NSW NURSES & MIDWIVES' ASSOCIATION

Submission to: SafeWork Australia Consultation on Options to Improve WHS Incident Notification

SEPTEMBER 2023

AUSTRALIAN NURSING & MIDWIFERY FEDERATION NSW BRANCH

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Foreword

The NSW Nurses and Midwives Association (the Association) is the registered union for nurses and midwives working in all areas including but not limited to public and private hospitals, residential aged care, disability, corrections, and in-home care.

The Association is NSW largest union representing approximately 76,000 nurses and midwives across the state. The Association is the NSW branch of the Australian Nursing and Midwifery Federation (ANMF). Nationally the ANMF has approximately 320,000 members.

Ensuring the health and safety of nurses and midwives at work is a major focus for the Association. Our vision is that nobody should go to work and be hurt or be killed, and that the safety of our members should not be compromised or placed second to the provision of first-class health care services for the community.

Workers in the healthcare and social assistance sector experience the highest numbers of serious injuries of any industry and have the second highest frequency rate of serious injuries (serious injuries per million hours worked).[1]

Psychological injury rates across the sector are climbing at alarming rates, with healthcare workers almost twice as likely as other workers to sustain a serious psychological injury. Psychological injuries for nurses have increased by 150.6% between 2013-2015 and 2019-2021, with the most common causes of psychological injury being bullying and harassment (38.4%), work pressures (23.1%) and occupational violence (18%)[2].

Despite the serious risks being faced by Association members, there is a distinct lack of regulatory action in the sector , this is in part due to the lack of regulator oversight of the issues that are causing harm to our members.

Safework NSW publishes details of prosecutions from 2017-2023 on their website. There have been no prosecutions in relation to injuries to nurses or midwives or indeed of any health agency or residential aged care provider in this period.

There have been no prosecutions of health agencies in relation to occupational violence in NSW since 2007, despite at least 3 nurse fatalities arising from violence in this period and multiple serious injuries sustained by nurses every week.

[1] https://www.safeworkaustralia.gov.au/sites/default/files/2023-01/key_whs_stats_2022_17jan2023.pdf

[2] Gelaw, A., Sheehan, L., Gray, S. and Collie, A. Psychological injury in the New South Wales Healthcare and Social Assistance industry: A retrospective cohort study. Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash
University (2022).

All workers have an equal right to healthy safe and respectful work, without discrimination and free from violence and aggression. However, nurses and midwives are facing significant threats to their physical and psychological health from role overload, occupational violence and bullying and harassment.

Workers must be protected from all hazards and risks at work, including psychosocial as well as physical hazards and risks. A change to the incident notification provisions is essential to ensure proper visibility and oversight of these matters by our safety regulators and an increased focus of the importance of managing these risks by PCBUs.

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General feedback

The NSW Nurses and Midwives Association (the Association) reiterates that a change in incident notification is required to:

1. Capture the changing profile of risks related to the nature of work and work organisation
2. Give visibility and prominence to PCBUs and workers of uncontrolled or poorly controlled hazards at work that should give rise to risk assessment and a review of control measures. This is a significant factor given the limited attendance capacity of regulators.
3. Increasing the profile of these hazards and illnesses/injuries will require a change for all involved – workers, PCBUs and regulators
4. The changes will address current shortcomings in the very limited profile of psychosocial hazards and will complement the introduction of Regulations and Codes of Practice on psychosocial hazards/risks
5. It is well accepted that many psychological injuries/illnesses are well entrenched by the time the PCBU/insurer is notified - it is essential to improve prevention and RTW outcomes the profile, for all stakeholders, of these injuries/illness must be increased.
6. The changes are about **work relatedness** and are not intended to cover all mental ill health which may impact work.

The Association agrees that incident notification is *designed to alert the WHS regulators to the most serious workplace incidents and potential breaches of WHS duties*. The Healthcare and social assistance sector has the largest number of serious injuries of any industry, and yet is underrepresented in terms of regulator enforcement activity as many of the serious injuries are currently not notifiable, despite causing considerable harm to our members.

The requirement to notify a regulator highlights the seriousness of the incident and signals to the Regulator the need to assess whether a risk still exists and what measures have been taken by the PCBU to control those risks. Notification additionally informs duty holders and relevant parties, including workers and their representatives, that a review of risk control measures is necessary.

The information gleaned from incident notification is critical to regulators' functions as outlined in Part 8 of the Act, but also to functions and rights of Parts 5 and 7. Following are examples of where this information is pertinent and necessary: e.g.

- section 48 Nature of Consultation,
- section 49 When is consultation required,

- Section 68 Powers and functions of health and safety representatives,
- Section 70 General obligations of PCBUs,
- section 117 Entry to inquire into suspected contraventions,
- section 120 Entry to inspect … information held by another person etc.

The lack of inclusion of hazards to psychological health and the inability of the current incident notification provisions to focus on disease or work-related suicide results in a low profile of these hazards for all workplaces parties and duty holders as well as regulators. The Association is very supportive of changes to increase the visibility and prominence of the hazards present in our sector. These are currently under recognised leading to inadequate risk control responses from duty holders and a lack of compliance activity by regulators for hazards which result in serious injuries and/or illnesses.

Chapter 5 - Periodic reporting of incapacity periods

Proposed options

1	Amend the model WHS Act to require periodic reporting (six monthly) of periods of incapacity from normal work for ten or more consecutive days due to a **psychological or physical injury, illness or harm** arising out of the conduct of the business or undertaking

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The Association agrees that there are significant gaps in the current incident notification provisions and that these gaps are leading to a lack of attention to the hazards and risks existing in the healthcare and social assistance sector that are profoundly affecting the health and safety of nurses and midwives.

The largest injury type in our sector continues to be musculoskeletal disorders (61.7% of workers compensation claims compared with 49.4% in other industries[3]) arising largely from patient transfers (manual handling of people) which often occur over time as well as resulting from patient violence (which may be a single incident). Often people sustaining these injuries are not admitted as an inpatient to a facility at the time, even if they go on to

[3] Gelaw, A., Sheehan, L., Gray, S. and Collie, A. Psychological injury in the New South Wales Healthcare and Social Assistance industry: A retrospective cohort study. Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University (2022), p31.

require surgery at a later time, and they regularly do not receive immediate treatment for their injuries. It may be some time before the full extent of the injury is known.

[redacted]

The fastest growing injury type in our sector is psychological injury. A recent study found that healthcare workers were twice as likely as other workers to sustain a compensable psychological injury and that there has been a 150% increase in psychological injuries for nurses[4]. The most common causes of psychological injuries of nurses have been found to be bullying and harassment, work overload and exposure to violence. These matters are largely not notified to the regulator.

[redacted]

Periodic reporting of periods of incapacity for work would allow the regulator to have oversight of these issues, and to take regulatory action, particularly where a clear pattern of issues is identified in a workplace.

[redacted]

None of these incidents are currently notifiable to the regulator, despite workers being fully incapacitated for work for at least 9 months.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association is very supportive of the introduction of incident notification requirements related to periods of incapacity so as to appropriately capture the serious injuries occurring in our sector, such as those outlined in the case studies above.

The Association supports the notification to relate to "incapacity for normal duties" as there are employers in our sector who are quick to have people with substantial injuries doing online training from home in order to reduce any evidence of LTIs even when injuries are significant.

[4] Gelaw, A., Sheehan, L., Gray, S. and Collie, A. Psychological injury in the New South Wales Healthcare and Social Assistance industry: A retrospective cohort study. Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University (2022).

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

The (re) introduction of reporting relating to periods of incapacity for work would have a very positive impact on our membership as it would provide for increased awareness, oversight and understanding of the issues causing serious injuries to nurses and midwives.

As well as being of assistance to workers, the increased prominence of these issues and the subsequent work undertaken to address them will assist in the ongoing delivery of healthcare services through improved retention of skilled and experienced staff. We have a nationwide shortage of nurses and midwives, and an important part of addressing retention must be preventing workers from being seriously injured.

Any discussion of increased compliance costs must be considered against the cost of not improving incident notification for the types of incidents causing serious injuries to healthcare workers. A failure to improve visibility and to ensure work is done to address these issues will result in more of the same.

We cannot afford to allow the trend of increasing serious injuries to healthcare workers to continue. SafeWork Australia key WHS statistics show that the healthcare and social assistance sector has the highest number of serious injuries of any industry and that this is increasing. The 2020 report showed 19,505 serious injuries in healthcare, (frequency 8.1, incidence 11.6), the 2022 report shows this has increased to 26,239 serious injuries, (frequency 10.2, incidence 14.6).

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

Prior to the introduction of the WHS Act in NSW in 2011, the previous NSW legislation required employers to notify the regulator of any injury or illness resulting in incapacity of 7 days. Similarly Queensland previously had reporting of periods of incapacity of 4 days. This reporting was required to be done at the time rather than through a system of batched reporting.

The Association supports incident notification of periods of incapacity from normal duties for a period of 5 consecutive days. The Association would prefer that the notification was made at the 5 day mark rather than through batched reporting.

Chapter 6 - Attempted suicide, suicide and other deaths

Proposed options

Option number	Description
1 Suicide and other deaths	Amend the guidance material to clarity that the 'death of a person' (s 35(a)) captures: • suicide of a person due to psychological harm arising out of the conduct of the business or undertaking • other death of a person due to exposure to psychosocial hazards (e.g. heart attack from work stress) arising out of the conduct of the business or undertaking • suicide of a person at a workplace where there is an identified risk of suicide in the workplace.
2 (Optional add-on) Suicide of a worker	Amend the definition of notifiable incident (s 35) in the model WHS Act to specifically capture: • the suicide of a worker, whether or not the suicide arose out of the conduct of the business or undertaking.

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The Association is extremely concerned about the lack of regulator oversight and understanding of workplace suicides. The Association is aware of at least 6 nurses/midwives in NSW who have died by suicide in circumstances relating to their workplaces in the last 9 months.

The Association is aware of many more attempted suicides, (as these members are generally reported as "impaired" to the nursing and midwifery board and we provide them with support for this process). These are largely not being reported to the safety regulator.

Recent research found that "*one in 10 Australian healthcare workers reported thoughts of suicide or self-harm during the pandemic, with certain groups being more vulnerable. Most healthcare workers with thoughts of suicide or self-harm did not seek professional help. Strong and sustained action to protect the safety of healthcare workers, and provide meaningful support, is urgently needed*".[5]

[5] Bismark, M., Scurrah, K., Pascoe, A., Willis, K., Jain, R., Smallwood, N., Thoughts of suicide or self-harm among Australian healthcare workers during the COVID-19 pandemic, Australian and New Zealand Journal of Psychiatry, Dec 2022.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports Option 1 with the add of outlined in Option 2 that s35 be amended to specifically capture the suicide of a worker, whether or not the suicide arose out of the conduct of the business or undertaking. We also support the similar amendment for attempted suicide, however, this would need to be de-identified, unless the worker gives explicit consent for the notification to be identified.

The Association supports provisions that ensure site preservation requirements include suicide/attempted suicide notes.

Suicides are complex and often multifactorial. It is inappropriate for PCBUs to be attempting to determine the relevant cause of the suicide (or attempt). Further, PCBUs are likely to seek to escape "blame" for the death of a worker by suicide and given that the worker is no longer able to speak for themselves, they are likely to attribute the cause of the death to anything other than the workplace. In the experience of the Association, PCBUs are largely not notifying even when there is clear evidence that there is a work connection.

Recent examples:

- [redacted]

[redacted]

[redacted]

[redacted]

- [redacted]

[redacted]

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

A change to the notification of suicides and attempted suicides of nurses and midwives would benefit our membership by ensuring that the issue has appropriate visibility so that attention and resources can be made available to address this urgent issue.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

The Association supports the ACTU suggestion of the development of a definition of work-related suicide or attempted suicide which reflects the French approach is required i.e. each suicide or death of undetermined cause was considered potentially work-related when at least one of the following circumstances was present:

- The suicide occurred in the workplace;
- A suicide note left by the deceased implicated working conditions;
- The deceased was in work clothes even if not working;
- The testimony of relatives implicated work-related difficulties, or work-related difficulties were identified by investigators.

Chapter 7 – Capturing Workplace Violence

Proposed options

Option	Description
1	Amend the model WHS Act to require immediate notification (de-identified) to the WHS regulator of: a. a **sexual assault** - including any sexual behaviour or act which is threatening, violent, forced, coercive or exploitative and to which a person has not given consent or was not able to give consent[6] b. a **serious physical assault** - including where a worker or other person in the workplace is assaulted with a weapon, punched, kicked, struck, beaten, shoved or bitten by another person c. the **deprivation of a person's liberty** - including being trapped, confined or detained by another person, and d. an **express or implied threat of serious violence** that causes genuine and well-founded fear of death, serious sexual assault or serious injury or illness. arising out of the conduct of the business or undertaking and that exposes a worker or any other person to a serious risk to a person's health and safety.
Optional add-on	Introduce a power to permit WHS regulators to approve alternative reporting arrangements for certain PCBUs with specific conditions.

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

Workplace violence is a major issue in the healthcare and social assistance sector. Injuries can be physical and/or psychological as well as leading to fatality. Workplace violence is currently underrepresented in notifications to the regulator.

The Association actively supports members who have been exposed to workplace violence, both individually, at a workplace level and with the safety regulator. In NSW, despite at least 3 nurse deaths and hundreds of serious career ending injuries, there hasn't been a prosecution of a health PCBU in relation to workplace violence since 2007.

The Association believes this is due in part to the lack of visibility of the issue to the safety regulator, (most issues are not reported) and partly due to the lack of industry specific knowledge of inspectors (no specialty inspectors for the sector in NSW – poor

[6] This description is consistent with wording in the Gendered violence: Notification of sexual harassment and/or assault to WorkSafe Mines Safety.

understanding of reasonably practicable controls). Improved incident notification provisions would increase the visibility of the issue and see increased regulator resources allocated to addressing this very serious issue.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports the proposal to amend the incident notification provisions to include the immediate notification of serious workplace violence and threats. This would provide greater visibility to one of the most serious WHS risks to the safety of our members.

The Association strongly opposes the idea of an optional add in to allow for alternative reporting arrangements for certain PCBUs, such as those that more frequently experience workplace violence (this is preposterous – and akin to suggesting that construction employers shouldn't be required to report falls from heights because they experience these at a greater frequency than other industries).

The reason we need violence to be notified is to increase visibility of the issue and nowhere is this more important than in industries where workers are regularly seriously harmed as a result of exposure to these hazards. Having different requirements for some industries will undermine the effectiveness of the revised incident notification provision and give the impression that PCBUs in the healthcare sector are not required to manage these risks (which is already a widely held view in the industry).

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

The requirement for notification of workplace violence would have a very positive impact on our membership as it would provide for increased awareness, oversight and understanding of this issue which is causing serious injuries to nurses and midwives.

As well as being of assistance to workers, the increased prominence of the issue of occupational violence and sexual assault and the subsequent work undertaken to address this issue will assist in the ongoing delivery of healthcare services through improved retention of skilled and experienced staff. We have a nationwide shortage of nurses and midwives, and an important part of addressing retention must be preventing workers from being seriously injured.

Any discussion of increased compliance costs must be considered against the cost of not improving incident notification for violence which is causing serious injuries to healthcare workers. A failure to improve visibility and to ensure work is done to address occupational violence will result in more of the same.

We cannot afford to allow the trend of increasing serious injuries to healthcare workers to continue. SafeWork Australia key WHS statistics show that the healthcare and social assistance sector has the highest number of serious injuries of any industry and that this is increasing. The 2020 report showed 19,505 serious injuries in healthcare, (frequency 8.1, incidence 11.6), the 2022 report shows this has increased to 26,239 serious injuries, (frequency 10.2, incidence 14.6).

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

No.

Are there particular types or circumstances of workplace violence that you think should or should not be notifiable to the WHS regulator that are not dealt with by the proposed option and descriptions? What would be the implications of including or excluding these incidents?

Other serious assault types experienced by healthcare workers include items being thown at them (such as hot coffee, full water bottles, computer monitors etc) and intentional exposure to body fluids such as being spat at, intentional exposure to blood products (attacked with a syrige or having blood spat in their faces) as well as having urine and faeces thrown at them.

In addition to the serious assaults contemplated in option 1, healthcare workers are often psychologically injured as a result of lower level exposures over time. E.g. long term patients who may be too physically frail to punch, kick etc, but who are regularly abusive when workers attempt to provide care, who scratch and spit at workers, demean and swear at workers, racially abuse workers providing care etc.

Chapter 8 - Periodic reporting of exposure to traumatic events

Proposed options

Option number	Description
1	Amend the model WHS Act to require periodic reporting (six monthly) to the WHS regulator of instances where workers, or other persons at the workplace, **are exposed to serious injuries, fatalities, instances of abuse or neglect that are likely to be experienced as traumatic by the worker**

	or other person, where the exposure arises out of the conduct of the business or undertaking.
Optional add-on	Assess the need for WHS regulators to have the ability to approve **alternative reporting arrangements** for certain PCBUs with specific conditions.

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

Healthcare workers are frequently exposed to traumatic events in the course of their work, and this can have a profound impact, particularly when occurring in environments where there is cumulative exposure to multiple psychosocial hazards (in healthcare this would include exposure to bullying, fatigue, role overload and violence as well as to traumatic events).

While the Association acknowledges that in healthcare dealing with some traumatic events is inevitable, the outcomes of such exposures is not inevitable. PCBUs must ensure that they implement appropriate risk control measures to minimise the risk to workers.

It must also be recognised that in industries where exposure to trauma is frequent, that there are still some incidents that are outside of the “normal” exposures for the industry that are likely to be experienced as extremely traumatic, some recent examples from our sector include:

- [redacted]

These extreme examples should be notified to the regulator at the time of the incident rather than via periodic reporting.

In the health and community services sector, arrangements should be put in place between regulators to ensure that information can be shared between WHS regulators and organisations such as ACQSC and NDISQSC in order to cross reference reporting of serious incidents to other persons (given that often these traumatic events affect patients/residents/clients as well as workers). It is noted that there is confusion (at least in NSW) about what incidents affecting “others” such as patients, residents, consumers, clients etc need to be reported to the regulator. This applies to all incident types, not only exposure to traumatic events, and should be clarified.

The Association acknowledges that guidance material with clear explanations as to what types of incidents are notifiable will be necessary.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports periodic reporting when workers are exposed to serious injuries, fatalities, instances of abuse or neglect that are likely to be experienced as traumatic by the worker or other person.

The Association has significant reservations regarding the optional add on in relation to alternative reporting requirements for some PCBUs, as it will undermine the effectiveness of the revised incident notification provision and give the impression that PCBUs in the healthcare sector are not required to manage these risks (which is already a widely held view in the industry).

If any alternative reporting arrangements are to be made, certain thresholds must be set e.g.

- Any arrangements entered into must be agreed with relevant unions;
- PCBUs must have clear documented processes for recording and managing risks arising from exposure to traumatic events; and
- PCBUs must have clear evidence of consultative arrangements with workers/HSRs.

The Association supports the commentary in the SafeWork Australia paper regarding site preservation i.e. case by case basis and to include documents etc.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

This would increase awareness about exposure to traumatic events as a WHS issue that needs to be managed, and would benefit healthcare workers.

Please see previous comments about the benefits to nurses and midwives and the community more broadly of improving notification provisions.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

No.

Chapter 9 - Periodic reporting of bullying and harassment

Proposed options

Option	Description
1 Unreasonable behaviours	Amend the model WHS Act to include a duty to periodically report (six-monthly, de-identified data) to the WHS regulator on **complaints <u>OR</u> instances,** arising out of the conduct of the business or undertaking **Of** a) **repeated and unreasonable** behaviour (bullying) towards a worker or group of workers, or b) **unreasonable behaviour** towards a worker(s) that a reasonable person would consider is abusive, aggressive, offensive, humiliating, intimidating, victimising or threatening *[including sexual harassment or harassment of any other kind]* where the behaviour may reasonably be considered to have occurred (excluding vexatious or frivolous claims), and that exposes a worker(s) to a risk to their health and safety.
2 Bullying; sexual harassment and harassment on protected grounds	Amend the model WHS Act to include a duty to periodically report (six-monthly, de-identified data) to the WHS regulator on **complaints <u>OR</u> instances** **Of** a) workplace **bullying** *repeated, unreasonable behaviour towards a worker(s) or group of workers* b) workplace **sexual harassment** of a worker(s) *that that involves unwelcome sexual advances, unwelcome requests for sexual favours or unwelcome conduct of a sexual nature* c) workplace **harassment** of a worker(s) *because of protected characteristics (e.g. race, sex, gender, sexual orientation, age, disability)* where the behaviour may reasonably be considered to have occurred (excluding vexatious or frivolous claims), and that exposes a worker(s) to a risk to their health and safety.

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

Bullying is a significant issue in the healthcare sector, with a recent study examining NSW workers compensation data for the sector finding that bullying and harassment is the top cause of psychological injury for nurses and midwives in NSW, responsible for 38.4% of compensible psychological injuries[7].

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports an amended Option 1 as proposed by the ACTU:

Amend the model WHS Act to include a duty to periodically report (six-monthly, de-identified data) to the WHS regulator on complaints OR instances, arising out of the conduct of the business or undertaking of

a) repeated and unreasonable behaviour (bullying) towards a worker or group of workers, or
b) unreasonable behaviour towards a worker(s) that a reasonable person would consider is abusive, aggressive, offensive, humiliating, intimidating, victimising or threatening; or
c) workplace sexual harassment of a worker(s) *that that involves unwelcome sexual advances, unwelcome requests for sexual favours or unwelcome conduct of a sexual nature.*

where the behaviour may reasonably be considered to have occurred (excluding vexatious or frivolous claims), and that exposes a worker(s) to a risk to their health and safety.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

See previous comments on the benefits of increasing the visibility of the WHS issues having greatest impact on nurses and midwives.

[7] Gelaw, A., Sheehan, L., Gray, S. and Collie, A. Psychological injury in the New South Wales Healthcare and Social Assistance industry: A retrospective cohort study. Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University (2022).

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

No

Chapter 10 - Long latency diseases – exposure to substances

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The Association is not convinced that the current work by SafeWork Australia listed in the consultation paper adequately addresses or concerns about the lack of understanding about exposure to substances in the healthcare sector and the capture of diseases prevalent in healthcare workers.

The Australian WHS regulatory system does not well regulate the use of hazardous medical products including cytotoxins, antineoplastics and antivirals which are known to be carcinogenic, mutagenic and toxic to reproduction. We are significantly behind the EU and the US in this regard. There has been a proliferation in the numbers of these drugs being used in Australia, as well as the conditions they are being used to treat and the settings in which they are being used (previously in oncology wards with highly qualified staff, now also present in general wards, aged care facilities and in people's homes where controls are less likely to be present and staff are less likely to be trained appropriately).

Similarly, while WES do exist for exposure to Nitrous Oxide, generally the only air monitoring undertaken in hospitals is in bulk storage, not in the wards/units where it is being used (particularly labour wards/birthing suites).

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

The Association strongly supports extending the obligation to record exceedances WES/WEL be extended to incident notification. Any exceedance of a WES/WEL should trigger notification.

Further, the Association supports a review of the regulatory arrangements in place in relation to hazardous medical products including cytotoxins, antineoplastics and antivirals which are known to be carcinogenic, mutagenic and toxic to reproduction.

Should exposure to hazardous substances in the workplace that cause latent diseases be recorded and reported? If so, for which substances?

Yes. The list of prohibited carcinogens in the WHS regulation should be updated (or a further schedule provided) to include the full list of hazardous medical products in use in Australia, and the use of these substances should be recorded and reported.

How are exposures to hazardous substances currently measured in the workplace (for example, air and health monitoring)? Do you have suggestions for options to improve monitoring to provide a better understanding of exposure to hazardous substances in the workplace?

Exposure to hazardous substances is not currently being appropriately measured in health workplaces as per nitrous oxide example provided above.

With regards to air monitoring, how are exceedances of the WES captured? Do you think recording and reporting WES exceedances is a good way to identify exposure to hazardous substances in the workplace? What other ways could exposures be recorded and reported?

Section 19 of the WHS Act requires a PCBU to monitor the conditions at the workplace and health of workers to protect persons from risks to their health and safety. It follows that if there is a requirement to monitor then there is an implied duty to record as how can one demonstrate that monitoring has occurred?

Regulation 50 clearly requires PCBUs to ensure the results of air monitoring carried out are recorded and kept for 30 years. Incident notification provisions should simply be about extending that obligation to notification. Any exceedance of a WES/WEL should trigger notification.

Should PCBUs be required to keep records of statement of exposure documents and make them available for inspection by the regulator? Should the statement of exposure requirement be broadened from prohibited or restricted carcinogens to include other substances which are known to cause long latency diseases? If yes, how should these substances be identified?

There is currently only one cytotoxin (cyclophosphamide) listed in schedule 10 of the WHS Regulation, however there are many other cytotoxins used in Australia which are equally if not more hazardous. This must be urgently addressed through the development of a schedule of hazardous medical products.

Records of statements of exposure documents should also be kept for exposure to substances known to be teratagenic, mutagenic or toxic to reproduction.
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Chapter 11 – Serious Head injuries

Proposed options

Option	Description
1	Amend the model WHS Act (s 36) to capture 'serious head injuries' (without applying the threshold of requiring 'immediate treatment').
2	Amend the model WHS Act (s 36) to capture 'suspected serious head injuries' requiring immediate treatment.
3	Address this potential gap through other options, including: • updating the guidance material to explain what is meant by 'immediate treatment' and how this applies to serious head injuries (refer Chapter 15), and • capturing serious head injuries through an incapacity period (Chapter 5).

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The Association supports the assessment of current gaps. Our experience is that there are many serious head injuries that are not currently reported due to different interpretations about what constitutes a serious head injury as well as what constitutes "immediate treatment", e.g.

a nurse is assaulted resulting in temporary loss of consciousness and fractured orbital socket. He was seen in an ED for an assessment of his injury but not admitted (though later required surgery). PCBU does not notify as they argue that a facial fracture is not a serious head injury and that the ED assessment and diagnosis is not "treatment".

Nurses frequently lose consciousness from head injuries and the seriousness of the injuries may not be well understood at the time.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports options 1 removing the requirement for "immediate treatment" for the reporting of serious head injuries, as well as option 2 including "suspected serious head injuries" requiring treatment.

This should be supported by improved guidance on what constitutes a serious head injury. These changes would ensure that serious head injuries sustained by nurses such as that outlined above would be reported.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

The practical impact of this change on nurses and midwives is improved regulator visibility and understanding of the serious head injuries being sustained by workers in the healthcare sector, which would hopefully lead to increased regulator activity in relation to this important issue.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?

No.

Chapter 12 – Other potential gaps in "serious injury and illness"

Proposed options

Option	Description
1	Amend the model WHS Act (s 36) to require immediate notification of all work-related injuries and illnesses requiring treatment as an outpatient in an emergency department.
2	Amend the model WHS Act (s 36(b)) to specifically capture 'serious bone fractures' and 'serious crush injuries' requiring immediate treatment.

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The Association believes there are other gaps in the current notifications of "serious injury and illness" including fractures and dislocations. The term "loss of bodily function" is not well understood by PCBUs.

X is a nurse working in [redacted] *hospital. She was kicked in the knee by a patient resulting in a dislocation and was seen in the ED of the hospital she works at. She has subsequently required a knee reconstruction as a result of the injury.*

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports option 1. Whilst it is acknowledged that this may led to more notifications, guidance material could be produced to clarify the obligations. This option would have the scope of including acute asthma attacks as the results of occupational asthma or serious contact dermatitis that requires treatment.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

Better oversight of the issues affecting nurses and midwives.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

Many injuries sustained by healthcare workers working in hospitals are currently reviewed in the emergency department of their workplace. It would be a concern if there was a change to practice in the industry and workers were no longer provided with this care due to this triggering a requirement to notify the regulator.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?
No.

Chapter 15 – Addressing minor gaps and ambiguities in the current incident notification provisions

Do you support the assessment of current gaps and impacts of addressing those gaps? Please provide any supporting information and evidence.

The Association supports the assessment of current gaps.

Do you support the proposed option(s)? Please explain why or why not and provide relevant evidence to support your views where possible.

The Association supports the proposed options to clarify incident notification provisions.

What practical impact, including costs and benefits, would the option(s) have on you, your organisation or your stakeholders? Please provide any details or evidence supporting your views, including the option's likely impact on WHS outcomes or any compliance costs or concerns.

Improved understanding of notification requirements.

Are there any likely unintended consequences of the proposed option(s)? How could these be best mitigated?

No.

Do you have another suggestion or preferred option for addressing the gap in WHS regulator visibility?
No.

Medical treatment for exposure to a substance

What health professionals should be covered by the definition of 'medical treatment'?

Health professionals that should be covered by the definition of "medical treatment include: doctors, nurse practitioners, registered nurses, enrolled nurses, assistants in nursing and paramedics.

Please provide reasons, including examples of what treatment the health professional is likely to provide for which type of exposure.

This question is large enough to be a submission on it's own, as there are many substances that workers may be exposed to and the medical treatments vary.

Medical treatment following substance exposure may include but not be limited to such things as:

- Blood tests including arterial blood gasses – this is to check organ function levels, toxicology, blood pH, oxygenation etc.
- Pulse oximetry – non-invasive monitoring of oxygen saturation in blood
- Vital signs – heart rate, blood pressure, respiratory rate, SpO2, temperature – basic signs to show patient deterioration.
- Urine analysis (check for haemolysis, level of substance poisoning, renal function etc)
- Chest Xray (CXR) – check for respiratory impact

- Pulmonary function tests (PFT) – assess respiratory tract if exposed to substance via inhalation
- Oxygen administration or intubation if necessary- if damage to respiratory tract or exposure to gas such as carbon monoxide.
- Intravenous fluid administration – to deliver medications, fluids and electrolytes to counter effect of substance.
- Irrigation of eyes and burns- if substance exposure to eyes
- Wash out – if substance exposed dermally
- Vision assessments/eye examinations- if substance exposure to eyes.
- Echocardiogram (ECG) and other cardiac monitoring- this is because certain substances cause changes to cardiac function
- Abdominal film- for ingested substances that are radio-opaque
- Medicinal administration – topical, oral, intravenous depending on the substance exposure and impact on worker.
- Wound assessment and treatment- if dermal exposure to substance
- CT scans- for oral or inhalation exposure to substance.

For example

Carbon monoxide poisoning:

Blood test for carbon monoxide poisoning; oxygenation through oxygen mask.

If through smoke inhalation: Oxygen mask, upper airway assessment for swelling and burns, blood test if CO inhalation.

Ammonia

Respiratory tract assessment, monitor respiration, monitor pulse oximetry, arterial blood gases, chest x-ray, pulmonary function tests. 24 hour observation if moderate to significant exposure.

For ingestion: gastroenterological review, intravenous fluids administration.

Dermal contact: flush area thoroughly, manage burns, manage frostbite with tepid water to regain circulation.

Ocular contact: irrigate affected eyes for at least 15 minutes, visual assessment, ophthalmologic review to assess for corneal burns.

Organophosphate

Organophosphate poisoning occurs after dermal, respiratory, or oral exposure to either organophosphate pesticides or nerve agents, intentional, workplace exposure or incidental, causing inhibition of acetylcholinesterase at nerve synapses. The term organophosphate poisoning only applies to those organophosphates that inhibit acetylcholinesterase.

Decontamination showers are routinely placed outside Emergency departments

Standard treatment is decontamination, resuscitation, supportive care, and use of atropine.

Those most likely to be involved in these activities or exposures include:

• nurses – providing direct patient care including decontamination, resuscitation, treatment, observations and care;

• medical officers – treatment, resuscitation and consultations.

Radiation

Decontamination showers are available outside Emergency departments and portable decontamination tents are in place at major trauma centres where risk is identified

Those most likely to be involved in activities or treatment exposures include:

• nurses - providing direct patient care and treatment including decontamination, treatment and care

• medical officers – treatment, surgery where required and consultations

• radiation therapy staff who conduct measurements and providing advice and support to clinicians as part of their speciality

NSW NURSES & MIDWIVES' ASSOCIATION

Submission to SafeWork Australia Consultation on Options to Improve WHS Incident Notification

SEPTEMBER 2023