A Better Culture

A Better Conduct: Designing for Positive Workplace Behaviours and Cultures

Consultation Draft December 2024

Acknowledgements

A Better Culture acknowledges and pays our respects to the Traditional Owners of the lands across Australia and extend our gratitude for their contributions to health and healing. Our offices are located on the lands of the Wurundjeri people of the Kulin nation and we pay our respects to their Elders and ancestors past and present and acknowledge that Sovereignty was never ceded.

The project was commissioned by the Commonwealth Department of Health and Aged Care in December 2022 to address high rates of bullying, discrimination, harassment and racism (BDHR) experienced by doctors, and is hosted by the Royal Australasian College of Medical Administrators (RACMA).

The Advisory Board and the project team extend sincere gratitude to the Reference Group members for their tremendous efforts and valuable contributions since the project's inception. We also acknowledge the invaluable support provided by various associations and organisations, including the specialist medical colleges, which have played a pivotal role in supporting the project and its working groups.

Disclaimer

These reports are consultation drafts developed based on discussions among the working group members. While the members represent diverse stakeholders within the healthcare sector, the reports, recommendations, and any views expressed are solely those of the working group and do not reflect the official positions or views of their respective organisations. The contents of these reports should not be attributed to any organisation.

Support Services

BDHR is a challenging issue. Reading this document may bring up strong feelings. Free and confidential 24-hour support services are available online and via telephone.

If you or someone else is in immediate danger, call emergency services on 000.

The National Sexual Assault, Domestic and Family Violence Counselling Service, 1800Respect, provides support for people who have experienced, or are at risk of experiencing, violence and abuse, including sexual violence. It also contains an online searchable database to locate services in your area. Call 1800 737 732 or visit www.1800Respect.org.au.

For confidential and qualified advice over the phone for any doctor or medical student in Australia, call Drs4Drs on 1300 374 377, available 24/7.

For crisis support or suicide prevention services, call Lifeline on 13 11 14 or visit www.Lifeline.org.au. For non-crisis mental health support, call BeyondBlue on 1300 22 4636 or visit www.BeyondBlue.org.au for more information.

Safe Work Australia can be accessed at www.safeworkaustralia.gov.au for information about work health and safety and workers' compensation.

The Fair Work Ombudsman can be accessed at www.fairwork.gov.au to learn more about pay, wages, leave and other entitlements or to report a workplace issue anonymously.

The Australian Human Rights Commission can be accessed at www.humanrights.gov.au for information about discrimination and human rights, including how to raise a complaint.

Accessibility

If you speak a language other than English and need help understanding this document, you can contact the free Translating and Interpreting Service on 131 450. If you are deaf and/or find it hard hearing or speaking with people who use a phone, the National Relay Service (NRS) can help you. Please contact the NRS Helpdesk by calling 1800 555 660 or through your preferred call option.

Contents

" Tolerating poor behaviours by our colleagues or from consumers should never be seen as an inevitable part of Australian healthcare delivery. With good will and serious investment we can all and will do better."

David Clarke
Immediate Past CEO of the Australian Patients Association
Workplace Behaviour Expectations Working Group Chair

1.0 Executive Summary

1.1 Executive Summary

The Workplace Behaviour Expectations Working Group (WBEWG) is part of A Better Culture, a project funded by the Commonwealth Department of Health and Aged Care. The group used the research literature and its lived experience to focus on the desired conduct of healthcare leaders, supervisors, and workers and the legal and moral obligations of duty holders to design and manage work better to support this outcome.

This report outlines:

a) insights, and system-level recommendations and opportunities for action, by key stakeholders to support positive workplace behaviours in healthcare, and
b) a set of broad positive 'workplace behavioural or conduct expectations' that can be used to inform future reviews of professional Codes of Conduct and organisational policies.

It is acknowledged that the healthcare system is large and complex with multiple stakeholders. Managing the competing pressures on the organisations is not simple. A range of interacting system factors, from the national to organisational levels, impact the design of work and management practices, which in turn impact day-to-day conduct and individuals, team, and organisational cultures.

Creating better conduct and cultures in healthcare is a shared responsibility. So, it will require commitment and collective action from a range of key stakeholders. While the task is large, the many strategic opportunities for change, such as those included in this report, will help sustainable improvements to be made.

1.2 Key Recommendations

R1. **All healthcare leaders and participants** should recognise staff health and safety is as important as patient health and safety, and that the two are inextricably connected.

R2. **All stakeholders** should recognise their shared responsibilities and collaborate to build capacity and appetite for reform to support positive healthcare workplace culture.

R3. **All stakeholders** should optimise use of data and evidence to support reform efforts.

R4. **Governments** should increase available resourcing or engage effective demand-management strategies so that healthcare professionals are not exposed to ever-increasing workload demands.

R5. **Governments** should give clear indications to duty holders of their intent to protect healthcare worker safety by taking appropriate responsive regulatory actions.

R6. **Governments and industry partners** should sponsor programs to support increased healthcare system duty holders' knowledge and capabilities around the legal frameworks and evidence-based risk management

R7. **Duty holders** should mature their work health and safety (WHS) risk management approaches to improve the design and management of work, optimising workplace behaviours and cultures.

R8. **Duty holders** should seek and use competent WHS experts of seniority appropriate to the degree of risk.

R 9. **Educators, advocates, and leading employers** should partner to reinforce consistent behavioural expectations and capabilities and develop evidence-based codes of conduct.

R10. **A Better Culture** should develop a targeted communication campaign with content that demonstrates to key healthcare stakeholders the value of a better culture.

2.0 Project Background

2.1 A Better Culture Project

"A Better Culture" is a project commissioned by the Commonwealth Department of Health and Aged Care in December 2022 using unspent Specialist Training Program funds held by RACMA. It is a response to the medical training survey, which has shown year on year that reported rates of bullying, harassment, discrimination, and racism (BHDR) were disturbingly high, with a disproportionately worse experience among First Nations trainees.

Following were the agreed outcomes at the time of project initiation:

- a multi-faceted engagement strategy
- a tangible, achievable approach that would be adopted by all key stakeholders.

An 11-member advisory board and 12 reference groups involving over 200 individuals were established to co-design the project's work program. Three key themes emerged:

1. Workplace behaviour expectations
2. Career-long learning
3. Measurement and action

To advance work in these areas, five working groups were formed:

1. Workplace Behaviour Expectations Working Group
2. Curriculum Design Working Group
3. Healthcare Worker Cultural Safety Working Group
4. Individual Level Interventions and Reporting Pathways Working Group
5. Leadership Diversity Working Group

In addition to the five working groups the project secretariat commissioned two additional pieces of work – a cultural measurement tool and an integrating strategic approach to weave the strands of the project together.

This report is the product of the efforts of the Workplace Behaviour Expectations Working Group, which was working under theme one, Setting Expectations for Workplace Behaviour. Reports from other working groups can be found on the A Better Culture website using this link.

2.2 Working Group Members

Workplace Behaviour Expectations Working Group (WBEWG) members included:

Table 1 Working Group Members List

Name	Role
Mr David Clarke (Chair)	Immediate Past CEO, Australian Patients Association
Dr Peta Miller (Lead Author)	Director, WHS Consulting
Dr Anes Yang	Dermatologist
Dr Ashwita Siri Vanga	Emergency Physician
Dr Clinton Schultz	Psychologist & Director of First Nations Strategy and Partnerships, Black Dog Institute
Professor Greg Rickard	Adjunct Professor of Health, UTAS
Dr Jan Sharrock	Executive Director of Fellowship Affairs, ANZCA
Ms Kay Dunkley	Wellbeing Program Coordinator, AMA Vic (until July 2024) and Executive Officer, Pharmacists' Support Service.
Ms Kaz Redmond	Senior Project Officer, Partnering and Consumers, Safer Care Victoria
Dr Leah Barrett-Beck	Deputy Chief Medical Officer, Metro North Health & RACMA Jurisdictional Coordinator of Training QLD/NT
Dr Lucy Mayes	Engagement Manager, Hush Foundation. Independent change facilitator. Author: Beyond the Stethoscope: Doctors Stories of Reclaiming Hope, Heart and Healing in Medicine.
Dr Samuel Gluck	Medical Admin Registrar & PhD candidate
Dr Shilpa Veerappa	Critical Care Specialist

2.3 Working Group Goals

The Workplace Behaviour Expectations Working Group (WBEWG) is part of the A Better Culture Project. The group drew on the research literature and its lived experience to:

a) provide insights and system-level recommendations and opportunities for action by key stakeholders to support positive workplace behaviours in healthcare, and
b) develop a set of broad positive healthcare "workplace behavioural expectations" to inform future reviews of professional codes of conduct and related organisational policies.[1]

The working group's focus was primarily on the expected workplace behaviours of healthcare leaders, supervisors, and workers and the legal and moral obligations of duty holders to design and manage work well. The scope included anywhere medical services are delivered.

The significant stress that results from poor behaviours by healthcare consumers and associated with workers' personal circumstances, such as family violence and financial stressors, will influence workplace behaviours. However, the strategies to manage these will be different and were not the focus of this body of work.

[1] A list of the key project activities is at Appendix A.

3.0 Insights and Opportunities for Action

3.1 Insights and Opportunities for Action

"Just as our patients want the quick fix in favour of lifestyle change, so too do our institutions want quick fix culture change, without the required 'lifestyle changes'. In health care we should know better than most that the long-term health of any system — human body or workplace — requires addressing denial and blame, and building willpower, psychological flexibility, disciplined attention to unconscious habits, positive inputs from the whole system and environment, investment, time, and faith. Until we care enough and are prepared to invest time and will, we will continue to be disillusioned by 'yet another failed behaviour and culture change initiative' and a belief that healthcare has an 'intractable culture'."

Lucy Mayes, Engagement Manager, Hush Foundation. Independent change facilitator. Author: Beyond the Stethoscope: Doctors Stories of Reclaiming Hope, Heart and Healing in Medicine.

3.2 Prioritise Workers' Health and Safety

The need for action is clear. Exposure to work-related psychosocial hazards, including violence, aggression, bullying, or any form of harassment and discrimination seriously harms people and their organisation's ability to deliver high-quality and cost-effective health services.

"While well-meaning, calling healthcare workers angels and heroes when we endlessly sacrifice our own health for the sake of patients — it is not helpful. It just reinforces the legitimacy of chronic underfunding. Nor should we as nurses and doctors — as we too often do — assume that self-sacrifice is part of being a healthcare professional."

Greg Rickard, FACN

Despite the legislative guardrails and stakeholder efforts, the prevalence of work-related psychological and physical harm in healthcare remains disturbingly high.

In 2021-22 the highest proportion of serious psychological harm in the healthcare and social assistance sector was attributed to work-related harassment and/or workplace bullying (31%), excessive work pressure (25%), and exposure to workplace or occupational violence (20%) (Safe Work Australia, 2024).

Figure 1 Healthcare and social assistance serious mental injury claims – adapted from Safe Work Australia (2024)

95% experienced work-related violence and aggression mainly from patients, families, and visitors (Griffiths et al 2015).

Recommendation

R1. **All healthcare leaders and participants** should recognise staff health and safety is as important as patient health and safety, and that the two are inextricably connected

3.3 Stakeholder Reform Commitment

A wide range of social, political, environmental, organisational, and work system factors contribute to positive or undesirable workplace behaviours, including in the healthcare system. (Salmon et al., 2021; Carayon et al., 2015)

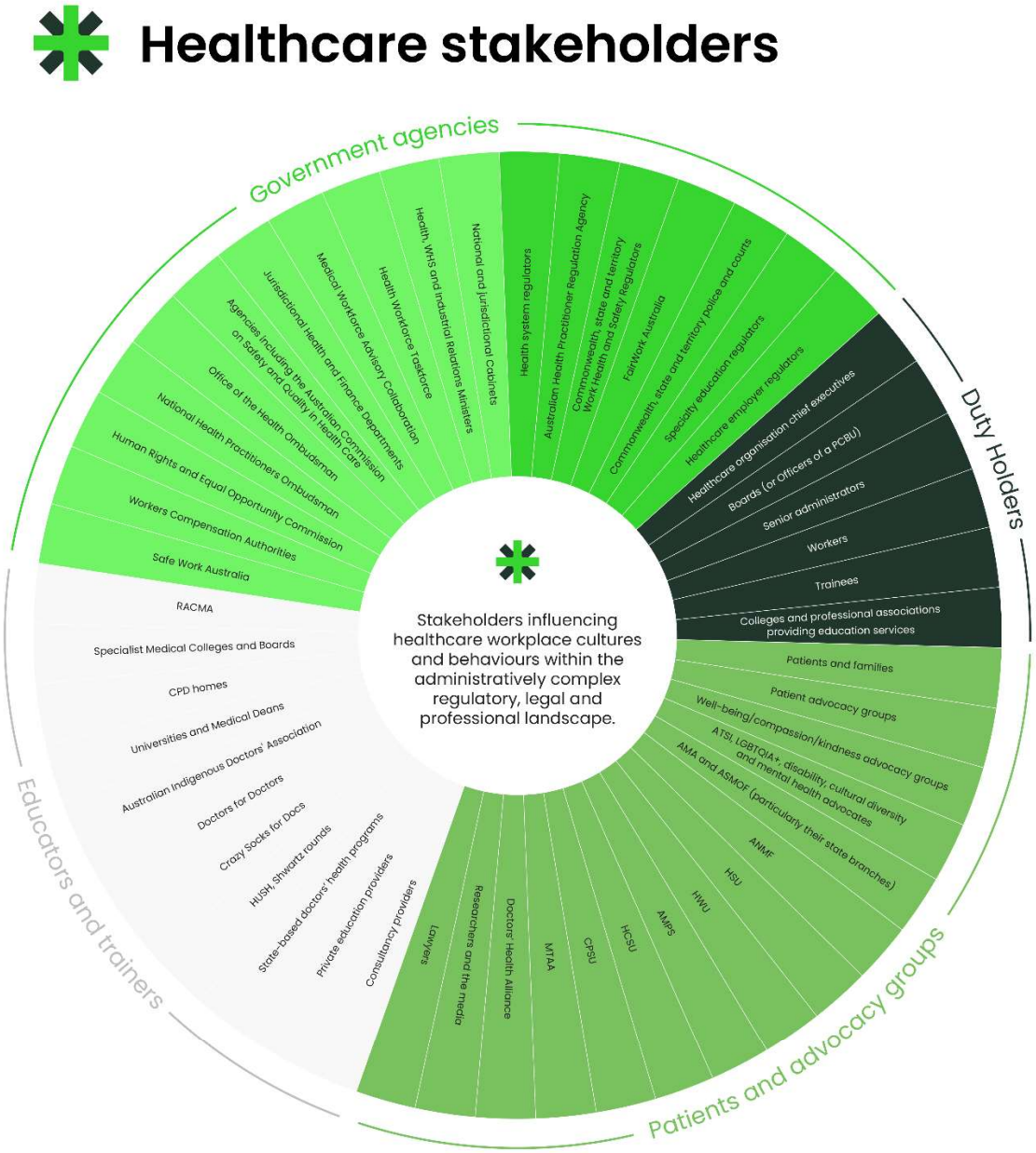
All Australian healthcare system stakeholders directly and indirectly impact work health and safety (WHS), positive organisational and team cultures, and worker and consumer behaviours.

"***While changing cultures and behaviours can be hard, there are useful lessons from how all stakeholders continue to work together to deliver gold standard patient safety. Similar stakeholder commitment and investments will be needed to support improved workplace behaviours."***

Dr Jillann Farmer, CEO, A Better Culture.

Figure 2 (overleaf) maps the key stakeholders in the Healthcare ecosystem.

Figure 2 Example Healthcare System Stakeholders[2]



Government agencies

Governments and agencies that oversee or implement policy.

Agencies that support and enforce compliance with the legislation

Duty Holders

Includes those with specific obligations under health, WHS or industrial relations legislation.

Patients and advocacy groups

Includes a diverse group of patients and those with a general interest in workplace behaviour, and those whose main role is to provide advocacy on behalf of workers or businesses on WHS and industrial relations matters.

Educators and trainers

Includes those whose main role is to provide training and certification to practise, may also be policy advocates.

Recommendations

R2. All stakeholders should recognise their shared responsibilities and collaborate to build capacity and appetite for reform to support positive healthcare workplace culture.

R3 All stakeholders should optimise use of data and evidence to support reform efforts.

Opportunities for Action

- To achieve genuine and sustainable improvements to workplace behaviours by staff and consumers, coordinated action will be required (multipronged and multi-level actions) by all stakeholders in the healthcare system. Coordinated implementation of programs should be a focus of future work of A Better Culture Project.
- A project to co-design healthcare-specific resources on systems thinking and other evidence-based analysis and prevention approaches would help to mature the primary prevention and secondary and tertiary responses proposed by all stakeholders.

3.3 Effective Healthcare Demand Management

The delivery of high-quality healthcare is challenging in an environment where there are significant and increasing fiscal and other business pressures.

"Almost universally, leaders attest that their people are their most important asset, and poor workplace behaviours are not tolerated. But the reality is, despite this rhetoric, many organisations routinely prioritise patient services over their own staff health and safety, and in some cases, punish the whistleblowers and reward the perpetrators or poor behaviours."

Kay Dunkley, AMA Victoria & Pharmacists' Support Service

A fundamental challenge will be the disconnect between the communities' expectations and demands on the system and the fiscal allocations by governments. As will be discussed later, this shortfall impacts healthcare facilities' capacity to deliver high-quality care while also ensuring WHS and workplace behaviours standards are met. This point was clearly raised at the 2024 IHI/BMJ Forum on Quality and Safety in Healthcare.

Recommendation

R4. Governments should increase available resourcing or engage effective demand-management strategies so that healthcare professionals are not exposed to ever-increasing workload demands.

Opportunities for Action

- Government funding models must be adequate, so organisations have sufficient human and financial resources to deliver high quality care while also ensuring the health, safety, and wellbeing of their staff.

3.4 Responsive Regulatory Action

Health care delivery is complex, and the harm data clearly demonstrates it is a high-risk industry. It is also one of the largest industries in Australia and governments are major employers.

WHS regulators consistently list the industry as one of their top priorities. Their data clearly shows harm and inadequate prevention efforts yet historically they continue to use ”light-touch” regulatory approaches.

The terrain appears to be slowly shifting, with some now prepared to prosecute (WorkSafe Victoria, 2021) or enter enforceable undertaking for serious contraventions related to hazardous workplace behaviours (NSW, 2022).

+ An interesting recent development is the preparedness of unions to use their right to prosecute. (*Prosecution Case Launched over Broken Health System — NSWNMA — the New South Wales Nurses and Midwives' Association*, 2023). The NSW Nurses and Midwives' Association recently commenced action against the New South Wales government on behalf of its members in the Supreme Court. This focused on inadequate staffing models that created WHS risks to its members.

In the face of serious budgetary pressures and the absence of legal and financial ramifications for serious WHS breaches, healthcare leaders' motivation to prioritise WHS, including behavioural standards, is likely to continue to be too low.

Governments should therefore be using *all* the tools in their responsive regulatory toolbox.

Recommendation

R5. Governments should give clear indications to duty holders of their intent to protect healthcare worker safety by taking appropriate responsive regulatory actions.

Opportunities for Action

- Behavioural insights and best practice regulatory theory can be used to design education programs to improve duty holder awareness of and compliance with the minimum legal standards designed to protect workers' health and safety (Newman & Wodak, 2022).
- Serious and persistent noncompliance should be met with responsive regulatory approaches (Walters et al., 2021) to push recalcitrant duty holders towards better compliance.

3.5 Improved WHS Risk Management

The WHS duty holders include the chief executive[3], board members and the most senior officers of the organisation. This includes those organisations like hospitals and those involved in the delivery of certification, education, and training of staff who use or visit those facilities (like universities and medical colleges). It also extends to employee doctors and those in private practice who use and visit the site. They *all* share a duty to manage the risks leading to and the consequences of poor workplace behaviours.

Every worker must take reasonable care through their acts or omissions not to harm themselves or others. This duty extends to all those conducting work in the organisation *irrespective* of their seniority and the nature of contractual engagement. That is, for example, it applies equally to a CEO as it does to the nurse or visiting doctors.

In response to reported confusion around the requirement to manage the work-related risks to psychological health and safety, and poor compliance by employers, many governments recently strengthened and clarified these duties. Regulations, codes of practice, and guidance have now been released by most of them[4].

[3] Generally, these under WHS legislation will be considered the person conducting the business or undertaking (PCBU)

[4] Commonwealth, NSW, Queensland, South Australia, Western Australia, ACT, and NT. Victoria is yet to amend its regulations but has a strong focus on psychological health and safety.

Amongst the recent changes, there will now be additional requirements related to incident notification[5].

Our group's review concluded that the Australian WHS and anti-discrimination legislation now provides a sound legal framework[6] and clear *minimum* standards related to acceptable workplace behaviours. But these need to be known, understood and applied by duty holders. And there must be an end to the relative impunity that healthcare organisations have historically enjoyed. This change will require explicit and targeted communication with the health sector, making clear that it is not exempt from responsibilities.

Recommendation

R6. Governments and industry partners should sponsor programs to support increased healthcare system duty holders' knowledge and capabilities around the legal frameworks and evidence-based risk management.

Opportunities for Action

- Duty holders' knowledge of their legal duties and where to access evidence-based resources could be improved through codesigned information programs collaboratively implemented by governments, colleges, educators, and key advocacy groups. Without question, there are complexities in healthcare, and these can be best addressed by development of resources specifically addressing those complexities.

3.6 Commitment to Worker Safety and Mature Approaches

Deeper and more mature understandings of the system-level drivers for unacceptable workplace behaviours are required. The application of a systems-thinking lens[7] can improve key stakeholders' understanding of the different causal pathways for good or poor workplace behaviours within the healthcare system.

---

[5] The WHS Act (ACT) now requires suspected or actual sexual assaults to be reported the WHS Regulator as of June 9 2023.

[6] Legislation relevant to the A Better Culture project is in Appendix C.

[7] It is based on the notion that the properties of a "work system" are created by the positive and negative actions of all key stakeholders — politicians, PCBUs, boards, senior managers, and WHS and human resources teams, supervisors, and workers. The systems view of causation looks beyond the most immediate causes to reveal a bigger picture of all the factors at various levels within the complex work system that contributed to the outcomes of interest. It emphasises understanding the dynamic interconnections and interactions within the system this helps identify solutions and improvements (Keating et al., 2021; Salmon et al 2021; Amissah, Gannon and Monat, 2020; Salmon et al 2020; Cassano-Piche et al, 2009).

This can reveal strategic opportunities for governments, duty holders, colleges, education providers, and advocacy groups to support positive workplace behaviours and fair proportional responses if incidents occur.

Work Design and Management

"I routinely see doctors that are chronically overworked are tired, stressed and burnout. So it is hardly surprising if their behaviour and performance does not always meet professional standards. If we do not make genuine system-level improvement to underlying causes, then nothing will change."

(Working Group Member)

Leadership and Risk Management

Regulators advise that organisational cultures and poor workplace behaviours are the by-products of the design and management of work, systems of work, and organisational and team norms, as well as the beliefs and attitudes of individual staff members.

Poor designs lead to exposure to a range of psychosocial and physical hazards and risks that in turn can lead to moral distress, emotional reactivity[8], exhaustion[9], hazardous workplace behaviours, stress, fatigue, burnout, serious errors, safety violations and dissatisfaction. These increase the likelihood of poor and even hazardous behaviours and erode team and organisational cultures. (Stratton et al., 2021; Giannetta et al., 2021; van Dijk et al., 2019; Jackson and Frame, 2018; Moser et al., 2013; Drew et al., 2012). The common hazards and risk are well known (see Appendix C).

The heaviest legal obligations to manage the risk of poor workplace behaviours and other WHS risks rest with the organisation's senior leadership team. This includes leaders of healthcare facilities and organisations, supervisors, colleges that provide education and training, and visiting private doctors using hospital services.

Leaders must, so far as is reasonably practicable, protect the physical *and* psychological health and safety of all their staff and those visiting their site; this includes from exposure to hazardous and unlawful behaviours.

They must proactively identify and then design out work-related sources of harm. Only if elimination of these is not possible, then they can also use a mix of evidence-based control measures to minimise the residual risks.

The leadership team is responsible for and guides the business and WHS risk-management processes. It determines the organisation's structure, governance and operational priorities, staffing levels and workloads, investment and maintenance of

[8] Where staff overreact to situations that they would tolerate in other circumstances.

[9] This leads to a lack of willingness to invest their discretionary effort, so reduces their willingness to support others or take on additional workloads

infrastructure, equipment, and supplies. Their decisions effectively design their organisation and work to be done, in turn shaping the culture and consequences for poor workplace behaviours, or incentives for positive workplace behaviours.

While healthcare leaders have minimal influence over an individual's deeply held beliefs and attitudes, better design and management of work will reduce the likelihood of those harmful workplace behaviours being displayed. They can ensure policies are in place (and used) and that these are consistently and fairly administered to deal with deviations from acceptable behaviour. If they are, they will then also have designed in a proportional and fair response to behavioural breaches.

"A key barrier is when the leader perceives WHS as a cost, rather than understanding that investing in prevention will improve staff and patient safety, and in the long run enhance their organisation's resilience. WHS regulators commonly cite that employers often feel overwhelmed and would benefit from specific, practical, evidence-based advice on which interventions are most helpful and cost-effective improvements."

Dr Peta Miller

Leadership commitment (evidenced by genuine attention and appropriate governance and resource investment) is consistently cited by regulators and WHS experts as central to good WHS.

"There is a critical need for practical research to demonstrate which interventions provide the best [return on investment]."

Dr Peta Miller

To be credible, the senior leadership team must "walk the talk", applying the same behavioural standards to itself that it expects of others.

Systems Thinking and Good Work Design

Duty holders should be using trusted evidence-based methods to design out the risks associated with poor workplace behaviours and design in protective features. The skills to do this already exist in healthcare, having been used for several decades to improve patient safety. However, despite the learnings of the value of system approaches in that sphere, workplace safety has not yet benefitted from these advanced ways of tackling the issues.

Advice on good work design is available on websites including Safe Work Australia (e.g. the Model Code of Practice: Managing psychosocial hazards at work) WHS regulators, government agencies, unions, industry and non-governmental organisations like the Mentally Healthy Workplace Alliance

A short scan of these indicates they advocate the use of systems thinking and work design. All will recommend the use of a combination of control measures across the hierarchy of control to:

1. optimise general, mental, emotional, and physical demands (i.e. making sure these are tolerable — that is neither not too high or too low) and
2. bolster support and resources that make it easier for workers to cope with these demands.

Common work designs to help reduce stress, fatigue and associated unacceptable behaviours include:

- appropriate workload management
  - use of realistic caseload mix algorithms,
  - ensuring adequate project planning whenever introducing new treatments, procedures, or equipment,
  - budgeting for and using sufficient and capable staffing,
  - ensuring rosters are realistic rosters,
  - matching tasks to reflect the available staff and their skills,
  - designing tasks to allow adequate rest and recovery,
  - deferring non-essential tasks during busy workload periods,
  - using task rotation to allow adequate rest and recovery[10],
  - scheduling time for difficult tasks to be completed safely (especially by inexperienced staff),
  - triaging patients and families with a high propensity of violence, and
  - outsourcing tasks to external companies with the capacity to deliver services safely (e.g. outsource tasks to companies that have appropriately skilled workers or specialised equipment)
- matching workers' level of job control to their skills and experience
- providing additional security guards and implementing timely incident procedures in high-risk areas.
- increasing emotional and practical support during periods of high demand (e.g. provide more workers, better equipment, or outsource tasks)
- improving hospital designs and layout to reduce physical workloads
- ensuring IT systems, medical technology, and other equipment is well designed and operational and that staff are trained in their safe use.
- providing staff with relevant timely induction, training, supervision, and instructions
- implementing safe work systems and procedures
  - tailored to the workforce (i.e.in suitable languages and formats) for culturally and linguistically diverse workers.
  - located where they can be easily found when needed.
  - that describe the most common psychosocial risks, how these will be managed, and the managers and workers' responsibilities.
  - provide practical advice on reporting incidents and complaints

[10] Task rotation is a work procedure that aims to minimise risk by limiting the amount of time and/or number of times a worker is exposed to a hazard. It can be used as part of job control to allow workers to choose (within reason) the order they do tasks, to help reduce stress, boredom, and fatigue.

        - explain what to do if hazardous behaviours like bullying occur, etc.
    - cultivating a high-trust learning culture
    - effective ongoing collaboration, consultation, and coordination with staff, and
- implementing local programs to shift attitudes and promote the safety and dignity of patients and workers that suit the users of that healthcare facility.

Recommendation

R7. Duty holders should mature their WHS risk management approaches to improve the design and management of work, optimising workplace behaviours and cultures.

Applying system-thinking[11], sociotechnical[12] and Safety 2 lenses can powerfully complement traditional WHS risk management approaches. Duty holders should use these to better understand the causal pathways of WHS risk generally and the causes of good and poor workplace behaviours and organisational and team cultures.

Opportunities for Action

- Funding to support targeted research into healthcare work design, management, and culture, and on which interventions are most effective to generate sustained cost-effective improvements, can supplement learnings from other high-risk industries.
- The application of good work design will help leaders meet their legal obligations to protect workers' and patients' health and safety and enhance the organisational resilience in times of high fiscal pressure and community demands.
- Resources produced by stakeholders should discuss the links between stress and exposure to psychosocial and physical risks to poorer behaviours and performance at work.
- College and Australian Medical Council accreditation teams have a criterion of work design in their evaluation criteria.
- Duty holders who share responsibility for workers' and visitors' health and safety should consult, collaborate and coordinate activities to improve the design and management of work and organisational and team cultures.

[11] In addition to the use of system-thinking tools such as AcciMap, the use of ActorMap can help visually depict the key elements and/or individuals that make up a system. This will include useful information such as the context, connection, patterns, and actors' perspectives of the issues. Actor-mapping is related to, but fundamentally distinct from, traditional stakeholder analysis.

[12] Socio-technical theory is that the design and performance of any organisational system can only be better understood and improved if both social and technical aspects are treated as interdependent parts of a complex system.

"WHS is often treated just as a compliance exercise and an inconvenience without a genuine commitment to address the underlying causes of poor behaviours."

(Working Group Member)

Organisational and Team Culture

"Most doctors most of the time behave well and make good healthcare decisions. But to err is human. In my experience, typically investigations are punitive and litigious; this undermines collegiality and learning cultures. We do not acknowledge, reinforce, and learn from what most of the time is going well, even under the most extraordinary pressures from the system. It is really demotivating."

(Nuclear medicine specialist)

A central tenet expressed by the group was the critical importance of organisational and team cultures and the subcultures within the different medical specialities. The medical colleges and education providers play a critical role in supporting positive cultures and behavioural expectations within the medical fraternity.

Another consistent theme was how many parts of the system influence the dominant day-to-day practices and behaviours. These, in turn, create the organisational and team cultural norms that can supress or enhance the likelihood that individuals will feel permission to behave in particular ways.

The core behavioural expectations described in section 3.9 call out the importance of designing in *just and learning cultures*. That:

- it is safe for staff to report alleged unacceptable behaviours without fear of retribution,
- investigations will be competently and fairly undertaken,
- the underlying system causes will be designed out, and
- there will be fair and proportional organisational responses to gross deviations from the accepted behavioural norms.

Opportunity for Action

- Organisations should ensure the work design supports a just learning culture.

Post Incident Assistance Programs

Evidence-based targeted critical incident debriefing programs can be useful in healthcare to support distressed staff exposed to poor workplace behaviours. Such debriefing must be conducted in accordance with protocols known to minimise re-traumatisation (e.g. avoidance of enforced recounting of traumatic events).

Employee assistance programs (EAP) provide confidential psychological support to staff and are often part of the services offered by major employers and sometimes by the medical colleges.

An EAP literature review was done by the NSW State Insurance Regulatory Authority in 2022 (Not health-specific). It made the following statement:

> *"According to the Productivity Commission's Mental Health Inquiry report (2020), there is considerable variation in service delivery, with this determined by the contractual arrangements. Given the variability in qualifications and experience of clinicians and providers delivering the services, there has been some concern about the reputation and perceived reliability of EAPs (Productivity Commission, 2020). This demonstrates that while EAPs can support workplace mental health, there is further work needed to ensure appropriate, effective, and quality service delivery."*

It could be argued that the quality of service and seniority of providers is particularly important when the client is a senior health professional, who will likely be quick to detect uncertainty or platitudes.

EAPs certainly have their place, particularly if monitored and evaluated for quality, but EAPs will not address the underlying risks generated by poor organisational work design and management, nor change poor cultures or other unacceptable workplace behaviours. It is not therefore regarded as a primary prevention tool by WHS regulators.

Opportunity for Action

- Where employers, colleges and professional associations provide access to EAP, they should ensure those providers are competent. WorkCover authorities develop tips to assist employers to select competent providers.

3.7 WHS Experts

"Healthcare services today appear to be the only remaining high-risk industry (risk to workers) that does NOT have strong WHS practices. Many do not apply WHS science to their organisation's risk management and have a tokenistic compliance culture. It has long been understood that just ticking compliance boxes does not make for healthy and safe nor productive workplaces."

David Clarke, Immediate Past CEO, Australian Patients Association, Chair, Workplace Behaviour Expectations Working Group

Emeritus Professor Andrew Hopkins notes that organisational structures have powerful impacts on culture and practice — that is, behavioural expectations. He argues that if a WHS expert is not part of the senior leadership team, safety is unlikely to be prioritised and viewed as being of equal importance to managing other operational pressures (Hopkins, 2019).

Appropriately qualified, certified, and experienced WHS experts, working at least at the executive level and providing direct, unfiltered advice to chief executives and boards, can provide duty holders with strategic advantage. They can assist the senior leadership team to move their organisation beyond a compliance mindset to a learning culture and use evidence-based approaches to design out the underlying causes of significant WHS risks, including poor behaviours.

Operational level WHS experts can assist with:

- consulting workers and key stakeholders on WHS risk management,
- supporting safety committees and health and safety representatives to effectively fulfill their roles and responsibilities,
- identifying and assessing critical workplace hazards and risks using systems thinking and other tools,
- developing and assisting with the implementation of targeted risk controls, including on improved work design and management approaches,
- developing incident management and reporting procedures,
- investigating WHS incidents using a systems-thinking approach,
- ensuring requirements around incident notification are met,
- reviewing and updating WHS policies and procedures, and
- advising the CEO and board on appropriate lead and lag performance metrics and continuous improvement options.

These activities can assist the person conducting a business or undertaking (PCBU) and the board to meet their due diligence obligations.

"Competent professionals must do incident investigations. In my hospital the person doing the investigation did not use systems thinking. They ended up just reporting it was poor doctor and nurse behaviour and their solution: more training and punishing those involved. It solved nothing."

(Working Group Member)

Recommendation

R8. Duty holders should seek and use competent WHS experts of seniority appropriate to the degree of risk.

Opportunities for Action

- Organisations should have a WHS expert as part of the leadership team, and
- WHS experts should be used to conduct sensitive WHS investigations using systems-thinking approaches.

3.8 Health Educators and Professional Associations

Providers who deliver education to health professionals should understand and comply with their WHS duties as PCBUs.

Medical colleges, universities, and accredited health educators along with healthcare facilities and management should be exercising substantial control over the activities of trainees and their supervisors. As a PCBU delivering education, they **share legal obligations** with the healthcare facility PCBU to ensure students and supervisors are not harmed by the work.

Many universities, medical colleges, societies, service providers, and other trainers should proactively collaborate with others to ensure the WHS risks to students are appropriately managed (Thomas Lawson Haskell et al., 2024).

All colleges and educators should appropriately **communicate, consult, coordinate, and cooperate** with those who share WHS duties for the health and safety of staff. This is a legal duty and critically cannot be delegated.

Colleges and educators should have processes in place to confirm (so far as reasonably practicable) that students comply with, understand and are aware of the sites' health and safety policies and procedures.

"Education providers like the colleges need to empower and support trainees to safely raise issues impacting their own and others safety. We need appropriate incident reporting and response."

(Working Group Member)

The national and individual codes of conduct and policies such as that produced by the health practitioner registration boards, medical colleges, professional associations, and

individual organisations (while not necessarily legally binding[13]) provide strong evidence and statements useful for all staff to meet their expected workplace behavioural standards.

Effective fair organisational responses to manage incidents of poor behaviours are integral to respectful workplace behaviours and culture.

"Doctors and trainees can justifiably fear if they complain or report poor behaviour by a senior doctor, their career progression will be seriously harmed."

Kay Dunkley, AMA Victoria, Pharmacists' Support Service

Medical colleges and educational programs need to reinforce behavioural expectations. This can be achieved through the development of and consistent fair application of codes of conduct applied to all their members, staff, and volunteers, as well as the provision of continuing accessible education and resources.

Recommendation

R9. Educators, advocates, and leading employers should partner to reinforce consistent behavioural expectations and capabilities and develop evidence-based codes of conduct.

Opportunities for Action

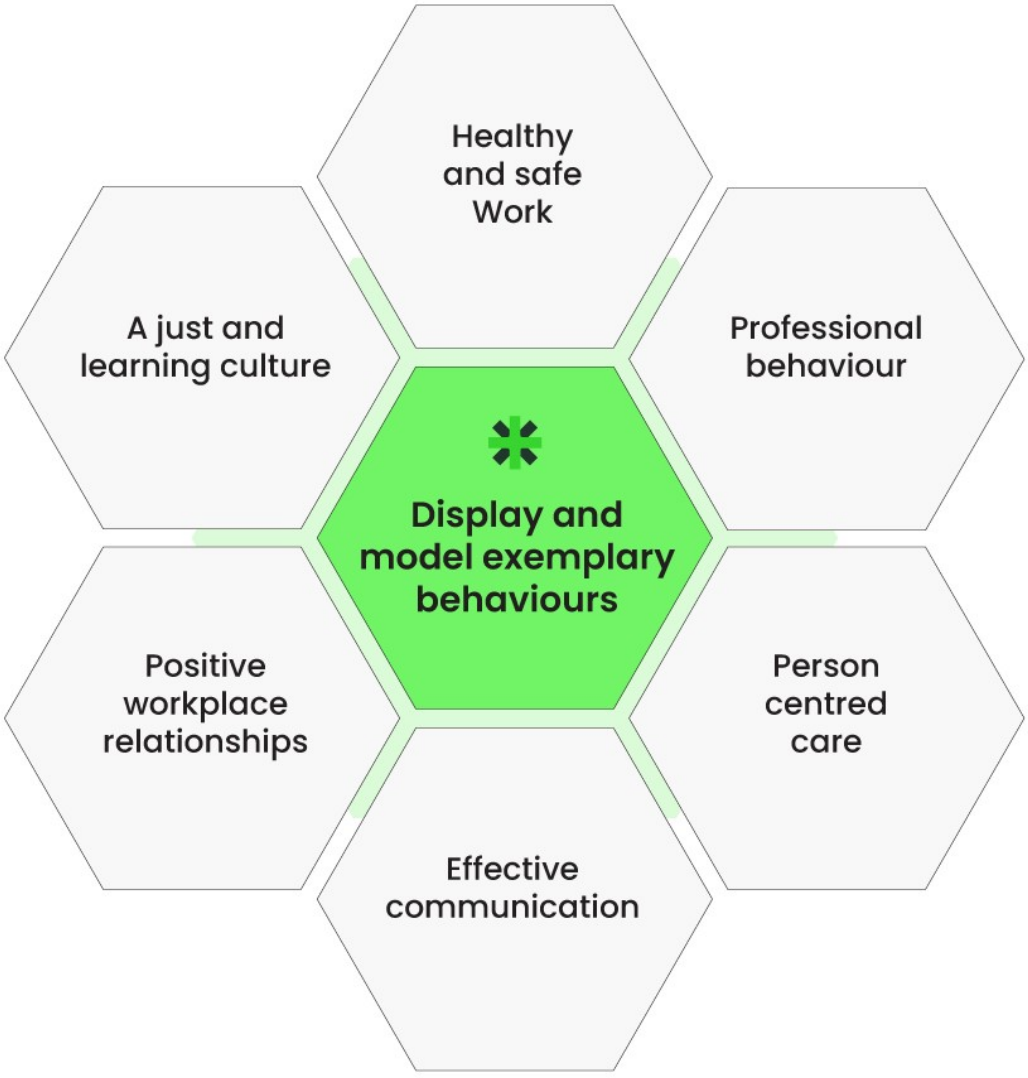
- Most medical and professional associations have guidance on workplace behavioural expectations. To be more useful, these should be evidence-based, reflect the recent legislative changes, embed the need for a just and learning culture, and other features suggested as noted below.
- A review of the existing conduct codes was undertaken (see Appendix E). This found there are clear opportunities to further improve the quality and utility of these documents and provide awareness and education around them.

[13] Although they may enforce sanctions for serious non-compliance

3.9 Suggested Inclusions in Codes of Conduct

To inform a future national healthcare code of conduct, the WBEWG proposed six overlapping behavioural categories that will support the desired outcomes (the central blue hexagon). Note, the emphasis on the below is to address and elevate the importance of preventing psychosocial hazards for workers and is intended to augment patient-centred codes of practice.

Figure 3 Workplace Behavioural Expectations



The overarching expectation is that *all* those working in healthcare will display and model other exemplary workplace behaviours. This includes interactions with other staff, patients, and site visitors.

If this occurs, staff can remain healthier and safer at work and better able to provide quality healthcare services.

Six overlapping behavioural categories are proposed to help support this outcome. The problem and rationale are noted under each.

Healthy and Safe Work

Key Sub Elements

- Comply with WHS duties.

Leaders, so far as reasonably practicable, manage WHS risks in line with the advice provided by their regulator. All staff follow reasonable WHS procedures and do not, through their actions or behaviours, harm themselves or others.

SafeWork NSW has released a useful guide on the WHS duties within a hospital setting).

- Effectively consult workers.

Those responsible for the design and management of the organisation, jobs, tasks, and systems of work ensure there is genuine and appropriate staff consultation on issues that may impact them. This is a legal duty but also makes sense, as workers can help identify key WHS risks and provide practical solutions. Better practice is to ensure relevant workers are part of the co-design of solutions to improve workplace behaviours.

- Apply systems thinking, evidence, and data to risk management.

To complement existing WHS risk management systems, those responsible for the design and management of the organisation, jobs, tasks, and systems of work apply a systems-thinking lens and collect and use relevant evidence and data. Staff use appropriate channels to promptly report unethical or unsafe behaviours and other WHS risks.[14]

This information and approach will help to better identify, assess, implement controls, and monitor the underlying causes of WHS risks, including poor behaviours.

- Implement “good work” design.

Leaders ensure the organisation, jobs, tasks, and systems of work are well designed and managed to eliminate or minimise psychosocial and physical risks. Leaders strive to exceed minimum legal standards and design and manage work to improve staff health, safety, and wellbeing.

- Provide appropriate information, training, instruction, and supervision.

Organisations ensure all staff are provided with appropriate information, training, instruction, and supervision to allow them to complete tasks safely and well.

[14] There is widespread underreporting of WHS risks and incidents to organisational leaders in health care (Lee et al., 2023). This hampers the understanding of risks and control effectiveness.

Workplace Behaviours

"Very few people go to work knowingly choosing to, or not caring that they are, behaving poorly or causing harm. For too long, we have blamed, shamed, and placed the responsibility for poor behaviours and toxic, harmful cultures on individuals. Such behaviours are caused, perpetuated, and excused by overwork, stress, and exhaustion. The best code of conduct in the world will not make a dent on these experiences without significant responsibility and focus by leaders and funders on work design and conditions."

Lucy Mayes, Engagement Manager, Hush Foundation. Independent change facilitator. Author: Beyond the Stethoscope: Doctors Stories of Reclaiming Hope, Heart and Healing in Medicine.

Key Sub Elements

+ Adherence to professional codes of conduct

At all times, staff behave ethically and honestly. For example, efficient authorised use of resources, avoiding professional conflicts of interest, respecting confidential or sensitive information (not just about patients, but about supervisees and other colleagues), and maintaining appropriate professional boundaries with colleagues and patients.

+ Technical competence and cultural safety

Maintain through continuous education and training and then apply evidence-based knowledge and skills relevant to your role.

For example, medical treatments and technologies, organisational policies and procedures, sociotechnical factors impacting healthcare and professional behaviours, and cultural matters such as how to respect colleagues and patients from different backgrounds.

+ Accountability

All workers take responsibility for their actions and decisions. For example, acknowledge any mistakes and take steps to rectify them fairly and reasonably.

Person-Centred Practices

Key Sub Elements

+ Understanding and respect

Holistically consider colleagues' needs and not just treat them as a problem to be managed. For example, taking the time to understand and respect their unique preferences, history, needs, and career goals.

+ Advocacy and empowerment

Advocate for the best interests of more junior staff, ensuring their rights and needs are prioritised.

Recognise and make accommodations for the power differentials and strive to empower them so they are partners in both care delivery and their own career development.

- Dignity and privacy

Protect supervisees' dignity and privacy in all interactions, including performance management situations.

Effective Communication

Key Sub Elements

- Effective communication, consultation, collaboration and coordination

Multidisciplinary teams must ensure effective consultation, collaboration, and coordination. This will facilitate better working relationships and better patient care. It is also a WHS duty.

- Respectfully listen

Listen carefully and use respectful, empathic, and inclusive language with colleagues, patients, and families. Be open and receptive to ideas from all people, and welcome others' insights and perspectives.

- Make room for emotions

Rather than viewing emotions as barriers to rationality, strive to understand why these are present and collaboratively address the causes.

Positive Workplace Relationships

Key Sub Elements

- Respect and empathy

Foster a respectful inclusive workplace free from discrimination, harassment, and bullying. Behaviours and actions promote inclusivity and respect diversity in all its forms. Show kindness and patience.

- Engaged leadership

Senior leaders should be engaged and committed to supporting systems that promote positive workplace behaviours.

All staff should where required show leadership and courage by respectfully challenging others' unacceptable workplace behaviours and seeking practical just/fair sustainable solutions to address these.

- Support others

Providing colleagues with practical and, where appropriate, emotional support to those experiencing stress will help to build positive workplace relationships and competence in others.

- Recognition

Ask for and share feedback constructively. Acknowledge others' relevant skills, experiences, expertise, and contributions.

A Just and Learning Culture

Key Sub Elements

+ A just culture

A just learning culture looks beyond human behaviour to identify factors that may be leading to poor workplace behaviours so the duty holders make sustainable changes.

It responds fairly and proportionally when workplace standards are not met or if errors occur.

It recognises there is personal accountability in circumstances such as criminality, intentional breaches, or deliberate abuse.

"We must not ignore the serious psychological and career harm that occurs from if a doctor speaks up about a bullying. Although rare, false accusations to try to discredit a rival or in response to a complaint can occur. So, it is critical the organisation has fair transparent known processes to investigate and then respond to accusations. This includes providing support to those alleging others poor behaviours and those who are accused of doing so."

Kay Dunkley, AMA Victoria, Pharmacists' Support Service

+ Restorative approaches

Where poor behaviours including breaches of trust have occurred, all members of the healthcare system strive to understand why these occur and to repair trust, rebuild damaged relationships and foster an environment of collective accountability.

+ Learning culture

The organisation sees and uses information about the business and health and safety risks, what is working well, near misses, errors, and serious incidents to improve patient care as well as the health, safety, and well-being of staff.

Organisational leaders are equally willing to expose areas of weakness as they are to display areas of excellence.

They value and reward proactive and balanced reporting of issues by staff and patients.

The organisation and individuals apply evidence-based responses to prevent future poor behaviour incidents and mitigate the harm, and then learn from the incident rather than blame individuals.

Creating a Sense of Urgency for Change

"We need to engage and encourage all healthcare advocates (unions, employer and professional associations, as well as patient advocacy groups) to send strong consistent messages about the expected behavioural standards for healthcare staff and consumers."

David Clarke, immediate past CEO, Australian Patients' Association, Workplace Behaviour Expectations Working Group Chair

Advocacy groups can and do influence key healthcare stakeholders. We should be encouraging trusted advocates to promote evidence-based views. This should emphasise the links between good WHS and good patient care.

A significant challenge for the future is resisting the normalisation of all forms of racism, harassment, bullying and violence between and against healthcare workers by the community. It is acknowledged that public attitudes can be hard to shift and will also require the assistance of those outside the health sector.

While most advocates will be allies to this cause, the media is not always so. We need to ensure the media also tells stories that reinforce the need for positive workplace behaviour and costs to consumers and workers if reform does not occur.

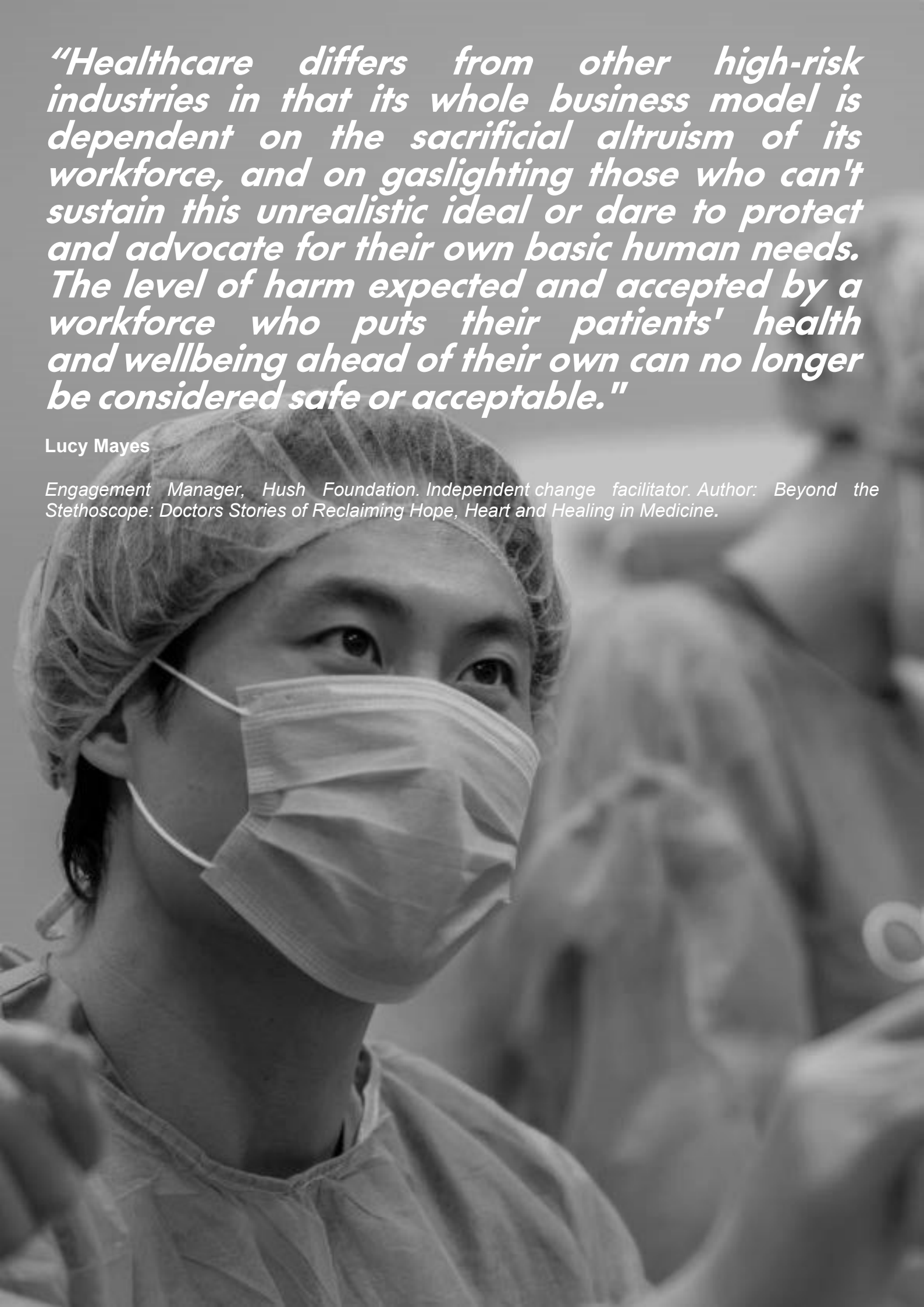
Recommendation

R10. A Better Culture should develop a targeted communication campaign with content that demonstrates to key healthcare stakeholders' the value of a better culture.

“Healthcare differs from other high-risk industries in that its whole business model is dependent on the sacrificial altruism of its workforce, and on gaslighting those who can't sustain this unrealistic ideal or dare to protect and advocate for their own basic human needs. The level of harm expected and accepted by a workforce who puts their patients' health and wellbeing ahead of their own can no longer be considered safe or acceptable."

Lucy Mayes

Engagement Manager, Hush Foundation. Independent change facilitator. Author: Beyond the Stethoscope: Doctors Stories of Reclaiming Hope, Heart and Healing in Medicine.



4.0
Conclusion

4.1 Conclusion

It is not a reasonable social expectation or notion that healthcare workers should just keep sacrificing themselves. It is an expectation of many organisations and healthcare professionals that unfortunately persists and reinforces itself at every level of the system from education, workforce planning, recruitment and then in day-to-day practice.

As this report notes, the healthcare system is large and complex with multiple stakeholders. The considerable challenges of managing the many competing demands are not underestimated.

A central tenet of this report is using a systems-thinking lens allows healthcare stakeholders to identify the underlying factors that support or undermine good workplace conduct and positive cultures. Using this information, they can then, rather than focusing on “problem individuals” develop strategic responses which can benefit all staff members.

This report highlighted just some of interacting system-level factors that impact the design of work and management practices. These, in turn, impact workplace behaviours and individual’s, team, and organisational cultures.

A Better Culture recognises that creating better conduct and cultures in healthcare is a shared responsibility. So, this report outlines recommendations and opportunities for action for the different stakeholders to implement. These will, in turn, also help to support gold-standard patient care and greater efficiency in the whole system.

While the task is large, the many strategic opportunities for change, such as those included in this report, will help sustainable improvements to be made.

5.0 Appendices

5.1 Appendix A: Workplace Behaviour Expectations Working Group TORs and Activities

Purpose and Scope

These terms of reference establish the Workplace Behavioural Expectations Working Group for A Better Culture.

The Working Group is established to support the advisory board via provision of content expertise and development of a consensus statement on model behaviours and capabilities that should underpin professional relationships in all healthcare workplaces.

Recognising that adverse behaviours are largely a symptom of system factors; the working group will also have a focus on those system factors and the leadership behaviours that are necessary to drive positive change.

The working group will be supported by experts in anti-discrimination, cultural safety, and psychosocial safety. These experts should bring content knowledge from current population programs such as Respect@Work, Safework Australia, etc. This expertise will be melded with health-industry specific knowledge of reference group members and inputs generated through the mapping activities of the national framework.

The Workplace Behavioural Expectations Working Group will be time limited and in place until the end of 2024, at which time it will be disbanded. Oversight will be provided by the advisory board until the project closes and hands over management of workplace culture reform to “business as usual” elements of various entities.

Responsibilities

The primary responsibility of the working group is to:

- analyse system vulnerabilities that drive negative workplace conduct, map the system drivers and influencers, and propose effective interventions to address these vulnerabilities.
- conduct a brief review of state and national codes of conduct for healthcare workers. Provide a comparative analysis to identify gaps and opportunities for revision of these codes.

Activities

The key activities conducted were:

1. Discussing and defining key terms (see Appendix B).

2. Compiling a list of the major healthcare stakeholders interested in behaviours and discussing their roles and how their actions directly or indirectly influence workplace behaviours and cultures. See Appendix C.
3. Reviewing the existing legislative requirements[15] for organisation duty holders and individuals to prevent harm at work, including harmful behaviours. See Appendix C.
4. Developing example workplace behaviour scenarios based on members' experiences. See one example, Appendix D.
5. Compiling AcciMaps to explore the theoretical underlying system and individual-level contributing and causal factors in poor workplace behaviour scenarios (see Appendix F).
6. Conducting a rapid review of a sample of professional codes of conduct (see Appendix H).
7. Summarising insights and system-level “opportunities for action” by key stakeholders to support positive workplace behaviours (see section 3.1), and
8. Developing a core workplace behavioural model.

[15] Acts, regulations, codes of practice, and standards.

5.2 Appendix B: Terms and Definitions

Table 2 Terms and Definitions

Term	Definition
Anti-Racism	**Anti-racism** is an active process, unlike the passive stance of 'non-racism' (Australian Human Rights Commission, 2022a). Anti-racism work requires consistent and targeted actions at systemic, institutional, interpersonal, and individual levels.
Bias	**Bias** is a tendency to favor one group over another. Unconscious bias, also known as implicit bias, is defined as "attitudes or stereotypes that unconsciously alter our perceptions or understanding of our experiences, thereby affecting behavior, interactions, and decision making" according to Marcelin et al. (2019).
Bullying	Repeated unreasonable behavior directed towards a worker or group of workers that creates a risk to health and safety (Safe Work Australia, n.d.). This includes bullying by workers, clients, patients, visitors or others.
Cultural Safety	**Cultural safety** is determined by Aboriginal and Torres Strait Islander individuals, families, and communities, with culturally safe practice requiring ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviors and power differentials in delivering safe, accessible, and responsive healthcare free of racism (Australian Health Practitioner Regulation Agency, 2019).
Discrimination	**Discrimination** occurs when a person is treated badly or unfairly compared to another person because of their background or certain personal characteristics (Australian Human Rights Commission, 2022b). Federal discrimination laws protect people from discrimination of the basis of their race (including colour, national or ethnic origin or immigrant status), sex, pregnancy, marital status, family responsibilities
Diversity	**Diversity** is about what makes each of us unique and includes our backgrounds, personality, life experiences, beliefs and all the things that make us who we are (Victorian Government, 2023). It is also about recognising, respecting and valuing differences based on ethnicity, gender, age, race, religion, disability and sexual orientation. It can also include an infinite range of individual unique characteristics and experiences,

Expected Behavior	Behaviours that are reasonable and appropriate in the workplace (New South Wales Public Service Commission, n.d.).
Good work	According to Safe Work Australia (2015), good work is healthy and safe work, where hazards and risks are eliminated or minimised "so far as is reasonably practicable". Good work should, through work design and management, optimise human performance, job satisfaction and productivity. It can protect workers from harm to their health, safety, and welfare, improve worker health and well-being, and improve business success through higher worker productivity.
Harassment	**Harassment** occurs when someone is treated less favourably due to personal characteristics such as age, disability, race, nationality, religion, political affiliation, sex, relationship status, family or carer responsibilities, sexual orientation, gender identity or intersex status (Australian Human Rights Commission, 2022b).
Leader	An individual who influences, guides and motivates others towards achieving goals (Jones, 2007).
Leadership	The concept of **leadership** has been defined as the ability to influence, guide, and direct others to achieve common goals (Northouse, 2021). It involves setting a vision, inspiring others, and effectively managing resources and relationships (Dubrin, 2023).
Lived and living experience	**Lived and/or living experience** is personal knowledge gained through direct, personal involvement in life events or circumstances. It also often refers to the insights and expertise of individuals who have experienced mental health issues, trauma, or other significant life challenges (Byrne et al., 2021).
Patient-centred care	**Patient-centred care** refers to a healthcare approach that respects and responds to the preferences, needs, and values of patients (Grover et al., 2022). Edgman-Levitan and Schoenbaum (2021) highlight that it emphasises collaboration, communication, and personalized care plans to improve patient outcomes and satisfaction.

Person-Centred Care	**Person-centred care** is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers (Australian Commission on Safety and Quality in Health Care, 2024). Widely accepted dimensions of person-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers and access to care.
Professional development	**Professional development** is achieved through continuous learning and skill enhancement activities that help individuals advance their careers and improve their professional competencies (Williams, 2022). It includes training, education, and experiential learning opportunities.
Psychological Safety	**Psychological safety** refers to a work environment in which employees feel safe to express themselves and take risks without fear of negative consequences such as humiliation, punishment, or discrimination (Safety Australia Group, 2023). Psychological safety is essential in ensuring a safe and healthy work environment.
Psychosocial risk or hazard	**Psychosocial risks or hazards** refer to work-related factors that may have negative effects on an employee's mental health and well-being, such as excessive workloads, workplace conflict, exposure to traumatic events etc. (Safety Australia Group, 2023).
Racism	**Racism** is the process by which systems, policies, actions and attitudes create inequitable outcomes for people based on race (Australian Human Rights Commission, 2024). It extends beyond prejudice in thought or action, occurring when this prejudice (whether individual or institutional) is accompanied
Reasonable behaviour in the workplace	This refers to actions and interactions that are fair, respectful, and considerate, complying with workplace policies and laws and can include being clear about expectations and communicating in an open and respectful manner (Jackson et al., 2024).
Senior management	**Senior management** refers to a group of high-level executives (such as CEOs, COOs, and others) responsible for overseeing the overall operations and strategic direction of an organisation.

Sexual Safety	An environment that is free from sexual harm including sexual harassment and sexual assault, and sexual activity in cases where such activity has the potential to cause harm (Victorian Department of Health, 2023).
Sexual Harassment	**Sexual harassment** is unwanted sexual behaviour that would cause a reasonable person to feel offended, humiliated or intimidated, and can include subjecting a person to unwelcome physical contact, sexually suggestive comments or jokes, comments or questions of a sexual nature about a person's private life or the way they look or unwanted displays of affection (Australian Human Rights Commission, 2022b).
Systems thinking	**Systems thinking** is an approach to problem-solving that views complex systems as wholes rather than just individual parts, requiring an understanding of the interconnected nature of various system components (Amissah et al., 2020).
Upstander	An **upstander** is a person who chooses to take action when they are a bystander. Actions include aiming to stop the perpetrator, using de-escalation techniques, supporting a target, formally reporting the incident or seeking assistance from others (Marcelin et al., 2019).
Workplace culture	**Workplace culture** is determined by the shared values and practices that characterise an organisation (Manley et al., 2011).
Work or job design	**Work or job design** is the process of structuring work tasks, roles and systems to improve efficiency, productivity and employee satisfaction, through managing job demands and the working environment (Knight et al., 2021).
Workplace	A **workplace** is any place where work is carried out or where a worker goes, or is likely to be, whilst at work (Work Health and Safety Act 2011 (NSW) s.8).
Worker	Refers to anyone who undertakes work for a person conducting a business or undertaking (PCBU) (Work Health and Safety Act 2011 (NSW) s.7). In healthcare, workers include all employees such as administrators and support staff, doctors, health professionals, trainee doctors, support staff, students, subcontractors, labour-hire employees or volunteers. Legal duties extend to all those conducting work in the health care facility irrespective of their seniority and the nature of engagement.

5.3 Appendix C: Healthcare Stakeholders

Healthcare stakeholders' interest and power (i.e., the capacity to influence directly or indirectly) positive workplace cultures and behaviours will vary. Some stakeholders have multiple strategic opportunities to drive positive change.

Some may have dual roles, such as the medical colleges who are both workplace duty holders under the WHS legislation but are also providers of postgraduate education, certification, and training.

Government Agencies

This includes governments and agencies who oversee or implement policy.

For example, National and jurisdictional cabinets, health, WHS and industrial relations ministers, the Health Workforce Taskforce, and Medical Workforce Advisory Collaboration, jurisdictional health and finance departments, agencies including the Australian Commission on Safety and Quality in Healthcare, Office of the Health Ombudsman, National Health Practitioners Ombudsman, Human Rights and Equal Opportunity Commission, Workers Compensation Authorities, Safe Work Australia, etc.

Other Government agencies that support and enforce legislative compliance.

For example, health system regulators, Australian Health Practitioner Regulation Agency, Commonwealth, state and territory work, health, and safety regulators, FairWork Australia, Commonwealth, state and territory police and courts, specialty education regulators, and healthcare employer regulators.

Hospital and Healthcare Providers

This includes those with specific obligations under health, WHS, or industrial relations legislation.

For example: healthcare chief executives and boards, senior leadership teams as the designers and managers of work; have the most direct control over factors that create organisational and team cultures and lead to positive or poor workplace behaviours.

Educators, Trainers, and Accreditors

This includes those whose main role is to provide training and certification to practice but also may be policy advocates.

For example: Specialists' Medical Colleges and Boards, Continuing Professional Development homes, universities and medical deans, Australian Indigenous Doctors' Association (AIDA), Doctors for Doctors, Crazy Socs for Docs, HUSH, Shwartz rounds, and state-based doctors' health programs, private education, or consultancy providers, etc.

The Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia have regulatory functions such as accrediting medical professionals. However, this is relating to protection of healthcare users, not medical professionals.

Representatives and the Media

This includes a diverse group of patients and those with a general interest in workplace behaviour.

For example: patient advocacy groups, wellbeing/compassion/kindness advocacy groups, Aboriginal and Torres Strait Islander, LGBTQIA+, disability and cultural diversity, and mental health advocates. It also includes those whose main role is to provide advocacy on behalf of workers or businesses on WHS and industrial relations matters, e.g., Australian Medical Association and Australian Salaried Medical Officers' Federation (particularly their state branches), Australian Nursing and Midwifery Federation, Health Service Union, Healthcare Worker Union, Australian Medical Professionals' Society, Health and Community Services Union, Community and Public Sector Union, Medical Technology Association of Australia, Doctors' Health Alliance, The Australian Institute of Health and Society, Human Factors and Ergonomics Society of Australia etc.

"Organisations that invest in qualified, experienced WHS advisors are far more likely to receive useful strategic advice on how to identify the underlying causes of poor behaviours and so can implement sustainable legally required improvements to their work system."

David Clarke, Immediate Past CEO, Australian Patients Association, Chair, Workplace Behaviour Expectations Working Group

Specialist researchers and sections of the media will be interested in behaviours in healthcare settings.

A final group, with its own complex agenda, is the legal profession and their peak body.

Others

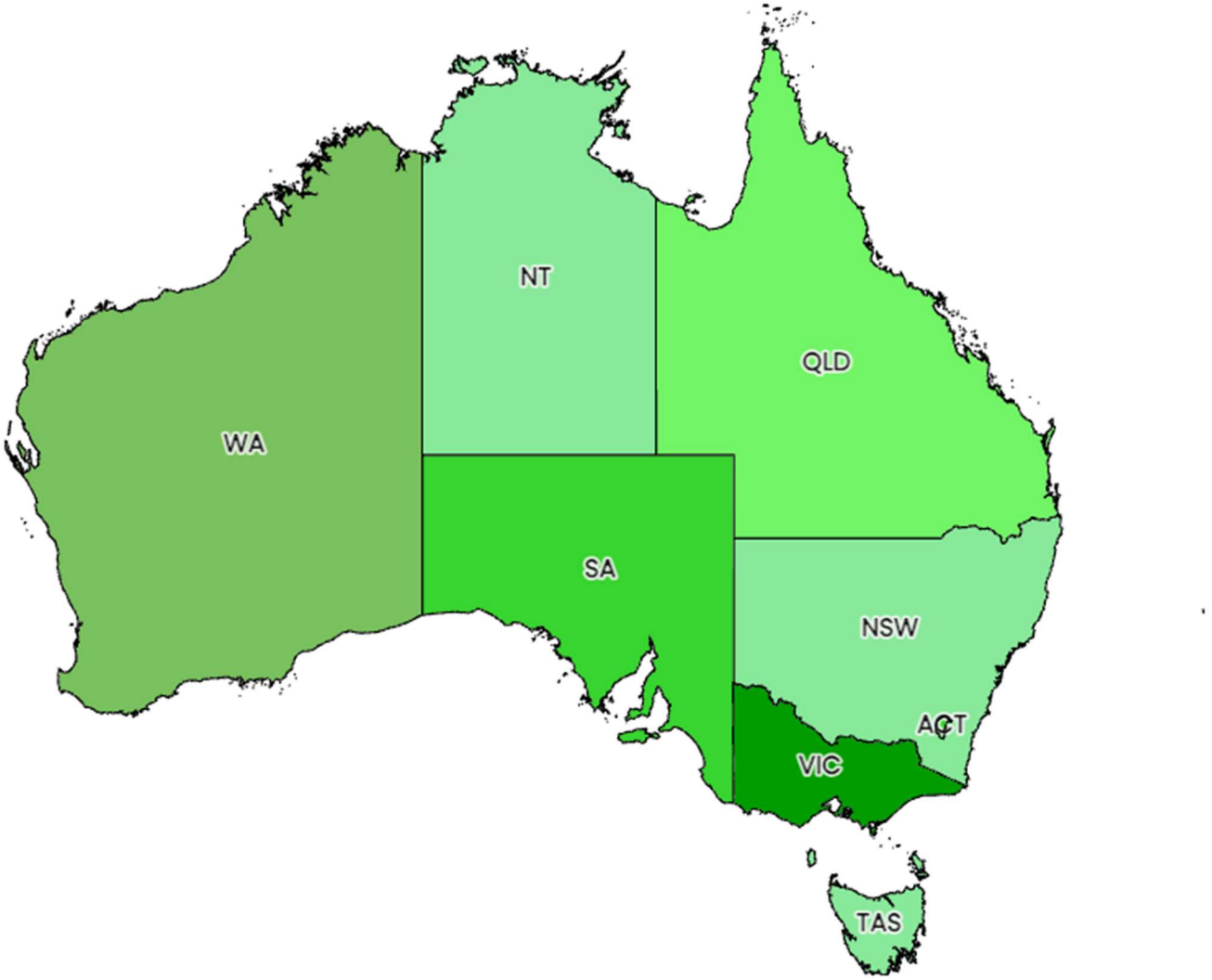
Other stakeholders who can influence organisational priorities include insurers.

5.4 Appendix D: Legal Frameworks

A range of legislation provides the legal framework for healthcare organisations in Australia. The Commonwealth, state, and territory governments develop legislation and policies, provide advice, and enforce compliance.

Click on the image below to view state or territory-specific legislation, regulations, and national laws.

Figure 4 State and territory legislation and regulations



WHS Legislation

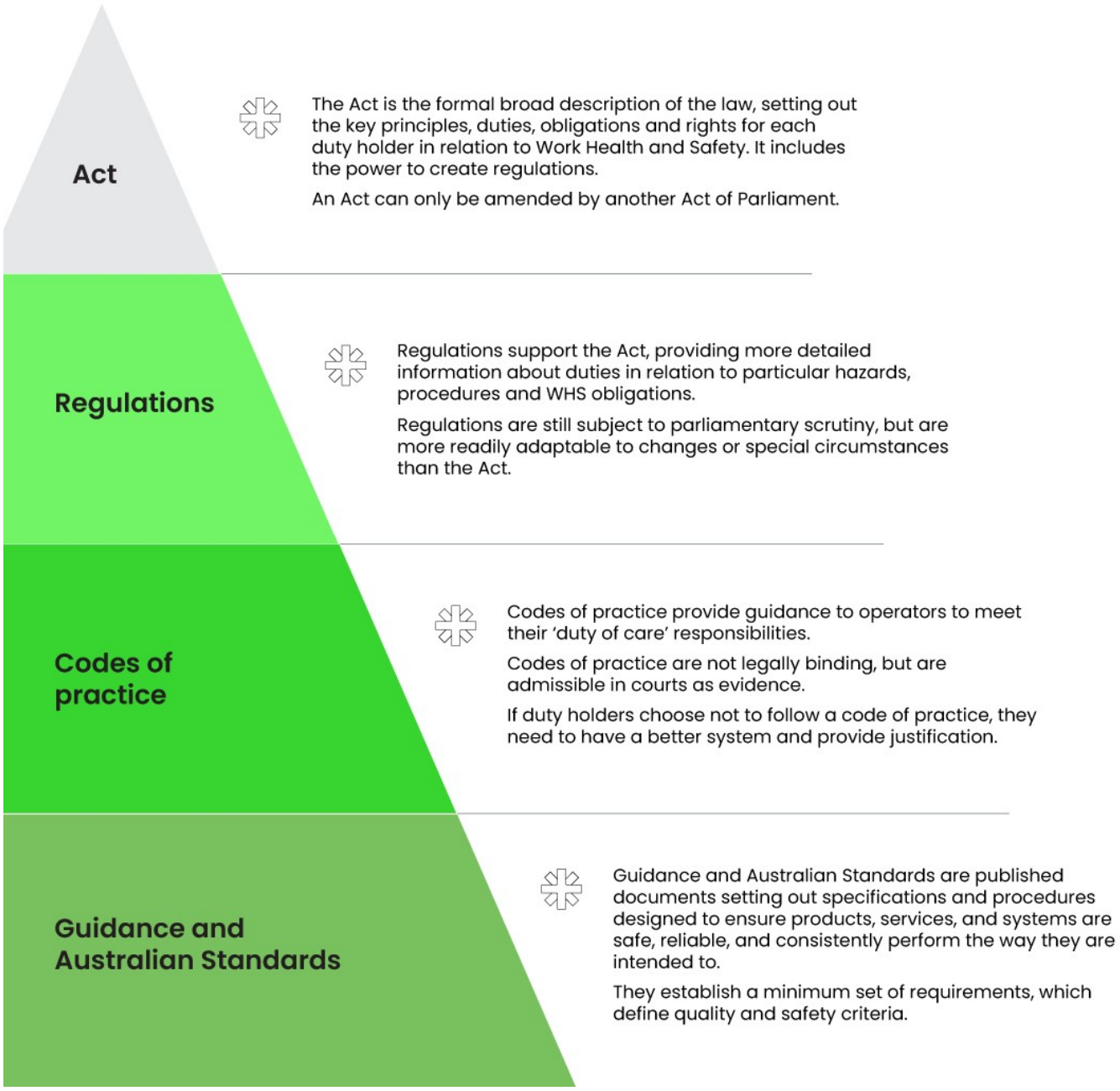
Work health and safety (WHS) laws are enacted by each Commonwealth, state, and territory parliament. All Australian jurisdictions, except Victoria, have adopted the Model WHS Act and Regulations.[16]

Compliance with the WHS Act and Regulations is mandatory. Supporting documents including Codes of Practice may be used as evidence in prosecutions. Guidance and standards are non-mandatory but provide practical compliance advice. This hierarchy is illustrated in Figure 4.

For more specific guidance on the WHS duties see the SWA Fact Sheet on WHS duties.

[16] Victoria uses the Occupational Health and Safety Act 2004 and OHS Regulation 2017 with a similar intent. Safe Work Australia (SWA) is the WHS tripartite policy body that leads the development of new model legislation.

Figure 5 WHS Legislative Framework



The healthcare PCBU, typically the chief executive officer of a healthcare facility or the owner of a private practice has a primary duty, so far as is reasonably practicable to ensure the health and safety of all workers while at work in the business or undertaking. This extends to "others" who may be affected by the carrying out of that work, such as patients and members of the public. A point often missed by healthcare duty holders is this duty also extends to workers not employed by the hospital but visiting the site, such as medical professionals, police, ambulance, and suppliers.

Critically, the regulation now clearly defines a psychosocial hazard as one that may cause psychological harm or physical harm that arises from, or relates to:

- the design or management of work,

- a work environment,
- plant at a workplace, or
- workplace interactions or behaviours; and
- may cause psychological harm (Work Health and Safety Regulation 2011(Cth) s.3.2.55(a))

Common psychosocial hazards in healthcare

- excessive workloads and time pressure,
- high physical, mental and emotional job demands,
- low job control,
- poor support,
- violence and aggression,
- bullying,
- harassment, including sexual, gender, and racially based harassment and discrimination,
- conflict or poor workplace relationships and interactions,
- lack of role clarity,
- poor organisational change management,
- poor organisational justice,
- traumatic events, remote or isolated work,
- poor physical environment, and
- inadequate reward and recognition.

The legislation specifies that the PCBU must implement control measures to *eliminate* psychosocial and physical risks so far as is reasonably practicable. Only if it is not reasonably practicable, the PCBU can then minimise risks using an appropriate effective mix of controls.

"All too commonly, health sector employers continue to rely on individual level interventions and training. What is disturbing is that many think they are then meeting their duties."

Jillann Farmer, CEO, A Better Culture

The amended WHS regulation now instructs the PCBU that they must have regard to *all* relevant matters, including (but not limited to):

- the duration, frequency, and severity of the exposure of workers and other persons to psychosocial hazards,
- how the psychosocial hazards may interact or combine,
- the design of work, including job demands and tasks,
- the systems of work, including how work is managed, organised, and supported,
- the design and layout, and environmental conditions of the workplace including the provision of:
    - safe means of entering and exiting the workplace; and
    - facilities for the welfare of workers; and
- the plant, substances, and structures at the workplace,
- workplace interactions or behaviours; and

- the information, training, instruction, and supervision that is provided to their workers (Work Health and Safety Regulation 2011(Cth) s.3.2.55(d))

Supporting the legislation is a wide range of guidance, including, for example:

- Model Code of Practice: Managing psychosocial hazards at work
- Model Code of Practice — sexual and gender-based harassment
- Guide for preventing and responding to workplace bullying
- Dealing with workplace bullying — a workers' guide
- Workplace violence and aggression
- Online abuse in the workplace, and
- Workers' mental health.

The WHS regulators have also issued clear additional guidance on these matters.

Other WHS duties relevant to the work of the A Better Culture project include that the PCBU must "so far as is reasonably practicable":

- design work to manage psychological risk,
- genuinely *consult workers* and others impacted by WHS issues,
- ensure appropriate consultation, cooperate and coordinate with other duty holders where they have a shared duty on WHS matters[17], and
- Ensure the *safe design* and *procurement* of healthcare buildings, medical technology and other equipment are without WHS risks to workers and others.[18]

Healthcare and hospital CEOs, members of the board and senior executives manage and are legally responsible for the business risks. They determine the organisation's structure, governance and operational priorities, staffing levels, investment in buildings, plant and equipment, and hospital supplies. So, their decisions "design the work" and shape the culture and perceptions of the consequences of poor behaviours at work.

Board members oversee operations and have *positive* due diligence duties under WHS legislation and now sex discrimination legislation. In some jurisdictions, the importance of hospital and health service boards is also recognised in other legislation.

For example, in Queensland hospital board members must promote positive workplace cultures and implement appropriate steps to support the health, safety, and wellbeing of all their staff and those in their facilities (Hospital and Health Boards Act 2011 (QLD) s.19.3(c) and s.22.2(c)).

[17] In addition to the use of system thinking tools such as AcciMap, the use of ActorMap can help visually depict the key elements and/or individuals that make up a system. This will include useful information such as the context, connection, patterns, and actors' perspectives of the issues. Actor mapping is related to, but fundamentally distinct from, traditional stakeholder analysis.

[18] If this is not possible then to minimise risks using a mix of controls measures including obtaining and passing on to workers information about its proper use and risks

Fair Work and Anti-Discrimination

A range of legislation prohibits discrimination, bullying, and harassment (Fair Work Act 2013; Disability Discrimination Act 1992; Racial Discrimination Act 1975; Sex Discrimination Act 1984*).*

Some of these have been recently strengthened. Commonwealth laws and state or territory laws generally overlap. However, some apply differently, so healthcare duty holders must know what these are to comply with all relevant legislation.

Workplace sexual harassment was also prohibited under the Fair Work Act from 6 March 2023.

Of note for health and hospital duty holders is that recent amendments to the Sex Discrimination Act 1984 (s.47(c) now include a *positive duty*[19] for employers to prevent workplace sexual harassment, sex discrimination and victimisation.

Health Practitioner Regulation National Act

This applies in all jurisdictions and is administered by the Australian Health Practitioner Regulation Agency (AHPRA). This is limited to the protection of healthcare consumers, not practitioners. This requires specified health professionals to be registered and accredited, for mandatory and voluntary notification relating to unacceptable professional behaviours, and immediate action including potential suspension of professional registration.

Privacy laws

There are several laws regulating the handling and disclosure of personal information and healthcare records (e.g. the Privacy Act (Cth) 1998)

Responsibilities for handling personal information, including information or opinions about an identifiable individual, can also arise under state and territory laws, particularly for health agencies.

[19] Positive duty of care refers to the legal obligation on employers and organisations to take proactive and meaningful action to prevent relevant unlawful conduct from occurring in the workplace or in connection to work.

5.5 Appendix E: Common Psychological Hazards and Design Solutions

Table 3 Common WHS consequence of poor work design and management

Common WHS hazards and risks in healthcare
Excessive workloads and long working hours
Time pressure and deadlines
Exposure to traumatic and distressing events
Emotional demands (e.g. exposure to traumatic events and moral distress)
Cognitive demands (e.g. critical decision-making under time pressure)
Physical demands (e.g. frequent manual handling and sustained awkward postures)
Exposure to violence and aggression, bullying, harassment (sexual, gender and racially based harassment and discrimination)
Conflict or poor workplace relationships and interactions
Lack of role clarity
Inadequate information, training, instruction, and supervision (performance support)
Low job control
Poor support from supervisors and colleagues due to understaffing
Poor organisational risk planning and resource allocations
Poor organisational change management
Inadequate reward and recognition
Poor organisational justice
Remote or isolated work
Poor physical environment
Hazardous chemicals and pharmaceuticals, etc.
Insecure employment contracts
Poor management of entitlements, especially where there are significant power imbalances within the group.

While we need to continue to use existing approaches to eliminate and manage poor workplace behaviours, many of the existing methods and techniques can continue to be used. The assimilation of a Safety-II view will also require new practices to look for what goes right, to focus on frequent events, to maintain a sensitivity to the possibility of failure, to wisely balance thoroughness and efficiency, and to view an investment in safety as an investment in productivity.

Duty holders should apply the principles of effective work design. The WHS regulation (s. 3.2.55D) and related code of practice (Managing psychosocial hazards at work by Safe Work Australia) calls out specific matters (see page 13 of this guide) to consider when choosing and putting in place control measures.

The Safe Work Australia's handbook *Principles of good work design* lists WHY, WHAT and HOW principles that underpin a good work design process.

Figure 6 SWA Principles of good work design – adapted from Safe Work Australia (2015)

Practical work design and systems thinking approaches to eliminating or managing poor workplace behaviours and other WHS risks are included in the recently released SafeWork NSW 2024 guide *Designing work to manage psychosocial risks*.

This guide includes additional how-to suggestions, including:

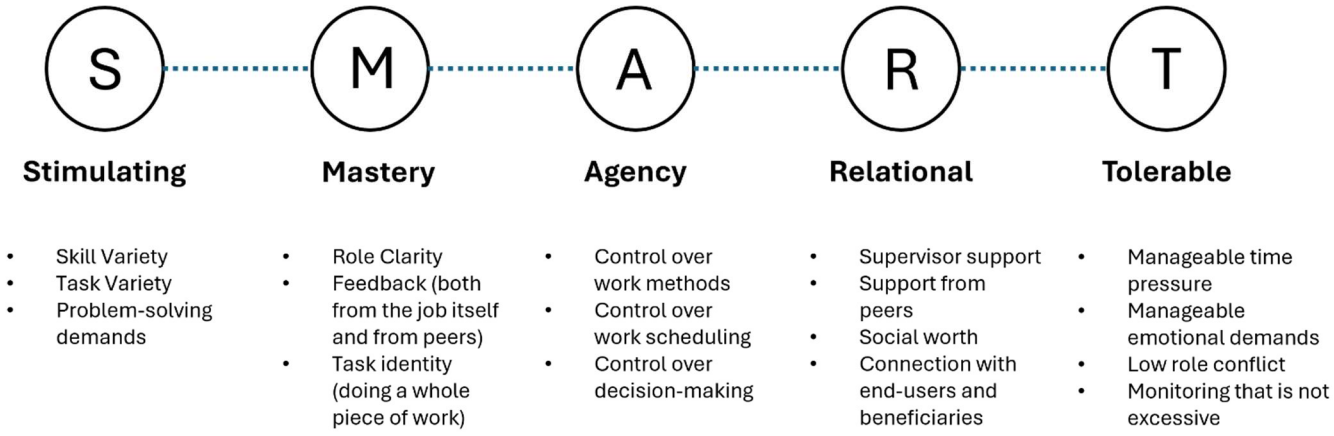
1. actively involve the people who do the work, including those in your supply chains and networks,
2. engage and get decision-makers and leaders' commitment to the work design process,
3. identify hazards and assess risk using a range of tools and approaches.
    - apply systems thinking techniques to identify sources of harm,

- collect and use your organisational data and intelligence, including from psychosocial risk assessments, task analyses, and prestart checks,
- know who really designs work in your organisation, and
- build trust and respect so workers report issues — this is more likely if there is a just culture that recognises honest mistakes are generally a product of poor work design and cultures.

4. control risks at the source:
   - ensure those who design work are competent — that they understand the WHS duties and requirements, have the appropriate knowledge about psychosocial hazards and risks and sources of risk, and work design expertise,
   - apply good project planning and management,
   - design for (organisational) resilience — recognise that work systems and people change over time and, with them, new psychosocial risks may emerge and old ones can re-emerge. Organisations need to have a resilient workplace health and safety management system that can anticipate, prepare for, respond, and adapt to incremental change and sudden disruptions to manage psychosocial risks, and
5. seek to continuously improve work designs.

Developed by Parker and Knight (2023), The SMART Work Design Model and resources are highly recommended to assist duty holders to design work that exceeds the minimum regulatory requirements.

Figure 7 SMART Work Design Model – adapted from the Centre for Transformative Work Design



5.6 Appendix F: Sexual Harassment Case Study

Situation and Context

Zhiming is a general surgical senior resident medical officer and is uncomfortable with the behaviour of her consultant Anton. Anton repeatedly makes unwanted physical contact with Zhiming, such as touching her on the arm or lower back, and putting his arm around her.

During surgery, Anton makes sexually suggestive comments to Zhiming. Other staff describe this behaviour as “good fun” and “banter”. Zhiming notices that registrars who join in with the “banter” quickly build rapport with Anton and enjoy a stronger relationship. Anton appears to be a popular member of staff, known for being jovial and providing good patient care.

Zhiming discussed these behaviours with a senior registrar, but her concerns were dismissed or minimised. She was told “He is just being friendly” and “That is just how he is”. She has considered who else she could discuss this with but is unsure what to do next. Zhiming is passionate about pursuing general surgery and is working hard to get on the training program. Anton is on the selection panel for the program and Zhiming is concerned that if she questions or reports his behaviour, it will jeopardise her chances of acceptance.

Insights

The current leadership has resulted in poor work design, where the organisation, jobs, tasks, and systems of work enable unacceptable workplace behaviour by perpetrators and disempower victims from reporting. Duty holders proactively identify the risk of sexual harassment in the workplace and “design out” the system-level causes of psychosocial hazards and risks. Poor behaviours are therefore more likely to be tolerated as the organisational and individual norms suggest they should just be accepted as part of the job. Leaders and staff need to do more to cultivate a culture that supports staff and bystanders to safely report or call out WHS risks such as sexual and racial harassment.

Intervention Options

Intervention could include:

- Actively seeking to understand the prevalence and nature of sexual and racial harassment in the organisation through staff surveys and consultation activities.
- Address staff hierarchies and power imbalances through clear role delineation, transparency, and accountability in rostering and recruitment processes.
- Recognise and address attitudes that excuse or downplay sexual harassment through fair and proportional restorative justice programs.
- Establish and promote safe and effective reporting systems and ensure de-identified information is available to work designers.

Figure X – Sexual Harassment Case Study Map

Type	***Factors that empower the perpetrator***				***Factors that disempower the victim***				
External	Rape culture and the normalisation of sexual violence	Lack of media coverage around the issue from politicians	Lack of transparency by regulators in the sexual harassment complaints process and a historical priority to "protect" the healthcare profession	Regulators may be disincentivised to place conditions on registration due to public scrutiny and political implications	Access to Government-provided victim support services such as counselling, healthcare, legal aid, financial guidance and emergency services may be limited	Limited public knowledge of anonymous reporting channels perhaps by a lack of attention from the regulators, media and other bodies	Anonymous complaints could risk identifying individuals due to small teams, departments or organisations	Victim shaming and stigma	Societal norms that downplay the impact of sexual harassment on women
Organisation	Perpetrator benefits from the hierarchy and/or relationships with powerful colleagues	Features of the hospital environment such as areas with limited surveillance (e.g. offices & consulting rooms)	Health orgs may avoid reporting perpetrators where they perceive a threat to accreditation, decreased availability of procedures, financial losses & their reputation	Lack of process to record and monitor individuals subject to HR complaints, particularly where individuals work in multiple orgs	Lack of training around identifying or managing sexual harassment	Victim lacks employment security		Attitudes and beliefs that trivialise sexual harassment in healthcare	
	Perpetrator may control employment conditions such as rostering, leave and overtime	Gender inequity in leadership positions	Perpetrator has employment security		Risk management processes lacking steps to minimise the risk of sexual harassment	The organisation may not collect or regularly review data on the prevalence of sexual harassment		Organisational culture that discourages bystanders from reporting sexual harassment they have witnessed	
	Career progression and acceptance into training programs may rely on perpetrator approval, exacerbating the power differential	Culture of socialising for work functions involving alcohol (e.g. rep dinners)	The hierarchy is reinforced by organisational structures, policies & norms	Acceptance of past poor behaviour reinforces and normalises sexual harassment	Employees unaware of their legal and professional obligations to report and manager sexual harassment	There may be a lack of clear reporting mechanisms for sexual harassment		Challenging disrespectful attitudes and behaviours is avoided due to fear of exclusion or reprisal	
Individual	Perpetrator's privilege and power	Perpetrator's use of behaviour to enforce gender-based social standing		A lack of professionalism	Individuals unaware of options for reporting	Victim may have prior trauma	Intersecting identities increase risk of sexual harassment (e.g. race or disability)	Financial stability of victim	Individuals may feel self-actualised shame

Type	***Strategies***					
Power balance	Delineation, transparency and accountability is applied in recruitment and rostering processes. Introduce mechanisms to identify when perpetrators hold such powers.	Radical change to organisational structures that are cooperative, democratic, collaborative and/or self-governing, meaning more transparency around these types of behaviours		Prioritise workforce gender balance and gender equality action plans.	Policies increase job security for junior doctors	Strategies to remind staff of reporting opportunities (whether witnessed, experienced and provided anonymously or by name) are implemented	Trauma-informed organisational policies are implemented Different types of support are offered for victims (e.g. financial, mentoring) instead of only relying on counselling or EAP providers
Incident response	Appropriate consequences for the perpetrator based on restorative justice principles	Prompt responses to all complaints to prevent further harm to both victim and perpetrator	Organisations collaborate with relevant bodies when complaints need reporting to the regulator		Incident reporting processes should be formalised and be managed by independent staff or with extensive external experience	Create clear and robust sexual harassment policies that define sexual harassment, include prevention strategies and are regularly updated	Onboarding and ongoing training includes education on how organisations support victims should an incident occur
	Perpetrators receive counselling and education where appropriate	Independent risk assessment of complaints	Maintain a central source of data on sexual harassment prevalence for benchmarking and measuring the effectivity of initiatives			Strategies to protect victim's privacy are implemented following a report	Victim suppport is provided by a professional agency such as Blue Knot or trauma specialist orgs
Prevention strategies	Social events are well planned with senior management ensuring risk strategies are in place for late meetings, work dinners and functions where alcohol is served		Organisational culture of bystanders is enabled, to encourage upstanders through calling out sexual harassment and supporting victims		Strategies to interrogate individuals and organisations biases are implemented		Education and intervention campaigns are proactive, managers lead this culture and express support to victims and upstanders
	Organisational codes of conduct include expectations around sexual safety at work and training around acceptable workplace behaviour is provided		Attitudes and beliefs around acceptable behaviour, sexual harassment and sexual safety are interrogated		Dicrimination against marginalised groups is recognised as occurring on a spectrum of behaviours and sexual harassment is understood to be on this spectrum		Training for WHS staff, HR reps or designated staff is ongoing and provided by an independent provider

5.7 Appendix G: Bullying and Harassment Case Study

Situation and Context

Khushboo is a doctor-in-training working in the emergency department under Level 1 supervision, and this is only her second shift at this hospital. Her induction to the facility was cursory.

An elderly patient, Elsie, was brought in by ambulance from her aged care facility following a fall. She has a suspected neck of femur fracture. Elsie kept calling out and needed to be urgently assessed to help control her pain. Her transfer notes indicated she has vascular dementia.

Khushboo approached Elsie together with one of the nursing staff, Julie, and spoke gently to her, explaining she needed to examine her to find out where and why she is experiencing pain. Khushboo examined Elsie's hip with Julie assisting. Elise grabbed Julie's arm and twisted it. Elise, despite her dementia, was quite strong and injured Julie, who had to leave the floor to apply an ice pack.

Khushboo wanted to administer pain relief to Elsie, as she believed this would reduce her aggression and allow her to be examined more easily. However, Khushboo needed assistance to do this safely, and all the nurses were busy. Khushboo approached her supervisor, Dave, and outlined Elsie's presentation and likely diagnosis, and how she would like to proceed. Khushboo advised Dave she needed assistance in case Elsie again became aggressive. Dave laughed at her, and said, "Oh dear, boohoo; is that little old lady scaring you? Can't you just manage this by yourself? I am busy!" Khushboo did not know how to respond as he was a senior supervising doctor, so said nothing in reply.

When she reached Elsie's bedside, she was then sleeping and barely stirred as pain relief was administered. Later in the day, Khushboo discovered her nursing colleague, Julie, sustained a fracture and was unable to work for four weeks. Khushboo now feels she would be reluctant to ask for assistance again. She did not report the incident to anyone.

Insights

There are multiple interacting factors that have contributed to this poorly handled situation.

Khushboo's lack of experience and lack of familiarity with the emergency room layout and procedures should have been recognised by her supervisor. He should have ensured she was provided with this information and given additional practical advice and emotional support until she was demonstrably capable and confident.

External factors, including how dementia, aggression and the elderly are perceived in society were likely to impact the way all three staff members handled Elsie's presentation. Khushboo did employ an empathetic, patient-centred approach to Elsie's care, while Dave seemed to discount the patient's experience and dismiss the risk for injury due to Elsie's age, assumed frailty, and possibly gender.

There appears to be a low level of care and support in this workplace, and a stigma towards nursing staff as Julie; the evidence being that even after communicating she was injured, this was not taken seriously, nor did it result in anyone escalating the level of caution when managing Elsie's care. Dave's dismissal and belittlement of Khushboo's concerns could be perceived as racist microaggression.

Work design contributing factors likely included staffing shortages and high workloads leading to stress and fatigue of Khushboo *and* her supervising doctor. Khushboo should have been assisted after she made a reasonable request for help.

The power imbalance between the junior doctor and her supervisor would have contributed to her reluctance to report the issue.

The inadequate allocation of resources is likely to also have been due to hospital or emergency ward funding and budgeting arrangements.

The failure to apply expected risk management standards by the hospital management and the regulators may have also played a role.

Organisational Level Intervention Options

- Rostering on adequate staff to allow time or spare capacity to deal with complex presentations.
- Ensuring new staff have adequate site inductions.
- Training around patient-centred care from a diverse array of trainers, on cognitive conditions, behavioural issues, etc. and supports for supervisors.
- Regular auditing of supervisor arrangements to ensure compliance.
- Senior staff modelling anti-racist patient-centred care behaviours.
- Calling out inappropriate behaviours and microaggressions.
- Feedback from supervisees being linked to supervisors' performance reviews, encouraging a more supportive approach.
- Promoting robust incident reporting and investigation following workplace injuries and near misses, and learning cultures.

Figure Y – Bullying and Harassment Case Study Map

Type	Factors that empower the perpetrator			Factors that disempower the victim			
External	Health expenditure by the Government and prioritisation of resources Lack of education around microaggressions against marginalised people and the link to systemic oppression Cost-cutting in the sector, with increased pressure and productivity expectations placed on staff	Public perception of the health profession - Doctors often put on a pedestal State and federal Government culture (despite the Coalition of Australian Governments) sees parties failing to act in unision in the best interests of partients for a range of reasons	Poor culture of supervision is often accepted due to supervisors own poor experiences in their early career Hierarchical nature of healthcare professions where doctors are seen as more valued than other staff	Aged care and hospitals lack rigorous information sharing procedures (or it is poorly applied in practice) around medical records (i.e. patient can be aggressive if agitated by pain or in an unfamiliar environment)	Racism and bullying behaviour here is not consistent with professional standards such as AHPRA's Code of Conduct for Doctors Mild to moderate WHS incidents seen as trivial due to lack of action against these behaviours in the past by regulators	Lack of coordination between two health providers (hospital and aged care facility)	Lack of standards around non-clinical staff conduct - HR staff have a responsibility to know and manage workplace hazards which in turn improves patient outcomes but lack a direct link to patient accountability
Organisation	Perpetrator likely has got away with similar behaviour before without intervention. This could be due to a variety of reasons such as lack of oversight, a culture of fear, the perpetrator being a hard-to-replace asset for the hospital etc. Lack of enforcement around supervision standards	Management is not present in this scenario despite needing to be involved due to a WHS injury, insufficient supervision and inappropriate behaviour by the supervising doctor. Lack of accountability of supervising doctor - understaffed, poor rostering/staff shortages. Positive workplace values such as respect for coworkers and patient not present	Environment where the incidents occurred may have resulted in less witnesses and opportunity for upstander behaviour Lack of support from management around positive supervision with a focus on mentoring and improved working relationships as opposed to just good clinical outcomes	Workloads and time pressures given by management contibuted to the unavailability of the supervising doctor at the time of the injury Lack of clinical protocol (or adherence to protocol) for managing an agitated patient Poor communication between staff - nurses, doctors, non-clinical staff, HR and management	Issues with resource allocation - management may have failed to adequately staff the unit due to instructions from the CFO around the high-cost of locums or temporary staff Level 1 supervision procedure not followed, junior doctor left alone to manage initially then dismissed and made fun of by supervisor	Pressure from management for experienced staff to get by without support may have caused the lack of adequate supervision A lack of inter-agency cooperation procedures Disrespectful to the patient, injured nurse and junior doctor to describe the patient as a little old lady	Belittling behaviour by supervising doctor (including disrespectful play on name/racist microaggression) exacerbates the power imbalance, making Khushboo unlikely to report incidents like these Poor handling of workplace injury, possible implication the worker was to blame (blame culture) Lack of WHS consideration by the doctor going into the situation - risk of violence was predictable in this case
Individual	Supervising doctor likely holds racist beliefs learnt through the course of his life in Australia as a white man	Supervising doctor may have not been adequately supervised himself as a junior doctor	Khushboo's upbringing may have made her more likely to show deference to more senior figures and put up with poor behaviour	Nurse may have had poor experiences with doctors before following an incident, impacting her likelihood to report her injury and in turn model positive behaviours for newer staff like Khushboo	Khushboo is inexperienced, may also lack experience working in an Australian healthcare setting if trained overseas	All workers bring their own level of fatigue, stress and other concerns to the workplace which impact behaviour, particularly in training and supervision	Supervising doctor may believe a lack of close supervision improves decision-making

Type	Strategies			
External	Improved public debate on healthcare quality, investment and reform, including the public's priority for health above other key government roles Explore mandating the employment of more highly trained WHS professionals in healthcare settings at different levels	Designing improved training programs for staff around uncivility, upstander behaviour and reporting that are regularly done and built into general training Hospitals and healthcare organisation boards committing to moving beyond WHS compliance culture to WHS science and practice Targeted funding focused on improving work design and workload issues	Improved shared access to medical records (while maintaing rights to privacy) Regulators considering opportunity to strengthen actions following incidents like this one Improved standards of conduct for staff, particularly supervisors and managers	Linking of HR staff's responsibilities to patient accountability in standards of conduct
Organisation	Improved internal standards of practice, with clearer training for supervisors showing the links between supervisor/management performance, clinical performance and patient safety Rigorous WHS incident review from all staff involved, including the nurse, supervising doctor and junior doctor Increased education around expectations of positive workplace behaviour, with appropriate consequences	Review of management standards, ensuring clearer consequences when incidents such as these occur without proper oversight from the management level Improvement standards of HR management relating back to patient safety outcomes Improved inter-agency cooperation	Review of training around following supervisor requirements - workload pressures should not result in supervision procedure being ignored Senior management should follow the incident review process closely and not see time pressures and workloads as out of their hands - work scheduling, rostering and resource allocation are within their control and have a major impact Modelling of calling in, upstander behaviours, no-blame culture by management Clearer protocols for communication between different types of staff	Clearer protocols for incident and injury review, with actions to be taken when management has not been present Generate more interest and motivation in building a positive team culture, linking this to improved patient outcomes and staff wellbeing
Individual	Support and supervision of the worker should consider their own levels of experience and knowledge of their working environment.	Improved risk management planning with an understanding of psychosocial hazards, emotional demands and incivlity	Review of resilience oB1:I22r wellbeing -type intiatives where the onus of workers wellbeing is placed on themselves alone, with more education around understanding it is generated by a variety of external, organisational and personal factors	

5.8 Appendix H: Codes of Conduct Review

This review was initiated to determine whether there are documents in use by jurisdictions, employers, or regulators that clearly outline the responsibilities of top-tier leadership alongside those of individual workers. Often, expectations for behaviour are placed solely on workers, but the working group concluded that leadership must create an enabling environment that fosters exemplary behaviour among staff.

The project team developed criteria to guide the analysis of relevant codes of conduct. The scope was limited to state health service codes of conduct for all employees, AHPRA codes of conduct for medical practitioners, allied health practitioners, midwives, nurses, and psychologists, as well as the healthcare worker code of conduct for unregistered practitioners.

The following criteria were used for to assess the codes:

A – Mentions professionalism in relation to colleagues.

B – Mentions bullying.

C – Mentions harassment (incl. sexual harassment).

D – Mentions discrimination.

E – Mentions racism.

F – Explains the incident notification and reporting process.

G – Explains that there are existing legal duties, and outlines or references these.

H – Mentions cultural safety.

Each criterion was analysed in terms of how evident it was (shown by shading). The review also identified each document's authorisers, recency, and legal status, and assessed whether the document comprehensively addressed the legal duties of all staff — not just workers — and included guidance on preventing and responding to system-level issues. See Figure Z overleaf.

Figure Z – Codes of Conduct Review Table

Name	Body	Applies to	Legal status/ consequences	Date updated	Refers to duties of workers								Refers to duties of supervisors and managers							Refers to duties of the executive							Refers to due diligence duties of the board						
					a	b	c	d	e	f	g	h	a	b	c	d	e	f	g	a	b	c	d	e	f	g	a	b	c	d	e	f	g
Good medical practice: a code of conduct for doctors in Australia	AHPRA / Medical Board of Australia	Doctors (all specialties)	Compliance affects registration with the MBA, linked to Section 39 of the Health Practitioner Regulation National Law (2009)	Oct 2020	●	●	●	●	●	●	●	●	○	●	●	●	●	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Shared Code of Conduct	AHPRA / Medical Boards	12 health professional specialties (eg. physios)	Compliance affects registration with the relevant Medical Board, linked to Section 39 of the Health Practitioner Regulation National Law (2009)	June 2022	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Code of conduct for midwives	AHPRA / NMBA	Midwives	Compliance affects registration with the NMBA, linked to the Health Practitioner Regulation National Law (2009)	June 2022	●	●	●	●	●	●	●	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Code of conduct for nurses	AHPRA / NMBA	Nurses	Compliance affects registration with the NMBA, linked to the Health Practitioner Regulation National Law (2009)	June 2022	●	●	●	●	●	●	●	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Code of Ethics	APS / AHPRA	Psychologists	Compliance affects registration with the Psychology Board, linked to the Health Practitioner Regulation National Law (2009)	Sep 2007	●	○	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
NSW Health Code of Conduct	NSW	All NSW Health employees	Some sections of the code reflect legal requirements and thus result in legal penalties while others only have consequences for employment	Dec 2022	●	●	●	●	●	●	●	○	●	○	○	○	○	●	●	○	○	○	○	○	○	●	○	○	○	○	○	○	○	○
Respectful behaviour policy directive (SA)	SA	All SA Health employees	SA health entities may be subject to audit/assessment, although consequences of breach not explained in this document	Dec 2021	●	●	●	●	○	●	●	○	○	●	●	●	○	●	○	○	●	●	●	○	●	○	○	○	○	○	○	○	○	○
Code of Conduct Policy (WA)	WA	All WA Health employees	The policy is a mandatory requirement for Health Service Providers under the Health Services Act (2016) and for the Department of Health under the Public Sector Management Act (1994)	Oct 2022	●	●	●	●	○	●	●	○	●	●	●	○	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
National Code of Conduct for healthcare workers	DoH&A	For health practitioners not registered with AHPRA *Note: not all jurisdictions have finished adopting this code	Consequences vary by jurisdiction. Once applied, breaches should be investigated by the Health Services Commissioner in each jurisdiction - linked to human rights legislation for that jurisdiction	2015*	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

○ Not evident ◐ Partially evident ● Sufficiently evident

A – Mentions professionalism in relation to colleagues
B – Mentions bullying
C – Mentions harassment (incl. sexual harassment)
D – Mentions discrimination
E – Mentions racism
F – Explains the incident notification and reporting process
G – Explains that there are existing legal duties and outlines/references these
H – Mentions cultural safety

The review found that only three jurisdictions — New South Wales, South Australia, and Western Australia — have publicly available codes of conduct for public sector healthcare workers. This highlights a need for a consistent national code of conduct for all healthcare workers, applicable across both public and private sectors.

Many existing codes are not comprehensive, lack updates to reflect recent legislative changes, and often fail to focus on system-level design and management issues.

Only four of the nine codes reviewed mention professionalism in relation to colleagues. In health care, the emphasis is typically on professionalism with patients and their families, often overlooking interactions with colleagues and overall workforce culture.

While most codes address bullying and harassment, only two explicitly mention racism. This aligns with findings from a recent Australian Human Rights Commission report, which highlights that Australia is not adequately addressing racism due to its limited presence in legal documents.

Only three codes provide guidance on what actions to take if the code is violated, suggesting a need for clearer instructions on who to contact and how to seek support if one experiences or observes a violation.

None of the codes reviewed addressed the responsibilities of leaders and hospital board members.

A few codes briefly reference the duties of supervisors and managers. Although leaders are also workers, they have an additional responsibility to support their teams, which should be explicitly outlined in codes of conduct.

Only South Australia's Respectful Behaviour Policy Directive mentions the responsibilities of executives in creating an environment that promotes positive behaviours among staff.

Furthermore, in cases where codes exist, it remains unclear if they are consistently and robustly enforced.

5.9 Appendix I: References

Australian Health Practitioner Regulation Agency. (2019). The national scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025(p. 9). Australian Health Practitioner Regulation Agency. https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx

Australian Human Rights Commission. (2022). Quick guide to discrimination law. Australian Human Rights Commission. https://humanrights.gov.au/education/employers/quick-guide-discrimination-law

Australian Human Rights Commission. (2023). Let's talk about equality and equity. Australian Human Rights Commission. https://humanrights.gov.au/lets-talk-about-equality-and-equity

Australian Human Rights Commission. (2024). Understanding racism. Australian Human Rights Commission. https://humanrights.gov.au/understanding-racism

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., & Saunders, M. (2021). National Lived Experience Workforce Guidelines (pp. 13–15). National Mental Health Commission. https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/national-lived-experience-peer-workforce-development-guidelines.pdf

Carayon, P., Hancock, P., Leveson, N., Noy, I., Sznelwar, L., & van Hootegem, G. (2015). Advancing a sociotechnical systems approach to workplace safety – developing the conceptual framework. *Ergonomics*, *58*(4), 548–564. https://doi.org/10.1080/00140139.2015.1015623

Cassano-Piche, A. L., Vicente, K. J., & Jamieson, G. A. (2009). A test of Rasmussen's risk management framework in the food safety domain: BSE in the UK. *Theoretical Issues in Ergonomics Science*, *10*(4), 283–304. https://doi.org/10.1080/14639220802059232

Cornell University. (2023). Sense of belonging. Cornell University Diversity and Inclusion; Cornell University. https://diversity.cornell.edu/belonging/sense-belonging

Deutsch, Van & Mossburg. (2022). Resilient Healthcare and the Safety-I and Safety-II Frameworks. *Agency for Healthcare Research and Quality.* https://psnet.ahrq.gov/perspective/resilient-healthcare-and-safety-i-and-safety-ii-frameworks

Driskell, T., Driskell, J. E., & Salas, E. (2014, January 1). *Stress, Performance, and Decision Making In Organizations*. https://www.researchgate.net/publication/313699422_Stress_Performance_and_Decision_Making_In_Organizations

Dubrin, A. J. (2023). Leadership: Research findings, practice, and skills. (10th ed., p. 2). Cengage Learning.

European Agency for Safety and Health at Work (EUSHW). (2023). *Psychosocial risks in the health and social care sector: A discussion paper*.

Frankel, A. S., Leonard, M. W., & Denham, C. R. (2006). Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability. *Health Services Research*, *41*(4p2), 1690–1709. https://doi.org/10.1111/j.1475-6773.2006.00572.x

Hollnagel, Wears, Braithwaite & Middelfart. From Safety-I to Safety-II: A White Paper. (2015). *Resilient Health Care Net*. https://psnet.ahrq.gov/issue/safety-i-safety-ii-white-paper

Gelaw, A. Y., Sheehan, L., Gray, S. E., & Collie, A. (2024). Incidence, trends and factors associated with psychological injury among health and social care workers in New South Wales, Australia: a retrospective cohort study of workers' compensation claims. *Occupational and Environmental Medicine*, oemed-109410. https://doi.org/10.1136/oemed-2024-109410

Giannetta, N., Sergi, R., Villa, G., Pennestrì, F., Sala, R., Mordacci, R., & Manara, D. F. (2021). Levels of Moral Distress among Health Care Professionals Working in Hospital and Community Settings: A Cross Sectional Study. *Healthcare (Basel, Switzerland)*, *9*(12), 1673. https://doi.org/10.3390/healthcare9121673

Griffiths, D., Morphet, J., & Innes, K. (2015). Occupational violence in health care: Final Report. *Research.monash.edu*. https://research.monash.edu/en/publications/occupational-violence-in-health-care-final-report

Haskell, T.L., Stankovich, J., & Merridew, N.L. (2024). A new framework for Australian specialty colleges and other healthcare leaders to address bullying, discrimination, and

harassment that involves doctors. *The Lancet Regional Health — Western Pacific*, *48*, 101118–101118. https://doi.org/10.1016/j.lanwpc.2024.101118

Hopf, S. C., Crowe, K., Verdon, S., Blake, H. L., & McLeod, S. (2021). Advancing Workplace Diversity Through the Culturally Responsive Teamwork Framework. American Journal of Speech-Language Pathology, 30(9), 1–13. https://doi.org/10.1044/2021_ajslp-20-00380

Hopkins, A. (2019). *ORGANISING FOR SAFETY: how structure creates culture.* Commo Australia.

Wyndham Clinic Pty Ltd prosecution result summary. (2021). WorkSafe Victoria https://www.worksafe.vic.gov.au/news/2021-10/hospital-fined-60000-after-worker-bullied

Jackson, A. T., & Frame, M. C. (2018). Stress, health, and job performance: What do we know? *Journal of Applied Biobehavioral Research*, *23*(4), e12147. https://doi.org/10.1111/jabr.12147

Kyung, M., Lee, S.-J., Dancu, C., & Hong, O. (2023). Underreporting of workers' injuries or illnesses and contributing factors: a systematic review. *BMC Public Health*, *23*(1). https://doi.org/10.1186/s12889-023-15487-0

Layson, M. (2023). *Preventing harms caused by moral injury in first responder communities.* Centre for Work Health and Safety and Chares Stuard University, St Marks National Theological Centre

Lukasik, K. M., Waris, O., Soveri, A., Lehtonen, M., & Laine, M. (2019). The relationship of anxiety and stress with working memory performance in a large non-depressed sample. *Frontiers in Psychology*, *10*(4). https://doi.org/10.3389/fpsyg.2019.00004

Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: The attributes, enabling factors and consequences of a new concept. International Practice Development Journal, 1(2). https://www.fons.org/wp-content/uploads/2024/03/IPDJ_0102_01.pdf

Marcelin, J., Siraj, D., Victor, R., Kotadia, S., & Maldonado, Y. (2019). The impact of unconscious bias in healthcare: How to recognize and mitigate it. The Journal of Infectious Diseases, 220(2), 62–73. https://doi.org/10.1093/infdis/jiz214

Newman, V., & Wodak, S. (2022). *How behavioural insights can improve work health and safety*. https://www.comcare.gov.au/__data/assets/pdf_file/0003/365106/vera-newman.pdf

Northouse, P. (2021). Leadership: Theory and Practice (9th ed., pp. 5–7). Sage Publications. https://books.google.com.au/books?id=HJ08DwAAQBAJ&pg=PT28&source=gbs_toc_r&cad=2#v=onepage&q&f=false

O'Neill, S. & Wolfe, K. (2017) *Measuring and reporting on work health & safety*, Canberra, Safe Work Australia.

Parker, S. K., & Knight, C. (2023). The SMART model of work design: A higher order structure to help see the wood from the trees. *Human Resource Management*, *63*(2). https://doi.org/10.1002/hrm.22200

Prosecution case launched over broken health system — NSWNMA — The New South Wales Nurses and Midwives' Association. (2023, March 14). NSWNMA — the New South Wales Nurses and Midwives' Association — Committed to Advocating for Healthier and Stronger Communities. https://www.nswnma.asn.au/prosecution-case-launched-over-broken-health-system/

Psychological health and safety in the workplace report | dataswa. (2023). Safeworkaustralia.gov.au. https://data.safeworkaustralia.gov.au/report/psychological-health-and-safety-workplace

Rasmussen, J. (1997). Risk management in a dynamic society: A modelling problem. Safety Science, 27(2-3), 183-213. https://doi.org/10.1016/S0925-7535(97)00052-0

Safe Work Australia (2019) design. Australian Government Canberra.

Safe Work Australia. (2022, August). *Model Code of Practice: Managing psychosocial hazards at work*. Safeworkaustralia.gov.au. https://www.safeworkaustralia.gov.au/doc/model-code-practice-managing-psychosocial-hazards-work

Safe Work Australia. (2024). *Safe Work Australia — Data report*. https://data.safeworkaustralia.gov.au/sites/default/files/2024-02/Psychological-health-in-the-workplace_Report_February2024.pdf

Safe Work Australia. (n.d.). Bullying. Safe Work Australia. https://www.safeworkaustralia.gov.au/safety-topic/hazards/bullying

Safe Work NSW. (2022, August 17). *Sydney Local Health District*. SafeWork NSW. https://www.safework.nsw.gov.au/compliance-and-prosecutions/enforceable-undertakings/2022-eu-accordion/sydney-local-health-district

Salmon, P., Coventon, L., & Read, G. (2021). *Understanding and preventing work-related violence in hospital settings: A systems thinking approach Final Report (Revised February 25, 2021)*. https://www.safework.nsw.gov.au/__data/assets/pdf_file/0006/964716/understanding-and-preventing-work-related-violence-in-hospital-settings-a-systems-thinking-approach.pdf

Salmon, P., Hulme, A., Walker, G., Waterson, P., Berber, E., & Stanton, N. (n.d.). *Something for everyone: A generic AcciMap contributory factor classification scheme*. https://publications.ergonomics.org.uk/uploads/Something-for-everyone-A-generic-AcciMap-contributory-factor-classification-scheme.pdf

Stratton, E., Johnson, A., & Glozier, N. (2021). Psychosocial Risks and Interventions for Mental Ill-health in the Workplace– A Meta-Review of the Evidence. NSW Government, Sydney

Stress and Job Performance. (2019, May 8). SAGE Publications Inc. https://us.sagepub.com/en-us/nam/stress-and-job-performance/book7187

Tuckey, M. R., Li, Y., Neall, A. M., Chen, P. Y., Dollard, M. F., McLinton, S. S., Rogers, A., & Mattiske, J. (2022). Workplace bullying as an organizational problem: Spotlight on people management practices. *Journal of Occupational Health Psychology*, *27*(6). https://doi.org/10.1037/ocp0000335

Van Dijk, D. M., van Rhenen, W., Murre, J. M. J., & Verwijk, E. (2020). Cognitive functioning, sleep quality, and work performance in non-clinical burnout: The role of working memory. *PLOS ONE*, *15*(4), e0231906. https://doi.org/10.1371/journal.pone.0231906

Victorian Government. (2023). What do we mean by diversity and inclusion? Department of the Premier and Cabinet; Victorian Government. https://www.vic.gov.au/dpc-diversity-and-inclusion-strategy-2019-2021/what-do-we-mean-diversity-and-inclusion

Victorian Safety Culture Guide | Safer Care Victoria. (2024). Vic.gov.au. https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide

Walters, D., Johnstone, R., Bluff, E., Limborg, H. J., & Gensby, U. (2021, May 18). *Improving Compliance with Occupational Safety and Health Regulations: An Overarching Review, European Risk Observatory Literature Review*. Anu.edu.au; European Agency for Safety and Health at Work. https://openresearch-repository.anu.edu.au/items/bff35656-8769-4c87-b9f5-1d531d07db68

Williams, T. (2022). What is CPD and why is it important? UTS Open; University of Technology Sydney. https://open.uts.edu.au/insights/professional-development/what-is-cpd-and-why-is-it-important/

Work as imagined versus work as done. (n.d.). RCOG. https://www.rcog.org.uk/about-us/quality-improvement-clinical-audit-and-research-projects/each-baby-counts-learn-support/safety-thinking-toolkit/work-as-imagined-versus-work-as-done/

Work Health and Safety Act 2011 (NSW). https://classic.austlii.edu.au/au/legis/nsw/consol_act/whasa2011218 Baldwin, C. A., & Krumm, A. M. (2024). Leveraging Consistent Communication Tools and Organizational Values to Promote Accountability Among Health Care Providers. *AORN Journal*, *120*(3), 144–154. https://doi.org/10.1002/aorn.14204

A Better Culture