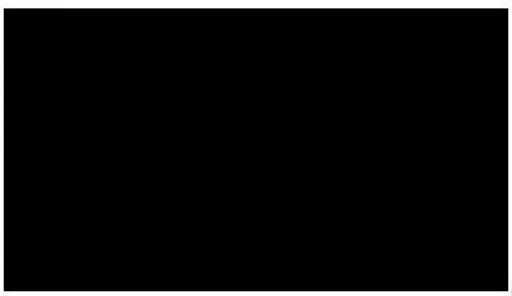
Queensland Nurses & Midwives' Union

Submission to

Safe Work Australia

Review of the Model Work Health and Safety Laws

April 2018



submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks Safe Work Australia for the opportunity to provide a submission to the Review of the Model Work Health and Safety Laws (the review).

Nursing and midwifery is the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 57,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

Work Health and Safety Legislation in Queensland

In October 2017, the Queensland Parliament passed the *Work Health and Safety and Other Legislation Amendment Act 2017* (the amendment Act).

The amendment Act amended the *Work Health and Safety Act 2011* (WHS Act), *Electrical Safety Act 2002* (ES Act) and the *Safety in Recreational Water Activities Act 2011* (SRWA Act) to implement key recommendations of the Best Practice Review of Workplace Health and Safety Queensland.

A summary of the amendments is outlined below.

Provisions to commence on assent of the amendment Act:

- introduction of a new offence of industrial manslaughter in the WHS Act with mirror amendments in the ES Act and SRWA Act;
- requirement for a person conducting a business or undertaking (PCBU) to provide the regulator with a list of Health and Safety Representatives and deputy Health and Safety Representatives for each work group;
- prohibiting enforceable undertakings being accepted for contraventions, or alleged contraventions, of the WHS Act that involve a fatality, with mirror amendments to the ES Act and the SRWA Act; and

- providing that codes of practice will expire five years after they are approved to allow for more timely review of codes.

Provisions to commence on 1 July 2018:

- restoring the status of codes of practice as existed under the repealed *Workplace Health and Safety Act 1995* to require the safety measures in a code to be followed unless equal to or better than measures can be demonstrated;
- mandating training for Health and Safety Representatives within six months of being elected to the role, with refresher training to be undertaken at three-yearly intervals;
- introducing the ability for a PCBU to appoint a Work Health and Safety Officer (WHSO);
- requiring a PCBU to display a current list of WHSOs for the workplace;
- enabling the appointment of a WHSO or the election of a HSR to be permissible as evidence that a PCBU has taken action to mitigate health and safety risks; and
- clarifying inspector investigation powers under section 171 of the WHS Act to ensure these powers are not inappropriately limited by a legal technicality.

Provisions to commence on proclamation:

- expansion of the jurisdiction of the Queensland Industrial Relations Commission (QIRC) to hear and determine disputes relating to work health and safety issues, cease work matters, requests for assistance by Health and Safety Representatives, and the provision of information to Health and Safety Representatives. Disputes will not be able to be lodged with the QIRC until 24 hours after an inspector has been requested to assist with resolving a dispute and the dispute remains unresolved;
- establishing an independent statutory office for work health and safety prosecutions. The statutory office will be headed by a WHS Prosecutor appointed by the Governor-in-Council for a five-year renewable term; and
- enabling inspectors to make a determination about whether the WHS entry permit holder has a valid right of entry or has complied with notice requirements under sections 119 or 122 of the WHS Act.

[WorkCover Queensland (2017)]

The QNMU supported these changes and we provide the review with our submission to the inquiry into the *Work Health and Safety and Other Legislation Amendment Bill 2017* for your consideration. In our view, the model Work Health and Safety Laws should reflect contemporary legislation operating in the States.

To assist the reviewer, we have provided information on the nursing and midwifery workforce to contextualise our comments and we have included three additional recommendations.

About the Nursing and Midwifery Workforce

Nursing and midwifery are physically and mentally demanding. Nurses and midwives work in unique occupational environments that can require rotating and night shifts, long hours, prolonged standing, lifting, and exposure to chemicals, infectious diseases, x-ray radiation and other hazards (Lawson et al., 2009). Hazardous manual tasks can contribute to musculoskeletal injuries which can be permanent and impact on a person's working ability and quality of life as well as the productivity and economic performance of their employer.

Nurses and midwives have one of the highest rates of work-related musculoskeletal injuries of any professional group (Mullen et al., 2015). Research has shown that nurses who found their jobs to be moderately or highly physically demanding were significantly more likely to report neck, shoulder, and back injuries (Trinkoff et al., 2003). In 2015-2016, workers in the health care and social assistance industry had the highest number of serious claims, accounting for 15% although the frequency rate per million hours worked was down from 8.7 in 2014-15 to 7.4 in 2015-2016 (Safe Work Australia, 2018).

During the course of their employment, nurses and midwives may experience exposure to a wide variety of physical, chemical, biological, psychosocial or other hazards (Timmins et al., 2008). All of these factors can negatively affect nurses' and midwives' health and performance.

Thus, nurses' safety is intrinsic to patient safety.

Primacy of Work Health and Safety Laws

Our members work in a complex regulatory environment that governs their professional practice and obligations to public safety. However, at times situations arise where nurses can be at risk of personal harm because the requirements of other legislation take precedence. Here, for example, we refer to the 'seclusion' provisions of Part 3 Division 1 of *the Mental Health Act 2016 Qld* and the difficulties our members experience in meeting the needs of the patient while being exposed to workplace violence. Other legislation such as the *Aged Care Act 1997* is similarly relevant particularly in relation to the treatment of dementia patients.

We provide the following case study to demonstrate our concerns.

Mental Health Unit

A patient being treated at a mental health unit in a large public hospital has assaulted 33 treating practitioners several of whom have made claims for workers' compensation. Because of his condition and behaviour, the patient is at times confined alone in a room or area from which free exit is prevented.

To treat the patient, nurses are required to enter this area with security officers in the knowledge the patient may respond violently. In complying with the seclusion provisions of the *Mental Health Act 2016* and meeting their professional obligations to treat this individual, the mental health nurses at this facility are compromising their own health and safety.

Recommendation

The QNMU recommends Work Health and Safety Laws must have a mandated precedence over other legislation when the health and safety of workers could be compromised.

Definition of a Person or Business or Undertaking (PCBU)

We ask Safe Work Australia to consider the adequacy of the current definition of PCBU. WorkCover Qld (2017) defines a PCBU as -

a business or an undertaking that is either conducted alone or with others, whether or not for profit or gain. A PCBU can be:

- a sole trader (for example a self-employed person);
- a partnership;
- a company;
- an unincorporated association;
- a government department;
- a public authority (including a municipal council).

To reflect contemporary practice, in our view this definition must include reference to the relationship between franchisees and master franchise owners. Changes to the delivery of aged and community care has seen the entry of franchise owners providing in-home care and assistance as well as nursing services including:

- Medication administration;
- Intravenous therapies and administration;
- Insulin injections;
- Wound care;
- Catheter care;
- Ostomy/Colostomy care;
- Palliative support.

Individuals with no knowledge or experience in the provision of healthcare or the regulatory environment can buy a franchise from a master franchise owner.

Given this industry sector is recognised as high risk nursing and personal care workers employed under franchise arrangements must be afforded adequate work health and safety protections particularly through the identification of the PCBU. Nurses working for these franchisees must comply with professional practices standards. Their work health and safety must be protected as a necessary part of their engagement.

Recommendation

The QNMU recommends the definition of the PCBU includes master franchise owners and franchisees.

Notifications

In our view, the current regulation for reporting and notifying injuries most particularly musculo-skeletal injuries would rarely require an employer to report. It is not uncommon for workers to sustain significant injuries that can result in them not returning to work that do not fall within the confines of notification requirements. As a consequence, the inspectorate may be unaware of injury trends and problems within a particular industry or workplace in a timely manner.

The vague definition of 'spinal injuries' under s. 36(b)(vi) of the *Work Health and Safety act 2011* does not provide enough detail. This section states:

36 What is a *serious injury or illness*

In this Part, ***serious injury or illness*** of a person means an injury or illness requiring the person to have:

(a) immediate treatment as an in-patient in a hospital; or

(b) immediate treatment for:

(i) the amputation of any part of his or her body; or

(ii) a serious head injury; or

(iii) a serious eye injury; or

(iv) a serious burn; or

(v) the separation of his or her skin from an underlying tissue (such as degloving or scalping); or

(vi) a spinal injury; or

(vii) the loss of a bodily function; or

(viii) serious lacerations; or

(c) medical treatment within 48 hours of exposure to a substance;

and includes any other injury or illness prescribed by the regulations but does not include an illness or injury of a prescribed kind.

A spinal injury could range from a disc protrusion to paraplegia, either of which could end a worker's employment.

Recommendation

The QNMU recommends the definition of 'serious injury' under s36(b)(vi) of the *Work Health and Safety Act 2011* provides more detail on the range of spinal injuries.

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Work Health and Safety and Other Legislation Amendment Act 2017 Queensland.

The QNMU made the following submission to the inquiry into the *Work Health and Safety Amendment Bill 2017 Queensland.* We contend the model Work Health and Safety Laws should set the national regulation standards and therefore include the Queensland amendments as passed by the Queensland parliament.

Industrial manslaughter amendments

The QNMU supports the introduction of a new offence in the *Work Health and Safety Act 2011* (the Act) of industrial manslaughter. Research has shown prosecution for industrial manslaughter aligns with public interest and society's view of work deaths as punishable (Almond & Colover, 2012; Johnstone, 2013). Studies have also found that victim's families experience a sense of justice from the prosecution process, knowing the death of their loved one was not in vain and measures would be implemented to reduce the risk of other workers suffering a similar fate (Matthews et al., 2014).

According to Field & Jones (2015) work-related fatalities in England have fallen since the introduction of the *Corporate Manslaughter and Corporate Homicide Act 2007*. This coincides with the increase in number of prosecutions. While it may be difficult to draw firm conclusions regarding a potential correlation between the decline in workplace deaths and prosecutions, it might well be that this legislation is having a deterrent effect (Field & Jones, 2015). The QNMU supports the introduction of industrial manslaughter where conduct by a senior officer or an employer negligently causes the death of a worker.

Independent statutory office for prosecutions amendments

The QNMU supports the establishment of an independent statutory office to conduct and defend proceedings under the Act before a court or tribunal and to advise the regulator on matters relating to the Act. The statutory office should be transparent in their processes and decisions and evidence gathered should be reliable, strong and of quality. Every decision should be capable of a logical explanation.

The statutory office could learn from processes used in previous workplace death investigations. In the investigation into the quality of workplace death investigations conducted by the Queensland Ombudsman (2015), the Ombudsman noted how a memorandum of advice from a legal officer which is insufficient or inaccurate may have a significant adverse impact on the quality of their prosecution decisions. All 20 of the Office of

Fair and Safe Work Queensland (OFSWQ) workplace death investigations the Ombudsman reviewed had an outcome of no further action - meaning no prosecution action was taken. In only three of the 20 cases did the memorandum of advice to the Director, Legal and Prosecution Services provide sufficient reasons to make an informed decision on whether or not to commence a prosecution (Queensland Ombudsman, 2015). Typically most memoranda provided no analysis about whether an incident constituted a potential offence under the Act and if so whether a prosecution was appropriate having regard to the Department of Public Prosecution guidelines.

Although the circumstances of the cases may not have ended in prosecution, the quality, strength and reliability of the legal advice was not supported by adequate reasoning (Queensland Ombudsman, 2015). The QNMU is not questioning the expertise of those involved; rather we are highlighting that the proposed statutory office should consider legal advice and other relevant information when determining if an incident should be prosecuted. This will require a high level of legal expertise to support recommendations on whether a case against duty holders may proceed.

The QNMU also advocates for the right of unions to bring prosecutions on behalf of workers or where Workplace Health and Safety Queensland (WHSQ) has decided not to initiate a prosecution. This would align with New South Wales legislation where unions can prosecute under section 230 of the *NSW Work Health and Safety Act 2011* (WorkSafe Queensland, 2017).

We use the following case study to demonstrate why this statutory office is supported as we believe it will allow for greater communication with relevant parties and to avoid unnecessary follow-up to determine progress. We anticipate an independent statutory office would enable these functions to be carried out more effectively.

Case study 1

Mental health unit

In 2013, nurses from a mental health unit contacted the QNMU seeking further information on an investigation centring on a dangerous situation where a group of patients attacked nursing staff causing very serious physical and psychological injuries. Members advised us the Department of Justice and Attorney-General had informed them the investigation into the event was to cease. The QNMU was concerned at the apparent haste of the decision and inadequate explanation provided.

We wrote to the then Minister seeking clarification of the situation. WHSQ and the Prosecutions Unit representatives then met with the QNMU and we were satisfied with the reasons provided for the matter not proceeding to prosecution. We also acknowledged the follow-up audit into the safety management systems.

It then came to our attention that a patient involved in the attack on staff in 2013 was responsible for further injuries to staff in 2015. In making our enquiries into the events leading to the assault, the employer advised they had not contacted WHSQ because they believed the Act did not require notification. Although we conceded the injuries sustained in the incident were not as described under s. 36 of the Act nor a dangerous event under the strict confines of s. 37, we believed when assessed globally the incident warranted notification.

In this case, although the QNMU and members were satisfied with the eventual outcome, much time and effort could have been saved if there was a more transparent and timely process for informing the parties. We believe an independent statutory office can operate according to rigorous timelines for processing matters and keeping individuals and their representatives informed.

Issue resolution amendments

The QNMU supports the proposal of transferring jurisdiction for the review of reviewable decisions from the Queensland Civil and Administrative Tribunal (QCAT) to the Queensland Industrial Relations Commission (QIRC). The QIRC is a specialist workplace tribunal for Queensland and has a long history of dealing with work-related matters.

We provide the following case study to demonstrate the importance of the process of dispute resolution for work health and safety issues that cannot be settled within the workplace.

Case study 2

Atherton Hospital

The QNMU helped members at Atherton Hospital secure air-conditioning for their hospital by using the Provisional Improvement Notices (PIN) process. Staff argued that the overheated hospital was not simply a matter of personal comfort but a WHS issue.

After exhausting all the available consultation mechanisms to rectify their concerns – including the relevant Health and Safety committees – two Health and Safety Representatives (HSR) at the site declared consultation requirements under section 90(2) of the Act had been met, and they could now progress the matter by issuing a PIN.

The PIN stated the exact provision within the Act they believed was breached. Attached to the PIN, the HSRs also provided evidence in the form of temperature readings taken during 2013 showing periods where employees were working in heat of more than 35 degrees Celsius. They also included references to workload reports in which staff raised concerns about working in the heat.

To support the claim that staff had exhausted other avenues of resolving the matter, the PIN notice also included a timeline detailing the consultation approaches used. Details of other contributing factors were also documented, including the physical attributes of the hospital that impacted on the conditions the staff were expected to work in.

The employer's response to the PIN was not supportive and they claimed that the installation of air-conditioning was not required as they had already made changes by installing fans to control the heat hazard. Management also argued that there was no specific evidence of heat strain caused by excessive heat.

After being notified by the regulator that the PIN would not be enforced, QNMU members collected evidence via a survey of the impact the heat was having on both themselves and patients, identifying clear symptoms of heat strain.

After considering this new information and following a further workplace visit by an inspector, the regulator issued the Health Service District, with an improvement notice.

It is our belief, that were the outcome not favourable, referral to the QIRC would be timelier than QCAT. This is pertinent as the process took in excess of six months to resolve.

Right of entry amendments

The QNMU supports the Bill in enabling inspectors to make a decision where WHS right of entry issues cannot be resolved. This allows for quick resolution and possibly without the need for escalation to a tribunal.

Right of entry provisions are an important workplace right that allow workers who are exposed to injury or illness the opportunity to have the situation assessed and rectified quickly. We supply the following case study to demonstrate the significance of right of entry provisions for the work nurses and midwives perform and the importance for the inspector to be able to intervene and make a determination.

Case study 3

Endoscopy unit

The QNMU became aware that members working in an endoscopy unit may have been exposed to glutaraldehyde, a hazardous substance used in the sterilisation/cleaning process. As a result of this exposure a member experienced a range of symptoms which resulted in her having to cease employment. The union sought immediate access to the site and evidence from the employer that proper risk assessment, training and procedures had been carried out. In the first instance the employer refused entry to the QNMU until the regulator intervened.

The QNMU continued to monitor the situation and noted training records obtained using the relevant legislation indicated workers received training on glutaraldehyde use after the union's initial request to enter the premises and prior to finally receiving permission to come onsite.

The employer has since changed the chemicals and equipment used for sterilisation.

Code of practice amendments

The Bill proposes the review of each code of practice every five years which is supported by the QNMU. This will allow for the content of the codes of practice to remain relevant and responsive to emerging safety issues, changes in industry work practices and technological advances. The review should be in consultation with key stakeholders (WorkSafe Queensland, 2017).

The QNMU also supports the requirement to follow the safety measures in a code of practice or exceed them. Nurses and midwives use codes of practice as practical guides to achieve standards of heath, safety and welfare required under the Act and *Work Health and Safety Regulation 2011*. This includes *Manual Tasks Involving the Handling of People Code of Practice 2001*, *Hazardous Manual Tasks Code of Practice* 2011 and *First aid in the workplace 2014*. Following a code of practice achieves compliance with health and safety duties in relation to the subject matter of the code.

Enforceable undertaking amendments

The QNMU supports the Bill in proposing that an enforceable undertaking cannot be accepted for any offences that involve a fatality. The proposal that the Bill will expand the Act for a

contravention or alleged contravention that is a category 1 offence to all circumstances involving a fatality is supported.

Workplace Health and Safety Officer and Health and Safety Representative amendments

The QNMU supports the Bill in proposing the person conducting a business or undertaking (PCBU) is to provide the regulator with a list of HSRs. This will close the gap between WHSQ and HSRs and allow for easy dissemination of information and promotion of advice and support to HSRs.

The QNMU supports the Bill in recognising the important work of HSRs. Mandatory training for HSRs is strongly supported as HSRs return to the workplace with the knowledge and skills to make their workplace safer. Where workplace health and safety is well organised and taken seriously by the employer, we have found staff are much better informed and less at risk. Similarly, workplaces lacking information and commitment to safe practices create hostility and increased risk. HSRs need to be aware of the protections offered under the Act so they can carry out their functions without the threat of reprisal.

Further, the ability for HSRs to issue PINs and direct unsafe work to cease is a critical function of the HSR. The requirement of the PCBU to forward to the regulator a copy of all PINs issued by the HSR is also supported. In our view, WHSQ should receive a copy of all PINs at the time they are issued. As these incidents are only progressed to WHSQ when the matter is unresolved, a more comprehensive reporting system would reflect the true extent of workplace hazards and incidents. There is a need for increased statistical information on PINs which could be used as an evidence base for WHSQ.

The proposed reintroduction of the role of the Workplace Health and Safety Officer (WHSO) as existed under the WHS Act 1995 is supported by the QNMU. This will enhance health and safety management at workplaces. As nurses and midwives work in various settings the QNMU supports the reestablishment of the WHSO whose role exists to facilitate and assist their employer to comply with work health and safety legislation (WorkSafe, 2017).

The case study below provides an example of why we advocate for WHSOs and WHSRs to be in workplaces as safety advocates for nurses and midwives and other workers.

Case study 4

Aged care dementia unit

In November 2016, a 59 year old Assistant in Nursing (AIN) working in a 16 bed secure dementia unit within a 128 bed residential aged care facility was assaulted by a resident who had a long history of aggression toward staff. This was the second assault the AIN had been subjected by the same resident the previous being in 2014.

As a result of the assault, the AIN sustained a severe musculoskeletal injury to her right shoulder requiring surgical repair.

Disturbingly, approximately 15 minutes later the same resident assaulted a hospitality worker in much the same manner by pulling and twisting the employee's arm in a downward motion resulting in a similar shoulder injury that also required surgical intervention to repair the damage.

Similar reports of aggressive behaviour toward staff were attributed to this resident. Two days preceding and two days post these events another two staff members were assaulted by being pushed against a wall and hit with a trolley handle respectively.

The two assaulted employees reported that on the shift these events took place only one clinical staff member was present aside from two undergraduate students on study placement as there was no replacement of staff on sick leave. Both injured workers contend staffing levels contributed to the resident's behaviour. They also report post assault they continued their shifts in pain as no other staff were available to replace them.

Compounding the physical effects of these injuries, no critical incident debriefing was made available to the injured staff and no approach was made by the facility manager to determine the impact of the assault or to offer support.

These staff also report they were never approached to participate in an investigation by the employer, nor was WHSQ made aware of these events despite the serious injuries they sustained.

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