenging behaviour and any violent incidents to supervisor;
 - seek assistance or advice prior to commencing any work;
 - seek information on all practicable steps that may be taken to eliminate, isolate or minimise risk of harm, from the supervisor and/or manager and/or workplace health and safety representative and/or medical advisor;
 - if assistance cannot be provided and there is significant risk of harm, advise employer that work cannot be performed safely;
 - advise employer and/or health and safety representative if duty of care conflicts with safe work practice.

Further Information

A Guide for Employers and Employees on Dealing with Violence at Work. OSH, Department of Labour, 1997.

Standards New Zealand. *Restraint Minimisation and Safe Practice Standard DZ8141.*

Workplace Violence Code of Practice. Worksafe Western Australia, 1999.

Guidelines for Clinical Risk Assessment and Management in Mental Health Services. Ministry of Health and Health Funding Authority, 1998.

Mental Health Professionals and Patient Information: Guidance Notes for Agencies in the Mental Health Sector. Prepared for the Mental Health Commission by the Privacy Commissioner, 1997.

Stress and Fatigue: Their Impact on Health and Safety in the Workplace. OSH, Department of Labour, 1998.

Section Four: Preventing and Responding to the Risk of Infection

Overview

Home caregivers and their clients can be at risk of acquiring infection. Infection can pass from client to worker, or from worker to client, or can be from other sources such as:

- other people or visitors to the home;
- animals, including cats, dogs, vermin;
- environmental sources such as inadequately prepared or stored food, contaminated water, soil or other substance.

Infections may be viral, bacterial or fungal. Workers can be exposed to diseases through respiratory contact, contact with blood and body fluids through broken skin, needlestick injury, splashes into eye or mouth, and in some settings from scratching, spitting or biting.

The combination of the number of organisms in the environment, the virulence of these organisms and the resistance of the individual ultimately determines whether or not the person will contract the disease.

The ways in which an infection is passed on (the mode of transmission) also affects whether or not a home-based caregiver may be at risk through their work. For example, a caregiver who does not come into contact with blood or body fluids will not be at risk of acquiring blood borne diseases such as hepatitis or HIV/AIDS through their work.

Some infections are significant hazards in certain circumstances, such as where the person at risk of exposure to the virus is pregnant (e.g. rubella) or immunocompromised (having little ability to fight infection due to existing illness or other condition, leaving them at risk of severe illness from any infection).

It is important to recognise that it is not always possible to know when a person may be infectious. For example, some viruses have no symptoms until some time after the infectious period has begun, or testing may be unable to reveal the presence of infection, such as in the early stages of infection with HIV. *For this reason, standard infection precautions should be followed for all clients.* (Further information on standard precautions follows later in this document.)

Examples of Biological Hazards that May Result in Infection

- hepatitis A, B, C;
- human immunodeficiency virus (HIV), the virus that causes AIDS;
- tuberculosis;
- childhood infectious diseases including chicken pox, rubella;
- skin (and hair) infections such as scabies, lice;

- food-borne infections may occur through inadequate cooking, preparation, or unsafe storage or handling of food, e.g. campylobacter.

Preventing Infection

There are three major steps to follow to reduce the risk of infection. These steps should be completed by the employer as part of a general infection control programme that includes the development of policies and procedures.

- *Identify* situations where employees, clients and others may be at risk of infection.
- *Assess* the degree of risk, and existing and potential controls. List all reasonable and practicable steps that may be taken.
- *Take action* to prevent infection, injury and harm, e.g. immunise where possible (hepatitis A and B), check antibodies to see if staff are immune or remain at danger (e.g. rubella in women of child-bearing age) etc.

Identify Situations with the Potential for Infection

Identification of hazards related to infection should be performed organisation-wide (for example, through an infection control audit) as well as for each health care setting and/or each client and carer situation. Hazard identification needs to be done before work begins, at any time when client condition or environmental factors change, and reviewed at regular intervals as part of general review of client care.

Employers need to ask:

- What is the likelihood of employees recognising the hazard and understanding the action needed to eliminate or reduce the risk?
- What factors would affect the situation? For example, staffing arrangements, experience, knowledge and skills, level of training and supervision, nature of clients to whom care is provided.
- How might employees be exposed to infection considering work performed, degree of invasive procedure, behaviour of client group?
- Who might be affected and how often would these people be exposed to the risk?

Assess the Degree of Risk

Task Analysis

A worksheet may be a useful tool when assessing risk in a range of situations or for a specific procedure. Consider:

- task and location, e.g. giving injections in a home care setting;
- description of the hazard, e.g. needlestick injury before during or after injection;
- people affected, e.g. worker, client;
- when or how often, e.g. daily during particular procedure;
- additional influencing factors.

Assessing Individual Client-Related Risks

Gathering information about the client and their home setting prior to care commencing is a critical factor in the management of risk.

Information to be gathered includes:

- client history and needs assessment;
- assessment of the home environment;
- plan of care;
- any transmission-based precautions required;
- any treatment or medication being provided.

The employer will also need to consider:

- the skill of caregivers and appropriate matching of client and caregiver;
- communicating relevant information to all caregivers and supervisors;
- adequate supervision of care and regular review of progress;
- prompt review of needs and care where condition changes;
- record keeping including protection of privacy.

In specific client care situations, managers, supervisors and the carer will need to ask: *Do I have the information I need to provide safe care to this client?*

Questions should include:

- Will the nature of care provided place the worker at risk of blood or body fluid exposure or other infection?
- Is there any evidence of existing infection or known history of high-risk behaviour that may create additional risks?
- Are there factors in the client's home environment that may affect the risk such as the physical environment, family or whanau, dogs?
- What protective equipment is required and available?
- Has there been adequate training in safe work practice?
- Is the worker at risk due to reduced resistance to infection or lack of immunity (e.g. protection through successful vaccination).

Assessing the Home Environment

Assess the general condition, standard of hygiene, washing facilities, layout, and furniture and fittings with consideration of factors affecting risk of exposure to infection. Identify potential sources of infection and determine protective clothing or equipment currently available.

For further information, see Appendix 3: Factors Relating to Infection Control in the Home Care Setting (pp. 74-75).

Hazards must be assessed to determine whether it is significant or not. Therefore each situation should now be considered in terms of how likely it is to cause harm. These situations can be rated in a number of ways, for example "high, medium or low".

In work settings where people are at significant risk of becoming infected, risk reduction must have a high priority for implementing control strategies.

Access to Personal Health Information on Infectious Status

Care must be taken to protect the privacy of the client's (or the worker's) personal health information. In some care situations, workers need to be informed of the infection status of their clients, for example:

- when caring for an infected wound;
- when additional precautions are required to avoid becoming infected;
- following exposure to infected material, blood or body fluids.

Decisions on the disclosure of the infectious status of the client should be made on the basis of advice from a health professional with knowledge of infection control, and advice from a person familiar with the requirements of the Privacy Act and the Health Information Privacy Code. The decision needs to consider whether consent for disclosure has been given by the client or their representative; and where consent has not been given, whether there are other legal grounds for disclosure of the information. (See Section Two for further information on privacy of health information.)

An underlying principle as to whether a person should have access to such information is whether there is "a need to know". In other words whether having that knowledge is necessary for safe work practice (or in the event of exposure, treatment) of that person.

The judgement as to which persons "need to know" will vary according to the duties of the worker caring for the client, the way the infection is able to be transmitted, and the resulting likelihood of the carer being exposed to the infection.

For example, workers who do not come into contact with blood or body fluids (or anything contaminated with blood or body fluids) as a result of their work would not generally need to be informed of a client's infection with a blood-borne disease.

Where actual exposure to blood or body fluids occurs, information on the status of the client should be sought as part of the management of that blood/body fluid exposure. The person who has been exposed will require information as to whether they are at risk of contracting (and passing on) infection and any follow-up and/or treatment required as a result of exposure. Health agencies need to have a procedure in place for the management of blood/body fluid exposures.

Control of Infection

Use of Standard Precautions

Standard precautions are precautions to be taken by all caregivers and applied to *all* clients, regardless of their presumed infectious status. Standard precautions recognise that blood, all body fluids, secretions and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin, and mucous membranes are potentially infectious, and that precautions are required to reduce the risk of transmission of disease from recognised and unrecognised sources of infection.

Standard precautions include the wearing of disposable gloves when in contact with blood and body fluids or non-intact skin.

Use of Transmission-Based Precautions

These cover additional precautions required to manage clients with infectious communicable diseases, such as active infectious tuberculosis, or MRSA. Such precautions would include notifying those involved in the care of the client of additional precautions required (such as the additional disinfections or the wearing of additional protective clothing, e.g. masks) to avoid transmitting the infection.

Policies and Procedures

These will need to reflect current accepted best practice as well as legislative requirements. (For example NZS 8142:2000 *National Infection Control*.)

Policies and procedures relating to the control of biological hazards include (but are not limited to):

- the use of standard precautions and transmission-based precautions;
- biological screening of clients prior to accepting into care, transfer and discharge from care;
- pre-employment screening (e.g. hepatitis B immune status, baseline Mantoux for TB) for workers providing personal care and/or others who may come into contact with blood or body fluids through their work;
- assigning caregivers with regard to immune status of worker and employee;
- notification requirements (e.g. notifiable diseases, serious harm);
- staff access to appropriate testing, vaccination and counselling programmes;
- procedures for monitoring employee health;
- a procedure for employees to report ill health, accidents and injuries with appropriate follow-up, including investigating all work-related ill health or injuries;
- management of blood/body fluid exposures;
- staff education and training in principles, policies and procedures of infection control;
- safe use and disposal of needles and other sharps;
- the provision of personal protective equipment such as masks, gloves, goggles, clothing;
- procedures to regularly monitor the work environment and work practices to assess compliance with infection control and health and safety policies.

Develop and Implement an Infection Control Programme

An infection control programme should be developed in consultation with relevant stakeholders, infection control personnel, health professionals and managers, and should be reviewed annually.

The content and detail of the programme will need to be relevant to the size, complexity and degree of risk associated with the service provided.

The organisation needs to have policies and procedures that minimise the risk of infection to clients, staff and visitors. These will include:

- a documented infection control programme;
- designated responsibility for infection control policy and practice;
- allocation of resources to enable infection control;
- a process for consultation and feedback when change is proposed;
- access to current information on infection control practice.

The infection control programme will include (but is not limited to) guidelines on the development, implementation and monitoring and review of the following procedures:

- staff training on handwashing and the use of standard precautions and transmission-based precautions;
- screening, placement and immunisation of employees;
- management of exposures to infection;
- outbreak management;
- cleaning, disinfection and sterilisation procedures;
- use of single-use items;
- waste management;
- surveillance of infection rates and reporting;
- use of microbial agents.

Larger organisations may have an infection control team that includes an infection control physician or nurse, managers, trainers and worker representatives. Medical input and ongoing education of team members will be required.

Training of Employees in Infection Control

Training should be evidence-based and in accordance with current accepted best practice and related health and disability sector standards.

Comprehensive information on the prevention and control of infection for home health workers must be made available to all carers and their supervisors at orientation and during training, at a level suitable to experience, knowledge and work performed. For example, home workers involved in the preparation and handling of food will need food safety training; health workers who may be exposed to blood and body fluids will require information on blood and body fluid infections and precautions.

Employers need to refer to best practice guidelines and infection control advisors when developing training programmes.

First Aid and Care Following Exposure to Infection

Employers will need to have a documented procedure on management of exposures to infection. The procedure should include:

- procedure for immediate reporting of exposure to infection;
- assigned responsibility for management of immediate and follow-up care;

- first aid treatment following exposure;
- medical screening tests and treatment to be initiated;
- support, health information and counselling for the person exposed;
- documentation of incident and investigation.

Medical advice will need to be sought in the event of an exposure to actual or potentially infectious material.

Guidelines for Employers, Managers and Supervisors on Prevention and Management of Infection

Health and safety policies and procedures should ensure that:

- information is collected in order to identify actual and potential biological hazards and any client with an infectious condition;
- risk of harm from infectious conditions is assessed, significant hazards are identified and all practicable steps are taken to eliminate, isolate or minimise the risk from infectious conditions and to protect employees from harm;
- general information on biological hazards and their controls is communicated to employees;
- caregivers who may be exposed to infection are informed of their risk of acquiring infection (within the limits imposed by the Privacy Act) and all practicable steps to be taken to prevent exposure;
- employees have access to, are trained in and are supervised in the use of protective equipment and clothing;
- appropriate matching of client and caregiver occurs to minimise risk of harm from infectious conditions;
- employees are trained in infection control methods;
- supervision of employees in safe work practice occurs at a level that ensures exposure to infectious conditions is minimised and monitored;
- client infection control needs and methods are promptly reviewed where conditions change;
- preventive maintenance of infection control equipment is carried out;
- blood/body fluid exposures, accidents and injuries are reported;
- health assessment and treatment is undertaken following injury or exposure and planned return to work to promote rehabilitation and prevent cross-infection.

See also Appendix Four: Blood/Body Fluid Incident Assessment Aid (pp.76-77).

Guidelines for Employees on Prevention of Infection

In order to provide safe care and to reduce the risk of acquiring infection, employees need to consider the following:

1. Do I have the information I need to provide safe care to this client?

Information required includes:

- employer's policy and procedures on infection control;
- any transmission-based precautions required for the client;
- any high-risk (or invasive) procedures to be performed for the client;
- influencing factors that may affect safety when providing care in the client's home, such as client characteristics, environmental factors, equipment needs (see information above on risks and influencing factors);
- results of any hazard identification and risk assessment in the client's home environment (see checklist in appendix ??? p.00);
- results of any staff screening for infection or immune status (such as hepatitis immunity).

2. Do I have the knowledge and skills required to provide safe care to this client?

This includes:

- knowledge of standard precautions for infection control;
- training in infection control techniques, both general and client-specific;
- training in the safe use of protective clothing and equipment;
- knowledge of first aid following exposure to blood or body fluids;
- knowledge of when and how to seek assistance during care procedures and following any exposure to actual or potential infection.

3. Do I have the support and equipment needed to provide safe care to this client?

Questions to consider:

- Are gloves and other protective clothing and equipment available?
- Is advice or information available on infection control procedures?
- Is assistance available when performing any high-risk procedures?
- Is equipment available for safe disposal of contaminated waste?
- Are there sufficient handwashing facilities?
- Are there barriers to the maintenance of cleaning, housekeeping and/or hygiene standards in the client's home?

4. If hazards are not controlled and care cannot be provided without significant risk of injury, what steps can be taken?

- report biological hazards or exposure to infection to supervisor;
- seek assistance or advice prior to commencing any work;

- seek information on all practicable steps that may be taken to eliminate, isolate or minimise risk of harm, from the supervisor and/or manager and/or workplace health and safety representative and/or medical advisor;
- if assistance cannot be provided and there is significant risk of harm, advise employer that work cannot be performed safely;
- advise employer and/or health and safety representative if duty of care conflicts with safe work practice.

Further Information

NZS 8142:2000 *National Infection Control*, Standards New Zealand.

“Guidelines for Infection Control in Health Care Personnel”, *American Journal of Infection Control*, 1998.

Guidelines for Tuberculosis Control in New Zealand, Ministry of Health, 1996.

“Revised Guidelines for the Control of MRSA”, *Journal of Hospital Infections*, 1998.

Section Five: Management of Manual Handling

Overview

Employees in the health care industry, including caregivers in the community, are recognised as being exposed to hazardous manual handling, which may cause musculoskeletal disorders. Musculoskeletal disorders is a collective name for a range of conditions that affect the muscles, tendons, bones and joints. The term includes occupational overuse syndromes, back injuries and acute low back pain.

“Manual handling tasks” means any actions or activities requiring the use of force exerted by a person to lift, lower, push, pull, carry or to move, hold or restrain a person, animal or thing. It may be one part of a job.

Musculoskeletal disorders may result from:

- frequent or prolonged periods of manual handling activity (e.g. frequent or repeated moving or repositioning of clients);
- sudden damage caused by intense or strenuous manual handling or awkward lifts (e.g. lifting in confined spaces, small bedrooms, low chairs to high beds); or
- sudden damage caused by unexpected movements (e.g. trying to stop a person who has slipped or collapsed from falling onto the floor).

Risk Factors in Manual Handling

A number of factors can increase the risk of musculoskeletal disorders, including:

- size, shape and the weight of objects (if carried or held) and the forces required (if pushed, pulled or restrained);
- sudden unexpected or jarring movements;
- awkward movements, such as twisting, bending, overreaching, especially if combined with load handling;
- static postures, like holding the body or part of the body in a fixed position for a long time; and
- personal factors, such as caregiver’s physical dimensions or disabilities.

These risk factors are further influenced by:

- how long and how often the tasks are performed (e.g. repetitive actions);
- the way work is organised (e.g. ability to share loads);
- the design and layout of work environment; and

- other environmental factors such as flooring and physical hazards causing slips, trips and falls;
- the degree of familiarity with the task and associated training;
- workplace stress and fatigue through its effect on the flexibility of muscles;
- caregiver’s knowledge and beliefs about risks and subsequent behaviour;
- caregiver’s level of fitness.

A combination of the above factors are likely to influence the degree of risk.

These risk factors may be further categorised similar to those within the *Code of Practice for Manual Handling*. (Refer to later in this section for further detail on the code). The categories are:

<i>Risk Factor</i>	<i>Example</i>
Load	Handling people produces particular difficulties, such as how to hold the person, and the need to counter unpredictable movements. The degree of assistance a person can provide, their ability to comply with the handling, the degree of pain experienced, and the presence of particular health conditions can also affect the way the handling must be done.
Environment	Handling that is otherwise safe may become hazardous if there is a risk of falling or slipping. Having to walk on steps, slopes ramps or obstacles increases the risk of falls or injury from sudden, uncontrolled movement.
People	All handling requires an element of training and skill specific to the task being done. If people work by themselves they may be at increased risk of harm because there is no one to help them with the hazardous manual handling task.
Task	If assisting with client mobility, the frequency of, duration of, and access to mobility aids all will affect the risk associated with the manual handling task.
Management	Shift-work introduces specific risk factors including the effects of sleep deprivation, poor concentration, and less support and supervision. Employees should also be involved in the selection, purchase, and trialing of new equipment. Bad decisions by managers can result in equipment that is not appropriate for the job, or not used.

Risk Factors in the Home Environment

Caregivers in the community frequently have to overcome a greater variety of obstacles than their hospital colleagues.

For example, in the home environment there may be:

- restricted space, cramped bedrooms, small bathrooms;
- inadequate lighting;
- general family clutter;
- low beds or beds with sagging mattresses;
- poor floor coverings or uneven surfaces.

The worker may find themselves having to stoop, push or pull equipment over uneven surfaces, crouch down, or reach across obstacles. All these movements and positions lead to postural stresses.

Other influencing factors caregivers in the community may encounter include:

- restricted availability of help from others to assist with lifts and transfers;
- lifting training that is not easily transferable to the home setting;
- limited range of available lifting and mobility aids or equipment;
- driving to clients' homes with poorly designed car seat;
- getting in and out of a car numerous times;
- loading and unloading of equipment.

Managing Manual Handling Hazards in Home Health Care

Manual Handling Hazard Identification

To determine the nature and extent of manual handling risks to employees, a manual handling assessment is a useful starting point. To do this, the employer needs to identify the hazardous manual handling.

Systems for manual handling hazard identification may include, but are not limited to:

- checking injury, incident and hazard reports for injuries or hazards related to manual handling;
- asking employees about which manual handling tasks they consider may lead to physical strain;
- talking to supervisors about any difficulties they are aware of that their staff have experienced carrying out manual handling tasks;
- consulting with safety and health representatives on manual handling problems that they have become aware of as part of their functions;

- carrying out workplace inspections to identify any relevant contributing factors, e.g. slippery floors;
- observing the manual handling tasks.

From the collected information, identify trends or common problems. Trends may indicate particular employee groups who are most at risk, or may indicate common problems such as inability to get assistance with lifts, lack of equipment or times of the day when problems are more frequent.

The last step in this hazard control process is to find out if hazardous manual handling is present in the task. Refer to the code of practice for further information about what factors you need to look for within a task.

Identifying Hazards in a Specific Client Care Situation

Gathering information about the client and their home setting prior to care commencing is a critical factor in the management of risk.

Information to be gathered may include (but is not limited to):

- client history and needs assessment;
- client weight, level of mobility and disability, known ability to weight bear or assist in transfers, or resistance when being lifted or transferred;
- assessment of the home location and environment;
- current procedures relating to manual handling;
- availability of equipment;
- tasks to be performed.

Client Needs

Consider the characteristics and abilities of the client that may influence safety in manual handling. Consider also — has there been any history of falls? Is the client confident or anxious when transferring or being repositioned? Are there others at home who can assist with lifts and what is their level of skills? Which techniques have been recommended or are most appropriate for the caregiver and client while maintaining safety? Are these recorded in the client's care record?

Home Environment

Look at the layout, and condition of the house, furniture and fittings with consideration of factors affecting risk of injury. Assess the number, type and condition of mobility aids and lifting equipment available. Look for factors that present risks of tripping, slipping or falling. Look at lighting for both day- and night-time care giving.

Manual Handling Risk Assessment

The nature and degree of risk arising from the hazards need to be assessed and significant hazards identified in order to determine which have priority over others for further assessment and risk control.

Expert or specialist advice may be useful in making difficult or complex risk assessments and developing risk control procedures. A person with an ergonomics background may be

appropriate for helping to assess the risk, whereas a person with an engineering background may be more suitable for helping to control the risk.

Assessing Tasks

How long and how often a load is handled are important factors influencing the degree of risk associated with manual handling. The types of postures used, the workplace layout and conditions, and the weight of the object that is handled are also important in determining risk.

In assessing the risk associated with a complex task (a task with a sequence of activities) it is easier to divide the task into its various activities. Each activity can then be checked for risks in terms of weights, forces, actions, movements, the people doing the work and the characteristics of the client.

For example, a number of injuries have been associated with the task of showering a client. This task could be broken into the following activities:

- lifting the client out of bed and transferring to a wheelchair;
- pushing the wheelchair to the shower;
- transferring the client into a shower chair;
- showering the client;
- transferring the client back into the wheelchair;
- dressing the client; and
- pushing the wheelchair.

It can also be very useful to divide tasks into activities when there are no obvious practical solutions.

The degree to which the task is broken down into activities should be determined by the variability of risk factors within the whole task. This will help determine the detail with which the task should be assessed and consequently managed. There may be one risk factor that changes, such as the space available to do the activities — this should be assessed in more detail than for example, the mobility level of the client, which may not change during the task.

Client mobility may be addressed more generally overall. For example, the client may need to have a walking stick for all activities and this may be noted as such on their care plan. Under- or over-analysis of the risk factors can complicate the process.

Determining Significance of the Assessed Hazard

The *Code of Practice for Manual Handling* suggests using the risk score method for assessing the risk. If the risk score is 10 or more, assess the contributory factors to identify the hazardous aspects of the task. The *risk score* determines the urgency of the need to put controls in place.

The *contributory factors* show how to control the hazards in the task.

In the majority of cases, the risk score and the contributory factors assessment will help the employer to determine whether the manual handling task poses a significant hazard.

Please refer to the *Code of Practice for Manual Handling* for further detail.

Control of Manual Handling Hazards

The steps of hazard management are:

- *eliminating* the manual handling activities; or
- where this is not practicable, *isolating* the hazard; or
- where this is not practicable, take all practicable steps to *minimise* the risk of injury from the hazard and protect the employee.

There are a number of approaches to managing manual handling hazards, including:

Introducing Lifting Devices and Mobility Aids

Obtaining mechanical lifting devices and mobility aids can eliminate the need for manual handling. Examples include the loan or purchase of hoists, hi-low beds, frames and bars, sliding pads, swivel boards, high toilet seats, rails, walkers, commodes, and other equipment. Also ensure preventative maintenance of equipment is carried out.

NOTE: Occasionally a client may refuse to have equipment introduced to the home. Solutions may include arranging for an independent assessment of equipment needs or discussing with the client alternative ways of providing care (such as a wash in bed rather than a shower or bath with the use of a hoist). If agreement with the client and the caregiver cannot be reached then withdrawal of service needs to be considered. (See Section 2.)

Modifying the Load

Some loads being handled (e.g. boxes of equipment) can be modified or repackaged into smaller weights, or a different size or shape.

Modifying Work Environment, Layout and Equipment

Rearrange the layout or modify equipment and furniture to reduce twisting, reaching, stooping and poor application of force. Provide adequate space for handling objects and improve the lighting. Initiate needs assessment for modifications such as installation of grab rails, ramps or bathroom alterations.

Redesigning Work Rate and Pattern

In determining safe work rates, some of the factors that need to be considered are:

- physical differences between people (e.g. size and strength);
- skills, knowledge and experience of employees;
- the training that has been received;
- the type of work and the equipment available.

Redesigning an employee's work pattern may involve changing how long an activity is done, how often it is done, and how it is done. These changes should result in a wider variety of actions and postures.

In redesigning work, consider the following:

Mix of Tasks

Rotate employees or change the job to include different actions and postures as part of daily routine. Where an activity requires a long period of repetitive actions or fixed postures, and it is

not possible to vary the activity, breaks made up of other tasks should be provided. The length and frequency of breaks will depend on the type of tasks that make up the job.

Peak Demand

Many activities have predictable peak periods, with wide variations in work demand. Increased manual handling risks during these peak periods can be prevented by providing sufficient people and equipment to cope during times of increased work.

Working Hours

It may be necessary to determine whether the type of manual handling work performed is suitable for extended hours or shifts. Work that is heavy, repetitive or demanding may need further consideration.

Special Individual Needs

It can be particularly important to provide suitable work patterns for employees with special needs. For example, injured workers returning to work may require their work patterns to be modified.

4. Follow-up and Review

Follow-up and review is an essential aspect of any hazard management plan. Control measures need to be reviewed to determine if the hazard is eliminated or controlled, or if new hazards have been introduced.

- Consult with employees, supervisors and safety and health representatives involved in manual handling tasks:
 - if the controlled manual handling task or activity is resulting in reduced physical strain or difficulty;
 - where controls have resulted in any new problems; and
 - where controls have made worse any existing problems.
- Observe each changed activity to determine whether the initial risk factors have been minimised as intended; and
- Assess the changes to ensure that no new hazards have been introduced.
- Monitor accident reports to ensure problems have been resolved.
- Check whether control strategies have been used; and
- Analyse injury data for any new trends in manual handling injury.

Once follow-up information is obtained, the following questions can be answered:

- Are control strategies operating effectively?
- Are new strategies now available to be applied?
- Is further risk assessment necessary?

Employers and supervisors need to be kept informed of new technology, industry standards and guidelines for reducing manual handling risks.

If new problems have occurred, or if there has been change to the work requirements or equipment used, then further risk assessment may be required.

Reporting Back Pain and Injury Management

Employers will need to have a documented procedure on reporting incidences of back pain. Training of employees should focus on the importance of early reporting of experiences of back pain for the purpose of rehabilitation and prevention of further injury.

An injury management policy will ensure appropriate medical advice is sought at an early stage and return to work in the event of an injury is managed to promote healing and prevent re-injury.

Manual Handling Training

Two types of manual handling training are needed: general training and task-specific training.

General Training

When should general training in manual handling take place?

- (a) during induction training; and
- (b) as part of an ongoing manual handling risk control programme.

Who should attend?

Everyone involved in organising and implementing manual handling processes or tasks where hazards have been identified.

Elements of training

The level of training provided should be comparable to the risk involved. Any training should focus on the specific problems identified in the assessment process.

Depending on the degree of risk, participants should have an understanding of some or all of the following:

- the role and responsibilities of the employer, employees and others, and the consultation which should take place between employer and employees in order to identify manual handling hazards, and to assess and control risks;
- the activities included in manual handling, and the types of injuries that can result;
- the relationship between the human body and risk of manual handling injury;
- the hazard management approach to manual handling; and
- application of relevant control strategies.

A behavioural component within training can be successful. Even when aware of risks, workers may be convinced that they are not susceptible to injury. Performing an activity repeatedly without adverse effect can generate a false sense of security, and vulnerability may not be recognised. Behavioural-based interventions attempt to influence the workers' attitudes, knowledge and beliefs about occupational-related injury.

Task-Specific Training

When should task-specific training take place?

- (a) during induction to the task;
- (b) as part of refresher training; and
- (c) when work tasks are about to be changed or introduced.

Instructions need to be specific to the work situation, and as such it may be necessary to carry out training on site. Training components should include:

- advice on workers' susceptibility to injury and cumulative stresses;
- back care information – maintaining back strength and flexibility;
- recognition of environmental factors;
- basics of ergonomics and how to apply them in diverse settings;
- training in handling of clients and basic biomechanics of lifting and handling;
- training in the correct use of assistive equipment.

Guidelines for Employers, Managers and Supervisors on Manual Handling

Health and safety policies and procedures should ensure:

- information is collected in order to identify existing and new manual handling hazards;
- information on manual handling hazards is communicated to employees;
- risk from manual handling hazards is assessed, significant hazards are identified, and all practicable steps are taken to eliminate, isolate or minimise manual handling hazards and protect employees from harm;
- employees have access to, are trained in and use protective equipment and/or clothing, including any mechanical lifting devices and mobility aids;
- appropriate matching of client and caregiver occurs to minimise risk of harm from manual handling;
- employees are trained on manual handling hazards and control methods;
- supervision of employees in safe work practice occurs at a level that ensures exposure to manual handling hazards is minimised and monitored;
- client manual handling needs and methods are promptly reviewed where conditions change;
- preventive maintenance of manual handling equipment is carried out;
- reporting of manual handling incidents, accidents and injuries is encouraged;
- health assessment and treatment is provided following injury and planned return to work to promote rehabilitation and prevent re-injury.

Guidelines for Employees on Manual Handling

In order to provide safe care and prevent manual handling injuries, employees need to consider the following:

1. Do I have the information I need to provide safe care to this client?

Information required includes:

- employer's policy and procedures on manual handling;
- the recommended manual handling methods for the client;
- results of any hazard identification and risk assessment in the client's home environment (see sample checklist);
- influencing factors that may affect safety when performing manual handling in the client's home, such as client characteristics, environmental factors, equipment needs (see information above on risks and influencing factors);
- availability of assistance when performing manual handling tasks.

2. Do I have the knowledge and skills required to provide safe care to this client?

Knowledge and skills required include:

- training in manual handling techniques, both general and client-specific;
- training in the safe use of lifting equipment and mobility aids required for the client;
- knowledge of back care;
- knowledge of when and how to seek assistance in manual handling for this client.

3. Do I have the support and equipment needed to provide safe care to this client?

- who can be called on to provide assistance with manual handling?
- are the recommended equipment and mobility aids available?

4. If hazards are not controlled and care cannot be provided without significant risk of injury, what steps can be taken?

Such steps include:

- report manual handling hazards to supervisor;
- seek assistance prior to commencing any work;
- seek advice and information on all practicable steps that may be taken to eliminate, isolate or minimise risk of harm, from the supervisor and/or manager and/or workplace health and safety representative;
- if assistance cannot be provided and there is significant risk of harm, advise employer that cannot perform work safely;
- advise employer and/or health and safety representative if duty of care conflicts with safe work practice.

Further Information

OSH, Department of Labour publications:

Code of Practice for Manual Handling

Back in Care: Preventing Back Pain and Back Injuries in Caregivers

Back in Care: Preventing Musculoskeletal Disorders in Staff in Hospitals and Residential Care Facilities

Manual Handling: A Workbook

ACC publications:

Active and Working! Managing Acute Low Back Pain in the Workplace: An Employer's Guide

The Patient Guide: Acute Low Back Pain Management

Appendix One: Definition “All Practicable Steps”

Many duties imposed by the Act are qualified by the words “take all practicable steps” and it is expected that people with duties will take measures that are practicable and, by definition, reasonable.

Whether it is reasonable needs to be considered taking into account:

- The nature and severity of the harm that may be suffered if the result is not achieved. That is, how ill or severely injured a person may become if the action is not taken.
- The current state of knowledge about the likelihood of harm of that nature and severity if the result is not achieved and the state of knowledge about harm of that nature. That is, how likely it is that the harm will occur if the action is not taken and what is known about the illness or injury that could occur.
- The current state of knowledge about the means to achieve the result and the likely efficacy of each. That is, what is known about the steps that can be taken, e.g. how effective providing lifting might be?
- The availability and cost of each of these means and the limits of resources. The cost of putting resource in place should be measured against the cost of failing to do so. That failure could ‘cost’ serious injury or fatality.

Any judgment of whether a step was “reasonably practicable” should be made taking common practice and knowledge into account. If hazards and the solutions to them are widely known and applied by others in the industry, it would then be expected that they would be reasonably practicable to take.

Appendix Two: Factors Relating to Violence in the Home Care Setting

Nature of Service

Some employees in home-based settings provide health care as a result of incidents of aggression or violence. In the area of elder abuse and neglect, for example, employees may enter a home to support a client who has been subjected to aggression, threatening behaviour and/or violence and be subject to the same tactics themselves.

Client Condition

In some home-based care settings, clients and/or their family/whanau, often under stress, can be hostile and display anger or aggression or threatening behaviour. Some clients may be under the influence of drugs or alcohol. Some have behavioural disorders and/or psychiatric illnesses in which violence or aggression is expressed. Additionally, the perceived presence of narcotics and drugs in the client's home may make the client and the home care worker subject to an increased possibility of burglary.

Isolation and Working Alone

The risk of injury or harm for people who work alone may be increased because of difficulties contacting support in an emergency. The consequences may be very serious and injury may be fatal.

Time of Day

People who work at night may face added risks.

Quality of Service

Due to the service provision nature of health care in home-based settings, the quality and appropriateness of service given to the client can be a factor in work-related violence. For example, a change in service may be perceived by the client as being of lesser quality, thereby increasing the potential for violent or aggressive behaviour. A lack of sensitivity or indifference to individual client needs may also contribute to aggressive behaviour.

Stressful work situations where there are not enough employees to handle the business of the day may result in frayed nerves and short tempers. In these situations, employees may lose control of the situation more easily.

Poor-quality service may result from inadequate training, mismatch between home care worker and client, poor communication and/or lack of information, poor performance due to stress or overwork, overtaxed or under resourced facilities.

Cultural Factors

Culture has an influence on values, beliefs about appropriate and inappropriate behaviour, lifestyle choices, ethnic, religious or spiritual expression. Culture may influence:

- Clients' attitude and response to illness;

- Behaviour in relation to cleanliness and hygiene and personal privacy;
- Food handling and preparation methods;
- Clients' attitudes to parts of their body and bodily functions;
- Clients' wishes in relation to personal care and treatment.

Accurate communication is vital to avoid cross-cultural misunderstanding. As such, interpreters or family members may be required to overcome language and communication barriers.

Cultural differences can affect the risk posed by hazards, for example where culturally inappropriate behaviour of the carer results in an escalation of aggression in the client.

Environmental Factors

A change in environment can be a trigger for aggressive or challenging behaviour. For example the potential for aggression may increase when there is a change in caregiver or care procedures, or when transporting clients.

Appendix Three: Factors Relating to Infection in Home-Based Health Care Settings

Although anyone may be exposed to infection from a variety of sources, a number of factors exist that may increase a worker's risk of infection.

Nature of Work

Employees at greater risk of infection include:

- those exposed to bodily fluids including blood, urine, faeces, saliva;
- those performing invasive procedures such as injections;
- those caring for clients whose behaviour can be unpredictable or aggressive can be at greater risk of blood-borne infection through bites, scratches, spitting or other injury-causing behaviour.

Client Condition

Clients with poor personal health care practices, or who display challenging behaviour present additional difficulties when managing infectious hazards.

Worker's Condition

Women who are pregnant face a number of additional risks from infection.

Workers who have infections themselves may pass their infection onto their clients.

Workers who themselves engage in high-health risk behaviour may carry and pass on infection.

Workers who are unwell, stressed, tired or are otherwise immunocompromised (e.g. are on steroids or other chemotherapy) may be at increased risk of infection.

Level of Experience and Training

Those with less experience and training are more likely to engage in unsafe practice when providing care and more likely to be exposed to infection through accidents, such as through needlestick injuries.

Environmental Factors

These include but are not limited to:

- general level of cleanliness and hygiene in the client's home;
- presence of animals or vermin;
- handwashing facilities;
- time of day – workers who are tired are more likely to have needlestick injuries;
- space constraints and lighting when performing invasive procedures.

Access to and Use of Safety Equipment

Factors include:

- availability, associated training and use of gloves, masks, goggles, protective clothing;
- sharps containers and other safety equipment;
- appropriate use of needleless systems and/or safety syringes.

Waste Management

Transport and disposal and/or cleaning of waste, soiled linen, clothing, equipment, needles.

Appendix Four: Blood/Body Fluid Incident Assessment Aid

	HEPATITIS B	HEPATITIS C	HIV
What is the risk of transmission after significant exposure?	30%	Average transmission rate of 1.8% ¹	0.3 ¹ %
Is immunisation available?	YES	NO	NO
Does OSH strongly suggest pre-employment screening and immunisation if antibody negative?	YES	No immunisation available	No immunisation available
What should happen after exposure?	<ol style="list-style-type: none"> 1. Carry out an incident risk assessment, as per the method outlined below. 2. Check the antibody status (HBVsAb) of the person exposed – if positive on baseline, no further HBV assessment is required. 3. Check the status of the patient/source. If HBsAg negative, no further HBV assessment is required. 4. If the patient/source is positive or unknown and the incident is classed other than low risk, offer immunoprophylaxis. 5. Offer an HBV immunisation course. 6. Follow up-antigen/body status at 12 weeks post-exposure or on symptoms. 7. Discharge from follow-up if staff member does not develop evidence of an infection at this stage. 	<ol style="list-style-type: none"> 1. Carry out an incident risk assessment, as per the method outlined below. 2. Check the antibody status of the affected staff member. If positive on baseline, refer to an infectious diseases consultant. 3. Check the status of the patient/source. 4. If the patient source is positive or unknown and the incident is higher than medium risk, check the HCV antibody, PCR and LFTs monthly for 3 months. 5. If the staff member's PCR or HCV antibody becomes positive or develops raised LFT, refer to the infectious diseases consultant for consideration of Interferon therapy². 6. If negative at 3 months, repeat tests at 6 months post-exposure. 7. Refer if positive. 8. Discharge from follow-up if staff member does not develop evidence of an infection at this stage. 	<ol style="list-style-type: none"> 1. Carry out an incident risk assessment, as per the method outlined below. 2. Check the antibody status of the staff member. If positive on baseline, refer to the infectious diseases consultant. 3. Check the status of the patient/source. 4. If the patient source is positive or unknown and the incident is higher than medium-risk, discuss with the infectious diseases consultant about prophylaxis. (Must be initiated within 24 hours of incident. Recommended to start within 2 hours of incident.) 5. Whether prophylaxis is prescribed or not, check HIV antibody status at 6 weeks, 3 months and 6 months. Refer if positive. 6. Discharge from follow-up if staff member does not develop evidence of an infection.

¹ Centres for Disease Control and Prevention. "Risk of Acquiring Hepatitis C for Healthcare Workers and Recommendations for Prophylaxis and Follow-up after Occupational Exposure". *Hepatitis C Surveillance Report No 56*, Atlanta CDC, 1995 3 - 6.

² Payton C. "Biological Hazards: an Overview" – In-depth review *Occupational Medicine* 50 (6) 375 – 6, 2000.

³ Stevens AB, Coyle PV. "Hepatitis C Virus: An Important Occupational Hazard?" – in-depth review *Occupational Medicine* 50 (6) 377 – 382, 2000. Stevens comments that patients most likely to clear the virus after treatment are those with non-1 genotype, low viral titre and minimal liver inflammation. He notes that it is proposed that early treatment of acute hepatitis increases the likelihood of clearing infection.

To use this method to find the risk of a BBFI, establish separate factors for the patient source, the incident and the staff member. Then multiply the three factors together. Compare the result with the assessments below the table. The calculation really needs to be done for each illness that is being considered.

PATIENT SOURCE	INCIDENT	STAFF MEMBER
Known HBV negative Known HCV negative Known HIV negative (No further action required of this incident but check staff HBV status and reinforce “safe behaviour at work” principles.) FACTOR VALUE = 0	Superficial injury (no bleeding). Exposure of staff member’s closed wound, conjunctivae or mucous membrane to any body fluid other than blood or blood contaminated fluid. Prolonged contact over large areas of intact skin. Skin wound due to human bite. Needlestick from a needle used at an IV port not visibly contaminated with blood. Injury with instrument not visibly contaminated with blood. FACTOR VALUE = 1	HBV Abs positive (value as 0 for HBV risk). While use of PPE and effective first aid will reduce risk, it does not affect rating.
Known HBV positive & unknown other status but not considered likely HCV or HIV positive OR Unknown status but not considered likely HBV, HCV or HIV positive. FACTOR VALUE = 5	Superficial injury (causing bleeding) from instrument visibly contaminated with blood. Exposure of staff member’s open wound or conjunctivae to blood or body fluid visibly contaminated with blood. Needlestick from a needle used at an IV port visibly contaminated with blood. Exposure of staff member’s closed wound to blood. FACTOR VALUE = 5	HBV Abs unknown or negative. While use of PPE and effective first aid will reduce risk, it does not affect rating.
Known HCV or HIV positive OR Unknown status but considered likely HCV or HIV positive. FACTOR VALUE = 100	Deep, penetrating injury from hollow bore needle contaminated with blood, particularly if flushed into staff member i.e. an injection occurred ¹ . In PCR positive HCV patients, exposures following solid organ or bone marrow transplantation are strongly (84%) associated with transmission ² . FACTOR VALUE = 10	HBV unknown or negative. While use of PPE and effective first aid will reduce risk, it does not affect rating. Staff member immunosuppressed (steroids, chronic disease, etc.) FACTOR VALUE = 10

HBV RISK = _____ 0 = likely no risk, > 0 start immunisation for HBV, > 5 consider immunoglobulin for HBV.

HCV RISK = _____ 0 = no risk, > 5 enrol in HCV recall and discuss with an occupational health physician.

HIV RISK = _____ 0 = no risk, < 125 enrol in HIV recall, > 125 discuss with an occupational health physician and consider prophylaxis.

¹ Cardo DM, Culver DH, Ciesielski CA et al. “A Case-control Study of HIV Seroconversion in Health Care Workers after percutaneous exposure”, *NEJM* 337 (21) 1997 1485 - 90.

² Payton C. “Biological Hazards: an Overview”, *Occupational Medicine* 50 (6) 375 - 6, 2000.

Appendix Five: Checklist for Health and Safety Systems

To use the checklist, consider each hazard type as if it were in the space marked ———. You may wish to copy this document and add to it for other hazard types. The space under each “Hazard” column is only one example, there will be numerous other issues that will be pertinent and may require a policy or procedure to be put in place. The listed suggestions are not limited.

<i>Policy and Procedure</i>	<i>Behavioural Hazard Control Example</i>	<i>Biological Hazard Control Examples</i>	<i>Manual Handling Hazard Control Examples</i>
Information is collected in order to identify existing and new ——— hazards.	Include client history and needs assessment, any known contributing factors and management techniques used.	What infectious conditions are employees managing?	What manual handling is required and does the environment preclude the use of safe handling techniques?
Information on ——— hazards is communicated to employees: ensure compliance with the Privacy Code.	Prior to them commencing work and when there is a change in the client's condition.	Prior to them commencing work and when there is a change in the client's condition.	Prior to them commencing work and when there is a change in the client's condition.
Risk from ——— hazards is assessed, significant hazards are identified and all practicable steps are taken to eliminate, isolate or minimise ——— hazards and protect employees from harm.	Remote location and high risk clients for challenging behaviours may warrant the use of personal alarms, higher staffing levels and frequent employee supervision.	Poor personal hygiene and inadequate handwashing facilities may warrant extra services to be provided for personal care and domestic cleaning services.	Stairway access to and within the house of a client using mobility aids may, in the interim, warrant two employees attending the client until adequate modifications can be made. Preventive maintenance of manual handling equipment.
Purchasing and maintenance of equipment: backup equipment in case of failure.	Personal alarms and regular testing of such equipment.	Needleless systems and disposal containers.	Electric and manual hoists.
Employees have access to and are trained in the safe use of personal protective equipment and/or clothing.	If attending client's outdoor day programmes, has adequate clothing and protection from extreme temperatures.	Employees have access to, are trained in and use protective equipment and/or clothing, gloves, masks, sharps containers.	Footwear and clothing that allows safe and free movement.
Appropriate matching of client and caregiver occurs to minimise risk of harm from ——— hazards. Hazard and health monitoring is required to ensure minimisation strategies are effective.	Ensure that the employee has knowledge of the way the client may respond to the medication that they are receiving. (i.e. the employee's knowledge is matched to the client needs).	Ensure that the employee does not have a suppressed immune system (i.e. the employee's health is matched to the client's health status).	Ensure that the employee has adequate musculoskeletal function to do the work.

<i>Policy and Procedure</i>	<i>Behavioural Hazard Control Example</i>	<i>Biological Hazard Control Examples</i>	<i>Manual Handling Hazard Control Examples</i>
Training of employees on ----- hazards and control methods.	Calming and restraint, or other appropriate courses and refresher courses.	Use of a needleless system for administration of medication.	Include mechanical lifting devices and mobility aids.
Supervision of employees safe work practice occurs at a level that ensures exposure to ----- hazards is minimised and monitored.	New graduate employees are trained in the appropriate response to challenging behaviour and have their responses reviewed within an appropriate period of their appointment.	New appointments, regardless of background, have their ability to manage infection monitored and modified where necessary.	Periodic supervision of employees occurs where injury rates have increased, with a view to reviewing the hazard management procedures.
Preparedness for general (e.g. fire) and specific ----- emergencies are effective.	Test the personal and other alarm procedures regularly.	Ensure that there is an effective response to needlestick injuries in place.	Ensure that there are adequate reporting and return to work procedures.
Reporting of ----- incidents, accidents and injuries occurs. Health assessment and treatment following injury and planned return to work to promote rehabilitation and prevent re-injury.	Debriefing, support, and counselling occur where there has been an exposure to violence has occurred.	Following incorrect drug administration, attendance at an appropriate refresher course.	Following back injury, an investigation identifying unforeseen cause results in review of care plan for a client.
Contractors know about and have systems in place for managing ----- hazards.	The principal checks for compliance and identifies policies and procedures that address the above issues amongst others.	The principal checks for compliance and identifies policies and procedures that address the above issues amongst others.	The principal checks for compliance and identifies policies and procedures that address the above issues amongst others.