World Health Organization

International Labour Organization

HealthWISE Work Improvement in Health Services

Trainers' Guide

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International Labour Organization and World Health Organization

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PREFACE

Workers are at the heart of health services, and contribute to the well-being of societies. Health sector workplaces are complex environments which can at times be dangerous; unsafe working conditions can lead to attrition of the health workforce. Decent working conditions in this sector must take into account workers' health and their well-being, as the quality of care provided by health workers is partly dependent on the quality of their work environment.

This publication, HealthWISE – a joint ILO/WHO product – is a practical, participatory methodology for improving the quality of health facilities, based on the principles of the ILO programme "Work Improvement in Small Enterprises" (WISE). It encourages managers and staff to work together to promote safe and healthy workplaces. This, in turn, helps improve health services' performance and ability to deliver quality care to patients. HealthWISE promotes the application of smart, simple and low-cost solutions, utilizing local resources, which lead to tangible benefits to workers and their employers.

The ILO and WHO have complementary mandates in health services, particularly on occupational safety and health; and in view of this, they have joined forces on HealthWISE to assist health policy-makers and practitioners in building their capacity to ensure safe, healthy and decent working environments for the health service workforce.

In 2010, a tripartite working party of experts comprising workers', employers' and government representatives, as well as ILO and WHO specialists, agreed on a framework for improving working conditions, safety and health for workers in health services. Publications developed as a result of this consultation include the ***Joint WHO/ILO/UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services*** (2010), ***and the ILO-WHO Global Framework for national occupational health programmes for health workers*** (2010).

HealthWISE has been developed to support the implementation of this guidance. In its draft form, HealthWISE was piloted in a number of hospitals and health facilities in Senegal, the United Republic of Tanzania and Thailand in 2011, revised in 2012, and reviewed again by ILO and WHO specialists, as well as the tripartite expert working party in 2013 before finalization.

HealthWISE combines action and learning. The Action Manual helps initiate and sustain changes for improvement and is designed to promote learning-by-doing. The Trainers' Guide is a companion document to the Action Manual and contains guidance and tools for a training course. The CD-ROM accompanying the Trainers' Guide includes a sample PowerPoint presentation for each training session.

We hope that people utilizing the Trainers' Guide and the Action Manual package will, in the future, develop a network of HealthWISE trainers and practitioners to promote practical approaches that will strengthen health systems in their own countries.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
BSC	Biological Safety Cabin
EtO	Ethylene Oxide
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSCIC	Health and Social Care Information Centre (UK)
ICN	International Council of Nurses
ILO	International Labour Organization
IV	Intravenous
MDR	Multi Drug Resistant
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSD	Musculoskeletal disorder
NIOSH	National Institute for Occupational Safety and Health (USA)
OSD	Occupational Specific Dispensation
OSH	Occupational Safety and Health
PEP	Post-Exposure Prophylaxis
PHSDBC	Public Health and Social Development Sectoral Bargaining Council (Southn Africa)
PIH	Partners In Health
PPE	Personal Protective Equipment
PSCBC	Services Coordinating Bargaining Council (South Africa)
RN	Registered Nurses
RO	Reverse Osmosis
SARS	Severe acute respiratory syndrome
SELF	Solar Energy Lighting Fund
TB	Tuberculosis
TOT	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV and AIDS
UVGI	Ultraviolet Germicidal Irradiation
VOC	Volatile Organic Compound
VRE	Vancomycin-Resistant Enterococcus
WHO	World Health Organization
XDR	Extensively Drug-Resistant

I. INTRODUCTION TO HEALTHWISE

What is HealthWISE?

HealthWISE stands for **W**ork **I**mprovement in Health **Se**rvices. Developed jointly by ILO and WHO, it is based on the ILO WISE methodology (Work Improvement in Small Enterprises), successfully applied for more than 20 years in 45 countries, and adapted to several economic sectors.

The aim of ***HealthWISE*** is to provide health-care institutions with a practical, participatory and cost-effective tool to improve work conditions, occupational health and safety for health workers, performance, and quality of health services. Improvements are introduced and sustained by the combined efforts of management and staff, brought together in a dedicated team.

HealthWISE is informed by the goal of decent work as defined by the ILO and endorsed by the United Nations General Assembly in 2008.

Decent work sums up the vision of a work environment where income is fair, employment is secure, working conditions are safe and healthy, and social protection is accessible when needed. Decent work is a fundamental right but also leads to improved productivity, efficiency and economic security.

HealthWISE also draws on recognized models such as Total Quality Management and complements existing quality improvement tools such as the ***5S Kaizen approach*** that is increasingly used in health-care facilities (Ministry of Health and Social Welfare, 2009; Hasegawa and Karandagoda, 2011).

HealthWISE has been developed jointly by ILO and WHO and is based on WHO and ILO standards , tools and policies for the health services.

HealthWISE puts the health workforce in focus and addresses topics that are key to delivering quality care. It encourages everyone to participate in making their workplace not only a good place to work, but also a quality health care environment appreciated by patients and the community.

HealthWISE is a combined action and learning tool, consisting of two handbooks: the Action Manual helps initiating and sustaining changes for improvement; it has been designed for immediate use promoting learning-by-doing; the accompanying Trainers' Guide contains the tools for an active training programme and includes a PowerPoint presentation for each module.

Who is HealthWISE for?

Anyone working in health care can use ***HealthWISE*** to improve their practice and place of work, whatever the size of their workplace. It is, however, most effective when implemented by a team representing both managers and workers. Staff at all levels and in all departments should be involved, because they all have a stake and role in improving their workplace and practice.

II. CONTENTS AND METHODOLOGY OF THE TRAINERS' GUIDE

II.1 Purpose of the Trainers' Guide

This guide is a companion document to the HealthWISE Action Manual. The package provides HealthWISE trainers and other practitioners with a complete set of action and training materials. The purpose is to help them conduct training in order to initiate and support workplace improvements in the health sector.

The Trainers' Guide consists of this handbook and a set of PowerPoint presentations on a CD-Rom. The handbook is aligned with the structure of the Action Manual, it has introductory information and general guidance, plus detailed notes for each of the eight modules in the Action Manual and accompanying PowerPoint presentations. Two additional PowerPoints introduce the Checklist and offer guidance on action plans.

Variety of course types. The guide makes it possible to conduct training at various levels, depending on local needs and circumstances; for example:

1. Within a health facility:
    - the HealthWISE focal person can use these materials to train a HealthWISE team for his or her own workplace;
    - the HealthWISE team can train other colleagues in order to extend understanding and good practice;
2. At a district or regional level: the HealthWISE trainer can use these materials to train representatives of several health facilities, who can then take on the role of HealthWISE focal persons in their own institutions.
3. At national or regional levels, training of trainers (TOT) can help build a group of HealthWISE experts who in turn organize trainings in their regions or districts for new HealthWISE focal points.

Ask the Ministry of Health or your local WHO or ILO office to see if there are any other HealthWISE trainers or training courses available in your country.

II.2 The HealthWISE approach

The HealthWISE training methodology is that of active learning: the Action Manual and the Trainers' Guide offer basic information relevant to a range of topics, but it's the experience of the participants –guided by the trainer– which will help define effective and appropriate solutions.

Active learning

Active learning is centred on the learner, not the trainer, and encourages participation. The students aren't passive recipients of information: their own experiences and ideas are recognized as a valuable resource. There is a two-way exchange between the trainer and the learners. Learning is negotiated and practical outcomes are sought through small group work and other activities.

Even in larger groups and plenary sessions there can be active learning: ask questions, stop and check that participants understand your line of reasoning, and invite comments. Presentations can be punctuated by short sessions of group work – just breaking up into pairs for a few minutes is a very effective way of keeping the whole group involved.

Adapt to local context

The advice in the Action Manual and Trainers' Guide is necessarily generic, and examples are taken from different institutions and systems across the world. However, we request that trainers using this Guide prepare the course by looking for examples of good practice locally. This will help to:

- make sure that practices are relevant to the situation and resources of the facilities represented; and
- encourage participants to make changes by showing them examples to which they can relate.

You can collect examples during the preparations for the training course, for example by visiting health facilities in your community or region.

The HealthWISE checklist

The checklist is the core tool used by all WISE programmes (see Session 2 for more detail). Its purpose is to make sure that the improvements taken by facilities are based on the realities of their situation and lead to practical action.

Each module of the Action Manual has a short introduction to the topic, then lists four or five checkpoints to help assess needs and move towards solutions. Each checkpoint has the same format: it explains ***why*** the point is important and then looks at ***how*** changes may be carried out. This Trainers' Guide, in addition, suggests various follow-up questions to help participants explore each point fully.

When participants return to their own departments or institutions, they use the checklist to assess needs, decide priorities and plan responses.

Checklist Exercise:

Plan for an exercise using the checklist at a health workplace. Ideally, participants will use the checklist directly at their own workplace as part of the course. In case of a course with participants from different facilities, small working groups could visit their respective workplaces or a nearby facility.

Remember, HealthWISE is about action, participation, and learning-by-doing.

II.3 The technical topics

The following topics are covered in the Action Manual, and the Trainers' Guide follows the same structure:

Module 1: Controlling occupational hazards and improving workplace safety

Safety is a high priority, for the sake of staff as well as patients – a hygienic, safe and hazard-free environment is essential to the delivery of quality health services. This module looks at ways of preventing or reducing hazards through implementing an integrated health and safety management system. The next four modules examine specific hazards, both physical and psychosocial, in more detail.

Module 2: Musculoskeletal hazards and ergonomic solutions

This module deals with musculoskeletal disorders – the sorts of injuries which can arise when staff lift weights that are too heavy for them, work in awkward positions, or carry out repeated actions. They are among the most common causes of staff injury and absence. The module helps you plan a set of ergonomic measures that have proved to be effective in a range of settings.

Module 3: Biological hazards and infection control, with special reference to HIV and TB

Biological hazards also represent a fundamental challenge to the health sector and are of great concern to workers. The spread of HIV, and its frequent co-infection, TB, has caused particular difficulties in medical and nursing terms and exposure at the workplace worries health workers in particular. This module deals with the ways of identifying and controlling biological risks across the board, with particular reference to some of the tools available to respond to the risks of HIV and TB at the workplace.

Module 4: Tackling discrimination, harassment and violence at the workplace

The hazards examined in this module are not necessarily recognized as risks to workplace safety, but they are as real as the threat of infection or the danger of fire –and need to be handled as firmly and as effectively. The module looks at three aspects of discrimination and violence: discrimination and violence suffered by staff from patients; by staff from co-workers; and

discrimination and violence suffered by patients from the health workers in whose care they've been placed.

Module 5: Towards a green and healthy workplace

Public awareness about environmental issues has grown over the last few decades, from the effects of carbon emissions and challenges of waste management, to the depletion of fossil fuels and water supplies. This module examines how even a small health facility can make a contribution to the reduction of waste and the sustainability of resources, bringing potential cost savings, as well as environmental benefits with positive effects on the health of workers, patients, and the community.

Module 6: The key role of staff: recruitment, support, management, retention

The health facility is nothing without staff –workers and managers, medical and non-medical. Making sure that you have sufficient numbers of qualified staff presents one set of challenges. Equally important is the need to value, support, inform, train, and motivate them. This module helps your facility improve practice in these areas.

Module 7: Working time and family-friendly measures

The organization of working time is a major responsibility in health facilities, most of which need to operate 24 hours a day. This module helps you develop protocols and procedures that balance the need of the workplace to deliver essential services with the personal responsibilities of workers and their need for vital rest.

Module 8: Selecting, storing and managing equipment and supplies

Ensuring an uninterrupted supply of appropriate and quality materials, tools, and equipment supports timely and efficient service delivery. This module connects the issues of selecting, storing and safe handling of equipment and supplies, and encourages you to plan for them in an integrated manner.

II.4 Planning your course

You may be responsible for one of two types of courses (or possibly both):

- A course for colleagues within your own facility
- A course for staff representing a range of facilities

The basic process of planning the training is the same for both. Answering the questions in the following checklist will help you prepare in a systematic way.

Planning a learning activity

- ✓ What is the principal aim of the activity?
- ✓ Who is it for? Do you know enough about the participants' institution or department, job position, needs?
- ✓ How will you ensure gender balance?
- ✓ What are the specific learning objectives (how will the knowledge, skills, attitudes or behaviour of participants be changed as a result of the activity)?
- ✓ How much time will it take? Will sessions be continuous or spread over several weeks?
- ✓ Where will it take place?
- ✓ What information and materials will need to be prepared in advance?
- ✓ Will you invite external resource persons?
- ✓ What will you ask people to do as a result of it?
- ✓ How will you evaluate whether the aims and objectives have been met?
- ✓ What is the budget? What are the sources of funding?
- ✓ How will you follow it up, in terms of maintaining contact with and among participants (even at distance), providing support, encouraging information-sharing, arranging additional activities?

You might find it helpful to summarize the main points of your plan in a simple table, such as this example:

Target group	Aims of training	Content and methods	Materials, equipment needed	How to evaluate	Follow-up

From training to implementation – the comprehensive HealthWISE approach

HealthWISE is not just a single training course to share knowledge –it goes much further in training participants to take initiative and engage in improvement action.

To introduce HealthWISE successfully as a new tool in a region, community, or facility, it is advisable to plan a cycle of events with time for promotional activities before the actual training course takes place, as well as supportive follow-up events that help the newly trained HealthWISE practitioners in progressing and sustaining their improvement action.

A complete training and action cycle could consist of the following steps:

1. **Stakeholder workshop:** Introduce HealthWISE and adapt to local context.
   Invite decision makers and key stakeholders, including workers and managers from health facilities, representatives of local communities, and any other relevant persons for an information session or a workshop. Present HealthWISE, introduce the methodology, discuss its relevance and benefits for local health facilities. You can also discuss how to adapt HealthWISE materials to the local context.

2. **Select health facilities** interested in implementing HealthWISE. Arrange for a preliminary facility walk-through with managers –this helps convincing them of the benefits and to commit to implementation. Invite participants from those facilities or institutions to the training course who will be future HealthWISE focal points or teams.

3. Conduct the **HealthWISE training;** a full-time training on the complete content may require between 5 and 8 course days. (See sample workshop programme at the end of the introduction). The full training could also be spread over several weeks by focusing in each session on one or two topics. The training course outcome is an action plan developed by participants for improvement action in their workplaces over an agreed period of time.

4. **Follow-up** during the implementation period can take two forms: supportive visits in the health facilities to review progress of implementation of the action plans that were developed during the training; and/or organizing a mid-term **"achievement workshop"** where participants of the training course share their progress on action, discuss challenges and brainstorm on solutions.

5. The **final workshop** aims at the public recognition of achievements after completion of the improvement action, evaluating the HealthWISE outcomes and planning for long-term improvement. It is important to present the results of the HealthWISE process to a broader public; invite leaders of the local communities or other important representatives as guest speakers to acknowledge the achievements, this will also motivate participants to sustain improvement action. Furthermore, it may be a good idead to establish a network among the participants for their continued exchange of experiences.

II.5 Practical tips for HealthWISE trainers

Teaching practices

- ✓ Know the key message you want to convey for each session, and make this clear to participants.
- ✓ Trainers should aim to:
  - emphasize practical ideas rather than general theory;
  - stimulate discussion and an exchange of ideas rather than lecturing;
  - include follow-up and next steps;
  - build on participants' strengths and achievements rather than problems and weaknesses;
  - create a trustful and friendly environment: face the audience, keep eye-contact; welcome questions and comments; thank people for their contributions.
- ✓ Try to build 'signposts' into your presentations to help participants keep track of where they are. Say what you are you are going to do in a session -at the end summarize what you have done. Remind the group what happened in the last session. For example: ''one of the challenges for today will be…; today we're going to focus on [three] key ideas…; the main points made yesterday were… ''
- ✓ Make sure you're well prepared:
  - Be familiar with the issues and anticipate possible questions;
  - Have as many improvement examples as possible, especially from local facilities, to help other people implement changes;
  - Test the equipment in advance and check the supply of materials, chairs, water...

Premises, equipment and visual aids

- ✓ Make sure that the premises are suitable, with space for group work, access to refreshments, and toilets.
- ✓ Make sure the room is set out properly – participants should not sit in rows, but around small tables if possible.
- ✓ Make sure that basic equipment is available, especially flipcharts and/or a blackboard or whiteboard. Use a flipchart or board during brainstorming sessions and group exercises; stick sheets to the wall as reminders or a quick way to report back from groups; have coloured pens, write short statements.
- ✓ Provide participants with a copy of the HealthWISE Action Manual or with copies of the relevant modules that will be covered during the course
- ✓ A data projector or overhead projector is necessary to show PowerPoint presentations or transparencies. If there isn't one available, you could print the slides and distribute to participants; you could give the course also without the slides.
  N.B. To save paper, print 4 or 6 slides on each page. Print out one copy of the slides with speakers' notes for your own use.

A word about PowerPoint presentations: these can kill communication and learning unless used carefully. Their main advantage is to clarify issues and focus on key messages – they should support the presentation but not repeat everything you say. Similarly, you shouldn't feel obliged to read every slide out loud – the audience can read for themselves! Rather you should pick out key points and develop them, ask questions, make sure the information is understood.

Note:
The PowerPoint presentations that accompany this Guide need to be adapted to the specific course objectives and local context. Some slides contain much text – this has been done so you can better understand the points made when you prepare for the training; it is recommended to shorten the text or reduce the number of slides; adjust the presentations to the course, the participants, and also to your facilitation style.

Learning activities

Learning activities are necessary to assist active learning. They usually involve a game, role play, demonstration, drafting exercise or group discussion.

Using the case studies

The case studies in the Action Manual and Trainers' Guide can be discussed as examples of good practice. They can be even more useful if you stop after the description of the problem or situation and cover the section describing what the institution's actions were. Invite participants to look carefully at the facts, suggest priorities and propose solutions. Then you can reveal what course of action was taken in practice, and compare it with the group's suggestions. Case studies can also be used in small group work.

Using group work

Small groups of participants can be given a variety of questions and tasks. Make sure these are clear: written instructions are easiest to follow. Have them appoint a moderator and reporter and set a time limit. Tasks could include discussion, a drafting exercise, the study of a law or policy, designing a poster or leaflet, etc. Groups then report back to the others using whatever supports are available. Try to have wall space to display the flipchart sheets so everyone can go and read them – a useful option if you don't have time for oral reports from each group.

Don't join the groups -you can help them, but don't interfere too much. After the reports, encourage general discussion –wrap up by pulling out the main points from the reports. Recommendations or action points may emerge from the groups -explain what follow-up is possible.

Using role play

A role play requires a small group to act out a situation or scenario. It is effective when recreating a group situation, such as a committee meeting or a negotiation. Prepare written notes explaining the objectives, setting the background, and providing a brief for each 'character'. The group selects who will play the different roles. Make sure the scenario isn't too complex and that it has the flexibility to involve different numbers of 'actors'. At the end, participants come out of their role and comment on the process. Each group then reports back to the plenary on what they learnt from the situation.

A sample workshop programme covering all modules
HealthWISE Training

DAY 1	**Opening ceremony and introduction to HealthWISE**	
	Morning	■ Opening ceremony ■ Introduction to HealthWISE Methodology ■ Introduction to the Checklist exercise
	Afternoon	■ Checklist exercise: Visit to a health-care facility, walk through selected units using checklist and taking pictures of good practices and opportunities for improvement ■ Group discussion and presentation to plenary ■ Plenary discussion and feedback from checklist exercise
DAY 2 -5	**Technical Topics (2 per day), incl. adapting modules to the local context**	
DAY 2	Morning	Module 1
	Afternoon	Module 2
DAY 3	Morning	Module 3
	Afternoon	Module 4
DAY 4	Morning	Module 5
	Afternoon	Module 6
DAY 5	Morning	Module 7
	Afternoon	Module 8
DAY 6	**Action planning and implementation**	
	Morning	Develop Action Plans;
	Afternoon	Follow-up planning: monitoring visits, knowledge-sharing workshop.
DAY 7	**Planning for final workshop and Training Evaluation**	
	Morning	■ Planning for final workshop ■ Sustaining improvement action ■ Participant feedback on training course ■ Closing Ceremony ■ Departure of participants

III. COURSE CONTENT: SESSIONS

There are eleven sessions if you are covering the complete Action Manual: one for each of the eight modules, an introductory session at the beginning, followed by a session on how to use the checklist, and a final session on planning.

Each session is supported by a PowerPoint presentation, case studies and factsheets to hand out. There are also notes for trainers on a number of slides, but these are for guidance only. The course will be most effective if you take ownership of it and use the elements in the ways you know will work best.

We won't repeat all the information given in the Action Manual; however, we expect you to use the introduction to the Module as your introduction to the session, and then draw on the information provided for each checkpoint. The group should have at least one copy of the manual to refer to at all times and preferably a copy for each participant as it will constantly be referenced. In case you are training HealthWISE practitioners, make sure that each participant receives a copy of the Action Manual for their work after the course.

The Trainers' Guide includes some additional material, including research findings, longer case studies and factsheets – the factsheets in particular are designed as handouts. Have them ready printed before the session and use them **either** for information and discussion (in plenary or small groups) during the session **or** for extra reading afterwards.

We don't set out fixed times for each session because we know that circumstances will vary considerably; however, you're unlikely to be able to cover a module in less than half a day – even that will be rushed and you'll have to leave out some learning activities.

The learning objectives of sessions 1 and 2 are presented at the beginning of these two sessions.

The learning objectives of sessions 3 to 11 are presented on page 24.

Session 1:

Introduction and overview of the course and manual

Learning objective:
By the end of the session, participants will understand the purpose of the course, what the sessions will cover and the learning approach of the course.

You will have your own ways of managing introductions and ice breaking at the start of a course. After the introductions, draw participants 'attention to the course title: the focus is on improving working practices and working conditions. Ask them to say what they understand by this, what they think might be included, and what their expectations are.

Stress the fact that the course and its key materials – especially the Action Manual – are practical tools for use by health practitioners. The experience of those practitioners present is also a key resource, and the facilitator (you!) will draw on their knowledge, ideas, and experience.

This means guiding the group towards their own answers and solutions, not simply giving them lists of things to do. Reassure them that the manual is meant to be used and adapted according the needs and resources of their own institution or department. One size never fits all.

Introduction

Don't spend too long on the background – the main point is that the WISE methodology is tried and tested in many different settings, and easy to grasp as well as adapt.

You will need to add a slide or verbally inform the group about the timetable of the course, depending on whether you're covering the modules selected in one workshop or splitting them over several weeks.

Next, show which modules the course as a whole will cover – the selection will already have been made in consultation with the institution(s) involved (see point 2. in the box on a comprehensive approach to HealthWISE training, page 10). If not all modules are included, ask them to look at the Action Manual to see what other modules are available.

The introduction then covers some basic ideas and approaches that will be useful for all the modules. These are:

- An integrated approach to planning – what does it mean?
- Introducing HealthWISE at your workplace
- Steps for introducing and implementing policy – **Distribute Factsheet 1: Drafting, agreeing and implementing a workplace policy or agreement**

Factsheet 1

Drafting, agreeing and implementing a workplace policy or agreement

A number of the modules suggest developing a policy for a given area, as a way of guiding and monitoring action, for example occupational safety and health, maternity protection or discrimination.

A workplace policy or collective bargaining agreement:

- provides a statement of commitment and a framework for action;
- lays down a standard of behaviour and gives guidance to supervisors and managers;
- helps employees understand their rights and responsibilities.

This approach may not be the norm in your country, for example:

- Policy may be developed at national or sectoral levels, not in individual workplaces.
- The workplace may establish rules or protocols to guide its practice, rather than policies.

The guidance offered below may not therefore be fully relevant, but we still advise you to consider the impact of a policy statement or expression of commitment to take action in a given area, however brief this may be.

Form of the policy

A policy should be developed through employer-worker collaboration. It may be very brief, such as a short statement of commitment, for example "This is a smoke-free environment"; or "In this health facility there is zero tolerance for violence perpetrated against staff, patients, visitors or other persons".

It may be a detailed policy or agreement specifically on one issue, for example HIV and AIDS, or part of a broader policy or agreement that already exists.

Example:

I. General statement

The policy begins with a general statement or introduction that relates the issue to the needs of the facility and existing laws/policies.

II. Policy framework and general principles

The policy establishes some general principles as the basis for other provisions, emphasizing the need to take action.

III. Specific provisions

The policy includes clauses on specific aspects of the issue.

IV. Implementation and monitoring

Steps are set out for putting the policy into practice, in particular establishing structures and appointing responsible persons.

Steps for developing workplace policies

The process of developing a workplace policy includes the following steps:

1. Agree on the issue that needs to be addressed.
2. Prepare a work plan. This process must include the participation and support of management, frontline workers and labour representatives.
3. Gather information and determine the needs of staff and management.
4. Check national laws and relevant regulations or protocols.
5. Write up the policy.
6. Consult all relevant stakeholders on the policy and revise accordingly.
7. Obtain approval of the policy.
8. Disseminate the policy and ensure staff awareness.
9. Draw up an implementation plan with a clear time frame and staff assigned clear roles.
10. Monitor periodically to check if it is necessary to amend or extend the policy.

Session 2:
Using the HealthWISE checklist

Learning objectives:

By the end of the session, participants will

- understand the purpose and use of the HealthWISE checklist;
- have practiced the use of the Checklist in a health facility.

Here you explain the use of the HealthWISE Checklist and prepare for the checklist exercise.

The Checklist is meant to be used as a tool for an initial workplace assessment. It provides a starting point for:

- Identifying good practices and areas where improvements can be made.
- The planning and monitoring of improvements.

Underscore that the Checklist is intended to aid planning, not to judge or criticize a health-care facility.

Point out that the questions in the Checklist correspond to the checkpoints of each module in the Action Manual. The four or five checkpoints of each module are a powerful tool for identifying improvements to be made in that area. They give ideas for action, not simply areas to check for possible problems. Many of the ideas are simple and easy to apply.

Make it clear that the Checklist is a tool that can be used by anyone who is committed to identifying issues for improvement and introducing change, ideally a joint management-worker team such as the OSH committee or HealthWISE team. Nevertheless management approval is normally required before staff can recommend or introduce improvements.

Reiterate that the Checklist brings together the specific checkpoints for the eight topics covered in the Action Manual. Each module discusses every checkpoint in turn and covers WHY it is a useful or important point/ issue and HOW to deal with it. Tell participants that it's up to them to decide whether action is needed or not in their particular facility, whether it's a priority and, finally, to plan action if needed.

The checkpoints may require participants to simply observe working conditions –for example the height of lab benches or the accessibility of a defibrillator– or they may need more detailed discussion with relevant staff. They should reassure staff that they are not being judged. On the contrary, their views and knowledge will be invaluable in identifying issues, gaps, and opportunities.

Hand out the HealthWISE Checklist and allow time for participants to read it and ask questions. Reassure participants that at this stage the checklist serves to provide an overview: they will better understand the purpose of the list and the checkpoints when they start using it during the following checklist exercise.

CHECKLIST EXERCISE

Objective: Learning how to use the checklist at a health workplace.

Duration: between 90 minutes and 4 hours

Immediately after the introduction to HealthWISE, initiate the checklist exercise

The Checklist Exercise is planned as the first training activity for several reasons:

- to emphasize the practical, action-oriented activities of the course;
- to show the trainers' respect for the participants' knowledge and experience;
- to assemble a pool of examples which will be discussed in the following activities;
- to initiate group work and the participants' involvement.

Careful arrangements are to be made for the health facility visit in order to conduct an effective Checklist Exercise, including prior authorization of the management and arranging for transport for participants to and from the facility.

Practical Hints for Conducting the Checklist Exercise

- After a brief introduction and interview of the manager, participants walk through selected units and apply the checklist while observing the workplace.
- Questions on how to apply the checklist are very relevant.
- Divided into groups they discuss results and present their views on good practice examples and priority actions for improvement.
- Participants are encouraged to take initiative and identify applicable solutions. DO NOT give detailed explanations or guide participants regarding which technical solutions should be given priority. Trainers should allow the participants to form their own judgements.

Adapted from WISE – Work Improvement in small enterprises: Package for Trainers. Bangkok: ILO, 2004.

HealthWISE Checklist

This checklist is the first step in the **HealthWISE** process; it is a workplace assessment tool for identifying and prioritizing areas of action for improvement, and is designed to be filled out while performing a walk-through of the health facility.

It is best to engage people who perform different types of functions in the health facility; for example, workers and managers can complete the assessment list in small groups or separately, and then discuss the responses as a group. This participatory approach will provide a variety of perspectives and a more comprehensive basis for analysing possible solutions.

Using this checklist first will give you an overview of areas where you can propose to take action and help you determine what to prioritise. These priorities guide you in planning for improvements.

Preparations:

- Make enough photocopies of the assessment list so that everyone/every group can complete the forms separately. Read the checklist questions before you start the assessment.
- Ensure availability of cameras to take pictures of examples of good practices and issues of concern; the aim is to take another picture after improvement action has been implemented. These before-after-photos are powerful tools to visualize achievements – it motivates and encourages everybody to keep going and convinces decision makers or sponsors to provide support. Pictures of good practices can be used as examples for other units to inspire their solutions.

How to use the checklist:

1. Define the issues or workplace area to be assessed.
   In the case of a small health facility, the whole workplace can be assessed. In the case of a larger health facility, particular work areas can be defined for separate assessments.
2. Read through the checklist and take time walking around the work area, take photographs and /or detailed notes of issues that are a cause for concern or which could be good practice models. Ask staff of the unit when you need more information from their experiences.
3. Consider each question carefully;
   Tick "YES" or "NO", according to your observations and information.
4. ***Ticking YES** means the condition or measure described in that question exists at the work place. However, one could still consider actions for improvements.*
   ***Ticking NO** means the condition or measure mentioned in the question is not available at the workplace. In that case, ACTIONS ARE NEEDED to ensure they are implemented.*
5. Write your ideas and suggestions for actions and improvement under
   WHAT ACTIONS DO YOU PROPOSE? Suggestions
   Tick the ***PRIORITY*** box for actions that you consider to be a high priority and for which you have ideas for feasible solutions.
6. Once the forms have been completed, note all the points on the checklist where you ticked the ***PRIORITY*** box; agree on an order of priority, and then identify the necessary measures.
7. Discuss and develop an action plan: start with the most feasible changes and set achievable goals. Agree on a time table and assign responsibilities. Build the changes into existing structures and procedures as far as possible.

HealthWISE Checklist

Assessment information	
Name of institution	.....
Unit / work area assessed	.....
Name of the assessor / team	.....
Date of assessment	.....

Module 1

Controlling occupational hazards and improving workplace safety

1.1	Are regular procedures applied to identify and assess workplace hazards (including physical, chemical, biological, ergonomic and psychosocial hazards)?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
1.2	Are there measures in place for hazard control and workplace safety?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
1.3	Is the reporting of incidents and disclosure of illness encouraged through a "no-blame" culture?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
1.4	Is there an occupational health and safety system implemented at the workplace, including hazard prevention and control as well as the provision of occupational health services?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 2

Musculoskeletal hazards and ergonomic solutions

2.1	Is there regular assessment to identify and prevent ergonomic hazards that arise from the lifting and transfer of patients or equipment?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
2.2	Are equipment and work practices suitable to reduce heavy lifting, pushing and pulling?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
2.3	Are work spaces designed to reduce strain, repetitive movements, and poor posture?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
2.4	Is there awareness raising and staff training on good ergonomic practice (e.g. skill practice with lifting equipment)?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 3

Bilogical hazards and infection control, with special reference to HIV and TB

3.1	Is there a routine to identify and assess biological hazards at the workplace?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
3.2	Are measures taken to prevent and control blood-borne hazards such as HIV and hepatitis?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
3.3	Are health workers, patients and visitors protected from exposure to air-borne hazards such as TB?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
3.4	Is a comprehensive workplace HIV and TB prevention and care programme implemented?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 4

Tackling discrimination, harassment and violence at the workplace

4.1	Is action taken to protect staff from violence?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
4.2	Are specific measures taken to address stigma and discrimination?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
4.3	Is there awareness raising and training about violence in the health workplace?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
4.4	Is the institution committed to a fair and respectful workplace?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 5

Towards a green and healthy workplace

5.1	Are there measures in place to identify, assess and reduce environmental health hazards?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
5.2	Is water conservation practiced?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
5.3	Are there measures to assess and improve energy efficiency?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
5.4	Does this health-care organization have a green strategy?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 6

The key role of staff: recruitment, support, management, and retention

6.1	Is a long term plan for staffing needs in place, with clear job descriptions?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
6.2	Are facilities for staff available for washing, changing clothes, resting, and eating?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
6.3	Are there non-monetary benefits and in-service training in place?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
6.4	Are communication, teamwork, and supportive supervision promoted?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
6.5	Are contract practices, grievance procedures, and disciplinary measures in place and are they transparent and fairly applied?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 7
Working time and family-friendly measures

7.1	Is working time scheduled in a way to reduce long hours and minimize irregular shifts?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
7.2	Do the staff get enough rest during work and between shifts and is overtime kept to a minimum?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
7.3	Are flexible working time and leave arrangements implemented?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
7.4	Are family, home, and social responsibilities of staff taken into account when planning work schedules?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
7.5	Are maternity protection and parental leave provided, including arrangements for breast-feeding?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Module 8

Selecting, storing and managing equipment and supplies

8.1	Are there written plans for equipment and supply needs for all units?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
8.2	Is the appropriate equipment selected for its safety as well as affordability and availability?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
8.3	Is there secure, safe, and clearly-labelled storage space for all items?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
8.4	Is there a system for stock-taking and maintenance in place, including hazard control?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority
8.5	Are staff trained on the safe use and maintenance of equipment, especially new products or models?	→	☐ Yes ☐ No
	What action do you propose? Suggestions:		☐ Priority

Learning objectives of sessions 3 – 11 on the technical topics:

- Participants understand the issues addressed in modules 1-8.
- They are able to identify good practice and areas for improvements based on their experiences in their workplaces, or following the checklist exercise.
- They know how to identify priorities and take planned action.

Session 3:

Module 1 – Controlling occupational hazards and improving workplace safety

Objectives (Slide 2):

- To identify and assess workplace hazards.
- To develop a system for prevention and control.

Why is it an issue (Slide 3)?

- Quality care is best provided where staff work in a safe and secure environment.
- Preventing incidents means protecting the well-being of patients, visitors and staff, maintaining productivity, and avoiding direct and indirect costs.
- Stress the fact that the health sector is a high-risk environment (see the examples in Module 1 of the Action Manual – one is reproduced below):

In Canada – out of 34 occupational categories – more days were lost among nurses than any other category but one; while in Ireland illness rates in the health sector were second only to agricultural workers.

Ask participants what direct and indirect costs they can identify.

Checkpoints (Slide 4)

1.1	Identify and assess workplace hazards
1.2	Put in place measures to control hazards and improve safety
1.3	Promote a 'no blame' culture which supports the reporting of incidents and disclosure of illness
1.4	Develop a system for workplace safety and the prevention and management of hazards

From here on, the session and slides deal with each checkpoint in turn, first asking 'why' action is necessary, and then 'how' it can be carried out. What follows are some suggestions for starter questions for each checkpoint to help you get the ball rolling. There are also questions in the speakers' notes for some slides. Alternatively –depending on the group and your timeframe- you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction -participants will need to consult widely at their facilities.

1.1 Identify and assess workplace hazards (Slides 5–8)

Questions:

Are hazards identified in a regular and systematic way? Is adequate information available about the full range of hazards, from chemicals to stress? What reporting procedures are in place? Are these followed? Once a hazard is identified, is the severity assessed? By whom? Is action always taken? By whom?

Before you show Slide 7 – hazard category and definition – ask the group for categories, examples, and effects of hazards (**see the first three columns of Factsheet 1.1**).

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

1.2 Put in place measures to control hazards and improve safety (Slides 9–22)

Questions:

Are the different types of control measures known and understood? Is the hierarchy of controls known and understood? Are resources –human, technical and financial – available to deal with hazards and improve safety? What partnerships and assistance are available to support OSH efforts?

Before you show Slide 11, hand out **Factsheet 1.2** on types of control measures, **Factsheet 1.3** on personal protective equipment (gloves), and **Factsheet 1.4** on safe disposal of sharps.

A role play suggestion is also provided (Slide 29) if you have time.

Conclusion:

Action is necessary: yes/no

It's a priority: yes/no

1.3 Promote a 'no blame' culture which supports the reporting of incidents and disclosure of illness (Slides 23–24)

Questions:

What is the procedure for reporting incidents? Do staff report incidents, even where they may be responsible, without fear of consequences? What measures exist to assist staff or patients who are exposed to risk or who suffer an incident? What measures exist to improve staff practice, where necessary? How does the institutional culture regard psychosocial hazards and disorders?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

1.4 Develop a system for workplace safety and the prevention and management of hazards (Slides 25–29)

Questions:

Does the facility have an occupational safety and health policy? If so, does it cover all units and departments? Does it cover all risks and hazards, physical and psychosocial? Are clear these measures in place, with responsible staff, and are measures followed? Is prevention given the highest priority?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

At the end of the session hand out **Factsheet 1.1** which provides **a summary of hazards and measures for prevention and control.** Allow time for participants to read it and ask questions for clarification. Finally, hand out **Factsheet 1.5 Department of Labour (South Africa) checklist for health and safety in workplaces** for them to take away, read and perhaps adapt for their own use. Give out the Glossary (at the end of the Guide) if you think it's necessary, for example if participants have no copy of the Action Manual at hand.

Factsheet 1.1

Summary of hazards and measures for prevention and control

Hazard category and definition	Examples found in health workplace	Health effects	Protective measures/ controls
Physical Agents or forms of energy that can harm the body if exposed.	Radiation, lasers, loud noise, extreme temperatures, electrical faults, fire, uneven floor, unsafe stairways and workplace violence.	Eye and skin burns, bruises, wounds, hearing loss, cancer, physical and psychological trauma.	*Administrative controls:* policy, instructions and training, medical check-ups. *Engineering controls:* regulation of temperature, ventilation, isolating wires *PPE:* protective shields and clothes
Chemical Various forms of chemicals that are potentially toxic or irritating to the body system, including medications, solutions, and gases.	Disinfectants, cleaning products and sterilants such as ethylene oxide, formaldehyde, and glutaraldehyde; waste anaesthetic gases; hazardous drugs such as cytotoxic agents, pentamidine, ribavirin. Chlorine-based products used in disinfectants, water purification; ethylene oxide in sterilizing; mercury in blood pressure devices and thermometers.	Eye and skin irritation, asthma, allergy, dermatitis, peripheral neuropathy, liver failure, cancer, spontaneous abortion and other reproductive effects.	*Elimination* of unncecesary chemicals (eg. It is not recommended to soak sharps in chlorine that will be incinerated) *Substitution* for less toxic chemcials that are equally effective. *Engineering controls:* closed systems, ventilation, substitutes for toxic chemicals. *Administrative controls:* policy, instructions and training, medical check-ups, hand hygiene. *Work practice controls:* pouring cleaning agents onto a surface or cloth instead of spraying. *Environmental:* cleaning chemical spills, waste management. *PPE:* gloves, eye protection, respiratory protection.
Biological Infectious/ contagious agents, such as bacteria, viruses, fungi, or parasites, which may be transmitted by contact with infected patients, contaminated body secretions/fluids, needlestick injuries; also by mildew, insects, vermin, animals.	Human immunodeficiency virus (HIV), Severe Acute Respiratory Syndrome (SARS), influenza, Vancomycin-Resistant Enterococcus (VRE), Methicillin-Resistant Staphylococcus Aureus (MRSA), hepatitis B virus, hepatitis C virus, tuberculosis.	HIV and AIDS, tuberculosis, hepatitis, liver cancer, and other diseases.	*Administrative controls:* written policy (standard precautions), worker education and training, hand hygiene, safe sharps disposal, reduced use of injections. *Engineering controls:* safe injection devices, needleless systems. *Environmental:* waste management, disinfection, cleaning up spills. *PPE*: gloves, mask, eye protection.
Ergonomic (mechanical/ biomechanical) Factors in the work environment that cause or lead to accidents musculoskeletal, injuries, strain, or discomfort.	Lifting and moving patients, tripping/ slipping hazards, unsafe/ unguarded equipment, confined spaces, cluttered or obstructed work areas/ passageways, forceful exertion, awkward postures, localized contact stresses, vibration, repetitive/ prolonged motions or activities.	Musculoskeletal disorders, back and upper extremity injuries, repetitive strain injury.	*Administrative controls:* risk assessment and measures to reduce manual lifting, improve work stations, training. *Engineering controls*: lifting devices, slide boards. *Environmental:* clear passage ways, eliminate slippery floor surfaces.

Factsheet 1.2

Types of control measures for occupational hazards

Standard precautions	Engineering controls	Administrative and work practice controls	Environmental controls	PPE and personal risk reduction strategies
■ Hand washing and antisepsis ■ Use of personal protective equipment (gloves, gowns, etc.) ■ Appropriate handling of equipment and linen ■ Prevention of sharps injuries ■ Environmental cleaning and spills management ■ Appropriate handling of waste	■ Safer needles such as resheathing or retractable sharps ■ Needleless IV systems ■ Closed system transfer devices for hazardous drugs ■ Mechanical lifting devices, slide boards ■ Laminar flow or aseptic containment isolators for hazardous drugs	■ Work practices such as no recapping of needles and no single-person manual lifts ■ Management policies to ensure an integrated OSH system ■ Isolating patients with communicable diseases ■ Measures to protect vulnerable patients and health workers ■ Information, instructions, and training for staff ■ Medical surveillance programmes ■ Maintenance of equipment and ventilations systems	■ Clean up spills ■ Waste management ■ Airborne particle sampling ■ Disinfection of surfaces and equipment ■ Damp dusting and other measures for dust control ■ Don't eat in workplaces ■ Clear passage ways and ensure non-slip floors	■ Respiratory protection ■ Gloves ■ Gowns ■ Eye and face protection ■ Sleeve, hair and shoe covers ■ Disposal of personal protective equipment worn ■ Immunization of health workers against hepatitis B, influenza and other vaccine-preventable diseases

Factsheet 1.3

Personal protective equipment, glove use when handling hazardous materials

- Use gloves that provide a chemical barrier. Nitrile gloves are recommended for use with chemotherapeutic agents and are more resistant to chemicals than latex.
- Double gloving is recommended because all gloves are permeable to some extent, and their permeability increases with time.
- When double gloving, one glove should be placed under the gown cuff and one over. The glove-gown interface should be such that no skin on the arm or wrist is exposed.
- To limit transfer of contamination from the Biological Safety Cabin (BSC) into the work area, the outer gloves should be removed after each task or batch, and should be placed in ''zipper'' -closure plastic bags or other sealable containers for disposal.
- Gloves should be changed regularly (hourly) or immediately if they are torn, punctured, or contaminated with a spill.
- Thicker, longer, latex gloves that cover the gown cuff are recommended with minimal or no powder since the powder may absorb the latex protein and aerosolize the allergenic particles.
- The worker should wear a protective disposable gown made of lint-free, low-permeability fabric, with a solid front, long sleeves and tight-fitting elastic or knit cuffs.
- Hand washing: hands should be washed and dried before gloves are put on, and after they are removed.

Factsheet 1.4

Sharps waste management: improvising sharps containers/disposal boxes

In case there is a lack of sharps disposal containers in your facility, a number of low-cost, easy solutions can be put in place.

You can find many containers in your health facility which can be improvised as sharps boxes as long as they are both puncture-proof and liquid-proof in order to insure safe disposal of needles.

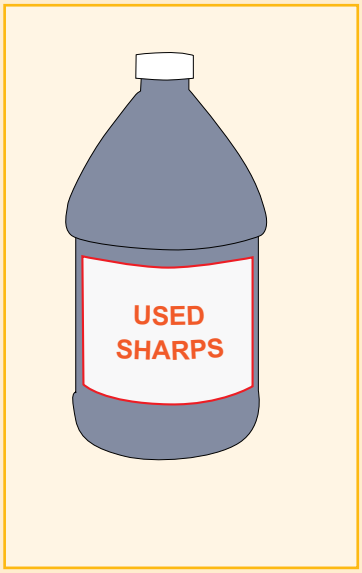
It is important to always label your sharps disposal containers: "used sharps" so that their content is clear to the users and risk of puncture is kept to a minimum.

Examples of improvised sharps containers could be:

- a plastic water bottle;
- a liquid soap or detergent container;
- a container for dialysis liquid or any other plastic container used to carry fluids for analysis in the laboratory;
- a cardboard box, provided a plastic bag is put inside to ensure it is liquid-proof. The box and the plastic bag should not be disposed of separately but as one unit.

1) Plastic water bottle

2) Liquid soap/detergent



3) Container for dialysis liquidcontainer

4) Cardboard box

Factsheet 1.5

Department of labour checklist for health and safety in the workplace

Inspections by the Department of Labour

Inspectors of the Department of Labour will be visiting workplaces to check the level of compliance with labour legislation. The following are some of the aspects the inspectors will be checking.

QUESTION	YES	NO
1. Are you registered with the Compensation Fund?		
2. Are you registered with the Unemployment Insurance Fund?		
3. Do you have a copy of the Occupational Health and Safety Act and the relevant Regulations on the premises and is the Act and the Regulations available to the workers if they want to read it?		
4. Do you display the Summary of the Basic Conditions of Employment Act?		
5. Do you display the Summary of the Employment Equity Act?		
6. Have you appointed Health and Safety Representatives?		
7. Have you established Health and Safety Committees in your workplace?		
8. Are you and your workers trained to recognise health and safety problems?		
• Are moving parts like drive belts and chains guarded?		
• Are chemicals used safely and stored in a safe place?		
• Are emergency exits clearly marked and easily accessible?		
• Are fire extinguishers accessible and serviced regularly?		
• Are flammable material stored and used correctly, for instance not near fires?		
9. Do you have fully equipped first aid boxes on the premises?		
10. Are all electrical wires insulated and proper plugs used in your workplace?		
11. Do you report injuries at work to the Department of Labour?		
12. Do you have clean and hygienic toilets and washing facilities provided for males and females?		
13. Do you have an attendance register at your workplace?		

It is the employer's duty to provide a safe and healthy workplace. If you answered NO to any of the above, you have to rectify immediately. **Failure to comply with the above constitutes a criminal offense.** Workers should report unsafe or unhealthy conditions to their employer and/or the health and safety representative.

Please assist the inspectors of our Department when they visit your workplace.

Provincial Offices of the Department of Labour

Eastern Cape	Tel: (043) 701 3000	Limpopo	Tel: (015) 290 1744
Free State	Tel: (051) 505 6200	Mpumalanga	Tel: (013) 655 8700
Gauteng North	Tel: (012) 309 5000	North West	Tel: (018) 387 1600
Gauteng South	Tel: (011) 497 3000	Northern Cape	Tel: (053) 838 1500
KwaZulu-Natal	Tel: (031) 336 1500	Western Cape	Tel: (021) 460 5911

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Department:
Labour
REPUBLIC OF SOUTH AFRICA

Session 4:

Module 2 – Musculoskeletal hazards and ergonomic solutions

Objectives (Slide 2):

- To raise awareness about the range of ergonomic risks to health workers;
- To highlight the importance of preventing and controlling such risks; and
- To provide practical guidance.

Why is ergonomics an issue? (Slide 3)

- Musculoskeletal hazards are the ones most likely to affect health workers and back injury may be the single largest contributor to the shortage of nurses.
- Safe patient handling is a priority responsibility for health institutions. Ergonomic approaches can be used to improve work processes and work station design.

Hand out **Factsheet 2.1 on terminology** and **Factsheet 2.2 on back injuries**. Read the introduction to Module 2 in the Action Manual, and give participants time to look at the data. Ask how their own experience compares with the findings from Nigeria, the UK or the USA.

Checkpoints (Slide 4)

2.1	Identify, assess and prevent ergonomic hazards
2.2	Adjust work to reduce heavy lifting, pushing and pulling
2.3	Adjust work to reduce strain, repetitive movements and poor posture
2.4	Raise awareness of staff about ergonomics and help them improve their practice

From here on, the session and the respective slides deal with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. Alternatively – depending on the group and your timeframe – you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction – participants will need to consult widely at their facilities.

2.1 Identify, assess and prevent ergonomic hazards (Slides 7–9)

Questions:

Do you know the scale of musculoskeletal disorders (MSDs) among staff? What monitoring system is in place? Can you identify any of the risk factors listed at your own workplace? Have you analysed the causes? It can be useful to note the units which report fewest MSDs and see what you can learn from them -take into account factors such as work organization and the role played by individuals. How are ergonomic hazards dealt with? Are they covered by a general OSH policy? If so, is this adequate to ensure preventative action?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

2.2 Adjust work to reduce heavy lifting, pushing and pulling (Slides 10–14)

These are the actions which cause most back injuries so they need close examination.

Note that 'work' is used in a broad sense to cover work organization (including numbers of staff), working practices and work stations (including equipment).

Questions:

Do you know the scale of specific back injuries among staff, and how these relate to MSDs in general? What steps have been taken to eliminate or reduce heavy lifting, pushing and pulling? Does your OSH policy specifically cover these actions? Have there been consultations with staff to solicit their ideas for improvements? Can you point to a good practice in reducing such injuries?

Give out **Factsheet 2.3**. Ask how the US findings compare to their own experience.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

2.3 Adjust work to reduce strain, repetitive movements and poor posture (Slides 15–18)

Questions:

Do you know the scale of MSDs not related to back injuries? Have you assessed hazards of this type? Are measures in place to reduce such hazards? Have there been consultations with staff to solicit their ideas for improvements? Can you point to good practices in reducing such injuries?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

2.4 Raise awareness of staff about ergonomics and help them improve their practice (Slides 19–21)

Successful action combines technical solutions with staff awareness and training.

Questions:

Is there a staff training plan specifically related to MSDs and good ergonomic practices? If not, are ergonomics included in general in-service training? In training for new staff? What are the main elements of the training, whether specialized or not? What other awareness-raising measures are used?

Hand out **Factsheet 2.4**, Top ten ergonomic principles, at the end of the session. Allow time for reading and discussion, if possible.

Factsheet 2.1
Definitions

Musculoskeletal disorders are health problems of the locomotor apparatus, that is, the muscles, tendons, skeleton, ligaments, and nerves. They range from light transitory disorders to irreversible disabling injuries. Parts of the body affected include the upper extremities (arms, hands, wrists, fingers); neck and shoulders; back and lower extremities. Different types of work affect different parts of the body in different ways; for example, disorders in the lower back are often caused by lifting and carrying loads or by exposure to vibration. Upper-limb disorders may result from repetitive or long-lasting static force exertion (e.g. lifting).

Ergonomics looks at the kind of work people do, the tools they use and the whole work environment. The aim is to find the best fit between workers and their job conditions so that they are safe, comfortable, and less prone to musculoskeletal disorders and injuries. This is achieved by designing tasks, work spaces, tools and equipment to fit the employee´s physical capabilities and limitations, supported by related training.

Factsheet 2.2

Data on back injuries among health workers, US and UK

- Direct and indirect costs associated with back injuries in the US health-care industry are estimated to be $20 billion annually.
- Nursing aides and orderlies suffer the highest prevalence (18.8 per cent) and report the most annual cases (269,000) of work-related back pain among female workers in the United States.
- In 2000, 10,983 registered nurses (RNs) suffered lost-time work injuries due to lifting patients.
- 12 per cent of nurses report that they left the nursing profession because of back pain (NIOSH).

The National Institute for Occupational Safety and Health (NIOSH) at http://www.cdc.gov/niosh/ and A Compendium of NIOSH Economic Research 2002–3 at http://www.cdc.gov/niosh/docs/2005-112/pdfs/2005-112.pdf

In the British National Health Service, sickness absence due to musculoskeletal disorders (MSDs) accounts for around 40 per cent of all such absences. Public sector union UNISON estimated in 2003 that around 3,600 nurses were forced to retire every year due to back injuries. Total days lost to sickness include non-working days if they fall within a reported absence period. Considering sickness absence rates in 2011–12, the UK Health and Social Care Information Centre (HSCIC) found that qualified ambulance workers recorded the highest rate of any main staff group at 6.18 per cent (405,000 days) and also the highest rate in the previous two years (6.18 per cent or 401,000 days in 2010/11 and 6.38 per cent or 404,000 days in 2009/10).

UNISON Health and Safety Organiser (http://www.unison.org.uk/acrobat/B868.pdf) and Health & Safety Information Sheet, Back Pain – Musculoskeletal Disorders (October 2010) http://www.unison.org.uk/safety/pages_view.asp?did=15123

HSCIC report, July 2012: see http://www.hscic.gov.uk/article/2421/Sickness-absence-rate-among-NHS-workers-falls-to-412-per-cent

Factsheet 2.3

Comparative research into ergonomic solutions, USA
Preventing patient lift and transfer injuries to health-care workers

A randomized controlled trial was conducted to compare the effectiveness of training and equipment to reduce musculoskeletal injuries, increase comfort, and reduce physical demands on staff at a large acute care hospital in the USA.

It compared two approaches to patient lifting, though in both cases staff received intensive training in back care, patient assessment, and handling techniques. The main difference was that one group –the one testing the 'safe lifting' approach– applied improved patient handling techniques using manual equipment only. The 'no strenuous lifting' group aimed to eliminate manual patient handling through the use of additional mechanical and other assistive equipment.

The results showed improvements for both groups in terms of fatigue, back and shoulder pain, and physical discomfort; however, staff using the mechanical equipment showed greater improvements. The study therefore concluded that the 'no strenuous lifting' approach, which combined training with availability of mechanical and other assistive patient handling equipment, most effectively improved comfort and safety in patient handling, decreased staff fatigue, and decreased physical demands.

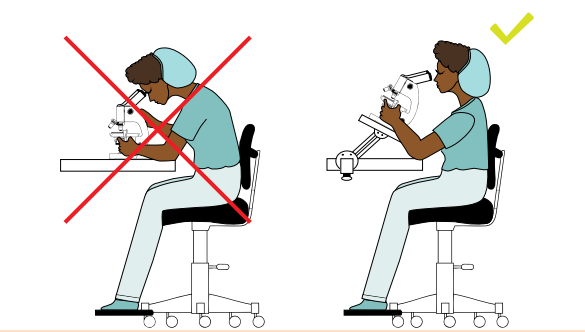
*Yassi, A. et al, A Randomized Controlled Trial to Prevent Patient Lift and Transfer Injuries of Health Care Workers, in **Spine**, 15 August 2001, Volume 26, Issue 16, pp. 1739–1746.*

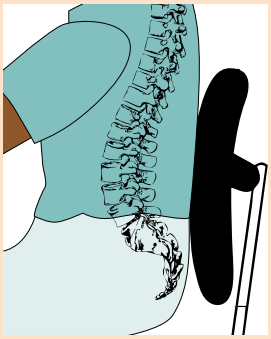
Factsheet 2.4

Top ten ergonomic principles

1. **Work in neutral positions**, that is with your back in an 'S' curve, neck straight, shoulders relaxed, elbows at sides, wrists in neutral positions.

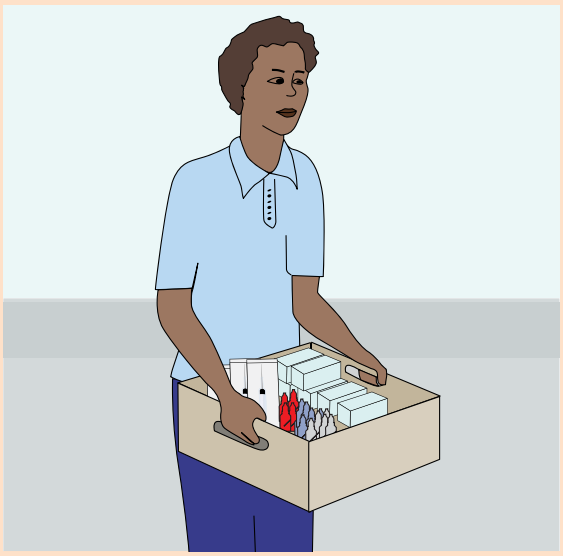
See examples in the illustrations below:





2. **Reduce excessive force**

Minimize the need for over-exertion, for example by breaking large loads into smaller ones, adding handholds or grips to packages and containers (see illustration below), and holding heavier objects close to the body. Provide some storage near work stations to reduce the need to carry materials.



3. **Keep everything within easy reach**

Reduce the size of the work area if reaching tools, equipment or supplies involves straining, twisting or bending.

4. **Work at proper heights**

Adjust the height of work surfaces (desks, trolleys, beds, lab benches, shelves) to avoid poor posture, upward or downward strain, fatigue or injury.

5. **Reduce excessive motions, especially those which repeat the same** motions

6. **Minimize fatigue/ static load**

Simple writers' cramp is an example of fatigue from sustained force and duration, even if the grip isn't intense. Take ergonomic measures to reduce strain such as reducing prolonged periods of writing and using a cushioned grip.

7. **Relieve pressure points**

Contact stress or direct pressure points are common to many work stations. Modify tools or instruments (including desks, chairs) to distribute pressure more evenly.

Disorders resulting from standing on hard floors for long periods can be prevented by the use of anti-fatigue mats and cushioned shoe inserts, as well as exercise and rest breaks, and a review of tasks to see if some can be performed sitting down.

8. **Provide clearance**

Provide head, knee and thigh clearance as well as visual access by re-organizing equipment and work stations and removing obstructions.

9. **Move, exercise and stretch**

During the work day, the human body needs to move in varied ways and stretch the muscles on a regular basis. Provide simple facilities to encourage exercise and make sure that breaks are taken by staff who sit for long periods.

10. **Maintain a comfortable environment**

A comfortable working environment depends on a combination of factors such as proper lighting, even and appropriate temperature, noise control and comfortable work area. Vibration, a common problem for maintenance workers, can be reduced by dampening vibrating tools, wearing vibration dampening gloves and changing the tools used.

Sources: Adapted from MacLeod, D.(2008). Ten principles of ergonomics. Available at: http://danmacleod.com/ErgoForYou/10_principles_of_ergonomics.htm; and ILO / IEA(2010). Ergonomic Checkpoints. Available at http://www.ilo.org/global/publications/books/WCMS_120133/lang--en/index.htm

Session 5:

Module 3 – Biological hazards and infection control, with special reference to HIV and TB

Important note: this module has a slightly different format and is a bit more substantial compared with the others. The reason is that it has been designed to also be used as a stand-alone briefing paper to guide action in this area, especially in the implementation of ILO Recommendation No. 200 concerning HIV and AIDS and the world of work (2010) and the ***Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services.***

Objectives (Slide 2):

- To identify what are biohazards and the risks of transmission
- To highlight the importance of effective measures for infection control
- To provide practical guidance on the effective prevention and management of biohazards

Why are biohazards an issue? (Slide 3)

Biological hazards (biohazards) exist in all health-care settings and include airborne and blood-borne pathogens.

All individuals coming into contact with biologically hazardous agents in health-care facilities are potentially at risk: staff in medical and non-medical services as well as patients and visitors. A risk-management strategy to prevent workplace exposure and protect staff also protects the patients.

The risk of infection following occupational exposure to

- hepatitis B is 18–30 per cent;
- hepatitis C is 1.8 per cent; and
- HIV 0.3 per cent.

In developing countries, 40–65 per cent of HBV and HCV infections in health-care workers were attributable to percutaneous occupational exposure. In industrialized countries, the figures are lower but not insignificant. HBV is 95% preventable after 3 doses of the HBV vaccine but there is no vaccine against HCV so prevention of exposure and early treatment are key.

Checkpoints (Slide 4):

3.1	**Identify and assess biohazards at your workplace**
3.2	**Implement measures to prevent and control blood-borne hazards such as HIV and hepatitis**
3.3	**Implement measures to prevent and control air-borne hazards such as TB**
3.4	**Implement a comprehensive workplace HIV and TB prevention and care programme**

From here on, the session deals with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. Alternatively –depending on the group and your timeframe- you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction -participants will need to consult widely at their facilities.

3.1 Identify and assess biohazards at your workplace (Slides 5–9)

Questions:

Start with identifying hazards: ask the group to give examples of occupational exposure or potential hazards at their own workplaces. Make this a quick brainstorm as they will shortly look in more detail at blood-borne and airborne transmission separately. Then distribute or refer them to **Factsheet 3.1, Biological hazards** in the Action Manual for information only. Now they need to think about assessing the likelihood and severity of risk. Which of the hazards you've mentioned worry you the most? Do you know of severe infections which have been contracted at your facility? How can you measure the level of risk faced by staff and patients?

Distribute or refer to **Factsheet 3.2, Sample HIV risk assessment checklist**, and go through this with the group. Are the questions useful? Are they complete? Would you add to the checklist or change anything?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

3.2 Implement measures to prevent and control blood-borne hazards such as HIV and hepatitis (Slides 10–16)

The next two checkpoints turn to measures that may be taken to reduce risk – this one in relation to bloodborne hazards and the next to airborne hazards.

Questions:

Which is the greater priority, prevention or control? Which seems to you to be easier to achieve? What are some measures you would take? For prevention? For control? How many of you have been vaccinated against Hepatitis B (HBV)? How well integrated are standard precautions at your facility? Is personal protective equipment adequate? How do you prevent sharps injuries? What are the key rules for safe use and disposal? After hearing the group's answers, distribute or refer to the box 'Preventing sharps injuries' in the Action Manual.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

There are several factsheets in the Actional Manual that are linked to this checkpoint to which you should draw the group's attention:

- ***Factsheet 3.3*** First aid on exposure to blood-borne pathogens
- ***Factsheet 3.4*** WHO Aide-mémoire on Hepatitis B vaccination
- ***Factsheet 3.5*** Comprehensive approach to the prevention of occupational transmission of blood-borne pathogens among health workers (WHO)
- ***Factsheet 3.6*** WHO Aide-mémoire on standard precautions
- ***Factsheet 3.7*** Health-care facility recommendation for standard precautions
- ***Factsheet 3.8*** Personal protective equipment for blood-borne hazards protection
- ***Factsheet 3.10*** Hand hygiene

There will not be enough time to read through all these in class, so you should encourage it for homework. We suggest you take **Factsheet 3.5 Comprehensive approach to the prevention of occupational transmission of blood-borne pathogens among health workers** for class work. Ask the group to discuss the four key elements (it shouldn't be necessary to spend much time on the hierarchy of controls, but the examples are useful to show how it can be applied to biohazards). As health worker vaccination is not mentioned in Factsheet 3.5, ask the group to look at **Factsheet 3.4 WHO Aide-mémoire on Hepatitis B vaccination**, for information, and stress the fact the vaccination is a key measure to prevent infection of health workers and that this should be a routine for everyone working in health care.

Exercise:

Try to find time for this short activity on hand hygiene. Arrange participants in a circle and have a soft ball to hand around, or even scrunched-up paper. Turn **Factsheet 3.10 Hand hygiene** into a question and answer session; for example, What do you use to wash hands? When should you use skin disinfectant? When should you use liquid soap? What are the benefits of antiseptic hand rub? Throw the ball to different people in the circle – those who catch it must answer. You needn't cover all the answers in the game – tell them to read the factsheet afterwards.

3.3 Implement measures to prevent and control airborne hazards such as TB (Slides 17–28)

Questions:

TB will probably be the main preoccupation of participants, but you might like to check what they know about SARS and Middle Eastern Respiratory Syndrome.

How severe a problem is TB at your health facility? What proportion of patients have TB? Have there been cases of occupational infection of staff? Does your facility have a TB infection prevention and control programme? If so, does it include staff as well as patients? Is TB covered in the OSH and/or infection control policy, if any? Do measures, if any, differ for MDR/XDR TB? What is respiratory hygiene?

Can you all give me an example of good practice from your own facility, and one suggestion for a measure not yet in place but which you believe might be useful?

You might like to use these questions from the assessment checklist in the Action Manual Module 3:

- Do patients and staff cover their nose and mouth when sneezing or coughing? Is a ventilation system in place? Are upper room or shielded ultraviolet

germicidal irradiation (UVGI) devices in place? Are respirators (N95/FFP3 or other) used, particularly for high-risk cough-inducing procedures?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

The relevant factsheets in the Action Manual are:

- *Factsheet 3.9* Personal Protective Equipment for airborne hazards protection
- *Factsheet 3.10* Hand hygiene
- *Factsheet 3.11* TB general risk map
- *Factsheet 3.12* TB infection risk map at health facilities

We suggest you keep discussion of the TB risk maps for the next checkpoint.

3.4 Implement a comprehensive workplace HIV and TB prevention and care programme (Slides 29–33)

TB is of course an airborne infection and HIV a blood-borne one, so why a separate checkpoint? This is a reasonable question that participants may ask so please explain that there are two main reasons:

HIV is greatly feared by health workers, has been responsible for the resurgence of TB, and is also very sensitive in a way that few other diseases are. In addition, it's one of the few diseases that is concentrated in the active adult population.

The ILO and WHO have produced guidelines for health workers relating to HIV, TB, and PEP and this checkpoint offers advice on implementation.

Questions:

What is the main cause of death in AIDS patients in your country, your facility? What services exist in your facility to protect staff from HIV and TB? Is there a policy, protocol, or collective agreement concerning HIV/TB at the workplace? Does your facility have a formal position on discrimination on the basis of HIV status, especially grounds for terminating employment? Do staff receive updated information, education and training on HIV/TB? Regularly or occasionally? Are arrangements in place for voluntary testing? For treatment? For post-exposure prophylaxis (PEP)? Are there any other measures designed to offer care and support to HIV-positive staff? Examples might include advice on nutrition, reasonable accommodation, or support for a staff self-help group or wellness centre –see the case study from Swaziland and invite comments.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

Refer to or distribute **Factsheet 3.12, TB infection risk map at health facilities** and invite discussion. If possible, divide participants into four groups as follows to discuss the risks set out at each step and agree on one key action for each step:

- Group 1 – steps 1 and 2
- Group 2 – steps 3, 4, 5
- Group 3 – steps 6, 7, 8
- Group 4 – steps 9 and 10

Refer to or distribute the box on ***Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services: workplace actions.*** Ask the participants to prioritise the list: what three actions would they rate as the highest priority?

Case studies are very good for triggering discussion on the issue of HIV and other occupational risks at the health workplace. If you do not have case studies at hand from your own professional experience, there are a lot of good materials available through the internet.

The video ***Sharp Sense*** produced by Public Services International is such an example of good visualization materials. In this video, a nurse, an HIV/AIDS counselor, and an HIV/AIDS physician share their personal experiences with needlestick injuries. The video underlines the importance of basic protection and prevention, personal coping with needlestick injuries, and management of potential risk with post-exposure prophylaxis.

Video

Sharp sense: promoting the safety of health care workers

- Full video (18 minutes): http://www.world-psi.org/en/sharp-sense-promoting-safety-health-care-workers
- Short version (4 minutes) http://www.world-psi.org/en/essential-sharp-sense

Public Services International, 2011.

Session 6:

Module 4 – Tackling discrimination, harassment and violence at the workplace

Note that role plays can be effective group activities for this session. Imagine a violent or discriminatory situation, and think of the people who might become involved and what their roles should be.

Objectives (Slide 2):

- To review the range of violent acts that may occur at the workplace and show their impact
- To identify risk factors
- To offer guidance on measures to deal with them

Ask participants what they consider workplace violence, then discuss the definitions on slide 3.

Why is workplace violence an issue? (Slide 4)

- Workplace violence can take a number of forms. The health sector is recognized as a high-risk sector regarding violence at work.
- The effects are negative not only for the victim but the workplace as a whole, causing insecurity, fear, and low morale.
- Since the large majority of the health workforce is female, the gender dimension of the problem must be recognized.

Note that harassment and discrimination are considered to be forms of violence.

Hand out or refer to **Factsheet 4.1, Research findings on health sector violence in Rwanda and Canada.**

Checkpoints (Slide 6):

4.1	**Take action to protect staff from violence**
4.2	**Take specific measures to tackle stigma and discrimination**
4.3	**Raise awareness and provide training about workplace violence**
4.4	**Create institutional commitment to a fair and respectful workplace**

From here on, the session deals with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. Alternatively – depending on the group and your timeframe – you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction - participants will need to consult widely at their facilities.

4.1 Take action to protect staff from violence (Slides 7–12)

Questions

Do the staff at your facility fear violence from the patients or visitors? Is the atmosphere among staff primarily trustful and friendly, or do some workers fear harassment or bullying? How can staff be protected? Have you any experience or knowledge of effective responses to workplace violence, especially where there is a gender dimension?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

4.2. Take specific measures to tackle stigma and discrimination (Slides 13–16)

Although discrimination is arguably a form of violence, it is a very particular issue that should be tackled directly through a combination of policy and education. In the face of the AIDS epidemic, discrimination against workers with HIV has been a serious problem, but many other forms of discrimination undermine equal opportunities at work, including discrimination on the grounds of gender, religion and disability.

Questions

What is your experience of stigma and discriminatory behaviour at work? Have you observed, experienced or heard of incidents? If so, did they mostly involve discrimination by management or among co-workers? What do you think is the most effective action? What role should the union play? Do you have examples of good practice? Hand out **Factsheet 4.4, Taking action on discrimination.**

How does their institution's response compare to the advice set out in Factsheet 4.4?

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

4.3. Raise awareness and provide training about workplace violence (Slides 17–19)

Questions

Are you aware of any incidences of violence at your workplace? In which way is being talked about violence at work, is it addressed at all? Has any sort of survey been conducted into workplace violence? If so, did it lead to action? If not, would it be useful? Does your facility make clear what standards of behaviour are expected from staff in terms of mutual respect? Are such efforts accompanied by peer education or by any form of training, especially for supervisors? Have any members of staff been assigned and trained to coordinate activities in this area, including in counselling, behaviour change communication and/or conflict resolution?

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

4.4 Create institutional commitment to a fair and respectful workplace (Slides 20–21)

Questions:

Do policies, protocols, guidelines, or action plans exist at any of your facilities which directly address workplace violence? Has any senior member of staff made a public statement on this issue? Can any existing policies or guidelines be adapted to cover violence? Are grievance procedures adequate to deal with violence?

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

Towards the end of the session hand out and discuss **Factsheet 4.2, Zero tolerance at Westfries Gasthuis hospital in Hoorn, the Netherlands,** and **Factsheet 4.3 Reducing workplace violence in the USA.** Ask them to read one or the other –not both as they're quite long. If time is very short use the case study from Thailand in the Action Manual. Also refer to **Factsheet 4.4 Taking action on discrimination.**

What do participants think of the measures taken? Could they be used in or adapted for their own situations?

Factsheet 4.1
Workplace violence in the health sector: research findings from Canada and Rwanda

Registered nurses in Alberta and British Columbia, **Canada**, were surveyed on their experiences of violence in the workplace over the last five shifts. This showed that nurses are experiencing many incidences of violence in a given work week, particularly in the emergency, psychiatric, and medical-surgical settings. Most violent acts are perpetrated by patients, but there is also a significant portion of violence and abuse committed by hospital co-workers, particularly emotional abuse and sexual harassment. Results also indicate that the majority of workplace violence is not reported.

Source: Hesketh et al. 2003. Workplace Violence in Alberta and British Columbia hospitals. In: Health Policy, Vol.63, Issue 3, March 2003, pages 311-321. Available at: http://www.ncbi.nlm.nih.gov/pubmed/12595130

In 2007, the **Rwanda** Ministries of Public Service and Health studied workplace violence in the health sector. Thirty-nine percent of health workers had experienced some form of workplace violence in the previous year. The study identified gender-related patterns of perpetration, victimization and reactions to violence. Men were perpetrators in most instances of bullying, physical attack, and sexual harassment, while women were more likely to be perpetrators in instances of verbal abuse. Negative stereotypes of women, and discrimination based on pregnancy, maternity and family responsibilities, affected female health workers' experiences and contributed to a context of violence. Gender equality lowered the odds of health workers experiencing violence.

Source: Newman et al. 2011. Workplace violence and gender discrimination in Rwanda's health workforce: Increasing safety and gender equality. In: Human Resources for Health. Available at: http://www.human-resources-health.com/content/9/1/19.

Factsheet 4.2

Zero tolerance plan at Westfries Gasthuis hospital in Hoorn, the Netherlands

Problem: In 2001 a number of 300 incidents were recorded at the Westfries Gasthuis hospital in Hoorn. The feeling of insecurity among the staff was growing. A 'Safe Care' plan was developed for that reason.

Solution: The plan of action was presented at the launch meeting. Following the presentation, a forum discussion was held with the project leader and representatives of the police, the Public Prosecutor's Department and the executive board. A working party composed of various members of staff from the at-risk departments was also formed. A survey showed that most incidents occur in reception/switchboard areas, in accident and emergency, and in psychiatry, at the weekend, in the evening, and at night.
A baseline measurement was carried out using the following data:

- Incident reports
- Examination of measures already taken in order to prevent incidents. These may be measures in the field of organization, design of buildings, and training.
- Results of surveys and interviews of staff in at-risk departments.

The working party first drew up a risk inventory. Using colours, the least safe areas were mapped on the hospital floor plans. The staff and the project leader coloured in the rooms using the appropriate colour, and this was used as a basis for discussion on how improvements could be made:

- **Red:** high risk of aggression and violence, and/or area contains valuable goods attractive to criminals.
- **Yellow:** No considerable risk of aggression and violence, and/or area contains goods which are attractive but not valuable.
- **Green:** No valuables: chance of aggression is small.

Each member of staff carries an alarm. The alarm can be activated as soon as there is any form of threat. Security staff will be on the scene in a matter of minutes. The seriousness of the situation is then assessed and in the first instance security staff attempt to bring the situation under control. If that is not possible, the police can be called. A 'card system' is used which breaks down the types of aggression as follows:

- **Verbal aggression:** swearing, threatening behaviour, non-serious threats, sexual intimidation.
- **Serious threats:** serious threatening, pestering, following, threatening families, threatening with an object, attempting to injure, attempting to strike or kick a person, discriminatory remarks.
- **Physical violence:** assault, including sexual assault, smashing furniture, throwing objects, preventing individuals from leaving the room, pushing, pulling, or spitting, biting or scratching, striking, kicking or head-butting, inflicting injury.

Card: "Safe care in your work".

European Agency for Safety and Health at Work, European Week for Safety and Health at Work, Prevention of Psychosocial Risks and Stress at Work in Practice, Bilbao, November 2002, p. 42.

Factsheet 4.3
Reducing workplace violence in the USA

Procedures were introduced to reduce violence among work colleagues (sometimes called 'lateral violence') at a neonatal intensive care unit in California, USA. The core message was 'Breaking the silence' and education was at the heart of the intervention/ programme. The three stages involved:

i) 'voicing the problem' through one-hour focus groups at the hospital and one-day retreats off site;

ii) staff education through in-house and off-site seminars conducted by an external counsellor and a team from the hospital, with regular follow-up sessions; and

iii) a 'zero tolerance' policy.

The results were positive, with staff expressing a high level of satisfaction with inter-personal relationships at work and a fall in reported complaints.

Needham et al. (ed.) 2008. Proceedings of the first International Conference on Workplace Violence in the Health Sector: Together, Creating a Safe Work Environment. Amsterdam: Kavanah.

Factsheet 4.4
Taking action on discrimination

Policy

- Draw up a policy or draft an agreement that:
  - protects workers against discrimination on any grounds;
  - safeguards employment (no dismissal on grounds such as pregnancy or HIV status); and
  - ensures confidentiality and privacy.
- Be aware of national laws and international conventions (especially ILO Convention No. 111 on discrimination in employment) which can be used to protect rights and provide a basis for redress in the event of discrimination.

Confidentiality

Respect for privacy and confidentiality helps create an atmosphere of trust. Workers should not be obliged to reveal personal information about co-workers, and access to personal or medical data should be bound by the rules of confidentiality consistent with the *ILO Code of Practice on the Protection of Workers' Personal Data* (ILO, 1997).

Education

The policy or CBA should be supported by information and education to help workers understand the issues. Managers and supervisors should also be part of education activities. They should be trained in how to implement the workplace policy and how to support workers who suffer discrimination.

Session 7:

Module 5 – Towards a green and healthy workplace

Climate change and environmental degradation and their negative effects are of increasing concern to many people. Hospitals, in particular, consume large amounts of energy and generate tons of waste, some of it hazardous, and thus can be a danger to the local community as well as the general environment. Some participants may not make the connection between environmental sustainability and healthy workplaces, so you can draw on the example from India in the introduction to Module 5 in the Action Manual to show the practical benefits, including cost savings. If possible, try to find similar examples from the local area.

Objectives (Slide 2):

- Introduce the idea of a green health care facility
- Identify opportunities for environmental improvements and savings
- Guide the development of a green strategy for the workplace.

Why are environmental concerns an issue? (Slide 3)

- We only have one earth –let's look after it!
- Experience shows that the greening of health facilities can enhance patient care, save money, promote productivity and reduce environmental damage.

Checkpoints (Slide 4):

5.1	Identify, assess and reduce environmental health hazards
5.2	Put in place measures to conserve water
5.3	Reduce waste and improve waste management
5.4	Assess energy efficiency and put in place measures to improve it
5.5	Establish a green strategy at all organizational levels

From here on, the session deals with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. Alternatively – depending on the group and your timeframe - you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions whether they consider action should be taken at their facility are just to get a first, personal reaction during the course -participants will need to consult widely at their facilities, once they apply HealthWISE there.

5.1 Identify, assess and reduce environmental health hazards (Slides 5–15)

Questions:

What environmental hazards result from health-care activities? What are some of the first hazards you can think of at your workplace? Note that many of them relate to chemicals. Hand out **Factsheet 5.2, Chemicals used in health facilities** –allow the group time to read it, and ask questions for clarification if necessary.

Then ask participants to apply the steps for hazard identification and assessment (Module 1) to the issues they've identified at their own facilities.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

5.2 Put in place measures to conserve water (Slides 16–18)

Questions:

What do you know about water consumption at your facilities? Where is water used most? Can you identify any procedures where water is wasted?

Have you any point of comparison with water consumption at another local facility? What ideas would you suggest to save water? Have you any examples of good practice in this area? Which of the suggestions for

water conservation in the Factsheet seem both useful and manageable?

Hand out and discuss EITHER **Factsheet 5.5: suggestions for water savings** OR the shorter list in the Action Manual (Point 2 of 'How') –this should depend on the needs and level of the group, and time available.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

5.3. Reduce waste and improve waste management (Slides 19–33)

Questions:

Do you know of any local regulations that apply to hospital waste? Does your facility have a waste management plan? How do you assess the quality of waste management at present? Is there separation of hazardous and non-hazardous waste? Do you know where the waste from your facility is finally disposed of when it leaves the facility? Which of the suggestions made in the Action Manual for waste management seem to you to be the most useful and manageable? Have you any examples of good practice in this area? What materials for waste segregation and collection are needed in order to improve waste management at your facility?

Hand out **Factsheet 5.3 Categories of waste and containers needed for safe management**

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

Learning activity: Waste segregation

Equipment and materials:

- flipchart or white board,
- photos of health-care waste,
- tape.

Give each participant five photos of health-care waste from different waste categories. Ask them to segregate their waste by putting up their photos on flipcharts. The sheets represent (1) general waste bin, (2) sharps waste container, (3) infectious (non-sharp) waste container, (4) chemical waste container, (5) other hazardous waste container. Review the results with the participants. If the information is available, you might put the cost of disposal of the different types of health-care waste, or ask participants if they know the cost of disposal of different types of waste streams.
NOTE: when waste is not segregated, the mixed waste is all hazardous and requires the most costly waste treatment and disposal processes.

Quicker alternative: Show the photos and ask where people would put each one.

5.4. Assess energy efficiency and put in place measures to improve it (Slides 34-36)

The nuts and bolts of this issue are quite technical, but a common sense reflection on where energy is used and where it appears to be wasted (and therefore where money can be saved and used for other needs) would be useful.

Questions:

Which of the suggestions made in the Action Manual for energy conservation seem both useful and manageable to you? Have you any examples of good practice in this area?

Hand out **Factsheet 5.6, Energy efficiency** and choose one case study to discuss with the group.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

5.5 Establish a green strategy at all organizational levels (Slides 37-38)

Questions:

What do you think about the idea of a 'green hospital'? What does this mean to you? Do you think that it is a worthwhile goal? Why 'yes', or why 'no'? What areas for improvement can you identify? How do you decide priorities and turn these into a strategy? What are the pros and cons of creating a special 'green team' versus dealing with environmental aspects within existing committees or working groups? Do you think it would help to have a green policy for your facility? Could you make some adjustments to existing policies or protocols? If the latter is the case, what would these be? How would you find out if there are any relevant national guidelines or legislation as a reference point?

Conclusion:

Action is necessary: ☐ **Yes** ☐ **No**

It's a priority: ☐ **Yes** ☐ **No**

Learning activity:
The green hospital taskforce

Equipment and materials:

- Flipchart sheets and pens for each group

Split participants into smaller groups, each one representing a hospital's taskforce that has been mandated to improve the environmental aspects of the hospital work. Ask each group to agree on a mission and a list of objectives in priority order.

Each group reports back to the plenary.

Alternative Learning activity:
Goals for green hospitals

Hand out **Factsheet 5.1, Ten goals for green hospitals**, and split the participants into smaller groups. Each group has to select the three goals they consider priority. For each of the three selected goals they have to suggest improvement actions to achieve the goal.

Each group reports back to the plenary.

Factsheet 5.1
Ten goals for green hospitals

The **Global Green and Healthy Hospitals Agenda** supports existing efforts around the world to promote greater sustainability and environmental awareness in the health sector, thereby strengthening health systems globally. It provides a comprehensive framework for hospitals and health systems everywhere to achieve greater sustainability and to contribute to improved environmental public health. The framework consists of ten interconnected goals. Each contains a series of ***Action Items*** that hospitals and health systems can implement. Tools and resources to support implementation are available at www.greenhospitals.net and www.noharm.org.

Ten goals
Each is fully explained in the Report,
available at: http://www.greenhospitals.net/wp-content/uploads/2011/10/Global-Green-and-Healthy-Hospitals-Agenda.pdf

1.	**LEADERSHIP**	Prioritize Environmental Health
2.	**CHEMICALS**	Substitute Harmful Chemicals with Safer Alternatives
3.	**WASTE**	Reduce, Treat and Safely Dispose of Health-care Waste
4.	**ENERGY**	Implement Energy Efficiency and Clean, Renewable Energy Generation
5.	**WATER**	Reduce Hospital Water Consumption and Supply Potable Water
6.	**TRANSPORTATION**	Improve Transportation Strategies for Patients and Staff
7.	**FOOD**	Purchase and Serve Sustainably Grown, Healthy Food
8.	**PHARMACEUTICALS**	Safely Manage and Dispose of Pharmaceuticals
9.	**BUILDINGS**	Support Green and Healthy Hospital Design and Construction
10.	**PURCHASING**	Buy Safer and More Sustainable Products and Materials

Factsheet 5.2

Chemicals used in health facilities

Health workers	Chemical hazards
Cleaning staff	■ Disinfectants and sterilants, floor stripping and polishing chemicals, cleaning chemicals
Laundry staff	■ Disinfectants, cleaning chemicals
Laboratory staff	■ Chemicals used in laboratories, such as formaldehyde, toluene, xylene or acrylamide; ■ disinfectants such as glutaraldehyde, sterilants, such as ethylene oxide (EtO)
Surgical suite staff	■ Waste anesthetic gases, disinfectants and sterilants such as ethylene oxide, cleaning chemicals
Pharmacy staff, doctors, nurses	■ Hazardous drugs
General	■ Disinfectants and sterilants, cleaning chemicals, ■ hazardous drugs, x-ray hardening agents such as glutaraldehyde

Factsheet 5.3
Definition

Volatile organic compounds (VOCs) are organic chemicals that have a high vapour pressure at ordinary, room-temperature conditions, resulting from a low boiling point. This causes large numbers of molecules to evaporate and enter the surrounding air. VOCs include both human-made and naturally occurring chemical compounds, some of which are dangerous to human health or cause harm to the environment. Their use is regulated by law, especially indoors, where concentrations are the highest – but they are difficult to measure and control. Harmful VOCs are typically not acutely toxic, but instead have compounding long-term health effects.

Factsheet 5.4

Alternatives to mercury use in medical equipment

CONTAINS MERCURY	ALTERNATIVE
Thermometers	Mainly digital or electronic
Blood pressure measuring devices (sphygmomanometers)	Mainly aneroid (mechanical dial or digital)
Thermostats	Electronic
Fluorescent tubes	Bulbs with low Hg content
Batteries	Mercury-free / rechargeable batteries
Amalgam dental fillings	Glass ionomer / composite / resin fillings
Gastrointestinal tubes	Tubes with tungsten weights

Factsheet 5.5
Suggestions for saving water

Domestic water reduction

- **Toilets and urinals**. Install toilet tank water displacement devices on older models or replace inefficient toilets and urinals with low-flow models, such as those with a double flush option.
- **Sinks and showers**. Install flow reducers and aerators on applicable plumbing fixtures. Install automatic shut-off valves or motion sensor-activated taps.

Process equipment

- As appliances and equipment wear out, replace with air-cooled or water-saving models.
- Steam traps**.** Steam traps are automatic valves that release condensed steam from a steam space while preventing the loss of live steam. They are present throughout many facilities (air and water heating, kitchen, laundry equipment, sterilizers, autoclaves, etc.). Faulty or inoperative steam traps can waste water and energy. Replace faulty steam traps with effective, low-maintenance units. Fit steam traps which reuse the condensed water rather than discharging it into the atmosphere.
- Sterilization equipment**.** Install steam condensate tamping systems on vacuum and gravity sterilizers. Replace water-induced vacuum devices on sterilizers with electric pumps.
- Switch from film-based radiological imaging equipment, which use large quantities of water, to digital imaging, which use no water and no polluting chemicals.
- Film processors. Replace or retrofit continuous flow-through systems with flow control equipment.
- Refrigeration equipment. Recover condensate from refrigerators, freezers and ice makers for reuse.

Water reuse

- Radiation therapy linear accelerator (creates high-energy radiation to treat cancers). Water can be taken from the reject side of the linear accelerator heat exchangers and pumped to the facility's cooling towers and reused for evaporative cooling.
- Reverse osmosis (RO). Reject water produced in the RO process (used for dialysis) can be reclaimed for potable water use, or in toilets and gardens.

Water supply/systems

Sprinklers. Minimize water use for irrigation (e.g. adjust sprinklers, install wet weather shut-off and/or soil moisture controllers). Investigate rain water harvesting with safe storage and grey water reuse.

Kitchen

Dish washing**.** Wash full loads only, turn off the continuous flow used to clean the drain trays of beverage machines (only clean the trays as needed).

Laundry

Reprogramme washing machines to eliminate additional rinse cycles, if this is possible and not restricted by the health department. Wash full loads only or reduce water levels to minimize the water required per load of washing.

Adapted from 'Water conservation opportunities' at Health Care Environmental Resource Center, http://www.hercenter.org/facilitiesandgrounds/waterconserve.cfm

Hospitals in the US typically find that a quarter of water use is domestic, i.e., sinks, showers, toilets – so it makes sense to start here. Similarly, kitchens consume a significant amount and offer many savings opportunities.

Providence St Peter Hospital, Washington, USA reduced its water use by over 4000 gallons a day by upgrading [retrofitting] its steam sterilizers to make them more water-efficient.

Source: http://www.epa.gov/watersense/commercial/types.html#tabs-hospitals

Factsheet 5.6

Categories of waste and containers needed for safe management

WHO recommended waste segregation scheme

Type of waste	Colour of container and markings	Type of container
Highly infectious waste	Yellow, marked "HIGHLY INFECTIOUS",with biohazard symbol	Strong, leak-proof plastic bag, or container capable of being autoclaved
Other infectious waste, pathological and anatomical waste	Yellow with biohazard symbol	Leak-proof plastic bag or container
Sharps	Yellow, marked "SHARPS", with biohazard symbol.	Puncture-proof container
Chemical and pharmaceutical waste	Brown, labelled with appropriate hazard symbol	Plastic bag or rigid container
Radioactive waste	Labelled with radiation symbol	Lead box
General health-care waste	Black	Plastic bag

WHO manual, *Safe Management of Wastes from Health Care Activities,* 2nd edition, 2013 (page 79).

Factsheet 5.7
Energy efficiency

Raising awareness about energy conservation: Sir Jamshedji Jeejeebhoy Hospital, Mumbai, India.

The hospital is among the oldest and largest hospitals in South-East Asia. In 2001, following the Indian Prime Minister's call for energy conservation, hospital authorities launched an awareness campaign to reduce energy use throughout the hospital campus. The campaign included slogans, posters, and other tools.

Modest energy conservation measures were also implemented campus-wide, including systematically turning off office equipment, using natural light during daylight hours in hospital corridors, and plugging leaks from the air conditioning system. The project resulted in a total energy savings of 812 000 kWh from 2002 to 2004, and a cost saving of US$ 90,000. The staff are now considering adopting additional conservation measures, including solar water heating and energy-efficient lighting.

Education for energy efficiency: Hospital General Dr Agosthino Neto, Guantanamo, Cuba.

An audit in 2006 of the hospital's total energy consumption pinpointed 30 problems in hospital energy practices. To date, 23 of these problems have been addressed and resolved. Overall, the hospital has achieved a 21 per cent reduction in energy use –an achievement that staff attribute to a hospital-wide education campaign and the participation of everyone, including physicians, boiler operators, and clothes washers.

Alternative energy sourcing in Rwanda: Partners in Health clinics in Mulindi, Rusumo, Rukira, Nyarabuye, and Kirehe.

Since only five per cent of Rwanda is on the power grid, the Partners in Health (PIH) organization faced the choice of using diesel power to run its five clinics in eastern Rwanda or choosing an alternative energy option. Since diesel fuel is expensive, polluting and unreliable, PIH turned to the Solar Energy Lighting Fund (SELF) for assistance. SELF developed solar diesel hybrid systems for the five PIH clinics. The sun now provides 90 per cent of the clinics' energy, with diesel used only as back-up.

Healthy Hospitals – Healthy Planet – Healthy People: Addressing climate change in health care settings. A draft discussion paper published by the World Health Organization and Health Care Without Harm.

Session 8:

Module 6 – The key role of staff: recruitment, support, management, retention

This session may be one of the most challenging, depending on the mix of workers or management, and their views and attitudes. The key message is that the working conditions and general wellbeing of workers, as well as their health and safety, are central to the capacity of facilities to deliver quality care. For each checkpoint, make sure that participants accept the 'why' before you go on to the 'how'.

If you have time, use Case Study 6.1 for a group discussion. If not, refer the group to the case study in the Action Manual.

Objectives (Slide 2):

- To explain the impact that good planning, supportive supervision and consultative management have on staff recruitment, retention and performance.
- To give examples of practical approaches for improvement.

Why is it an issue? (Slide 3):

- Health workers are at the heart of delivery and the health facility's most valuable resource.
- Good human resource management starts with transparent recruitment practices, clear job descriptions and fair contracts, and appropriate training.
- Retaining health workers by ensuring a constructive employment relationship and supportive work environment saves recruitment and retraining costs, the loss of experience and institutional memory, and inconsistent productivity.
- Health workers are a scarce as well as a valuable resource: there has been estimated a shortage of more than 4.3 million health workers across the world in 2006 (WHO).

The reasons for these shortages are complex and range from high numbers leaving the profession or migrating because of poor working and living conditions, to the lack of infrastructure in rural areas, to insufficient training capacities or missing employment opportunities in the national health sector. A literature review related to health workforce wastage in Africa found that poor personnel management, inefficient and inappropriate deployment of staff, a mismatch between skills and needs, and poor health and safety were among the main reasons for such wastage.

Checkpoints (Slide 4):

6.1	Plan staffing needs over the longer term, with clear job descriptions
6.2	Provide necessary facilities for staff in terms of washing, changing, resting and eating
6.3	Provide non-monetary benefits and in-service training
6.4	Promote communications, teamwork and supportive supervision
6.5	Have in place contract practices, grievance procedures and disciplinary measures that are transparent and fairly applied.

From here on, the session deals with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. Alternatively – depending on the group and your timeframe – you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction -participants will need to consult widely at their facilities.

6.1 Plan staffing needs over the longer term, with clear job descriptions (Slides 5–10)

Questions

Is the staff turnover at your facility comparable with others in the area? Do you monitor the reasons staff give for voluntary departure? Is there a staffing plan or are appointments made as needs arise? What criteria do you use to estimate needs for different categories of workers? How do you draw up job descriptions? Do you carry out a job analysis before drawing up job descriptions and recruiting? Have all workers been consulted over their job descriptions? Do they all understand what they should be doing, how they should be doing it, and whom they must report to? Are they aware of the rights and the responsibilities relating to their work?

Case study 6.1 describes retention measures taken in South Africa. **Case study 6.2** shows action taken in Australia and the USA to improve staff-patient ratios. This may not be a practical option for many facilities that do not have the resources, but you might still find it useful to discuss the issue and get a sense of the situation in participants' workplaces. There is also a suggested exercise for **group work on job descriptions**, if you have the time.

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

6.2 Provide necessary facilities for staff in terms of washing, changing, resting and eating (Slides 11- 13)

Questions

Which of the facilities described in the module are available at your workplace? What may be the reasons for missing facilities? Are staff adequately supported in terms of satisfying physical needs? What do staff appreciate most about practical arrangements of this sort at your workplace? Are such facilities seen by management as a right or a privilege, a cost or an investment?

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

6.3 Provide non-monetary benefits and in-service training (Slides 14–16)

HealthWISE assumes that the responsibility for setting wages is outside the control of the workplace. It therefore concentrates on benefits in kind. Training is introduced here as a benefit but the facility's training needs should also be taken into account in the staffing plan.

Questions

What in-kind benefits do you provide? Do you use them to supplement wages, to provide incentives or to reward performance? All of these/ none of these? Are they accessible to all staff and do all workers understand how they are awarded? How is good performance appreciated or recognized? Is staff training adequate to meet the institution's needs? Is there a training plan or strategy? How do staff perceive training opportunities? On what basis are staff selected for training?

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

6.4 Promote communications, teamwork and supportive supervision (Slides 17–18)

Questions

Is the concept of supportive supervision clear? Do you feel it is already taking place at your workplace? If not, would it be helpful to move in this direction? How would you rate communications at your workplace? How does information flow, is it timely and effective? Do you have a communications strategy? What team strengths can you identify? At what level (unit, department, facility) are the strongest teams? What steps do you take to promote team spirit?

Hand out **Factsheet 6.3: Some ideas for building teams and developing team spirit** before you move on to the next checkpoint. Ask the group to read the ideas for team building and choose one to try at some point during the course.

Conclusion:

Action is necessary: ☐ Yes ☐ No
It's a priority: ☐ Yes ☐ No

6.5. Have in place contract practices, grievance procedures and disciplinary measures that are transparent and fairly applied (Slides 19–22)

Do you know if there are different contract types in your health facility? How are contracts drawn up and assessed? Is the union or workers' representative (as relevant) consulted? Are contracts, grievance procedures and disciplinary measures fair and transparent, and do staff understand them? Do staff believe they are fairly treated? What action do you take if workers report a grievance? Are existing grievance procedures (if any) adequate to deal with most situations that arise? What improvements can be made?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

Case study 6.1: Retaining staff - South Africa

Situation: Loss of highly skilled health professionals to private sector and other competitive employers.

Action: A collective bargaining agreement was signed in 2007 on Occupational Specific Dispensation (OSD). The OSD recognizes scarce human resources in the public service, including nurses, midwives, doctors, radiographers, physiotherapists and pharmacists. It provides for higher salaries and improved pay progression with a view to retaining them in the public sector. It gives additional recognition to the scarcest specialities and years of clinical experience. The collective agreement consists of the following elements:

- Unique salary structure per occupation;
- Centrally determined grading structures and broad job profiles;
- Career opportunities based on competencies, experience and performance;
- Pay progression within the salary level.

Result: This system has been successful in recruiting nurses and other scarce health professionals back into the public sector hospitals in South Africa.

Cost and sustainability: The system required additional funding from the state and is being phased in over a number of years to accommodate all health professionals and other public servants such as teachers.

Public Services Coordinating Bargaining Council (PSCBC) and the Public Health and Social Development Sectoral Bargaining Council (PHSDBC) in South Africa http://www.pscbc.org.za/content.aspx?PageID=168

Case study 6.2: Increasing nurse to patient ratios

Situation: Insufficient nursing staff due to nurses leaving health service, often as a result of the workload – this leads to a downward spiral of declining nurse to patient ratios.

Action: In 2001 Victoria, Australia implemented mandatory minimum nurse/patient ratios in all public sector facilities. The core ratio was 5 (nurses) for 20 (patients). The minimum ratios vary to meet the needs of different units and shifts. The ratio in maternity units, for example, is 1:5 + 1 in charge during the day and 1:6 at night. For unconscious patients, e.g., in a recovery room, the ratio is 1:1.

The state of California (USA) passed legislation in 1999 that established minimum nurse/patient ratios to be progressively implemented over the next five years. Ratios vary depending on the unit.

Results: Improvements reported in Victoria, Australia, since the implementation of the ratios:

- More than 3000 extra nurses employed in hospitals
- Decreased staff turnover and absenteeism
- 25% increase in candidates for nursing schools
- Greater public approval of the State government.

Cost and sustainability: Because staff size increased, costs were incurred. No data could be found on the Australian example but the California example indicated increases of up to 1,7% in nurse salary budgets. These ratios have been maintained to date.

ICN Fact sheet on Nurse: Patient Ratios; Gordon, S. 2007 and Coffman, J.M.; Seago, J.A. & Spetz, J. (undated). Minimum Nurse-To-Patient Ratios in Acute Care Hospitals in California.

Factsheet 6.1

Positive practice environments - Quality workplaces for quality care

This is a checklist of the main characteristics of **quality health-care workplaces**. It is designed as a tool to assess the strengths and weaknesses of the practice environment, and to develop appropriate strategies. They involve rights and responsibilities for all concerned -employers, employees and managers. Mutual respect and consideration are basic components of the organizational climate that should be established and rigorously maintained.

Professional recognition

- Recognize the full range of competencies provided by health-care workers and provide the autonomy for these competencies to be fully realized.
- Promote professional control over practice and pace of work.
- Recognize and reward employees' contributions/ performance.
- Regularly assess employee satisfaction and act on outcomes.

Effective management practices

- Commit to equal opportunity and fair treatment.
- Provide adequate and timely compensation commensurate with education, experience and professional responsibilities.
- Maintain effective performance management systems.
- Offer decent and flexible benefit packages.
- Involve employees in planning and decision-making affecting their practice, work environment, and patient care.
- Encourage open communication, collegiality, team work and supportive relationships.
- Foster a culture of mutual trust, fairness and respect.
- Adopt policies and procedures that positively encourage the reporting of professional misconduct or violation of laws/regulations.
- Provide clear and comprehensive job descriptions/ specifications.
- Promote transparency in decision-making processes (where applicable).
- Ensure effective grievance/complaints procedures are in place.
- Demonstrate effective management and leadership practices.

Support structures

- Invest in health and work environments.
- Foster positive relationships among employers/ employees/co-workers/patients.
- Adhere to regulatory frameworks that ensure safe working conditions.
- Provide access to adequate equipment, supplies and support staff.
- Engage employees in continuous assessment and improvement of work design and work organization.
- Promote a healthy work-life balance through policies and programmes that support fair and manageable workloads and job demands/stress, and flexible work arrangements.
- Offer employment security and work predictability.
- Ensure employees practice under an overarching code of ethics.
- Communicate clearly and uphold standards of practice.
- Regularly review scopes of practice and competencies.

Educational opportunities

- Support opportunities for professional training, development and career advancement.
- Offer thorough orientation programmes for new staff.
- Foster effective supervisory, mentoring and peer coaching programmes.
- Occupational health and safety
- Adhere to safe staffing levels.
- Adopt occupational health, safety and wellness policies and programmes that address workplace hazards, discrimination, physical and psychological violence, and issues relating to personal security.

International Council of Nurses (2007), ***Positive practice environments: quality workplaces = quality patient care.*** Information and Action Tool Kit

Factsheet 6.2
Common elements of a job description

Job title:

Department: department or unit of the organisation where the work takes place.

Position reports to: line managers or supervisor.

Role and key responsibilities: function within the department or unit, including managerial functions and coordination with other people or departments.

Specific tasks: daily work assignments.

Skills and competencies: requirements for the particular job, for example, skills necessary for intensive care nursing, midwifery, unit management or skills to maintain specialised equipment as well as general skills such as good communication, record-keeping, etc.

Qualifications: including the level of education, professional training and accreditation of qualifications with regulatory authorities and professional associations.

Experience and other requirements: minimum period of practice experience, special work requirements such as ability to manage projects or to work independently.

Factsheet 6.3
Some ideas for building teams and developing team spirit

- Consult staff in all units to see how they would like to organize work teams.
- Encourage regular, short meetings within teams to help them coordinate their work.
- Teams benefit from a degree of autonomy on how they divide up tasks.
- Organize workshops for staff to exchange skills and work-specific experiences
- Provide opportunities for staff to do activities together not related to work.
- Consider introducing team-building exercises –these can be fun as well as helping to improve communications and building trust. They are more effective if built into regular meetings and not just carried out once or twice a year. See box below for some examples of simple exercises –there are lots more on the internet, or you can invent your own.

My logo. Ask everyone to roughly design a personal logo that they feel reflects themselves, then have the group guess which logo goes with which person.

What's a team? Ask each person in the group to make an acronym for the word TEAM (for example, Totally Entertaining And Manic)!

Presentations. Invite group members to present briefly on a casual topic like a favourite colour or their favourite sports team.

Back-to-Back drawing. Divide your group into pairs, and have each pair sit back to back. Ask one person in each pair to think of a shape, or give them a picture. This person must then give verbal instructions to their partners on how to draw the shape –without actually telling the partners what it is. After they've finished, ask each pair to compare their original shape with the actual drawing.

Two truths and a lie. Each member of the team writes down two true things about themselves and one lie. The others can ask questions and then guess which is the lie. ***Note***: this can be spread over a number of sessions, so that just one person answers questions each time and the activity only takes a few minutes.

Survival scenario. This exercise forces your group to communicate and agree to ensure their 'survival.' Tell your group that their airplane has just crashed in the ocean. There's room on the lifeboat for every person, plus 10 items they'll need to survive on the island. Ask the team to choose which items they want to take. How do they decide? How do they rank or rate each item?

Session 9:

Module 7 – Working time and family-friendly measures

The content covered in this module is very dense. You may consider dividing the session into two sessions, depending on the available time, so that it isn't too packed. Please note that the slides for this module have been divided into two parts to make the presentation more manageable: the first covers working time (Checkpoints 7.1 – 7.3) and the second family-friendly measures (Checkpoints 7.4 and 7.5).

Objectives (Presentation 1, Slide 2):

To present the different ways that working time can be organized in order to:

- assist with planning work schedules that improve safety, efficiency and service delivery; and
- take account of staff needs to balance work with private life and family responsibilities.

Why is working time an issue?

(Presentation 1, Slides 3-4)

This is really an extension of workplace health and safety: the health of staff is supported by reasonable working time arrangements which enhance their wellbeing and performance and thus the quality of patient care.

Optimum organization of working time means:

- staff with fewer stress symptoms, lower illness rates, better attendance;
- more consistent work output;
- lower overtime costs;
- fewer accidents and improved patient safety and care.

Checkpoints (Presentation 1, Slide 5):

7.1	Organize working time to reduce long hours and minimize irregular work schedules
7.2	Make sure that all staff get enough rest time and that overtime is kept to a minimum
7.3	Use flexible working time and leave arrangements
7.4	Plan working time to take into account the family, home and social responsibilities of staff
7.5	Provide maternity protection and parental leave, including arrangements for breast-feeding

Points 7.4 and 7.5 are covered in the second presentation, but the notes are provided below.

From here on, the session and respective slides deal with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. Alternatively – depending on the group and your timeframe – you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction -participants will need to consult widely at their facilities.

7.1 Organize working time to reduce long hours and minimize irregular work schedules

(Presentation 1, Slides 6- 11)

Hand out Factsheet 7.1 EU Working Time Directive – invite comments on the list of main provisions: how closely do they match arrangements at the participants' workplace(s)?

Hand out **Factsheet 7.2 Reminder about shift patterns** only if you think it's needed.

Questions:

What working time arrangements work well and where could there be improvements? To which extent is staff consulted or involved in the design of shift schedules? What are the participants' views on designing working time arrangements with the participation of staff? Ask for views on shift work and night work, and before you show Slide 8 'Reduce the negative impact of shift work' ask for participants' own suggestions. Finally, is there an issue with irregular work schedules or are these well planned in advance?

Don't discuss rest periods at this point as these are covered under the next checkpoint.

Conclusion:

Action is necessary: ☐ **Yes** ☐ **No**
It's a priority: ☐ **Yes** ☐ **No**

7.2 Make sure that all staff get enough rest time and that overtime is kept to a minimum (Presentation 1, Slides 12–15)

Questions:

Note what the EU directive says about rest time. How does this match the experience of participants? What are their views on the importance of rest time? What are the consequences of fatigue? Is overtime avoidable? How much is it used at their workplace(s) and can it be reduced? How?

Draw participants' attention to the example in the Action Manual from Heidelberg, Germany, on ways to manage overtime.

Conclusion:

Action is necessary: ☐ **Yes** ☐ **No**
It's a priority: ☐ **Yes** ☐ **No**

7.3 Use flexible working time and leave arrangements (Presentation 1, Slides 16–19)

Note: Some of the ideas here may be new to some participants so take your time to explain what benefits they offer. Try to find a participant who has some experience of flexible working time to give his or her opinion.

Learning Activity

Role play: Divide into groups of 3–4 persons.

Each group has the following characters:

- a worker making a request to change to part-time or to a compressed working week or flexible working time;
- a manager who is resistant; and
- the union representative.

Each person takes 5 minutes time to consider her or his arguments. Then the characters start a negotiation at the request of the worker. Stop after 15 minutes.

One additional participant in each group could be the observer who takes notes and provides feedback to the individual characters on their arguments or the way they presented them; as well as on the entire process of negotiation: what went well and what were challenges. (5 minutes)

Then groups report back to the plenary and exchange their experiences. Did they come to an agreement, find an interim solution or was there just no constructive dialogue? Ask participants how they felt in their respective roles and how they would approach such a situation in real life, whether as manager, employee or union representative.

Questions:

What are some examples of flexible working time? What are the possible benefits and disadvantages of each one?

Conclusion:

Action is necessary: ☐ **Yes** ☐ **No**
It's a priority: ☐ **Yes** ☐ **No**

Give out **Factsheet 7.3 Tips for health workers who work shifts (**for private reading and use after the training session) and **Factsheet 7.4 General points for managing working time** –brainstorm to find out participants' views on which point they believe is the most important.

Use the second set of slides for checkpoints 7.4 and 7.5 which follow – split into a second session if possible.

Why are family-friendly measures and maternity protection an issue?

(Presentation 2, Slide 3)

Start with the obvious point that work and home can't be kept separate. They are both vital aspects of a person's life, so it makes sense to try to harmonize them as fully as possible. Introducing family-friendly measures including maternity protection has the following advantages:

- it improves working relationships, morale and job satisfaction, and reduces absenteeism and staff turnover;
- it makes it easier to attract and retain good staff;
- it promotes equal employment opportunities and reduces gender inequalities;
- it helps maintain the health and incomes of workers and their families, enhancing the prosperity and wellbeing of the local community.

7.4 Plan working time, leave arrangements and workplace facilities to take into account the family, home and social responsibilities of staff (Presentation 2, Slides 4–8)

Questions:

It's difficult to plan without knowing more about the needs of staff, so questions could start there. How many workers have care responsibilities, how many of them have long journeys to work, how many of them are single parents? What facilities or arrangements already exist –such as flexible working time and leave arrangements, orchild care– which can support staff? What change would be most helpful in this area? You may need to deal with entrenched views about gender roles and responsibilities. Rather than directly challenging a person, encourage other participants to express different points of view.

Discuss the example of child care arrangements from Beaulieu, France, in the Action Manual. Help participants see that the key to success was the pooling of resources –something that can be done on any scale.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

7.5 Provide maternity protection and parental leave, including arrangements for breast-feeding (Presentation 2, Slides 9–19)

You might find some resistance to the idea of paternity or parental leave, but don't hesitate to open a discussion about its benefits, including parental bonding and strengthening of the family unit. It will also be helpful to find out views on and the understanding of breastfeeding.

Questions:

What is the law in this area, and has it been incorporated into workplace policy and practice? Have you evidence of wastage of female staff due to the lack of maternity protection, breastfeeding arrangements and/or child care? What simple measures might improve working conditions for future and nursing mothers?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

Factsheet 7.1
EU Working Time Directive

The Working Time Directive of the European Union (Directive 2003/88/EC of 4 November 2003) defines working time as 'any period during which the worker is working, at the employer's disposal and carrying out his activities or duties, in accordance with national laws and/or practice'. Rest periods are defined as 'any period which is not working time'. There is no interim category.

Working time is one of the most important areas of employment where the EU has intervened through legislation to improve employment conditions and the health and safety of workers. The Directive applies to all sectors of activity, both public and private. The main provisions are:

- a maximum average working week of 48 hours, including overtime (calculated over a four-month reference period);
- a limit of eight working hours, on average, per 24 hours for night workers –defined as a person who normally works at least three hours during night time;
- a rest break after six consecutive hours' work;
- rest periods of at least 11 hours consecutive hours per 24-hour period and 35 consecutive hours per seven-day period;
- a minimum of four weeks' paid annual leave which needs to be taken during the leave year stipulated, and cannot be paid in lieu except where the worker's employment is terminated, or in the case of a short-term casual worker, where it may be translated into pay.

Notes: **Overtime work** is work performed by an employee in excess of the normal hours of work which has been officially requested and approved by management. It is work that is not part of an employee's regularly scheduled working week and for which an employee may be compensated. A **reference period** is a period of time, set by legislation or by agreement, over which weekly working time can be averaged. A **casual worker** is a worker on a temporary employment contract with generally limited entitlements to benefits and little or no security of employment.

The EU Working Time Directive is available at http://eur-lex.europa.eu//en/index.htm

Factsheet 7.2
Reminder about shifts and rotas

Shifts

Fixed shifts: the shifts cover the same hours, and start/finish times, each day for an indefinite period.

Rotating shifts: the period worked changes periodically, so nurses in an intensive care unit could work from 8 am until 3 pm one week, then from 3 pm until 11 pm the next week followed by a week of eight shifts from 11 pm until 7 am. Where transport is limited, or if they have long journeys, workers may prefer 12-hour shifts, especially during the night. Rotating schedules are often used because they are considered to be fairer to all staff, while on the other hand they tend to bring more health risks. Shift rotation involves planning, scheduling and early notice to staff so that they can manage their personal time and family responsibilities.

Forward shift rotation: it is recommended that shifts rotate forward from day to afternoon to night because human body rhythms adjust better when moving ahead rather than backwards. It is also preferable because there are longer intervals between shifts.

Rotas

Rotas are based on a register of names showing the order in which people take their turn to perform certain duties. They should be made available on a regular basis and in good time before the duty date.

Factsheet 7.3
Tips for health workers who work shifts

Dietary and eating patterns

- Afternoon staff should have their meal in the middle of the day instead of the middle of their work shift
- Night staff should eat lightly throughout the shift and have a moderate breakfast
- Relax during meals and allow time for digestion
- Drink lots of water
- Cut back on highly salted foods
- Reduce foods that are high in fat
- Maintain regular eating patterns with well balanced meals
- Eat the usual balance of vegetables, fruit, lean meat, poultry, fish, dairy products, grains, and bread
- Avoid excessive use of antacids, tranquilizers and sleeping pills
- Minimize the intake of caffeine and alcohol
- Avoid fast food and vending machines

Sleep

- Make sure that your family and friends are aware and considerate of your sleep hours and needs
- Ensure you have a comfortable, quiet place to sleep during the day
- Air conditioning, telephone answering machine, foam ear plugs and good blinds are examples of devices that may improve the worker's sleep
- Make time for quiet relaxation before bed to facilitate better sleep ***(reading, breathing exercises, muscle relaxation techniques, etc.)***
- Sleep on a set schedule to help establish a routine and to make sleep during the day easier
- Avoid strenuous exercise before sleeping because your body's metabolism will remain elevated for several hours and this makes sleeping difficult
- If failing to fall asleep after one hour, read a book or listen to quiet music
- If sleep still does not come, reschedule sleeping hours for later in the day

Social activities

- Schedule at least one daily meal with the family; this helps to keep communication channels open and promotes good eating habits
- Socialize with other shift staff and their families; this helps to minimize the disruption that shift work can have on your social life
- Keep in touch with your partner and children each day
- Set time aside for just you and your partner
- Carefully plan family activities; family ties are precious (plan days off in advance if possible)
- Pay close attention to physical fitness; a regular exercise programme helps the body adjust to the negative effects of shift work and it can also help improve the quality and quantity of sleep
- Practice stress reduction
- Use a calendar to schedule events
- Try to prioritize tasks and tackle one at a time

Adapted from ***Shiftwork: Health Effects & Solutions, Occupational Health Clinics for Ontario Staff Inc ,*** revised 2005.
Available at http://www.healthunit.org/workplace/Toolkits/Shift%20Work/OHCOW-Shiftwork.pdf.

Factsheet 7.4
General points for managing working time

- Involve staff in planning, allow choice for workers
- Structure shifts for optimum productivity
- Prevent long working hours
- Limit the use of overtime
- Manage the use of night work
- Ensure enough rest time
- Use flexible working time arrangements
- Promote gender equality through working time
- Take account of personal/ family responsibilities and make provisions for pregnant and nursing workers

Adapted from ***ILO (2007). Decent Working Time - Balancing Workers' Needs with Business Requirements.*** Available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_145391.pdf

Session 10:

Module 8 – Selecting, storing and managing equipment and supplies

The timely availability of appropriate and functioning equipment and supplies is a key element of effective health services delivery.

Objectives (Slide 2):

- To examine and evaluate each part of the process of equipment and supplies management, including:
  - assessing needs;
  - selecting appropriate equipment and supplies;
  - organizing storage and stock management and maintenance of equipment;
  - ensuring staff know how to use equipment and handle storage and stock control.
- To make the connections between the different parts of the process and show how an integrated system can improve flow and efficiency.

Why is it an issue? (Slide 3)

Materials, equipment and other supplies are costly components of healthcare.

Proper storage and handling of stock:

- ensures smooth work flow and saves time through easy access to items;
- prevents interruptions to service delivery due to missing items in stock;
- supports workplace safety;
- avoids tying up funds in excessive stock.

This module concerns very practical issues and it shouldn't be difficult for participants to agree that improvements can usefully be made in their institutions. Make the point that organizing stock and storage needn't be dependent on resources. They might be interested to hear about the case study from the UK, where several facilities were found to have out of date and useless stock!

Summarize or hand out **Factsheet 8.1.**

You may need to check that participants are comfortable with the concept of an integrated stock and storage system, and that they feel they can manage this approach. Be sure you can explain the figure on Slide 6, and allow time for discussion.

Checkpoints (Slide 4):

8.1	**Plan for the needs of all units in relation to equipment and supplies**
8.2	**Select the safest and most appropriate equipment available and affordable**
8.3	**Provide secure, safe and clearly-labelled storage space for all items**
8.4	**Have in place a system for stock-taking and maintenance, including hazard control**
8.5	**Provide staff training in the safe use and maintenance of equipment, especially new products or models**

From here on, the session and respective slides deal with each checkpoint in turn, first asking 'why' action is necessary and then 'how' it can be carried out. We suggest below some starter questions for each checkpoint to help you get the ball rolling. There are also questions in the speakers' notes on some of the slides. Alternatively – depending on the group and your timeframe – you may prefer to ask participants to suggest useful questions. Explain that the conclusion questions are just to get a first, personal reaction – participants will need to consult widely at their facilities.

8.1 Plan for the needs of all units in relation to equipment and supplies (Slides 5–8)

Questions:

How are needs for equipment and supplies assessed in your facility? Is equipment available and fit for purpose to meet the requirements of all units and departments? When did you last do a list of what's missing or not working. Are priorities of needs established with the staff concerned, bearing in mind patient safety, the duty of care, as well as staff safety and health? Have you identified the sort of equipment that is well used and appreciated?

Repeat the enquiry for supplies (from bandages and medicine to cleaning products and printing paper).

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

8.2 Select the safest and most appropriate equipment available and affordable (Slides 9–11)

Questions:

(Note that these mainly apply to the person responsible for procurement)

What criteria should be followed in selecting equipment and supplies? Have you any evidence of accidents due to poor or faulty handling of equipment? Apart from cost and availability, bear in mind the possibilities of local sourcing and of appropriate technology, as well as patient safety, the duty of care, and staff safety and health. Hand out **Factsheet 1.3. Government of Victoria, Australia: Purchasing Board Guidelines 2007**

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

8.3 Provide secure, safe and clearly-labelled storage space for all items used (Slides 12- 16)

Questions:

How is storage organized at present? Is there enough space? Is it in the right place(s)? Are all items in use and in date? Are they easy to find and quickly accessible if necessary?

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

8.4. Have in place a system for stock-taking and maintenance, including hazard control (slides 17–18)

Questions:

Does a system exist to keep track of the quantity of stock and ensuring timely replacement? Is the storage system linked to stock-taking? Does stock-taking extend to checking the quality and performance of equipment and supplies? Is there a maintenance plan? Have you evidence of accidents due to poor or faulty handling of equipment?

Hand out **Factsheets 8.4 and 8.5** on stock control**, and Factsheet 8.6,** Maintenance schedule form**.**

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

8.5 Provide staff training in the safe use and maintenance of equipment, especially new products or models (Slides 19–21)

Questions:

What sort of training is provided at present? Does it cover all equipment and all staff who use equipment? Is it systematically available when new equipment is obtained? Have you evidence of accidents due to poor or faulty handling of equipment? Have you evidence of equipment breaking or wearing out too quickly as a result of poor handling? Also identify what training staff have appreciated and found useful and see what can be learnt from this.

Conclusion:

Action is necessary: ☐ Yes ☐ No

It's a priority: ☐ Yes ☐ No

At the end of the session, distribute **Factsheet 8.2,** Forms for supply management and inventory control, for the future use of participants. Allow enough time for them to ask questions for clarification and how they can adapt them to their local context.

Factsheet 8.1

Stock control issues in the UK

Waste can be reduced and significant cost savings achieved through better stock control. In a 2010 inventory of five hospitals in the UK, out-of-date medical supplies were found on the shelves at all of them; in the case of one, some sterile medical supplies had expired in 2002.

Up to 20 per cent of what's stored in hospitals can be removed because it's no longer used. It helps problems with available space and improves patient safety. Some of the old stock can even be used for training rather than just binned. A separate survey, conducted by UK Healthcare and ***Nursing Magazine***, found that 63 per cent of nurses and 56 per cent of doctors put an up to date view of stock levels among their top three priorities for IT support.

An assessment to look at exactly what's being ordered, and why, is a vital first step. All too often the purchasing process is unquestioning –regular orders go in and supplies turn up, but some remain unused and stock builds up. Alternatively, when something is used a replacement is ordered regardless of whether it's actually needed. It's not the fault of any individual; it's simply that they are stuck with old-fashioned, often paper-based systems, that belong to a past era. Healthcare is now so complex, demanding such an enormous variety of equipment and materials, that such systems are simply not fit for purpose.

Source: Haspel,J. "The impact of poor stock control". In SupplyChain Digital, Sept. 2010. Available at http://www.supplychaindigital.com/blogs/economics/impact-poor-stock-control

Factsheet 8.2
Integrated supplies and equipment plan

The following questions will help the responsible staff shape the integrated supplies and equipment plan.

Logistics management information

1. What forms does your facility use to keep track of consumables in stock?	☐ Stock cards ☐ Store ledgers ☐ Other (specify): ..... ☐ None
2. What forms does it use for ordering supplies?	☐ Order book ☐ Delivery note ☐ Requisition and issue voucher ☐ Other (specify): .....
3. What forms does it use for receiving supplies?	☐ Delivery note ☐ Requisition and issue voucher ☐ Other (specify): .....
4. Who determines how much to order?	☐ Department head ☐ Central management ☐ Other (specify): .....
5. What information do you use to calculate how much to order?	☐ Average monthly consumption ☐ Number of patients ☐ Stock remaining ☐ Other (specify): ..... ☐ Don't know/not sure

Inventory control

1. Is there a set minimum stock level for consumables?
2. Are stock balances monitored regularly so that procurement decisions and actions can be made? How often is the stock level reviewed?
3. What action is taken after stock levels have been reviewed?
4. Is there a set maximum stock level for consumables above which the inventory level should not go?
5. Are damaged/expired products physically separated from inventory and removed from stock records?

Storage

1. Is the existing storage capacity adequate to handle the quantities of supplies required at present? Are needs likely to expand over the next 3–5 years, and is capacity adequate for increased quantities?
2. Is the existing cold storage capacity adequate to handle the current quantities of medication and reagents requiring refrigeration? And any additional needs over the next 3–5 years?
3. Is there an established distribution system for supplies and equipment to the relevant units?

Factsheet 8.3

Government of Victoria, Australia: purchasing board guidelines 2007

Obtaining Quotes for Purchases up to AUD 102,500

Context:

The procurement objective in relation to purchases less than AUD 102,500 is to test the market to encourage competition and ensure that the purchase will represent value for money.

Key requirements:

1. **Purchase of Goods or Services <$2,000**
   - A minimum of one verbal or written quote must be obtained.
   - All verbal quotes are to be recorded on file and certified by the receiving officer.
2. **Purchase of Goods or Services between $2,000 and <$15,400**
   - A minimum of one written quote must be sought.
3. **Purchase of Goods or Services between $15,400 and <$102,500**
   - A minimum of three written quotes must be sought or reasons for not obtaining the required minimum number of quotes must be recorded on file.
4. **Purchase from a Standing Offer Agreement (State Purchase Contracts, Open State Purchase Contracts or Department Standing Offer Agreement)**
   - The rules of use apply when purchasing from a Standing Offer Agreement.
   - If there are no rules of use in relation to sourcing offers from the Standing
   - Offer Agreement, standard quote and tender requirements apply.
5. **Purchase Recommendation Report**
   - The basis for the selection of the preferred quote must be documented and placed on file.

Source:
Ombudsman Victoria (2008). Probity controls in public hospitals for the procurement of non-clinical goods and services.
http://www.ombudsman.vic.gov.au/resources/documents/probity_controls_in_public_hospitals_august_082.pdf

Factsheet 8.4
Options for stock control

The simplest manual system is the **stock book**, which suits small facilities with limited stock items. It enables you to keep a log of stock received and stock issued.

Stock cards are used for more complex systems. Each type of stock has an associated card, with information such as:

- description
- value
- location
- re-order levels
- supplier details
- information about past stock history

More sophisticated manual systems incorporate **coding** to classify items. Codes might indicate the value of the stock, its location and which batch it is from, which can be useful for quality control.

Computerized stock control systems apply similar principles to manual ones, but are more flexible and information is easier to retrieve. You can quickly get a stock inventory or valuation if needed. A computerized system is a good option for workplaces dealing with many different types of stock. Other useful features include automatic stock monitoring, triggering orders when a certain stock level is reached.

The Leeds Teaching Hospitals Trust in the UK has developed a stock control and forecasting system that uses **bar codes** to help staff maintain a live update of stock usage. The system provides accurate inventory information that reduces costs because they can keep just the right amount of stock. The automated stock control system has significantly reduced the amount of money tied up in stock while improving the service level to 98% since 2007.

Source: GS1UK: Company case study - Leeds Teaching Hospitals NHS Trust (Bar coding and RFID) - Using asset tracking to improve patient safety and productivity (2007).
Available at: http://www.gs1uk.org/news/Pages/CaseStudyDetails.aspx?CaseStudyID=2

Factsheet 8.5
Stock control tasks

The following description of the duties of a stock controller are useful as an example of a job description (see Module 6) and as an insight into the **stock control system** of a hospital in Pretoria, South Africa.

Key outputs expected of stock controller

Ordering and Receiving Stock

- Maintain minimum stock levels in bulk store room and respect credit limitations.
- Monitor stock usage on instructions from the Theatre / Day Manager or request from Hospital staff, order items that are either a once off or require specialist handling, e.g. prosthesis and sutures.
- Obtain quotations and secure best prices.
- Source specialist products on request of unit manager.
- Maintain a formal record of all stock ordered (purchase orders) and ensure that the appropriate authority is received and signed for before any order is enacted (with possible exception of daily system replenishment process that is based on billing).
- Closely liaise with the relevant Billing Clerk to ensure that specific items are billed; e.g., one-off prosthesis, etc.
- Place and receive stock from suppliers, checking the quantity received against the delivery note/packing slip/invoice.
- Check quality of packaging for any breakages, damage, leakage or any fault that may affect the quality of product for issue or dispensing purposes.
- Reconcile supplier statements of the stock received against the order issued and in the event of price discrepancies, advise the Theatre Manager and take up with supplier to rectify in the form of a credit note or other appropriate documentation.
- Ensure that bar code labels are attached to all internal stock received.
- Capture receipt of invoice into computer system within 6 hours of receipt and identify products received with individual barcode stickers so that stock records are regularly updated.
- Provide unit manager with a credit note for capturing purposes.
- Keep accurate records keeping of all invoices, order, quotations and credit notes per supplier in a monthly order.
- Ensure statements are processed in time by cap invoices to ensure credit limit control.

Housekeeping and Stock Taking Duties

- Ensure that all stock is consistently packed and stored according to agreed standards and assist wards with store room management.
- Regularly check that all stock is barcoded and where labels are missing take action to replace them as a matter of urgency.
- Assist hospitals with stock take control and cycle counts and monitor and report trends leading to losses.

Security and Quality Control

- Ensure that all stock received is handled in the area specifically allocated and that the access doors are locked at all times.
- Ensure that the stock rooms are only accessed by authorized staff.
- Adhere to Hospital procedures and standards, and monitor work process problems or bottlenecks that prevent the achievement of goals, objectives and targets.
- Take appropriate action through discussions with the Theatre Manager in improving any process that will allow the improvement to work flow, reduction of cost and/or improvement to quality, service and productivity.
- Ensure integrity of data and that regular price updates acquired in line with protocol.
- Build and maintain productive working relationships with Medical Professionals and suppliers through ongoing communication and feedback.

Source: Job advertisement at http://www.jobspace.co.za/job/stock_controller_-_irene_day_hospital_pty_ltd/930664

Factsheet 8.6

Equipment maintenance schedule form

Name and model of machine/ tool/ equipment	User manual available	Service contract/ local agent available	Machine log book up-to-date	Equipment working / not working (dates, details)	Part needed (give details)	External labour needed	Cost estimate	Repair authorized (date, name)	Repair completed

Session 11:

Drafting and implementing an action plan for HealthWISE improvements

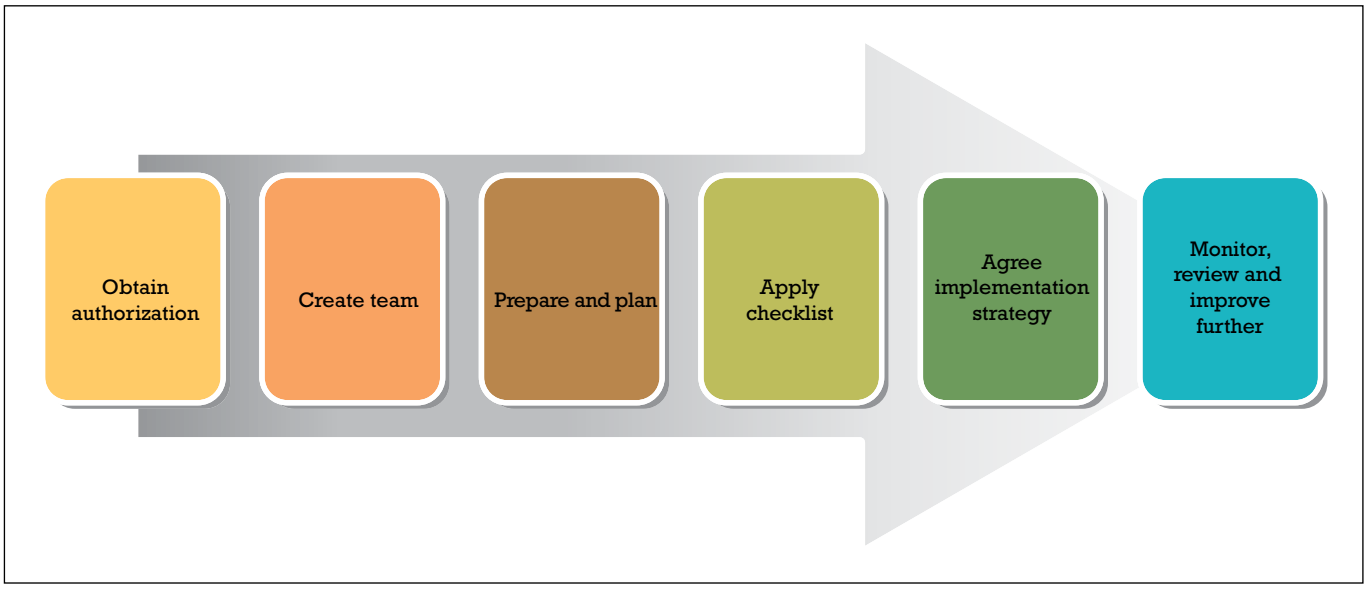
Now that the course participants have completed the modules (all of them or the selection you agreed upon) the next step is for them to implement ***HealthWISE*** in their own organization or department.

The task will be different for those who are alone to introduce ***HealthWISE*** to their facilities and for those who will be part of a ***HealthWISE*** team. But the basic responsibility is the same: to collaboratively translate the information and guidance they have gained into practical and sustainable action at their places of work.

In some cases the institution will be aware of ***HealthWISE***. In others the participant will need to consult with the management or authority in order to work out how to proceed. The five steps summarized in the diagram below are covered in the Action Manual in the section called 'How to use the Action Manual'. This aims to lead practitioners from the stage of introducing the ***HealthWISE*** concept and package at their facilities, through the examination of the checklists and accompanying materials, to the point where an implementation strategy/ plan needs to be put in place. ***Please adapt and use as relevant to your participants' situation.***

Summarize the information given for each step. Alternatively, if participants have printed copies, you can simply go through the relevant pages with them. Encourage discussion, ask for example: how would you persuade your hospital board to implement ***HealthWISE***? What are the benefits and disadvantages of setting up a ***HealthWISE*** team? How would you create the team?

Note that the first three steps are designed to create the conditions to carry out the checklist exercise effectively, and the next steps are to implement the changes that have been identified as necessary, plus monitoring. The key step –the implementation strategy or action plan– is the nub of this session.



What do you do?

After having used the checklist at their workplaces, the participants should have a much clearer idea of where improvements are needed. The implementation strategy/ plan is a blueprint for action to address them.

Learning Activity:

Hand out the action plan template to participants. Take time to explain the template; discuss if participants would adapt it by adding other items.

Then participants will develop their own action plans based on the results of the checklist exercise.

Those participants who are from the same facility form a team to translate the information from the checklist exercise into an action plan. Others will have to work alone on their action plan. Make sure that you are available to all participants to help them develop their plans.

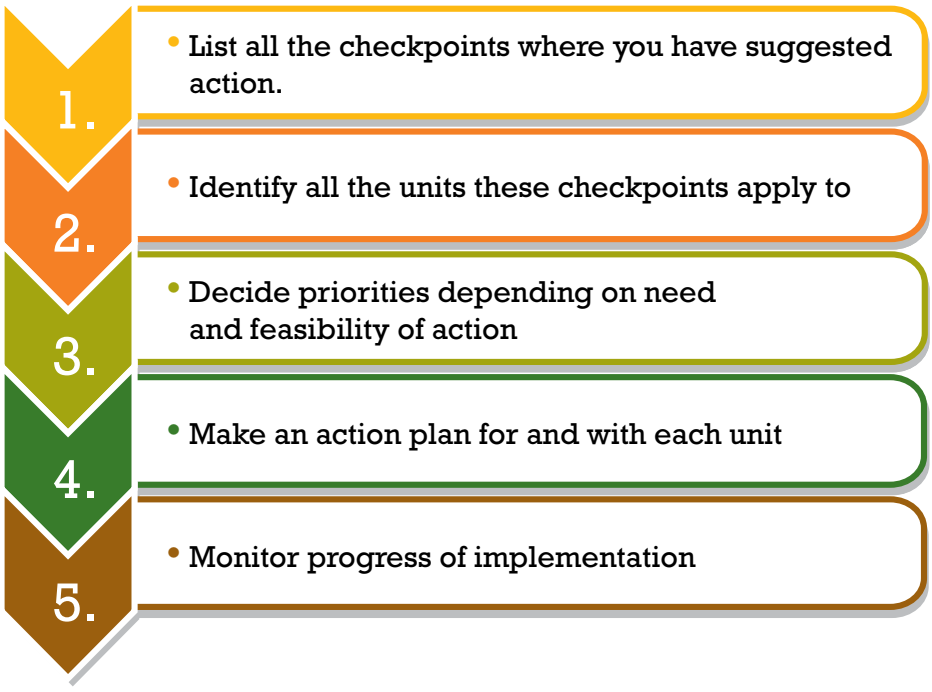
Participants take their completed checklists and start by noting all the points on the checklist where they suggested action, with a focus on those where they identified priorities; they should then agree on an order of priority, and identify the necessary measures, time frames, and responsibilities. Underscore that they should start with the most feasible changes and set achievable goals. Build the changes into existing structures and procedures as far as possible.

Allow for sufficient time to develop the action plan.

The draft plans then are presented and discussed in plenary. This peer review is helpful in providing constructive feedback by asking constructive questions or helping with suggestions where there are challenges. You should always encourage the "reality check" by insisting on concrete practical and realistic measures to take. Remind participants on the ***HealthWISE*** principles to look for simple, low-cost solutions, built on local practices and resources.

An action plan at the unit or department level can be developed as follows:

- staff are informed and mobilized to participate;
- staff take part in consultations with the ***HealthWISE*** team or coordinator focusing on the technical areas covered by the checklists –aims and priorities are agreed;
- staff draft an action plan –the core elements are the proposed activity, the timeframe (start and end of action), responsible person(s), and expected results;
- staff select an individual or small team to monitor progress and report back to the HealthWISE team.



ACTION PLAN: suggested template

Unit name:						
Technical area	Description of problem	Proposed improvement	Date of completion	Who is responsible	What is needed	Current status at [date] [1]

[1] To save time you can use terms such as: * started, ** advanced, *** completed

Monitoring should be built into the implementation strategy from the start. It will help the ***HealthWISE*** coordinator or team to track progress in implementing the action plan and to evaluate the impact of the changes being introduced. They should also agree indicators for the main tasks or areas of action. To develop an indicator, they should think of an improvement they would like to see, and then work out what would count as evidence of successful change.

Indicators can be measurable; for example:

- A decline in quantity of drugs thrown away because they are out of date.
- Reduced absenteeism/ staff turnover.
- Numbers of staff trained on key issues (waste reduction, hazard prevention, non-discrimination).
- Numbers of relevant policies or protocols introduced or amended.

It is also useful to carry out surveys of staff into some matters that are harder to measure; for example, levels of satisfaction with leave arrangements or working hours, sense of security (or not) as they work, quality of relationship with line managers.

Tips for successful implementation

Here are five simple rules to help participants achieve the results they want. They are also useful for making continuous improvements over the longer term.

Note: they are reproduced on the accompanying PowerPoint, but you might prefer to print them out for group discussion; either way, use the questions to encourage participation.

1. Develop a comprehensive solution

Improvements sometimes don't work because the measures taken are partial. For example, if the need is to improve injection safety, consider all the units and processes concerned. What is the complete package of changes needed in order to achieve the specific aim of safe injections? What changes must take place,

☐ **in equipment and materials?** _____
_____

☐ **in control of other hazards?** _____
_____

☐ **in premises, lighting, welfare facilities or workstation design?** _____
_____

☐ **in work time management and organization?** _____
_____

☐ **in training and supporting staff?** _____
_____

See the example 'An integrated approach to needle safety' in the Action Manual introduction.

2. Make sure ideas are feasible

Anticipate problems and make sure that all important factors have been taken into account. What makes you believe that this improvement will work well?

☐ **You have tried out different ways of solving similar problems and this one works best**

☐ **You have tried it out on a small scale and it works well**

☐ **You have seen it work in similar conditions in another health facility**

☐ **You have read about or received advice from someone who made similar changes.**

☐ **Other reason** _____
_____
_____

3. Mobilize staff support

Your programme of improvements depends on the informed cooperation and active support of those who are directly affected by the changes. In order for staff to support what you are doing, they need to understand your intentions.

What techniques will you use to prepare staff for introduction of change?

☐ **Prior and ongoing explanation and discussion**

☐ **Consultation with the union and/or staff association**

☐ **Involving staff in the design and introduction of the improvement**

☐ **Showing how this innovation works in another health facility**

☐ **Provision of training**

☐ **Other** _____

Then ask yourself:

- Who will be directly affected by this change?
- In what ways will they be affected?
- Positively? Negatively?
- What will you do to eliminate or reduce negative effects?

4. Make improvements that will last

Many good innovations eventually disappear because no specific actions were taken to make them sustainable. Old habits die hard! There are two main ways to help to counteract this:

- build the change into equipment, facilities, procedures and systems; ***and***
- change people's habit, attitudes and behaviour.

What changes will you make to tools and equipment to help ensure improvements are sustainable?

☐ **Remove any tools or equipment which makes it possible or easier to return to the old habits**

☐ **Build the improvement into equipment so that it cannot be removed**

☐ **Design new or modified equipment so that it is easier to use and maintain in the new way**

☐ **Ensure sufficient supplies and well-managed storage**

☐ **Provide posters with instructions, flow charts, and make other changes so that the improvement is easily visible and natural to follow.**

Other _____

_____

_____

_____

_____

_____

_____

5. Organize change

Build the following into your planning:

☐ **Define tasks clearly –break down more complex tasks into manageable parts; agree indicators for the main tasks**

☐ **Establish a firm but realistic deadline for each task**

☐ **Assign a responsible person to coordinate and monitor implementation**

☐ **Allocate adequate resources (time, materials, and money)**

☐ **Request regular progress reports and respond rapidly to issues or bottle necks identified**

☐ **Check that the improvements are working, are accepted by staff and have no unintended side effects**

☐ **Make sure that you and your supervisors lead the way by following rules and acknowledging staff who use or promote the improvement**

☐ **Build in ways of encouraging feedback from staff; for example, a suggestion scheme (the best ideas are posted or rewarded); regular meetings where staff are encouraged to explain problems and suggest ideas; exercises where staff use the checklist and make proposals.**

Other _____

_____

_____

_____

_____

_____

HEALTHWISE GLOSSARY- TRAINERS' GUIDE:

Abuse	Behaviour that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual.
Accident	*See occupational accident*
Airborne pathogens	Disease-causing agents that spread infection through mechanisms such as droplets or dust.
Assault/ attack	Behaviour intended to hurt or harm another person physically, including sexual assault.
Biological hazards/ biohazards	Infectious agents or hazardous biological materials that present a risk or potential risk to the health of humans, animals or the environment. The risk can be direct through infection or indirect through damage to the environment.
Blood-borne pathogen	Hazardous microorganisms present in human blood capable of causing diseases in humans.
Breastfeeding Arrangements	This involves making (simple) arrangements to help workers breastfeed or express milk to save for later feeding at the workplace.
Bullying/mobbing	Repeated vindictive, cruel, or malicious attempts to humiliate or undermine an individual or groups of employees.
Compressed work week	A system that allows for the re-arrangement of working time into fewer but longer shifts. This results in shorter work weeks.
Contamination	In the healthcare context, contamination is the presence of a potentially infectious or hazardous agent on a surface, on or in materials, and substances; this includes, for example, the presence of blood, body fluids and other potentially infectious biological materials on an instrument or on a surface.
Controls (Administrative)	The use of administrative measures (i.e. policies and procedures and enforcement measures) to reduce the risk of exposure to pathogenic organisms or other occupational risks.
Controls (Engineering)	Controls that isolate or remove a hazard from a workplace. They may include the use of appropriate mechanisms, methods and equipment to prevent worker exposure.
Controls (Work practice)	Practices incorporated into the everyday work routine that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g. prohibiting recapping of needles by a two-handed technique).
Discrimination	It entails treating people differently because of certain characteristics, such as race, colour or sex, which results in the impairment of equality of opportunity and treatment.

Ergonomics	The study of the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work.
Exposure	Work-related situation, condition or activity that puts the worker in contact with a potential occupational hazard.
Family-friendly (workplace measures)	Practices that facilitate the reconciliation of work and family life, and are introduced to complement statutory requirements.
Family responsibilities	Family responsibility encompasses more than working mothers or fathers caring for children; it also includes any worker caring for another family member for example, single adults caring for aunts or uncles, or adult siblings taking care of each other .
Flexible working time	A system where the employee's hours of work may vary, either from one duty period to the next, from week to week or across the year. They are commonly characterized by variations in the start and finish time of individual duty periods and/or in the days that are worked (and, in the case of shift work, the shifts that are worked).
Green hospital/health-care facility	The word 'green' is used to describe actions that make health services more environmentally-friendly, safer, and healthier for staff and patients, as well as more energy-efficient and less wasteful.
Harassment	Any conduct based on particular characteristics of the victim (for example age, gender, race, religion, disability, sexual orientation, HIV status etc.) that is unreciprocated or unwanted and which affects the dignity of men and women at work.
Hazard	The source or potential source for harm or adverse effect on the health of an employee or patient; anything which may cause injury or ill health to anyone at or near a workplace is a hazard.
Hierarchy of hazard controls	A method of prioritizing strategies and measures to control occupational health hazards listed in order of effectiveness: elimination; substitution; engineering controls; administrative controls; work practice controls and personal protective equipment.
Healthy work-life balance	The extent to which an individual is equally engaged in -and equally satisfied with- his or her work role and family role. Work-life balance consists of three components: • time balance refers to equal time being given to both work and family roles; • involvement balance refers to equal levels of psychological involvement in both work and family roles; • and finally, satisfaction balance refers to equal levels of satisfaction in both work and family roles.
Incident	An unsafe occurrence resulting out of, or in the course of work, where no personal injury is caused, or where personal injury requires only first-aid treatment.
Inspections (Workplace)	Structured and formal evaluation of workplaces to assist with the identification of hazards, assessment of risks and monitoring of implementation and compliance of health and safety policies.
Maternity leave	A woman's right to a period of rest from work in relation to pregnancy, childbirth and the postnatal period.

Musculoskeletal disorders	Injuries or disorders of the muscles, nerves, tendons, joints, cartilage and supporting structures of the upper and lower limbs, neck, and lower back that are caused, precipitated or exacerbated by sudden exertion or prolonged exposure to physical factors such as repetition, force, vibration, or awkward posture.
Occupational accident	Unexpected and unplanned occurrence, including acts of violence, arising out of or in connection with work which results in one or more workers incurring a personal injury, disease or death.
Occupational disease/ illness	Any disease contracted as a result of an exposure to risk factors arising from work activity.
Occupational Injury	Any kind of personal injury, disease, or resulting death from an occupational accident.
Paternity leave	Employment-protected leave of absence for employed fathers at the time of childbirth. In general, periods of paternity leave are much shorter than for maternity leave. Because of the short period of absence, workers on paternity leave often continue to receive full wage payments.
Parental leave	Employment-protected leave of absence for employed parents, which is often supplementary to specific maternity and paternity leave periods, and usually, but not in all countries, follow the period of maternity leave. Entitlement to the parental leave period is either for each parent or for the family, but entitlement to public income support is often family-based, so that in general only one parent claims such income support at any one time.
Part-time work	When an employed person's normal hours of work are less than those of comparable full-time workers.
Precautions (standard)	A set of measures designed to reduce the risk of bloodborne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients.
Post-exposure prophylaxis	An immediate short-term provision of antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure.
Reporting	Procedure specified by the employer in accordance with national laws and regulations, and in accordance with the practice of the enterprise, for the submission by workers to their immediate supervisor, competent person, or any other specified person or body, of information on any occupational accident or injury to health which arises in the course of or in connection with work; suspected cases of occupational diseases; commuting accidents; and dangerous occurrences and accidents.
Residual risk	The remaining level of risk after all risk treatment measures have been taken.
Risk	A combination of the likelihood of an occurrence of a hazardous event and the severity of the injury or damage that the event causes to the health of people or to property.
Risk assessment	The process of evaluating risks to workers' safety and health from workplace hazards. It is a systematic examination of all aspects of work that considers the likelihood of an occurrence of a hazardous event and the severity of the injury or damage that the event causes.
Risk management	The systematic application of policies, procedures and practices to the tasks of identifying hazards, assessing, controlling and monitoring risk.

Rotas	Systems that show the order in which people take their turn to perform certain duties (they are different from shifts which may be fixed or rotating).
Sterilization	A physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.
Stigma	Describes reactions to or feelings about a group or individual on the basis of certain characteristics, be it their sex, colour, religion, health status, sexual orientation, or some other quality. Very often it results from a lack of understanding –including false information and misconceptions, fear of the unknown, or simply because of intolerance.
Threat	Promised use of physical force or power (i.e., psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals or groups.
Violence (physical)	The use of physical force against another person(s) which results in physical and/or psychological harm. Examples are pushing, pinching, beating, kicking, slapping, stabbing, shooting, and rape.
Violence (psychological)	The intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment, and threats.
Violence (workplace)	Any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work; this extends to all places where workers need to be or to go by reason of their work and which are under the direct or indirect control of the employer.

ANNEXES

Examples of learning activities

Module 1

Exercise 1.1: Identifying occupational hazards

Time: 20 min

Equipment and materials:

- ☐ 5 flipchart sheets with categories of occupational hazards prepared by trainers in advance (use the model on next page; adapt to local context)
- ☐ Tape
- ☐ Coloured stickers / post-its / sticky notes (two different colours)
- ☐ Pens

Note: if you do not have stickers, use pens of two different colours to mark the items

Distribute at least 10 stickers to each participant (5 of one colour and 5 of another).

Ask participants to stick them to a flipchart to mark the hazards they consider a priority to address in their healthcare facility. Participants should use one colour to mark hazards for ***medical staff*** and the second colour for ***cleaning staff.*** (Alternatively they mark the hazards with a pen in two different colours)

Give the participants 2 minutes to stick all their post-its. Then count the marks for each of the hazards and summarize: which of the hazards the group distinguished as most important to address.

Also allow participants to write additional hazards on the flipcharts that were not included on the original list.

Discuss and analyse together: What do the participants think is the biggest problem? What presents the biggest hazards the staff is exposed to? What is the origin of occupational-related incidents and illnesses in the healthcare facility?

Remind participants that eliminating the risk at its source is the most effective response.

Exercise 1.1: Identifying occupational hazards (ctd)

Models for flipcharts with categories of occupational hazards

Biological hazards

- Hepatitis B virus, Hepatitis C virus
- Tuberculosis (TB)
- Measles virus
- Human immunodeficiency virus (HIV)
- Influenza
- SARS
- Gastro-enteric infections

Ergonomic, mechanical/biomechanical hazards

- Lifting and moving patients
- Tripping hazards, slippery floors, confined spaces, cluttered or obstructed work areas/ passageways
- Unsafe/unguarded equipment
- Awkward postures, repetitive/prolonged motions or activities,

Physical hazards

- Radiation
- Lasers
- Noise
- Electricity
- Extreme temperatures

Chemical hazards

- Disinfectants and sterilants (ethylene oxide, formaldehyde, and glutaraldehyde)
- Waste anesthetic gases;
- Hazardous drugs (cytotoxic agents, pentamidine, ribavirin)

Psycho-social hazards

- Stress
- Workplace violence
- Shift work
- Inadequate staffing, heavy workload
- Long working hours

Module 1

Exercise 1.2: No latex gloves - dispute resolution

Time: 45 min

Preparation time	10 min
Mediation of dispute and reporting back	25 min
Discussion	10 min

Equipment and materials:

☐ Copies of Background Information Handout (see next page)

Divide participants into groups representing employers, health workers/trade union and mediators. You will need 1-2 participants as mediators. The mediators' role is to neutrally facilitate the process of negotiation and report back from each group on the agreement they've reached in the time given as well as main points of arguments both parties used.

The employers' group and the health worker /union group should be briefed on the dispute regarding the use of latex gloves as protective equipment, and provided with the background information handout.

Dispute:

Staff have requested that latex gloves are replaced with non-latex, due to the high prevalence of latex allergy in the hospital. Management has indicated that it cannot afford to purchase non-latex gloves as there is no additional money in the budget for protective equipment. Furthermore, the hospital already has significant number of latex gloves in stock. Management has recently adopted new policies increasing awareness about occupational health and the importance of using personal protective equipment. The administration is promoting a safety culture within the health facility to meet new government targets on reducing workplace injuries and nosocomial infections.

Each group has 10 minutes to discuss and agree on their arguments. Then the groups meet for negotiation: Have the groups present their arguments separately to the mediator, then they discuss. The mediator helps facilitate a resolution of the dispute.

A final plenary discussion should focus on the complexity of workplace safety and the importance of shared decision making to reach feasible long-term solutions.

Exercise 1.2 (ctd)

Handout: Background Information

- Latex allergy is globally recognised as an occupational health risk for healthcare staff. Nurses association estimated 8 – 20% of healthcare workers are allergic to latex. While no deaths have to date been linked to the use of latex gloves, allergic reactions are on the increase.
- Latex proteins enter the body through skin, mucous membranes, intravascularly, or via inhalation. Cornstarch powder used in latex gloves is a carrier of the protein. Allergic reactions develop over time and lead to broken skin which may cause the staff member to withdraw from work activities where the use of gloves is required.
- The cost of non-latex gloves is two to three times higher than latex gloves. The limited availability and price fluctuation of non-latex gloves are dependent upon the ability of synthetic manufacturers to supply the raw materials for production and the lack of consistent demand. Therefore it is difficult for hospital administrators to access a reliable and affordable supply of non-latex gloves.
- It is difficult for managers to compare the cost of non-latex gloves with the cost of lost productivity, such as sick-leave, as a result of latex allergy.
- Non-latex gloves appear to have a higher failure rate than latex gloves. Some of the defects of non-latex gloves are not visible to the naked eye and may be an indirect cause of surgical wound infection, or may contribute to the risk of cross-contamination of blood-borne pathogens

Module 2

Exercise 2.1 Move, stretch and exercise

Time: 5-10 min

Equipment and materials:

☐ CD-Player or computer with speakers, and both, energizing/dance music track and relaxing slow music track.

During the course, take some time every now and then to break for some physical exercise. This can be simple, such as standing up and moving around, or invite for a short dance; or do some stretching exercises. Ask individual participants to give instructions for an exercise that the group has to do.

With slow music you can give instructions for relaxing exercises, such as conscious breathing.

Ask participants if they could do some exercises when they are back at their workplaces.

Module 4

Exercise 4.1: Workplace violence - Risk Assessment

Time: 30 min

One of the first steps when considering the prevention of workplace violence is an assessment of the related risks. An analysis should be conducted within each workplace and for each category of workers as a pre-condition for a targeted and effective intervention.

Equipment and materials:

- ☐ For each participant a copy of the handout on Risk Assessment of workplace violence (see following pages)
- ☐ The facilitator should prepare flip charts with the headings from the 5 sections of the assessment, with the headings: ***(note: the last two could fit on the same chart)***
  a. Type of workplace violence
  b. Occupations exposed to the risk of violence
  c. Situations that could pose a special risk of violence
  d. Work areas of special risk
  e. Work times of day when the risk of violence is more likely to occur

(Refer the participants to the definitions of the terms in the Glossary of the Action Manual.)

First, each participant should complete the assessment individually based on their workplace experience.

Then, in plenary, the facilitator should go through the types of violence and ask how many marked high, medium, or low and show the totals on the flip chart. For each section (Type of violence, occupations, the areas, situations, times) the facilitator should summarize the results and highlight those that were considered as the highest risk. This is followed by a general discussion based on the results. Participants should indicate if there were any surprises, what they learned while going through this process, and if they have any ideas on how to reduce the risks.

Exercise 4.1 (ctd)

Handout: Workplace Violence Risk Assessment

A. Identify the **type of workplace violence** experienced in your workplace by risk relevance:

Physical assaults/attacks	HIGH	MEDIUM	LOW
Bullying/ mobbing/harassment	HIGH	MEDIUM	LOW
Verbal abuse	HIGH	MEDIUM	LOW
Sexual harassment	HIGH	MEDIUM	LOW
Racial harassment	HIGH	MEDIUM	LOW
Threats	HIGH	MEDIUM	LOW
Other …….	HIGH	MEDIUM	LOW

B. Identify the **occupations** exposed to the risk of violence in your workplace by risk relevance:

Doctors	HIGH	MEDIUM	LOW
Nursing staff – registered	HIGH	MEDIUM	LOW
Nursing staff - auxiliary	HIGH	MEDIUM	LOW
Administrative staff	HIGH	MEDIUM	LOW
Ambulance staff/paramedical staff	HIGH	MEDIUM	LOW
Technical staff	HIGH	MEDIUM	LOW
Maintenance Staff	HIGH	MEDIUM	LOW
Management	HIGH	MEDIUM	LOW
Other……	HIGH	MEDIUM	LOW

C. Identify the **situations** at your workplace that are at special risk of violence by risk relevance:

Working alone (e.g. night and homecare nursing staff)	HIGH	MEDIUM	LOW
Working in contact with the public (e.g. information desk)	HIGH	MEDIUM	LOW
Working with valuables (e.g. cashiers)	HIGH	MEDIUM	LOW
Working in environments open to "external" violence (e.g. first aid)	HIGH	MEDIUM	LOW
Working with people in special distress	HIGH	MEDIUM	LOW
Other……..	HIGH	MEDIUM	LOW

D. Identify the **areas** at special risk of violence in your workplace by risk relevance:
(These may overlap with the situations under point C)

General care	HIGH	MEDIUM	LOW
Intensive care	HIGH	MEDIUM	LOW
Emergency care	HIGH	MEDIUM	LOW
Psychiatric care	HIGH	MEDIUM	LOW
Geriatric care	HIGH	MEDIUM	LOW
Disability care	HIGH	MEDIUM	LOW
Other ……..	HIGH	MEDIUM	LOW

E. Identify **times** at special risk of violence in your workplace by risk relevance:

Morning	HIGH	MEDIUM	LOW
Middle of the day	HIGH	MEDIUM	LOW
Afternoon	HIGH	MEDIUM	LOW
Evening	HIGH	MEDIUM	LOW
Night	HIGH	MEDIUM	LOW
Late in the night	HIGH	MEDIUM	LOW
Dawn	HIGH	MEDIUM	LOW
Change of shifts	HIGH	MEDIUM	LOW

Module 4

Exercise 4.2: Recognising stigma and discrimination in the workplace

Time: 30-40 min

Equipment and materials:

☐ Handout: Basic forms of HIV-related discrimination (see following page)

☐ Flipchart sheets

Disseminate the handout to participants and ask them to read and tick the box they think is most appropriate (5-10 minutes)

Present the following questions (on a flipchart sheet, copy or slide) for the participants to discuss in small groups of 3 or 4 persons:

(a) What are some discriminatory practices performed by staff in health care?

(b) Why are these practices used?

(c) How do you think people living with HIV feel about these measures?

(d) What is stigma and how could it affect people living with HIV?

(e) How are health workers living with HIV affected at their work / at your facility ?

(f) What can be done to ensure that people are adequately protected from infection, as well as feel less stigmatised?

(g) Which measures are taken at your health facility to prevent stigma and discrimination related to HIV?

Provide 15 minutes for discussion in small groups and 15 minutes for sharing with the rest of the group what they had identified. List all the issues mentioned by the participants on a flip chart so that they can be referred to later.

Exercise 4.2 (ctd)

Handout: Basic forms of HIV-related discrimination

The following are indicators from the UNAIDS ***"Protocol for the identification of discrimination against people living with HIV"*** (UNAIDS/2000/1). The purpose is to identify whether any of the items in the columns provides a particular restriction, distinction or exclusion amounting to possible arbitrary discrimination of people living with HIV&AIDS (actual or presumed).

ISSUE	Acceptable	Discriminatory/ unacceptable	Legal or unlawful?
I. HEALTH CARE			
1. Refusal to treat on grounds of HIV&AIDS status, actual or presumed.			
2. Different treatment on grounds of HIV&AIDS status, actual or presumed.			
3. Testing without knowledge.			
4. Refusal to inform a person of the result of an HIV test.			
5. Health controls, quarantine, compulsory internment, and/or segregation in hospital, clinic, nursing home, etc.			
6. Compulsory notification of HIV&AIDS status to sexual partner(s) and/or relative(s).			
7. Non-confidentiality: supplying names of individuals found to be HIV-positive to any other party, or knowingly or negligently allowing confidential files to be consulted.			
II. EMPLOYMENT			
8. Mandatory testing at recruitment.			
9. Mandatory testing during employment.			
10. Questions on recruitment forms and/or during interview related to HIV&AIDS status and/or 'lifestyle'.			
11. Lack of confidentiality regarding HIV&AIDS status.			
12. Dismissal, or change(s) in conditions of employment, on the grounds of HIV&AIDS status, actual or presumed.			
13. Restrictions due to HIV&AIDS status, actual or presumed (e.g., promotion, job location, training and/or employment benefits).			
14. Denial of employment on grounds of HIV&AIDS status, actual or presumed.			

Full document available at http://data.unaids.org/Publications/IRC-pub01/jc295-protocol_en.pdf

Module 6

Exercise 6.1: Drafting a job description

Time: 40-50 min

Group-work	20 min
Reporting back	15-20 min
Discussion	10 min

Equipment and materials:

- ☐ Flipchart sheets for each of the groups
- ☐ Pens
- ☐ Copies of the handout for Exercise 6.1: Common elements of a job description

Instructions:

Ask participants to break into small groups (4-5 persons). Distribute copies of the handout ''Common elements of a job description''.

Each group gets the task to draft a job description for one of the following jobs, using the handout as a structure: (Note: Adjust job titles to local context)

- Doctor (Emergency department)
- Nursing service manager
- Administrative clerk

The group should first choose the type of healthcare organization that is hiring. The group should define the job tasks for the position in question and the skills needed for each task. What qualifications are necessary for the post? What experience would you like the worker to have? How to find and attract an experienced qualified candidate for this for this position?

The participants can use flipchart sheets to write down the job description and to present it to the plenary.

Conclusion: A job description for new jobs helps managers to select staff on the basis of their skills and other relevant criteria. A job description also helps a team analysing existing work in a health facility to improve work organization.

You can extend the exercise with the following discussion:
Ask participants to analyse the tasks that need to be performed for each of the positions and whether the selected professional category is the best person to complete the task. Could tasks be allocated differently

- to utilize the workers' skills and experience most effectively
- to prevent overload of workers
- to make a work process smother?

Conclusion: It is useful to consider which tasks can be performed by which occupational category. Some tasks can be shifted to staff in a different category who could be easily trained to complete the work, such as auxiliary, administrative or maintenance staff. The working time of a doctor or a nurse can be better used for patient care rather than doing the job that could be successfully performed by someone else. It is important to keep in mind regulations of scope of practice and limits of delegation of authority. Ultimately, patient and worker safety and quality should be balanced against efficiency and effective use of resources.

Exercise 6.1 (ctd)

Handout: COMMON ELEMENTS OF A JOB DESCRIPTION

Job title:

Department: department or unit of the organisation where the work takes place.

Position reports to: line managers or supervisor

Role and key responsibilities: including managerial requirements and coordination with other people or departments.

Specific tasks: daily work assignments

Skills and competencies: requirements for the particular job. For example: intensive care nursing, midwifery, unit management or skills to maintain specialised equipment as well as general skills such as good communication, record-keeping, etc.

Qualifications: including the level of education, professional training and accreditation of qualifications with regulatory authorities and professional associations.

Experience and other requirements: special work requirements such as ability to manage projects or to work independently.

Module 6

Exercise 6.2: Practical suggestions on staff management and motivation

Time: 30 min

Group-work	10 min
Reporting back and discussion	20 min

Equipment and materials:

☐ Flip chart sheets & pens for each small group

Instructions:

Ask participants to break into small groups (5-6 persons) to discuss and identify:

- Two positive examples of practices of managing and motivating staff that they observed or discussed during the facility visit or at their own workplace;
- Three practical, concrete suggestions for improving practices in managing and motivating staff;
- The potential impact that these suggestions could have.

Remind participants that their suggestions should benefit both staff and the organisation. Suggestions should be practical, feasible and low-cost. If they have no concrete ideas for the visited facility, participants can think about their own organisation. Each group should select someone to present the results of the discussion.

Ask the groups to present their suggestions, and encourage a discussion on the suggestions made by the different groups.

At the end have the entire group prioritize the most important and feasible recommendations.

Module 7

Exercise 7.1: Impact of Long Hours

Time: 20-30 min

Group-work	10 min
Reporting back and discussion	20 min

Equipment and materials:

☐ Two flip charts & pens

Discuss the impact of working long hours on the safety, productivity, and quality of the services provided. Consider the points of view of patients, workers, managers, and overall quality for health services.

Divide the group into two ***(make sure that the groups are mixed with participants from different types of job categories).*** One side (pros) must come up with a list of all the benefits of working long hours. The other side (cons) must list all the problems caused by working long hours. Both sides should consider the different points of view- for patients, workers, managers, and quality of care etc.

Pros

- What are the benefits of long hours?
- How could those benefits be achieved while working shorter/ more regular schedules?

Cons

- What are the negative consequences of long hours? What impact does long hours have on medical errors or the risk of patient/worker injuries?
- Can the negative impact be minimized? How?

The results of the group work should be presented to plenary. Which suggestions are the best compromises to improve both productivity and to avoid errors and injuries?

Module 7

Exercise 7.2: Practical Suggestions on working time

Time: 30 min

Ask participants to break into small groups (5-6 persons) to discuss and identify:

- Two positive examples of practices concerning working time that they observed or discussed during the facility visit;
- Three practical, concrete suggestions for improving practices of managing working time in healthcare facilities;
- One or two suggestions for involving staff in improving work schedules;
- The potential impact that these suggestions could have.

Remind participants that their suggestions should benefit both staff and the organisation. If they have no concrete ideas for the visited facility, participants can think about their own organisation. Each group should select someone to present the results of the discussion.

Ask the groups to present their suggestions, and encourage a discussion on the suggestions made by the different groups.

At the end have the entire group prioritize the most important and feasible recommendations.

Module 7

Exercise 7.3: Advantages of introducing family-friendly measures

Time: 20-30 min

Equipment and materials:

- ☐ Flipchart sheets for each group
- ☐ Pens
- ☐ Tape

Ask the participants to divide into 2 groups.

One group discusses the advantages of introducing family-friendly measures for mothers and fathers, and the other group discusses the advantages for managers or the organization as a whole.

Ask them to list the main points on the flipchart and present to the rest of the group.

Display the slide on the benefits of family-friendly measures (Part 2, Slide 5) and compare the ideas presented by the groups to the benefits listed on the slide and discuss.

Conclusion: Emphasize that family-friendly measures are a win-win workplace strategy, which can help staff balance their work and private life easier, but also benefit the health facility in improving staff performance and quality of services provided.

Module 7

Exercise 7.4: Daily agenda

Time: 20-30 min

Equipment and materials:

- ☐ 2 flipchart sheets with hour-by-hour agenda prepared by trainers in advance (use model next page)
- ☐ Pens
- ☐ Tape

Divide participants into 2 groups, one only men and one only women. Ask each group to discuss and list their activities and tasks for a regular workday on a flipchart hour by hour for 24 hours, including work tasks, household work, rest periods and leisure time. Each group presents their 24 hour agenda to the rest of the participants. Place the lists of daily tasks of men and women next to each other and analyse the difference. It will most probably emerge that women have a greater load of responsibilities and longer work hours including their professional work, housework and family care (both paid and unpaid work). Discuss with participants how to balance the workload within a family.

Conclusion: Summarize discussion with a message on the necessity of shared responsibilities.

Exercise 7.4: An average daily schedule in my life (work and private time)

TIME	Tasks performed, activities and rest times
06:00 – 07:00	
07:00 – 08:00	
08:00 –09:00	
09:00 – 10:00	
10:00 – 11:00	
11:00 – 12:00	
12:00 – 13:00	
13:00 – 14:00	
14:00 – 15:00	
15:00 – 16:00	
16:00 – 17:00	
17:00 – 18:00	
18:00 – 19:00	
19:00 – 20:00	
20:00 – 21:00	
21:00 – 22:00	
22:00 – 24:00	
24:00 – 06:00	

Module 8

Exercise 8.2: Safe storage

Time: 20 min

Equipment and materials:

- ☐ Containers of different shapes and sizes, with labels indicating what they contain
- ☐ Alternatively: pictures of different containers of products used in health-care facilities

On a table, place a number of containers labelled as drugs or medication, cleaning agents, creams and lotions for external use, disinfectants, food and beverages, and other. Alternatively, if you use pictures, show the pictures on a wall or flipchart.

Ask participants to suggest good ways to store these items safely. List the ideas put forward by the participants on a flip chart or white board or slide. Allow the participants to put forward whatever ideas they may find useful to safely store these items. You can also let them organize the containers or pictures themselves. Discuss what might be the best way to separate and store different types of materials to ensure patient and staff safety. Invite comments about the different needs of different departments within the health facility. From the discussion distil a list of basic principles that should be followed when organizing equipment and materials.

Module 8

Exercise 8.3: Examples of storage cupboards

Time: 15 min

Equipment and materials:

- ☐ Photographs of good practices and of issues of concern taken during the checklist assessment exercise.
- ☐ Flipchart sheets
- ☐ Pens, tape

Display photographs with examples of equipment and supplies storage from the real healthcare facilities one by one and let participants comment on what they observe: what is good and what is poor practice and why. Encourage participants to think of examples of good and bad storage cupboards in their own facilities.

Participants should also discuss the link between storage and health workers' and patient safety as well as efficiency of health services. Encourage the participants to find both good and bad things on the same photo. You may write down the comments and keep a count of positive and negative points on a flipchart.

Follow-up to HealthWISE training

Follow-up to a training course is the most critical phase of the HealthWISE approach. It is in this phase that the lessons learnt during the training course will be progressively transformed into the expected improvements in working conditions and productivity. For monitoring the implementation of action plans, here are some examples of follow-up activities. (See also introduction, box "from training to implementation- the comprehensive HealthWISE approach) Well-coordinated follow-up activities often help local participants in creating an information network to sustain their improvement activities.

Visualize - Take pictures

Remind participants that they should document progress on their actions with photographs to visualize the improvements made with before-after-pictures.

Organize supportive follow-up visits

The participants' organisations are supported in their improvement plans and their progress is continuously monitored and evaluated. The visits could include the trainer and other participants from the course to encourage information exchange among peers.

Participants of the facility will present and discuss achievements and constraints with their visiting group mates and trainers. Practical hints for overcoming their specific challenges can be picked up from local wisdom and success examples. HealthWISE trainers should look into the organisational aspects of these improvements such as mobilisation of local resources and the scope of involvement of supervisors and workers.

Organize "Achievement workshops"

All participants of the training course from different health facilities meet to present their progress in implementing the action plans and the results in an informal and relaxed atmosphere. HealthWISE trainers will assist participants in preparing presentations that detail their action plans and achievements. Visual presentations involving slides or photographs and transparencies will be commended, particularly when it involves before and after the improvement workplace situations. Not only will they be convincing material of the course's results, they can also be added to the training materials of future courses.

Organize a final workshop

At the end of the agreed implementation period, the final workshop will summarize and acknowledge all improvements and achievements. It is important to present the results of the HealthWISE process to a broader public. Distinguished guest speakers are invited to give congratulatory addresses. The main part of this workshop is the final presentations of the participants' achievements and future plans followed by brief discussions.

Promotional activities

- **Networking of HealthWISE practitioners and trainers**

  Trainers and practitioners should be encouraged to organize themselves in networks for the exchange of experience, mutual support and planning. The idea is that they will meet regularly to discuss together the advancement of HealthWISE activities and overcome possible difficulties. Eventually teams of trainers might also set up their own body offering their technical and advisory services to participants.

- **Award a local HealthWISE champion**

  The identification of a local HealthWISE champion among health organisations can trigger positive imitation and the quick spreading of the methodology.

- **Prize to the best team of trainers**

  To further foster the initiative and motivation of trainers, a prize to the best team of trainers who assist with delivering the best HealthWISE improvements could be envisaged. Initiative taken in particular focus areas could also be acknowledged.

- **Case studies**

  Exemplary cases of successful HealthWISE interventions in health organisations should be collected and disseminated to enhance their replication and further development in other health organisations.

HealthWISE training evaluation form

Name:	.....
Date:	.....
Your job title:	.....
Name of health facility or organization:	.....

In order to improve HealthWISE training, we would appreciate receiving your feedback.

Please take a few minutes to share your views, comments and suggestions. If you prefer, you can give your feedback anonymously.

Mark responses with an X, as shown in the example below.

Needs improvement		Reasonable	X	Good		Excellent	

Your evaluation of the HealthWISE course

General aspects of the training

1. The time provided for the training was:

Adequate		Too little		Too long	

2. The teaching materials used were:

Insufficient		Reasonable		Good		Excellent	

3. The trainers managed to communicate the message:

Not very well		Quite well		Well		Very well	

General comments (how to improve the use of training time, materials, educational aspects, etc.)

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Session 1: Introduction and guide to the course and manual

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 2: Using the HealthWISE checklist

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 3: Controlling occupational hazards and improving workplace safety

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 4: Ergonomics: eliminating musculoskeletal hazards

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 5: Biological hazards and infection control, with special reference to HIV and TB

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 6: Tackling discrimination, harassment and violence at the workplace

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 7: Towards a green and healthy workplace

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 8: The key role of staff: recruitment, support, management, retention

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 9: Working time and family-friendly measures

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 10: Selecting, storing and managing equipment and supplies

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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Session 11: Drafting and implementing an action plan for HealthWISE improvements

Do you consider this topic relevant for your health facility or organization?

A Little		Reasonable		A lot	

What is your general assessment of the presentation?

Needs improvement		Reasonable		Good		Excellent	

What aspect of the session needs improvement?

Content		Examples		Exercises		None	

Please suggest how the presentation can be improved:

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HealthWISE Trainers' Guide

Health services are complex work environments, which can at times be hazardous. Unsafe working conditions may lead to attrition of the health workforce. Decent work in the health sector must include workers' health and well-being, since the quality of the work environment can influence the quality of care provided by health workers.

HealthWISE – a joint ILO/WHO publication – is a practical, participatory quality improvement tool for health facilities. It encourages managers and staff to work together to improve workplaces and practices. HealthWISE (Work Improvement in Health Services) promotes the application of smart, simple and low-cost solutions leading to tangible benefits for workers and health services, and ultimately for patients. The topics are organized in eight modules addressing occupational safety and health, personnel management and environmental health issues.

HealthWISE combines action and learning. The Action Manual helps initiate and sustain changes for improvement, using a checklist as a workplace assessment tool, designed for identifying and prioritizing areas of action. Each of the eight modules illustrates key checkpoints to help guide action. The Trainers' Guide contains guidance and tools for a training course and is accompanied by a CD-ROM, which includes a sample PowerPoint presentation for each of the training sessions.

HealthWISE is designed for use by all who are concerned with improving workplaces in the health sector, including health workers and health-care managers, supervisors, workers' and employers' representatives, labour inspectors, occupational health specialists, trainers and educators.

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