



Aged Care Association  
Australia-NSW



Aged & Community Services  
Association of NSW & ACT

# PROJECT REPORT

# Manual Handling Audits of Aged Care Facilities

November 2008

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### Foreword

The Aged & Community Services Association of NSW & ACT and the Aged Care Association Australia - NSW represent approximately 95% of the sector's employers within NSW and the ACT. This covers a combined membership of 933 residential aged care facilities in metropolitan and regional areas across NSW. All facilities, whether part of larger organisations or small, independent facilities, operate within the same regulatory framework.

Aged care industry is a major employer in NSW, particularly in regional areas. The industry has for many years experienced a skill shortage, most specifically in qualified staff such as registered nurses and allied health professionals. This is even more critical in some areas as unemployment rates are at an all time low. The industry has embarked on a number of strategies to combat this, including investing in education to both attract staff to, and retain in the industry.

Aged care is mainly funded by the Australian Government and almost all of its income sources are subject to government control. With fixed sources of revenue the aged care providers have limited degrees of ability to provide additional resources, training and expertise.

Whilst some progress have been obtained through the assistance of previous WorkCover Assist funding, a significant proportion of improvements and best practices have also been achieved by providers despite the constraints of funding.

For over a decade, the industry associations have partnered with WorkCover NSW to research, develop, implement and monitor strategies that assist employers to better manage occupational risks. This report, targeting manual handling, is part of the ongoing commitment to make aged care workplaces, safer workplaces.

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### Executive Summary

Despite interventions in recent years, injuries from manual handling remain a significant risk for staff working in aged care and a significant cost for employers and the industry.

This project, funded by WorkCover NSW through the Assist Grants, involved auditing 32 aged care facilities to provide a snapshot of how manual handling is being managed. The information obtained will enable the industry to benchmark manual handling performance and provide a framework for targeting solutions to address this significant occupational issue.

The focus was on manual handling, however the scope was broadened to encompass associated risks to staff from occupational overuse, and musculoskeletal injury potential from slips, trips and falls and resident aggression.

The audit highlighted a number of key strengths, including:

- All facilities that participated in the audit had policies and programs aimed at reducing manual handling risk.
- All facilities had staff allocated to OHS, manual handling and/or education roles.
- All facilities had resident handling equipment.
- All facilities had mechanisms for managing resident handling issues, specifically through resident assessment.
- Resident aggression was managed very well.
- In a few facilities, Board members were taking very active, hands on roles in managing OHS issues, including manual handling, and
- Several facilities have implemented a range of *best practice* interventions, some of them novel, but all effective in addressing manual handling issues - a selection of these strategies are included in the report.

The audit also highlighted areas where manual handling was not managed well. Some of these reflect the industry struggling to keep pace with the changes in aged care, others reflect issues of management. The key weaknesses identified include:

1. **Risk Management:** None of the facilities had been assessing manual handling risk in accordance with the legislation.
2. **Supervision:** Managers and supervisors are not supervising effectively. Almost no supervision of non care tasks.
3. **Small operators:** Smaller, stand alone facilities are struggling to research and implement OHS.
4. **Incident investigation** is very poor.

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5. **Consultation** - while the majority of facilities had a range of communication strategies, these did not conform to requirements for consultation i.e. strategies were often one-way. There was no monitoring of strategies communication outcomes as part of quality.
6. **Purchasing** was generally good, however for the facilities belonging to groups, purchasing was often centralised and this had some inappropriate outcomes. Consultation prior to refit or building work was very poor.
7. **Aggression** from relatives is increasing and not being dealt with at all - most affecting senior staff and largely going unreported.
8. **Registered nurses** generally do not practice safe patient handling.
9. **Documentation** - excessive documentation, often duplicated, generally of poor quality with little understanding of the implication of what is written.
10. **Staff levels** - no consistency, even within some workplaces. Some procedures were unworkable with staffing levels e.g. two to use hoist when only one person on duty.
11. **Education** - training provided for carer/nursing staff, almost none for others. Over-assessing of carer/nurses and quality generally poor - skill assessment not competency assessment. Very little training for RNs.
12. **Introduction of computerisation** is generally poor with almost no consideration of ergonomics including software design, furniture, equipment and environment.
13. **Age of Staff** - Many facilities engage both young workers, those under 18 years, and older workers, those over 55 years. While age should not preclude employment, risk control measures must be robust as injuries to these workers tend to be more significant.
14. **Facility design** - The design of resident care areas has significantly increased the space requirements so that staff have to walk, and move residents and equipment over significantly larger distances, increasing handling risk. Storage continues to be a problem, both in quantity and placement.
15. **Low Care** facilities are increasingly accommodating high care residents. Care staff do not have anywhere near the level of training in resident handling that high care staff receive, nor do they necessarily have suitable resident handling equipment.
16. **Bariatric Residents** - Very few facilities are being designed to consider bariatrics, or the care of the morbidly obese resident.

This report provides a focus for employers as well as an opportunity for the industry to further advance manual handling performance and control this significant risk.

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### Definitions

#### Manual Handling

Manual handling is defined as any activity requiring the use of force exerted by a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any animate or inanimate object.

Source: c 79, OHS Regulation 2001

#### Manual Task

A manual task is physical work activity and can comprise, wholly or partly, any activity requiring the person to use his or her musculoskeletal system in performing work. It can include:

- the force for lifting, lowering, pushing, pulling, carrying or otherwise moving, holding or restraining any person, animal or object
- repetitive actions
- sustained work postures, and
- exposure to vibration

Source: National Standard for Manual Tasks, ASCC, 2007

#### OOS

Occupational overuse syndrome, also known as repetition strain injury or RSI, is a collective term for a range of conditions characterised by discomfort or persistent pain in muscles, tendons and other soft tissues, with or without physical manifestations. It is usually associated with tasks that involve:

- repetitive and/or forceful movement, and
- sustained, awkward postures.

Source: National COP for the Prevention of Occupational Overuse Syndrome, NOHSC, 1994

#### Bariatric

An internationally accepted term applied to patients whose weight far exceeds recommended guidelines, and where body size restricts their mobility, health, or access to available services. The patient's weight increases morbidity and mortality, and causes numerous care challenges.

Source: OHS Issues Associated with Management of Bariatric (Severely Obese) Patients  
NSW Health Guideline, 2005.

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### Introduction

#### Background

Over recent years there have been significant changes in aged care, including increased dependency of residents. These changes have had an impact on the way work is done, the tools and equipment used, and the environments in which the work is done.

Despite interventions to address manual handling, injuries from manual handling remain a significant risk for staff working in aged care and a significant cost for employers and the industry.

This project was proposed to provide greater insight into the causes of manual handling incidents and injuries in residential aged care facilities. The information obtained will enable the industry to benchmark manual handling performance and provide a framework for targeting solutions to address manual handling in this industry.

This project, which had a working title of *Digging Deep for Data*, was funded through a WorkCover NSW Assist Grant and overseen by the Aged Care OHS industry Reference Group.

#### Project

The project involved auditing 32 aged care facilities across NSW. The focus was on manual handling, however the scope was broadened to encompass occupational overuse, and musculoskeletal injury potential from slips, trips and falls and resident aggression.

The scope embraced all areas within the aged care environment and was not limited to reviewing issues relating to direct care i.e. addressed manual handling as a risk for all staff.

#### Objectives

The key objective of the audit was to provide a snapshot of how manual handling was being managed in residential aged care facilities, including:

- exploring the recent causes of manual handling / OOS injuries, and

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- determining how manual handling is being managed, both from a preventive aspect and post incident.

Data from the audit was intended to provide direction for developing future strategies for the prevention and management of manual handling injury in this industry.

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### Audit

#### Facilities

Thirty two [32] aged care facilities participated in the audit. The facilities were invited by the industry associations, based on the following criteria:

- all facilities were members of one of the employer associations
- representation from the range of residential aged care facilities - group, stand alone, private, not-for-profit, small [<50 residents] and large [> 51 residents]
- representation from low care, high care and mixed care facilities
- all facilities were required to have had at least one MH injury during the 2007 financial year
- only one facility per group was permitted, and
- all facilities had to volunteer, or be volunteered by their parent organisation, and had to agree to complete an action plan following the audit.

The audit included both metropolitan and regional residential aged care facilities, specifically:

- Metropolitan - 15 facilities located throughout the Sydney regions - North, South, Inner West, West and East
- Central Coast - 5 facilities
- Hunter and New England - 3 facilities
- Illawarra - 2 facilities
- Far North Coast - 2 facilities, and
- 1 facility from each of the following regions - South Coast, Mid North, Far West, Riverina and Central West.

Due to the nature of the audit, and the importance of obtaining valid and reliable information from individuals and facilities, it was agreed that individuals would not be identified in the audit report. While the OHS Reference Group and the Industry Associations are aware of the facilities that participated in the audit, it was also agreed that these facilities would not be identified in this project report, or any reports or presentations relating to this audit.

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### Auditors

Four auditors were involved in the project:

**Project Coordinator:** Louise Whitby, *Louise Whitby and Associates Pty Ltd*

Christine Aickin, *Workability Pty Ltd*

Marcia Lusted, *Ergonomics Australia Pty Ltd*

Lea Maher, *LMA - The Safe Move Pty Ltd*

All auditors are OHS professionals and/or ergonomists, all have health backgrounds [either nursing or physiotherapy], and all have been involved extensively in developing materials relating to manual handling for the health industry. Three of the auditors have qualifications in OHS auditing and all have conducted audits previously.

For the initial four audits, the auditors teamed up in pairs to ensure consistency in approach. For the remaining audits, only one auditor undertook the audit.

Auditors were precluded from undertaking audits of any facilities for which they had a conflict of interest, specifically where the auditor may have undertaken consulting work, an immediate relative as a resident of the facility, or where they have prepared expert reports in common law matters associated with the facility. Given the background of the auditors, it was not possible to exclude the possibility that the auditors may have trained key personnel in the facilities they were allocated e.g. OHS Leadership and Change program, attended seminars or workshops in manual handling.

### Audit Criteria

The audit addressed four criteria:

- 1 management commitment
- 2 communication
- 3 risk management, and
- 4 information, training and supervision

The auditors used a standard survey instrument to address each of these criteria in detail - refer to Appendix 1 for the Audit Tool.

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Guidelines were forwarded to all participating facilities on the approach to be taken for the audit, the documents required and the personnel with whom the auditors would need to consult - refer to Appendix 2.

### Audit Process

The audits commenced on 9 October 2007 and were completed by 28 November.

The audit was conducted over one day and involved:

- on-site meeting with management and key people including the OHS Coordinator / Chair OHS Committee / HSR
- examining and evaluating documentation, such as OHS policies and procedures, risk assessments, reports and records of action to implement controls, training records and injury/incident records
- conducting focus groups/interviews with employees and supervisors to determine issues, effectiveness of controls
- interviewing employees who had sustained manual handling or OOS injury within last 2 years [if not at work, phone interview - again voluntary participation]
- reviewing operating procedures, training and supervisory practices and other risk control methods
- conducting an exit meeting with the manager.

A draft report was prepared for each facility. Facilities had the opportunity to discuss any issues directly with the auditor before preparing an action plan to address the issues raised in the report. Guidelines for the Action Plan are included at Appendix 3.

Once the action plan was received, the report was finalised. All reports were finalised on 8 February 2008.

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### Discussion

The following is a general discussion of the information gleaned from the audit, including demographics information. The key information is referenced against the audit criteria.

### Demographics

The facilities reflected the broad range of residential aged care facilities in NSW, including high care, low care, stand alone, group etc. While many of the facilities had community programs such as DVA Nursing and Community Aged Care Packages, this audit was specific for residential facilities and did not address care issues in the community relating to manual handling.

All facilities were accredited with the aged care accreditation agency. The smallest facility audited had 30 beds and the largest over 200 beds.

Over 50 percent of facilities audited had participated in the premium discount scheme, achieving between 10% and 15% reduction to premium.

Two facilities employed all personnel who worked on-site, only contracting specific trade services such as plumbing. However, the majority of facilities employed core employees such as nursing, office, catering and cleaning but engaged professional services on contract, including nursing [agency], physiotherapy, massage therapist, diversional therapist, podiatrist and hairdresser. Some facilities contracted labour for specific functions such as catering, maintenance and laundry.

All facilities utilised the services of volunteers.

The process for staff allocation remains a mystery. There was no consistent approach or ratio, even between wards/units at the same facility. In most cases, staff allocation was historical i.e. 'that's the number of people we have always had'. The single determinant common to all facilities was funding allocation i.e. the number of staff rostered was based on the funding allocated for that workplace.

Several of the facilities participated in training of Certificate II Aged Care Work students who were still in high school. All accepted nurses who were under 18 years. Many facilities

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currently employed staff in both care and non care work who were under 18 years, including on traineeships.

One facility had all employees aged under 55 years. However, over half the facilities had several employees aged over 65 years and one facility had an employee aged 76 years.

All facilities had at least one manual handling injury in the 2007 financial year. Two facilities had had an investigation of an incident by either WorkCover NSW or the NSW Nurses Association. No facility reported receiving a Notice for manual handling related issues. No facility reported being aware of any impending common law action for manual handling or related injury.

### Management Commitment

*Management demonstrates commitment to ensure the workplace has systems to reduce the potential for injury from manual handling and related risks [OOS, slips, trips and falls and resident aggression].*

All facilities had OHS policies and most had separate manual handling policies. While generally these policies outlined requirements consistent with legislative requirements, none of the policies reviewed embraced all of the considerations. Specific deviations included:

- policies that are not aligned with NSW legislative requirements, specifically in respect to the requirements of Cc 79-81 of the OHS Regulation 2001
- policies that did not include any reference to consultation
- policies that did not include commitment to supervise
- policies that did not include consideration of manual handling in purchasing, including contracts with external providers and on-hire labour suppliers such as nursing agencies
- policies that did not include consideration of manual handling in design and fitout of the facility
- policies that did not include consideration of young, older, and special needs workers e.g. pregnant staff or injured employees, and
- policies that only addressed resident handling.

Only two facilities included the prevention of occupational overuse in their policies. This is relevant in both care and non care roles.

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Almost all facilities had a falls prevention policy, however without exception, this was limited to falls of residents. Given the age of the staff, the consequence of staff falling is at least as significant as the risk to residents.

Many facilities had a policy on resident aggression. Again, the focus was on the resident, with little reference to the potential injury to staff. However, of significance were the reports from several facilities of the problem of aggression by relatives and the perceived lack of guidance and support from the employer in addressing this issue. It was reported that aggressive and threatening behaviour by relatives was often directed to care managers in private, without witnesses. Such managers indicated reluctance to involve police so as not to disadvantage the resident. However, it was reported to the auditors that the over-riding reason was that the manager did not believe that the employer would back them if police were involved.

### Communication

*Management is committed to consultation on manual handling. Opportunities are provided for employees and residents to express their views.*

All facilities had formal consultation processes with employees that included:

- OHS Consultation Committees, or agreed arrangements
- minuted staff meetings
- daily communication e.g. handover for care staff, communication books, intranet / email

However, apart from OHS Consultation Committees, there is little evidence that these strategies are consultative. While management generally considered that staff had opportunity to raise issues at staff meetings, staff often reported that they were told what was going to happen rather than being included in the decision making process. Staff meeting minutes generally record outcomes rather than record discussion, which would provide some evidence that staff had the opportunity to express opinions on matters raised.

At smaller facilities, there was little evidence of general communication / consultation between quarterly staff meetings and this has significant implications for alerting changes to work practices.

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Some larger facilities had meetings with night duty, which included discussion on manual handling issues. Many facilities had also conducted staff surveys that included manual handling specifically.

All facilities had communication processes with residents / their representatives which included formal meetings. However, OHS and manual handling specifically were not discussed at these meetings. Some facilities provide a resident handbook, some of which included information on resident handling and OHS.

Consultation prior to purchasing was generally satisfactory if the evaluation and consultation was managed in-house at a specific facility e.g. trialling new beds. Group facilities, however, did not generally manage this well as equipment tends to be standardised across the group, and while consultation may have occurred, it did not necessarily involve trials or consultation at all facilities in the group. Hence, there were some significant examples where equipment was purchased that was unsuitable e.g. electric beds that did not fit.

Almost all facilities had undergone some major building work in recent years. Apart from some notable exceptions that are indicated in the Best Practices section, consultation throughout this process was very poor. In many facilities, staff were not even shown the plans until after the work had been approved and there were no opportunity for changes. The consequences at many of the facilities was that there were significant post occupancy problems which impacted on care delivery and/or placed staff at significant risk of injury e.g. entrance to a new wing was too narrow so that none of the new electric beds could fit through the door, new floor surfaces that required treatment to increase slip resistance.

## Risk Management

### Manual Handling

While mechanisms exist in all aged care facilities for manual handling hazards to be reported, such reports are very few. In contrast, maintenance issues / repairs are very well reported and addressed.

Staff, including management, do not appear to have the knowledge to identify manual handling hazards, except if they can be addressed as maintenance issues. The introduction of computerisation to care environments is a good example - in all but two facilities, this has been managed very poorly because it is not even recognised as a potential problem.

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For the few hazards that are identified, there is a process for controlling the risk. In most cases, there is no risk assessment, hazard identification proceeds straight to control. While there were a few examples of well constructed and effective risk assessment, in all cases these assessments did not comply with legislative requirements outlined in C 81 of the OHS Regulation 2001. Generally, the risk management process was poorly attended, with little understanding of the documentation. Further, risk assessment did not always involve consultation with the people actually performing the work, nor did it involve residents or volunteers where such involvement would have been appropriate e.g. modifications to the bus, selection of beds, resident furniture, changes to equipment in laundries. As a consequence, risk controls are not altogether effective.

Another factor is that where higher order controls are required, which generally involved financial investment, there were very few considerations of interim solutions to mitigate the risk e.g. changes to work practices. The work practice continued until the control was available. It was accepted, and expected, that work still had to go on, despite it being considered unsafe.

Another issue is that management is not aware of some of the work practices that are occurring, particularly in the non care areas. While many of the facilities had adopted minimal/safe handling practices for the care environment, other areas such as the laundry, kitchen and particularly maintenance, were doing all the heavy load handling. One notable example was where maintenance were lifting 240 L Sulo bins full of glass bottles onto the back of a utility truck to take for recycling, a task they had been doing every week for years.

Many facilities do have safe operating procedures, however these do not always address the manual handling issues. In many cases, these are generic and have not been adapted for the specific workplace.

### Resident Handling

Hazards associated with the handling of residents were identified, assessed and well controlled generally. Most facilities had a structured program for resident assessment, including initial assessment by a physiotherapist. Some facilities had physio aides to assist in this process. Most facilities had programs for dealing with resident aggression.

While many facilities have provided a range of resident handling equipment, the availability of the equipment can still create problems for users. Storage and accessibility continue to be a

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problem, particularly as facilities are spread over much larger areas and equipment has to be moved over longer distances.

There was also a problem in some facilities with redundant equipment - equipment no longer used. This equipment tended to clutter up storage areas or transform functional areas into temporary storage bays e.g. bathrooms when not in use.

There were also examples where it is impossible for staff to comply with work procedures involving the use of equipment. Examples include:

- Falls policies that require staff to let patients fall rather than trying to prevent the fall are totally impractical. It is a natural reaction to respond to prevent a fall and staff must be trained how to do this safely [fall deceleration techniques].
- Handling procedures that specify two staff to operate resident handling equipment, such as hoists, when only one person is rostered to work in the area.

Another area that the industry has not really addressed well is the care of bariatric residents. While safe working loads are known for hoists and beds, general furniture such as dining chairs, resident lounges, shower chairs etc. do not have known safe working loads. No facility had rooms designed or equipped for accepting bariatric residents.

Further, with the increased dependency of residents, furniture supplied in common areas is often inappropriate and makes assisting residents difficult e.g. dining chairs are not designed to be pushed under load to get the resident into or up from the dining table. Very few facilities had identified this as a problem or attempted to control this risk.

### Incident Investigation

One of the ways hazards are identified is through the reporting of incidents. While all facilities had procedures and documentation for the reporting of incidents, the investigation of these staff incidents, which is effectively risk assessment, was universally poor.

While the documentation is appropriate, it was apparent that management and supervisory staff in all but two facilities, have no training in incident investigation and this is evident in the comments for corrective action, which were limited to counselling, behavioural modification or recommending further training.

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Many facilities are relying on their OHS Committee, which meets quarterly, to investigate the incident. This is inadequate.

In contrast, incidents involving residents were generally well investigated and controls put in place promptly. Resident and staff incidents were combined at several facilities - this hampered the investigation process and staff incidents were not investigated unless they proceeded to workers compensation.

### Information, Training and Supervision

All facilities had an induction program for new staff that included an introduction to manual handling, although for carers the focus was on resident handling, work procedures and use of resident handling equipment.

Many of the facilities were using the *Manual Handling in Aged Care* training programs as the basis of their training. Only one facility was using the updated *Manual Handling for Nurses* package, released in 2006.

For staff involved in resident care, all facilities considered their training to be competency based. However, in practice this is for the most limited to skills assessment e.g. can the carer use the hoist / slidesheet. Competency encompasses knowledge, skills and attributes - it is not just skills assessment. Very few facilities provided evidence of compliance with workplace training and assessment protocols which comply with competency requirements, specifically including:

- skills training
- supervised practice in real environments, and
- assessment of competency, not just skill, sometime after adequate practice.

Training is referenced in the OHS legislation as follows:

- **OHS Act 2000, s8 1[d]** requires employers to provide such information, instruction, training and supervision as may be necessary to ensure the employees' health and safety at work,
- **OHS Regulation c 80 (2)(c)** of OHS Regulation 2001 requires an employer to ensure the persons carrying out manual work tasks are trained in manual handling techniques, correct use of mechanical aids and team lifting procedures appropriate to the activity.

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The Aged Care Standards reference training as follows:

- **Standard 1.3 Education** - that the knowledge and skills of all staff are regularly assessed and documented
- **Standard 4.5 OHS** - that equipment used is fit for the purpose intended, well maintained and staff trained in its use.

Competency-based training is the current standard for workplace training. WorkCover NSW has funded projects to produce manual handling competencies for nurses, and a training package that supports these competencies. Nevertheless, competency-based training is neither specified in the legislation nor in the Aged Care Standards.

The only reference to competency in the Aged Care Standards is in **Assessment Module 8**, which is guidance material and does not form part of the Standards. This includes a reference to competency, specifically for staff qualifications and skills that there is evidence of education and competency records.

Facilities are also under the impression that they are required to reassess competence every year. The only reference to regular assessment is under Standard 1.3 of the Aged care Standards. There is no requirement to reassess staff for the same skills. This is contrary to the whole philosophy of competency based training - once competence is achieved, reassessment is not required unless there is evidence of non-compliance. This does not mean that retesting is required to ensure compliance, otherwise there would be an annual retest for driving licence, or trade qualifications.

Repeating the same training, year after year, devalues the training. Further, it does not provide new skills, which is central to the philosophy of competency training. This is a significant cost for the industry and is definitely not producing the improvements in *competence* expected.

While carers were generally subject to over-training, the opposite was true for non carer staff. The majority of facilities provided some manual handling training at induction, however several facilities provided no training at all for non-carer personnel.

Only two facilities had included OHS considerations in any training provided to staff to introduce computerisation.

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Training for registered nurses in OHS responsibilities and supervisory skills is almost non-existent. Refer to comment in previous section on incident investigation. Further, in all but a few facilities, it was clear that registered nurses do not either know or practice safe resident handling. Nor are registered nurses being assessed for competency. Yet, registered nurses are supposed to supervise.

Many facilities rely on agency nursing personnel. It is not possible or practical for facilities to orientate each agency nurse, particularly if the position is anticipated for a single shift. While for ward staff this may not be a problem as work procedures can dictate that staff work in pairs, however it is a problem if agency personnel are paired together due to lack of available in-house staff, or if the agency nurse is the nurse in-charge for the shift.

Supervision is generally poor as most carers work in pairs, with care to residents generally provided in private. In-charge nurses are also allocated their own work. Some nurse educators worked with nurses to assess competence, but this was rare, and it is not the role of the nurse educator to supervise. Supervision of non-carers was almost non-existent, except in very large facilities where there are managers for some departments such as catering, cleaning. There is no supervision of maintenance, and in some facilities this was where there were significant manual handling risks evident e.g. lifting electric beds, handling bins, installing clothes dryers in independent units.

The standard industry qualification to deliver training and assess personnel for competence is the Certificate IV in Training and Assessment [TAA], or its predecessor. While many of the nurse educators have this qualification, the physiotherapists delivering and assessing manual handling training generally do not. While some of the physiotherapists have done courses in resident handling through their professional association, many of the nurses have done no training in manual handling or resident handling. For the nurse educators, manual handling is only one of their topics they are required to provide training in, however many are under-resourced and under-trained.

Further, some facilities have appointed staff as coordinators for manual handling or OHS. While this is to be encouraged, as it provides opportunities for development for individual staff, it is also important that these staff have training in the role and are adequately resourced.

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### Key Findings

The audit highlighted a number of key strengths, including:

- All facilities that participated in the audit had policies and programs aimed at reducing manual handling risk.
- All facilities had staff allocated to OHS, manual handling and/or education roles. Some staff had done training, including **OHS Leadership and Change** or **Trainer Workshops in Patient Handling**. All educators had workplace training qualifications.
- All facilities had a range of resident handling equipment.
- All facilities were managing resident handling issues very well, with resident assessment a central component. Also managing falls risk for residents well.
- In a few facilities, Board members were taking very active, hands on roles in managing OHS issues, including manual handling. This is largely due to the **Boardsafe** program, and
- Several facilities have implemented a range of *best practice* interventions, some of them novel, but all effective in addressing manual handling issues.

The audit also highlighted areas where manual handling was not managed well. Some of these reflect the industry struggling to keep pace with the changes in aged care, others reflect issues of management. The key weaknesses identified include:

1. **Risk Management:** None of the facilities had been assessing manual handling risk in accordance with the legislation. Where risks could not be controlled immediately, facilities did nothing to mitigate the risk temporarily.
2. **Supervision:** Managers and supervisors are not supervising effectively, in part due to the fact that they have their own duties to perform. There was almost no supervision of non care tasks, particularly in areas where staff work on their own.
3. **Small operators:** Smaller, stand alone facilities are struggling to research and implement OHS.
4. **Incident investigation** is very poor - no facilities were doing this well.
5. **Consultation** - while the majority of facilities had a range of communication strategies, these did not conform to requirements for consultation i.e. strategies were often one-way. There was no monitoring of communication outcomes as part of quality.
6. **Purchasing** was generally good, however for the facilities belonging to groups, purchasing was often centralised and this had some inappropriate outcomes. Consultation prior to refit / building work was very poor.
7. **Aggression** - resident aggression is managed very well. Aggression from relatives, however, is increasing and not being dealt with at all - most affecting senior staff and largely going unreported. No procedures for dealing with this issue.

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8. **Registered nurses** generally do not practice safe patient handling.
9. **Documentation** - excessive documentation, often duplicated, generally of poor quality with little understanding of the implication of what is written.
10. **Staff levels** - no consistency, even within some workplaces. Some procedures were unworkable with staffing levels e.g. two to use hoist when only one person on duty.
11. **Education** - training provided for carer/nursing staff, almost none for others. Over-assessing of carer/nurses and quality generally poor - skill assessment not competency assessment. Very little training for RNs.
12. **Introduction of computerisation** is generally poor with almost no consideration of ergonomics including software design, furniture, equipment and environment.
13. **Age of staff.** Many facilities engage both young workers, those under 18 years, and older workers, those over 55 years. While age should not preclude employment, risk control measures must be robust as injuries to these workers tend to be more significant. Falls risk must also be considered for staff.
14. **Design of facilities** - The design of resident care areas has significantly increased the space requirements so that staff have to walk, and move residents and equipment over significantly larger distances. Distance over which a load is carried is a risk factor for manual handling, and distances are getting longer not shorter. While new equipment tends to be better designed for manoeuvrability, and floor surfaces more level, handling risk for staff is not being adequately considered in building design. Further, placement of storage areas for equipment, and provision of adequate equipment continue to be problems for most facilities. If the equipment is not accessible and in sufficient quantities, staff will continue to employ more risky behaviour.
15. **Low Care** facilities are increasingly accommodating high care residents. Care staff do not have anywhere near the level of training in resident handling that high care staff receive, nor do they necessarily have suitable resident handling equipment.
16. **Bariatrics** - Very few facilities are being designed to consider the care of bariatric residents, specifically room accommodation, bathing and hygiene facilities, and furniture and equipment. While new equipment is purchased with known safe working limits, for much of the current furniture and equipment in use for residents and visitors, little is known about safe working loads.

## Manual Handling Audits of Aged Care Facilities

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### Best practice

While the preceding sections have highlighted areas identified through this audit process as requiring improvement to meet legislative compliance, some facilities have exceeded these requirements and are performing, in some areas at least, to worlds-best standards. The following highlights some of these strategies.

#### Management Commitment

- 1 Inclusion of a Board member on the OHS Committee, and each rotation includes full OHS Consultation training.
- 2 Each Board member being responsible for an area, prior to each Board Meeting, inspecting and consulting with residents and staff.
- 3 Board and all staff from the laundry conducted a fact finding visit to other ACFs and hospitals to review design, layout and fitout prior to consulting with a designer for upgrading their laundry facility.
- 4 Manual handling related issues included in the Strategic Plan, specifically the effect on the ageing workforce, consideration of slips, trips and falls for staff, and computer workstation ergonomics. The plan is the framework upon which all subsequent policies and work procedures are developed.

#### Consultation

- 1 Survey of all care staff to identify high risk tasks and potential solutions.
- 2 Staff satisfaction surveys post implementation of workplace change, including post occupancy, new equipment, changed work practices.
- 3 Providing some employees with training in reading architects plan drawings so that these employees can facilitate consultation groups in work areas affected by any rebuilding.

#### Risk Management

- 1 Rather than expecting everyone to be skilled in risk management, training a team from a range of work disciplines, to identify, assess and recommend controls. The team was flexible, with only three people required for each assessment. Training included specific requirements for manual handling risk assessment, and could co-opt the physio and other staff to assist.
- 2 OHS clearance, subject to risk assessment, prior to purchase of furniture, equipment and tools.
- 3 Skilling a team of employees to undertake a Job Safety Analysis for all jobs so that safe work procedures can be developed.
- 4 Matching staffing requirements to the outcome of the Job Safety Analysis.

## Manual Handling Audits of Aged Care Facilities

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- 5 Regional facility was concerned about the affect of fatigue and driving for staff who live some distance. Staff who are rostered for back to back late-morning shift are now provided free overnight accommodation and are definitely considered 'off duty'.
- 6 Designing gardens for low maintenance. Raised planter boxes incorporating both access and seating for visitors/residents.
- 7 Mobile scissor platform trolleys for transporting and installing white goods in independent units.
- 8 Risk assessing the need for electrical checks for all appliances - consideration of manual handling risk in accessing and handling items for such checks.
- 9 Providing basic computer skills, mouse-taming and computer ergonomics for staff migrating to computers.

### Training

- 1 Mentor program for new staff.
- 2 Training and resourcing educators for manual handling.
- 3 Providing supervisors, including registered nurses, with First Line Management training, including incident investigation.

## Manual Handling Audits of Aged Care Facilities

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### Future Directions

While the industry has certainly made progress over the last 15 years in managing manual handling risks, this audit has highlighted a number of key findings, which the auditors believe, will hamper further progress and continue to place staff at risk of sustaining injury from manual and associated tasks.

### Employers

- 1 Ensure that strategic planning, policies and procedures are current, relevant, fair and equitable to all work groups, workable within their environments and consistent with legislation.
- 2 Ensure that consultation occurs with the staff actually doing the work and that staff are provided with sufficient and appropriate information to enable them to contribute effectively to the consultation process - refer to the Code of Practice for Consultation.
- 3 Provide training and resources for staff engaged in risk management and staff education.
- 4 Ensure that risk management, and in particular risk assessment, complies with legislative requirements. When control strategies cannot be implemented immediately, provide alternative solutions to mitigate the risk until the control is available.
- 5 Ensure that risk is considered at all facilities within the group prior to purchasing, refit and building work being undertaken.
- 6 Ensure that OHS is considered within a quality framework, particularly addressing documentation, staff training, staff allocation and supervision.
- 7 Commit to upskilling supervisors and provide support for their involvement in OHS, including their key role in supervision.
- 8 Continue to provide equipment for safer handling, with special consideration of storage, the distances loads must be moved, and bariatrics.
- 9 Provide strategies to enable staff to deal effectively with the increasing level of aggression from non-residents, including post incident management.

### Industry Associations

- 1 Continue to provide and promote training programs in OHS and manual handling, specifically hazard identification, risk assessment and the control of manual handling risks.

## **Manual Handling Audits of Aged Care Facilities**

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- 2 Develop training in Front Line Management, linked to AQF, specifically for registered nurses and care managers.
- 3 Develop training in Incident Investigation, linked to AQF, specifically for supervisors and care managers.
- 4 Continue to provide conferences, workshops, and other resources that address and promote OHS and safe manual handling.
- 5 Facilitate the development of guidelines to assist in matching staffing to job tasks, based on a risk management model.
- 6 Facilitate the development of guidelines for relationships with on-hire labour suppliers.

## Manual Handling Audits of Aged Care Facilities

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### Acknowledgements

A project of this nature involves the work of many individuals and organisations and their contribution is duly acknowledged:

- WorkCover NSW for funding this project under WorkCover Assist.
- Both the Industry Associations, in particular, Geoff Liggins, Jane Brady, Col Frize and Pauline Thornton.
- The Aged Care OHS Reference Group.
- Auditors Christine Aickin, Marcia Lusted, Lea Maher and Louise Whitby [project coordinator], and
- The aged care facilities that participated in the audit, in particular the management and the staff who contributed directly to this project.

Appendix 1

# **Audit Tool**

# 2007 Manual Handling Audits for NSW Residential Aged Care Facilities

incorporating prevention of musculoskeletal disorders from manual handling, OOS, STF and resident aggression

a project funded through WorkCover NSW Assist Grant 2007 to the aged care industry

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Name of Facility	
Street Address	
Suburb	
Postcode	
Contact / Liaison	
Phone Number	
Email	

Auditor/s	
Date of audit	
Date of report	

## DEMOGRAPHICS

Facility info	<input type="checkbox"/> High care _____	<input type="checkbox"/> Low care _____	<input type="checkbox"/> Mixed _____	
	<input type="checkbox"/> Group	<input type="checkbox"/> Stand alone	<input type="checkbox"/> Ageing in place	
	Age of oldest building _____		<input type="checkbox"/> CACPs	
	Date of last accreditation _____		<input type="checkbox"/> Respite	
	Date of last OHS audit _____		<input type="checkbox"/> Other	
Staffing	Management _____	Physiotherapy / Ptx Aids _____	Contractors	
	Supervisors _____	Other therapists _____	<input type="checkbox"/> Nursing/Carer <input type="checkbox"/> Physio	
	Nursing / carer	Kitchen _____	<input type="checkbox"/> Hairdresser <input type="checkbox"/> Cleaning	
	- Day _____	Cleaning _____	<input type="checkbox"/> Maintenance <input type="checkbox"/> Other	
	- Afternoon _____	Laundry _____	Age of youngest staff member _____	
	- Night _____	Maintenance _____	Age of oldest staff member _____	
	- Community _____	Other _____	School placements	YES <input type="checkbox"/> NO <input type="checkbox"/>
In the last 2 years	N <sup>o</sup> MH injuries _____	_____	N <sup>o</sup> WC claims for MH _____	
	N <sup>o</sup> OOS injuries _____	_____	N <sup>o</sup> com law matters for WMSDs _____	[current or settled in last 2 yrs]
	N <sup>o</sup> WMSDs for slips, trips and falls _____	_____	N <sup>o</sup> Investigations by WCA/Union _____	
	N <sup>o</sup> WMSDs for resident aggression _____	_____	N <sup>o</sup> Notices for MH related issues _____	Type _____



# Assessment Criteria

# Management Commitment

Management demonstrates commitment to ensuring the workplace has systems to reduce the potential for injury from manual handling and related risks [OOS, slips, trips and falls, and resident aggression].

Element	Evidence	Comments
MH Policy	<ul style="list-style-type: none"> <li><input type="checkbox"/> Written policy – can be part of OHS policy</li> <li><input type="checkbox"/> Policy includes prevention of OOS</li> <li><input type="checkbox"/> Policy includes link to slips, trips and falls and resident aggression.</li> <li><input type="checkbox"/> Written procedures [safe work methods statements]</li> <li><input type="checkbox"/> Declared commitment from management</li> <li><input type="checkbox"/> Signed by senior manager</li> <li><input type="checkbox"/> OHS is referenced in the corporate or strategic plan</li> <li><input type="checkbox"/> Current [within two years of last revision]</li> <li><input type="checkbox"/> Provides for regular review</li> <li><input type="checkbox"/> Displayed or accessible</li> <li><input type="checkbox"/> Consistent with legislative requirements</li> <li><input type="checkbox"/> Acknowledges the National Standard and Code of Practice for Manual Handling as the approved COP</li> <li><input type="checkbox"/> Roles and responsibilities are clearly defined</li> <li><input type="checkbox"/> Policy compliance included in position descriptions</li> <li><input type="checkbox"/> Includes requirement for reporting MH hazards and injuries</li> <li><input type="checkbox"/> Includes commitment to consult with staff on MH issues</li> <li><input type="checkbox"/> Includes commitment to supervision</li> </ul>	

## Assessment Criteria

## Management Commitment

MH Policy cont ...

- Includes commitment to training
- Nominates person/position to coordinate MH program and commits resources to facilitate this work
- Provides for consideration of MH in purchasing and contracts with external providers
- Provides for consideration of MH in design of facilities
- Includes provision for young, older workers, and special needs workers e.g. pregnancy, on rehab

Resident Handling Policy

- Written policy – can be part of MH Policy
- Written procedures for patient handling
- Standard procedures based on risk assessment
- Specific procedures for certain residents, based on risk assessment
- Includes commitment to provide appropriate equipment, including providing maintenance
- Includes commitment to provide training
- Includes commitment to supervision
- Includes provision for young, older and special needs workers e.g. pregnancy, on rehab
- Includes aspects relating to residents i.e. resident responsibilities, advising residents/guardians to the requirements at the facility
- Regular review

## Assessment Criteria

## Communication

Management is committed to consultation on manual handling. Opportunities are provided for employees and residents to express their views.

Element	Evidence	Comments
Employee involvement in MH decision making	<ul style="list-style-type: none"> <li><input type="checkbox"/> Minutes of meetings where manual handling could be discussed e.g. OHS Consultation, staff meetings, planning meetings for facility upgrade</li> <li><input type="checkbox"/> Staff access to minutes</li> <li><input type="checkbox"/> List of employee representatives displayed</li> <li><input type="checkbox"/> Employees involved in risk management activities e.g. inspections, risk assessments, selection and trial of equipment or services, refurbishment planning</li> <li><input type="checkbox"/> Committee <i>terms of reference</i>, procedures</li> <li><input type="checkbox"/> After hours consultation practices</li> <li><input type="checkbox"/> Consideration of staff with low literacy or from NESB</li> </ul>	
Resident Consultation	<ul style="list-style-type: none"> <li><input type="checkbox"/> Minutes of residents meetings</li> <li><input type="checkbox"/> Resident induction - alerting resident / family to requirements for assessment and potential use of handling equipment</li> <li><input type="checkbox"/> Residents involved in risk management activities e.g. risk assessments, selection and trial of equipment, facility layout and modifications</li> <li><input type="checkbox"/> Consideration of residents from NESB</li> </ul>	

## Assessment Criteria

## Risk Management

Management has systems for the identification of manual handling and related hazards, assessment of these hazards to determine risk, and elimination or control of the risk.

Element	Evidence	Comments
Hazard identification	<ul style="list-style-type: none"> <li><input type="checkbox"/> Opportunities exist for staff, visitors and residents to report hazards e.g. verbal reports, hazard logs, communication books, team meetings</li> <li><input type="checkbox"/> Distinction between hazard reports and maintenance requests</li> <li><input type="checkbox"/> Checklists developed for workplace inspections</li> <li><input type="checkbox"/> Workplace inspections undertaken regularly i.e. at least quarterly</li> <li><input type="checkbox"/> Injury / incident reports are analysed</li> <li><input type="checkbox"/> Incident investigation occurs</li> <li><input type="checkbox"/> Equipment specifications are reviewed before workplace trials</li> <li><input type="checkbox"/> Resources accessed to keep up-to-date on industry hazards e.g. WorkCover News, Association Journals, attend conferences</li> </ul> <p>Provide examples of manual handling / DDS / STF or resident aggression hazards alerted in past 12 months</p>	

## Assessment Criteria

## Risk Management

## Risk Assessment

- Risk assessment is undertaken on all residents to determine manual handling care requirements
- Risk assessment of identified tasks is undertaken
- Risk assessment of equipment, furniture and fixtures and vehicles is undertaken prior to purchase to assess for manual handling or OOS risk
- Risk assessment of work systems is undertaken
- Risk assessment is performed by a team including staff who undertake the task, use or plan to use the equipment, and clean or maintain the equipment
- Risk assessment considers after hours work
- Risk assessments are undertaken post injury/incident
- Risk assessments conform to the requirements of the OHS Regulation, with reference to the relevant COP for manual handling and OOS
- Risk assessments are documented and subject to regular review – review dates

Provide examples, conducted during the past 12 months, of manual handling risk assessments, including OOS, STF and resident aggression.

## Assessment Criteria

## Risk Management

Elimination or control of manual handling risks

- Incident investigation records appropriate actions to be taken to prevent recurrence
- Control strategies are documented
- Control strategies are planned and promoted to staff and residents, where appropriate
- Control strategies are implemented in a timely manner
- Control strategies reflect the hierarchy of control, with preference for higher order controls
- Interim control strategies are implemented if required
- Control strategies are referred to the OHS Consultation Committee, or other review mechanism
- Control strategies are reviewed to ensure controls are effective, staff compliance, or any problems post implementation

Provide a list of strategies implemented in the last 12 months to eliminate or otherwise control manual handling risks

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## Assessment Criteria

## Risk Management

Cont ...

Provide a list of strategies implemented in the last 12 months to eliminate or otherwise control QOS risks

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Provide a list of strategies implemented in the last 12 months to eliminate or control the risk of staff sustaining musculoskeletal injury from slips, trips or falls

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Provide a list of strategies implemented in the last 12 months to reduce injury potential from resident aggression.

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**Workplace Inspection during audit**

## Assessment Criteria

## Risk Management

## General

- Documentation supporting the risk management process is retained for a minimum of 5 years
- Risk assessment and risk control strategies are reviewed periodically to ensure currency.
- Notification to WorkCover NSW of incidents involving injury resulting in an employee or contractor being unable to work for 7 days
- Immediate notification to WorkCover NSW of prescribed incidents e.g. collapse of load-bearing equipment, such as a bed or hoist, whether injury sustained or not
- For group facilities, collective reporting and sharing of hazards, risk assessments [where appropriate] and the elimination or risk control strategies.

## Assessment Criteria

## Information, Training and Supervision

All employees receive appropriate training in the manual handling and associated risks relevant to their work and are supervised in the performance of this work

Element	Evidence	Comments
Induction training	All staff, contractor and volunteers, where appropriate, receive induction training addressing manual handling – policy, procedures and use of equipment	
Staff training	<ul style="list-style-type: none"> <li><input type="checkbox"/> All nursing / carer staff receive periodic training in patient handling, including use of equipment</li> <li><input type="checkbox"/> All nursing / carer staff receive training in the use of any new item of equipment</li> <li><input type="checkbox"/> All other personnel (cleaning, kitchen, laundry, office and maintenance) receive manual handling / OOS training related specifically to the work they undertake</li> <li><input type="checkbox"/> All first-line staff undergo periodic skills assessment to ensure compliance with procedure</li> <li><input type="checkbox"/> All personnel receive training in hazard reporting</li> <li><input type="checkbox"/> Personnel who lead in risk assessments have received specific training in risk assessment</li> <li><input type="checkbox"/> Personnel who participate in risk assessment have received some training in risk assessment</li> <li><input type="checkbox"/> Personnel who undertake workplace inspection have received training</li> </ul>	

## Assessment Criteria

## Information, Training and Supervision

Supervisors	<input type="checkbox"/> Supervisors are trained in their responsibilities for OHS, including risk management and preparation of safe work procedures relevant to the work their supervise <input type="checkbox"/> Supervisors are trained in incident investigation	
Workplace educators / trainers	<input type="checkbox"/> Trainers have appropriate qualifications for delivery and assessing work skills <input type="checkbox"/> Trainers have appropriate resources to develop and deliver training <input type="checkbox"/> Trainers maintain currency of their skills through attendance at training courses and conferences <input type="checkbox"/> External training consultants have appropriate skills to deliver training and assess employees	
General	<input type="checkbox"/> Training content is documented <input type="checkbox"/> Records are retained for a minimum of 5 years on all training presented <input type="checkbox"/> Individual training and assessment records are permanently retained <input type="checkbox"/> Skills matrix and future training requirements determined	

## Summary

Auditor to summarise the strengths and weaknesses of the audit and provide verbal advice on opportunities for improvement. Formal report to follow.

Criteria	Strengths	Weaknesses	Opportunities
Management commitment			
Communication			
Risk Management			
Information, Training and Supervision			

Appendix 2

# **Guidelines for the Audit**

# 2007 Manual Handling Audits for NSW Residential Aged Care Facilities

a project funded through WorkCover NSW Assist Grant 2007 to the aged care industry

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## Manual Handling Audit Guideline

### Background

Firstly, thank you for agreeing to participate in this important project for the aged care industry in NSW.

The audit will confirm the things you are doing well to address manual handling and reduce musculoskeletal injuries. It will also highlight the aspects of your safety management program that need addressing to improve manual handling. A key outcome will be the development of an action plan, providing you with a framework for how best to address these issues over the next twelve months.

Information gathered from the audits will help the industry associations plan future strategies to further advance the safe performance of manual tasks for all aged care facilities in NSW.

### The Auditors

There are four auditors involved in this project, although only one auditor will undertake the audit at your facility. All auditors are ergonomists, all have health backgrounds (either nursing or physiotherapy), and all have been involved extensively in developing materials relating to manual handling for the health industry. All auditors also have qualifications in OHS auditing.

### The Audit Process

You will be contacted by phone to arrange a suitable date for the audit. The auditor who will be conducting the audit will also contact you to discuss any last minute arrangements or issues with you.

On the day of the audit, the auditor will need a quiet environment, such as a spare office, meeting or training room.

The audit is expected to take one day on site and will include:

- interviews with a range of personnel, including management, supervisors, OHS personnel and staff from all operational areas
- review of documentation, and
- a workplace tour,

A suggested timetable is included at the end of this document.

At the end of the day, you will receive a debriefing and the auditor will work with you to develop a draft manual handling action plan.

You will receive a formal, written report approximately one week after the audit. From this you will then be able to prepare the final action plan, which we require to complete the audit process.

### **Audit Focus**

The audit is designed to address the potential of staff to sustain musculoskeletal injury from:

- manual handling
- occupational overuse - OOS
- slips, trips and falls, - STF, and
- resident aggression

The audit will address these issues in the context of all work performed at the workplace – it is not limited to the work of carer and nursing personnel.

### **The Audit Criteria**

The audit will address four criteria:

- management commitment
- communication
- risk management, and
- information, training and supervision

The auditor will determine whether the criteria have been met by:

- evaluating documentary evidence of the system to be followed
- sighting records that confirm compliance with the system
- confirmation from personnel, and
- through observation.

### **Documentation**

The audit will require evidence of the systems you have in place to address manual handling, including OOS, STF and resident aggression. Examples of documentation specific to manual handling may include:

- policies and work procedures, including work practices e.g. safe work method statements
- risk management procedures
- hazard identification, risk assessments and risk control documents

- training programs and records
- minutes of DHS committee meetings, staff meetings, management meetings, resident meetings
- injury records
- workplace inspection reports
- DHS or strategic plans
- other audit or consultant reports, if any, addressing manual handling
- Notices issued by WorkCover NSW

You do not need to provide copies of this material – it will usually be sufficient for the auditor to sight this documentation, however you may be requested to provide a copy of a particular document for the auditor to take away. A copy of the table of contents from your DHS Manual would be helpful.

Only documents pertaining to the last 24 months need to be viewed.

### **Interviews with Personnel**

Please ensure that all personnel are briefed on the audit.

The auditors will need to speak with a range of people, including:

- Supervisors
- MH training coordinator
- DHS Consultation Committee
- Staff, contractors and volunteers, such as:
  - Staff from nursing, cleaning, catering, laundry and maintenance, diversional therapy.
  - Contractors who work regularly on site such as catering or cleaning, hairdresser
  - Volunteers who undertake manual handling e.g. bus driver
  - Any one who has sustained a musculoskeletal injury from manual handling, DQS, STF or resident aggression.

Discussions with supervisors, DHS Consultation Committee and the MH Training Coordinator will take about 30 minutes. For all other personnel, interviews should only take 15 minutes. Small groups [up to 5 people] are preferred and we can fit in with operational requirements, such as meal breaks etc. If it is easier, we can consult with some staff in their work area. Please pre-arrange all personnel for interviews.

Note that information collected from interviews with any individual will be kept confidential and not attributed to any person. As part of the auditing procedure, names of all interviewed will be recorded but retained for reference only by the auditor.

Facilities will not be required to bring off-duty personnel in to the workplace for this audit. However, the auditors need to speak with some personnel who are not on duty at the time of the audit e.g. weekend staff, night duty personnel. Please provide the auditor with the names of people who are off work and a suitable time when they can be contacted at work by the auditors, or an alternate contact number with consent from the individual.

All facilities being audited have at least one staff member who sustained a musculoskeletal injury during the last 12 months. As part of the audit, the auditors would like to speak to all such persons. If the person is not at work, please provide their contact details and a suitable time for contact – you will need to obtain their consent for passing their details to the auditor.

### **Suggested Audit Timetable**

<b>Time</b>	<b>Interview</b>
09.00 – 10.00	Interview with managements. Overview of the facility, Brief overview of workplace.
10.00 – 10.30	Interview with OHS Committee members, HSR, preferably as a group
10.30 – 11.30	Interview with supervisors, preferably as a group
11.30 – 12.00	Interview with training coordinator
12.00 – 13.00	BREAK
13.00 – 15.00	Interviews with small groups of employees or individuals, including anyone who has sustained injury from manual handling
15.00 – 16.00	Tour of workplace - for large facilities the scope of the tour will be determined on the day by the auditor – the auditor will need to be escorted
16.00- 16.15	Auditor reflection time
16.15 – 17.00	Feedback to management and chair of OHS Committee. Preparation of the draft action plan.

Note that there is some flexibility in this schedule to account for operational considerations.

Appendix 3

# **Guidelines for the Action Plan**

# 2007 Manual Handling Audits for NSW Residential Aged Care Facilities

a project funded through WorkCover NSW Assist Grant 2007 to the aged care industry

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## Manual Handling Action Plan

A key outcome of this manual handling audit is to identify strengths and weaknesses in your organisation's safety management system, and turning these into opportunities for moving the manual handling program forward.

A condition of your participation in this project is that your facility would provide an action plan for how this will be achieved.

### Getting Started

On completion of the audit, the auditors will provide some guidance as to the aspects of your current program that require attention and propose some strategies for how this could be managed. The auditors will work with you to develop a draft action plan, providing the tool and some additional resources to get you underway.

A week after the audit, you will receive the formal written report. Once you have this you will need to complete the action plan.

### Important Considerations

The action plan is intended to be a valid, relevant working document. It should be consistent with other workplace plans, such as the strategic plan or general OHS plan, and it must involve employee input before being endorsed by management.

The action plan is designed to address the core issues for compliance; specifically that there are processes for identifying manual handling hazards, assessing the hazards to determine risk, and putting in place effective elimination or control strategies. The action plan is not designed to address individual resident issues or issues that should be dealt with by routine maintenance / housekeeping e.g. threadbare carpet.

For the purposes of this project the Manual Handling Action Plan should address a period of at least 12 months e.g. 2008 calendar year.

### For help or more information

Please contact your auditor \_\_\_\_\_ on \_\_\_\_\_

# 2007 Manual Handling Audits for NSW Residential Aged Care Facilities

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## The Tool

The Manual Handling Action Plan incorporates the following:

### Issues

These highlight the key components of your manual handling strategy, including both strengths and weaknesses.

For the things you are already doing well [your strengths] it is important to maintain existing standards, so the strategies will reflect how best to achieve this. You may also want to improve on these standards. The action plan will help identify opportunities to move your manual handling program to the next level.

The issues must also include your weaknesses – the areas where there is real need for improvement. Remember, the starting point must be legislative compliance.

### Actions

The specific activities that need to occur to address each issue.

### Target Date

The date by which each action is to be completed.

### Responsible Person

The person/s who are responsible for completing the action by the target date. It is preferable to specify the name of the person/s, rather than positions.

### Resources

What will be provided to enable the action to be realised.

The Manual Handling Action Plan will include:

### Signatories

Chair, OHS Committee and Facility Manager

### Review Date

Date when the plan will be reviewed.

## Once the Action Plan is Done

The action plan needs to be returned to the Audit Coordinator by:

### Fax

02 9659 6591

### Mail

Louise Whitby  
PO Box 7605  
BAULKHAM HILLS BC NSW 2153

### Email

[LouiseWhitby@bigpond.com](mailto:LouiseWhitby@bigpond.com)