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# INQUIRY INTO WORKPLACE FATIGUE AND BULLYING IN SOUTH AUSTRALIAN HOSPITALS AND HEALTH SERVICES

3RD REPORT

OF THE 54TH PARLIAMENT

# PARLIAMENTARY COMMITTEE ON OCCUPATIONAL SAFETY, REHABILITATION AND COMPENSATION

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*Tabled in the House of Assembly and ordered to be published on 18 February 2020*

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**Second Session, Fifty-Fourth Parliament**

## Presiding Member's Foreword

Workplace fatigue and bullying in the health care sector have been the subject of extensive research and investigation in recent years, with many stories emerging of staff being subjected to unacceptable behaviour by their superiors and colleagues, and/or being required to work unreasonable hours.

Given the nature and significance of these issues, along with the Committee's broad responsibility to ensure that matters relating to occupational safety are kept under review, we resolved (on 16 October 2018) to inquire into and report on workplace fatigue and bullying in South Australian (SA) hospitals and health services.

As part of this Inquiry, the Committee accepted a total of 66 submissions, including 23 from organisations and 47 from individuals who shared their own personal experiences of workplace fatigue and bullying with the Committee. The Committee further received 24 supplementary submissions, most of which were responses to a short questionnaire sent to all individual submission authors. In addition to this, the Committee held 12 witness hearings at which it heard from a total of 48 individual witnesses, 13 of which were individuals who are current or past employees within the SA health care sector. The remaining witnesses represented 19 Australian-based organisations.

The Committee was keen to ensure that it consulted as widely as possible, and as part of this consultation process developed a survey which included a range of questions relating to the experience of individuals with workplace fatigue and bullying. The Committee received a total of 2,299 valid responses and an overview of the results is available in Appendix 2.

To gain a deeper understanding of some of the issues facing SA hospitals and health services, Committee members also undertook a site visit to a selection of SA Health sites in the Adelaide metropolitan area, including Flinders Medical Centre, Royal Adelaide Hospital, SA Ambulance Service Headquarters and the Lyell McEwin Hospital. The Committee valued the opportunity to speak directly with SA Health staff about issues pertinent to this Inquiry, including matters such as rostering practices, human resources procedures, fatigue risk management and incident reporting tools.

In reflecting on the evidence gathered throughout this Inquiry, the Committee has made 27 recommendations aimed at reducing the impact of workplace fatigue and bullying in SA hospitals and health services. While the Terms of Reference for this Inquiry were sufficiently broad to include consideration of private hospitals and health services, the evidence received by the Committee predominately related to the public health system and as such, the majority of the recommendations are directed to the Minister for Health and Wellbeing and SA Health. The Committee notes that many health care professionals work across both the public and private health system, and many health-related peak bodies that gave evidence to the Inquiry represent members who work (or have worked) across both systems. The Committee heard little evidence suggesting any major differences between

the public and private systems in terms of how workplace fatigue and bullying are managed, hence the focus for the Committee has been on SA's public system.

The Committee found that there were a number of factors commonly raised as contributing to workplace fatigue and bullying in SA hospitals and health services. The high-pressured nature of the work, coupled with the need to work long hours, shift work, overtime and on-call work (all as part of a 24/7 operation), creates an environment that places health professionals at greater risk of workplace fatigue and bullying. This is then further exacerbated by a poor workplace culture stemming from a hierarchical workforce and a lack of contemporary management skills amongst many clinical leaders, leading to poor behaviour and practices becoming entrenched within the workplace. Furthermore, where incidents arise, inadequate complaint resolution processes mean that underlying issues are often not resolved, and staff are either discouraged from reporting inappropriate behaviour or feel like reports they make won't result in action being taken.

Workplace fatigue and bullying can have very detrimental impacts on the health and wellbeing of health care professionals. These impacts, on both mental and physical health, often stem from unsafe working practices such as working excessive hours, having inadequate breaks and working irregular shift patterns. Further to this, both workplace fatigue and bullying can create a risk of emotional and physical burnout among staff. The impacts can also stretch beyond the workplace itself, with one example being the heightened risk of being involved in a road accident when commuting to and from work.

The recommendations in this Report aim to address areas where the Committee sees weaknesses in the way that workplace fatigue and bullying are currently being managed. The recommendations broadly fit into four categories as follows:

- **Improvement to systems and processes** – the Report includes a series of recommendations focussing on ensuring that SA Health takes a risk-based approach to preventing workplace fatigue and bullying and that it has sufficient high-quality data to allow it to do so;
- **Complaint management/resolution** – while preventative measures are a key focus of the recommendations in this Report, the Committee received evidence to suggest that existing SA Health complaint management/resolution processes have deficiencies which need to be resolved;
- **Appropriate levels of accountability** – the Committee sees the advent of new Local Health Network (LHN) Governing Boards as an opportune moment to improve accountability. To this end, the Committee has included a series of recommendations designed around LHN Boards reporting against key performance indicators relating to workplace fatigue and bullying. The Committee also sees SafeWork SA as playing a greater and more proactive role in ensuring

that hospitals and health services are providing safe working environments for their staff and reducing the impacts of workplace fatigue and bullying.

- **Accreditation** – notwithstanding that much of the framework around the accreditation of hospitals and health services is managed outside of the SA jurisdiction, the Committee considers that there is an opportunity to more effectively address issues of workplace fatigue and bullying through accreditation processes.

The Committee received evidence that workplace fatigue and bullying can lead to serious negative effects on the performance of staff, which can ultimately impact on patient safety. If for this reason alone, it is important that workplace fatigue and bullying in SA hospitals and health services are addressed as a matter of priority.

The Committee would like to thank all those who contributed to this Inquiry by giving their time and expertise to assist the Committee in understanding the complexities associated with the issues of workplace fatigue and bullying. As part of our ongoing commitment to occupational safety related issues, the Committee intends to keep these matters under review and monitor progress with respect to the implementation of the recommendations outlined in this Report. I would also like to express my thanks to my fellow members of the Committee for their input and deliberations, as well as the Committee staff who contributed over the course of this Inquiry – Parliamentary Officers Mr Simon Macdonald, Ms Anthea Howard and Mr Phil Frensham, and Research Officer Mr Eugene Braslavskiy.

**……**

**Mr Stephen Patterson MP**
Presiding Member
Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation

**18 February 2020**

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## RECOMMENDATIONS

**Recommendation 1 (page 49)**

That the Department for Health and Wellbeing (DHW) and the Department of Treasury and Finance work together to review the impact and application of Clauses 5.1.8 and 5.4.10 of the *Nurses (South Australian Public Sector) Award 2002* on workplace fatigue amongst nurses in SA hospitals, with a view to determining whether further clarification within the Enterprise Agreement is desirable and feasible. The Committee notes that Enterprise Agreement negotiations are currently underway and as such this investigation should be undertaken in preparation for the next round of enterprise bargaining.

As part of this review the Committee encourages the DHW to consult with other jurisdictions, including Queensland Health which has recently made changes to its nursing enterprise agreement.

**Recommendation 2 (page 52)**

That the Minister for Health and Wellbeing works with the Commonwealth Minister for Health to facilitate the introduction of changes to the clinical governance section of the National Safety and Quality Health Service Standards (NSQHS).

These changes should explicitly address workplace fatigue and bullying matters and be incorporated as part of the Australian Health Services and Quality Accreditation Scheme coordinated by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The primary aim of such changes is to ensure that medical professionals have a healthy and safe workplace allowing them to provide patients and consumers with safe and high-quality care.

**Recommendation 3 (page 52)**

Pending update of the NSQHS Standards (refer recommendation number 2 above) the Committee recommends that the Minister for Health and Wellbeing implements State based arrangements which ensure that matters of workplace fatigue and bullying are assessed in addition to the broader National accreditation/re-accreditation of South Australian hospitals and health services.

**Recommendation 4 (page 55)**

That the Minister for Health and Wellbeing works with the Commonwealth Minister for Health to encourage the National Boards established under the Health Practitioner Regulation National Law to more assertively address workplace fatigue and bullying including, where relevant, via the use of their registration/accreditation related powers.

**Recommendation 5 (page 55)**

That the Minister for Health and Wellbeing liaises with the following organisations/agencies with a view to encouraging them to more assertively address workplace fatigue and bullying in SA hospitals and health services including, where relevant, via the use of their accreditation related powers:

- SA MET Advisory Council;
- The Australian College of Nursing; and
- The Australian Specialist Medical Colleges.

**Recommendation 6 (page 71)**

That the DHW works collaboratively with the LHNs to ensure that all individual units/wards undertake a full assessment of their workplace fatigue risk and subsequently implement a local area fatigue management policy that is appropriately scaled to their risk level.

**Recommendation 7 (page 71)**

That the DHW, in collaboration with the LHNs, determines a minimum risk level at which the use of a Fatigue Risk Management System (FRMS) is mandatory and ensures that any business units/wards that have a risk level that is sufficiently high implement a comprehensive FRMS as a matter of urgency.

**Recommendation 8 (page 71)**

That the DHW appoints a senior manager to oversee the development, implementation, review and monitoring of fatigue management policies and FRMS established across SA Health sites.

**Recommendation 9 (page 72)**

That the DHW actively monitors and evaluates the effectiveness of fatigue management policies and FRMS developed across its sites with a view to ensuring that these policies/systems are updated and improved overtime.

**Recommendation 10 (page 72)**

That the DHW, in collaboration with the LHNs, ensures that all local area fatigue management policies and FRMS incorporate, where relevant, consideration of hours worked by staff as part of any employment arrangements they have outside of SA Health.

**Recommendation 11 (page 77)**

That the DHW oversees and coordinates a trial of a bullying risk audit tool at a SA Health site. The Committee notes that the Northern Adelaide Local Health Network (NALHN) has already been approached to be involved in a trial being conducted by the Office of the Commissioner for Public Sector Employment (OCPSE) as part of the follow-up action plan arising from the Your Voice Survey.

If NALHN is involved in the OCPSE bullying risk audit trial, the Committee recommends that the DHW plays an active role in the implementation and review of that trial (as it relates to NALHN) with a view to ensuring broader implementation of an audit tool across SA Health can be achieved more seamlessly.

If the results of the trial demonstrate a reduction in workplace bullying, the Committee recommends that the DHW prioritises funding for the timely implementation of this risk audit tool more broadly. The Committee suggests that the roll out of the tool is prioritised in areas where workplace bullying rates are highest.

**Recommendation 12 (page 80)**

That the DHW proactively works with the LHNs to develop and implement regular and ongoing local area audits of staff 'time and attendance'. The Committee recommends that the 'time and attendance' audits focus on trainee medical officers in the first instance.

If the audits identify any areas of concern particularly with respect to the under-reporting of hours worked and/or overtime claimed, the Committee recommends that the DHW/LHNs develop appropriate strategies aimed at addressing these issues, including penalties for wilful non-compliance by hospital management.

**Recommendation 13 (page 82)**

That the DHW prioritises the upgrade/redevelopment of existing computer-based systems which would allow for the more effective collection of staff working hours data. Any system upgrades or changes should also consider the need for flexible and user focussed reporting functionality. In making this recommendation, the Committee encourages the DHW to consider best practice approaches and systems used in other jurisdictions.

**Recommendation 14 (page 82)**

That the DHW prioritises funding to allow, as a matter of urgency, the roll out of consistent rostering software across LHNs.

**Recommendation 15 (page 83)**

That the rostering software adopted across LHNs (refer recommendation number 14 above) should allow for the management of working hours and overtime within a risk management framework.

**Recommendation 16 (page 87)**

That the DHW monitors and subsequently evaluates the Cognitive Institute programs ('Speaking up for Safety' and 'Promoting Professional Accountability') being implemented by NAHLN. Should these programs prove successful in improving workplace culture, the Committee recommends that the DHW works with the LHNs to select, implement and embed suitable early intervention programs across its sites.

**Recommendation 17 (page 88)**

That the DHW works collaboratively with the LHNs to ensure the availability of consistent and high-quality leadership training for early-mid career clinicians, with a view to developing future leaders who are equipped with the necessary skills (over and above clinical expertise) for management/leadership positions within the health sector.

**Recommendation 18 (page 91)**

That the DHW, in collaboration with LHN Governing Boards, implements strategies to ensure that the following areas of concern relating to complaints management are addressed:

- quality and frequency of communication with complainants;
- transparency of process and accountability for complaint resolution; and
- resolution of complaints regardless of whether the complainant or alleged bully moves elsewhere within the public sector.

**Recommendation 19 (page 91)**

That the DHW, in collaboration with the LHN Governing Boards, implement a system which allows for the recording, tracking, and management of bullying related complaints across SA Health. The system should have reporting functionality which allows for comparison across LHNs as well as individual business units/wards.

**Recommendation 20 (page 91)**

That the DHW, in collaboration with the LHN Governing Boards, works to ensure that, where feasible, all policies, processes and procedures relating to complaint management/handling, are consistent across LHNs.

**Recommendation 21 (page 91)**

That the DHW, in collaboration with LHN Governing Boards, review HR staffing arrangements and takes any necessary follow-up action to ensure that staff are adequately trained and experienced in the management of workplace bullying related complaints.

**Recommendation 22 (page 94)**

That the DHW, in collaboration with the Governing Boards of each LHN, develops, implements, monitors and reports against a standardised series of qualitative and quantitative key performance indicators (KPIs), embedded within the strategic planning framework, designed to reduce the instance and impacts of workplace bullying and fatigue.

Potential metrics which should be considered as part of the development of the KPIs may include:

- Rates of absenteeism;
- Complaint resolution times and rates;
- Levels of staff satisfaction;
- Staff turn-over rates; and
- Reliance on use of overtime/recall.

**Recommendation 23 (page 95)**

That the DHW oversees and coordinates regular short electronic workplace culture focussed surveys (including questions relating to workplace fatigue and bullying), the results of which should feed into the LHN Governing Board reporting against KPIs (referred to in recommendation number 22 above).

**Recommendation 24 (page 102)**

That the DHW takes the necessary steps to make the workplace fatigue related questions in the SA Health Safety Learning System (SLS) mandatory.

**Recommendation 25 (page 104)**

That SafeWork SA develop and implement targeted strategies and plans, developed in conjunction with hospital employers, aimed at reducing instances of workplace fatigue and bullying. This could be achieved as part of an update of the existing Hospitals Action Plan if appropriate.

**Recommendation 26 (page 105)**

That the DHW organises and leads twice yearly sector-wide forums focussed on ensuring more effective coordination of strategies aimed at reducing workplace fatigue and bullying amongst relevant agencies/organisations. These forums should aim for broad agreement amongst stakeholders about practical and coordinated strategies to address workplace fatigue and bullying.

At a minimum the Committee suggests that the following organisations be invited to attend these forums:

- Representatives from universities involved in the training of graduates who are employed in hospitals and health services (e.g. – Medical Deans, Nursing and Midwifery Deans);
- Relevant Australian Specialist Medical Colleges;
- Relevant unions including the ANMF, AEA, HSU and SASMOA;
- SA MET Health Advisory Council;
- AMA (SA);
- SafeWork SA;
- Representatives from individual private hospitals and/or the Australian Private Hospital Association; and
- Medical professional indemnity insurers.

**Recommendation 27 (page 106)**

That the DHW and SafeWork SA appear separately before the Committee to provide a progress update on the implementation of the Inquiry recommendations relevant to them within 18 months of the Inquiry Report being tabled.

# 1. PARLIAMENTARY COMMITTEE ON OCCUPATIONAL SAFETY, REHABILITATION AND COMPENSATION

## 1.1 Preamble

This is the 3rd Report (of the 54th Parliament) of the Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation (the Committee).

On 16 October 2018, on its own motion, the Committee resolved to inquire into and report on workplace fatigue and bullying in South Australian hospitals and health services. The Committee received evidence from both individuals affected by workplace fatigue and bullying, as well as organisations with an interest in these issues. This evidence has informed the findings and 27 recommendations made by the Committee in this Report.

It is the Committee's hope that the recommendations will be implemented as swiftly as possible and go some way to addressing workplace fatigue and bullying in SA hospitals and health services, and thereby improving working conditions for health care professionals to ensure they are able to focus on providing the best possible care to patients.

# 2. COMMITTEE MEMBERSHIP AND FUNCTIONS

## 2.1 Members of the Committee

The membership of the Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation is as follows:

Mr Stephen Patterson, MP (Presiding Member)

Hon John Dawkins, MLC

Hon Tammy Franks, MLC

Mr Jon Gee, MP

Mr Steve Murray, MP

Hon Tung Ngo, MLC.

## 2.2 Committee Staffing

The Committee was supported by Parliamentary Officer Ms Anthea Howard from the commencement of the Inquiry through to 31 December 2018. Mr Simon Macdonald supported the Committee as Research Officer during this same period and from 31 December 2018 to 3 January 2020 in the role of Parliamentary Officer. Mr Phil Frensham supported the Committee as Parliamentary Officer from 6 January 2020 through till the conclusion of the Inquiry. Mr Eugene Braslavskiy supported the Committee as Research Officer from 8 January 2019 until the conclusion of the Inquiry.

## 2.3 Functions of the Committee

Section 15F of the *Parliamentary Committees Act 1991* defines the functions of the Occupational Safety, Rehabilitation and Compensation Committee as:

(a) to keep the administration and operation of the *Occupational Health, Safety and Welfare Act 1986,* the *Workers Rehabilitation and Compensation Act 1986,* and other legislation affecting occupational health, safety or welfare, or occupational rehabilitation or compensation under continuous review; and
(b) to examine and make recommendations to the Executive and Parliament about proposed regulations under any of the legislation mentioned in paragraph (a), and in particular regulations that may allow for the performance of statutory functions by private bodies or persons; and
(c) to perform other functions assigned to the Committee by this or any other Act or by resolution of either House of Parliament.

## 2.4 Referral Process

Pursuant to section 16(1) of the *Parliamentary Committees Act 1991,* any matter that is relevant to the functions of the Committee may be referred to the Committee —

(a) by resolution of the Committee's appointing House or Houses, or either of the Committee's appointing Houses
(b) by the Governor, by notice published in the Gazette;
(c) of the Committee's own motion.

### 2.5 Ministerial Responses

Pursuant to section 19(2) of the *Parliamentary Committees Act 1991,* any recommendations directed to a Minister of the Crown require a response from that Minister within four months. This response must include statements as to:

(a) which (if any) recommendations of the Committee will be carried out and the manner in which they will be carried out; and
(b) which (if any) recommendations will not be carried out and the reasons for not carrying them out.

The Minister must cause a copy of the response to the Committee's Report to be laid before the Committee's appointing House within six sitting days after it is made.

## 3. MOTION

On 16 October 2018 and pursuant to section 16(1)(c) of the *Parliamentary Committees Act 1991*, the Committee resolved to inquire into workplace fatigue and bullying in South Australian hospitals and health services.

## 4. TERMS OF REFERENCE

The Terms of Reference for the Inquiry were as follows:

*That the Committee will inquire into, and report on workplace fatigue and bullying in South Australian hospitals and health services, and in particular:*

a) *The factors contributing to workplace fatigue and bullying in South Australian hospitals and health services;*
b) *The impact of workplace fatigue and bullying on the health and wellbeing of health care professionals;*
c) *The impact of workplace fatigue and bullying on quality, safety and effective health services;*
d) *The extent to which current work practices comply with relevant legislation, codes and industrial agreements;*

e) *Opportunities, costs and impacts of measuring fatigue and using risk management tools, audit and compliance regimes, including those in other industries (e.g. aviation, mining and transport industries) to reduce the occurrence or impact of fatigue and bullying;*

f) *Measures to improve the management and monitoring of workplace fatigue and bullying;*

g) *The extent to which fatigue, including a comparison to other industry sector practices, is a factor that is taken into account during investigations into medical misadventure;*

h) *Any other relevant matters.*

## 5. GLOSSARY

| | |
|---|---|
| **ACEM** | Australasian College for Emergency Medicine |
| **ACN** | Australian College of Nursing |
| **ACSQHC** | Australian Commission on Safety and Quality in Health Care |
| **AHPRA** | Australian Health Practitioner Regulation Agency |
| **AMA** | Australian Medical Association |
| **AMSA** | Australian Medical Students' Association |
| **ANMF** | Australian Nursing and Midwifery Association |
| **ANZCA** | Australian and New Zealand College of Anaesthetists |
| **ATSB** | Australian Transport Safety Bureau |
| **CALHN** | Central Adelaide Local Health Network |
| **CASA** | Civil Aviation Safety Authority |
| **CDNM** | Council of Deans of Nursing and Midwifery |
| **CHSALHN** | Country Health South Australia Local Health Network |
| **DHW** | Department for Health and Wellbeing |

| | |
|---|---|
| **FRMS** | Fatigue Risk Management System |
| **HCASA** | Health Consumers Alliance of SA Inc |
| **HR** | Human Resources |
| **ICAC** | Independent Commissioner Against Corruption |
| **KPI** | Key Performance Indicator |
| **LHN** | Local Health Network |
| **MIGA** | Medical Insurance Group Australia |
| **NALHN** | Northern Adelaide Local Health Network |
| **NHVR** | National Heavy Vehicle Regulator |
| **NMBA** | Nursing and Midwifery Board of Australia |
| **NSQHS** | National Safety and Quality Health Service |
| **OCPSE** | Office of the Commissioner for Public Sector Employment |
| **OPI** | Office for Public Integrity |
| **RACS** | Royal Australasian College of Surgeons |
| **RANZCP** | Royal Australian and New Zealand College of Psychiatrists |
| **SAAS** | South Australian Ambulance Service |
| **SALHN** | Southern Adelaide Local Health Network |
| **SA MET** | South Australian Medical Education and Training |
| **SASMOA** | South Australian Salaried Medical Officers Association |
| **SLS** | Safety Learning System |
| **WCHN** | Women's and Children's Health Network |
| **WHS** | Work Health and Safety |

# 6. BACKGROUND

The prevalence and impact of workplace fatigue and bullying in the health care sector has been the subject of considerable research and discussion across the world in recent years. This section of the Report sets out the definitions of workplace fatigue and bullying used for the purposes of this Inquiry as well as providing background information regarding the scale of these issues with relevance, where possible, to the South Australian context.

While there are limitations and difficulties associated with the collection and analysis of data (particularly surveys) associated with workplace fatigue and bullying, the evidence received by the Committee clearly indicates there are serious and widespread issues in the health care industry which have been protracted and ongoing and which require urgent consideration and attention.

## 6.1 Workplace fatigue

### *6.1.1 Definition*

In a work context, fatigue is mental and/or physical exhaustion that reduces your ability to perform your work safely and effectively. This definition, used by Safe Work Australia and adopted by the Committee for the purposes of this Inquiry, emphasises that fatigue is more than simply feeling tired and drowsy.[1] There are various signs of fatigue, which can include tiredness even after sleep, reduced hand-eye coordination and slow reflexes, problems with short term memory and concentration, blurred vision or impaired visual perception, and needing extended sleep during days off work. Fatigue can occur due to prolonged mental or physical activity, sleep loss and disruption of the internal body clock. Both work and non-work factors may contribute to fatigue, and its impacts can accumulate over time.[2]

[1] Safe Work Australia 2018, *Fatigue*, https://www.safeworkaustralia.gov.au/fatigue, viewed 7 August 2019.

[2] Safe Work Australia 2013, *Guide for Managing the Risk of Fatigue at Work*, https://www.safeworkaustralia.gov.au/system/files/documents/1702/managing-the-risk-of-fatigue.pdf, viewed 22 August 2019.

### *6.1.2 Measuring the scale of the problem*

Accurately measuring the scale of workplace fatigue tends to be challenging because it generally relies on worker self-assessment. Notwithstanding this, workplace fatigue remains a problem with significant implications. Results from a 2002 survey conducted by the *National Sleep Foundation* in the US estimated that fatigue in the workplace costs American industry at least USD $77 billion annually,[3] while a 2007 study in the *Journal of Occupational and Environmental Medicine* estimated that fatigue carried estimated costs of more than USD $136 billion in health-related productivity.[4] In an Australian context, a 2000 report by the House of Representatives Standing Committee on Communication, Transport and the Arts estimated that fatigue related vehicle accidents (in the transport industry) alone cost the country $3 billion annually.[5] More recently in Australia, a 2017 Deloitte study commissioned by the Sleep Health Foundation estimated that the total costs of inadequate sleep (one of the causes of fatigue) was estimated to be $66.3 billion in 2016-17. This figure was made up of financial costs of $26.2 billion and wellbeing costs of $40.1 billion.[6]

#### *Peak body surveys*

The Australian Medical Association (AMA) has been collecting data on fatigue in the medical workforce through its Safe Hours Audit conducted every five years since 2001. The audit collects data on the hours of work, on-call hours, non-work hours and sleep time of doctors, and then uses this information to categorise participants into one of three risk categories – lower, significant and higher. Figure 1 shows that the number of doctors at a significant or higher risk of fatigue, as reported in the Safe Hours Audit, has fallen since 2001. Notwithstanding this positive trend, the audit data still

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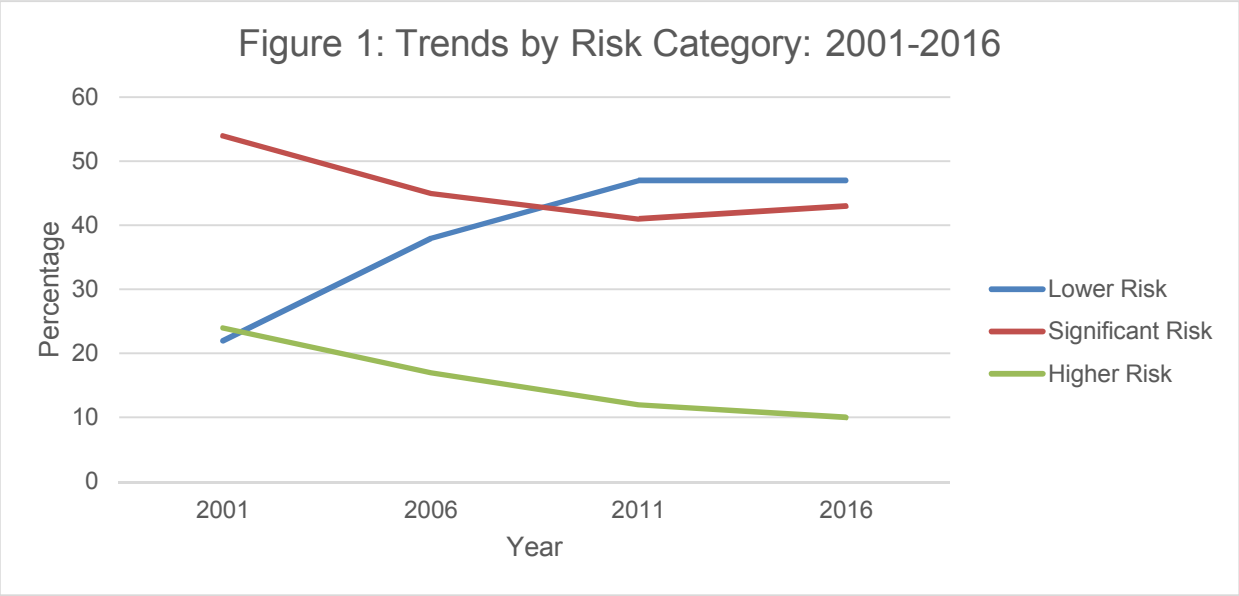
[3] EHS Today 2002, *Severe Impact of Fatigue in the Workplace Examined*, https://www.ehstoday.com/archive/article/21914831/severe-impact-of-fatigue-in-the-workplace-examined, viewed 23 December 2019.

[4] EHS Today 2007, *Study: Workplace Fatigue Common, Costly*, https://www.ehstoday.com/archive/article/21913457/study-workplace-fatigue-common-costly, viewed 23 December 2019.

[5] Parliament of the Commonwealth of Australia 2000, House of Representatives Standing Committee on Communication, Transport and the Arts, *Beyond the Midnight Oil: An inquiry into managing fatigue in transport*, https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=cita/manfatigue/mfcontents.htm, viewed 23 December 2019.

[6] Sleep Health Foundation 2017, *Asleep on the job: Costs of inadequate sleep in Australia*, https://www.sleephealthfoundation.org.au/files/Asleep_on_the_job/Asleep_on_the_Job_SHF_report-WEB_small.pdf, viewed 23 December 2019.

demonstrates that in 2016, 53 per cent of doctors were still working unsafe hours that put them at significant or higher risk of fatigue.[7]




The AMA Safe Hours Audit suggests that there are a range of indicators that a medical professional may be working unsafe hours, including longer hours worked, longer continuous periods of work, less full days free of work, more days on-call and more days without a meal break.

A number of health-related peak bodies, including medical colleges and unions have also conducted surveys and studies which demonstrate that fatigue may be prevalent amongst their membership base. A survey of junior doctors conducted in 2016 by the South Australian Salaried Medical Officers Association (SASMOA) reported a third of respondents described their workload as beyond an appropriate capacity, with over a third claiming that staffing levels in their unit were insufficient.[8] In response to the announcement of this Inquiry, SASMOA undertook another survey. Amongst junior doctors, a significant majority reported having to commence work prior to their rostered shift time, with many not claiming non-rostered overtime due to workplace culture and fears that doing so may harm their future career prospects. 80 per cent of junior doctors reported having had concerns over making clinical errors due to fatigue, with over 80 per cent also concerned about their own personal health and safety due to the hours they worked.[9] With respect to senior doctors, the situation was not much

[7] Australian Medical Association (AMA) 2017, *Managing the Risks of Fatigue in the Medical Workforce: 2016 AMA Safe Hours Audit*, https://ama.com.au/system/tdf/documents/v1%202016%20AMA%20Safe%20Hours%20Audit%20Report.pdf?file=1&type=node&id=46763, viewed 5 August 2019.

[8] South Australian Salaried Medical Officers Association (SASMOA), Submission No 50, 14 February 2019.

[9] Ibid.

better with 90 per cent reported having suffered from workplace fatigue, and over 70 per cent having had had concerns over making clinical errors due to fatigue, and also concerns over their own health and safety.[10]

The SA Branch of the Australian Nursing and Midwifery Federation (ANMF) partnered with the University of South Australia (UniSA) in 2017 to undertake a Nursing and Midwifery Workforce Climate Survey. The survey found that a significant percentage of nurses and midwives were working more hours than they would like, as shown in Table 1 below.

**Table 1: Nursing and Midwifery Workforce Climate Survey 2017 – perception of current work hours**[11]

| | **Midwife** | **Enrolled Nurse** | **Registered Nurse** |
|---|---|---|---|
| A bit more than you would like | 27.2% | 21.9% | 27.7% |
| A lot more than you would like | 14.3% | 11.0% | 14.2% |

The Australasian College for Emergency Medicine (ACEM) conducted a Workforce Sustainability Survey in 2016 which showed that many of its members were working excessive hours with limited opportunities to take annual leave, putting them at higher risk of workplace fatigue. 65.3 per cent of respondents reported working more than 40 hours per week. There were significant rates of overtime and working unpaid hours reported, along with many respondents taking either no annual leave or less than the annual entitlement. 69 per cent of respondents reported difficulties in arranging annual leave and 70 per cent reported difficulties in being able to take a break at work.[12]

In a survey of its members, Professionals Australia (which represents a range of health professionals across Australia) found that nearly 95 per cent of respondents said that there was a fatigue management problem in their workplace.[13] Many members reported that workplace fatigue is not an ad hoc problem and is a "constant struggle to put patients first with their dwindling resources."[14]

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[10] Ibid.

[11] Corsini, N, Adelson, P, Anikeeva, O, Ramsey, I, Peters, MDJ, Sharplin, G, Eckert, M 2018, *Nursing and Midwifery Workforce Climate Survey 2017*, Rosemary Bryant AO Research Centre, University of South Australia.

[12] Australasian College for Emergency Medicine (ACEM), Submission No 49, 8 February 2019.

[13] Professionals Australia, Submission No 27, 31 January 2019.

[14] Ibid.

### *SA Health data*

SA Health uses a Safety Learning System (SLS) as its primary tool for recording and reporting on workplace incidents. Included within the SLS is a series of four questions relating to wakefulness and fatigue. These questions capture information on the time of day when the incident occurred, the type of work pattern or shift type, the amount of time the person was awake, and the amount of sleep they had in the 24-48 hours prior to the incident. SA Health reported that of the 43,060 Work Health and Safety (WHS) incidents reported in the SLS between 2013-18, there were 33,620 incidents (78.1 per cent) where the reporter answered at least one of the four questions.[15] Notwithstanding the relatively large percentage of incidents (78.1%) where fatigue may have been a contributing factor SA Health acknowledged that the optional nature of the four fatigue related questions is likely to result in under-reporting.[16] Further information regarding the SA Health SLS and commentary on the optional nature of the fatigue related questions included within it can be found in section 7.7.2.

SA Health also reported that in the 2013-2018 financial years, there was a total of 6,686 workers compensation claims across SA Health (including SAAS). While it is difficult to quantify the extent to which fatigue was a contributing factor in these claims, SA Health noted in its submission that 268 claims (4 per cent) were coded as being due to 'work pressure' and a further 104 (1.6 per cent) had 'fatigue' and other related key words in the worker's description of the injury.[17] Of the 268 claims coded as 'work pressure', 166 claims had lost time, with a cumulative total of 10,943 days lost from work at a cost of $9.073 million.

### *Committee survey*

In an effort to get a better understanding of the issues pertinent to this Inquiry, the Committee conducted its own survey of South Australian health professionals (refer Appendix 2 for further information). The survey questions relating to workplace fatigue were loosely based on a number of the relevant factors considered in the AMA Safe Hours Audit, along with additional questions that sought to understand the experiences of respondents with respect to fatigue. Our results found that nearly a quarter of respondents worked 44 or more hours in a typical week.[18] Medical staff tended to

[15] SA Health, Submission No 56, 26 February 2019.

[16] Ibid.

[17] Ibid.

[18] OSRC Committee Survey Results, 28 June 2019.

perform worst on indicators of fatigue. They were more likely to be working longer hours (see Table 2 below), have less days free of work, more days on-call, more days without meal breaks, and most likely to strongly agree that the demands of their work interfered with their personal lives. These factors point to respondents being at a higher risk of fatigue.[19] Despite this, medical staff were least likely to take sick leave as a result of fatigue. Responses from ambulance service staff were also more heavily skewed towards longer working hours (see Table 2 below).

**Table 2: Number of hours worked over a typical 7-day period**[20]

| | Medical | Nursing and midwifery | Allied health | Ambulance services | Hospital administration | Facilities services | Other | Total |
|---|---|---|---|---|---|---|---|---|
| 0 to 38 | 18.72% | 52.17% | 56.85% | 17.46% | 49.09% | 45.45% | 46.34% | 45.20% |
| 38 to 43 | 27.18% | 31.45% | 30.46% | 31.75% | 31.64% | 36.36% | 36.10% | 31.04% |
| 44 to 50 | 26.67% | 8.68% | 6.60% | 30.16% | 8.73% | 15.15% | 8.78% | 12.12% |
| 51 to 57 | 13.33% | 2.39% | 1.52% | 7.94% | 2.91% | 3.03% | 2.93% | 4.36% |
| 58 to 64 | 5.38% | 2.39% | 2.03% | 9.52% | 3.27% | 0.00% | 1.46% | 3.05% |
| 65 to 71 | 3.85% | 1.19% | 1.02% | 1.59% | 0.36% | 0.00% | 0.49% | 1.44% |
| 72 to 78 | 2.56% | 1.30% | 1.02% | 0.00% | 3.27% | 0.00% | 2.93% | 1.92% |
| Over 78 | 2.31% | 0.43% | 0.51% | 1.59% | 0.73% | 0.00% | 0.98% | 0.87% |
| No. of responses[21] | 390 | 922 | 394 | 63 | 275 | 33 | 205 | 2294 |

Only 13 per cent of respondents reported having submitted a formal complaint regarding factors that contribute to workplace fatigue, and of those who had, 80 per cent reported that the complaint was not resolved to their satisfaction. 58 per cent of respondents reported having taken sick leave as a result of workplace fatigue, and while the survey did not ask how many sick days were taken, if extrapolated across the whole of SA Health, the budget impact is likely to be considerable.[22]

[19] AMA 2017, *Managing the Risks of Fatigue in the Medical Workforce: 2016 AMA Safe Hours Audit*, https://ama.com.au/system/tdf/documents/v1%202016%20AMA%20Safe%20Hours%20Audit%20Report.pdf?file =1&type=node&id=46763, viewed 5 August 2019.

[20] OSRC Committee Survey Results, 28 June 2019.

[21] Numbers of responses do not add up to total as not all respondents identified their profession.

[22] OSRC Committee Survey Results, 28 June 2019.

## 6.2 Workplace bullying

### *6.2.1 Definition*

The definition of *workplace bullying*, as used by Safe Work Australia and adopted by the Committee for the purposes of this Inquiry, is repeated and unreasonable behaviour directed towards a worker or group of workers that creates a risk to health and safety.[23] Bullying in the workplace can take different forms and can include psychological, physical and indirect behaviour. It is important to make the distinction between bullying and reasonable performance management, as this can affect individuals' perceptions of what constitutes bullying behaviour.

### *6.2.2 Measuring the scale of the problem*

As is the case with workplace fatigue, measuring the scale of workplace bullying can be challenging. A 2010 Productivity Commission report noted that, using international studies as a guide, the estimates of the annual costs of workplace bullying to employers and the Australian economy ranged from (in 2000) $6 billion to $36 billion.[24]

Where survey-based workplace bullying data is available, the true scale of the issue can be difficult to determine. Many of these surveys rely on self-identification and therefore can result in under-reporting if staff feel uncomfortable with disclosing information about their experiences. Conversely, surveys focussed on collecting information about workplace bullying are likely to attract individuals who have experienced this behaviour and as a result the true scale of the issue may be overstated. These difficulties aside, much analysis of the prevalence of workplace bullying has been undertaken and an overview of this analysis is outlined below.

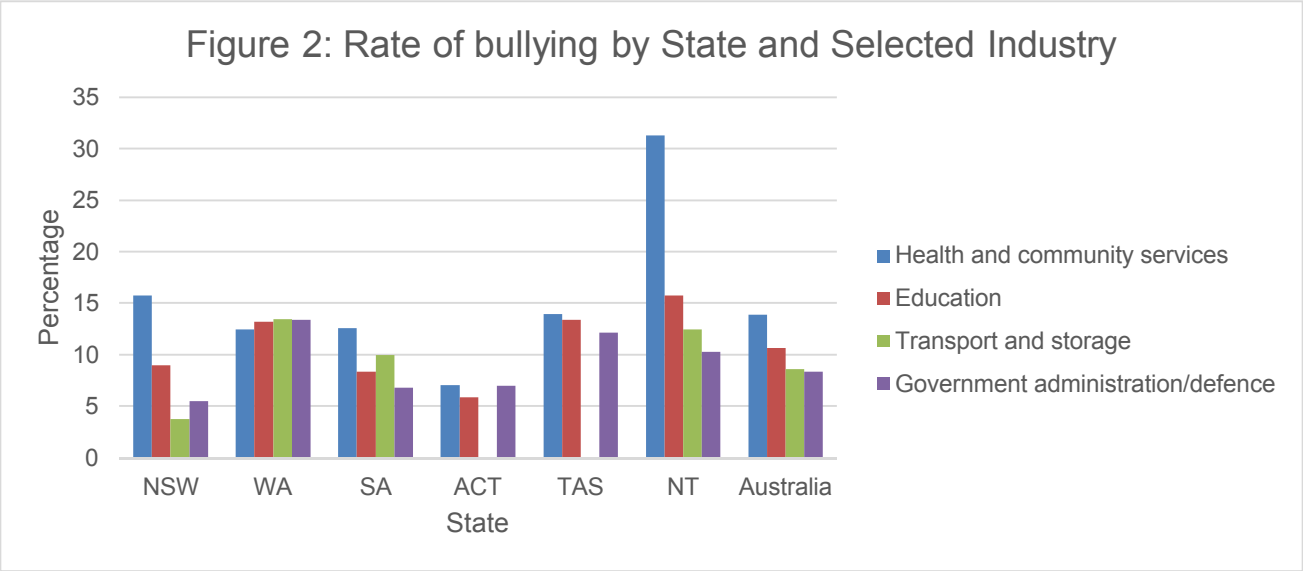
#### *National surveys*

The Australian Workplace Barometer project conducted over 2009-2011 found that 6.8 per cent of Australian workers had been bullied at work in the six months prior to being surveyed, with 3.5 per

[23] Safe Work Australia 2019, *Bullying*, https://www.safeworkaustralia.gov.au/bullying, viewed 30 July 2019.

[24] Productivity Commission 2010, *Performance Benchmarking of Australian Business Regulation: Occupational Health & Safety: Productivity Commission Research Report*, https://www.pc.gov.au/inquiries/completed/regulation-benchmarking-ohs/report/ohs-report.pdf, viewed 23 December 2019.

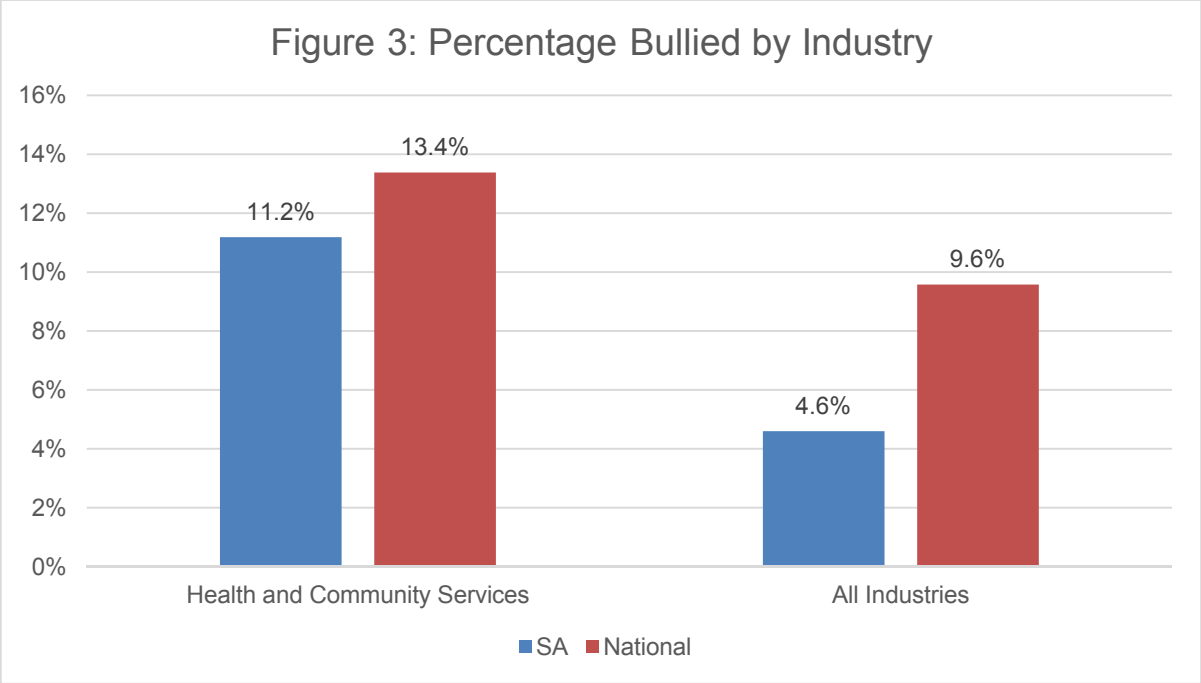
cent having experienced bullying for longer than six months.[25] At a national level, the health and community services industry was found to have the highest rate of bullying victimisation of 13.9 per cent, with a rate of 12.6 per cent for South Australia. Figure 2 shows a comparison with the four industries reporting the highest rates of workplace bullying.




In the 2014-15 update of the Australian Workplace Barometer project, it was found that on average 11.2 per cent of participants from the SA Health and Community Services sector reported bullying, and that this was nearly 2.5 times higher than the SA average across all industries. This was however lower than the national sector average of 13.4 per cent.[26] Figure 3 below shows a comparison of how SA compared to the national average for both the Health and Community Services sector, as well as all industries combined.

[25] Dollard, M, Tuckey, M, Bailey, T & McLinton, S 2012, Parliamentary inquiry submission on workplace bullying and harassment: Results from the Australian Workplace barometer, http://www.aphref.aph.gov.au/house/committee/ee/bullying/subs/sub182.pdf, viewed 30 July 2019.

[26] Dollard, MF and Bailey, T 2019, *Bullying in the SA Health and Community Services Sector: Results from the Australian Workplace Barometer Project 2014/15*, Centre for Workplace Excellence, University of South Australia, response to questions on notice from Committee witness hearing on 2 August 2019.

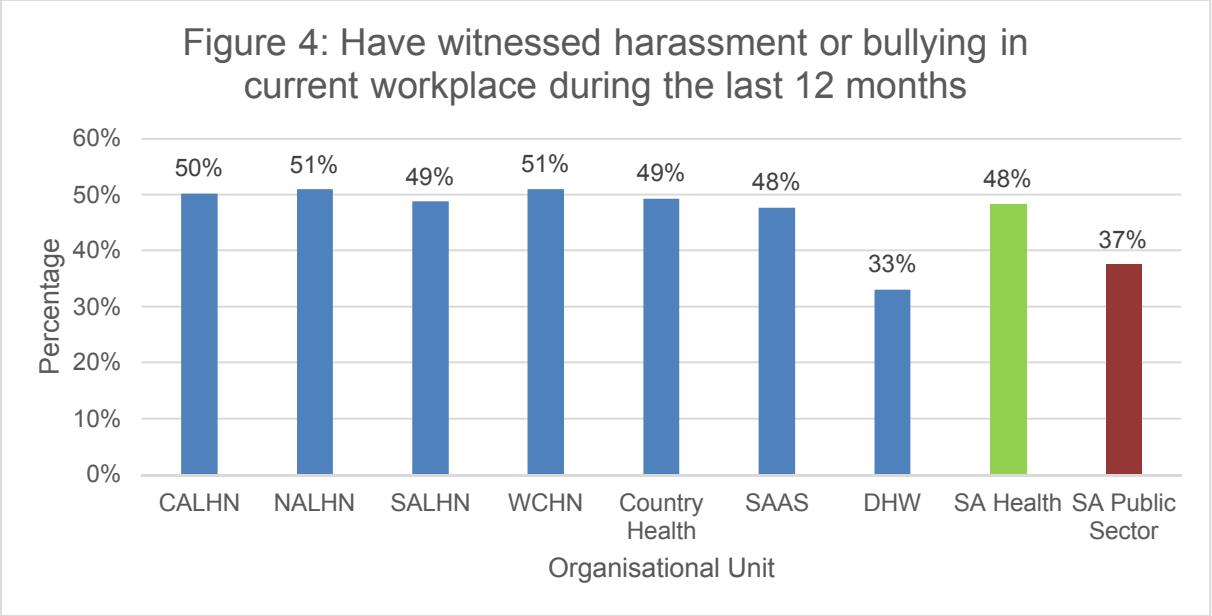


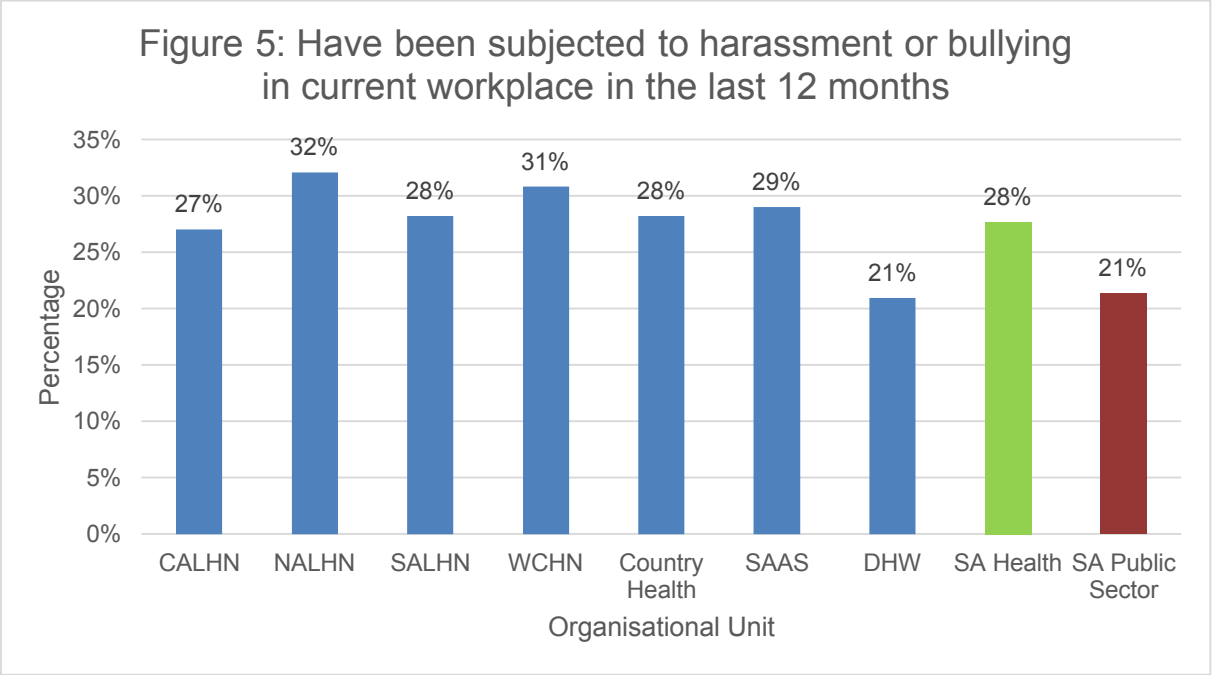

***South Australian surveys***

In 2018, the Office of the Commissioner for Public Sector Employment (OCPSE) conducted the inaugural *I WORK FOR SA – Your Voice Survey* which was open to all SA public sector employees. The survey included a number of questions which focussed on workplace bullying and harassment. 37 per cent of all public sector employees reported having witnessed harassment or bullying in their current workplace during the last 12 months, with 21 per cent having been subjected to harassment or bullying in their current workplace in the last 12 months.[27] The OCPSE also provided further data to the Committee which showed that SA Health staff reported considerably higher rates of harassment and bullying than the overall SA public sector, with 48 per cent having witnessed and 28 per cent having experienced harassment or bullying in their current workplace in the last 12 months (see Figures 4-5 below).[28] Appendix 3 contains a more detailed breakdown of these results.

[27] Office of the Commissioner for Public Sector Employment (OCPSE) 2019, *I WORK FOR SA – Your Voice Survey: South Australian Government Highlights Report*, https://publicsector.sa.gov.au/wp-content/uploads/SA-Government-Highlights-Report-2018.pdf, viewed 31 July 2019.

[28] Letter from Erma Ranieri, Commissioner for Public Sector Employment, response to Committee request for SA Health *Your Voice Survey* data, 18 April 2019.




The Independent Commissioner Against Corruption (ICAC) ran a *Public Integrity Survey* in 2018 in order to better understand the attitudes and experiences of public officers around issues of integrity. A large proportion of survey respondents reported having encountered some form of corruption or inappropriate conduct, with only 45.5 per cent of respondents reporting *not* having encountered corruption or inappropriate conduct in the last five years. Respondents were asked to identify the types of behaviour they had encountered, with the most prevalent being bullying and harassment

(44.1 per cent) and nepotism and favouritism (41.7 per cent).[29] The ICAC further advised the Committee that 52.6 per cent of SA Health participants in the survey reported personally encountering bullying and harassment, which was the third highest rate reported across all government agencies.[30]

***Peak body surveys***

Various peak bodies have undertaken surveys which indicate that workplace bullying is a problem among health professionals. In its 2016 survey of junior doctors, SASMOA found that 40 per cent had witnessed or experienced bullying, and 20 per cent had witnessed or experienced harassment. Nearly 8 per cent reported having witnessed or experienced sexual harassment.[31] In its more recent survey, SASMOA found that 70 per cent of junior doctors and 64 per cent of senior doctors reported that bullying and harassment was a problem in their workplace. The main perpetrators of the bullying were reported as being senior doctors, nursing staff and medical and hospital administrators. While 70 per cent of senior doctors stated that they would speak up if they saw someone being bullied or harassed, only 46 per cent of junior doctors reported that they would speak up in a similar situation, with the main reasons for not reporting being a concern about future career prospects, fear of retaliation, and a belief that nothing would be done.[32]

The Australian and New Zealand College of Anaesthetists (ANZCA) regularly surveys its trainees and fellows. In its latest survey (conducted in 2017), ANZCA found that 33 per cent of fellows had personally experienced workplace bullying and 57 per cent had personally witnessed bullying, noting that these are national figures and the rates were marginally lower in SA/NT (30 per cent and 55 per cent respectively). Among trainees, ANZCA found that 29 per cent had personally experienced bullying and 47 per cent had personally witnessed bullying (14 per cent and 34 per cent in SA/NT).[33]

The ACEM conducted a survey of its members in 2016 on the issues of discrimination, bullying and sexual harassment, and 49.5 per cent of respondents reported having been subjected to this

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[29] Independent Commissioner Against Corruption (ICAC) 2018, *ICAC Public Integrity Survey 2018*, https://icac.sa.gov.au /system/files/ICAC_Public_Integrity_Survey_2018.pdf, viewed 31 July 2019.

[30] ICAC – Office for Public Integrity (OPI), Submission No 69, 17 June 2019.

[31] SASMOA, Submission No 50, 14 February 2019.

[32] Ibid.

[33] Australian and New Zealand College of Anaesthetists (ANZCA), Submission No 45, 4 February 2019.

behaviour in the workplace. 36.9 per cent reported having been specifically subjected to bullying, with many of these having experienced bullying multiple times across their careers.[34]

Professionals Australia reported that its membership survey resulted in 80 per cent of respondents stating that they had been bullied at work, 50 per cent of whom had been bullied in the last 12 months.[35]

### *SA Health data*

SA Health reported that in the 2013-2018 financial years, there were 517 WHS harassment and bullying incidents reported across the agency (1.1 per cent of all WHS incidents reported). Over the same time period, there were 250 workers compensation claims that were coded as 'work related harassment and/or workplace bullying' (3.7 per cent of the total), of which 166 claims included lost time, with a cumulative total of 9,215 days lost from work at a cost of $10.161 million.[36]

SA Health also reported that in the July-September 2018 quarter, there were 418 new referrals to the SA Health Employee Assistance Program, over which 45 (10.8 per cent) were related to workplace harassment or bullying.[37]

### *Committee survey*

As noted above, the Committee conducted its own survey of South Australian health professionals to get a better understanding of the issues pertinent to this Inquiry. The workplace bullying survey questions were based on some similar questions in the OCPSE *I WORK FOR SA* survey, as well as the Johns Hopkins Continuum of Disruptive Behaviours at Work[38] in order to give the Committee a sense of the type and severity of bullying behaviour that was been experienced by health professionals. The Committee's survey results showed considerably higher levels of workplace

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[34] ACEM, Submission No 49, 8 February 2019.

[35] Professionals Australia, Submission No 27, 31 January 2019.

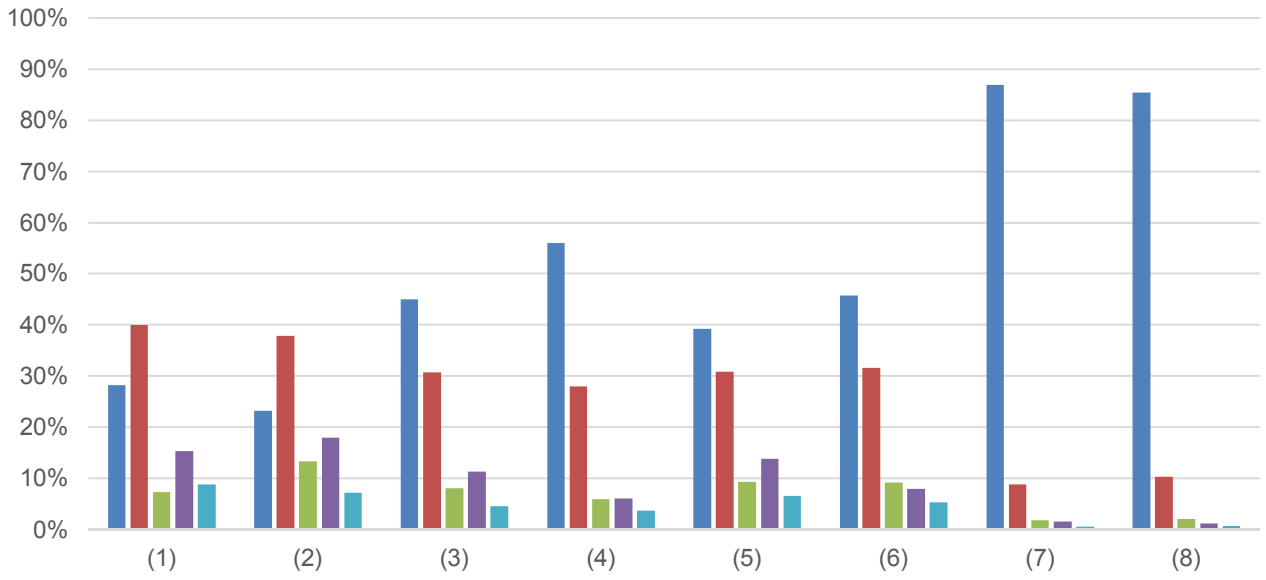
[36] SA Health, Submission No 56, 26 February 2019.

[37] Ibid.

[38] The Johns Hopkins University Safe at Hopkins 2018, *Workplace Bullying*, https://www.safeathopkins.org/workplace-bullying/, viewed 9 December 2019.

bullying than similar surveys mentioned above such as those run by the OCPSE and ICAC. Given the nature of the Committee's survey and its focus on the issues associated with this Inquiry, it was expected that the results might show rates of bullying that may not necessarily be reflective of all individuals working in SA hospitals and health services. Nonetheless, the results show that workplace bullying is an issue that is experienced by a large number of SA health professionals. 75 per cent of respondents reported having witnessed bullying in their current workplace in the last 12 months, with 49 per cent reporting having been subjected to bullying in the same time period.[39] There was a wide range of behaviour reported, and while the behaviour reported as occurring most frequently was at the lower end of the severity spectrum (e.g. inappropriate, disrespectful, rude or discourteous behaviour), there were some respondents who reported having experienced the most severe forms of bullying, including stalking, threats and physical violence (see Figure 6 below).

Figure 6: Type and frequency of bullying behaviour




(1) Inappropriate behaviour such as making rude remarks, telling degrading jokes, swearing
(2) Disrespectful, rude or discourteous behaviour, including dismissive or degrading actions directed towards you
(3) Being ignored, ridiculed or insulted in public
(4) Verbal abuse (e.g. yelling or screaming)
(5) Interference with work tasks (e.g. withholding information, undermining or sabotage)
(6) Inappropriate/unfair application of workplace policies/procedures (e.g. performance management, access to leave)
(7) Stalking and threats
(8) Physical violence, injury and harm

Never Occasionally Monthly Weekly Daily

Fellow co-workers were the most heavily identified group of perpetrators of the bullying behaviour. Only 18 per cent of respondents reported having submitted a formal complaint about workplace

[39] OSRC Committee Survey Results, 28 June 2019.

bullying, and unfortunately 70 per cent of these reported that the complaint was not resolved to their satisfaction. Furthermore, 33 per cent reported having taken sick leave due to workplace bullying.[40]

# 7. REPORT AGAINST TERMS OF REFERENCE

## 7.1 Factors contributing to workplace fatigue and bullying

***Term of Reference***

a) *The factors contributing to workplace fatigue and bullying in South Australian hospitals and health services.*

The Committee received evidence regarding a number of factors that contribute to workplace fatigue and bullying in the hospitals and health services context. The most commonly raised factors included:

- the type and nature of the work;
- poor workplace culture;
- inadequate complaint resolution processes;
- resourcing; and
- industrial conditions and practices.

Each of these will be considered in turn.

### *7.1.1 Type and nature of work*

The type of work being undertaken in hospitals and health services and the high-pressure environment in which many staff work makes them vulnerable to workplace fatigue and bullying. Common frustrations such as job pressure and stress can result in creating an environment where bullying and fatigue are able to flourish.[41] Health care professionals have a level of responsibility for

[40] Ibid.

[41] Magee, C, Gordon, R, Caputi, P, Oades, L, Reis, S and Robinson, L 2014, *Final Report: Workplace Bullying in Australia*, Centre for Health Initiatives, University of Wollongong, https://www.headsup.org.au/docs/default-source/resources/workplace-bullying-in-australia-final-report.pdf?sfvrsn=2, viewed 5 August 2019.

the health of their patients which can predispose them to a higher risk of psychological distress.[42] The impact can be particularly pronounced for first responders and emergency service workers due to the potential for repeated exposure to trauma.[43] This high-pressure environment can also expose potential workplace 'soft skill' weaknesses in staff and result in individuals acting rudely and/or inappropriately towards each other. Heavy workloads can also result in aggression and dissatisfaction between staff.[44] This was highlighted by Chris Moy from the AMA (SA) by way of an example of what this looks like "on a day-to-day basis in SA hospitals":

> This is Dr A of one ward ringing Dr B on another ward requesting him to assess a patient for possible admission to Dr B's ward to which Dr B says, [*expletive*] and puts the phone down, and that's the end of the discussion…That second consultant – consultant B, Dr B – is going to say [that] because he's got no beds, and he's been up for five days.[45]

In addition to a high-pressure environment and high levels of responsibility, the health care industry is affected by a number of structural factors that also contribute to fatigue, including that staff work long hours, night work, on-call work, and working rotating or irregular shifts.[46] The AMA Safe Hours Audit identifies that the profile of a doctor at high risk of fatigue typically involves longer total working hours, longer shifts, more days of being on call, less days off, and being more likely to skip a meal break.[47] These are all relevant risk factors that contribute to the level of fatigue of staff working in the health system. The 2016 Audit found that 53 per cent of doctors were working unsafe hours that put them at significant or higher risk of fatigue.[48] Nonetheless, there is a view that long hours may be necessary for junior staff to gain the appropriate knowledge and experience required. The Royal Australasian College of Surgeons (RACS) argues that the nature of surgical work means that 55-65 hour working weeks (across seven days) can be appropriate in certain circumstances.[49]

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[42] Medical Deans Australia and New Zealand, Submission No 64, 31 May 2019.

[43] Royal Australian and New Zealand College of Psychiatrists (RANZCP), Submission No 22, 31 January 2019.

[44] Australian College of Nursing (ACN), Submission No 34, 31 January 2019.

[45] Dr Chris Moy, AMA (SA Branch), *Committee Hansard*, 13 September 2019.

[46] Reynolds, A, Jay, S, Dawson, D, Dorrian, J and Ferguson, S 2017, *Shift work and health: Development of accessible information to support education and awareness of the health outcomes associated with shift work*, Appleton Institute, Central Queensland University (CQU), http://library.safework.sa.gov.au/attachments/69058/1631%20CQU%20Final%20Report%20v4.pdf, viewed 22 August 2019.

[47] AMA 2017, *Managing the Risks of Fatigue in the Medical Workforce: 2016 AMA Safe Hours Audit*, https://ama.com.au/system/tdf/documents/v1%202016%20AMA%20Safe%20Hours%20Audit%20Report.pdf?file =1&type=node&id=46763, viewed 5 August 2019.

[48] Ibid.

[49] Royal Australasian College of Surgeons (RACS), Submission No 42, 1 February 2019.

It is generally accepted that shift work is a significant contributing factor to fatigue, and shift workers, particularly those who work night shifts, are at a higher risk of fatigue.[50] The inherent nature of the 24/7 service that hospitals and health services provide means that shift work is a necessary requirement, along with the use of overtime and on-call/recall arrangements.[51] The Australian College of Nursing (ACN) also emphasised that the majority of nurses, who make up the largest group of health care workers in Australia, work rotating shifts, and erratic shift patterns disrupt the body's natural sleep patterns and Circadian rhythm.[52] Night work can disrupt a person's natural body rhythm, which can affect sleeping patterns, body temperature, hormone levels and digestion. The body is naturally programmed for different levels of wakefulness and alertness at different times of day. Work scheduling can therefore cause fatigue if there is insufficient time for staff to physically and mentally recover from shifts.[53] Older workers may be particularly prone to difficulty in adjusting to changes in their sleep cycle. One submission author noted that "[w]ith the advancing average age of nursing and midwifery staff, tiredness can be a problem with alertness and other general health problems."[54] This notion is generally supported by SA Health which noted that around 50 per cent of its workforce is aged 45 years or older.[55] This is a further risk factor contributing to workplace fatigue.

The ACN also noted that in a profession where your job is to care for people in pain and suffering, there is a risk that this may be internalised and result in compassion fatigue, ultimately leading to professional burnout and job dissatisfaction:

> Providing emotional support, compassion and care to patients is an integral part of a nurse's day-to-day duties. It is what helps them excel in supporting a patient's healing process. However, these qualities may also put nurses at risk for compassion fatigue, which is a condition that may develop when carers such as nurses internalise the suffering and pain of other people in their work environment. Compassion fatigue is also known as secondary traumatic stress (STS), and is sometimes referred to as a lesser form of burnout.[56]

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[50] Safe Work Australia 2018, *Fatigue*, https://www.safeworkaustralia.gov.au/fatigue, viewed 7 August 2019.

[51] Australian Nursing and Midwifery Federation (ANMF) (SA Branch), Submission No 53, 18 February 2019.

[52] ACN, Submission No 34, 31 January 2019.

[53] Safe Work Australia 2013, *Guide for Managing the Risk of Fatigue at Work*, https://www.safeworkaustralia.gov.au/system/files/documents/1702/managing-the-risk-of-fatigue.pdf, viewed 22 August 2019.

[54] Jeanette Birtles, Submission No 12, 30 January 2019.

[55] SA Health, Submission No 56, 26 February 2019.

[56] ACN, Submission No 34, 31 January 2019.

There can be behavioural, emotional and physical consequences as a result of compassion fatigue, and the ACN considers it to be a key contributor to workplace fatigue for nurses. The ANMF's Nursing and Midwifery Workforce Climate Survey 2017 also found that on average, nurses and midwives feel emotionally overextended and exhausted by their work a few times per month.[57]

The ANMF noted that "challenging behaviours and violence is another safety issue that our members are regularly subjected to and is also a major contributing factor to work fatigue and bullying."[58]

> Violence against nurses, midwives and personal care workers is anecdotally reported as a significant concern in the workplace; however, it is significantly under reported as a work health and safety hazard. The ANMF (SA Branch) continues to receive consistent feedback (from our members) that incidents of violence are increasing and becoming more life threatening, however, these incidents are not necessarily captured well within the available reporting mechanisms, especially in acute care, emergency, community and aged care settings.[59]

The under-reporting of violence against staff by patients and their families was an issue that was also noted by the Medical Deans Australia and New Zealand, particularly in the context of medical students, and it should be recognised that this is a significant issue that contributes to workplace fatigue and bullying.[60]

### *7.1.2 Poor workplace culture*

Evidence received by the Committee suggests that poor workplace culture is a key cause of fatigue and bullying in hospitals and health services.

One of the key issues identified is the hierarchical nature of the workforce, which has allowed a culture to develop where junior staff do not feel like they are able to speak out about issues without prejudicing their career progression. Senior clinicians have a significant influence over more junior staff, and the Committee received evidence to suggest that many see inherent difficulties with challenging someone

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[57] Corsini, N et al 2018, *Nursing and Midwifery Workforce Climate Survey 2017*, Rosemary Bryant AO Research Centre, University of South Australia.

[58] ANMF (SA Branch), Submission No 53, 18 February 2019.

[59] Ibid.

[60] Medical Deans Australia and New Zealand, Submission No 64, 31 May 2019.

who "has accumulated outstanding specialist expertise, a significant professional and possibly also public reputation, powerful associations and significant formal and informal influence."[61] Junior staff also report a sense of futility about reporting inappropriate behaviour noting that reported matters are not always effectively dealt with or that any reports they make will result in retaliation against them.[62,63] This can then result in a culture where such behaviour becomes accepted and tolerated.[64] Junior staff and trainees may also feel like they might not progress in their training program or retain ongoing employment if they speak out against the person who may very well be responsible for the inappropriate behaviour in question. Rod Mitchell from the ANZCA noted that:

> …an issue is people not wanting to complain because they think it will all come back against them. I have three kids. Two are young doctors and one who is a fifth-year medical student. I am reminded of the realities of young doctors wanting to get into a training program, wanting to get good references, wanting to get good reports, and the pressure that can be brought to bear on those people to not complain.[65]

Cultural issues within SA Health were also identified as a significant problem in the *Troubling Ambiguity* report by the ICAC. The report noted that:

> The nature of the professions employed in DHW and the LHNs means that power imbalances inevitably exist between those professional persons and administration staff. Those power imbalances do not often appear to have been managed in a way that promotes good public administration.[66]

These power imbalances mean that those employed at much lower levels do not always feel comfortable calling out inappropriate behaviour. The ICAC report also suggested that distrust and failure to cooperate across SA Health "makes it difficult for DHW to issue policies across SA Health which are complied with, thereby making it difficult for SA Health to effectively create and enforce standards across the whole of SA Health," and can also lead to decisions being made "without sufficient regard as to whether they might meet broader organisational objectives."[67]

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[61] SA Health, Submission No 56, 26 February 2019.

[62] SASMOA, Submission No 50, 14 February 2019.

[63] ANZCA, Submission No 45, 4 February 2019.

[64] Council of Deans of Nursing and Midwifery (CDNM) Australia and New Zealand, Submission No 63, 20 May 2019.

[65] Dr Rod Mitchell, ANZCA, *Committee Hansard*, 5 July 2019.

[66] Lander, B 2019, *Troubling Ambiguity: Governance in SA Health*, ICAC.

[67] Ibid.

The Australian Medical Students' Association (AMSA) suggested that workplace fatigue and bullying begin at university due to a "deep-rooted and widespread" culture of bullying, harassment and overwork.[68] AMSA noted that students still experience a culture of "teaching by humiliation" where they are "asked a number of difficult questions by superiors in front of peers, other teachers or seniors and sometimes patients in a high pressure manner and often results in embarrassment and humiliation for the student."[69] This sort of treatment can happen regularly as students are often paired with the same superior for a number of weeks. The AMSA cited a study which suggested that 74 per cent of medical students had experienced teaching by humiliation, and 83.6 per cent had witnessed it.[70] The Council of Deans of Nursing and Midwifery (CDNM) also noted that some students actually model the 'toxic' behaviours learned while on placements as a survival mechanism, or a way of 'fitting in'.[71] Anita Filleti from the Medical Insurance Group Australia (MIGA) noted that a common theme among the bullying related inquiries that MIGA deals with is the culture that is passed on by senior staff and management:

> With most of the bullying inquiries in a hospital setting, it does tend to be more junior staff members who are contacting us for assistance and usually the pressures are coming from senior staff and management. A quite common a theme is this whole sort of rite of passage argument, that, 'The senior staff went through this, so we need to go through this as well.' A lot of the time, when they contact us, they are quite hesitant to take it any further internally for fear of impacting their future career. That is definitely a common theme that I see.[72]

Matthew Thomas from the Appleton Institute also noted that:

> In much of our work…heads of department, directors of nursing and middle senior management at the departmental level have provided the biggest barriers to changing the way in which work is done, not the least of which because they have lived through a particular regime. You hear, echoing through the halls of any healthcare facility, 'That's the way I did it, so toughen up. You do it, too.'[73]

One element of the poor workplace culture results from managers not having appropriate skills and training in how to manage staff. While medical managers may be technically skilled, there is evidence

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[68] Australian Medical Students' Association (AMSA), Submission No 39, 31 January 2019.

[69] Ibid.

[70] Ibid.

[71] CDNM, Submission No 63, 20 May 2019.

[72] Ms Anita Filleti, Medical Insurance Group Australia (MIGA), *Committee Hansard*, 13 September 2019.

[73] Associate Professor Matthew Thomas, Appleton Institute, *Committee Hansard*, 28 June 2019.

to suggest that some lack management skills and have an insufficient understanding of what acceptable behaviour is.[74] The AMA explained how the current process for appointing clinical leaders works:

> This is what happens normally: the job of leadership is given to the most senior person, maybe the most eminent individual on a ward. They may not be suited. They may not have the temperament, be positive or make the hard decisions, for example. They are not given any training, they are not given any skills in leadership and then they are expected to manage the entire unit while they are still doing their clinical job. This leads to chaos. People talk about fish rotting at the head. This sets the whole unit up for failure.[75]

SASMOA noted in its submission that "[m]edical managers frequently receive no training on how to manage, there is no instruction, no mentoring, and no framework for medical managers. There is no advice on what is and is not acceptable behaviour and there is no auditing of behaviour."[76] In the last round of enterprise bargaining SASMOA attempted to include a clause regarding the monitoring of medical managers' style and approach to address concerns about bullying, however this was rejected by SA Health.[77] The ACN also cited research which showed that where line managers demonstrate behaviours of 'authentic leadership', it is less likely for bullying and incivility to be present. The same study also noted that promotions in the health care sector are often based on technical skills in treating patients, and not on soft skills such as people and relationship management.[78] The ACN suggested that "[p]romotions to managerial positions should be based on whether a person has the people skills to professionally and genuinely lead subordinates, and the discipline to follow organisational values."[79]

The Committee also heard evidence to suggest that there is cultural pressure on staff to work long hours. In response to a question on whether it was a fair assessment that a large part of fatigue-related issues is due to lack of veracity of timesheets, Bernadette Mulholland from SASMOA agreed that this would "correlate with fatigue and bullying."[80] Anita Filleti from MIGA also confirmed that MIGA receives reports from its members that there is a pressure to not report their full hours worked.[81] It is

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[74] SASMOA, Submission No 50, 14 February 2019.

[75] Dr Chris Moy, AMA (SA Branch), *Committee Hansard*, 13 September 2019.

[76] SASMOA, Submission No 50, 14 February 2019.

[77] Ibid.

[78] ACN, Submission No 34, 31 January 2019.

[79] Ibid.

[80] Ms Bernadette Mulholland, SASMOA, *Committee Hansard*, 15 February 2019.

[81] Ms Anita Filleti, MIGA, *Committee Hansard*, 13 September 2019.

alluded that timesheets are not being accurately completed because there is a cultural pressure to work hard and, in an environment where there are cost pressures, not to claim the full extent of hours worked. Tim Bowen from MIGA noted that:

> It's not necessarily anyone telling them that they 'shouldn't do this'. It's a matter of, 'I don't feel I should because it doesn't feel like the right thing—everyone is working so hard at the moment.' So it's almost a culture of silence, not because everyone is telling you that it's not, but because they feel it's the right thing to do.[82]

This pressure was demonstrated in a number of examples provided by submission authors. One individual described a situation where they had to take carer's leave due to their child rapidly developing a life threatening illness, and while on leave they continued to receive revised rosters, had repeated requests from a colleague to make up time, and their head of unit "expressed the view verbally that it was appropriate for me to make up the time, as it was not me who was sick."[83] Bernadette Mulholland noted how "doctors aren't going home at the end of their shift. They don't want to leave the junior doctors there, in the EDs, to cope with the workload."[84] In extreme scenarios, there can be blatant disregard for working conditions set out in enterprise agreements and an expectation to work beyond what is required:

> There is an entrenched culture of mistreating trainee medical officers throughout SA Health which perpetuates the bullying and burnout of our young doctors. The only time I ever complained about excessively onerous rostering, I was told in writing "it doesn't matter what's in your EBA, this is what's expected of you" by the Director of Physician Training at a CALHN Hospital. I was so exhausted and demoralised by that stage that I didn't have the will or the strength to escalate the complaint, I just quit my job.[85]

### *7.1.3 Inadequate complaint resolution processes*

Where the processes for resolving complaints do not adequately address the underlying issues behind these complaints, this further discourages people from speaking out and making reports, as well as empowering bullies to continue their inappropriate behaviour.

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[82] Mr Tim Bowen, MIGA, *Committee Hansard*, 13 September 2019.

[83] Confidential, Submission No 4, 29 December 2018.

[84] Ms Bernadette Mulholland, SASMOA, *Committee Hansard*, 15 February 2019.

[85] OSRC Committee Survey Results, 28 June 2019.

The ICAC *Troubling Ambiguity* report made several observations (based on the findings of the 2018 *Public Integrity Survey*) about the attitude of SA Health employees towards reporting inappropriate conduct:

> - SA Health employees who responded (SA Health respondents) appear to have a lower awareness of their reporting obligations to the OPI, and are less willing to report inappropriate conduct to the OPI, than the rest of South Australian public administration. For those reasons I may be unaware of the full extent of corruption, misconduct and maladministration that may be occurring in SA Health.
> - SA Health respondents also seem less willing to report inappropriate conduct internally; are more likely to believe SA Health discourages reporting; and are less confident that SA Health would take action on a report. Accordingly SA Health may itself be unaware of the full extent of corruption, misconduct and maladministration occurring.
> - SA Health respondents are less aware that SA Health has policies and procedures in place for reporting; are less likely to agree that SA Health provides information about reporting; and have less confidence that SA Health has adequate protections for those who report.
> - SA Health respondents have also reported being more confused about the conduct that should be reported.
> - SA Health respondents also report being more worried about the security of their jobs if they report; feel more intimidated to report; are more likely to feel they will get in trouble with their colleagues as a consequence of reporting; and know of others who have experienced negative consequences as a result of reporting.[86]

Failure to act promptly in dealing with complaints can inadvertently foster a culture of minimisation of the problem and discourage reporting or any changes being made.[87] SASMOA reported having difficulties getting complaints processed and investigated in a timely manner, and a general sense that there is a failure to acknowledge concerns of their members.[88] SASMOA's staff survey conducted in response to this Inquiry found that 47 per cent of both junior and senior doctors were not confident that bullying and harassment behaviour would be dealt with if they reported it to their line manager or employer.[89] A number of submissions referred to the fact that the complaint resolution process is

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[86] Lander, B 2019, *Troubling Ambiguity: Governance in SA Health*, ICAC.

[87] AMA 2015, *AMA Position Statement: Workplace Bullying and Harassment*, https://ama.com.au/position-statement/workplace-bullying-and-harassment, viewed 9 August 2019.

[88] SASMOA, Submission No 50, 14 February 2019.

[89] Ibid.

lengthy and does not always resolve the matter. For example, one individual described the process as follows:

> I have experienced:
>
> …
>
> - Repeated managerial inaction in response to reports of bullying behaviour and continued bullying
> - Lodging two formal and detailed complaints of bullying, both of which have not been progressed
> - Where action occurs by management and Human Resources it's consistently not been prompt or timely…[90]

One witness who gave evidence to the Committee described how her bullying complaint had dragged on for four years and that she would not hear from HR for months at a time.[91]

There are a number of possible avenues for pursuing complaints, which can potentially lead to some confusion with respect to the appropriate process. Apart from raising matters internally, staff can also refer issues to a relevant peak body, such as their union, professional college or relevant regulatory authorities. The Committee received some evidence that the process is not always clear and staff suffering from workplace fatigue and/or bullying may not know to whom their complaint should be referred. SASMOA's most recent survey reported that 60 per cent of junior doctors did not know the process for reporting bullying and harassment. Only half of senior doctors responded that they knew the process for reporting this type of behaviour.[92] MIGA also suggested that "a lot of the time they don't actually know that [the internal] process is even available to them until they speak to us. They don't even know that they can contact human resources about these types of issues…"[93] The RACS also suggested that there is a lack of coordination between the various regulatory and oversight bodies and that better communication is required:

> The oversight for health professions is often multi-layered and difficult to distinguish. Varying entities are involved including medical colleges, health departments, hospitals and regulators including the Medical Board of Australia, and the Australian Health Practitioners

[90] Confidential, Submission No 20, 31 January 2019.

[91] Rachel Edwards, *Committee Hansard*, 6 December 2019.

[92] SASMOA, Submission No 50, 14 February 2019.

[93] Ms Anita Filleti, MIGA, *Committee Hansard*, 13 September 2019.

> Regulatory Authority. There is a clear lack of coordination between these bodies and a strong requirement for better communication.
>
> Too often the complex system of complaints management in many Australian hospitals means that appropriate information is not shared. Additionally, concerns regarding a practitioner's competence are not passed on to the regulator, due to a reluctance to breach an individual's right to practice. While RACS respects individual liberties, it is imperative that they are not prioritised ahead of the fundamental responsibility of protecting patient safety.[94]

A recent review of Adult Community Mental Health services within SA Health (the Stevens' Report) found that there was little understanding of SA Health's Respectful Behaviour Policy. The review identified a number of key reasons why the formal process for resolving complaints was not being accessed, or where previously accessed by a staff member, would not be again, including:

- The lack of support and guidance given by HR generally
- The anonymity of the HR staff handling the complaint
- The length of time taken to resolve the complaint
- The complainant does not get to see the perpetrator's response or the response of any other witnesses
- The complainant is never advised the outcome of their complaint. i.e. Upheld in full / Upheld in part / Dismissed / Not proven
- The complainant is sometimes offered mediation with the perpetrator in obviously inappropriate circumstances
- The complainant is not always told when their complaint has been finalised.[95]

The RACS' submission (which referred to the work of their Expert Advisory Group established in 2015 to develop strategies to prevent discrimination, bullying and sexual harassment) included reference to similar matters, noting that these issues are "relevant and applicable across the entire health sector."[96]

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[94] RACS, Submission No 42, 1 February 2019.

[95] Stevens, G 2017, *Adult Community Mental Health: Report from Greg Stevens of interviews with staff*, https://www.sahealth.sa.gov.au/wps/wcm/connect/0fa5218041d6e8fab1b5f3fc48414beb/Community+Mental+Health+Summary+Report.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-0fa5218041d6e8fab1b5f3fc48414beb-mi9LZbO, viewed 12 September 2019.

[96] RACS, Submission No 42, 1 February 2019.

Another potential barrier to making a complaint is the hierarchical structure of the workforce.[97] Often it is the line manager that is the bully or behaving inappropriately, and yet they are the first step in the complaint process. This can make it difficult for staff to gain access to upper management.[98] Junior doctors are also at a particular risk when their line manager also has input into whether they pass their training program. Chris Moy from the AMA (SA) noted that medical students and unaccredited registrars (those not yet in a training program) are particularly vulnerable and "are reluctant to report because of potential impacts for reporting their abuse with regard to future [career] prospects."[99] The AMSA also noted that medical students are vulnerable and choose to stay silent for fear of academic reprisals and future career prospects, given many students choose to work at the same hospital where they completed their training.[100]

Lack of support for victims and whistle-blowers was also raised as an issue.[101] MIGA suggested that in their experience, "there is often little in the way of supports to those involved in such a process unless the practitioners concerned have developed their own informal, private support network, or sought private counsel or medical support."[102] There was a view expressed in some submissions that HR was not there to support the complainant, but rather to protect the senior management, and that making complaints would only lead to a worsening of the situation. One submission author described making a bullying complaint which was only investigated "informally" with no official record of the complaint being made. The only consequence to the bully was that he was removed as the line manager of this particular individual. When contacted by the bully a number of years later, the victim discovered that there was no record of them ever having made a complaint:

> Quite simply, he got away with [his] behaviour entirely unscathed and with no real consequence which teaches him that he can get away with such behaviour because of his high position. Yet for me, my reputation has been tarnished for making the claim, I have since been excluded from participating in decision making meetings, and have been overlooked for roles [where] my skill set/qualifications are clearly a match. It seems grossly unfair that the victim of bullying suffers all the consequences for seeking justice – this is

[97] Ibid.

[98] Confidential, Submission No 48, 8 February 2019.

[99] Dr Chris Moy, AMA (SA Branch), *Committee Hansard*, 13 September 2019.

[100] AMSA, Submission No 39, 31 January 2019.

[101] RACS, Submission No 42, 1 February 2019.

[102] MIGA, Submission No 66, 31 May 2019.

> probably the reason why most victims of bullying leave the organisation rather than stay and complain because they know this will be the likely outcome.[103]

One submission author also noted her experience of having to confirm on numerous occasions that she did not wish to withdraw her bullying complaint just because the bully was no longer her line manager. She detailed her frustrations with the management at her LHN which viewed the removal of her line manager as an outcome, without necessarily investigating the bullying behaviour in question.[104]

Another submission described how victims are silenced while bullies are allowed to defend themselves:

> The bully was able to disclose their side of the story…and provide her own narrative to anyone who would listen. The victims, and indeed all staff who were not direct supporters [of the bully] were told by executive that we were not allowed to discuss the issue, even to our friends and family and even in private. We were told we could lose our position if we discussed the matter. So the victims were effectively silenced, allowing the bully to provide all information on the matter.[105]

Numerous other examples were provided in submissions of HR and management being dismissive of complaints, and indeed the complainants being targeted with bullying behaviour after speaking out to raise concerns, including about matters of patient safety. The Committee heard examples of staff being discouraged from making formal complaints:

> We were discouraged from going down the formal complaint path because we were told repeatedly that it would be very hard to prove, that we would likely have to be removed from our clinical area while the investigation was undertaken and placed somewhere else, so for a long time we were actively discouraged from [doing that]. Essentially the victim has to go out on a limb by themselves and make themselves vulnerable even further to pursue a formal complaint of bullying, so we were discouraged from doing that.[106]

Another submission alleged that staff were actively discouraged from making reports in the SA Health SLS:

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[103] Confidential, Submission No 60, 27 March 2019.

[104] Confidential, Submission No 20, 31 January 2019.

[105] Confidential, Submission No 48, 8 February 2019.

[106] Confidential, *Committee Hansard*, 18 October 2019.

> If I or other member of staff make reports [in] the SLS system, we are treated with disrespect and discouraged from doing so. We are subjected to smart remarks and criticism for using the only system available to us to report incidents and concerns.[107]

The Committee also received some evidence that "SLS reports are being used by managers and employees to make personal and accusatory comments or reports on other employees" and that SLS reports which "identify problems in the system of work are not managed appropriately as the blame is placed back on to individual workers rather than resolving underlying problems."[108]

### *7.1.4 Resourcing issues*

Understaffing was an issue that was frequently raised in submissions to the Inquiry as being a contributory factor to workplace bullying and fatigue. Understaffing can result in staff not taking enough breaks within shifts, a greater reliance on overtime, more sick days being taken, and greater use of agency staff.[109] The Committee heard evidence from the ACEM that under-resourcing in the health system is a major cause of bullying, fatigue and burnout due to the stressful environment that is created.[110] Other peak bodies such as the ACN also raised staffing and funding shortages as a significant issue, in part exacerbated by lack of efficient planning around staffing numbers.[111] In addition to increasing the levels of fatigue, the high-pressure environment that is created can result in an increase in bullying behaviour. In response to a question on the impact of overstressed emergency departments, Brian McKenny from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) noted that "it affects our trainees, who become very anxious and stressed about working in those environments, and some of the interpersonal relationships become frayed when people are under stress."[112]

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[107] Kathy Walker, Submission No 40, 31 January 2019.

[108] OSRC Committee Survey Results, 28 June 2019.

[109] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[110] Dr Simon Judkins, ACEM, *Committee Hansard*, 9 April 2019.

[111] ACN, Submission No 34, 31 January 2019.

[112] Dr Brian McKenny, RANZCP, *Committee Hansard*, 28 June 2019.

### *7.1.5 Industrial conditions and practices*

#### *Rostering*

A number of submissions to the Inquiry expressed concerns about rostering practices. A 2006 study of Australian nurses found that the most important factor in determining fatigue levels was the shift pattern worked, in particular the rotation including night duty.[113] The ACN noted that it is common in the nursing profession that staff work unpredictable shift patterns and rotations and that this makes staff more prone to workplace fatigue.[114]

An example of a particularly problematic rostering pattern is where a late shift is immediately followed by an early shift.[115] One individual described this as a "common rostering complaint" which contributes to workplace fatigue:

> This is where a late shift finishes at 9:30pm and the midwife is rostered to return to work for an early shift starting at 7:00am the next day. After a busy shift and the commute home (up to 45 minutes for some), not being able to "wind down" or go to sleep is commonly reported, and sleep is often disrupted waiting for the alarm to go off early the next morning. Despite there being 9.5 hours between shifts, actual sleeping time is often only 5 – 6 hours. While this can be endured as an occasional one-off, when it features regularly in shift patterns, it is not long before workplace fatigue arises.[116]

A suggestion was made that despite the various restrictions on rosters outlined in relevant Awards and Enterprise Agreements, there is still some discretion given to those involved in rostering, and that this opens up the risk of staff using the rostering process as a tool for bullying. One individual noted that "[n]urses are reliant on the person doing their rostering to be experienced, skilled and morally/ethically competent" and that this could give rise to "rostering being used as a tool for bullying staff who are not well liked by an unethical manager."[117] Another individual suggested that it is often the manager that is the bully and that "this creates a justified fear of recriminatory [behaviour] such as deliberate unsatisfactory rostering and non-approval for annual leave and staff development

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[113] Winwood, PC, Winefield, AH and Lushington, K 2006, *Work-related fatigue and recovery: the contribution of age, domestic responsibilities and shiftwork*, Journal of Advanced Nursing, Vol. 56, Issue 4, https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2648.2006.04011.x, viewed 2 October 2019.

[114] ACN, Submission No 34, 31 January 2019.

[115] Name withheld, Submission No 18, 31 January 2019.

[116] Confidential, Submission No 25, 31 January 2019.

[117] Name withheld, Submission No 18, 31 January 2019.

training."[118] This could manifest itself in rosters consistently disadvantaging certain individuals, and rostering requests not being fairly honoured, making work-life balance difficult to achieve and leading to fatigue.[119] The Australian College of Nursing also noted that:

> Inequities in workload distribution and shifts is a contributing factor in bullying, meaning when nurses feel they are working more or worse shifts compared to others, they are more likely to bully or harass those other nurses. Strategies to decrease inequities in workload distribution through automation of processes are likely to mitigate this problem.[120]

### *Nursing*

A number of individuals raised a specific issue regarding the application of the '8-hour break rule' in the *Nurses (South Australian Public Sector) Award 2002*.[121,122,123,124] Clause 5.1.8 of the Award requires that an employee, wherever practicable, have at least eight hours free from duty between the completion of one rostered shift and the commencement of the next rostered shift. Clause 5.4.10 further requires that employees (other than casual employees) who work so much overtime between shifts that they do not have at least eight consecutive hours off duty, must be released after completion of such overtime until they have had eight hours off duty. The Committee received submissions to the effect that this 'rule' is ambiguous with regards to whether an 8-hour break is required following an emergency recall. The ACN noted that Clause 5.4.10 can be interpreted in two ways:

> Firstly, a nurse can have an 8-hour break after an Emergency Recall because they have worked so much overtime, or secondly when a nurse has completed a scheduled shift and has an 8-hour break and is recalled on an emergency shift, they are not entitled to another 8-hour break before their next scheduled shift.[125]

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[118] Confidential, Submission No 23, 31 January 2019.

[119] Name withheld, Submission No 18, 31 January 2019.

[120] ACN, Submission No 34, 31 January 2019.

[121] Brenda Joy, Submission No 8, 29 January 2019.

[122] Confidential, Submission No 9, 29 January 2019.

[123] Confidential, Submission No 10, 30 January 2019.

[124] Name withheld, Submission No 43, 1 February 2019.

[125] ACN, Submission No 34, 31 January 2019.

In practice, this means that nurses can be recalled during the night, as long as they have had eight hours off work prior to the recall, and still be expected to attend a morning shift the following day without necessarily having had sufficient time to recover. This was highlighted to the Committee by Bernadette Hoffman, a clinical nurse at the Lyell McEwin Hospital, by way of an example of potential working hours:

> …if I finish work at 4.30 and I get called in at 2am, and I am there for three hours, I have had my eight-hour break. I still need to present to start my shift the next day at whatever time that may be, and that could be anywhere from 7.30, 8, 8.30 or 9.[126]

If a nurse then feels like they are unable to report for work at their allocated shift time, many feel that they have no option other than to take sick leave, which in turn can result in individuals not having sufficient leave entitlements available at other times.[127]

***Medical***

In terms of the medical profession, the ACEM suggested that the working conditions set out in the *SA Salaried Medical Officers Enterprise Agreement 2017* are a cause of fatigue because while doctors must have a minimum of eight consecutive hours of rest between shifts, there are no fixed hours and no defined breaks within shifts (other than that there must be a 30 minute break within a six hour period, but no paid rest break).[128] The ACEM's 2016 Workforce Sustainability Survey also showed 34.7 per cent of their members working excessive overtime (45+ hours), 62.5 per cent working unpaid hours, 69 per cent having difficulties arranging leave, and 70 per cent having difficulty taking a break at work.[129]

A survey conducted by SASMOA following the announcement of this Inquiry also found that many doctors reported being required to commence work prior to their rostered shift time, and many were also only sometimes paid non-rostered overtime or not at all.[130] SASMOA also reported that there

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[126] Ms Bernadette Hoffman, *Committee Hansard*, 17 May 2019.

[127] Name withheld, Submission No 43, 1 February 2019.

[128] ACEM, Submission No 49, 8 February 2019.

[129] Ibid.

[130] SASMOA, Submission No 50, 14 February 2019.

was some evidence of junior doctors in particular being pressured not to claim overtime or report having not taken a meal break.

> Junior doctors are frequently asked to deliberately under report non-rostered overtime; report taking a break when their work load is too high and a break knowingly not possible; not to report clinical incidents that could embarrass their seniors and; not report when they are fatigued because they do not want to be seen as not coping with a workload that is simply unmanageable. This leads to corners being cut and patient safety [jeopardised].[131]

SA Health also advised that "SASMOA has raised concern regarding the impact of receiving telephone calls which do not result in recall to work or undertaking work from home through telemedicine and that impacted individuals must have sufficient time away from work to allow for rest and recuperation."[132] SASMOA has sought interpretation of whether 'required duty' under the *Salaried Medical Officers Enterprise Agreement 2017* includes the taking of telephone calls where this does not result in a recall or work performed from home through telemedicine, and SA Health advised that the matter was before the South Australian Employment Tribunal (SAET).[133]

This evidence suggests that the industrial conditions under which doctors are operating are potentially allowing work practices that are causing fatigue in the workplace and that the protections in place in the enterprise agreement do not necessarily achieve the aim of preventing fatigue.

### *Use of agency and casual staff*

Another industrial related factor of relevance to the health sector is the use of agency, locum or casual staff. Where individuals are not employed directly by a hospital or health service, it can be difficult to monitor their work and sleep history which can make monitoring fatigue levels more difficult. The Appleton Institute also raised the issue of 'moonlighting', where health professionals work in more than one position and perform additional overtime, often in response to financial pressures arising from educational expenses.[134] This may result in staff working inappropriate rosters and excessive hours and can be a contributory factor to fatigue. One individual also noted that locums and agency

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[131] Ibid.

[132] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[133] Ibid.

[134] Appleton Institute, CQU, Submission No 30, 31 January 2019.

staff do not have the same industrial protections as they are not employed under relevant Enterprise Agreements, and hence employers are not always required to provide the same workplace conditions.[135]

## 7.2 Impact on the health and wellbeing of health care professionals

***Term of Reference***

*b) The impact of workplace fatigue and bullying on the health and wellbeing of health care professionals.*

### *7.2.1 Mental health*

There can be extremely detrimental effects on the mental health of anyone who is subjected to workplace fatigue or bullying. The SafeWork SA Hospitals Action Plan 2018-2020 provides background information regarding work injury claims in SA, noting that between 2013-14 and 2016-17 there were on average more than 3,400 work injury claims per year in SA in the Health Care and Social Assistance industry. Furthermore, the Plan notes that 9 per cent of work injury claims were as a result of psychological injuries.[136]

The Appleton Institute cited studies which have shown higher rates of depression, anxiety and stress among nurses, paramedics and doctors in comparison to the general population. This has been linked to work patterns such as shift work and on-call requirements. Some potential symptoms of this include a higher risk use of alcohol and drug abuse, as well as a heightened risk of suicide.[137] Unsafe working practices such as excessive working hours, inadequate breaks, inappropriate speed and direction of shift rotations, irregular work schedules and night shifts undertaken following a long period of duty can all predispose a health professional to mental illness.[138]

The National Mental Health Commission noted that:

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[135] Confidential, Submission No 62, 23 April 2019.

[136] SafeWork SA, *Hospitals Action Plan 2018-2020*, https://www.safework.sa.gov.au/sites/default/files/hospitals_action_plan.pdf?v=1533004586, viewed 6 September 2019.

[137] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[138] RANZCP, Submission No 22, 31 January 2019.

> Research shows a clear link between workplace bullying and the experience of depression and anxiety conditions. These conditions are potentially disabling, and associated with a wide range of adverse outcomes for affected individuals, including the risk of premature death by suicide. These conditions also impact on family, friends, workplace colleagues, and on society more broadly.[139]

Beyond Blue has also identified a range of risk factors that can potentially impact on the mental health and wellbeing of health professionals at work. These include "heavy workloads, long working hours, shift work, compassion fatigue, occupational violence, exposure to trauma, bullying and harassment, and abuse/mistreatment from patients and patients' families."[140] This suggests that being subjected to workplace fatigue and/or bullying can be a significant risk factor to the mental health of health care professionals.

### *7.2.2 Burnout*

The ANMF noted that its recent workforce climate survey indicated that there is an ongoing risk to staff of emotional and physical burnout or exhaustion due to workloads, staffing shortages, inadequate skill mix and poor rostering.[141] The effects of bullying and fatigue on individuals can be evidenced through factors such as lower self-esteem, anxiety and increased use of sick leave.[142] This can in turn lead to higher rates of turnover with more staff choosing to leave their employment as a result. The ANMF survey reported approximately one third of participants planned to leave their employment within the next five years, and 11-15 per cent planned to leave within the next 12 months.[143] Leaving a profession into which one has invested substantial time and effort over many years can also come with a significant psychological, emotional and financial impact.[144] The AMSA also noted that medical

[139] National Mental Health Commission, Submission No 47, 5 February 2019.

[140] Beyond Blue 2017, *Developing a workplace mental health strategy: A how-to guide for health services*, https://www.suicideinfo.ca/wp-content/uploads/2017/12/Developing-a-workplace-mental-health-strategy_oa.pdf, viewed 6 September 2019.

[141] ANMF (SA Branch), Submission No 53, 18 February 2019.

[142] ACN, Submission No 34, 31 January 2019.

[143] Corsini, N et al 2018, *Nursing and Midwifery Workforce Climate Survey 2017*, Rosemary Bryant AO Research Centre, University of South Australia.

[144] Medical Deans Australia and New Zealand, Submission No 64, 31 May 2019.

students may feel compelled to leave their degree due to burnout, which represents "a wasted pool of government funding and individual talent."[145]

A 2012 American study based on a survey of 22,275 registered nurses across 577 hospitals in a number of states found that longer shift lengths resulted in a greater likelihood of adverse outcomes such as burnout, and "nurses working shifts of ten hours or longer were up to two and a half times more likely than nurses working shorter shifts to experience burnout and job dissatisfaction and to intend to leave the job."[146] Another American study also found that workplace bullying of novice nurses negatively affected their productivity "by affecting their cognitive demands and ability to handle or manage their workload."[147]

A 2016 survey of nurses and midwives by the Monash Business School found that 80 per cent of respondents "indicated that they were proud of their work every day but chronic exposure to elevated workload and exhaustion, along with poor appreciation for their dedication to the job was hampering work engagement levels."[148] The survey further found that "32 per cent indicated they have considered leaving the nursing/midwifery profession and 25 per cent reported they were either likely or very likely to leave the profession, compared to an industry average range of between three to six percent."[149]

The Stevens' Report into Adult Community Mental Health found that burnout was a significant issue, including a high degree of negativity and helplessness. There were two groups in particular which stood out as suffering the most from burnout. The first group was older staff, mainly nursing clinicians, in the 50-60 age category with many years of experience, with a number looking to take early retirement rather than face another 10 to 15 years of employment. The second group was the younger and less experienced staff (mainly allied health professionals, given the review was in the context of community mental health services), typically in the 25-35 age category. This group reported struggling

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[145] AMSA, Submission No 39, 31 January 2019.

[146] Witkoski Stimpfel, A, Sloane, DM and Aiken, LH 2012, *The Longer The Shifts For Hospital Nurses, The Higher The Levels Of Burnout And Patient Dissatisfaction*, Health Affairs, Vol. 13, No. 11, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.1377?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed, viewed 20 September 2019.

[147] Berry, PA, Gillespie, GL, Gates, D and Schafer J 2012, *Novice Nurse Productivity Following Workplace Bullying*, Journal of Nursing Scholarship, Vol. 44(1), https://www.researchgate.net/profile/Peggy_Berry/publication/221837552_Novice_Nurse_Productivity_Following_Workplace_Bullying/links/5c3bf6d892851c22a3735ddf/Novice-Nurse-Productivity-Following-Workplace-Bullying.pdf, viewed 25 September 2019.

[148] Monash Business School 2016, *Australian nurses and midwives contemplate leaving profession as workloads bite*, Monash University, https://www2.monash.edu/impact/articles/leadership/australian-nurses-and-midwives-contemplate-leaving-profession-as-workloads-bite-survey/, 22 September 2016.

[149] Ibid.

to keep up with the workload, and many also reported they had experienced disrespectful behaviours in the workplace.[150]

### *7.2.3 Physical health and safety*

Working in unsafe conditions, particularly when fatigued, can potentially impact on the physical health and wellbeing of health care professionals.

Shift work and working long hours are linked to inadequate sleep and potential sleep disorders.[151] The Commonwealth Parliamentary Inquiry into Sleep Health Awareness in Australia noted that inadequate sleep and sleep disorders have been linked to workplace injuries and accidents. In its submission to this Commonwealth Parliamentary Inquiry, the Sleep Health Foundation also noted that the rate of accidents for shift workers is double that of non-shift workers in Australia, and that it is highly likely that much of this additional risk is sleep-related.[152] The Inquiry further found that shift work can disrupt sleep patterns and in turn cause physical health issues such as obesity.

The Appleton Institute also cited research which has showed that working long hours and excessive overtime is associated with a greater likelihood of occasional or frequent work injuries, including things such as needle stick injuries, sprains and strains.[153] Declined neurocognitive performance as a result of fatigue can also increase the likelihood of injury due to error.[154]

As mentioned above, there were on average more than 3,400 work injury claims per year between 2013-14 and 2016-17 in the SA Health Care and Social Assistance industry. The SafeWork SA

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[150] Stevens, G 2017, *Adult Community Mental Health: Report from Greg Stevens of interviews with staff*, https://www.sahealth.sa.gov.au/wps/wcm/connect/0fa5218041d6e8fab1b5f3fc48414beb/Community+Mental+Health+Summary+Report.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-0fa5218041d6e8fab1b5f3fc48414beb-mi9LZbO, viewed 12 September 2019.

[151] Caruso, CC 2014, *Negative Impacts of Shiftwork and Long Work Hours*, Rehabilitation nursing, the official journal of the Association of Rehabilitation Nurses, Vol. 39(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629843/pdf/nihms731739.pdf, viewed 23 September 2019.

[152] Parliament of the Commonwealth of Australia 2019, House of Representatives Standing Committee on Health, Aged Care and Sport, *Bedtime Reading: Inquiry into Sleep Health Awareness in Australia*, https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024220/toc_pdf/BedtimeReading.pdf;fileType=application%2Fpdf, viewed 8 August 2019.

[153] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[154] Caruso, CC 2014, *Negative Impacts of Shiftwork and Long Work Hours*, Rehabilitation nursing, the official journal of the Association of Rehabilitation Nurses, Vol. 39(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629843/pdf/nihms731739.pdf, viewed 23 September 2019.

Hospitals Action Plan 2018-2020 also notes that the top three categories of work injury claims were joint/ligament and muscular trauma (58 per cent), musculoskeletal diseases (16 per cent), and wounds, amputations and internal organ damage (9 per cent), with body stressing and mental stress among the main identified causes.[155]

There can be significant longer-term effects of fatigue on physical health, with potential complications including heart disease, diabetes, high blood pressure, gastrointestinal disorders, lower fertility, cancer and musculoskeletal complaints.[156,157] Some of the detrimental physical health conditions can be caused due to poor health behaviours such as short sleep duration, smoking, obesity, low physical activity and higher alcohol use, which are all linked with shift and working long hours due to staff using these behaviours as unhealthy ways of managing their fatigue.[158]

The Appleton Institute noted that given that "there are well established links between poorly managed fatigue and adverse short and long-term health outcomes…it is increasingly likely that organisations will be held accountable for the way they manage these risks associated with fatigue, and as such are increasingly exposed to litigation and compensation."[159]

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[155] SafeWork SA, *Hospitals Action Plan 2018-2020*, https://www.safework.sa.gov.au/sites/default/files/hospitals_action_plan.pdf?v=1533004586, viewed 6 September 2019.

[156] Safe Work Australia 2013, *Guide for Managing the Risk of Fatigue at Work*, https://www.safeworkaustralia.gov.au/system/files/documents/1702/managing-the-risk-of-fatigue.pdf, viewed 22 August 2019.

[157] Reynolds, A et al 2017, *Shift work and health: Development of accessible information to support education and awareness of the health outcomes associated with shift work*, Appleton Institute, CQU, http://library.safework.sa.gov.au/attachments/69058/1631%20CQU%20Final%20Report% 20v4.pdf, viewed 22 August 2019.

[158] Caruso, CC 2014, *Negative Impacts of Shiftwork and Long Work Hours*, Rehabilitation nursing, the official journal of the Association of Rehabilitation Nurses, Vol. 39(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629843/pdf/nihms731739.pdf, viewed 23 September 2019.

[159] Appleton Institute, CQU, Submission No 30, 31 January 2019.

### *7.2.4 Higher risk of accident while driving*

Fatigue caused by shift work, night work and working long hours is acknowledged to impact on workplace safety and increase the risk of vehicle crashes and incidents.[160] The National Heavy Vehicle Regulator (NHVR) reported in its submission that:

> Fatigue can affect a driver's ability to control their vehicle by influencing certain factors associated with attention, reaction, and vigilance therefore increasing the likelihood of road crash occurrence. Fatigue similarly impairs the driving performance of drivers, with drivers more prone to making constant errors while driving tired.[161]

The ANZCA noted that workplace fatigue can have the equivalent effect of being over the legal blood alcohol limit:

> The decrement in cognitive psychomotor performance after 17 hours of sustained wakefulness is equivalent to the performance impairment observed with a blood alcohol level of 0.05 per cent, and after 24 hours to a blood alcohol level of 0.1 per cent.[162]

In this context, workplace fatigue can have consequences for health care professionals while they are commuting to and from work,[163] particularly where they have been performing night shifts, overtime or extended working hours.[164] This issue was raised in several submissions and is of particular relevance to individuals working in a regional hospital or health service. For example:

> The furthest a member of staff on call can be from the hospital is 40 minutes by car. That's 40 minutes of driving to work for a morning shift, 40 minutes of driving home after that shift, 40 minutes return when phoned for a re-call to work at 1am and then another 40 minutes home again at 5am, then expected to drive 40 minutes back to work again for their next shift at 7 or 8am and then home once again! That's 4 hours spent just driving in one 24-hour period, after 12 or more hours of work, potentially on long country roads, at 110km/hr, at night time, while fatigued.[165]

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[160] See e.g. Di Milia, L, Rogers, N.L and Åkerstedt, T 2012, *Sleepiness, Long Distance Commuting and Night Work as Predictors of Driving Performance*, PLOS ONE, Volume 7, Issue 9, https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0045856&type=printable, viewed 5 August 2019.

[161] National Heavy Vehicle Regulator (NHVR), Submission No 67, 4 June 2019.

[162] ANZCA, Submission No 45, 4 February 2019.

[163] RANZCP, Submission No 22, 31 January 2019.

[164] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[165] Confidential, Submission No 10, 30 January 2019.

The SASMOA survey that was conducted in response to this Inquiry also provided evidence in this regard, noting that 20 per cent of junior doctors reported having fallen asleep driving home from work, with 34 per cent reporting having fallen asleep at traffic lights. For senior doctors, the rates were 14 per cent and 25 per cent respectively.[166] This would indicate a significant safety issue for health professionals even beyond their actual workplace.

## 7.3 Impact on health services

***Term of Reference***

*c) The impact of workplace fatigue and bullying on quality, safety and effective health services.*

One of the key concerns raised in submissions to the Inquiry was the potential impact on patient safety when health care professionals are subjected to workplace fatigue and bullying.

The Health Consumers Alliance of SA Inc (HCASA) cited international studies which show a link between workplace fatigue, bullying, general rudeness and reduced efficacy of clinicians. These factors can all impact on diagnostic and procedural performance, which in turn affects the level of patient care that is delivered.[167] A 2012 American study found that patients were less satisfied with their care when there was a higher proportion of nurses working longer shifts (13 or more hours) and more satisfied when there was a higher proportion of nurses working shorter shifts (11 hours or less).[168]

Fatigue has also been shown to have detrimental effects on performance and safety in high-risk industries and can cause cognitive impairment in areas such as vigilance, attention, decision making and memory.[169] There are numerous examples of studies which have linked fatigue-related

[166] SASMOA, Submission No 50, 14 February 2019.

[167] Health Consumers Alliance of SA Inc (HCASA), Submission No 13, 30 January 2019.

[168] Witkoski Stimpfel, A, et al 2012, *The Longer The Shifts For Hospital Nurses, The Higher The Levels Of Burnout And Patient Dissatisfaction*, Health Affairs, Vol. 13, No. 11, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.1377?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed, viewed 20 September 2019.

[169] Appleton Institute, CQU, Submission No 30, 31 January 2019.

impairments with reduced job performance and errors in the delivery of patient care.[170] Potential outcomes of this include surgical complications and medication errors, which can ultimately result in longer hospital stays, worse health outcomes for patients, and in the worst case scenario even death. Fatigue also reduces alertness which can lead to errors when performing critical tasks that require a high level of concentration, or when undertaking night or shift work during times when one would ordinarily be sleeping.[171] A number of individuals who made submissions expressed a concern that fatigue would cause them to make a mistake. For example:

> Physical, mental and emotional fatigue…very obviously impact hugely on the provision of optimum and safe patient care. It is important to note that when called out after hours, it is to attend an emergency. This by its definition indicates that the situation being attended was serious and required critical thinking skills…My greatest concern (frequently voiced) was that I would eventually make a mistake secondary to fatigue and a patient would be injured (or worse) as a direct result of this.[172]

SASMOA also suggested that unmanageable workloads and fatigue can lead to "corners being cut and patient safety [jeopardised]".[173]

In a negative working environment, staff become at risk of cynicism and reduced levels of empathy, which can directly impact on the patient experience. Non-technical skills can also be affected, such as teamwork, communication, monitoring, leadership and social skills.[174,175] These non-technical skills are still essential for the provision of good health care for patients. Possible impacts of these skills being compromised include the patient not feeling that they are being heard, respected or believed, poor communication, being denied appropriate treatment or testing, and potentially even experiencing unnecessary discomfort, pain, disability or death.[176]

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[170] See e.g. Caruso, CC 2014, *Negative Impacts of Shiftwork and Long Work Hours*, Rehabilitation nursing, the official journal of the Association of Rehabilitation Nurses, Vol. 39(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629843/pdf/nihms731739.pdf, viewed 23 September 2019.

[171] Safe Work Australia 2013, *Guide for Managing the Risk of Fatigue at Work*, https://www.safeworkaustralia.gov.au/system/files/documents/1702/managing-the-risk-of-fatigue.pdf, viewed 22 August 2019.

[172] Deborah Williams, Submission No 17, 31 January 2019.

[173] SASMOA, Submission No 50, 14 February 2019.

[174] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[175] ACEM, Submission No 49, 8 February 2019.

[176] HCASA, Submission No 13, 30 January 2019.

The National Mental Health Commission noted that:

> The impact of unprofessional behaviour can [lead] to a fear of communicating with, or expressing a differing opinion to, a perceived abuser, is responsible for reduced quality of consumer care, and ultimately deteriorating consumer safety.[177]

Workplace fatigue and bullying can also lead to higher rates of absenteeism and presenteeism, which puts more pressure on the remaining staff and can lead to a higher likelihood of patients receiving poorer care. There is potentially a greater chance of errors being made as a result given that absent staff only exacerbate the problems of workplace fatigue and bullying further.[178]

Ultimately, workplace fatigue and bullying can lead to staff leaving the profession, and this can potentially impact the quality of service provided to patients. One individual summed up the potential for this to happen through their own experience:

> [M]ental health nursing…is a challenging area which is best served by those with passion and expertise for the unique patient cohort. Sadly as a result of this toxic culture many skilled nurses who shared my passion and unique skills in this area have now left…and are employed in other areas. This is a loss of the exact people who should be working in this environment and the patient care has suffered as a result of not being able to replace us.[179]

## 7.4 Extent of compliance with legislation, codes and industrial agreements

***Term of Reference***

*d) The extent to which current work practices comply with relevant legislation, codes and industrial agreements.*

There is a variety of legislation, codes and industrial agreements that hospitals and health services are required to comply with. In addition, hospitals and health services are subject to comprehensive accreditation processes to ensure compliance with national standards. A summary of these key requirements follows.

[177] National Mental Health Commission, Submission No 47, 5 February 2019.

[178] HCASA, Submission No 13, 30 January 2019.

[179] Confidential, Submission No 23, 31 January 2019.

### *7.4.1 Legislation*

From a legislative perspective, workplace fatigue and bullying are considered work health and safety issues and dealt with under the *Work Health and Safety Act 2012* (SA). Section 19 of the Act outlines the primary duty of care of an employer to ensure the health and safety of staff, including the provision and maintenance of "safe systems of work." Section 27 of the Act also imposes a duty on officers of the employer, which would include managers and supervisors, to exercise due diligence to ensure that the employer complies with their duties and obligations under the Act. While workplace fatigue and bullying are not specifically mentioned, these issues arguably go to the heart of the provision of a safe working environment. Importantly, section 28 of the Act also imposes a duty on workers to take reasonable care for their own health and safety and that of others, and comply with the health and safety policies of their employer. In this context, it means that staff must take some responsibility for any bullying behaviour, and must also take reasonable steps to ensure they are not fatigued at work to the point where they may cause a risk to the health and safety of themselves or others.

Another piece of legislation that is of relevance to public sector staff is the *Public Sector Act 2009* (SA). The Public Sector Principles are outlined in section 5 of the Act, which among other things require public sector employees to behave ethically and with professional integrity, with public sector agencies required to treat staff fairly, justly and reasonably and prevent unlawful discrimination.

### *7.4.2 Codes*

Section 6 of the *Public Sector Act 2009* requires public sector employees to observe the public sector code of conduct, which includes requirements for employees to display professional and courteous behaviour, as well as report unethical behaviour.[180]

Health care professionals are required to comply with the code of conduct for their profession (where they exist). There are 15 National Boards established under the Health Practitioner Regulation National Law, which include the Medical Board and the Nursing and Midwifery Board of Australia.[181,182] These Boards each have a code of conduct for their respective professions. The Nursing and

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[180] OCPSE, *Code of Ethics for the South Australian Public Sector*, https://publicsector.sa.gov.au/wp-content/uploads/20180411-Code-of-Ethics-for-the-South-Australian-Public-Sector.pdf, viewed 12 August 2019.

[181] *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA).

[182] Australian Health Practitioner Regulation Agency (AHPRA) 2017, *National Boards*, https://www.ahpra.gov.au/ National-Boards.aspx, viewed 12 August 2019.

Midwifery Board advised that it recently acted on the recommendations arising from a research and consultation process to include a specific section on bullying and harassment in its codes of conduct for nursing and midwifery.[183] The Medical Board also advised that it is in the final stages of reviewing its code of conduct to strengthen references to bullying, harassment and racism and make it clear that these behaviours are unacceptable and should not be tolerated.[184]

Many of the professional colleges, unions and regulatory bodies also have non-binding policies, guidelines and position statements covering issues broadly associated with workplace fatigue and bullying.

### *7.4.3 Industrial agreements*

SA Health staff operate under a number of relevant enterprise agreements, including:[185]

- *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016*
- *SA Health Salaried Medical Officers Enterprise Agreement 2017*
- *SA Ambulance Service Enterprise Agreement 2017*
- *SA Health Clinical Academics Enterprise Agreement 2018*
- *SA Health Visiting Medical Specialists Enterprise Agreement 2019*
- *South Australian Modern Public Sector Enterprise Agreement: Salaried 2017*
- *South Australian Public Sector Wages Parity Enterprise Agreement: Weekly Paid 2017*

There are also a number of relevant industrial awards from which the enterprise agreements are derived, including:[186]

- *Nurses (South Australian Public Sector) Award 2002*
- *South Australian Medical Officers Award*
- *SA Ambulance Service Award*

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[183] Nursing and Midwifery Board of Australia, Submission No 19, 31 January 2019.

[184] Letter from Dr Anne Tonkin, Chair, Medical Board of Australia, response to questions from Committee, 29 July 2019.

[185] South Australian Employment Tribunal (SAET), *Enterprise Agreements,* https://www.saet.sa.gov.au/awards-agreements-and-registers/enterprise-agreements/, viewed 12 August 2019.

[186] SAET, *List of Industrial Awards*, https://www.saet.sa.gov.au/awards-agreements-and-registers/industrial-awards/list-of-industrial-awards/, viewed 12 August 2019.

- *Medical Scientists (South Australian Public Sector) Award*
- *South Australian Government Health etc Ancillary Employees Award*
- *SA Public Sector Salaried Employees Interim Award*

Most of the enterprise agreements and awards that are of relevance to SA Health contain provisions which govern workload management, such as maximum shift lengths, required breaks between shifts, staffing levels and skills-mix requirements.[187] Appendix 1 provides a summary of some of the key workload management provisions.

***Addressing the '8-hour break rule'***

As mentioned above (refer section 7.1.5), one of the key concerns raised by nurses as contributing to workplace fatigue is the application of the '8-hour break rule' in the *Nurses Award 2002*. Given the potentially ambiguous interpretation of the rule, it would appear that even if the relevant clause is complied with, it can still result in an outcome where nurses end up working hours that are not conducive to optimal fatigue management. The Committee wrote to SA Health seeking to clarify the rationale behind the interpretation of the rule and was advised that recalls to work usually occur as part of an on-call arrangement and that this "by definition, is not a period of work assigned to the employee on a roster" and is therefore not a rostered shift for the purposes of the rule.[188]

In response to a similar issue, Queensland Health recently agreed to amend the equivalent rule in its certified agreement with nurses and midwives. As of 25 September 2018, when a nurse or midwife is recalled to work for any period between rostered shifts, the recall triggers a fresh ten-hour break before they are required to recommence duty.[189]

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[187] SA Health, Submission No 56, 26 February 2019.

[188] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[189] Queensland Government, Submission No 115 to Parliament of Australia House of Representatives Standing Committee on Health, Aged Care and Sport, *Inquiry into Sleep Health Awareness in Australia*, https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/SleepHealthAwareness/Submissions, 26 October 2018.

***Committee view***

The Committee considers it would be prudent to review the impact of '8-hour break rule' and determine whether further clarification is needed. As public sector enterprise bargaining and Award matters are ultimately a responsibility of the Industrial Relations and Policy Branch of the Department of Treasury and Finance (DTF), it would be best placed to lead such a review in conjunction with the DHW.

**Recommendation 1**

That the DHW and the Department of Treasury and Finance work together to review the impact and application of Clauses 5.1.8 and 5.4.10 of the *Nurses (South Australian Public Sector) Award 2002* on workplace fatigue amongst nurses in SA hospitals, with a view to determining whether further clarification within the Enterprise Agreement is desirable and feasible. The Committee notes that Enterprise Agreement negotiations are currently underway and as such this investigation should be undertaken in preparation for the next round of enterprise bargaining.

As part of this review the Committee encourages the DHW to consult with other jurisdictions, including Queensland Health which has recently made changes to its nursing enterprise agreement.

### *7.4.4 Accreditation standards*

Hospitals and health services are required to meet certain accreditation standards set by regulatory bodies and professional colleges. Hospitals and LHNs are required to undertake assessment against the National Safety and Quality Health Service (NSQHS) accreditation standards set by the Australian Commission on Safety and Quality in Health Care (ACSQHC), which include standards assessing the effectiveness of organisational governance, leadership and risk management.[190,191] Where hospitals are delivering training programs, these must also be accredited by regulatory bodies such as the

[190] SA Health, Submission No 56, 26 February 2019.

[191] Australian Commission on Safety and Quality in Health Care (ACSQHC) 2017, *National Safety and Quality Health Service Standards*, 2nd ed, https://www.safetyandquality.gov.au/sites/default/files/2019-04/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf, viewed 13 August 2019.

South Australian Medical Education and Training (SA MET) Health Advisory Council, as well as any relevant professional college.

***National accreditation schemes***

While the NSQHS Clinical Governance Standard does not specifically address workplace fatigue and bullying, the intention of this standard is "[t]o implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care." Specifically, the Standard includes the following criteria:

- Governance, leadership and culture – Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.
- Patient safety and quality systems – Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.
- Clinical performance and effectiveness – The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients.
- Safe environment for the delivery of care – The environment promotes safe and high-quality health care for patients.[192]

The National Boards established under the Health Practitioner Regulation National Law also have accreditation functions and are responsible for accrediting programs of study and education providers.[193] They are also responsible for registration of health practitioners and have a core role in protecting the public and ensuring the practitioners have the necessary qualifications to provide safe care.[194] The Nursing and Midwifery Board of Australia (NMBA), one of the National Boards, noted in its submission that even though bullying and harassment is covered by its code of conduct, it is not typically an issue that the NMBA deals with:

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[192] ACSQHC 2017, *National Safety and Quality Health Service Standards*, 2nd ed, https://www.safetyandquality.gov.au/sites/default/files/2019-04/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf, viewed 13 August 2019.

[193] AHPRA 2019, *Accreditation authorities*, https://www.ahpra.gov.au/Education/Accreditation-Authorities.aspx, viewed 19 December 2019.

[194] AHPRA 2019, *Registration Standards*, https://www.ahpra.gov.au/Registration/Registration-Standards.aspx, viewed 19 December 2019.

> The NMBA regulatory responsibility to protect the public is shared with the employers of nurses and midwives as well as with the registrants of the two professions. While the codes clearly indicate that bullying and harassment is not acceptable and should not be tolerated, in most circumstances issues relating to bullying and harassment should be managed by the employer as a performance issue. Bullying and harassment is not usually a matter for the NMBA and the Australian Health Practitioner Regulation Agency (AHPRA). It would only be cases where bullying and harassment is at a level where patient safety is being placed directly at risk or care is being compromised that a notification should be made to the NMBA.[195]

The Medical Board of Australia also expressed a similar view to the NMBA.[196]

***Committee view***

Given the evidence that workplace fatigue and bullying can ultimately impact on the delivery of services and the quality of patient care, the Committee considers that the NSQHS accreditation standards are broad enough to include a consideration of these matters. The Committee wrote to both the ACSQHC and the Australian Council on Healthcare Standards (which is an approved accrediting agency that undertakes accreditation against the NSQHS standards and is the main agency used by SA Health) inviting them to make a submission or attend a witness hearing. Both organisations declined on the basis that they did not view workplace fatigue and bullying as being within the scope of their accreditation activities given there are no accreditation standards dealing directly with workplace fatigue and bullying, and as such did not feel they could contribute to the Inquiry. The Committee is concerned with this view given the potential impacts that workplace fatigue and bullying can have on patient outcomes.

The Committee notes that in SA Health's Respectful Behaviour Policy Directive, the NSQHS Clinical Governance Standard is ticked as being relevant to the Policy Directive.[197] This would suggest that

[195] Nursing and Midwifery Board of Australia, Submission No 19, 31 January 2019.

[196] Letter from Dr Anne Tonkin, Chair, Medical Board of Australia, response to questions from Committee, 29 July 2019.

[197] SA Health 2016, *Respectful Behaviour Policy Directive*, https://www.sahealth.sa.gov.au/wps/wcm/connect/feb55680476d0276a375fb2e504170d4/Directive%2B-%2BRespectful%2BBehaviour%2BPolicy%2BDirective%2B-%2BDec2016.pdf?MOD=AJPERES&CACHE=NONE&CONTENTCACHE=NONE, viewed 3 January 2020.

SA Health recognises the relevance of providing a safe and respectful working environment to the national accreditation standards.

The Committee is concerned with the approach taken by the ACSQHC given that the current NSQHS standards (particularly the Clinical Governance Standard) are arguably broad enough to encompass consideration of workplace fatigue and bullying related matters.

The Committee acknowledges that it has no jurisdiction over the ACSQHC, however given the importance that the NSQHS accreditation standards have in ensuring patient safety, the Committee sees this as being an appropriate mechanism through which to drive meaningful change by requiring hospitals and health services to treat workplace fatigue and bullying with the same level of seriousness as other risks to patient safety. Accordingly, the Committee is of the view that the Minister for Health and Wellbeing should work with their Commonwealth counterpart to encourage the implementation of necessary changes to the NSQHS standards as per the recommendation below, and in the meantime implement State-based arrangements for the assessment of workplace fatigue and bullying to be undertaken concurrently with any national accreditation activities.

**Recommendation 2**

That the Minister for Health and Wellbeing works with the Commonwealth Minister for Health to facilitate the introduction of changes to the clinical governance section of the National Safety and Quality Health Service Standards (NSQHS).

These changes should explicitly address workplace fatigue and bullying matters and be incorporated as part of the Australian Health Services and Quality Accreditation Scheme coordinated by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The primary aim of such changes is to ensure that medical professionals have a healthy and safe workplace allowing them to provide patients and consumers with safe and high-quality care.

**Recommendation 3**

Pending update of the NSQHS Standards (refer recommendation number 2 above) the Committee recommends that the Minister for Health and Wellbeing implements State-based arrangements which ensure that matters of workplace fatigue and bullying are assessed in addition to the broader national accreditation/re-accreditation of South Australian hospitals and health services.

### *Training program accreditation*

SA MET noted that "[w]hile the [SA MET] standards do not currently specifically address bullying and fatigue the standards ensure healthcare organisations monitor and support prevocational trainee medical officer welfare, working hours, supervision and professional development."[198] It is noted that there have been occasions where SA hospitals have failed to obtain unconditional accreditation. One of the more recent examples occurred in 2018 where the SA MET Health Advisory Council failed to give unconditional accreditation following visits to the Royal Adelaide Hospital (RAH) and Queen Elizabeth Hospital (QEH), in part due to concerns over governance and workload levels.[199]

SA Health advised that in the event that matters such as workloads, work practices and bullying are raised as part of an external accreditation process (e.g. by SA MET, a professional college, or other relevant body), these issues are referred through the appropriate management processes for resolution.[200]

Other peak bodies expressed some reservations about the use of accreditation processes to address workplace fatigue and bullying. Chris Moy from the AMA (SA) noted that while medical colleges have acknowledged that workplace fatigue and bullying are problems, "they can only do so much because they are not the employers. They only have one lever to control things, which is actually accreditation of the teaching unit, for example, and it is a blunt instrument." Failing accreditation "can be embarrassing" and could potentially undermine the teaching activities of the major hospitals.[201] Rod Mitchell from the ANZCA also noted the effect that withdrawal of training program accreditation can have on trainees:

> We have had a couple of dealings in recent times…with large hospitals that have a culture of bullying. When we go in and—I don't want to use the word 'threaten'— but rather "talk about" withdrawing accreditation, we are aware of the stressful effect that has on the staff who are there and the trainees. To withdraw accreditation means that trainees are now suddenly working in an environment where their time there is not going to be counted anymore, and they have to seek alternative employment.

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[198] South Australian Medical Education and Training (SA MET) Health Advisory Council, Submission No 58, 12 March 2019.

[199] ABC News 2018, *'Major' workload concerns: SA hospitals put on notice after training accreditation failure*, https://www.abc.net.au/news/2018-07-03/sa-hospitals-on-notice-after-training-accreditation-failure/9931310, viewed 18 December 2019.

[200] SA Health, Submission No 56, 26 February 2019.

[201] Dr Chris Moy, AMA (SA Branch), *Committee Hansard*, 13 September 2019.

> There are two particular hospitals currently being assessed in relation to bullying and fatigue. These are big departments where there is a very poor culture around bullying and fatigue. There's a very fine line between adding to that by threatening to withdraw accreditation but supporting the staff who are there…
>
> But it's a fine balance because the big stick we hold in terms of addressing bullying—and this is the end-of-the-road stick—is to withdraw accreditation of the college. We need to use that very carefully because it can have unintended negative consequences. There's an ongoing issue to make sure that our dealings with allegations around bullying, fatigue and harassment are done in concert with the local department. Our approach has been that, when these complaints come to our attention, we liaise initially with the department and expect that they will deal with it with their processes.[202]

Kevin Forsyth from SA MET also noted that while SA MET receives feedback throughout the year which can ultimately result in hospitals and health services not being accredited, he believes that they do not "have enough systematic granular information from our junior doctors across SA Health as to how they are travelling."[203] A new survey is being rolled out by SA MET to collect information on issues such as discrimination, bullying, workloads and work-life balance, which is aimed at providing SA MET with further information on the experiences of junior doctors during their training programs. It was also noted that the SA MET Health Advisory Council "doesn't have any particular authority in its own right, but it's advisory in the way it works" so its role is only to advise SA Health.[204]

***Committee view***

The Committee acknowledges the challenges of using training program accreditation as a tool to improve outcomes with respect to workplace fatigue and bullying, and the argument made by a number of organisations that these are ultimately matters for individual employers to address. The Committee considers the various accreditation processes as being one of the most effective ways to keep hospitals and health services accountable for addressing issues which affect patient safety and staff wellbeing. The Committee accepts that the decision to withdraw accreditation cannot be taken lightly, however in light of the evidence that workplace fatigue and bullying are systemic issues across the health sector, the Committee considers it to be useful for the Minister for Health and Wellbeing to

[202] Dr Rod Mitchell, ANZCA, *Committee Hansard*, 5 July 2019.

[203] Professor Kevin Forsyth, SA MET Health Advisory Council, *Committee Hansard*, 2 August 2019.

[204] Ibid.

encourage the various accrediting agencies to be more proactive in addressing these issues, including through the use of accreditation where necessary.

**Recommendation 4**

That the Minister for Health and Wellbeing works with the Commonwealth Minister for Health to encourage the National Boards established under the Health Practitioner Regulation National Law to more assertively address workplace fatigue and bullying including, where relevant, via the use of their registration/accreditation related powers.

**Recommendation 5**

That the Minister for Health and Wellbeing liaises with the following organisations/agencies with a view to encouraging them to more assertively address workplace fatigue and bullying in SA hospitals and health services including, where relevant, via the use of their accreditation related powers:

- SA MET Advisory Council;
- The Australian College of Nursing; and
- The Australian Specialist Medical Colleges.

### *7.4.5 Extent of compliance*

The Committee received little concrete evidence to suggest deliberate and widespread failure to comply with legislation, codes and industrial agreements with respect to workplace fatigue and bullying. However, SA Health acknowledged that given the complexities of its service delivery requirements and the industrial arrangements under which its staff operate, there are times when it does not meet all of its obligations outlined above.[205] Drew Dawson from the Appleton Institute also made the observation that in practice, industrial agreements are not complied with and "we all know that" but there is a fundamental challenge in the health sector that "sometimes a tired doctor is better than no doctor at all."[206]

[205] SA Health, Submission No 56, 26 February 2019.

[206] Professor Drew Dawson, Appleton Institute, *Committee Hansard*, 28 June 2019.

The ANMF (SA Branch) argued that rather than being an issue of lack of compliance, the current legislation and industrial awards do not adequately protect staff from workplace fatigue and bullying and only provide for base level minimum standards:

> The legislation and relevant awards do not provide adequate protection for workers in terms of addressing or preventing bullying and fatigue. The relevant awards and most enterprise agreements merely provide for minimum standards regarding shift lengths, breaks, overtime and on-call/recall provisions. The ANMF (SA Branch) has been successful in negotiating staffing and workload provisions which that provide an avenue for members to raise concerns and an obligation for the employer to address those concerns. The [*Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016*] specifically provides for minimum safe staffing levels which, despite regular reports of understaffing, are a mechanism by which SA Health is held to account for poor rostering practices and chronic understaffing, factors which are well documented to lead to workplace fatigue and burnout.[207]

A number of witnesses suggested that workplace fatigue and bullying are issues which are not best addressed with legislation, codes and industrial agreements, as the fundamental cause of these matters relates to poor workplace culture, which is not something that can be easily fixed with further regulation. MIGA suggested that "legislation, codes and industrial agreements can be of limited use in dealing with work practice issues such as bullying and fatigue."[208] Tim Bowen from MIGA further emphasised that MIGA "don't point to any particular deficiencies in South Australia's law"[209] and Anita Filleti also noted that from the claims she has dealt with, "there hasn't been a situation where there has been an issue about the legislation having any deficiencies that we can't rely on to support our member."[210]

Craig Stevens from Authentic Workplace Relations was able to provide the Committee with a legal perspective on the issues of workplace fatigue and bullying and it was his view that in general "there is sufficient overarching regulation in the form of key umbrella legislation, such as the Work Health and Safety Act, and adequate regulation generally."[211] He also noted that health professionals are already subject to significant oversight and regulation, as outlined above.

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[207] ANMF (SA Branch), Submission No 53, 18 February 2019.

[208] MIGA, Submission No 66, 31 May 2019.

[209] Mr Tim Bowen, MIGA, *Committee Hansard*, 13 September 2019.

[210] Ms Anita Filleti, MIGA, *Committee Hansard*, 13 September 2019.

[211] Mr Craig Stevens, Authentic Workplace Relations, *Committee Hansard*, 18 October 2019.

***Committee view***

Based on the evidence received, the Committee does not consider that legislative or regulatory changes are necessary in order to positively impact on workplace fatigue and bullying in SA hospitals or health services. The Committee is of the view, however, that there are a range of practical steps broadly relating to matters such as workplace culture, governance, data collection and system improvements and accreditation that should be made in order to address workplace fatigue and bullying. Recommendations relating to these matters are outlined elsewhere in this report.

## 7.5 Use of risk management tools, audit and compliance regimes

***Term of Reference***

*e) Opportunities, costs and impacts of measuring fatigue and using risk management tools, audit and compliance regimes, including those in other industries (e.g. aviation, mining and transport industries) to reduce the occurrence or impact of fatigue and bullying.*

### *7.5.1 Implementation of a Fatigue Risk Management System (FRMS)*

The Appleton Institute emphasised that workplace fatigue is a complex problem, particularly in the health care industry, and that there are a number of causal factors and operational requirements that need to be considered in managing it. Perceived simple solutions such as placing limits on working hours may be inadequate, as such arrangements can produce unintended consequences such as patient care not being delivered in a timely manner.[212] Other potential issues include less time for staff to pursue educational opportunities and reduced exposure to different cases. Shorter shifts may also result in increased patient handovers and a lack of consistency of care, which increases the likelihood of an adverse event for a patient.[213] Restrictions on hours worked may also not solve workplace fatigue as it does not address the impacts of cumulative fatigue or circadian rhythm, and tends to ignore non-work factors such as commute and actual sleep times.[214] Given the limitations of these prescriptive methods of fatigue management, the current research suggests that a more suitable approach is the implementation of a Fatigue Risk Management System (FRMS), which can be defined

[212] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[213] Ibid.

[214] Ibid.

as “a data-driven means of continuously monitoring and managing fatigue related safety risks, based upon scientific principles and knowledge as well as operational experience that aims to ensure relevant personnel are performing at adequate levels of alertness.”[215]

***Heavy vehicle industry***

The limitations of prescriptive hours-of-service requirements have been recognised by the heavy vehicle industry as being “an overly simply solution to a complex problem.”[216] While simple to enforce, the prescriptive based Heavy Vehicle National Law (HVNL) provisions are easy to breach if honest records are not kept. Similarly, some of the major causes of fatigue are not addressed by this, with the National Heavy Vehicle Regulator (NHVR) citing many of the same factors as the Appleton Institute (refer above).[217]

Given the shortcomings of prescriptive hours of work, there has been a recent shift towards more comprehensive risk-based management of fatigue and the development of FRMS.[218] This approach recognises that staff are likely to be fatigued at times during their work, and rather than simply restricting their working hours, the fatigue is managed within a risk-based framework. This involves assessing the likelihood of fatigue, the likelihood and consequences of a fatigue related error or incident, and the implementation of appropriate strategies to mitigate the risk to allow staff to continue to work safely.[219] This allows fatigue to be managed with operational needs in mind, such as ensuring that community demand for health care services continues to be met, as well as bearing in mind any risks to the health and safety of staff. The Appleton Institute emphasised that “[t]his does not necessarily mean that employees never experience fatigue, but that fatigue is identified early, and appropriate measures can be taken to ensure that accidents or incidents do not result.”[220]

The NHVR noted that a FRMS is desirable because it is driven by data and measures actual risks, while developing tailored controls where multiple factors are considered. In this way, it can actually

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[215] International Civil Aviation Organization (ICAO) 2013, *Fatigue Management*, https://www.icao.int/safety/fatiguemanagement/ArticlesPublications/Flyer_US-Letter_ANB-Fatigue-Management_2013-08-23.pdf, viewed 15 October 2019.

[216] NHVR, Submission No 67, 4 June 2019.

[217] Ibid.

[218] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[219] Ibid.

[220] Ibid.

enhance operational flexibility in a way that prescriptive working hour restrictions cannot. A FRMS also requires risks to be managed proactively, and is a systematic and documented approach to fatigue management.[221] A challenge to implementing a FRMS is ensuring that staff have a sufficient understanding and commitment to it, as the success of such a system ultimately relies on staff input and a "safety culture in which there is open and honest reporting of safety issues within the organisation."[222] A shared responsibility model, whereby staff have some of the responsibility for managing fatigue, is also needed for such a system to work. Current transport law is based on a Chain of Responsibility principle, where all parties in the transport supply chain share the responsibility for ensuring the safety of their transport activities. This includes drivers and workers themselves.[223]

In the heavy vehicle industry, the NHVR has already developed materials available to the public (including heavy vehicle operators) relating to the development of Safety Management Systems (SMS).[224] The NHVR reported that it would be easy for an operator to include fatigue risk management within such a system.[225] Figure 7 below shows the key components of a SMS.

[221] NHVR, Submission No 67, 4 June 2019.

[222] Ibid.

[223] Ibid.

[224] NHVR 2019, *SMS guidance material and templates*, https://www.nhvr.gov.au/safety-accreditation-compliance/safety-management-systems/sms-guidance-material-and-templates, viewed 15 August 2019.

[225] NHVR, Submission No 67, 4 June 2019.

**Figure 7: Components and elements of a SMS**[226]

The NHVR explained how a FRMS could work based on its existing SMS components and elements:

- Fatigue Safety Policy and Documentation – Documenting safety processes and activities associated with fatigue is very important. As a minimum, organisations should have a clear commitment to fatigue safety in their business.
- Fatigue Safety Risk Management – Sound risk management practices provide the foundation for managing fatigue-related safety risks that could impact on heavy vehicle organisations/operators, their employees, other road users and the public.
- Safety Promotion and Training – Safety promotion would be an important part of an FSMS. Safety promotion includes activities to support the implementation and operation of an FSMS in a business.
- Safety Assurance – Safety assurance is the process of monitoring and measuring how a FSMS is performing. It's about looking at the things a business is doing to manage fatigue-related safety to see what's working well and what isn't.[227]

[226] NHVR 2018, *Safety Management Systems (SMS) Fact Sheet*, https://www.nhvr.gov.au/files/201805-0797-sms-fact-sheet.pdf, viewed 15 August 2019.

[227] NHVR, Submission No 67, 4 June 2019.

The NHVR emphasised that an effective FRMS requires a shared responsibility for fatigue risk management between regulatory bodies, employers and individuals, as summarised in Table 3.

**Table 3: Responsibilities for fatigue risk management**[228]

| Government/Regulatory Responsibilities | Organisational Responsibilities | Individual Responsibilities |
|---|---|---|
| • Prescribe requirements/framework for FRMS<br>• Assess compliance<br>• Audit non-compliance<br>• Where appropriate, investigate incidents<br>• Produce guidance material and information | • Provide support for compliance with legislation, policy development, training and education, and error/incident reporting systems<br>• Ensure work schedules provide adequate opportunity for rest and recovery between shifts<br>• Assess specific work tasks for fatigue-related risk | • Use time away from work appropriately to obtain adequate rest and recovery, and ensure fitness for work<br>• Report any potential risks to manager if experiencing fatigue-related symptoms<br>• Report any situation that may present fatigue-related risk |

Use of FRMS would complement the existing fatigue management accreditation scheme in the heavy vehicle industry which allows operators to have some flexibility of hours of service for their drivers if they meet certain fatigue management standards. There are two levels of accreditation that can be achieved (Basic and Advanced) depending on the number of standards met.[229] These include standards around scheduling and rostering, readiness for duty, fatigue knowledge and awareness, and appropriate governance arrangements around responsibilities, internal reviews and keeping of records and documentation.

Andreas Blahous outlined how the NHVR assesses a FRMS:

> The FRMS essentially takes away the prescriptive rules and work and rest limits that are, under hours of right, active and allows an operator to develop their own scheduling and rostering and develop rules for their own operations. We assess the risks associated with those rules using seven principles, based on prolonged wakefulness, sleep, circadian rhythms. We also assess the controls and countermeasures proposed where there are high and medium risks associated with those proposed rules.
>
> Where we are satisfied that the risks are managed and the net risk profile is tolerable, we will issue an instrument to the operator that will make those rules that they have nominated for themselves legally binding and enforceable on the side of the road. So it's still a

[228] Ibid.

[229] Ibid.

> prescriptive system, but it's a prescriptive system based on that operator's scope of operations and planned controls for mitigating their risk.[230]

Mr Blahous further explained the productivity benefits to a heavy vehicle operator from using a FRMS:

> There is an incentive. It is not necessarily extra hours. Typically, our research shows that actually they work fewer hours than the hours of right. What they are able to do is manage those hours in a way that maximises their productivity. So they get productivity benefits by enabling vehicles to get back to the depot to be reallocated, enabling jobs that exceed normal limits to be completed and any risks compensated for; or they potentially have the ability to design new work patterns which allow them to access types of work that aren't available under the hours of right rule.[231]

### *Civil aviation industry*

The Civil Aviation Safety Authority's (CASA) approach to fatigue management is based on the four basic scientific principles, established by the International Civil Aviation Organization (ICAO), that underpin fatigue management regulations:

- the need for adequate sleep and the impact of extended time awake;
- the impact of sleep loss and recovery;
- daily rhythms in the ability to perform work that are driven by the brain's circadian clock; and
- the influence of workload.[232]

These principles are reflected in CASA's Civil Aviation Order (CAO) 48.1 Instrument 2019, which has recently been released following an independent review of the new fatigue rules introduced in 2013.[233] Much like the NHVR, CASA recognises that fatigue management is a shared responsibility between pilots and operators, as reflected in CAO 48.1 Instrument 2019 which requires pilots to take steps to

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[230] Andreas Blahous, NHVR, *Committee Hansard*, 15 November 2019.

[231] Ibid.

[232] Civil Aviation Authority (CASA) 2019, *CASA's approach to fatigue management*, https://www.casa.gov.au/safety-management/fatigue-management/casas-approach-fatigue-management, viewed 11 October 2019.

[233] *Civil Aviation Order 48.1 Instrument 2019*, https://www.legislation.gov.au/Details/F2019L01070, viewed 11 October 2019.

manage fatigue risk, including potentially not operating an aircraft if they feel that they are unfit to do so due to fatigue.[234]

CAO 48.1 Instrument 2019 allows operators to mitigate the effects of fatigue through two broad methods – either a prescriptive approach or a performance-based approach under a FRMS.[235] These approaches are outlined in the Appendices of CAO 48.1 Instrument 2019. Broadly speaking, a prescriptive approach with basic limits is considered the simplest method, however such an approach may not allow sufficient flexibility for most operators. More complex prescriptive approaches are available but require greater effort to implement and maintain. CASA has developed a number of approaches that are optimised for different types of operations (e.g. multi-crew, single pilot, ballooning operations, medical transport and emergency services, etc).[236] The most flexible approach however is a FRMS, but greater oversight from CASA is mandated if an operator wishes to use a FRMS.[237] Formal approval to trial a FRMS is required to be obtained from CASA, and the FRMS must meet certain prescribed requirements.

Jason McHeyzer explained CASA's three-tiered approach to fatigue management as follows:

> In simplistic terms, what our rules now say is that we have three different types of fatigue management rules. We have our really basic rule, which is just a simplistic split/rest kind of rule. We call that Appendix 1 in our instrument. That's really for operators who just do simple stuff by day. We reduced all the overheads by putting really simple limits in place.
>
> Then we have, effectively, our enhanced rules, where the operators need to do more; they need to collect a little bit more data. It allows them to fly for longer periods of time and allows them to do things like what we call crew augmentation…the enhanced rules allow you to do things with additional mitigation, like crew augmentation; split/rest, where you do some work in the morning, have a bit of a sleep during the day and do some work in the afternoon; crossing time zones, those things that add complexity; or stand-by, where you are sort of waiting to go flying and then you go flying for an extended period. You need a bit more enhanced rules to deal with that.

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[234] Ibid, section 16.

[235] CASA 2019, *CASA's approach to fatigue management*, https://www.casa.gov.au/safety-management/fatigue-management/casas-approach-fatigue-management, viewed 11 October 2019.

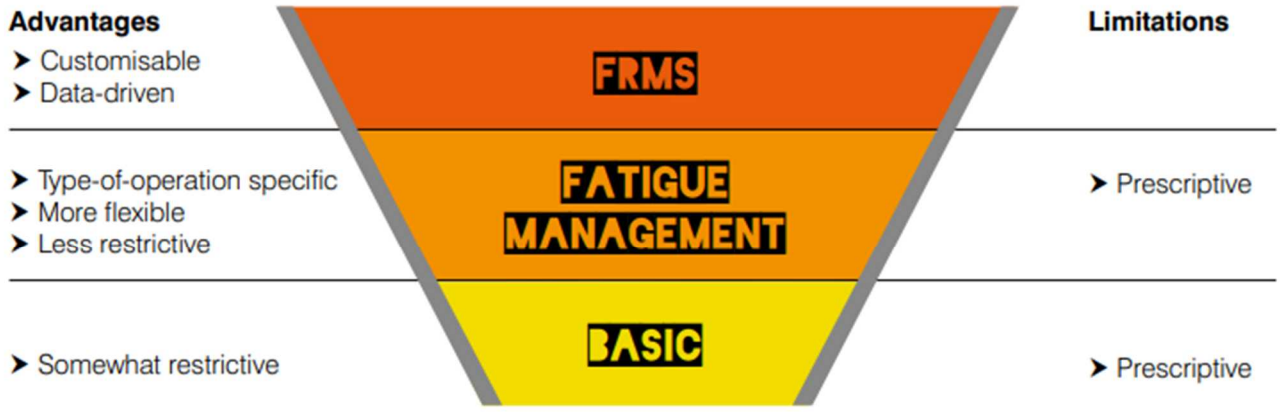
[236] Ibid.

[237] Appendix 7, *Civil Aviation Order 48.1 Instrument 2019*, https://www.legislation.gov.au/Details/F2019L01070, viewed 11 October 2019.

> Then we have an FRMS, a fatigue risk management system, which is really a bespoke system for that operator, designed by that operator, but approved by CASA…what we expect operators to do there is have a look at their existing work practices, look at their fatigue reporting, have a look at what the risks are, and identify how they are going to mitigate the specific risks for their operation, how they are going to monitor those mitigations, and how they are going to deal with reporting to continually improve their system.
>
> It allows them to write a different system to our prescriptive rules that actually fits their operation, but it has to have defences in place. Those defences have to be monitored and CASA gets a say in approving that system before they can start using it.[238]

Figure 8 below summarises CASA's three-tiered approach to fatigue management and what requirements operators must fulfil in addition to basic fatigue management requirements.

**Figure 8: The three-tier approach to fatigue management**[239]




**Operator requirements**

| | | |
|---|---|---|
| **FRMS** | ➤ Policy and documentation<br>➤ Risk management processes | ➤ Safety assurance processes<br>➤ Safety promotion processes |
| **Fatigue management** | ➤ Hazard identification<br>➤ Limitations taking into account identified hazards | ➤ Continuous monitoring<br>➤ Transitional procedures<br>➤ Training for flight crew members |
| **Basic** | ➤ No additional requirements | |

[238] Jason McHeyzer, CASA, *Committee Hansard*, 15 November 2019.

[239] CASA 2016, *Fatigue Risk Management Systems: Fatigue – The Rules Have Changed*, https://www.casa.gov.au/files/fatigue-risk-management-systems-rules-have-changed, viewed 14 October 2019.

CASA's approach to designing a FRMS mirrors what the NHVR suggested in terms of following a similar framework to safety management systems (SMS). Figure 9 below shows the basic principles for designing an appropriate FRMS. CASA suggests that an organisation's FRMS must be able to integrate with any broader SMS it already uses.

**Figure 9: Basic principles for designing a FRMS framework**[240]

| SMS framework | FRMS framework |
|---|---|
| **Safety policy & objectives**<br>➤ Management commitment and responsibility<br>➤ Safety policy<br>➤ Safety accountabilities<br>➤ Appointment of key staff members<br>➤ Safety response planning<br>➤ SMS documentation | **FRMS policy & objectives**<br>➤ Management commitment<br>➤ FRMS accountabilities and responsibilities<br>➤ FRMS objectives<br>➤ FRMS processes and procedures<br>➤ FRMS documentation |
| **Safety risk management**<br>➤ Hazard identification<br>➤ Risk assessment and mitigation | **Fatigue risk management**<br>➤ Identification & assessment of fatigue-related risks<br>➤ Fatigue-related risk mitigation/controls<br>➤ Implementation |
| **Safety assurance**<br>➤ Safety performance monitoring and measurement<br>➤ Management of change<br>➤ Continuous improvement | **FRMS assurance**<br>➤ Monitor FRMS effectiveness<br>➤ Processes for managing change (to the operational/organisation environment and/or to the FRMS itself)<br>➤ FRMS evaluation<br>➤ Continuous improvement of the FRMS |
| **Safety promotion**<br>➤ Training<br>➤ Safety communication | **FRMS promotion**<br>➤ Training programs<br>➤ FRMS training records<br>➤ FRMS communication plan |

CASA identifies three key factors in establishing an effective FRMS:

- Management commitment – it is critical for senior management to champion the use of a FRMS;

[240] Ibid.

- Scalability and flexibility – a FRMS needs to be relevant to the specific organisation, and should be scaled to an appropriate level of complexity depending on the nature of the organisation; and
- A safety reporting culture – the organisation must foster a positive and supportive culture of safety that does not seek to apportion blame but rather encourages open and honest reporting.[241]

CASA provides various fatigue management resources for operators to use to assist them in developing appropriate fatigue management policies and procedures that meet the requirements set out by CASA.[242]

***Designing and implementing a FRMS in the health industry***

The Appleton Institute noted that best practice for designing a FRMS typically involves five key layers of control mechanisms:

1. ensuring that staff have adequate breaks between shifts to obtain sleep (i.e. hours of work guidelines);
2. assessing actual sleep/wake data;
3. recognising and responding to signs and symptoms of fatigue;
4. detecting and reporting fatigue-related errors and incidents; and
5. reviewing and updating relevant policies and procedures.[243]

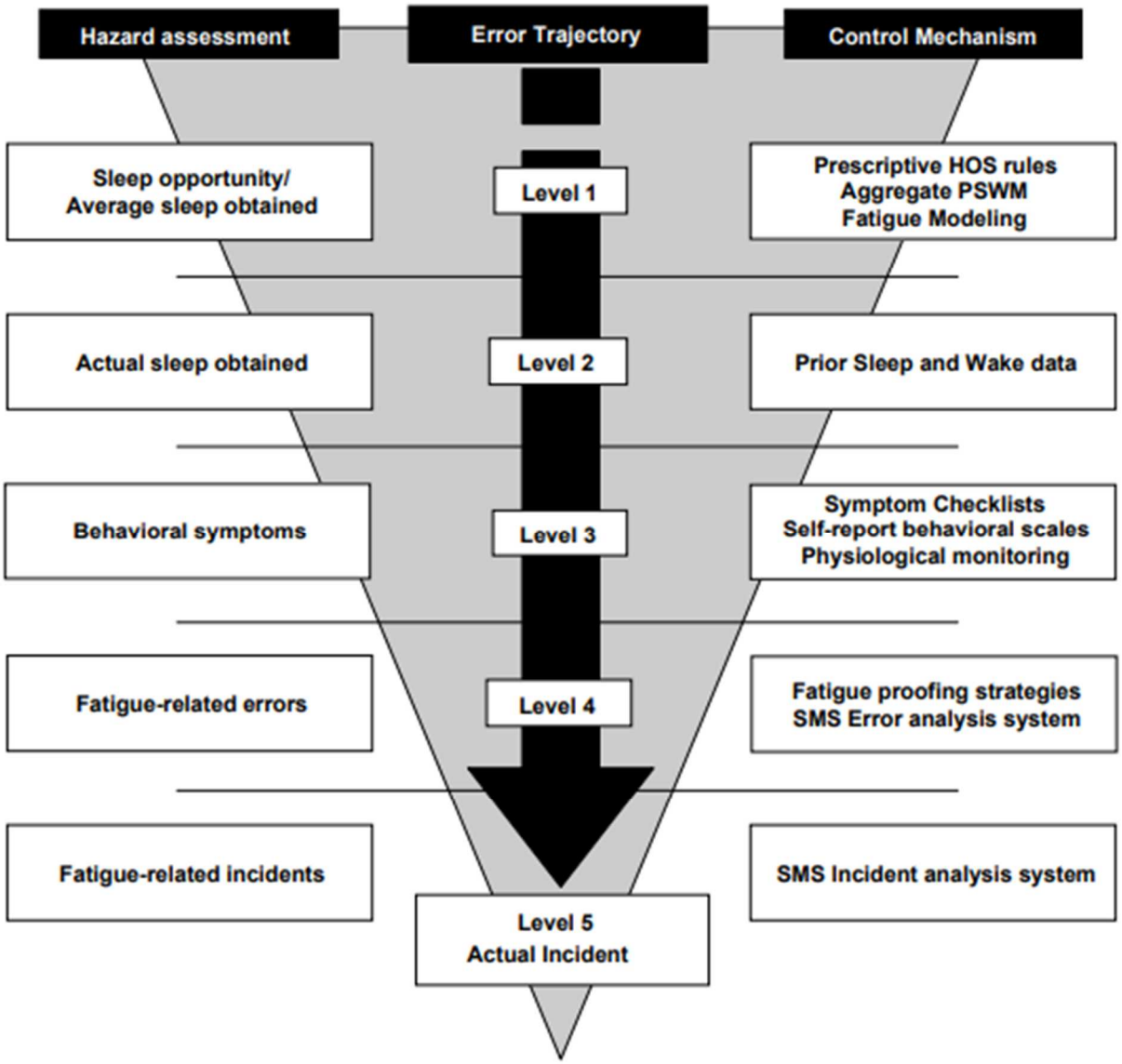
Figure 10 below outlines these different levels of defence prior to having to deal with a fatigue-related incident.

[241] Ibid.

[242] CASA 2019, *Fatigue management resources*, https://www.casa.gov.au/safety-management/fatigue-management/fatigue-management-resources, viewed 14 October 2019.

[243] Appleton Institute, CQU, Submission No 30, 31 January 2019.

**Figure 10: Error trajectory and levels of defence**[244]




**HOS – hours of service; PSWM – prior sleep/wake model; SMS – safety management system**

Implementation of a FRMS was raised by several organisations that made submissions. The ACEM argued that SA Health should "commit to safe working hours for emergency doctors that takes into account the specific risks of fatigue for this workforce."[245] The ACEM cited research that a FRMS should be used as part of a broader safety management system that includes relevant policies, reporting systems, incident investigation, training and sleep management. The ACN also

[244] Dawson, D and McCullogh, K 2005, *Managing Fatigue: It's about sleep*, Sleep Medicine Reviews 9 365-380, https://www.pacdeff.com/pdfs/Dawson_McCulloch%20Managing%20Fatigue%20Its%20About%20Sleep.pdf, viewed 16 August 2019.

[245] ACEM, Submission No 49, 8 February 2019.

recommended that "an integrated FRMS designed by OEM [Occupational and Environmental Medicine] Physicians should be put in place to manage fatigue in the Health Care sector in Australia."[246] The ACN cited research suggesting that a FRMS is important in industries which are "safety-sensitive" and where people work during hours where they would typically be sleeping, and that a FRMS is more flexible than prescriptive hours of duty and/or rest.[247]

The Appleton Institute has developed a FRMS for Queensland Health, and have also started rolling out a similar model in Canada. The most important point that was emphasised was that in the Queensland Health model, "there is a policy requirement from government now that says you have to tell us how you are managing fatigue", however the actual way in which fatigue should be managed is not mandated. It is up to each individual work unit to explain how they will manage fatigue.[248] It was also noted that it would be acceptable for management to "delegate…to a clinician who can champion the discussion around fatigue and risk, and bypass perhaps the socio-political impediments" to fatigue management.[249] This is a similar approach to that taken by the NHVR and CASA as described above, whereby transport operators are afforded greater flexibility in their operations if they are able to demonstrate how they are managing workplace fatigue.

A FRMS, based on a Fatigue Self-Assessment Tool (FSAT), has been in use within the SA Ambulance Service (SAAS) since 2010, with an updated version introduced in April 2017.[250] The FSAT is a point-in-time tool which requires staff to answer a short questionnaire regarding their level of fatigue. Depending on the answers to the questions, certain actions are required to be taken. Completing a FSAT at the commencement of a shift is not compulsory, however when an incident arises which requires a report in SAAS' Incident Report and Quick Assessment (IRQA) system (the SAAS equivalent of SA Health's SLS), a FSAT must be included as part of the report.[251] SAAS also provides education to its staff to encourage them to use the tool to report workplace fatigue, and completion of an online fatigue training package is a compulsory requirement of accreditation for paramedics.

The FSAT used by SAAS allows a paramedic to assess their fitness for duty based on their quality of sleep and whether they have experienced any physical or mental signs of fatigue immediately prior

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[246] ACN, Submission No 34, 31 January 2019.

[247] Ibid.

[248] Professor Drew Dawson, Appleton Institute, *Committee Hansard*, 28 June 2019.

[249] Associate Professor Matthew Thomas, Appleton Institute, *Committee Hansard*, 28 June 2019.

[250] SA Health, Submission No 56, 26 February 2019.

[251] SA Ambulance Service (SAAS), *Incident Report and Quick Assessment Procedure*, January 2018.

to or during a shift. It provides a simple traffic light assessment (green, amber or red), with certain actions and mitigating strategies required to be implemented depending on the outcome of the assessment. A 'Red' assessment requires the staff member to immediately report to the State Duty Manager and not to commence a shift or undertake any safety critical task. Where necessary, SAAS will pay for a taxi to take a staff member home if they are too fatigued to drive themselves. An 'Amber' assessment requires the staff member to discuss appropriate mitigation strategies with their partner or State Duty Manager, which could include taking breaks as appropriate, restructuring work tasks, greater monitoring by a crew partner, and increased self-awareness and monitoring of fatigue levels.[252]

The Appleton Institute emphasised that a FRMS does not need to be prescriptive, and that the way in which fatigue is best managed is going to vary across local areas. However, they suggested that there needs to be a policy requirement from government that requires health employers to be required to demonstrate how they are managing fatigue, and the role of the regulator is to "look at how well you are managing it, but we are not going to tell you how to manage it."[253] The Appleton Institute also emphasised that "it's critical that people care" about workplace fatigue and that the management of fatigue is championed by clinicians.[254] Andreas Blahous from the NHVR noted that rather than mandating a FRMS for everyone, the important thing to focus on is making sure that the "safety culture" is documented and formalised because if it isn't, "the research evidence shows that [organisations tend] to perform at the lower level and be less successful in managing the risks that the system is generally trying to prevent."[255]

### *New SA Health Prevention of Fatigue Guide*

SA Health provided the Committee with a new Prevention of Fatigue educational risk management guide for South Australian Health Services, along with associated resources and tools. The resources are intended to "guide the development, implementation and maintenance of a local Fatigue Risk Management System (FRMS) should one be required for the local workplace."[256]

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[252] SAAS, *Fatigue Risk Management Procedure*, July 2019.

[253] Professor Drew Dawson, Appleton Institute, *Committee Hansard*, 28 June 2019.

[254] Associate Professor Matthew Thomas, Appleton Institute, *Committee Hansard*, 28 June 2019.

[255] Andreas Blahous, NHVR, *Committee Hansard*, 15 November 2019.

[256] SA Health 2019, *Prevention of Fatigue: An education risk management guide for South Australian Health Services*, email correspondence from Department for Health and Wellbeing, Corporate Services, 4 March 2019.

SA Health's FRMS resources have been designed to have a "preventative risk management focus" and include the following steps:

- identifying hazards that can contribute to worker fatigue;
- assessing the risks of these hazards;
- implementing and maintaining risk control measures; and
- reviewing the effectiveness of the control measures.[257]

The resources provide guidance for LHNs, individual business units and health services on setting up their own localised FRMS, including how to undertake a Fatigue Scan (FScan) to determine whether the work environment puts staff at risk of fatigue, as well as developing a fatigue risk register. The resources adopt the SAAS FSAT as a suggested tool for SA Health staff to utilise in order to drive worker self-awareness of their fatigue levels. They also provide advice on appropriate rostering and scheduling design, fatigue incident reporting and investigation, and fatigue prevention training.[258]

The resources developed by SA Health are only "broad policy and guidelines" and LHNs are ultimately responsible for addressing fatigue in a way deemed most appropriate by them. The FRMS resources are not mandatory and "LHNs are responsible for operationalising such material in the context of their local operating environments."[259] This approach is broadly consistent with the new governance arrangements within SA Health which place greater responsibility on individual LHN Boards to manage operational matters.

[257] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[258] SA Health 2019, *Prevention of Fatigue: An education risk management guide for South Australian Health Services*, email correspondence from Department for Health and Wellbeing, Corporate Services, 4 March 2019.

[259] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

***Committee view***

Given the significant amount of evidence received by the Committee regarding the benefits of managing workplace fatigue through a FRMS, the Committee's view is that the DHW should take a leadership role in ensuring that all individual wards and business units across SA Health implement a local area fatigue management policy that is tailored to their fatigue risk and operational needs. The Committee does not consider that it is sufficient for the DHW to simply issue guidelines and resources. Given the significant and serious nature of workplace fatigue across SA Health, it is the Committee's view that the DHW should actively work with the LHNs to ensure that appropriate fatigue management policies are in place across the whole organisation, and that having a FRMS is made mandatory for those local areas that are deemed to have a sufficiently high level of fatigue risk. The Committee understands that this process needs to be led by clinicians as they are best placed to assess the fatigue risks of their local area, however it is important that the DHW and LHNs ensure that all local areas across SA Health are able to demonstrate how they are managing safety risks around workplace fatigue, whether that be through a FRMS or other mechanism that is more suited to their level of fatigue risk.

**Recommendation 6**

That the DHW works collaboratively with the LHNs to ensure that all individual units/wards undertake a full assessment of their workplace fatigue risk and subsequently implement a local area fatigue management policy that is appropriately scaled to their risk level.

**Recommendation 7**

That the DHW, in collaboration with the LHNs, determines a minimum risk level at which the use of a FRMS is mandatory and ensures that any business units/wards that have a risk level that is sufficiently high implement a comprehensive FRMS as a matter of urgency.

**Recommendation 8**

That the DHW appoints a senior manager to oversee the development, implementation, review and monitoring of fatigue management policies and FRMS established across SA Health sites.

**Recommendation 9**

That the DHW actively monitors and evaluates the effectiveness of fatigue management policies and FRMS developed across its sites with a view to ensuring that these policies/systems are updated and improved overtime.

**Recommendation 10**

That the DHW, in collaboration with the LHNs, ensures that all local area fatigue management policies and FRMS incorporate, where relevant, consideration of hours worked by staff as part of any employment arrangements they have outside of SA Health.

### *7.5.2 Implementation of a bullying risk audit tool*

The UniSA Centre for Workplace Excellence, in collaboration with the ANMF and SASMOA, developed a Workplace Bullying Risk Audit Tool as part of a SafeWork SA commissioned research project.[260] The core proposition behind the use of a risk audit tool is that treating workplace bullying as an interpersonal problem between staff members, rather than addressing the root causes of such behaviour within an organisation's functions and structure, is a major barrier to adequately addressing the issue. Their research suggests that it is the underlying risk factors that are embedded within the job design and management of an organisation that result in workplace bullying, and hence it is not primarily an interpersonal problem.[261] Given this, bullying prevention requires a systematic organisational-focussed approach, and only targeting the behaviour itself is akin to treating the symptoms and not the cause. Taking a risk management approach means assuming that the hazards which result in bullying emanate from the workplace itself, and the employer takes ultimate responsibility for controlling the exposure of their staff to these hazards.[262] This requires a shift from

[260] Tuckey, MR, Li, Y, Neall, AM, Mattiske, JD, Chen, PY and Dollard, MF 2018, *Developing a Workplace Bullying Risk Audit Tool: Final Project Report*, University of South Australia, The Asia Pacific Centre for Work Health and Safety.

[261] Centre for Workplace Excellence, University of South Australia, Submission No 65, 31 May 2019.

[262] Notelaers, G 2010, *Workplace bullying: A risk control perspective*, PhD dissertation, University of Bergen, http://bora.uib.no/bitstream/handle/1956/4605/Kappe%20Notelaers.pdf?sequence=1&isAllowed=y, viewed 9 October 2019.

the current approach of dealing with bullying behaviour after it occurs, rather than focussing on prevention, as was noted by Michelle Tuckey from the Centre for Workplace Excellence:

> Common ways of addressing bullying – things like policies, awareness training, investigations – tend to focus on bullying behaviours. If you look at the evidence, though, from across the scholarly and academic literature but also the evidence from our own analysis of 342 bullying complaints lodged with SafeWork SA, we see that bullying behaviours arise from the way that work is designed and managed in workplaces. To really prevent bullying, then, the emphasis needs to shift to tackling the root causes. That means tackling how people and tasks are coordinated at work. By managing these underlying risk factors, there is scope for sustainable and effective workplace bullying prevention.[263]

A risk control cycle designed to control tangible hazards that cause workplace bullying should contain the following steps:

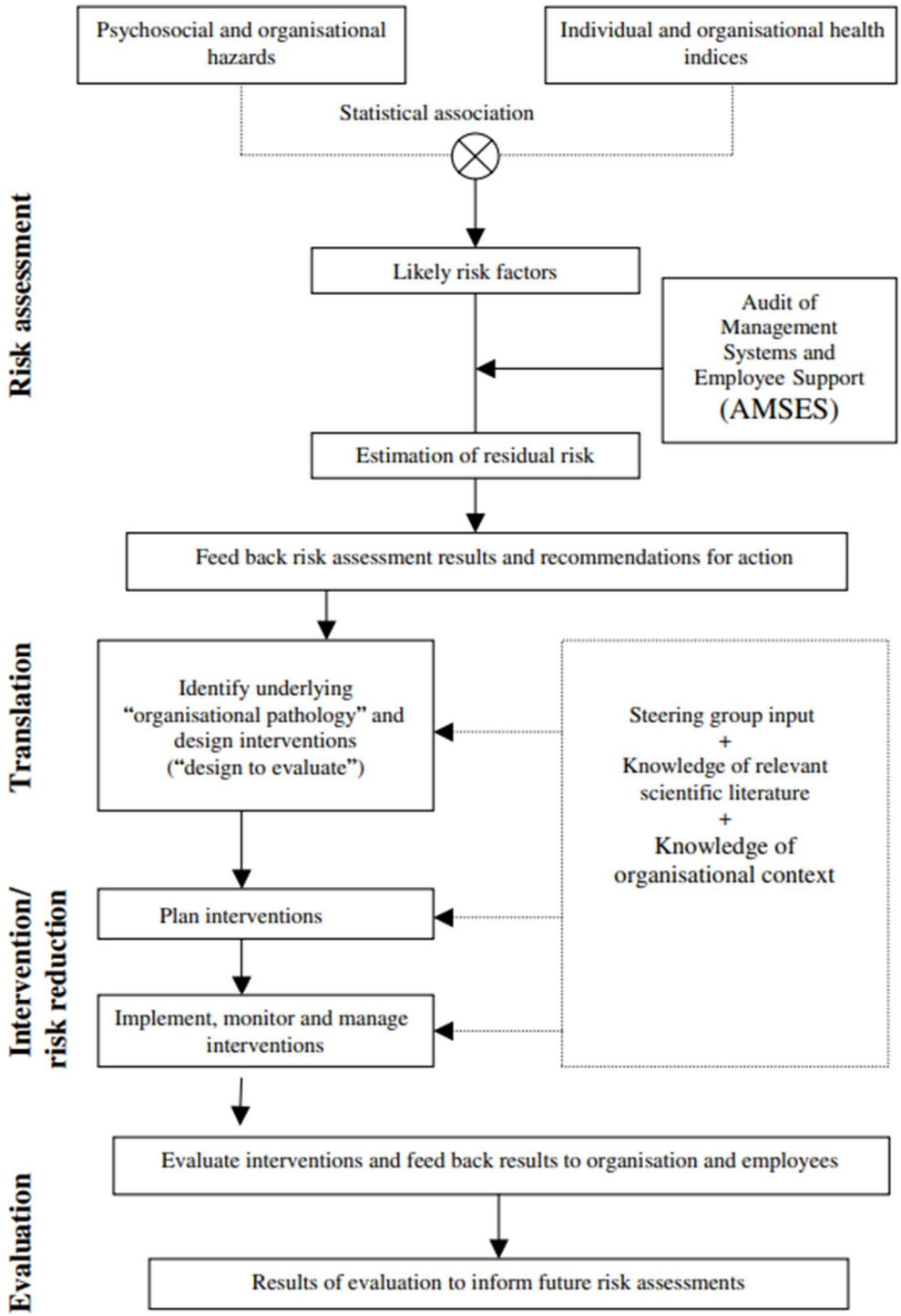
a) identification of hazards;
b) assessment of associated risk;
c) implementation of appropriate control strategies;
d) monitoring of the effectiveness of control strategies;
e) reassessment of hazard/risk; and
f) a review of the information needs and training needs of workers exposed to hazards.[264]

Figure 11 below depicts a typical model of risk management.

[263] Associate Professor Michelle Tuckey, Centre for Workplace Excellence, *Committee Hansard*, 2 August 2019.

[264] Notelaers, G 2010, *Workplace bullying: A risk control perspective*, PhD dissertation, University of Bergen, http://bora.uib.no/bitstream/handle/1956/4605/Kappe%20Notelaers.pdf?sequence=1&isAllowed=y, viewed 9 October 2019.

**Figure 11: Model of risk management**[265]




[265] Cox, T, Griffiths, A and Randall, R 2003, *A Risk Management Approach to the Prevention of Work Stress*, in Schabracq, MJ, Winnubst, JAM and Cooper, CL (eds), *The Handbook of Work and Health Psychology*, 2nd ed, Chapter 10, http://www.al-edu.com/wp-content/uploads/2014/05/Handbook-of-Work-and-Health-Psychology-2Ed-2003.pdf#page=204, viewed 9 October 2019.

The Centre for Workplace Excellence's risk audit tool can be used to identify organisational risk factors for workplace bullying, proactively respond to complaints and meet duty of care obligations under work health and safety legislation. It also allows for data collection to inform better decision-making on bullying matters. The tool was developed in three stages. The first was to identify the risk factors (or behavioural indicators) for workplace bullying, which was done through an analysis of official SafeWork SA case records and critical incident interviews. The second stage was to independently validate the behavioural indicators and categorise them to develop a risk audit tool. The last stage was to evaluate the tool by assessing its ability to predict workplace bullying exposure. The evaluation was conducted on 25 teams (212 individual team members) from three SALHN hospitals (Flinders Medical Centre, Repatriation General Hospital and Noarlunga General Hospital) and showed that the tool was able to predict exposure to bullying.[266]

Michelle Tuckey noted that the tool can be used to root causes of bullying behaviour well before complaints reach a body like SafeWork SA, which only sees "the tip of the iceberg":

> The tool is exactly at the opposite end, right at the base of the iceberg. It is about identifying what is going on a daily basis in the way that people and tasks are coordinated in the workplace. If those things continue, workers start to feel mistreated and start to feel bullied. They may eventually complain within the organisation or they may complain to a regulator. So it is getting right back to those root causes, months and months and months before it will ever turn out to be a complaint with SafeWork SA.[267]

Chris Moy from the AMA (SA) recommended that the Committee give further consideration to this "evidence-based" risk audit tool given it "identifies the risks in a workplace and then gives an idea of what you need to fix in that workplace. It reinforces that giving people reasonable hours, managing their performance and providing positive leadership reduce the risk of bullying."[268] The CDNM also suggested that "[a] blueprint for driving change would be to undertake a mixed method research project that would identify risks, gaps and risk hotspots, and develop plans accordingly."[269]

Following the initial pilot program conducted by the Centre for Workplace Excellence to develop their tool, SA Health determined that given the costs of the initial trial, ongoing use of the tool "was not

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[266] Centre for Workplace Excellence, University of South Australia, Submission No 65, 31 May 2019.

[267] Associate Professor Michelle Tuckey, Centre for Workplace Excellence, *Committee Hansard*, 2 August 2019.

[268] Dr Chris Moy, AMA (SA Branch), *Committee Hansard*, 13 September 2019.

[269] CDNM, Submission No 63, 20 May 2019.

considered a viable option given the size of SA Health."[270] While there would be a financial cost associated with rolling out a risk audit tool on an organisation-wide basis, Michelle Tuckey noted that "[t]he investment needed to get the tool to a point where it could be used large scale across a whole sector in the state would be inconsequential compared to the benefit."[271]

Arising from the *I WORK FOR SA – Your Voice Survey Action Plan 2019-20*, the OCPSE is undertaking a project to "[d]evelop and implement preventative measures to reduce the incidence of harassment and bullying across the sector." This project includes the following two key actions to be delivered:

- A review of existing data-capture mechanisms to identify improved business processes for psychosocial hazard and incident reporting (including harassment and bullying).
- Pilot program to assess and address psychosocial risks using an evidence-based risk audit tool be delivered in selected agencies.[272]

The project is planned to be delivered by June 2020 and is expected to have the following outcomes:

- Improved line of sight to reported incidents of harassment and bullying across the sector.
- Improved channels for employees to feel safe reporting alleged harassment or bullying (multiple escalation points).
- Bespoke organisation-centric interventions implemented in business areas with high rates of reported harassment and bullying.
- Developing in-house capability to identify and mitigate risk factors that contribute to reported harassment and bullying.[273]

SA Health advised the Committee that NALHN has been approached to be one of three participating agencies to be involved in the pilot project to trial a risk audit tool for psychosocial risk factors, and that it was awaiting confirmation of NALHN's participation.[274]

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[270] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[271] Associate Professor Michelle Tuckey, Centre for Workplace Excellence, *Committee Hansard*, 2 August 2019.

[272] OCPSE 2019, *I WORK FOR SA – Your Voice Survey: South Australian Public Sector Action Plan 2019-20*, https://publicsector.sa.gov.au/wp-content/uploads/South-Australian-Public-Sector-Action-Plan-2019-20-V1.pdf, viewed 16 December 2019.

[273] Ibid.

[274] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

***Committee view***

The Committee sees value in trialling a risk audit tool as a preventative measure to address workplace bullying, with a view to rolling it out across SA Health if it is proven to reduce the instances of workplace bullying. If NALHN is indeed involved in the OCPSE trial, this would be an appropriate starting point from which to assess the viability of such a tool on a broader scale across SA Health.

The Committee acknowledges that there would be a financial cost associated with rolling out a risk audit tool, however the potential benefit in terms of a reduction in workplace bullying and its associated costs may well outweigh any initial outlay required to operationalise a risk audit tool on an organisation-wide basis.

**Recommendation 11**

That the DHW oversees and coordinates a trial of a bullying risk audit tool at a SA Health site. The Committee notes that NALHN has already been approached to be involved in a trial being conducted by the OCPSE as part of the follow-up action plan arising from the Your Voice Survey.

If NALHN is involved in the OCPSE bullying risk audit trial, the Committee recommends that the DHW plays an active role in the implementation and review of that trial (as it relates to NALHN) with a view to ensuring broader implementation of an audit tool across SA Health can be achieved more seamlessly.

If the results of the trial demonstrate a reduction in workplace bullying, the Committee recommends that the DHW prioritises funding for the timely implementation of this risk audit tool more broadly. The Committee suggests that the roll out of the tool is prioritised in areas where workplace bullying rates are highest.

## 7.6 Measures to improve the management and monitoring of workplace fatigue and bullying

***Term of Reference***

*f) Measures to improve the management and monitoring of workplace fatigue and bullying.*

### *7.6.1 Improving data integrity and quality*

The starting point for improving the management and monitoring of workplace fatigue and bullying is ensuring that the problem can be accurately measured and tracked over time. The Committee received evidence to suggest that data integrity and quality is an issue at SA Health. The ICAC *Troubling Ambiguity* report further supports this point in that it makes reference to poor records management at SA Health and the impact that this has on the ability to investigate any issues or allegations that are raised.[275] Lack of accurate and timely data could similarly pose a challenge for health administrators and managers in seeking to address workplace fatigue and bullying.

#### *Timesheet accuracy*

One particular issue that was drawn to the Committee's attention was the accuracy of timesheet records, particularly among junior doctors. As part of a survey it conducted, SASMOA found that among junior doctors who responded to the survey:

- Over 50% of those surveyed stated that they were always required to commence prior to their scheduled rostered shift time. 36% of junior doctors stated they were only required sometimes to commence prior to their rostered shift starting time.
- 70% of junior doctors stated that they were paid non-rostered overtime only sometimes or not at all. The reason why junior doctors said they were not paid their non-rostered overtime, was varied. 50% of junior doctors stated it was due to workplace culture; 30% stated they believed it would be detrimental to their future career; 20% stated that they have been told not to claim the overtime by the administration; 30% stated that [they have] been told not to claim the overtime by senior doctors; 13% stated they were told not to claim overtime by their line manager.

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[275] Lander, B 2019, *Troubling Ambiguity: Governance in SA Health*, ICAC.

- Over 70 percent of junior doctors advised that they could not take a standard 30-minute meal break away from their duties.[276]

A previous 2016 survey of junior doctors conducted by SASMOA also found that one in three described their workload as beyond appropriate, and almost 60 per cent had not claimed non-rostered overtime (more than double the number reported in an equivalent 2005 survey).[277] This evidence suggests that some junior doctors are feeling pressured to inaccurately record their working hours and not claim the overtime they have worked. The ACEM 2016 Workforce Sustainability Survey also found that 62.5 per cent of respondents reported working unpaid hours, and 70 per cent reported difficulty in being able to take a break at work,[278] despite this being an industrial requirement under the relevant enterprise agreement. As mentioned previously (refer section 7.1.2), there appears to be a cultural pressure on staff to work long hours, which may explain some of the above survey results. This further suggests that working hours are not always being accurately recorded by staff, thereby making it difficult for health administrators to have an accurate understanding of the total hours being worked by staff, and whether industrial requirements are being complied with.

***Committee view***

SA Health advised the Committee that "[r]ecent internal audits of time and attendance suggest that local audits of timekeeping concerning staff are not undertaken as standard practice."[279] Given the evidence that staff, in particularly junior doctors, are potentially feeling pressured not to record all of their hours worked, the Committee is of the view that there needs to be a systematic way of determining if there are issues with timesheet accuracy. Regular auditing of timesheets and attendance records would likely assist in this regard.

Given the evidence of cultural pressures on staff to work long hours and potentially not report their full hours worked, the Committee formed the view that any deliberate attempt by managers or hospital administrators to pressure staff to misreport their hours should be penalised. This view was supported by a number of organisations that spoke with the Committee. SASMOA considered it to be a "worthy"

[276] SASMOA, Submission No 50, 14 February 2019.

[277] Ibid.

[278] ACEM, Submission No 49, 8 February 2019.

[279] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

avenue to pursue, although emphasised that it is important that junior medical officers were not penalised for timesheet falsification and that any penalties were directed at hospital administrators given that "[t]hey have the final say in the operational responsibility of a hospital service."[280] The RACS was somewhat more cautious and emphasised a focus on the "root cause" of why timesheets might be falsified, but did agree with the suggestion that a sanction of some sort may be needed where a manager actively procures a falsification.[281] The ACEM strongly agreed with the suggestion that there should be penalties where junior doctors are discouraged from reporting all their overtime hours or where timesheets are subsequently altered, and suggested that "we need some sticks to change that culture because the junior doctors are often taken advantage of."[282]

**Recommendation 12**

That the DHW proactively works with the LHNs to develop and implement regular and ongoing local area audits of staff 'time and attendance'. The Committee recommends that the 'time and attendance' audits focus on trainee medical officers in the first instance.

If the audits identify any areas of concern particularly with respect to the under-reporting of hours worked and/or overtime claimed, the Committee recommends that the DHW/LHNs develop appropriate strategies aimed at addressing these issues, including penalties for wilful non-compliance by hospital management.

***Data collection and reporting***

As part of the evidence it provided, SA Health acknowledged that there are ongoing issues with their data collection and reporting systems. SA Health noted that recent reviews by Deloitte and KordaMentha had found issues with data quality and integrity, with accurate reporting requiring significant manual analysis and data manipulation.[283] This makes it challenging to get accurate and timely reporting on information such as total hours worked and overtime.

[280] Ms Bernadette Mulholland, SASMOA, *Committee Hansard*, 15 February 2019.

[281] Mr John Biviano, RACS, *Committee Hansard*, 9 April 2019.

[282] Dr Simon Judkins, ACEM, *Committee Hansard*, 9 April 2019.

[283] SA Health, Submission No 56, 26 February 2019.

Professionals Australia reported that it has been advised by CALHN on multiple occasions that the HR management system used across government (CHRIS21) does not allow for easy extraction of data, which makes it difficult to monitor workplace fatigue given the lack of readily available data on things like working hours and overtime.[284]

SA Health advised that much of the organisation uses the ProAct rostering system, predominantly for nursing staff, which allows for generation of electronic timesheets for the payment of staff. SA Health noted that "ProAct has reporting capabilities and is able to produce detailed working hours data."[285] A joint Electronic Timesheet Project was launched in April 2019 by SA Health and Shared Services SA to provide for the roll out of ProAct to other employee groups across SA Health. The first phase of the project is expected to be complete by June 2020 and includes "in-scope non-medical employees", with medical employees captured in the second phase which is expected to be rolled out in 2020-21. SA Health believes that the expansion of ProAct "will ensure more effective collection of staff working hours data and ease of reporting."[286]

The Appleton Institute also noted that there is "commercially available software that has been in the market since 2000 that enables you to measure the fatigue-related risk associated with the schedule of work"[287] and could hence potentially be integrated within a broader risk management framework. One example that was cited as having been used at Queensland Health is the FAID Quantum Assessment Tool, which determines a FAID Score that indicates the level of exposure to fatigue by taking into account the following factors:

- Duration of work & breaks;
- Time of day of work & breaks;
- Work history from preceding 7 days; and
- Biological limits on recovery sleep.[288]

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[284] Professionals Australia, Submission No 27, 31 January 2019.

[285] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[286] Ibid.

[287] Professor Drew Dawson, Appleton Institute, *Committee Hansard*, 28 June 2019.

[288] InterDynamics 2020, *FAID Quantum uses the FAID Score*, https://www.interdynamics.com/fatigue-risk-management-solutions/faid-score/, viewed 9 January 2020.

***Committee view***

The Committee supports the roll out of consistent rostering software across SA Health. While undertaking a site visit to several hospitals across metropolitan Adelaide, the Committee was shown examples of current rostering practices which appear to rely on manual recording and processing through the use of spreadsheets. It is not clear that these practices are consistent across individual business units and wards. Rostering is an important function undertaken by managers and can have a significant impact on workplace fatigue if done poorly. The complexities of the industrial conditions under which SA Health staff operate also makes rostering a challenging task. The Committee considers it important that these processes are automated where possible, to ensure that all industrial conditions are being met and to allow for more effective and functional reporting capability. Having a common system would also provide for a greater level of consistency in rostering practices. While the Committee is not in a position to comment on the use of the ProAct system specifically, it acknowledges the work already underway to roll this system out across SA Health and encourages this to be undertaken as quickly as practicable. Regardless of the rostering system which is implemented, the Committee notes the importance of ensuring that it is flexible enough to allow for the management of working hours and overtime within a broader risk management framework such as a FRMS.

Based on the evidence received, the Committee also suggests that any other existing systems used across SA Health outside of rostering (e.g. payroll) are also upgraded or redeveloped to allow for improved reporting functionality.

**Recommendation 13**

That the DHW prioritises the upgrade/redevelopment of existing computer-based systems which would allow for the more effective collection of staff working hours data. Any system upgrades or changes should also consider the need for flexible and user focussed reporting functionality. In making this recommendation, the Committee encourages the DHW to consider best practice approaches and systems used in other jurisdictions.

**Recommendation 14**

That the DHW prioritises funding to allow, as a matter of urgency, the roll out of consistent rostering software across LHNs.

**Recommendation 15**

That the rostering software adopted across LHNs (refer recommendation number 14 above) should allow for the management of working hours and overtime within a risk management framework.

### *7.6.2 Improving workplace culture*

The poor workplace culture at SA Health was a common theme throughout the Inquiry and was raised as an issue in many submissions and by many witnesses who gave evidence to the Inquiry (refer section 7.1.2). Improving workplace culture is hence seen as a crucial part of the solution to workplace fatigue and bullying.

The Committee recognises that a number of peak bodies have already acknowledged the importance of improving workplace culture in hospitals and health services and have begun introducing new initiatives aimed at achieving this. The RACS established an Expert Advisory Group in 2015 to provide advice on strategies to prevent discrimination, bullying and sexual harassment in the surgical workplace. This led to the implementation of a 'Building Respect, Improving Patient Safety' initiative, which provides an action plan for how RACS plans to address these issues into the future. The RACS and SA Health have also co-signed "a Statement of Intent aimed at achieving cultural change and agreeing to promote greater information sharing, and support for Fellows, Trainees and IMGs [International Medical Graduates]."[289] The RACS is also collaborating with the ANZCA in aiming to eliminate discrimination, bullying and sexual harassment by sharing information and educational resources and supporting activities to promote respectful behaviour.[290]

SA MET has rolled out the PERMA+ (Positive Emotion, Engagement, Relationships, Meaning and Accomplishment PLUS, Physical Activity, Nutrition, Sleep and Optimism) program for junior doctors.[291] This program has been designed by The Wellbeing and Resilience Centre at the South Australian Health and Medical Research Institute (SAHMRI) and is designed to use the science of positive psychology to improve mental wellbeing and resilience.[292]

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[289] RACS, Submission No 42, 1 February 2019.

[290] ANZCA, Submission No 45, 4 February 2019.

[291] SA MET Health Advisory Council, Submission No 58, 12 March 2019.

[292] The Wellbeing and Resilience Centre, South Australian Health and Medical Research Institute (SAHMRI), *PERMA+*, https://www.wellbeingandresilience.com/sites/swrc5/media/pdf/permaandcentreoverview.pdf, viewed 20 December 2019.

The recent Independent Review into the Workplace Culture within ACT Public Health Services found significant problems with the workplace culture within the ACT Public Health System. Some of the key findings from the submissions made to the Independent Review highlighted the following:

- inappropriate behaviours and bullying and harassment in the workplace
- inefficient procedures and processes including complaints handling
- inadequate training in dealing with inappropriate workplace practices
- inability to make timely decisions
- poor leadership and management at many levels throughout the ACT Public Health
- System, and
- inefficient and inappropriate Human Resource (HR) practices, including recruitment.[293]

The Independent Review cites research that shows that early intervention strategies can prevent inappropriate behaviour from escalating into bullying and harassment. A program based on the Vanderbilt University Medical Center (US) early intervention program is proposed to build a culture of safety and quality in the workplace through appropriate training. Existing programs adopting Vanderbilt principles in Australia include the St Vincent's Health Australia Ethos Program and the Cognitive Institute's 'Speaking Up for Safety' and 'Promoting Professional Accountability' programs. Programs such as these allow staff to receive and consider feedback early and modify their behaviour. Peer-to-peer coaching, joint action planning and peer reviews are used to support individuals to change their behaviour. The ACEM also noted the importance of the fact that the St Vincent's Ethos Program "links negative and disruptive behaviours to its negative impact on patient care."[294] The Independent Review made the following recommendation in this regard:

> That a program designed to promote a healthier culture to reduce inappropriate workplace behaviour and bullying and harassment be implemented across the ACT Public Health System. The model adopted should be based on the Vanderbilt University Medical Center Patient Advocacy Reporting System (PARS) and Co-worker Observation Reporting System (CORS).[295]

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[293] Reid, M, Brew, F and Watters, D 2019, *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services*, https://health.act.gov.au/sites/default/files/2019-03/Final%20Report%20Independent%20Review%20into%20Workplace%20Culture.pdf, viewed 19 December 2019.

[294] ACEM, Submission No 49, 8 February 2019.

[295] Reid, M et al 2019, *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services*, https://health.act.gov.au/sites/default/files/2019-03/Final%20Report%20Independent%20Review%20into%20Workplace%20Culture.pdf, viewed 19 December 2019.

The Vanderbilt model is based on "peer-delivered interventions that support improvements in care delivery."[296] It is ultimately based on supporting clinicians to change their behaviour where they have behaved in an improper manner.

SA MET noted that the Statement of Intent co-signed by the RACS and SA Health is based on using the Vanderbilt principles "as a basis for promoting respectful behaviour and dealing with unacceptable behaviour in the workplace."[297] Chris Moy from the AMA (SA) noted that "there are fantastic models such as Vanderbilt's" however this should not take away from a focus on early intervention methods such as the use of a risk audit tool to prevent incidents before they happen (refer section 7.5.2).

SA Health advised that NALHN launched the Cognitive Institute's 'Speaking Up for Safety' in September 2018. The program provides formal training to staff to give them practical skills to speak up and challenge inappropriate behaviour. "The key message is for all staff to feel comfortable and to respectfully approach one another to let them know about an issue/s that could cause unintended harm."[298] The training is mandatory for all NALHN staff. The Committee discussed this program when on a site visit to the Lyell McEwin Hospital and the staff the Committee spoke to were supportive of the program and its benefits. The Committee was further advised that the 'Promoting Professional Accountability' program was planned for roll out at NALHN in 2020.

The ACEM also noted a similar program in the US called Civility, Respect and Engagement in the Workforce (CREW). The CREW program "was established as a culture change initiative to improve the workplace climate through more civil and respectful interactions. Participating departments identify areas of working relationships that require improvement and trained facilitators assist with discussions and activities to improve staff relations over a 6-month period."[299]

As mentioned previously (refer section 7.1.2), one of the key problems causing poor workplace culture in hospitals and health services is the fact that clinical leaders are not always skilled in management, leadership and what is appropriate behaviour. The Independent Review into the Workplace Culture within ACT Public Health Services also found that a lack of clinical leadership was considered a root cause of the poor work culture in the ACT Public Health System. The Independent Review suggested

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[296] Vanderbilt University Medical Center (VUMC) 2019, *The Center for Patient and Professional Advocacy (CPPA)*, https://prd-medweb-cdn.s3.amazonaws.com/documents/cppa/files/CPPA%20INTRO%20revised%2001-31-19.pdf, viewed 19 December 2019.

[297] SA MET Health Advisory Council, Submission No 58, 12 March 2019.

[298] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[299] ACEM, Submission No 49, 8 February 2019.

that there were various organisational models that could be used to improve clinical leadership, but the one that was favoured was for Clinical Divisions to progressively become clinically led by senior clinicians, with appropriate business management support. It was suggested this should be an 'earned autonomy' arrangement where the Clinical Director is given the opportunity to demonstrate their ability to lead a division with clear strategic goals, within budget, and with the desired culture. To provide the skills to facilitate this earned autonomy, the Independent Review recommended that appropriate leadership and mentoring programs should be developed and implemented for both current and emerging leaders.[300]

The ANMF (SA Branch) has recognised the need to equip staff with the skills they need to provide high-quality care and has reached an agreement with SA Health to implement a workforce renewal plan. Part of this plan involves a coaching program which allows staff to "job-share their role with the person selected as their ultimate replacement." In addition to minimising fatigue in the workforce, the program is aimed at ensuring that staff are "well equipped for leadership positions in the future to guide the workforce moving forward."[301]

The CDNM also noted the importance of having leadership programs:

> …the literature strongly depicts where you have inadequate leadership, then you have poor workplace practices and poor behaviours in the workplace. Again, universities offer leadership programs for nurses and midwives. We are in a situation now where the majority of people who choose to do that pay for their programs, and that can be a limitation.
>
> Unfortunately, we don't see the sort of numbers of postgraduate nurses coming through those leadership programs at masters level, for example, which would assist them at that post-registration level to enhance their leadership and management skills. I can't emphasise how important leadership at all levels is. Sometimes people think about leaders as being just those high-level managers, but leaders are actually out there every day at the coalface, having transformation leadership skills that improve patient outcomes and make it a good place to work.
>
> Gone are the days where you have those 'born leaders'; they do need to be educated and supported, and they need to know how to do things like performance management with their

[300] Reid, M et al 2019, *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services*, https://health.act.gov.au/sites/default/files/2019-03/Final%20Report%20Independent%20Review%20into%20Workplace%20Culture.pdf, viewed 19 December 2019.

[301] ANMF (SA Branch), Submission No 53, 18 February 2019.

staff. They need to be empowered to call out bad behaviours. That is the sort of thing that we are looking at working with industry to support.[302]

***Committee view***

The Committee is of the view that improving the poor workplace culture at hospitals and health services is a crucial part of addressing workplace fatigue and bullying. The benefits of culture improvement programs have been recognised by a number of health sector peak bodies that gave evidence to the Inquiry. Given that NALHN has already introduced a culture change program that is based on the Vanderbilt principles, the Committee considers this to be a good opportunity for the DHW to assess the success of the program and ensure that similar programs are rolled out across SA Health if they are proven to be successful in improving workplace culture.

A key element of driving culture change is ensuring that clinical leaders are also skilled in non-clinical skills that are nonetheless necessary for good management and high-quality leadership. Given the concerns expressed by a number of organisations that clinical leaders in hospitals and health services are presently not equipped with the skills required to be effective leaders and manage staff, it is important that the DHW ensures that appropriate training is made available across all LHNs to prepare staff for management and leadership roles.

**Recommendation 16**

That the DHW monitors and subsequently evaluates the Cognitive Institute programs ('Speaking up for Safety' and 'Promoting Professional Accountability') being implemented by NAHLN. Should these programs prove successful in improving workplace culture, the Committee recommends that the DHW works with the LHNs to select, implement and embed suitable early intervention programs across its sites.

[302] Professor Carol Grech, CDNM, *Committee Hansard*, 6 December 2019.

**Recommendation 17**

That the DHW works collaboratively with the LHNs to ensure the availability of consistent and high-quality leadership training for early-mid career clinicians, with a view to developing future leaders who are equipped with the necessary skills (over and above clinical expertise) for management/leadership positions within the health sector.

### *7.6.3 Improving complaint resolution process*

Problems with the existing complaint resolution processes at SA Health were highlighted in numerous submissions made to the Inquiry and have been identified previously in this report (refer section 7.1.3), and as noted earlier, poor complaints management processes can allow a negative workplace culture to flourish.

The responsibility for complaint resolution lies with the Governing Boards and Chief Executives of each individual LHN. SA Health has issued a Respectful Behaviour Policy Directive which "applies to all SA Health employees and requires employees to act respectfully, actively encourage respectful behaviour, hold each other accountable for behaviour at work, not tolerate disrespectful behaviour and actively challenge any disrespectful behaviour that is witnessed and use the management of *Disrespectful Behaviour Guideline* to respond promptly and constructively to incidents of disrespectful behaviour."[303] The Respectful Behaviour Policy Directive requires Chief Executive Officers and Executive Directors to, among other things, ensure that all staff are aware of the Policy Directive and are held accountable for disrespectful behaviour. Managers and supervisors also have responsibilities in this regard.[304]

[303] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[304] SA Health 2016, *Respectful Behaviour Policy Directive*, https://www.sahealth.sa.gov.au/wps/wcm/connect/feb55680476d0276a375fb2e504170d4/Directive%2B-%2BRespectful%2BBehaviour%2BPolicy%2BDirective%2B-%2BDec2016.pdf?MOD=AJPERES&CACHE=NONE&CONTENTCACHE=NONE, viewed 3 January 2020.

The SA Health Management of Disrespectful Behaviour Policy Guideline supports the Respectful Behaviour Policy Directive and provides a guide for managing and resolving concerns of disrespectful behaviour in the workplace.[305] It provides a number of possible options for addressing such behaviour:

1. Local resolution/De-escalation between parties involved;
2. Informal resolution (early intervention) involving management/HR;
3. Facilitated discussion involving all parties;
4. External mediation;
5. Formal complaint; and
6. Other circumstances (if above options are not considered to be appropriate).[306]

The SA Health Safety Learning System (SLS) is the main tool used by SA Health to record incidents (further discussion of the SLS can be found below in section 7.7.2). The SLS includes a module for the reporting of work health and safety incidents, which can include instances of workplace fatigue and bullying. There is also a module which allows for employee disciplinary matters to be recorded and managed, however this module is only used for formal complaints under investigation.[307] Given the various ways in which allegations of bullying can be made and subsequently managed, there are a range of circumstances in which no record would be made within the SLS, a point which is acknowledged by SA Health:

> The processes for resolving allegations of bullying can be varied and employees making such allegations can decide to proceed down multiple resolution paths, such as direct resolution of the matter between the parties, management facilitated discussion, mediation, HR assistance or a formal complaint. Accordingly, it is not possible to accurately capture the scope of such complaints and resolution times.[308]

[305] SA Health 2016, *Management of Disrespectful Behaviour Policy Guideline*, https://www.sahealth.sa.gov.au/wps/wcm/connect/ce03c4804c6828cd837bcbdbb1e972ca/Guideline_Mgt%2Bof%2BDisrespectful%2BBehaviour_13042016.pdf?MOD=AJPERES&CACHE=NONE&CONTENTCACHE=NONE, viewed 3 January 2020.

[306] Ibid.

[307] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[308] Ibid.

***Committee view***

In light of the concerns identified by numerous submissions and raised previously in this Report, the Committee considers it important that the DHW and all of the LHNs work collaboratively to implement strategies to address key areas of concern around communication with complainants, transparency and accountability and ensuring resolution of complaints regardless of any staff movement (either the perpetrator or victim). While the DHW has issued broad policies and guidelines with respect to the management of disrespectful behaviour, the Committee's view is that it should also be taking a more active role in ensuring that the implementation of these policies is as consistent as possible across all LHNs.

The Committee is also concerned that there is inadequate record keeping relating to bullying complaints where matters do not reach the point where they need to be recorded in the SLS. As mentioned previously, the ICAC *Troubling Ambiguity* report noted that poor records management was a significant issue at SA Health, and cited some examples of HR records not being kept up to date (e.g. employment records, training records, etc).[309] This further corroborates evidence received by the Committee regarding less than ideal record keeping.

In this context, the Committee is of the view that SA Health should have a single system where all bullying complaints can be recorded. The system should allow for SA Health to track and report on the management and outcomes of complaints. Given that the SA Health Management of Disrespectful Behaviour Policy Guideline explicitly identifies a number of methods through which complaints can be resolved, it would also seem appropriate that the method used to resolve the complaint is recorded in the system so there is a record of the outcome of the complaint, even if that may be an informal resolution or that the allegation was not substantiated.

Given some of the criticisms of HR staff that were made in a number of submissions, the Committee is of the view that the DHW should undertake a review of its HR staffing arrangements across SA Health and ensure that staff are adequately skilled in the resolution of bullying complaints. The Committee notes that a similar recommendation was made in the Independent Review into the Workplace Culture within ACT Public Health Services.[310]

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[309] Lander, B 2019, *Troubling Ambiguity: Governance in SA Health*, ICAC.

[310] Reid, M et al 2019, *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services*, https://health.act.gov.au/sites/default/files/2019-03/Final%20Report%20Independent%20Review%20into%20Workplace%20Culture.pdf, viewed 19 December 2019.

**Recommendation 18**

That the DHW, in collaboration with LHN Governing Boards, implements strategies to ensure that the following areas of concern relating to complaints management are addressed:

- quality and frequency of communication with complainants;
- transparency of process and accountability for complaint resolution; and
- resolution of complaints regardless of whether the complainant or alleged bully moves elsewhere within the public sector.

**Recommendation 19**

That the DHW, in collaboration with the LHN Governing Boards, implement a system which allows for the recording, tracking, and management of bullying related complaints across SA Health. The system should have reporting functionality which allows for comparison across LHNs as well as individual business units/wards.

**Recommendation 20**

That the DHW, in collaboration with the LHN Governing Boards, works to ensure that, where feasible, all policies, processes and procedures relating to complaint management/handling, are consistent across LHNs.

**Recommendation 21**

That the DHW, in collaboration with LHN Governing Boards, review HR staffing arrangements and takes any necessary follow-up action to ensure that staff are adequately trained and experienced in the management of workplace bullying related complaints.

### *7.6.4 Accountability for addressing workplace fatigue and bullying*

Ensuring that appropriate governance arrangements are in place to allow for clear lines of accountability and responsibility with respect to the management of workplace fatigue and bullying is

critical. The establishment of new governance arrangements across SA Health from 1 July 2019[311] provides an opportunity to consider how the new structure can best be used to address workplace fatigue and bullying.

The CDNM suggested that there needs to be a "long-term strategy" and "some indicators to success aligned to workforce occupational health and safety, with data-driven results."[312]

Michelle Tuckey from the Centre for Workplace Excellence reflected on her experience in having discussions with senior staff at the UK National Health Service and the benefits of key performance indicators (KPIs) around workplace bullying:

> I have been over to the NHS in the UK and some conversations with some senior people there suggest that when bullying is added as an indicator for hospital boards, to which they're accountable, they finally start to see some traction… because it becomes part of the governance framework then, not just a side issue. It becomes really integrated with the performance of the hospital.[313]

Professor Tuckey also noted that a risk audit tool could feed into a KPI or ongoing metric and agreed with the suggestion that this would be a desirable outcome.[314]

Any KPIs that are implemented need to be able to be measured in a consistent and systematic way, and short and regular surveys can be a method of achieving this aim. Some organisations such as SA MET have recognised the value of using surveys to gain an understanding of the issues that are affecting staff. SA MET is rolling out a new survey to collect information from medical trainees on issues such as discrimination, bullying, workloads and work-life balance, which is aimed at providing data on the experiences of junior doctors during their training programs.[315] A number of medical colleges, peak bodies and unions have also undertaken surveys of their own members. Details of these surveys have been referenced throughout this Report.

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[311] SA Health 2019, *About the SA Health governance reforms*, https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/governance+reforms/about+the+reforms, viewed 24 December 2019.

[312] Professor Carol Grech, CDNM, *Committee Hansard*, 6 December 2019.

[313] Associate Professor Michelle Tuckey, Centre for Workplace Excellence, *Committee Hansard*, 2 August 2019.

[314] Ibid.

[315] Professor Kevin Forsyth, SA MET Health Advisory Council, *Committee Hansard*, 2 August 2019.

The CDNM noted that there were many validated survey tools, but it is important "that people actually see outcomes. So many times there's work done to collect data, but it's the same old, same old, and that just perpetuates demoralising…with any strategy like that, it has to be action focused, so that people see there is a positive outcome."[316] Carol Grech from the CDNM also noted that "when you set up that competition about one department or one hospital doing better than the others, that you actually have the support structures for those that aren't performing well to be able to lift by a whole range of things to support them."[317] Marion Eckert suggested that while HR could implement a survey or other benchmarking system, ultimate responsibility for making changes needs to sit with the Chief Executive and other staff in leadership positions:

> The responsibility for implementing it could come from the HR units—executive office takes responsibility. The survey is completed but…the challenge is about what is done with those results. It has to be owned by the CEO, and then from the top down, that leadership level and that middle-management level.[318]

The CDNM also provided some suggestions about the sorts of KPIs regarding the management of workplace fatigue and bullying that could be measured. Professor Grech suggested the following:

> Indicators would be around simple things like decreased absenteeism. If you are going to use tools around the culture, utilising survey instruments as you have talked about, also using existing tools like performance management as the conversation in terms of how you collect data about staff performance. There would be a lot of analytic tools behind the scenes that you could actually utilise.[319]

Professor Eckert also added that KPIs around training, professional development and succession planning could be included.[320]

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[316] Professor Carol Grech, CDNM, *Committee Hansard*, 6 December 2019.

[317] Ibid.

[318] Professor Marion Eckert, CDNM, *Committee Hansard*, 6 December 2019.

[319] Professor Carol Grech, CDNM, *Committee Hansard*, 6 December 2019.

[320] Professor Marion Eckert, CDNM, *Committee Hansard*, 6 December 2019.

***Committee view***

The Committee's view is that each of the new LHN Governing Boards should be required to report against a standardised series of KPIs relating to the management of workplace fatigue and bullying. The new governance arrangements provide an opportunity to design a series of KPIs which will allow the LHNs to be benchmarked against each other in terms of how well they are managing issues relating to workplace fatigue and bullying and will ensure that Boards are held accountable for the wellbeing of their staff. While the Committee acknowledges that the new governance arrangements are aimed at providing individual LHNs with more autonomy and decision-making responsibilities, the widespread and systemic nature of workplace fatigue and bullying across SA Health suggests that a consistent approach which allows for a comparison between LHNs is important. While individual LHNs would still be able to determine their own strategies for meeting their KPIs, it is important that the KPIs are consistent across the LHNs.

The Committee sees value in regular electronic surveys focussing on workplace culture being run across SA Health, with the results being used to feed into the reporting against relevant KPIs. It is important that the reporting of results allows LHNs to drill down and identify any problem areas that require specific attention. These survey tools can also be utilised within the context of a risk audit tool used to identify any 'hotspots' of inappropriate behaviour. Individual LHNs appear to have conducted their own culture surveys from time to time, however a standardised set of questions should be used across all of SA Health to allow for meaningful comparisons to be made.

**Recommendation 22**

That the DHW, in collaboration with the Governing Boards of each LHN, develops, implements, monitors and reports against a standardised series of qualitative and quantitative key performance indicators (KPIs), embedded within the strategic planning framework, designed to reduce the instance and impacts of workplace bullying and fatigue.

Potential metrics which should be considered as part of the development of the KPIs may include:

- Rates of absenteeism;
- Complaint resolution times and rates;
- Levels of staff satisfaction;
- Staff turn-over rates; and
- Reliance on use of overtime/recall.

**Recommendation 23**

That the DHW oversees and coordinates regular short electronic workplace culture focussed surveys (including questions relating to workplace fatigue and bullying), the results of which should feed into the LHN Governing Board reporting against KPIs (referred to in recommendation number 22 above).

## 7.7 Consideration of workplace fatigue in investigations

***Term of Reference***

*g) The extent to which fatigue, including a comparison to other industry sector practices, is a factor that is taken into account during investigations into medical misadventure.*

### *7.7.1 Investigations in the transport industry*

The Australian Transport Safety Bureau (ATSB) is the national transport safety investigator and is responsible for conducting investigations and improving transport safety for civil aviation, rail and interstate and overseas shipping.[321]

When undertaking an investigation, the ATSB completes an initial evidence collection phase. In addition to collecting physical evidence through site observations, gathering relevant wreckage, materials, recorded data, operational records and technical documentation, the ATSB will also gather "human performance related information such as work and rest patterns and time awake, workload, perceptual limitations, communications, and social norms," as well as interviewing any involved parties and witnesses.[322]

Throughout the examination and analysis phase of an investigation, the ATSB looks to establish the safety factors which may have contributed to the incident. These factors can range from being specific to the particular occurrence, to being as a result of organisational influences. Figure 12 below shows the different levels.

[321] Australian Transport Safety Bureau (ATSB), Submission No 70, 24 September 2019.

[322] Ibid.

**Figure 12: Safety Factor Levels**[323]

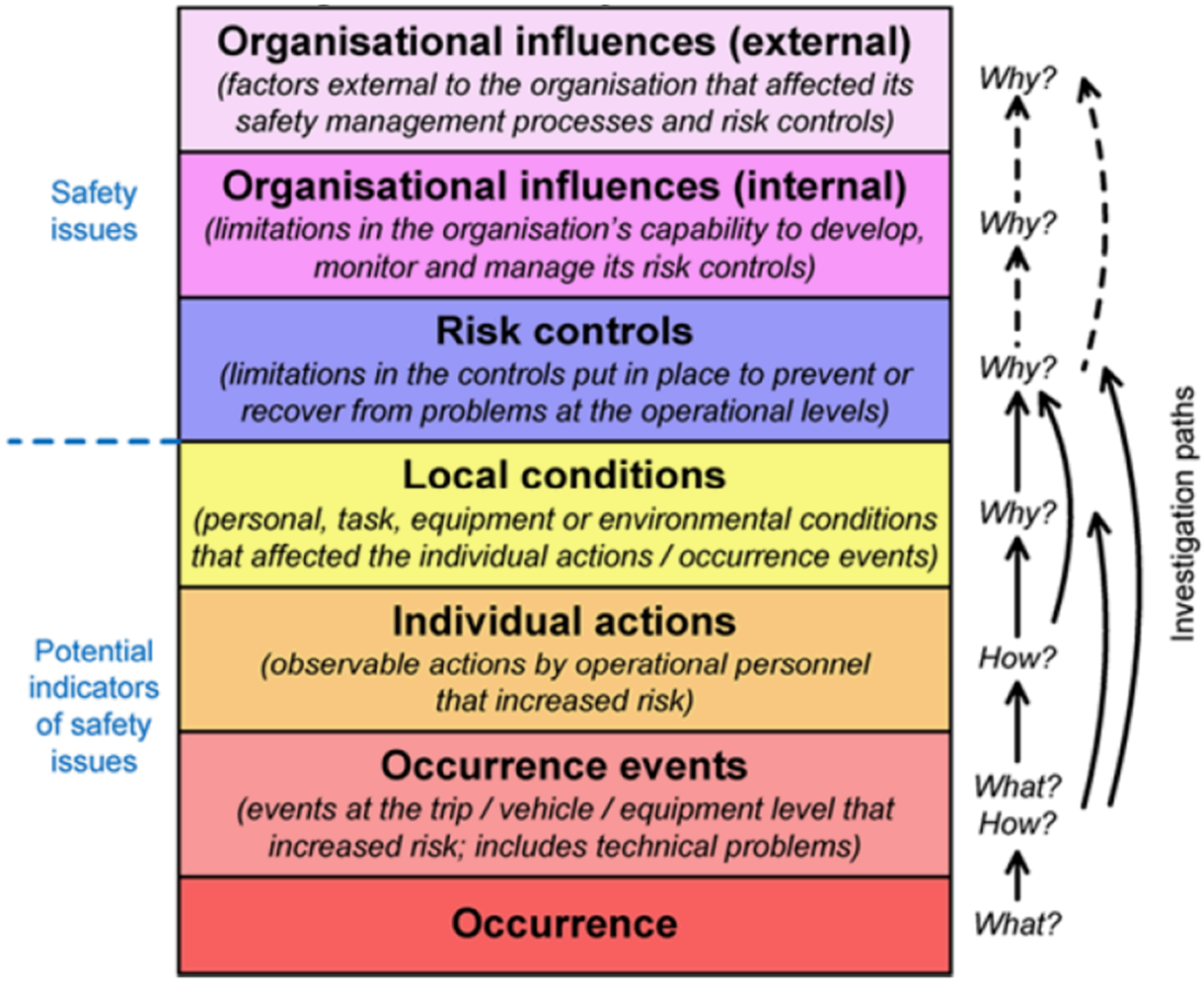
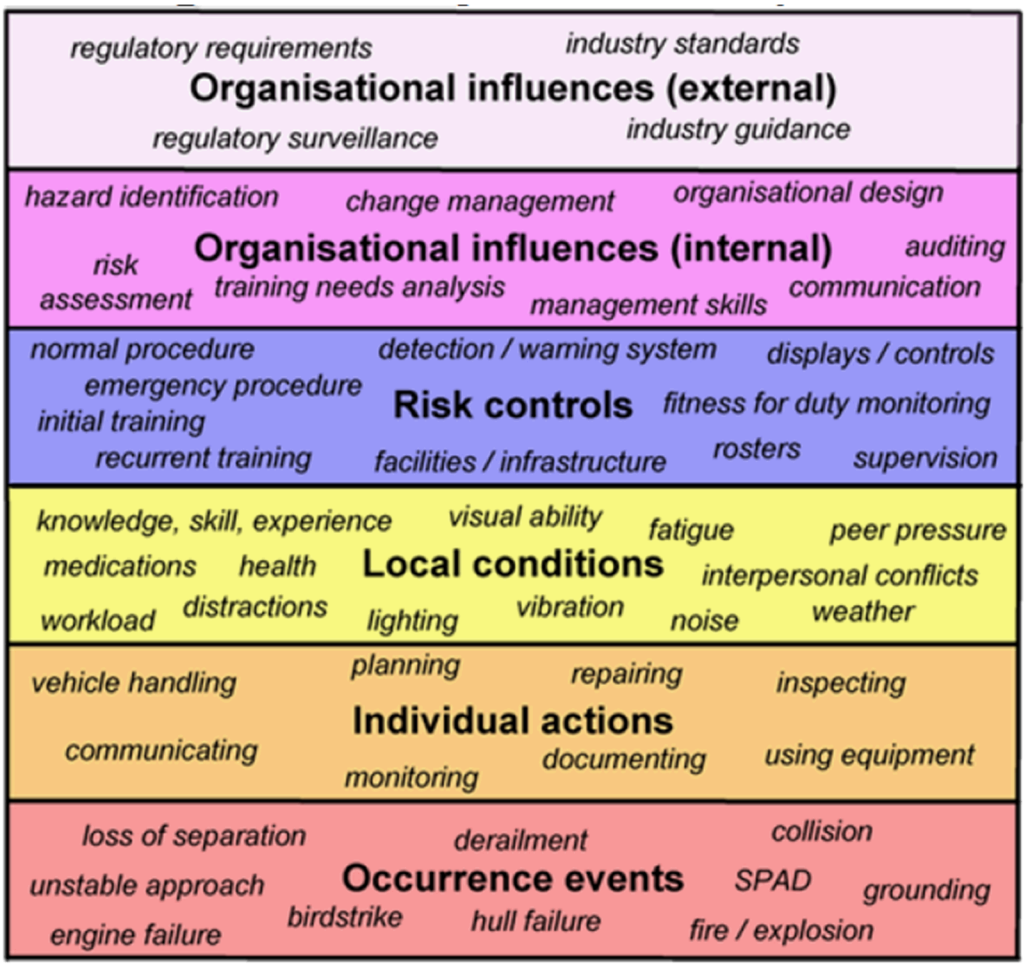



Figure 13 below then shows some of examples of potential factors that might be considered within each level.

[323] Ibid.

**Figure 13: Safety Factor Examples**[324]




The ATSB noted that it takes the following approach in considering workplace fatigue:

> The ATSB considers the influence of fatigue as 'local condition' on individual actions. If fatigue is found to be a factor the ATSB will look at what might have influenced an individual acting in a fatigued state. This could be other local conditions and/or extend further into 'risk controls' and 'organisational influences'.[325]

Essentially, this means that while workplace fatigue is considered as something which may be localised to a particular incident, whether or not the fatigue may have been caused by broader and more systemic issues at an organisational level is also taken into account.

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[324] Ibid.

[325] Ibid.

The NHVR noted that it has a limited role in investigation of heavy vehicle accidents and that the primary investigative role in SA is carried out by SA Police. However, the NHVR can provide assistance to SA Police where specifically requested and has recently conducted joint investigations in relation to Chain of Responsibility matters (refer section 7.5.1). Fatigue is considered in the same way as any other factor which may lead to an incident, near miss or fatality, and the role played by off road duty holders is included in this consideration.[326] This demonstrates a similar approach to the ATSB in terms of looking at fatigue with a broader systemic focus by considering how off road factors may have contributed to an incident.

The ATSB noted that some other countries have accident investigation authorities that conduct investigations across multiple industries, such as the Finnish Safety Investigation Authority which has completed investigations in the health field in the past. It also noted that the UK has a health safety investigatory agency which conducts investigations based on the same model as is used by the ATSB in the transport industry.[327] These examples point to the appropriateness of having a central agency with relevant expertise responsible for investigating incidents.

### *7.7.2 Investigations at hospitals and health services*

MIGA outlined the range of investigations into medical misadventure that could at a SA hospital or health service, including:

- Internal hospital investigations, whether through a morbidity and mortality meeting, root cause analysis or quality assurance processes, or otherwise
- Coronial investigation and inquest where the misadventure involved patient death
- Professional regulatory assessment, investigation and response by professional boards (i.e. the Medical Board of Australia) and the Australian Health Practitioner Regulation Agency (AHPRA)
- Health complaints entity assessment and investigation (the South Australia Health and Community Services Complaints Commissioner - HCSCC)
- Civil damages claims.[328]

[326] NHVR, Supplementary Submission No 67a, 28 August 2019.

[327] ATSB, Submission No 70, 24 September 2019.

[328] MIGA, Submission No 66, 31 May 2019.

MIGA notes that "[t]he extent to which fatigue is taken into account can vary from process to process."[329] An internal investigation or coronial inquest was suggested as being more likely to look at systemic issues, however there is no mandate to take into account any particular factors. An investigation by a professional regulatory or health complaints body is considered more likely to focus on particular individuals and wouldn't typically require an organisational response. MIGA expressed the view that there is not a sufficient focus on underlying fatigue-related causes of medical misadventure and that there is too often a focus on individual performance issues rather than underlying causes. MIGA's submission specifically points out that the Medical Board of Australia could improve identification of fatigue-related issues when complaints are made to them.[330] MIGA suggested the Medical Board could adopt something similar to the Medical Council of NSW Health Program, which is a non-disciplinary and non-adversarial way of resolving a notification made against a medical practitioner.[331] The Committee has made a recommendation (see number 4 above) suggesting that the National Boards established under the Health Practitioner Regulation National Law are encouraged to take a more proactive role in addressing issues such as workplace fatigue.

In terms of internal investigations, the SA Health Safety Learning System (SLS) is the electronic tool used by SA Health since 2010 for incident reporting. It is used "to support recording, managing, investigating and analysing patient and worker incidents across SA Health, with the exception of SAAS which uses its own system."[332] The SLS can be accessed from any SA Health computer and notifications can be made by individual staff or on behalf of another individual. The system enables the progress of incident resolution to be tracked.

There are five SLS Modules available to staff to report incidents:

- Patient incidents;
- Worker incidents;
- Security incidents;
- Consumer feedback; and

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[329] Ibid.

[330] Ibid.

[331] Medical Council of New South Wales 2013, *Health Program: Participant's Handbook*, https://www.mcnsw.org.au/sites/default/files/health_program_participants_handbook_-_updated_september_2014.pdf, viewed 23 December 2019.

[332] SA Health, Submission No 56, 26 February 2019.

- Notifications (with respect to any notifications required to be made to external agencies).[333]

The Appleton Institute noted the limitations of incident reporting systems in identifying the role that workplace fatigue may play in an incident:

> Traditionally it has been very difficult to determine whether fatigue was a causal factor in errors or incidents. At this point in time within South Australian hospitals and health services there are limited methods of determining the role of fatigue in errors or incidents. Traditional systems, such as incident reporting, have been shown to provide very limited, if any, details of the role of underlying human factors issues such as fatigue in adverse events.[334]

The Appleton Institute outlined that a new approach for investigation of incidents has recently been developed based on similar principles to the investigation of road accidents, which could be applied in the health care industry. It is based on looking at the following three factors:

> 1) Determining the likelihood that the individual was fatigued at the time of the accident
> 2) Estimating the degree to which the phenomenology of the accident is consistent with a fatigue related error
> 3) Is there another likely cause (non-fatigue related) of the accident?[335]

To determine the likelihood that an individual was fatigued at the time of the incident (refer to first point above), the following three levels may be examined:

> Level 1: What was the prior sleep opportunity of the individual?
> Level 2: How much sleep had the individual actually obtained?
> Level 3: Was the individual experiencing any signs or symptoms of fatigue?[336]

In 2013, a number of wakefulness and fatigue related questions were added to the Worker Incident module in the SLS. These questions capture data on the following fatigue-related risk factors which may potentially contribute to an incident:

- Time of the day the incident occurred;
- The type of work pattern/shift type;
- Amount of time the person was awake; and

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[333] SA Health 2019, *Safety Learning System*, https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/safety+learning+system, viewed 20 December 2019.

[334] Appleton Institute, CQU, Submission No 30, 31 January 2019.

[335] Ibid.

[336] Ibid.

- Amount of sleep in the 24-48 hours prior to the incident.[337]

However, the fatigue-related questions are not mandatory and as such rely on self-reporting by the person making a SLS notification. SA Health acknowledges that this is likely to lead to underestimation in the fatigue indictors.[338] SA Health advised that "[d]uring the development of the Prevention of Fatigue Guide and resources, DHW proposed to make these questions mandatory, however, concerns were expressed during the consultation phase by SASMOA from a medical negligence/malpractice perspective, i.e. potential repercussions if healthcare professionals were obliged to report that they were fatigued when an adverse patient outcome occurred."[339] Given that the SLS was designed to be a 'no fault' system, it was determined that the fatigue questions should remain optional so as to encourage reporting.

SA Health advised that it "relies on investigating managers to identify whether fatigue is a contributing factor." It acknowledges that this can be complex given the multiple factors which may contribute to fatigue, however if fatigue is found to have contributed to an incident, "the investigating manager and/or local leader is required to review local systems and modify these to prevent a recurrence, using the hierarchy of controls."[340]

***Committee view***

The ATSB's submission emphasised the importance of looking at all the relevant safety factors when investigating an incident. Given that the SA Health SLS is the primary tool by which internal investigations are conducted, the Committee is concerned that potential fatigue-related incidents are not being recorded as such in the SLS due to the fatigue-related questions being optional. While acknowledging SASMOA's concerns, the Committee considers it important that answering the fatigue-related questions when making an incident report in the SLS should be mandatory. Unless this change is made, there is no guarantee that all relevant factors, including workplace fatigue, are being taken into account when incidents are investigated.

[337] SA Health, Submission No 56, 26 February 2019.

[338] Ibid.

[339] Letter from Dr Christopher McGowan, Chief Executive, SA Health, response to questions from Committee, 23 October 2019.

[340] Ibid.

The Committee did not receive sufficient evidence to make any findings regarding the extent to which workplace fatigue is taken into account in external investigations such as coronial investigations or those conducted by professional regulatory bodies, however acknowledges MIGA's submission that their experience is that fatigue-related causes of medical misadventure are not given sufficient focus.

While the Committee only heard from the ATSB on the issue of investigations in the transport industry (across multiple modes of transport), it would nonetheless encourage SA Health to monitor any developments in other industries to ensure it follows best practice in the way it investigates workplace fatigue and the impact it may have on incidents in hospitals and health services.

**Recommendation 24**

That the DHW takes the necessary steps to make the workplace fatigue related questions in the SA Health Safety Learning System (SLS) mandatory.

## 7.8 Other relevant matters

***Term of Reference***

*h) Any other relevant matters.*

### *7.8.1 SafeWork SA involvement*

Workplace fatigue and bullying are ultimately issues that fall under work health and safety legislation, and as such, SafeWork SA is the agency which is tasked with ensuring that employers are compliant with their obligations under the *Work Health and Safety Act 2012* (SA), particularly with respect to the provision of a safe working environment for staff.

SafeWork SA advised the Committee that in the period from 2008-2018, it received 70 complaints or reports from SA Health staff relating to bullying and 10 relating to fatigue.[341] Given the rates of workplace fatigue and bullying that have been reported in numerous surveys and studies (refer sections 6.1.2 and 6.2.2 above), these numbers are surprisingly low. Martyn Campbell, the Executive

[341] Letter from Mr Martyn Campbell, Executive Director, SafeWork SA, response to questions on notice from Committee witness hearing on 7 December 2018, 1 February 2019.

Director of SafeWork SA, agreed that "for the size of SA Health, that level of reporting appears to be quite low."[342]

Mr Campbell noted that SafeWork SA has a team that is "dedicated to psychosocial investigations" and while it is predominantly taking reactive calls, if they have received relevant intelligence and "know that there is a particular issue in a particular organisation then we will go on a proactive campaign." However, he acknowledged that if there are no complaints coming into SafeWork SA, this could be a "red flag" in itself and "[j]ust because somebody is not complaining and we don't get complaints, doesn't mean there's [not] a problem."[343]

In response to a question on what role SafeWork SA should play in addressing systemic bullying and fatigue, Craig Stevens from Authentic Workplace Solutions noted that "the Work Health and Safety Act provides an essential role for SafeWork SA and it should be conducting investigations and initiating prosecutions where appropriate, or providing feedback to the agencies as to improvements in policy, practice, etc., that need to be made."[344]

SafeWork SA has developed a Hospitals Action Plan 2018-2020, which aims to improve health and safety outcomes and reduce workplace injuries.[345] The Plan identifies psychological injury as a specific category of injury that needs to be addressed, recognising that this can be caused by fatigue and bullying. The Plan has eight strategic outcomes, which include eliminating or minimising hazards and risks in the workplace, improving work health and safety culture, and improving physical and mental health and wellbeing. Fatigue from shift work and leadership and culture are among the identified focus areas. Among the 10 actions to achieve in 2018-2020 is the roll out of a Physical and Mental Health and Wellbeing Program, and a Safety Leadership and Culture Program.[346]

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[342] Mr Martyn Campbell, SafeWork SA, *Committee Hansard*, 7 December 2018.

[343] Ibid.

[344] Mr Craig Stevens, Authentic Workplace Relations, *Committee Hansard*, 18 October 2019.

[345] SafeWork SA, *Hospitals Action Plan 2018-2020*, https://www.safework.sa.gov.au/sites/default/files/hospitals_action_plan.pdf?v=1533004586, viewed 6 September 2019.

[346] Ibid.

***Committee view***

The Committee is of the view that given the extent of reported workplace fatigue and bullying at SA Health and the clear mismatch in the number of reports being made to SafeWork SA, a more proactive role needs to be taken by SafeWork SA to address workplace fatigue and bullying and ensure that hospitals and health services are meeting their work health and safety obligations.

**Recommendation 25**

That SafeWork SA develop and implement targeted strategies and plans, developed in conjunction with hospital employers, aimed at reducing instances of workplace fatigue and bullying. This could be achieved as part of an update of the existing Hospitals Action Plan if appropriate.

### *7.8.2 Cooperation between stakeholders*

There are a range of organisations which contribute (directly and indirectly) to the operation and regulation of SA hospitals and health services. In addition to relevant employers, there are numerous professional colleges which are responsible for designing and accrediting training programs for their profession, regulatory authorities with responsibility for ensuring patient care is safe and effective, educational institutions which train staff, relevant unions, and many others. Many of these organisations recognise the importance of workplace fatigue and bullying and have their own position statements, policies or intervention programs aimed at trying to address these issues.

In addition to causing confusion amongst existing and potential complainants (refer section 7.1.3), there appears to be a lack of coordination of effort and consistency of approach amongst these organisations. The AMA (SA) appears to have recognised the need for greater cooperation in this regard and has announced that it will be holding a summit with key stakeholders to address workplace culture and bullying in the medical profession:

> …the AMA will be holding a culture and bullying summit, with the support of the minister and involving other key stakeholders. The reason we are doing this—and people ask why we

> are doing this—is that it is a lightning rod to progress with practical solutions to reduce bullying and fatigue.[347]

It is also noted that the Independent Review into the Workplace Culture within ACT Public Health Services recommended the establishment of a 'Cultural Review Oversight Group' to implement the Review's recommendations, with the membership including the relevant Ministers, senior ACT Health executives, and various unions and peak bodies.[348]

***Committee view***

The Committee's view is that given the widespread cultural problems at hospitals and health services, the AMA (SA) suggestion to hold a summit needs to be expanded to include all health professions and relevant stakeholders. The Committee considers that the DHW should lead sector-wide forums on a regular basis, with the aim of agreeing on coordinated strategies to address workplace fatigue and bullying.

**Recommendation 26**

That the DHW organises and leads twice yearly sector-wide forums focussed on ensuring more effective coordination of strategies aimed at reducing workplace fatigue and bullying amongst relevant agencies/organisations. These forums should aim for broad agreement amongst stakeholders about practical and coordinated strategies to address workplace fatigue and bullying.

At a minimum the Committee suggests that the following organisations be invited to attend these forums:

- Representatives from universities involved in the training of graduates who are employed in hospitals and health services (e.g. – Medical Deans, Nursing and Midwifery Deans);
- Relevant Australian Specialist Medical Colleges;
- Relevant unions including the ANMF, AEA, HSU and SASMOA;
- SA MET Health Advisory Council;

[347] Dr Chris Moy, AMA (SA Branch), *Committee Hansard*, 13 September 2019.

[348] Reid, M et al 2019, *Final Report: Independent Review into the Workplace Culture within ACT Public Health Services*, https://health.act.gov.au/sites/default/files/2019-03/Final%20Report%20Independent%20Review%20into%20Workplace%20Culture.pdf, viewed 19 December 2019.

- AMA (SA);
- SafeWork SA;
- Representatives from individual private hospitals and/or the Australian Private Hospital Association; and
- Medical professional indemnity insurers.

### *7.8.3 Implementation of the Inquiry's recommendations*

***Committee view***

The Committee acknowledges that many of the problems identified as part of this Inquiry are long-standing and, in many cases, have been raised as part of other reviews and reports. In this context, the Committee would like to ensure, as far as possible, that this Inquiry results in meaningful action being taken to address workplace fatigue and bullying. As such, the Committee wishes to maintain oversight over the implementation of the recommendations made in this Inquiry and would like to see a progress update from the DHW and SafeWork SA within 18 months, which is considered sufficient time to have made significant progress with this.

**Recommendation 27**

That the DHW and SafeWork SA appear separately before the Committee to provide a progress update on the implementation of the Inquiry recommendations relevant to them within 18 months of the Inquiry Report being tabled.

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# APPENDIX 1 – SUMMARY OF WORKLOAD MANAGEMENT PROVISIONS IN EXISTING ENTERPRISE AGREEMENTS AND INDUSTRIAL AWARDS

The following summary was provided by SA Health in response to questions on notice from the Committee witness hearing on 7 December 2018.

| | |
|---|---|
| *SA Health Salaried Medical Officers Enterprise Agreement 2017* | Consultants have no fixed hours of duty (cl 27).<br><br>There is a requirement that Consultants have at least 8 consecutive hours free of duty between the conclusion of their last required shift and the start of their next required shift (cl 28).<br><br>There are separate provisions regarding hours of duty for Medical Practitioner Group (MPG) employees.<br><br>MPG employees must not be rostered to work in excess of 12 hours per shift (cl 55.3.1), or in excess of 68 hours in one week (cl 55.3.2), or in excess of 272 hours in any four weeks (cl 55.3.3).<br><br>In addition, MPG employees must have 4 days free from duty in every 28 day cycle (cl 56.1.1) which must include at least one weekend (cl 56.1.2).<br><br>MPG employees will not be required to work in excess of 8 consecutive days except in an emergency (cl 56.1.3). MPG employees receive penalty payments where they are required to work more than 8 consecutive days (cl 56.1.4).<br><br>Like Consultants, there is a requirement for MPG employees to have 8 hours free from duty between the conclusion of required duty on one day and the commencement of required duty on the next day (cl 56.2).<br><br>The minimum shift length for MPG employees is 3 hours and the maximum shift length is 12 hours (cl 58). |
| *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016* | This EA includes provisions regarding safe staffing levels (cl 3.1), skills mix provisions (cl 3.2), rostering arrangements (cl 3.4). Specific safe staffing levels are outlined in Appendices 1 through 5. There is a provision under cl 3.1.9 for the safe staffing levels to be renegotiated.<br><br>Clause 3.5 outlines the administration of 10 hour night shifts.<br><br>Minimum periods of engagement are 3 hours. Clause 3.6 enforces this for casual employees and clause 3.7 for part time employees. |

| | |
|---|---|
| *Nurses (South Australian Public Sector) Award 2002* | The Award (cl 5.1.8) provides for employees to have a minimum of 8 hours free of duty between the conclusion of one rostered shift and the commencement of the next rostered shift, more where shift lengths exceed 8 hours.<br><br>The Award also provides that an employee changing between night and day duty will have 20 hours free of duty between the changing shifts (cl 5.1.9).<br><br>In addition, cl 5.1.11 affords for the maximum number of consecutive days that employees will be required to work. Employees will not be required to work on more than 8 consecutive days where shifts are of no more than 8 hours duration; on more than 6 consecutive days where shifts are of more than 8 but less than 9 hours; on more than 5 consecutive days where shifts are of more than 9 hours duration; and employees will not be required to work more than 66 hours over consecutive days where the employee's shifts consist of a combination of 10 hour night shifts and shifts of less than 10 hours duration.<br><br>Cl 5.1.12 affords that where employees are only working 10 hour night shifts the employee may, by mutual agreement, work up to 6 consecutive days. |
| *SA Ambulance Service Enterprise Agreement 2017* | Where SA Ambulance Service employees have worked a fatiguing shift and there are no appropriate sleeping facilities at the employee's place of work, clause 30 of the enterprise agreement provides that SAAS is required to fund the employee's travel home in a taxi. The employee will also be reimbursed for reasonable costs associated with the return to the workplace to retrieve their vehicle. |
| *SA Ambulance Service Award* | "Non-operations" employees are rostered over 5 days of the week, Monday to Friday. The award provides that a "non-operations" employee's ordinary working hours shall not exceed 38 hours in one week, 76 hours in 14 consecutive days, 152 hours in 28 consecutive days. In addition, in each four week period an employee can take one ordinary working day as an accrued day off (subject to organisational requirements).<br><br>"Operations" employees are rostered over 7 days of the week; the Award provides that their hours of work shall not exceed 152 hours in 28 consecutive days. These employees are also able to take an ordinary working day as |

| | |
|---|---|
| | an accrued day off in each 28 day period (subject to organisational requirements).<br><br>The Award also includes provisions for 10/14 hour and 12/12 hour shift cycles. These arrangements operate on an 8 day work cycle and cross over between day shift and night shift.<br><br>“Country employees” (defined as an operations employee who works in agreed regional areas) may be rostered on-call in addition to working ordinary hours. The Award also affords for breaks after periods of on-call. Where an on-call period of work occurring between 2300 and 0600 hours exceeds 3 hours, a 10 hour break applies at the conclusion of that period of work. Where two or more cases are attended between the hours of 2300 and 0600, the 10 hour break will also apply. |

# APPENDIX 2 – COMMITTEE SURVEY RESULTS

Parliament of South Australia

**PARLIAMENTARY COMMITTEE ON OCCUPATIONAL SAFETY, REHABILITATION AND COMPENSATION**

**54th Parliament**

**Inquiry into Workplace Fatigue and Bullying in SA Hospitals and Health Services**

**Survey Summary Results**

As part of its Inquiry into Workplace Fatigue and Bullying in SA Hospitals and Health Services, the Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation ran a survey to facilitate engagement with individuals currently working in SA hospitals and health services on issues relevant to the Inquiry.

The survey was open from 3 April to 31 May 2019, and in order to ensure that information about it was distributed to as many stakeholders as possible the Committee asked a range of relevant agencies/organisations (including SA Health, the College of Emergency Medicine and the Australian Nursing and Midwifery Federation) to assist with its distribution. The Committee greatly appreciated the assistance it received in this regard.

All individual responses to the survey were anonymous and confidential. Each of the 23 questions were optional, however in order to be considered a valid response, individuals were required to have answered at least one question on workplace fatigue (survey questions 7-15), workplace bullying (survey questions 16-22) or provided information as part of the 'free text' question (survey question 23). A total of 2,299 valid responses were received.

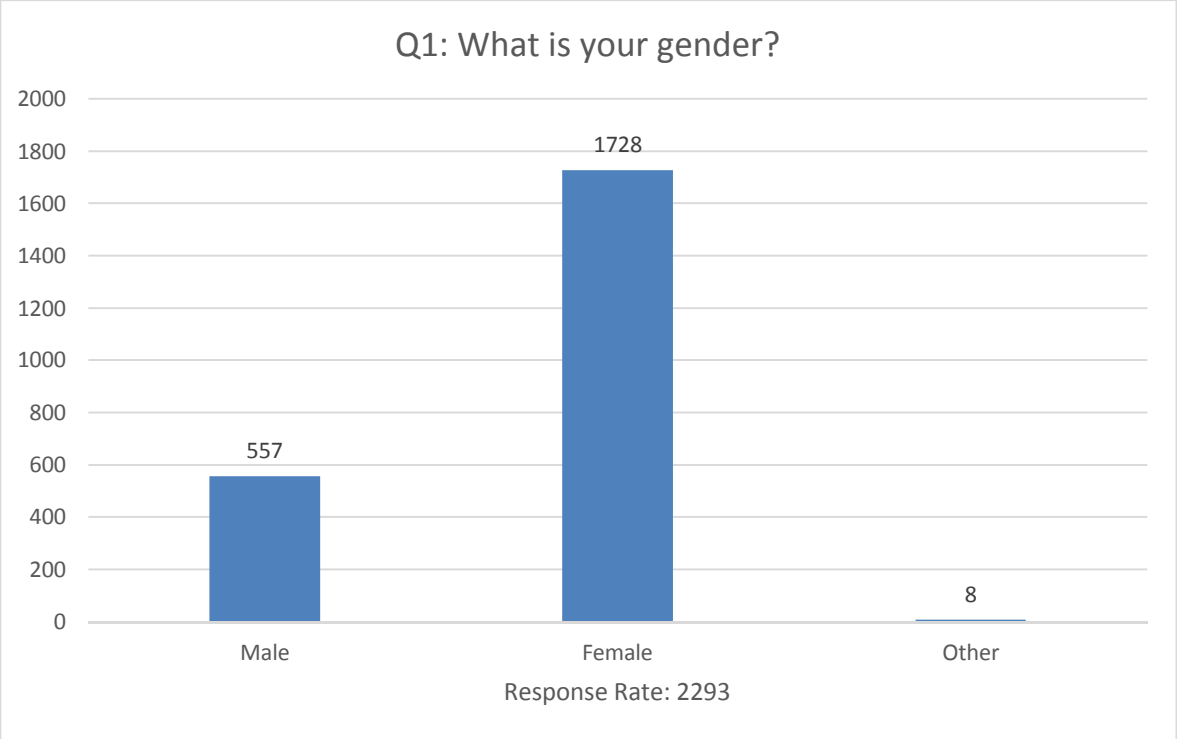
The Committee acknowledges that this was a voluntary self-selecting survey, and hence was more likely to attract respondents who are affected by workplace fatigue and/or bullying. As such, the rates of bullying and fatigue reported in the survey may not be reflective of the experiences of all individuals working in SA hospitals and health services.

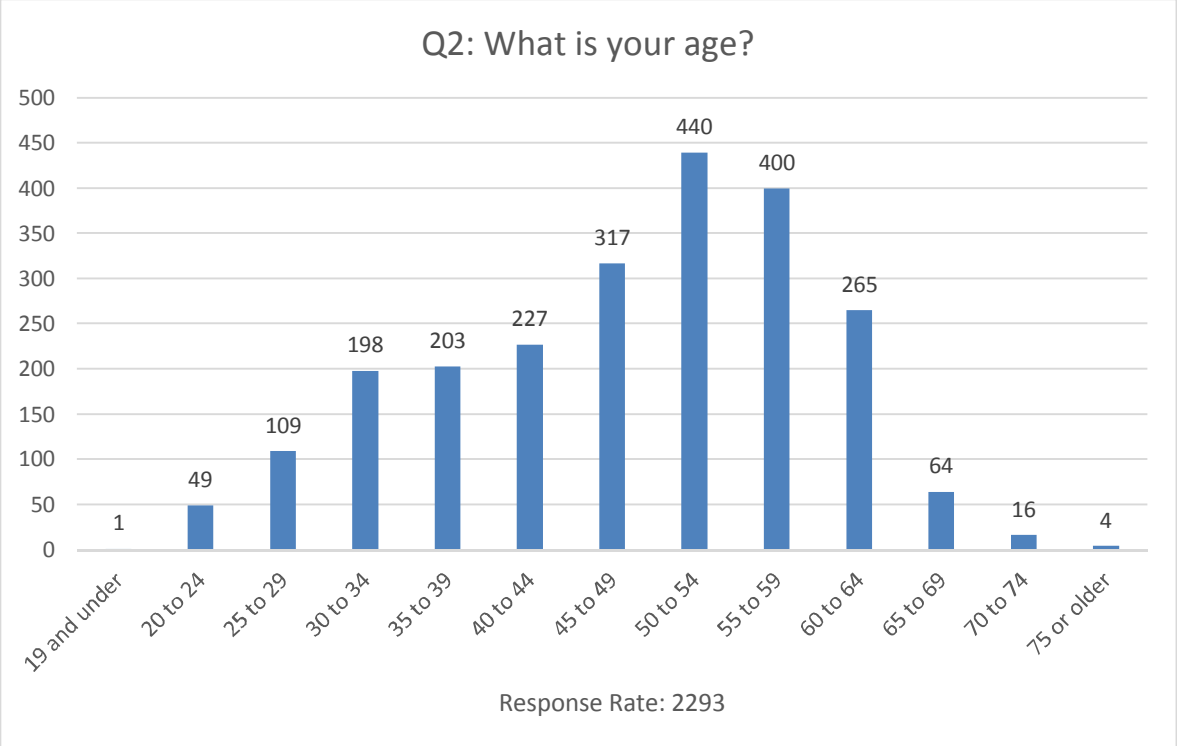
The Committee committed to publishing an overview of the survey results on its webpage. The following series of graphs shows the responses to each question (excluding the 'free text' responses - question 23).

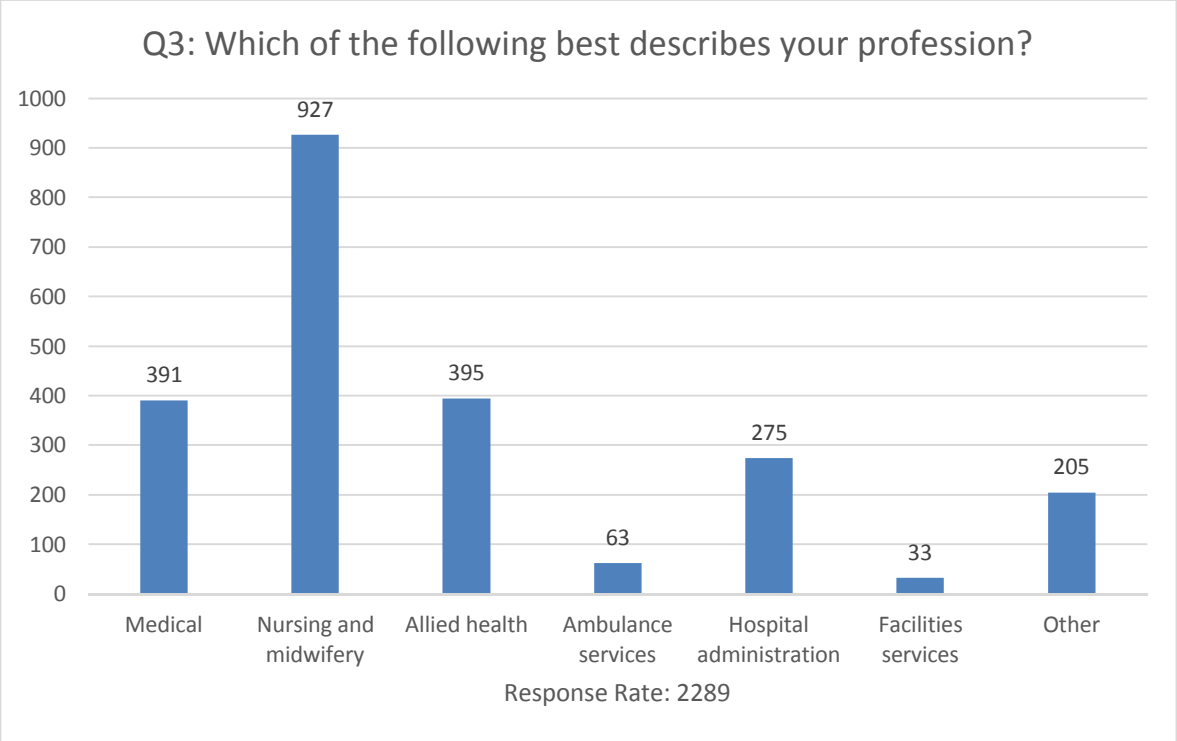
Mr Stephen Patterson MP
Presiding Member
Parliamentary Committee on Occupational Safety, Rehabilitation and Compensation

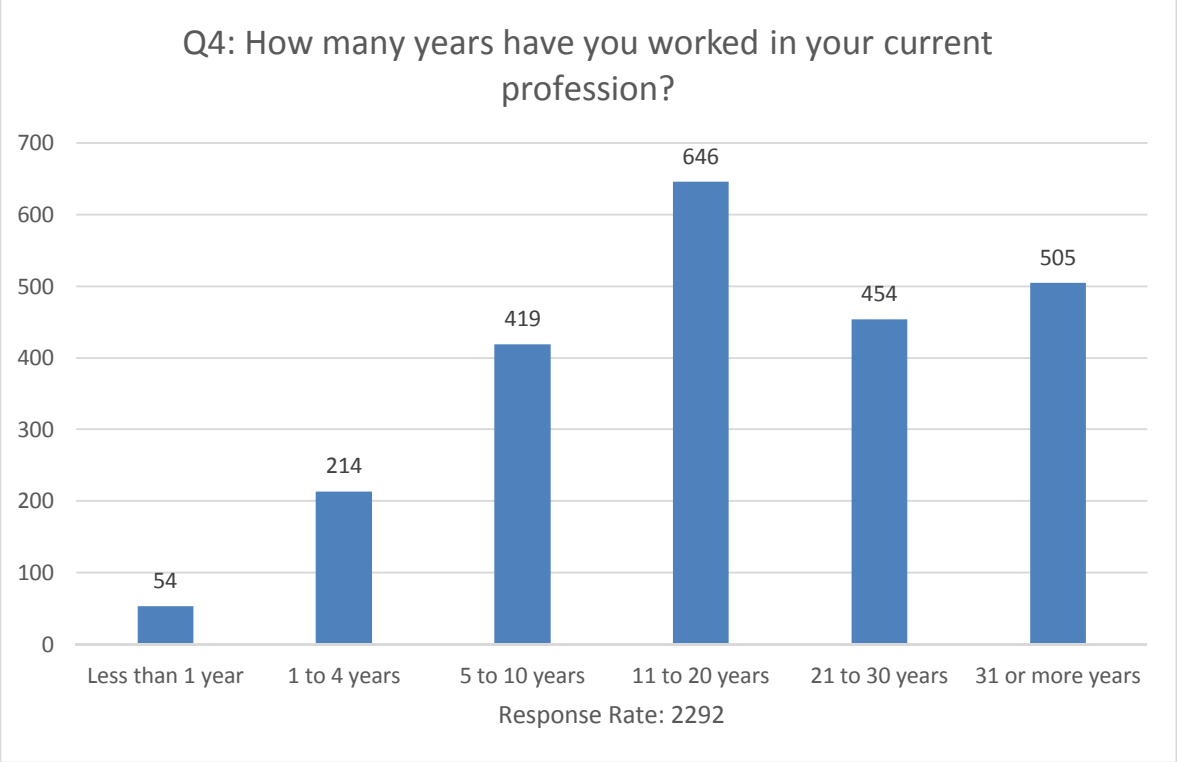
28 June 2019

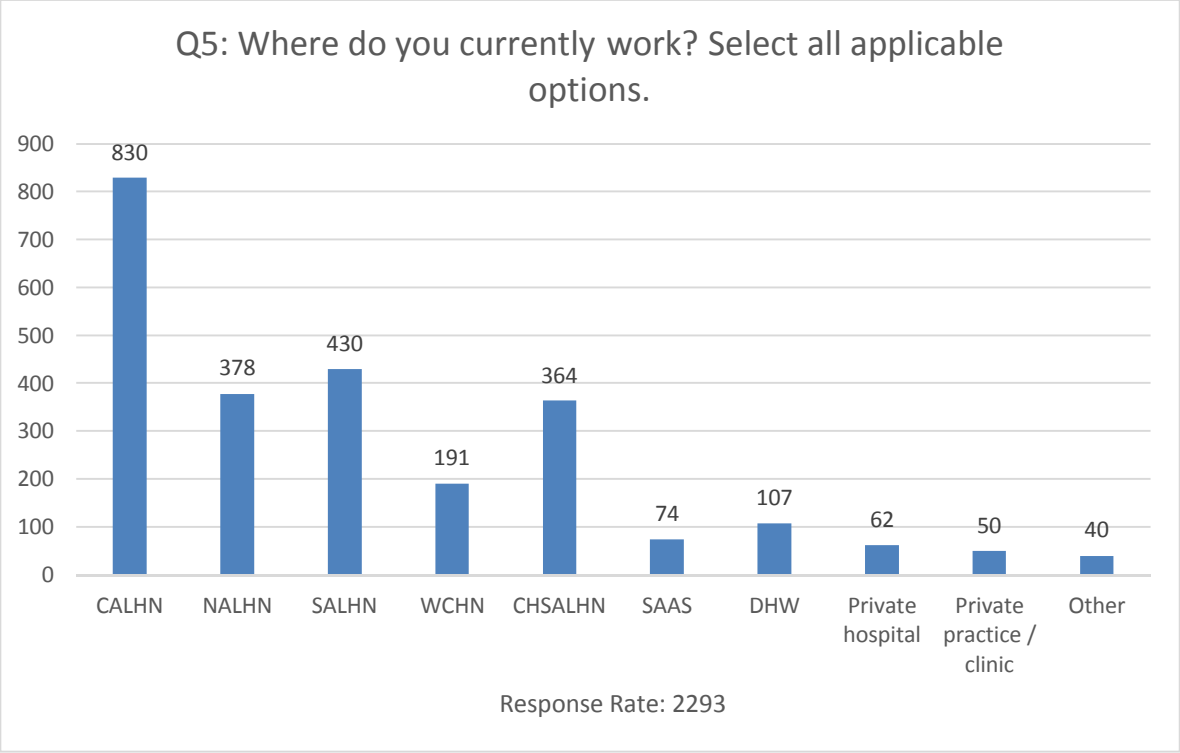
Demographic Questions

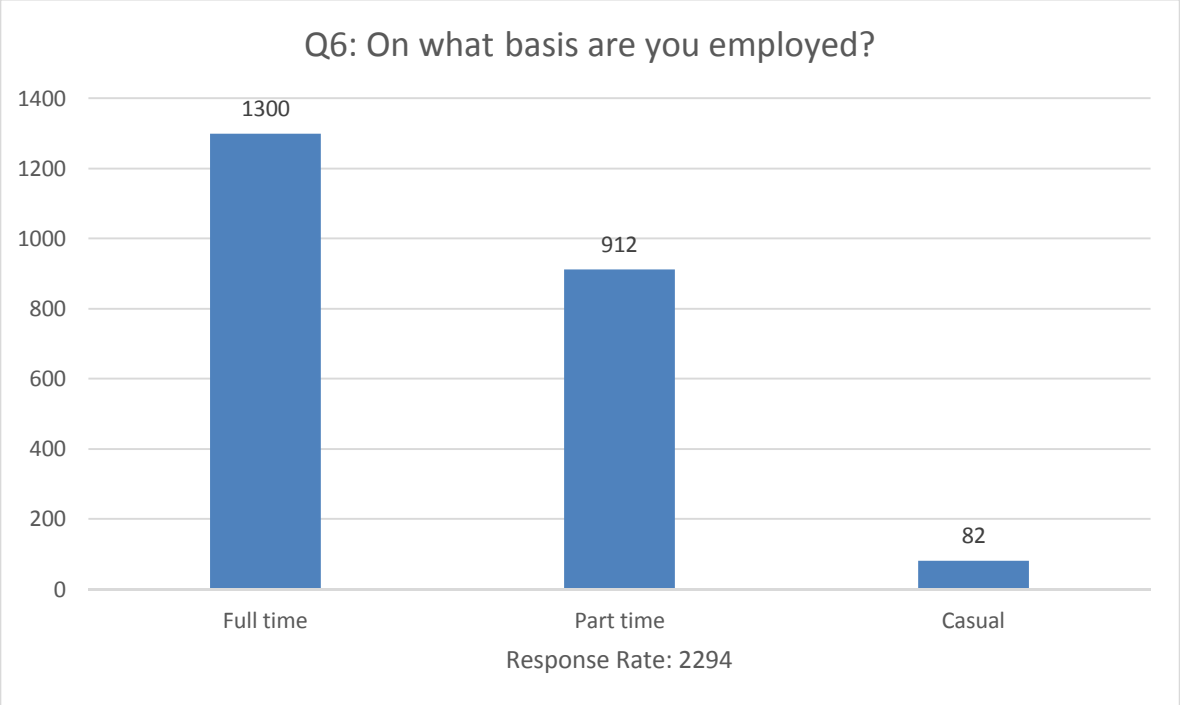


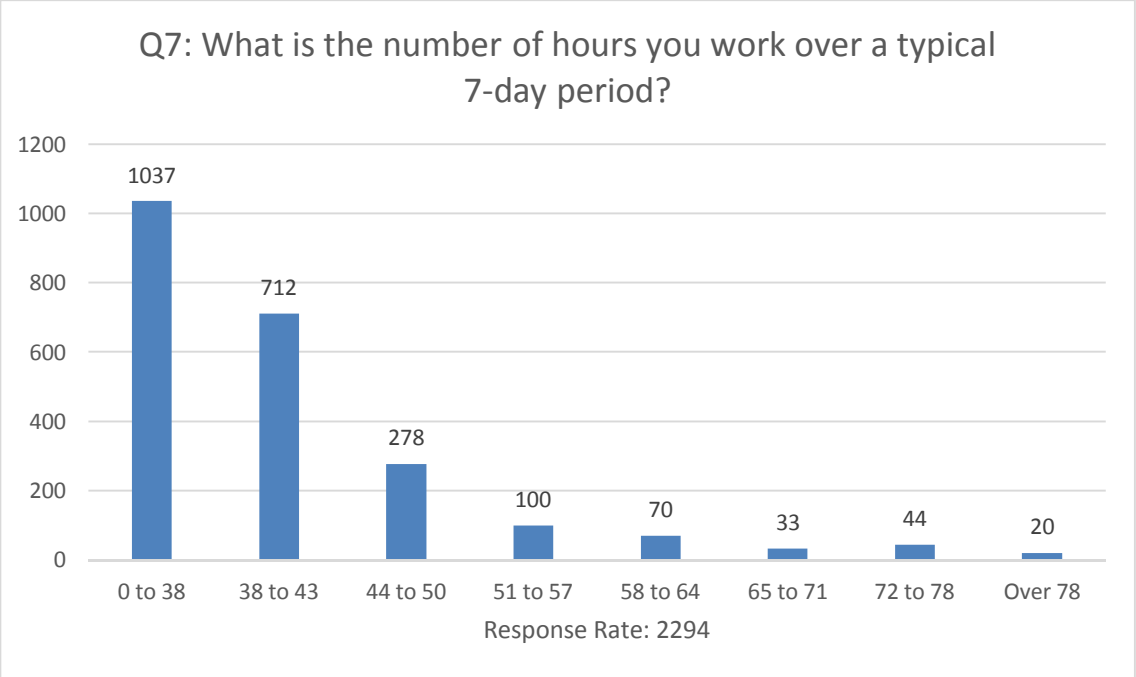

Q3: Which of the following best describes your profession?
1000
900
800
700
600
500
400
300
200
100
0
391
927
395
63
275
33
205
Medical
Nursing and midwifery
Allied health
Ambulance services
Hospital administration
Facilities services
Other
Response Rate: 2289

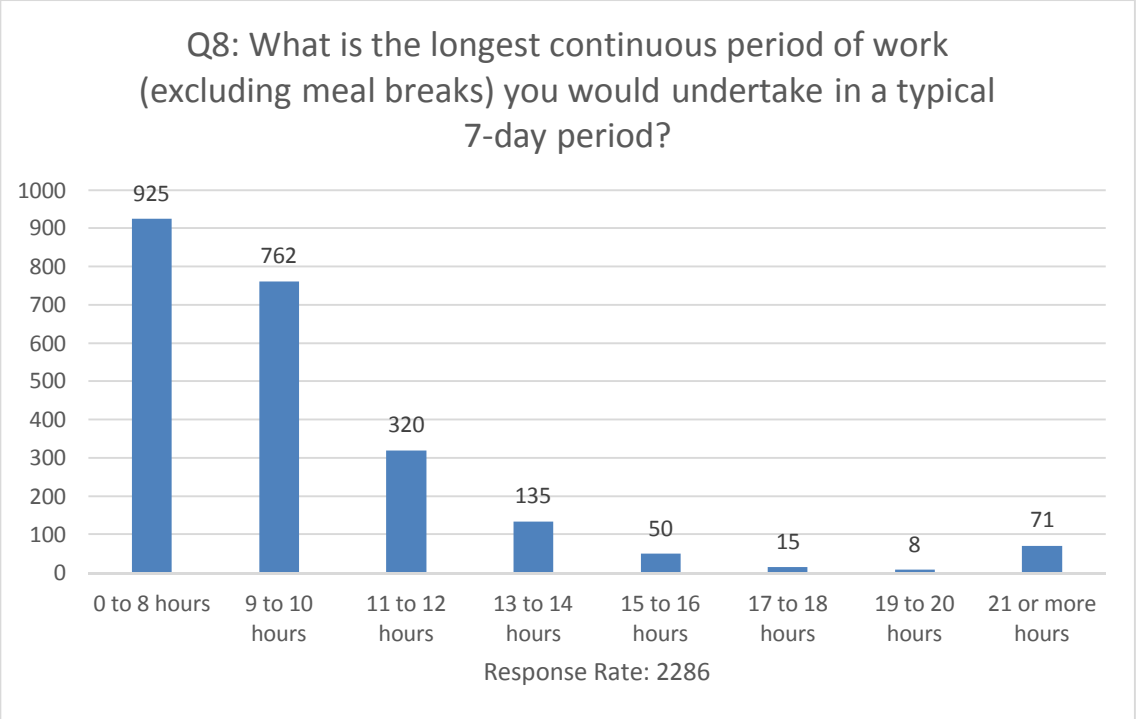

Q4: How many years have you worked in your current profession?
700
600
500
400
300
200
100
0
54
214
419
646
454
505
Less than 1 year
1 to 4 years
5 to 10 years
11 to 20 years
21 to 30 years
31 or more years
Response Rate: 2292

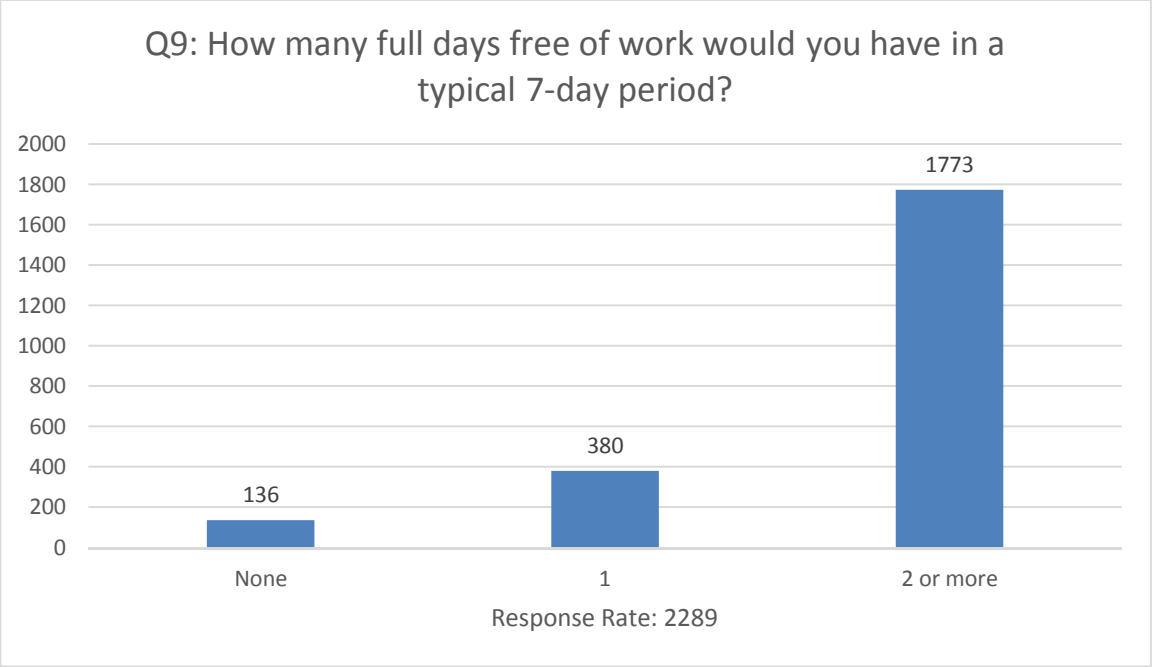

Q5: Where do you currently work? Select all applicable options.
900
800
700
600
500
400
300
200
100
0
830
378
430
191
364
74
107
62
50
40
CALHN
NALHN
SALHN
WCHN
CHSALHN
SAAS
DHW
Private hospital
Private practice / clinic
Other
Response Rate: 2293

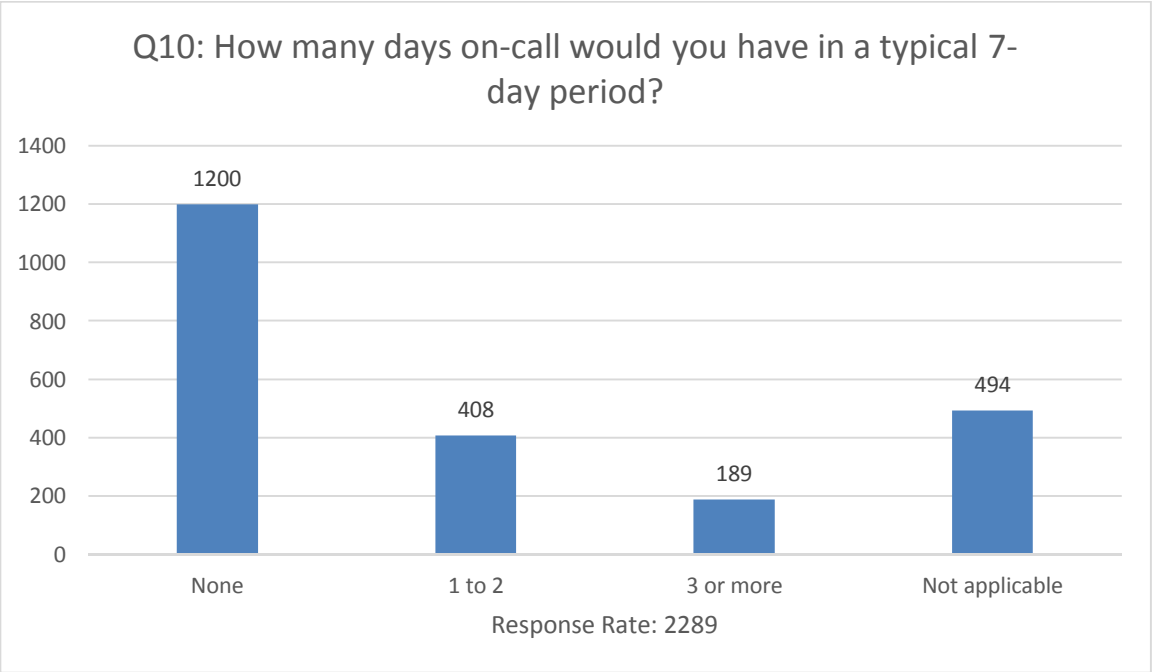

Q6: On what basis are you employed?
1400
1200
1000
800
600
400
200
0
1300
912
82
Full time
Part time
Casual
Response Rate: 2294

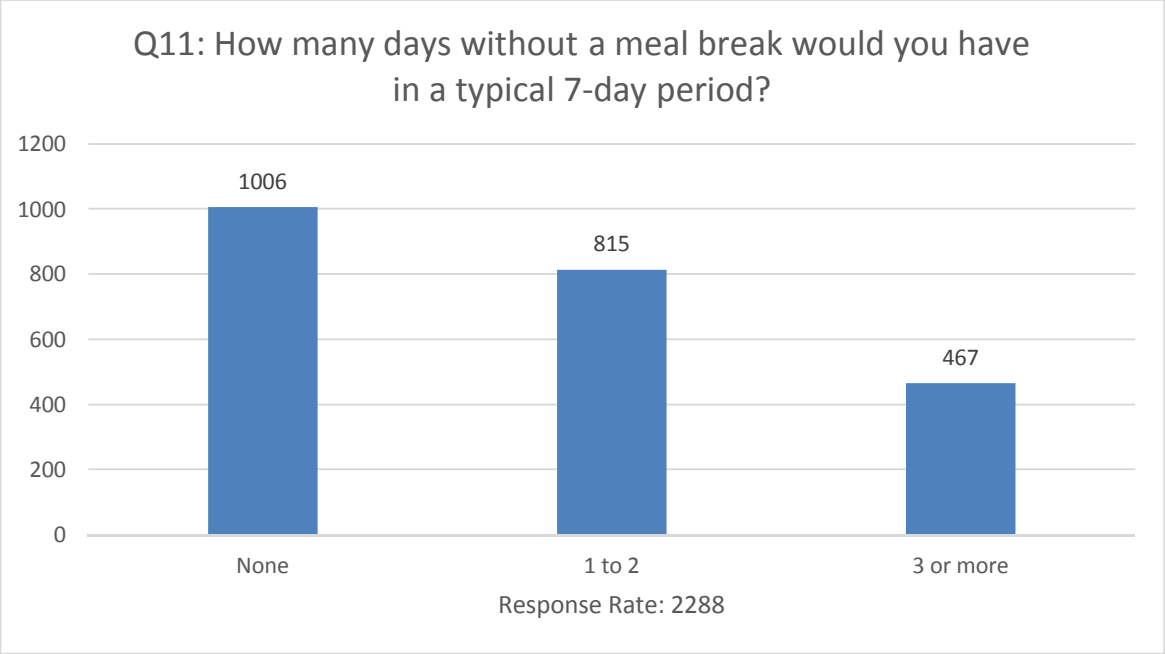
Workplace Fatigue Questions

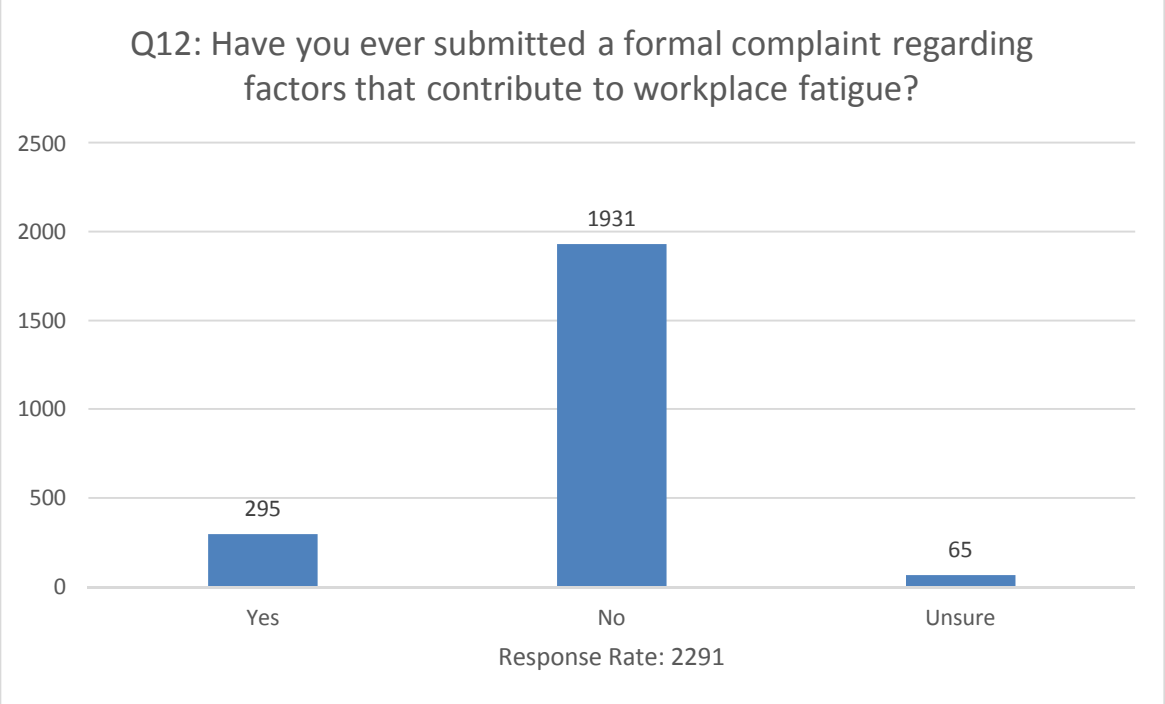


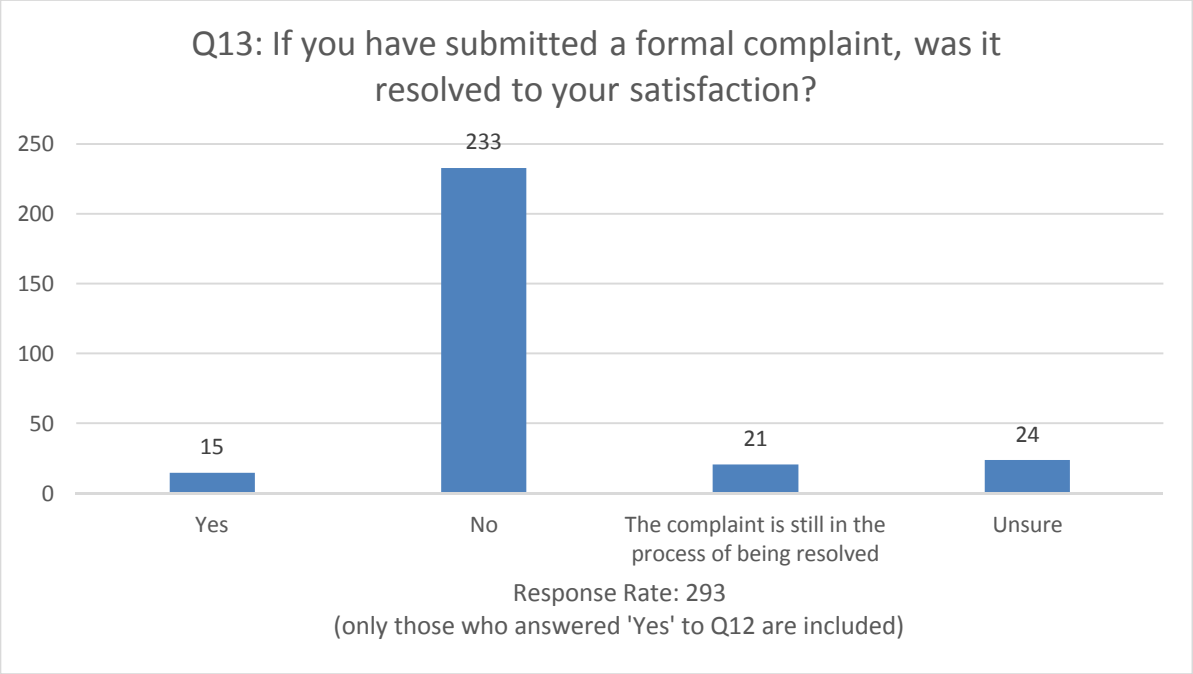



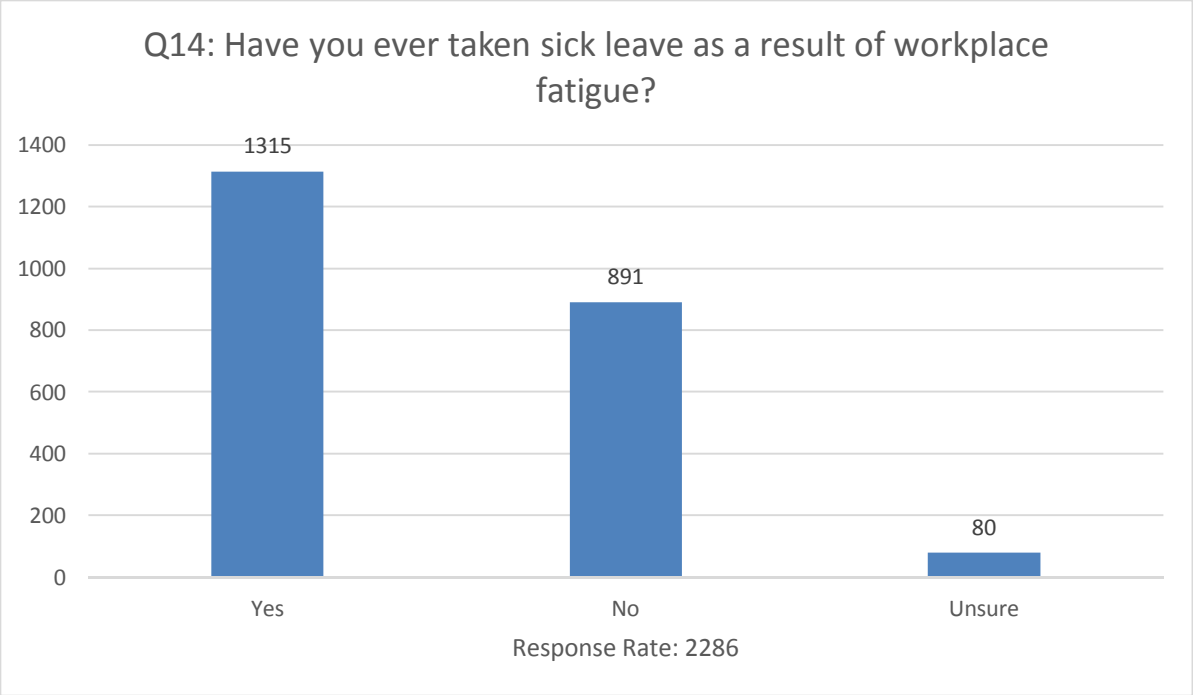

Q9: How many full days free of work would you have in a typical 7-day period?
2000
1800
1600
1400
1200
1000
800
600
400
200
0
136
380
1773
None
1
2 or more
Response Rate: 2289

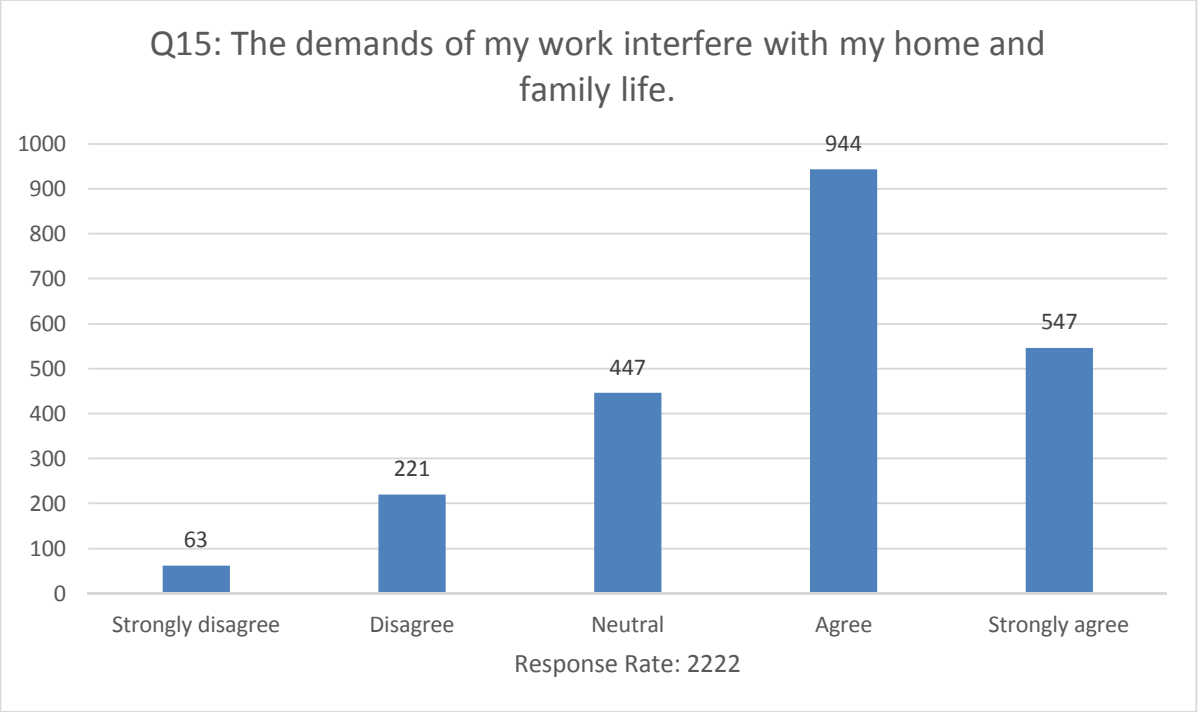

Q10: How many days on-call would you have in a typical 7-day period?
1400
1200
1000
800
600
400
200
0
1200
408
189
494
None
1 to 2
3 or more
Not applicable
Response Rate: 2289


Q11: How many days without a meal break would you have in a typical 7-day period?
1200
1000
800
600
400
200
0
1006
815
467
None
1 to 2
3 or more
Response Rate: 2288

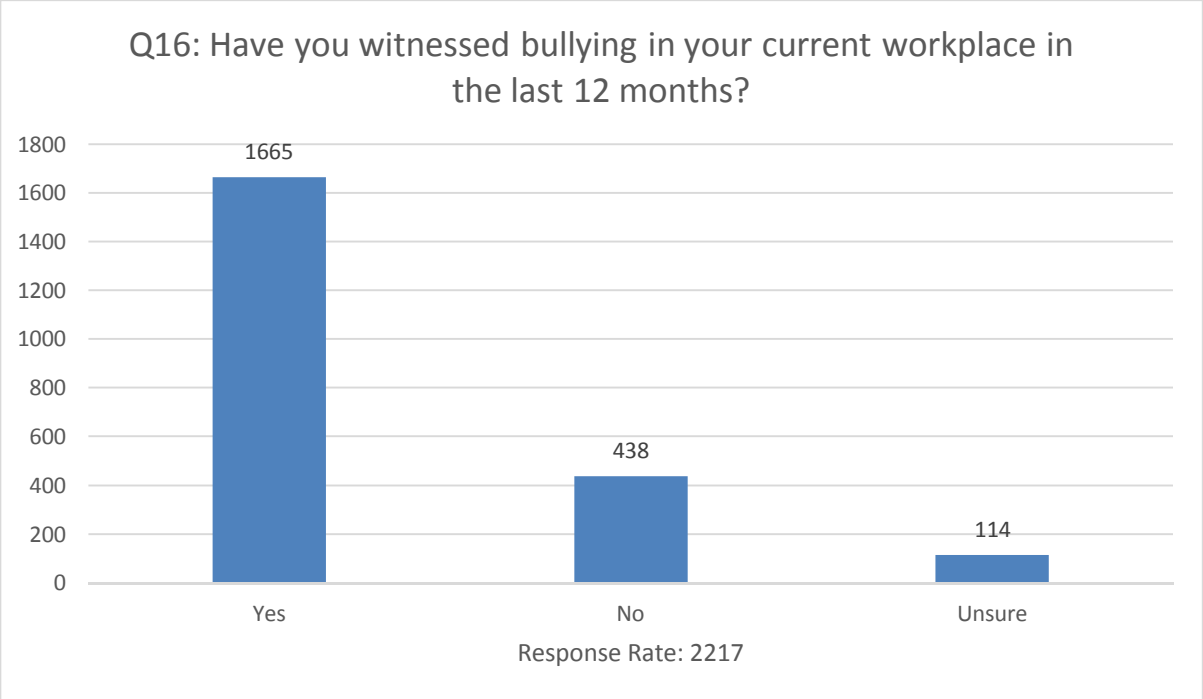

Q12: Have you ever submitted a formal complaint regarding factors that contribute to workplace fatigue?
2500
2000
1500
1000
500
0
295
1931
65
Yes
No
Unsure
Response Rate: 2291

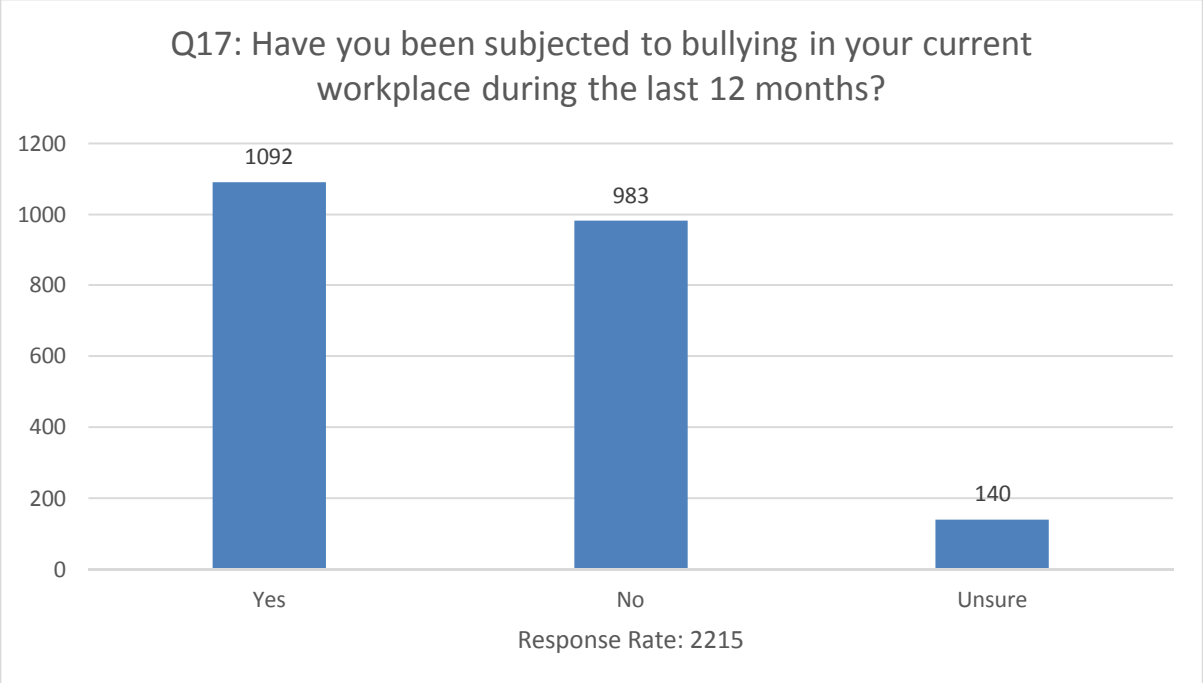

Q13: If you have submitted a formal complaint, was it resolved to your satisfaction?
250
200
150
100
50
0
15
233
21
24
Yes
No
The complaint is still in the process of being resolved
Unsure
Response Rate: 293
(only those who answered 'Yes' to Q12 are included)


Q14: Have you ever taken sick leave as a result of workplace fatigue?
1400
1200
1000
800
600
400
200
0
1315
891
80
Yes
No
Unsure
Response Rate: 2286

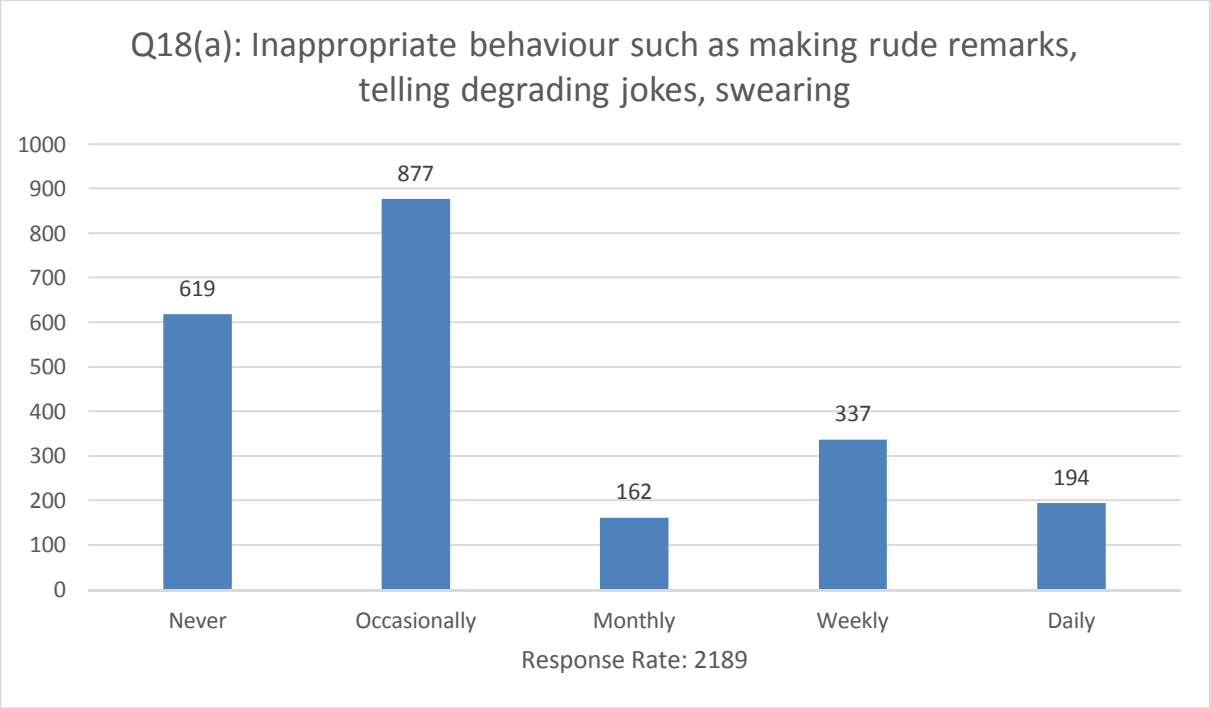

Q15: The demands of my work interfere with my home and family life.
1000
900
800
700
600
500
400
300
200
100
0
63
221
447
944
547
Strongly disagree
Disagree
Neutral
Agree
Strongly agree
Response Rate: 2222

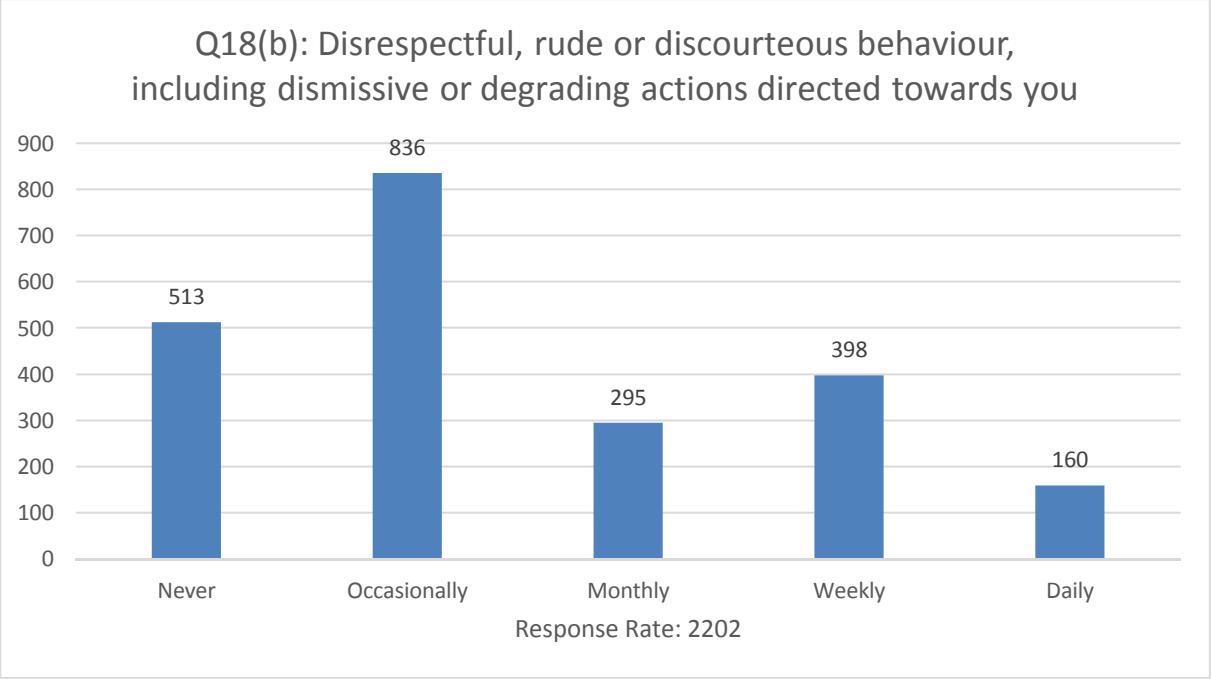
Workplace Bullying Questions

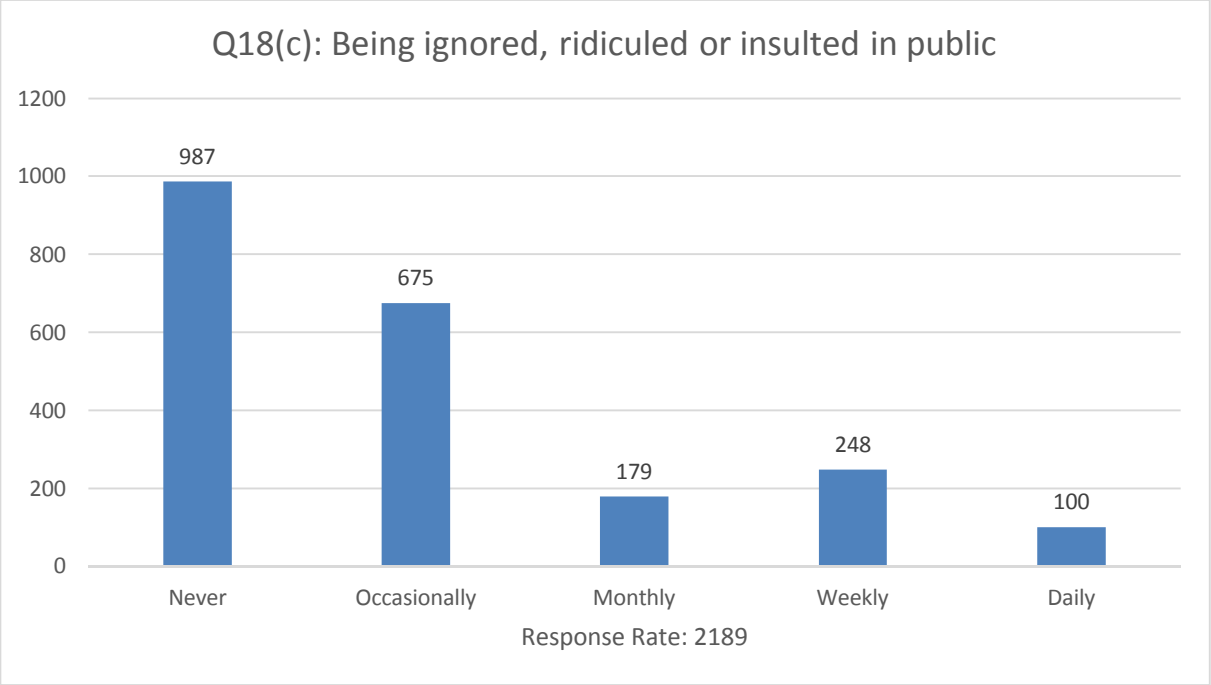


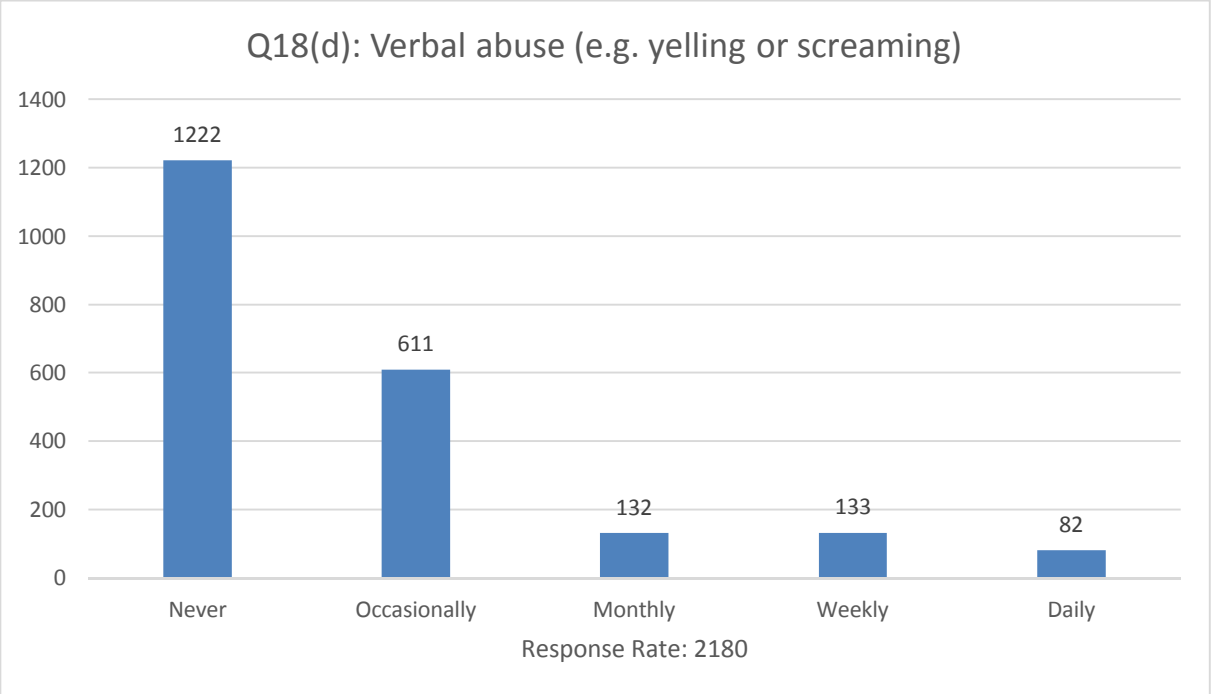



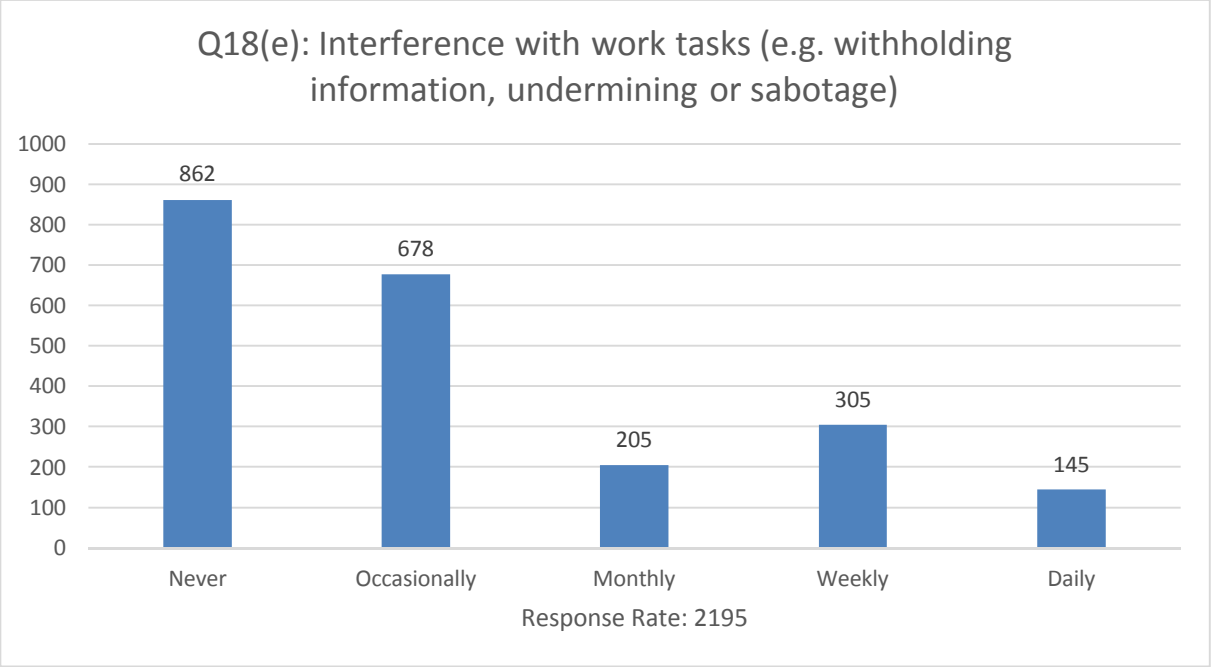
Q18: How frequently have you experienced the following behaviours in your workplace in the last 12 months?

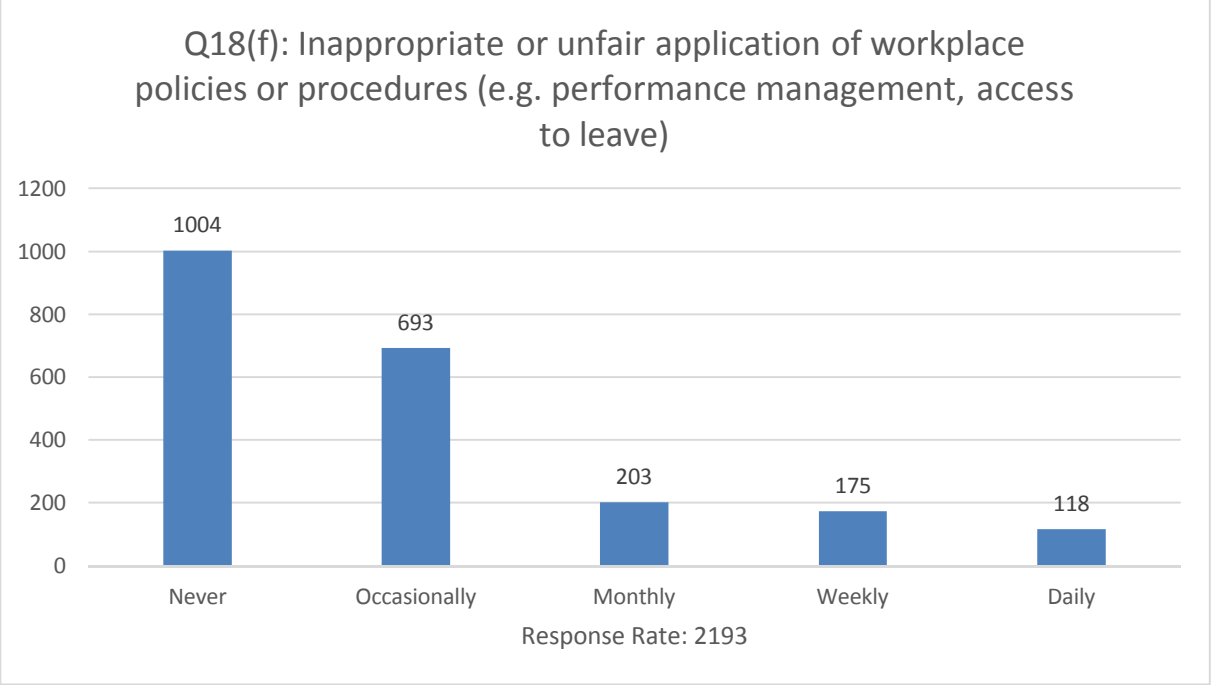


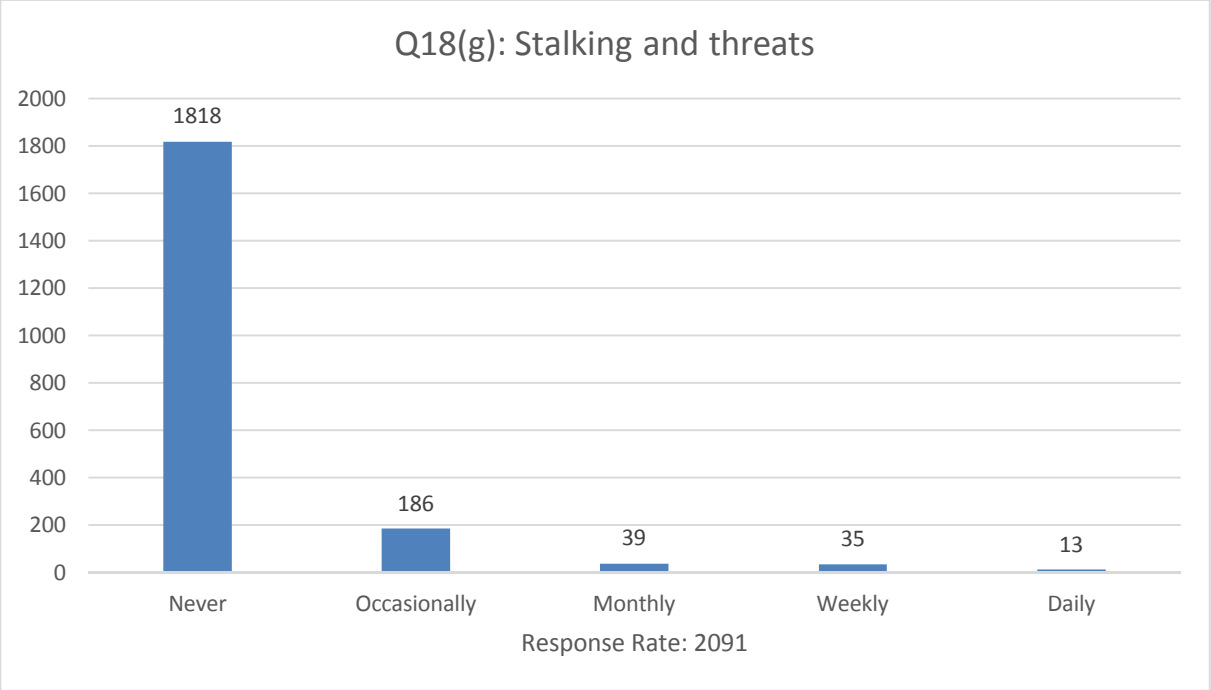



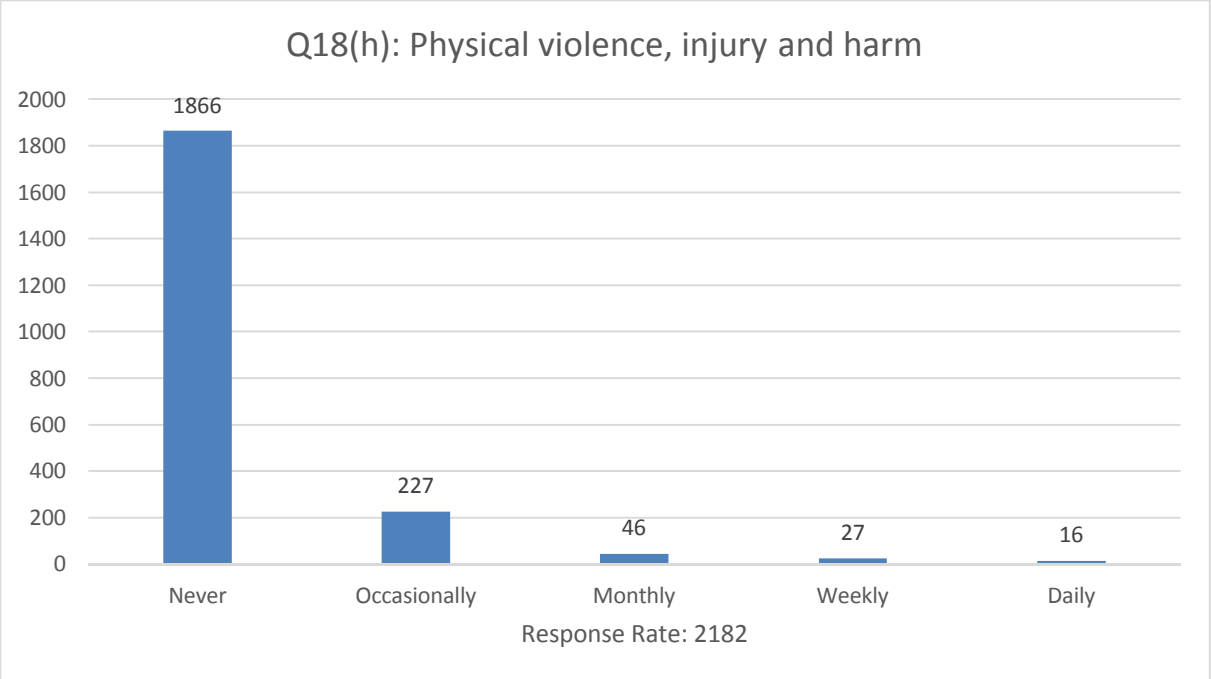

Q18(c): Being ignored, ridiculed or insulted in public
1200
1000
800
600
400
200
0
987
675
179
248
100
Never
Occasionally
Monthly
Weekly
Daily
Response Rate: 2189

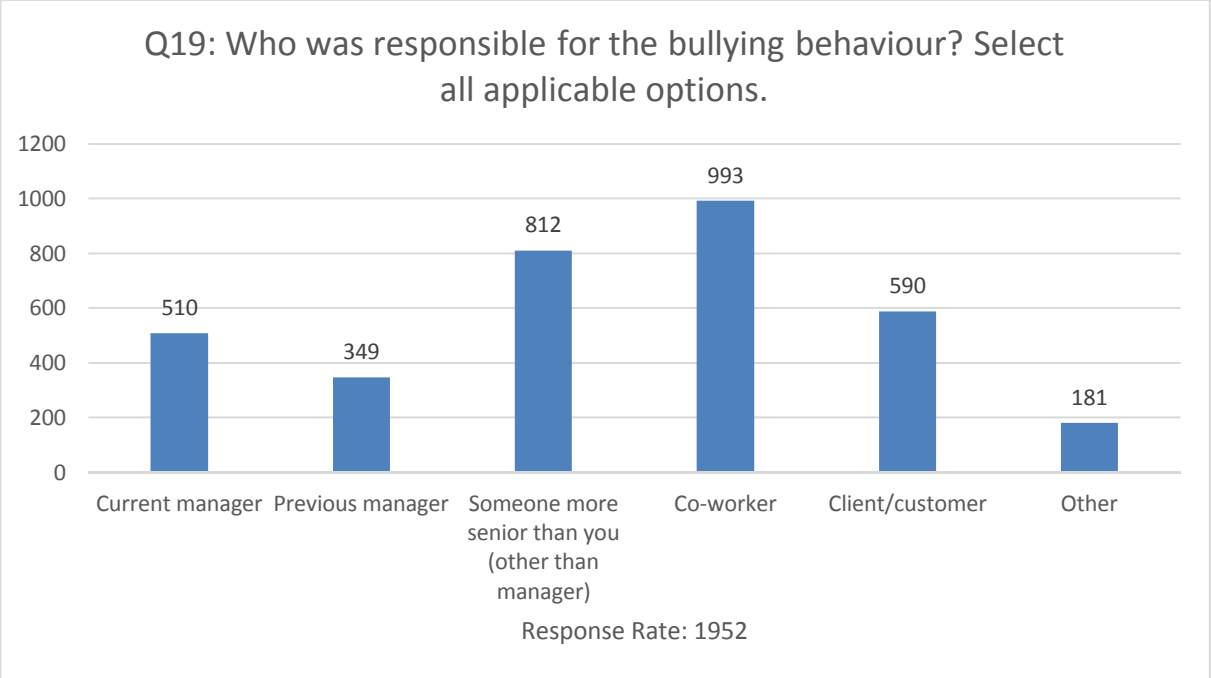

Q18(d): Verbal abuse (e.g. yelling or screaming)
1400
1200
1000
800
600
400
200
0
1222
611
132
133
82
Never
Occasionally
Monthly
Weekly
Daily
Response Rate: 2180

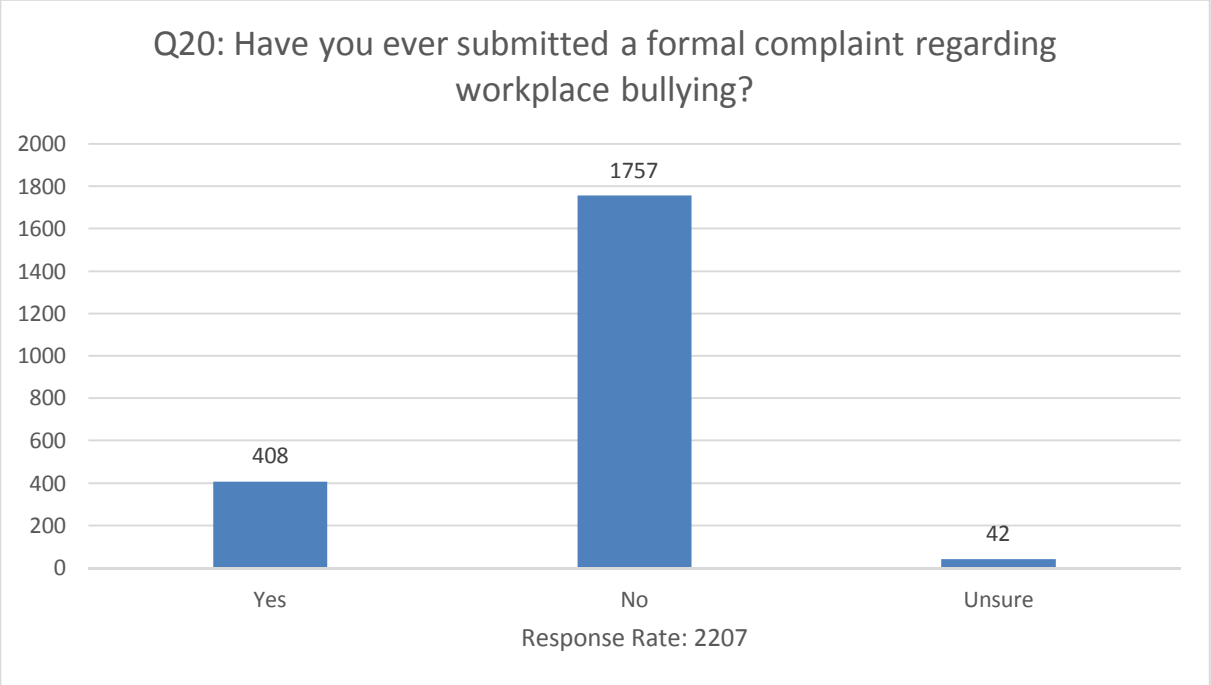

Q18(e): Interference with work tasks (e.g. withholding information, undermining or sabotage)
1000
900
800
700
600
500
400
300
200
100
0
862
678
205
305
145
Never
Occasionally
Monthly
Weekly
Daily
Response Rate: 2195


Q18(f): Inappropriate or unfair application of workplace policies or procedures (e.g. performance management, access to leave)
1200
1000
800
600
400
200
0
1004
693
203
175
118
Never
Occasionally
Monthly
Weekly
Daily
Response Rate: 2193

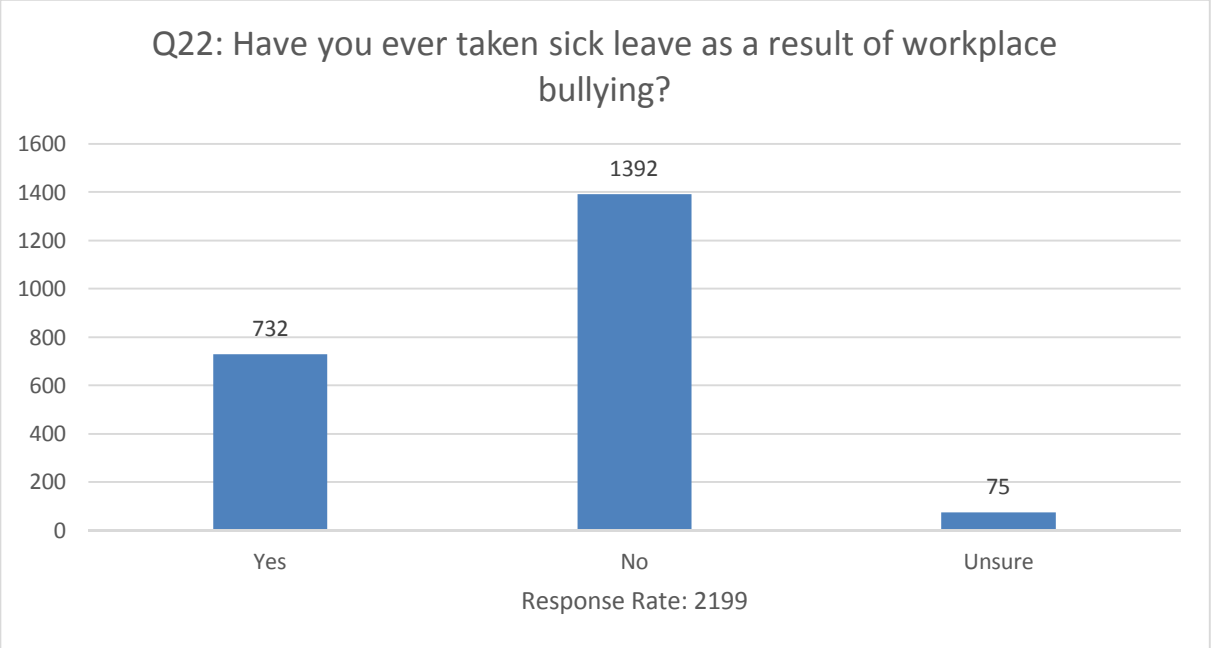

Q18(g): Stalking and threats
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1818
186
39
35
13
Never
Occasionally
Monthly
Weekly
Daily
Response Rate: 2091


Q18(h): Physical violence, injury and harm
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1866
227
46
27
16
Never
Occasionally
Monthly
Weekly
Daily
Response Rate: 2182


Q19: Who was responsible for the bullying behaviour? Select all applicable options.
1200
1000
800
600
400
200
0
510
349
812
993
590
181
Current manager
Previous manager
Someone more senior than you (other than manager)
Co-worker
Client/customer
Other
Response Rate: 1952


Q20: Have you ever submitted a formal complaint regarding workplace bullying?
2000
1800
1600
1400
1200
1000
800
600
400
200
0
408
1757
42
Yes
No
Unsure
Response Rate: 2207

Q21: If you have submitted a formal complaint, was it resolved to your satisfaction?
300
250
200
150
100
50
0
65
284
34
24
Yes
No
The complaint is still in the process of being resolved
Unsure
Response Rate: 407
(only those who answered 'Yes' to Q20 are included)


Q22: Have you ever taken sick leave as a result of workplace bullying?
1600
1400
1200
1000
800
600
400
200
0
732
1392
75
Yes
No
Unsure
Response Rate: 2199

## APPENDIX 3 – OCPSE YOUR VOICE SURVEY DETAILED RESULTS

The following data was provided by the Office of the Commissioner for Public Sector Employment (OCPSE) in response to the Committee's request for SA Health *Your Voice Survey* data.

| Survey Summary Statistics | CALHN | NALHN | SALHN | WCHN | CHSALHN | SAAS | DHW | SA Health | SA Public Sector |
|---|---|---|---|---|---|---|---|---|---|
| Total Staff | 14,674 | 4,941 | 7,602 | 3,793 | 9,147 | 1,802 | 1,766 | 43,725 | 109,901 |
| Total Responses to Survey | 2,913 | 740 | 996 | 530 | 1,189 | 400 | 700 | 7,468 | 24,341 |
| Response Rate | 20% | 15% | 13% | 14% | 13% | 22% | 40% | 17% | 22% |

**Survey Question 20:** During the last 12 months, have you witnessed harassment or bullying in your current workplace?

| | CALHN | NALHN | SALHN | WCHN | CHSALHN | SAAS | DHW | SA Health | SA Public Sector |
|---|---|---|---|---|---|---|---|---|---|
| Total responses to Q20 | 2,598 | 659 | 918 | 482 | 1,110 | 379 | 643 | 6,789 | 22,454 |
| Total responding 'Yes' to Q20 | 1,305 | 336 | 448 | 246 | 547 | 181 | 213 | 3,276 | 8,419 |
| Percentage responding 'Yes' to Q20 | 50% | 51% | 49% | 51% | 49% | 48% | 33% | 48% | 37% |

**Survey Question 21:** During the last 12 months, have you been subjected to harassment or bullying in your current workplace?

| | CALHN | NALHN | SALHN | WCHN | CHSALHN | SAAS | DHW | SA Health | SA Public Sector |
|---|---|---|---|---|---|---|---|---|---|
| Total responses to Q21 | 2,587 | 660 | 916 | 483 | 1,104 | 379 | 643 | 6,772 | 22,416 |
| Total responding 'Yes' to Q21 | 700 | 212 | 259 | 149 | 312 | 110 | 135 | 1,877 | 4,797 |
| Percentage responding 'Yes' to Q21 | 27% | 32% | 28% | 31% | 28% | 29% | 21% | 28% | 21% |

# APPENDIX 4 – SUBMISSIONS AND HEARINGS

## Submissions

The following submissions were received by the Committee:

| No. | Submission date | Organisation / Individual |
|---|---|---|
| 1 | 6 January 2019 | Confidential |
| 2 | 7 January 2019 | Confidential |
| 3 | 10 January 2019 | Confidential |
| 4 | 29 December 2018 | Confidential |
| 5 | 22 January 2019 | Confidential |
| 6 | 23 January 2019 | Confidential |
| 7 | 25 January 2019 | Confidential |
| 8 | 29 January 2019 | Brenda Joy |
| 9 | 29 January 2019 | Confidential |
| 10 | 30 January 2019 | Confidential |
| 11 | 30 January 2019 | Confidential |
| 12 | 30 January 2019 | Jeanette Birtles |
| 13 | 30 January 2019 | Health Consumers Alliance of South Australia Inc. |
| 14 | 30 January 2019 | Confidential |
| 15 | 30 January 2019 | Confidential |
| 16 | 30 January 2019 | Confidential |

| | | |
|---|---|---|
| 17 | 31 January 2019 | Deborah Williams |
| 18 | 31 January 2019 | Name withheld |
| 19 | 31 January 2019 | Nursing and Midwifery Board of Australia |
| 20 | 31 January 2019 | Confidential |
| 21 | 31 January 2019 | Lynne Snodgrass |
| 22 | 31 January 2019 | Royal Australian and New Zealand College of Psychiatrists |
| 23 | 31 January 2019 | Confidential |
| 24 | 31 January 2019 | Confidential |
| 25 | 31 January 2019 | Confidential |
| 26 | 31 January 2019 | Confidential |
| 27 | 31 January 2019 | Professionals Australia |
| 28 | 31 January 2019 | Confidential |
| 29 | 31 January 2019 | Confidential |
| 30 | 31 January 2019 | Appleton Institute, Central Queensland University |
| 31 | 31 January 2019 | Confidential |
| 32 | 31 January 2019 | Thong Wing Chan |
| 33 | 31 January 2019 | Confidential |
| 34 | 31 January 2019 | Australian College of Nursing |
| 35 | 31 January 2019 | Confidential |

| | | |
|---|---|---|
| 36 | 31 January 2019 | Confidential |
| 37 | 31 January 2019 | Danee Davis |
| 38 | 31 January 2019 | Confidential |
| 39 | 31 January 2019 | Australian Medical Students' Association |
| 40 | 31 January 2019 | Kathy Walker |
| 41 | 1 February 2019 | Confidential |
| 42 | 1 February 2019 | Royal Australasian College of Surgeons |
| 43 | 1 February 2019 | Name withheld |
| 44 | 31 January 2019 | Confidential |
| 45 | 4 February 2019 | Australian and New Zealand College of Anaesthetists |
| 46 | 3 February 2019 | Confidential |
| 47 | 5 February 2019 | National Mental Health Commission |
| 48 | 8 February 2019 | Confidential |
| 49 | 8 February 2019 | Australasian College for Emergency Medicine |
| 50 | 14 February 2019 | South Australian Salaried Medical Officers Association |
| 51 | 12 February 2019 | Confidential |
| 52 | 16 February 2019 | Confidential |
| 53 | 18 February 2019 | Australian Nursing and Midwifery Federation (SA Branch) |
| 54 | 21 February 2019 | Confidential |

| | | |
|---|---|---|
| 55 | 21 February 2019 | Confidential |
| 56 | 26 February 2019 | SA Health |
| 57 | 12 March 2019 | Confidential |
| 58 | 12 March 2019 | SA Medical Education and Training Health Advisory Council |
| 59 | 15 March 2019 | Confidential |
| 60 | 27 March 2019 | Confidential |
| 61 | 1 April 2019 | Civil Aviation Safety Authority |
| 62 | 23 April 2019 | Confidential |
| 63 | 20 May 2019 | Council of Deans of Nursing and Midwifery Australia and New Zealand |
| 64 | 31 May 2019 | Medical Deans Australia and New Zealand |
| 65 | 31 May 2019 | Centre for Workplace Excellence, University of South Australia |
| 66 | 31 May 2019 | Medical Insurance Group Australia |
| 67 | 4 June 2019 | National Heavy Vehicle Regulator |
| 68 | 17 June 2019 | Confidential |
| 69 | 17 June 2019 | Independent Commissioner Against Corruption, Office for Public Integrity |
| 70 | 24 September 2019 | Australian Transport Safety Bureau |

## Supplementary Submissions

The following supplementary submissions were received by the Committee:

| No. | Submission date | Organisation / Individual |
|---|---|---|
| 1a | 8 April 2019 | Confidential |
| 2a | 8 April 2019 | Confidential |
| 3a | 8 April 2019 | Confidential |
| 4a | 8 April 2019 | Confidential |
| 9a | 12 April 2019 | Confidential |
| 11a | 30 May 2019 | Confidential |
| 12a | 5 April 2019 | Jeanette Birtles |
| 14a | 8 April 2019 | Confidential |
| 15a | 8 April 2019 | Confidential |
| 18a | 5 April 2019 | Name withheld |
| 20a | 18 April 2019 | Confidential |
| 21a | 17 April 2019 | Lynne Snodgrass |
| 24a | 17 April 2019 | Confidential |
| 25a | 12 April 2019 | Confidential |
| 32a | 6 May 2019 | Thong Wing Chan |
| 33a | 8 April 2019 | Confidential |
| 36a | 5 April 2019 | Confidential |

| | | |
|---|---|---|
| 37a | 5 April 2019 | Danee Davis |
| 41a | 5 April 2019 | Confidential |
| 51a | 9 April 2019 | Confidential |
| 52a | 8 April 2019 | Confidential |
| 57a | 11 April 2019 | Confidential |
| 60a | 11 April 2019 | Confidential |
| 67a | 28 August 2019 | National Heavy Vehicle Regulator |

## Hearings

| **Hearing date** | **Witnesses** |
|---|---|
| 7 December 2018 | Don Frater, Deputy Chief Executive, SA Health<br><br>Melisa Kaharevic, Acting Director, Corporate Services, SA Health<br><br>Peter Pollnitz, Program Manager, WorkFit and Wellbeing, SA Health<br><br>Jon Logie, Executive Director, Media and Communications, SA Health<br><br>Martyn Campbell, Executive Director, SafeWork SA<br><br>Barry Sheppard, Acting Manager, Community and Events and Business Services Team, SafeWork SA<br><br>Elizabeth Dabars, Chief Executive Officer/Secretary, Australian Nursing and Midwifery Federation (SA Branch)<br><br>Rob Bonner, Director, Operations and Strategy (SA), Australian Nursing and Midwifery Federation (SA Branch) |
| 15 February 2019 | Bernadette Mulholland, Senior Industrial Officer, South Australian Salaried Medical Officers Association |

| | |
|---|---|
| 9 April 2019 | John Biviano, Acting Chief Executive Officer, Royal Australasian College of Surgeons<br><br>Simon Judkins, President, Australasian College for Emergency Medicine<br><br>Thiru Govindan, South Australian Faculty Chair, Australasian College for Emergency Medicine<br><br>Michael Edmonds, Fellow, Australasian College for Emergency Medicine<br><br>Peter Bruce, Fellow, Australasian College for Emergency Medicine |
| 17 May 2019 | Marina Buchanan-Grey, Executive Director, Professional Division, Australian College of Nursing<br><br>Walid Aly, Fellow, Australian and New Zealand College of Anaesthetists<br><br>Bernadette Hoffman, Clinical Nurse, Lyell McEwin Hospital |
| 28 June 2019 | Brian McKenny, Representative, Royal Australian and New Zealand College of Psychiatrists<br><br>Drew Dawson, Associate Vice-Chancellor (South Australia), Director, Engaged Research Chair, Appleton Institute<br><br>Matthew Thomas, Deputy Director, Appleton Institute |
| 5 July 2019 | Rod Mitchell, President, Australian and New Zealand College of Anaesthetists<br><br>Jack Chan, Clinical Nurse, Royal Adelaide Hospital<br><br>Deborah Williams, Remote Area Nurse, Katherine West Health Board, Northern Territory |
| 2 August 2019 | Kevin Forsyth, Presiding Member, SA Medical Education and Training (SA MET) Health Advisory Council<br><br>Peter Roberts-Thomson, Emeritus Professor, College of Medicine and Public Health, Flinders University<br><br>Michelle Tuckey, Associate Professor, Centre for Workplace Excellence, University of South Australia |

| | |
|---|---|
| 13 September 2019 | Chris Moy, President, Australian Medical Association, South Australia Branch<br><br>Samantha Mead, Chief Executive Officer, Australian Medical Association, South Australia Branch<br><br>Hajisa Teague, President, Health Services Union SA/NT<br><br>Zerebar Karimi, Organiser, Health Services Union SA/NT<br><br>Tim Bowen, Senior Solicitor, Advocacy, Claims and Education, Medical Insurance Group Australia<br><br>Anita Filleti, Principal Workplace Lawyer, Medical Insurance Group Australia |
| 27 September 2019 | David O'Mahoney<br><br>Cherilyn Alport, Work Health and Safety Consultant, Country Health SA |
| 18 October 2019 | Reece Bretag-Norris, Neuropsychiatry Registrar, Royal Adelaide Hospital<br><br>Craig Stevens, Director, Authentic Workplace Relations<br><br>Confidential<br><br>Confidential<br><br>Confidential |
| 15 November 2019 | Kathy Walker<br><br>Jason McHeyzer, Region Manager, Civil Aviation Safety Authority, Southern Region<br><br>Paul Hibberd, Branch Manager, Regulation and Implementation, Civil Aviation Safety Authority<br><br>Melissa Cashman, Branch Manager, Government Relations, Civil Aviation Safety Authority<br><br>Bevan Rowland, Safety Assurance Adviser, Fatigue, National Heavy Vehicle Regulator<br><br>Andreas Blahous, Principal Safety Assurance Adviser, Fatigue and Human Factors, National Heavy Vehicle Regulator |

| | |
|---|---|
| 6 December 2019 | Carol Grech, CDNM Representative, Council of Deans of Nursing and Midwifery (Australia and New Zealand)<br><br>Marion Eckert, CDNM Representative, Council of Deans of Nursing and Midwifery (Australia and New Zealand)<br><br>Rachel Edwards, Clinical Lead/Senior Social Worker, Southern Adelaide Local Health Network |

**Site Visits**

| | |
|---|---|
| 1 November 2019 | Flinders Medical Centre<br><br>Royal Adelaide Hospital<br><br>SA Ambulance Service Headquarters<br><br>Lyell McEwin Hospital |