Community Care Options

SAFE CARE MANUAL

CCO SAFE CARE MANUAL

Index

Section Four – Risk Management

4.1 CCO WH&S Risk Management Policy and Forms
4.2 Accidents
4.3 Bullying and Harassment
4.4 Dealing with Challenging Interactions
4.5 Emergency Management
4.6 First Aid
4.7 Hazardous Substances
4.8 Infectious Diseases
4.9 Manual Handling
4.10 Personal Protective Equipment
4.11 Safe Driving
4.12 Slips/Trips/Falls
4.13 Smoke Free Environment
4.14 Stress
4.15 Sun Protection
4.16 Working at External Locations/In Isolation
4.17 Workplace Violence
4.18 Reportable Incidents

Section Five – Incident Management

5.1 Incident Management Framework
5.2 Policy and Procedures
5.3 Responsibilities

Section Six – Injury Management

6.1 Workers Compensation Acts
6.2 Workers Compensation Regulations
6.3 CCO Return to Work Policy & Procedures

Section One – General WH&S Policy and Information

1.1 CCO WH&S Policy

1.2 CCO WH&S Improvement Plan

1.3 WH&S Vision for CCO

1.4 Work Health and Safety Responsibilities

1.5 Employee Assistance Program

1.1 Community Care Options Work Health & Safety Policy

This CCO WH&S Policy was endorsed and implemented in December 2011.Reviewed and updated by WH&S Committee November 2020.
It demonstrates CCO's commitment to providing a safe and healthy workplace.

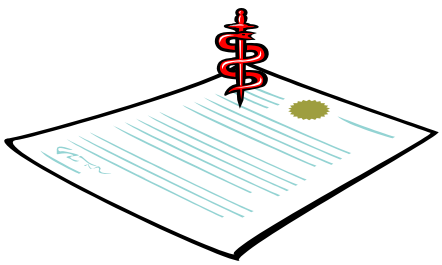
Work Health and Safety

Position Statement

The work health and safety of all persons employed by, serviced by and visiting CCO is considered to be of the utmost importance. Resources in line with the importance attached to workplace health and safety will be made available to comply with all relevant Acts, Regulations, Codes of Practice, Standards and Guidelines and to ensure that the workplace is safe and without risk to health.

In order to implement the general provisions of this policy, a program of activities and procedures will be set up, continually updated and effectively carried out. The program will relate to all aspects of work health and safety including -

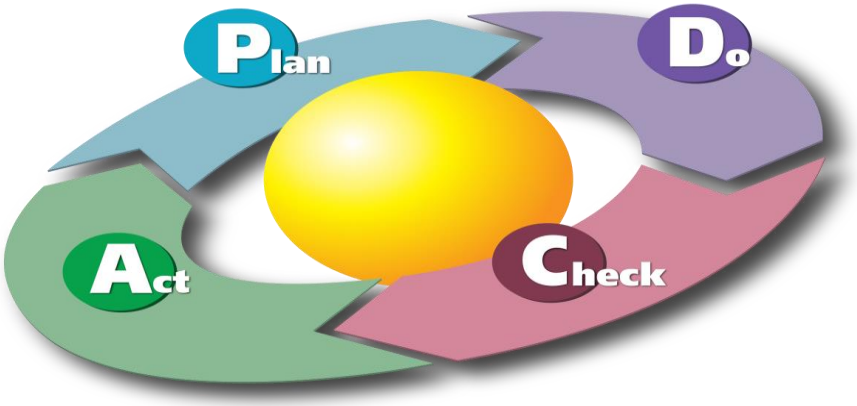
- WH&S training and education including staff induction - all new staff are provided with a copy of the Safe Work Manual
- Provision of information to employees, contractors and sub contractors
- Development of safe work procedures
- Emergency procedures and drills
- Provision of WH&S equipment, services and facilities
- Regular workplace inspections and evaluations
- Reporting and recording of incidents, accidents, injuries and illnesses.



1.2 CCO Work Health and Safety Improvement Plan

CCO aims to improve its WH&S performance by providing a safer working environment. This is achieved through implementation of WH&S strategies, which have the following key objectives –

- Commitment to a WH&S system that ensures all employees, fulfil their WH&S responsibilities;
- Ongoing consultation with employees to identify WH&S issues and to develop, implement and evaluate risk control strategies;
- Ongoing training and development of staff to enable them to carry out their WH&S responsibilities;
- Identification of hazards and development of control procedures to reduce the risk of workplace injury and illness;
- Active management of injured employees with the emphasis on their early return to work;
- Regular review of WH&S strategies to ensure continuing improvement of workplace systems and procedures.



1.3 Work Health and Safety Vision for CCO Employees

CCO believes that successful risk management is an integral part of excellent client service. CCO has always taken pride in its ability to deliver high quality client service. However, 'quality services can only be provided if, in turn, the staff providing the services can do so safely'.

CCO has adopted a Vision Statement to help focus all employees on working safely as they perform their daily tasks. It states that -

"Through the commitment and involvement of all staff and the adoption of Best Practices, CCO will provide quality client service safely".

1.4 Work Health and Safety Responsibilities

Legislative Responsibilities - Work Health and Safety Act 2011

The Act lays down specific requirements for health, safety and welfare, which must be met in all places of work in NSW.

1) The main object of this Act is to provide for a balanced and nationally consistent framework to secure the health and safety of workers and workplaces by -

(a) protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work or from specified types of substances or plant; and
(b) providing for fair and effective workplace representation, consultation, co-operation and issue resolution in relation to work health and safety; and
(c) encouraging unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting persons conducting businesses or undertakings and workers to achieve a healthier and safer working environment; and
(d) promoting the provision of advice, information, education and training in relation to work health and safety; and
(e) securing compliance with this Act through effective and appropriate compliance and enforcement measures; and
(f) ensuring appropriate scrutiny and review of actions taken by persons exercising powers and performing functions under this Act; and
(g) providing a framework for continuous improvement and progressively higher standards of work health and safety; and
(h) maintaining and strengthening the national harmonisation of laws relating to work health and safety and to facilitate a consistent national approach to work health and safety in this jurisdiction.

Workers Compensation Act 1987 and the Workplace Injury and Workers Compensation Act 1998

These Acts establish a workplace injury management and workers compensation system that assists in securing the health, safety and welfare of workers and provides for effective and proactive management of injuries.

WHS Regulation 2012

The regulation supports the Act. It adopts a performance-based approach to work health and safety while maintaining prescribed controls in highly hazardous areas, such as working with asbestos.

Workplace Injury Management and Workers Compensation Regulation 2002 and the Workers Compensation Regulation 2003.

These regulations provide for the management of injured workers return to work programs.

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*

DVA Notes for community nursing providers

- ✓ Sections 4,5.3.1, 5.3.2, 5.3.3, 6, 7.4.3, 7.6.21,8

CCO clearly defines the individual roles and responsibilities of all CCO employees as follows –

The WHS Act places primary duty of care and various other duties and obligations on a 'person conducting a business or undertaking' (PCBU). The organisation is deemed to be a PCBU.

PCBU's have a 'primary duty of care' to ensure, so far as is reasonably practicable, the health and safety of –

- ✓ workers engaged directly or indirectly by the PCBU;
- ✓ workers whose work activities are influenced or directed by the PCBU; and
- ✓ other persons present where work activities are being conducted.

Duties of PCBU's to meet this primary duty of care include provision of –

- ✓ safe work environments;
- ✓ safe systems of work;
- ✓ safe plant and structures;
- ✓ safe substances;
- ✓ facilities;
- ✓ information, instruction, training and supervision;
- ✓ monitoring of workers health and workplace conditions.

Section 27 of the WHS Act – Duty of Officers states –

'If a person conducting a business or undertaking has a duty or obligation under this Act, an officer of the person conducting the business or undertaking must exercise due diligence to ensure that the person conducting the business or undertaking complies with that duty or obligation.'

The Members of the Board of Management and Senior Managers are considered to be Officers of the PCBU (see definitions). An officer of the PCBU must actively take steps to ensure that the PCBU complies with its duty or obligations. The officer is liable for his/her own conduct or omission. The advantages of placing a positive duty on officers is that it requires the officer(s) to take active steps to make sure the PCBU meets its primary duty of care in the first instance – not only after a breach has occurred.

Importantly an officer cannot delegate this duty to someone else in the organisation.

The Board of Management are responsible for –

- ensuring that systems are in place and resourced to identify, assess, eliminate or control all WH&S risks to workers, clients and visitors;
- planning, developing, implementing and evaluating WH&S plans in consultation with staff and workplace WH&S Committees/Representatives;
- promoting and encouraging participation, communication and awareness raising in regard to workplace health and safety by all staff;
- ensuring managers responsible for the workplace understand the requirements of this policy and implement it;
- ensuring that managers monitor the operation of this policy;
- due diligence in respect of the direction and management of the organisation's Work Health and Safety policies and practice.

Due diligence means taking care in the workplace - it means taking every precaution reasonable in the circumstances to protect the health, safety and welfare of all people. Under the Act the 'duty' of the PCBU to maintain a safe and healthy workplace is absolute. Evidence of due diligence is one of the two defences available to a director or person concerned with the management of an organisation charged with an offence under the Act.

The reasonable steps officers must take to ensure they are exercising due diligence includes, but is not limited to –

- ✓ acquiring and keeping up to date with knowledge of work health and safety matters;
- ✓ gaining an understanding of the operations of the business and the hazards and risks involved;
- ✓ ensuring appropriate resources and processes are provided to enable hazards to be identified and risks to be eliminated or minimised;
- ✓ ensuring information regarding incidents, hazards and risks is received and the information is responded to in a timely way;
- ✓ ensuring the PCBU has, and implements, processes for complying with any legal duty or obligation;
- ✓ ensuring processes are verified, monitored and reviewed.

Though not exhaustive, these elements form part of a unified system for ensuring organisational compliance.

In order to fulfill their obligations in relation to "due diligence" the Board will require the CEO to verify the following –

- ✓ regular consultation with employees regarding all health and safety issues has occurred prior to any changes being implemented;
- ✓ that Policy statements are signed, dated and visibly displayed;
- ✓ that all employees are aware of, and trained in, the organisation's safety rules;
- ✓ that there is on-the-job training for employees;
- ✓ that everyone in all of the organisation's workplaces, knows what to do in an emergency;
- ✓ that throughout each workplace in the organisation, there are visible safety signs and reminders;
- ✓ that there is safety labelling on all products and services;
- ✓ that the organisation has regular maintenance systems in place for plant, tools and equipment;
- ✓ the WHS program gives emphasis on eliminating hazards through redesign;
- ✓ that employee morale is good and there are few or no customer complaints.

The CEO is responsible for –

- ➢ leading the development, implementation and evaluation of WH&S strategies;
- ➢ providing staff with a safe work place;
- ➢ ensuring that systems are in place and resourced to identify, assess, eliminate or control all WH&S risks to staff, clients and visitors;
- ➢ planning, developing, implementing and evaluating service WH&S plans in consultation with staff and workplace WHS Committees/Representatives;
- ➢ promoting and encouraging participation, communication and awareness raising in regard to workplace health and safety by all staff;
- ➢ drafting appropriate policies and procedures;
- ➢ updating WH&S policies and procedures in a changing environment and ensuring they are in accordance with relevant legislation;
- ➢ monitoring the development, implementation and evaluation of WH&S plans and programs;
- ➢ supervising and supporting other Managers and staff; and holding them accountable for their specific responsibilities;
- ➢ communicating effectively with all staff in regard to WH&S issues and their management;
- ➢ providing ongoing education;
- ➢ appraising WH&S performance;
- ➢ targeting resources effectively to achieve WH&S performance improvement;
- ➢ promoting and maintaining best practice in workplace health and safety;
- ➢ developing, implementing and evaluating appropriate WH&S strategies;
- ➢ identifying unsafe practices and eliminating them;
- ➢ ensuring incident investigations are conducted within 7 days of notification;
- ➢ cost allocation strategies that support the WH&S plan;
- ➢ actively participating in, and ensuring the effectiveness of the WH&S Committee;

- ensuring Managers responsible for a workplace understand the requirements of this policy, implement it and monitor its operation.

Managers are responsible and accountable for taking all practical measures to ensure -

- that the workplace under their control is safe and without risks to health;
- that the behaviour of all persons in the work place is safe and without risks to health.

If the Manager does not have the authority to fix a problem, they will be held accountable for reporting the matter promptly - together with any recommendations for remedial action – to the CEO who does have the necessary authority.
Managers are responsible for effective communication with staff members and/or clients and their carers, to effectively control risks as far as is reasonable in client homes.

The Client Services Manager is responsible for –

- monitoring the development, implementation and evaluation of WH&S plans;
- supervising and supporting staff (Support Planners/Care Managers and others) to conduct effective risk assessments of client homes and other work environments and to develop appropriate and responsive risk management plans for these environments;
- appraising WH&S performance;
- regularly checking during quarterly client reviews with Support Planners/Care Managers that current risk management plans are in place;
- targeting resources effectively to achieve WH&S performance improvement;
- promoting Best Practice;
- developing, implementing and evaluating appropriate WH&S strategies;
- cost allocation strategies that support the WH&S plan;
- actively supporting staff representatives participating in and ensuring the effectiveness of the WH&S committee;
- detecting any unsafe or unhealthy conditions or behaviour;
- ensuring all staff are trained and competent to carry out their work;
- educating stakeholders about CCO's WH&S practices.

The Manager People & Culture is responsible for –

- leading the development and implementation of safe work practices as part of the process of managing accident/injury prevention;
- ensuring active injury management;
- participating in WH&S forums;
- supervising and supporting administrative staff with safe work practices;
- appraising the WH&S performance of administrative staff;

- targeting WH&S resources effectively.

Support Planners/Care Managers are responsible for –

- contributing to the development, implementation and evaluation of WH&S strategies;
- undertaking effective workplace risk assessment and development of risk management plans as indicated through assessment;
- targeting WH&S resources effectively;
- ensuring incident investigations are conducted within 7 days of notification;
- ensuring active injury management on a day to day basis as required;
- managing the control of workplace risk through implementing and supervising workplace safety review, hazard reporting and safe work practices;
- ensuring equipment and work systems do not pose a risk to the health and safety of employees and others;
- risk alerts are current so that Support Workers are alerted to potential risks before accessing a client's home;
- ensuring that where new or updated equipment is required to assist the client with transfers, manual handling etc that an effective assessment is undertaken by an OT to ascertain the safety requirements and/or training needs for staff;
- participating in WH&S forums such as the WH&S committee.

Service Coordinators are responsible for –

- supporting and resourcing Support Workers to understand workplace risks and to effectively implement risk management strategies;
- advising Management if they become aware of any workplace risks or unsafe issues through either client or Support Worker contact/communication;
- ensuring that each Support Worker is provided with any relevant risk information from Roster Alerts or OH&S Alerts prior to attending a client service – through memo and/or verbally if insufficient time for collection of memo.

Support Workers are required to cooperate with CCO management by –

- ✓ conducting workplace safety reviews;
- ✓ reporting hazards and incidents;
- ✓ adopting safe work practices consistent with WH&S guidelines, and adhering to any documented procedures provided by their supervisor, Support Planner or Manager;
- ✓ participating in WH&S forums such as the WH&S committee;
- ✓ attending WH&S training and development as rostered;
- ✓ refusing to undertake unsafe tasks.

Buddies/Mentors are responsible for –

- delivering presentations/information with clearly stated outcomes linked to Safe Care;

- delivering presentations/information that skills employees to fulfil their WH&S responsibilities;
- delivering presentations/information that is regularly evaluated, reviewed and revised to reflect the changing needs of employees in relation to WH&S requirements;
- providing feedback to management on the changing needs of employees in relation to WH&S.

All Workers (as defined under the WH&S Act) have responsibilities to –

- ✓ take reasonable care for their own health and safety in the performance of their duties and in their interactions with other staff, with clients and with others;
- ✓ take reasonable care to ensure acts/omissions do not adversely affect others health and safety;
- ✓ comply with reasonable instructions from the PCBU;
- ✓ ensure that health and safety is promoted;
- ✓ cooperate with others to comply with safety regulations and procedures;
- ✓ cooperate with the PCBU's WH&S policy and programs to ensure their own health and safety and the safety of others in the workplace; and
- ✓ ensure that management are made aware of unsafe conditions by: verbally communicating unsafe conditions to their direct supervisor; and
- ✓ submitting a written report using the WH&S hazard or incident reporting form.

Worker's have the right to cease or refuse to carry out work if –

- ✓ they have a reasonable concern that the work would expose them to a serious risk to health and safety from an immediate or imminent exposure to a hazard.

A worker may also be directed to cease unsafe work by their Health and Safety Representative (HSR).

Health and Safety Representatives are responsible for –

- representing workers in relation to work health and safety;
- monitoring the measures taken by the PCBU to meet their duties;
- investigating complaints from members of the work group;
- inquiring into risk to the health and safety of relevant workers;
- directing unsafe work to cease when necessary (if trained);
- issuing of provisional improvement notices when necessary (if trained).

HSR activities may include –

- inspecting all or part of the workplace – at any time <u>after</u> giving notice;
- at any time <u>without notice</u> after an incident or where there is a serious and
- immediate or imminent risk to health and safety of a person;

- accompanying an inspector during an inspection;
- being present at an interview between a worker or a group of workers (with their
- consent) and an inspector or the PCBU;
- requesting the establishment of a Health and Safety Committee;
- receiving information on the health and safety of workers – except personal or
- medical information (without the consent of the worker) unless the information
- cannot be used to identify the worker;
- requesting the assistance of another person where necessary eg union rep.

WH&S Committee Members are responsible for –

- ✓ facilitation of cooperation between the PCBU and workers in instigating, developing and carrying out measures to ensure workers' health and safety;
- ✓ assisting in the development of health and safety standards, rules and procedures to be used and complied with in the workplace;
- ✓ providing input and advice in the development and maintenance of incident
- ✓ investigation/hazard reporting systems;
- ✓ reviewing all reports (hazard/incident/claims), collating statistical information and making recommendations to Management and the Board;
- ✓ contributing to the development of a safe working environment and safe systems of work;
- ✓ investigating WH&S risk exposures and attempting to resolve them;
- ✓ reviewing WH&S policies and procedures and making recommendations for improvements and/or further information;
- ✓ providing information sharing of Best Practice between staff.

Other persons at the workplace have a duty to –

- ✓ take reasonable care for his or her own health and safety;
- ✓ take reasonable care that his or her acts or omissions do not adversely affect the
- ✓ health and safety of other persons; and
- ✓ comply, so far as is reasonably able, with any reasonable instruction given by the
- ✓ PCBU to allow the PCBU to comply with their duties.

1.5 Employee Assistance Program

Under the WH&S Act (2011), CCO accepts that it has a Duty of Care to ensure the health, safety and welfare of its employees while at work. The organisation seeks to achieve this by establishing and maintaining a work environment that promotes physical and psychological health.

CCO recognises that at times during an employee's career, circumstances may arise, either within or outside the work environment, which may affect work performance, adversely.

In such situations, CCO accepts that it has a responsibility to assist employees to resolve their issues. This may include accessing appropriate guidance and counselling from qualified professionals.

Such support is intended to assist employees to resolve personal or work related issues and is not to be confused with grievance procedures and disciplinary measures.

To access information relating to the Employee Assistance Program staff should ask their Manager or the Operations Manager.

Section 2 – WH&S Legislation

2.1 Work Health and Safety Act

2.2 A summary of the WH&S Act

2.3 Work Health and Safety Regulation

2.4 Summary of the WH&S Regulation

2.5 WH&S Responsibilities and Accountabilities

2.6 Codes of Practice

2.1 Work Health & Safety Act

The Act relevant to workplace health and safety in NSW is the Work Health and Safety Act (2011).
All workplace activities are subject to absolute obligations imposed by the Work Health and Safety Act (2011).
It applies to all situations where persons perform work as either employees or self-employed persons.

2.2 A Summary of the Work Health & Safety Act

- ✓ *Managers and supervisors need a working knowledge of the WH&S Act so that they can apply it in the workplace. See attached Summary*.

2.3 Work Health and Safety Regulation

The WH&S Regulation provides a risk management framework and supports the WH&S Act in providing a performance-based approach to WH&S.

2.4 A Summary of the Work Health and Safety Regulation

- ✓ *Managers and supervisors need a working knowledge of the WH&S Regulation so that they can apply it in the workplace. See attached Summary of WH&S Regulations.*

2.5 WH&S Responsibilities and Accountabilities

The WH&S Act and Regulation outline specific responsibilities and accountabilities for managers and staff at all levels. A summary of these responsibilities and accountabilities can be found at - Section – 1.4.

2.6 Codes of Practice

A code of practice provides details on how to achieve the standards required under the work health and safety (WHS) legislation, by identifying hazards and managing risks. Codes of Practice are produced by employer, union and national bodies like Standards Australia, Safe Work Australia and WorkCover NSW and represent a uniform procedure for handling particular issues.

They are advisory by nature and generally not legally enforceable unless given regulatory status under Part 4 Industry Codes of Practice of the Act. However, they represent a good guide to handling particular WH&S issues.

They are issued by WorkCover NSW and are approved by the Minister for Industrial Relations and published in the Government Gazette. They are 'approved' under Part 4 of the WH&S Act.

New WHS Codes of Practice which became available from 1st January 2012 and which are relevant to CCO include -

- ✓ Hazardous manual tasks
- ✓ How to manage work health and safety risks
- ✓ Managing the risk of falls at workplaces
- ✓ Labelling of workplace hazardous chemicals
- ✓ Managing the work environment and facilities
- ✓ Work health and safety consultation, coordination and cooperation**.**

Section 3 – WH&S Forums

3.1 Introduction

3.2 WH&S Consultation and Communication Framework

3.3 Office WH&S Improvement Groups

3.4 Health and Safety Representatives

3.8 WH&S Committee

3.6 Health & Safety Representative and Committee Member Rights

3.7 Penalties

3.1 Introduction

The CCO WH&S Consultation Policy and Procedure underpins this section.

CCO recognises that ongoing consultation with staff is important and will result in improved WH&S performance and increased awareness of health and safety matters in the workplace. CCO acknowledges that formal and informal mechanisms are necessary to allow both employer and employee to identify and resolve WH&S problems at every level of the organisation. A safe workplace is more easily achieved when employers and workers talk to each other about potential problems and work together to find solutions.

In order to achieve wide ranging input from all levels of the organisation CCO promotes the following WH&S forums -

- ✓ Health & Safety Representatives
- ✓ Office WH&S Improvement Groups
- ✓ WH&S Committee
- ✓ Work group Review
- ✓ Management Review
- ✓ Board Review

CCO wants strong links between each of the forums so that health and safety messages and good ideas feed from the grass roots of CCO through the WH&S Committee to the Board. Feedback to employees will occur in the reverse.

3.2 WH&S Consultation and Communication Framework

Position Statement
Community Care Options fosters open and effective communication and recognises its vital role for good industrial relations, quality management and effective management of Work Health and Safety. Consultation and communication enables CCO to meet organisational and legal requirements on consultation and ensure all workers/clients have a genuine opportunity to effectively participate in decision making on matters with potential to affect their environment.

Establishment of consultation arrangements
Community Care Options Inc established consultation arrangements with its workers in July 2001. After a number of staff meetings, it was agreed to appoint WH&S Representatives and a WH&S Committee. Calls for nominations to the Committee were taken and representatives from each workgroup were appointed to the Committee by election.

Further consultation has taken place with workers in anticipation of the introduction of new WH&S legislation, at an All Staff meeting on 22nd November 2011. The staff confirmed the different work groups, elected to have Health and Safety Representatives for each of these work groups and were asked to nominate a new HSR for their work group or re – elect the existing WH&S representative to represent them as the HSR for their work group. Staff also elected to continue to have a WH&S Committee, which HSR's would participate on and which will continue to meet bi-monthly as a means of effective consultation across the organisation.

The Act - Section 47 – states that a PCBU must, so far as is reasonably practicable, consult with workers who carry out work for the business or undertaking who are, or likely to be, directly affected by a work health and safety matter.

Section 46 also states that the duty holders with overlapping WH&S duties must, so far as is reasonably practicable, consult, cooperate and coordinate activities with each other.

CCO recognises that effective consultation requires –

- ✓ that there are agreed procedures and that these are followed;
- ✓ that the relevant HSR is involved;
- ✓ that relevant information about a matter is shared with workers;
- ✓ that workers are given the opportunity to express views, raise WH&S issues and contribute to decision making;
- ✓ that the views of workers are taken into account by the PCBU; and
- ✓ that workers are advised of the outcome of WH&S matters in a timely manner.

Consultation is required when –

- identifying hazards and assessing risks;
- making decisions about how to eliminate and minimise risks;
- making decisions about facilities for welfare of workers;
- proposing changes that affect the WH&S of workers; and
- when decisions are made about procedures for - consultation, issue resolution, health monitoring, monitoring the condition of the workplace and information and training.

In complying with its obligations in terms of consultation CCO will –

- ✓ make sure workers are aware of WH&S matters as soon as possible;
- ✓ encourage workers to ask questions about WH&S;
- ✓ encourage workers to raise concerns and report problems;
- ✓ encourage workers to make suggestions to solve WH&S problems;
- ✓ involve workers in the problem solving process; and
- ✓ inform workers of the outcome of consultation and decisions promptly.

The major objectives of the Health and Safety Representatives and the WH&S committee are to –

- ✓ facilitate cooperation between CCO and its workers in developing and carrying out measures designed to ensure a safe and healthy working environment;
- ✓ formulate, review and disseminate to workers of CCO and where appropriate to clients, their relatives, and others affected by the work of the PCBU, the standards, rules and procedures relating to WH&S.

The WH&S Representatives are responsible for specific health and safety issues that arise in the workplace. Workers should raise any health or safety concerns to their immediate supervisor immediately through the hazard/incident reporting process. They may also choose to raise them with their WH&S Representative. CCO will ensure that HSR's are advised of any hazards/incidents reported for their work group. Where the WH&S Representative cannot resolve the issue, it is agreed that the issue shall be taken to the WH&S Committee.

WH&S Committee

The WH&S Committee is made up of the WH&S representatives, Management/Officers of the PCBU, and the First Aid Officer. The Committee represents all workers of Community Care Options Ltd and recognises the overlapping responsibilities and duties of work groups, allowing collective identification and review of information.

The WH&S Committee will assist with the development and monitoring of safe work practices and systems, and discuss issues that affect the health, safety and welfare of all workers of CCO.

The organisation will respond to the WH&S Committee recommendations within a timeframe agreed by the Committee, set according to the particular issue and its complexity.

How employees will be consulted about WH&S

- ✓ *Agreed procedures – in accordance with Sect 48.*

WH&S will be included as an agenda item for all meetings held at CCO, with the opportunity for staff to discuss issues and required actions. It is the responsibility of the meeting coordinator to refer issues raised to Management and the WH&S Committee and to ensure that action is noted in the minutes of the meeting.

Specific WH&S Report to be sent to Management from each group including 'nil report'.

Arising WH&S issues will be tabled for discussion with Health and Safety Representatives at Work Health and Safety Committee Meetings and as they arise.

Incident/hazard data will be reviewed at Work Health & Safety Committee meetings to analyse trends, discuss preventative options.

Minutes of WH&S Committee meetings will be posted on noticeboards in each office. Staff, clients, visitors and contractors will be encouraged to use the Hazard Report form to notify the organisation of issues needing to be addressed. The Hazard Report form will be available at the front office and information about this form will be included in the CCO newsletter.

When an issue is raised either by the organisation, a worker or the WH&S Committee, the WH&S representative will consult members of their work group. The WH&S Representative will also provide feedback to their work group on outcomes from the WH&S Committee meetings. Minutes of the meetings will be held in a folder kept in an accessible place for all employees. The WH&S Committee will also recommend which outcomes are to be included in the staff newsletter.

Workers have a duty to report to their immediate supervisor and WH&S Representative any health or safety concerns that they have about the workplace so the issue can be promptly addressed. Any issues that remain unresolved to the employees' satisfaction after being reviewed and actioned by the WH&S Committee, should be drawn to the attention of management in writing.

Review of Consultation Arrangements

It has been agreed by Community Care Options and the organisation's workers that these consultation arrangements will be monitored and reviewed on an on-going basis, to ensure that consultation with all employees is effective, and that all safety issues are being addressed.

3.3 Office WH&S Improvement Groups

Although these groups do not have the same status as the WH&S Committee, they are the first and most important forums to identify and resolve WH&S matters at the local office level. The main purpose of Office Improvement Groups is to assist in identifying, prioritising and dealing with hazards. Problems can be solved and risks dealt with using the skills, experience and expertise of a variety of staff both administration and field, leading to improved risk management in the workplace.

Group Membership includes -

All staff in outer offices. WH&S is to be an agenda item on monthly office meetings.

3.4 Health and Safety Representatives

At the All Staff Meeting held on 22nd November 2011 work group representatives were elected by their peers as the Health & Safety Representative for their work group. Nomination and election of new HSR's occurs as needed.

The number of Health & Safety Reps elected by their peers are reflective of CCO service locations ie: Coffs Harbour, Woolgoolga, Urunga and provide a broad representation across various positions.

- ✓ *Support Workers*
- ✓ *Service Coordinators*
- ✓ *Support Planners/Care Managers*
- ✓ *Management*
- ✓ *Administration/Finance*

The WH&S Representatives are responsible for specific health and safety issues that arise in the workplace. Workers should raise any health or safety concerns to their supervisor immediately through the hazard/incident reporting process. They may also choose to raise them with their WH&S Representative. CCO will ensure that HSR's are advised of any hazards/incidents reported for their work group. Where the WH&S Representative cannot resolve the issue, it is agreed that the issue shall be taken to the WH&S Committee.

HSR powers and functions are limited to work group except where issues overlap.

CCO will consult with HSR's on WH&S issues affecting the work group.

CCO will allow access to WH&S information relevant to the work group.

Powers and Functions of HSR's

The functions of HSR's are similar to previous functions of OH&S Representatives and OH&S Committee members ie they –

- represent workers in relation to work health and safety;
- monitor the measures taken by the PCBU to meet their duties;
- investigate complaints from members of the work group;
- inquire into risk to the health and safety of relevant workers.

Additional powers and functions include (where trained to do so) –

- directing unsafe work to cease when necessary;
- issuing of provisional improvement notices when necessary.

HSR activities may include –

- inspecting all or part of the workplace – at any time after giving notice; at any time without notice after an incident or where there is a serious and immediate or imminent risk to health and safety of a person;
- accompanying an inspector during an inspection;
- being present at an interview between a worker or a group of workers (with their consent) and an inspector or the PCBU;
- requesting the establishment of a Health and Safety Committee;
- receiving information on the health and safety of workers – except personal or medical information (without the consent of the worker) unless the information cannot be used to identify the worker;
- requesting the assistance of another person where necessary eg union representative.

3.5 WH&S Committee

A PCBU must establish a health and safety committee within 2 months of being requested to do so by –

- ✓ A HSR for the workgroup carrying out the work;
- ✓ 5 or more workers at the workplace;
- ✓ If required to do so by the regulation; and
- ✓ If the PCBU wishes to establish a committee on their own initiative.

Function
The function of the WH&S Committee is to –

- ➢ Facilitate cooperation between the PCBU and workers to instigate, develop and carry out WH&S measures;
- ➢ Assist to develop health and safety standards, rules and procedures to be complied with at the workplace; and
- ➢ Perform such functions as prescribed by the regulation or agreed between the PCBU and the Committee.

The WH&S committee provides an opportunity for employees and employers to come together to identify and solve health and safety problems, and to assist in the development of and monitoring of safe work systems and procedures.

Composition of the WH&S Committee

- ✓ elected Health & Safety Representatives
- ✓ appointed Management representatives
- ✓ the CEO

Frequency of Meetings
The representatives will meet bi monthly – but at a minimum every three months.

Issues Discussed
At committee meetings members concentrate on the issues of workplace health and safety which will have the most impact on injury prevention and result in a reduction in work related injuries and illnesses.

Requirements of Health & Safety Representatives
The procedures with respect to the establishment and composition of WH&S Representatives and the WH&S Committee comply with the Code of Practice – How to consult on Work Health and Safety.

- ✓ Work group representatives must be elected by their work group
- ✓ Election must be conducted in a manner that is consistent with recognised democratic principles
- ✓ Employer representatives must not exceed employee representatives
- ✓ Chairperson is not to be an employer representative
- ✓ Elected for a period of three years or less, can be re elected for a further term
- ✓ Employer representative must have authority to act on behalf of the employer in WH&S matters
- ✓ Elections can be conducted by a Union.

HSR's are not personally liable for anything either done or omitted in their role as a HSR if done in 'good faith' (immunity).

The functions of Health & Safety Representatives are now somewhat different from the roles and functions of OH&S Committee Members.

A Health & Safety Representative represents the interests and issues relevant to their work group and can only act on behalf of their work group unless the issue is overlapping with other work groups.

Functions of the WH&S Committee
The functions of the WH&S Committee are –

- ➢ to promote work place health and safety
- ➢ to make recommendations to management on WH&S issues
- ➢ to coordinate activities to prevent injury/illness
- ➢ to assist in the development and maintenance of accident investigation/hazard reporting systems
- ➢ to review all reports (hazard/incidents), collate statistical information and make recommendations as required
- ➢ to assist in the development of a safe working environment and safe systems of work in the workplace
- ➢ to investigate WH&S risk exposures and attempt to resolve them
- ➢ to review WH&S policies and procedures and make recommendations for improvements and or further information
- ➢ to provide information and sharing of better practices between staff groups.

Meetings Process
Management and representatives will try and reach consensus on all aspects of the organisations WH&S policy and program. Changes to WH&S policies and procedures will be drafted and tabled for consultation and endorsement by the WH&S Committee and then submitted to the Board of Management for approval.

Agenda items will be sought from staff prior to WH&S meetings.

Each HSR will have the opportunity to table any matters raised with them or that they are aware of for their work group.

WH&S reports from other CCO meetings will be tabled for discussion of any issues identified.

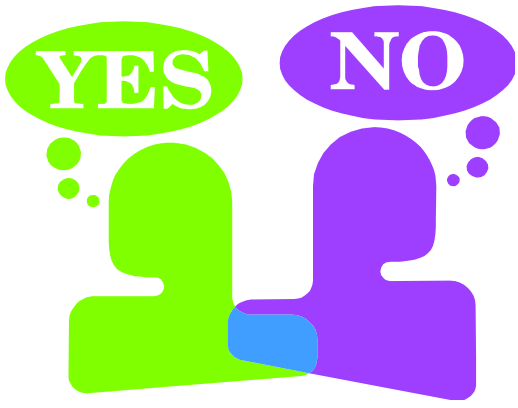
Incident/hazard information will be tabled and reviewed in terms of trends, issues unresolved or, changes that need to be made to policy, procedure or practice.

HSR's will be responsible for feeding back information to their work group at work group meetings.

Urgent matters will be discussed and an appropriate mechanism for communication agreed at the meeting or with the relevant HSR.

Issue Resolution Process

If there is disagreement about the appropriate course of action to be recommended or taken with regard to a work health and safety issue then the HSR's will vote on a course of action ie seek more information before making a decision or refer the matter to an independent body such as Work Cover for information and advice. The majority vote will decide the course of action taken.



3.6 Health & Safety Representative and Committee Member Rights

A PCBU must allow a member of the Health and Safety Committee, with respect to health and safety matters –

- ✓ Reasonable time to attend HSC meetings and carry out functions as a Health & Safety Representative and member of the HSC.

- ✓ Access to information on hazards (including associated risks) and the health and safety of workers of the work group with the workers consent (information must not contain any information that may allow identification).

Whilst undertaking committee activities or training, committee members and/or Health & Safety Representatives are entitled to be paid as it they are engaged in their usual work, including pay (at the appropriate award rate) for any period which exceeds their ordinary hours of work.

Health and Safety Representatives are entitled to be provided with training, upon request, to assist them to carry out their functions. Such training is to be provided by the employer and is to consist of –

- ✓ Attendance at an accredited training course which provides training in the duties of Heath & Safety Representatives
- ✓ Attendance, as necessary, at further courses ie refresher training.

3.7 Penalties

HSR's and Committee Members endorsed this inclusion in the policy at a meeting on 6th December 2011.

That CCO enact penalties for staff who are deemed to be in breach of their responsibilities under the Work Health and Safety Act.

The Health and Safety Committee stance re penalties reflects the organisations commitment to improved work health and safety and a safer work place for all, and the importance attached to this goal. All staff must work together as a team to identify, prevent and respond to risks in our work places.
The Management Team will determine if penalties should be imposed ie disciplinary process, commencing with a first formal warning; where they become aware of the following

- ✓ staff are aware of risks and do not identify them;
- ✓ incidents have occurred that have not been reported;
- ✓ staff not following correct WH&S procedures and practices to protect themselves and
- ✓ others ie not practicing universal infection control;
- ✓ staff acting in a manner which places themselves and or others at risk of harm.

Staff found in breach of their responsibilities will be issued with a yellow card as their first formal warning.

All efforts will be made by Management and HSR's, including provision of information, mentoring, buddying, further training and development to support the staff member to improve their practice.

Three strikes (yellow cards) however, may result in termination. The Management Team will determine each case on its merits based on the seriousness of the breach, impact circumstances.

Section Four – Risk Management

4.1 CCO WH&S Risk Management Policy and Forms

WH&S Risk Management Policy

Definition

Risk – is the possibility that harm (death, injury or illness) might occur when exposed to a hazard.

Hazard – means a situation or thing that has the potential to harm a person.

Risk Control – means taking action to eliminate health and safety risks so far as is reasonably practicable, and if it is not possible, minimising the risks so far as is reasonably practicable. Eliminating a hazard will also eliminate any risks associated with that hazard.

Risk Management is a logical, step by step process of identifying hazards, assessing the risk associated with those hazards, eliminating or controlling those risks and monitoring and reviewing risk assessments and control measures. The objective of this process is to improve workplace health and safety by addressing problems before injuries and incidents occur.

Position Statement

CCO aims to promote and implement the principles and processes of Work Health and Safety risk management in order to create and maintain a safe and healthy working environment for all staff, clients, contractors and visitors. We recognise it is our legislative responsibility, to effectively manage workplace risks in order to prevent injuries and incidents and improve safety in the workplace. It is also recognised that improving WH&S performance plays a key role in improving overall organisational performance and thereby allowing the organisation to better position itself to deliver effective services and programs to our clients.

Legislation

- ✓ *Work Health and Safety Act 2011*
- ✓ *Work Health and Safety regulation 2012*
- ✓ *Code of Practice – How to Manage Work Health and Safety Risks*

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Management*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 7 – Human Resources*

National Disability Standards

- ✓ *Standard 6 - Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*

- ✓ *Implementing Behaviour Support Plans*

DVA Notes for Community Nursing

Risk management is important because it plays a vital role in creating a safer and healthier workplace and assists us to meet our legislative responsibilities. Under the Work Health and Safety Act 2011 and Regulations all PCBU's have a responsibility to ensure that the workplace is free of risks that can cause injury or illness to workers, contractors, and other people such as visitors and clients.

Risk management involves a systematic process by which hazards are identified and the risk of injury or illness is eliminated or reduced. Risk management is applied to all organisational WH&S programs and all work practices, systems and processes in the workplace. The following table illustrates the WH&S framework and how risk management (and consultation) impact on all WH&S practices.

<table>
<tr><td colspan="2">WH&S Policy</td></tr>
<tr><td>WH&S Risk Management Policy</td><td>WH&S Consultation Policy</td></tr>
<tr><td colspan="2">Policies for WH&S Programs such as Manual Handling and operational policies relating to managing the risks associated with providing care to clients</td></tr>
<tr><td colspan="2">Tools to implement WH&S Programs eg procedures, training, guidelines and forms as well as operational processes and systems designed to manage the risks involved with providing services and programs to clients</td></tr>
</table>

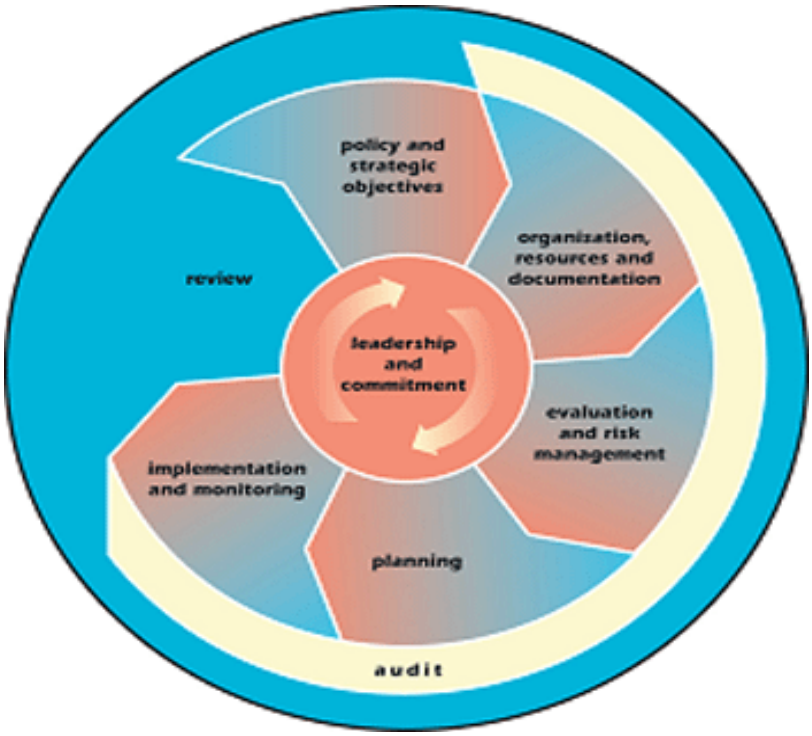
Risk management provides the framework by which health and safety issues are identified and addressed and provides tools and processes to make improvements to local workplace safety practices.

CCO will implement a risk management process through the following mechanisms –

- ✓ Staff WH&S induction and training
- ✓ Provision of personal protective equipment
- ✓ Hazard identification and reporting
- ✓ Risk assessment and control
- ✓ Workplace review.

Risk management is required at all stages of a work process including –

- ✓ prior to establishing and using a workplace, including starting a new business or purchasing a business;
- ✓ when planning and designing work processes;
- ✓ before selecting, purchasing, installing and using equipment, new or used;
- ✓ before using new substances;
- ✓ before changes are made to work practices, procedures or the work environment;
- ✓ when planning to improve productivity or reduce costs;
- ✓ whenever there is new information about work processes, and risks;
- ✓ when responding to workplace incidents (even if there is no injury);
- ✓ when responding to concerns raised by workers, health and safety representatives or others at the workplace; and
- ✓ as required by the WH&S regulations for specific hazards.



Staff WH&S Induction and Training

- ✓ All staff will have knowledge of work health and safety issues.
- ✓ During their initial orientation support staff will be trained in work health and safety including back care, transferring and safe lifting, and universal precautions.
- ✓ Each staff member will attend Work Health and Safety training at least annually.
- ✓ Individual training will be provided if a staff member is inexperienced in the use of

any piece of equipment or in general safety procedures.

- ✓ WH&S Induction Checklist to be completed for each staff member. See attached.

Staff are informed of what constitutes unsafe working areas and conditions. These include but are not limited to the following –

- Unsafe equipment eg. electrical equipment;
- Unsafe access eg. stairs;
- A need for grab rails or walking aids;
- Home and garden maintenance needs;
- Hazards in the client's kitchen eg. open fires, gas ovens, especially if in poor repair;
- Positioning of bathroom aids (grab rails, bath seats, etc) and the need for any alterations or aids;
- Poor lighting;
- Electrical appliances, faulty connections, worn or frayed cords, extension cords in walkways etc;
- Faulty heaters and electric blankets;
- Electric blankets used where there is risk of incontinence;
- Polished floors when clients have mobility issues;
- Loose mats;
- Uneven floors and steps in bad repair; and
- External hazards (rubbish, overhanging trees and shrubs, poor lighting)
- Client behaviour eg use of drugs and alcohol, smoking, mental health issues.

Safety is everyone's responsibility

WH&S INDUCTION CHECKLIST

Employee Name:			
Position:			
Task Specific Training Required:			
WHS INDUCTION REQUIREMENTS – Updated due to changes in WH&S legislation as of 1.1.2012	**Carried out at induction**		Date covered
	Yes (tick)	**No (tick)**	
Overview of new legislation			
WHS Policy and procedures			
Employer and employee obligations			
Consultation strategy			
Repair and maintenance procedure			
Risk Assessment			
Hazard Reporting – Hazard report form			
Incident Reporting procedures			
Workers Compensation and RTW policy			
Specific work related hazards			
Drug and alcohol and smoking policy			
Bullying and Harassment			
Emergency procedures			
First aid			
Slips/trips/falls prevention			
Computer workstation adjustment			
Safe Driving			
Fire Safety			
Safe plant and equipment			
Cold and flu prevention			
Manual handling			
Infection control			
PPE issued and discussed			
Safe work procedures – specific training provided			
Risk Management			

Training and meeting schedule			
Hazardous substances and MSDS			
Working at External locations			
Children's Services			
Workplace Violence – client behaviour			
Comments:			
I have discussed and confirm that I understand all the above requirements including the organisation's requirements and my responsibilities :			
Employee Signature:		Date:	
Induction carried out by:		Date:	

Thinking safety together – we're OK

The I'm OK, You're OK, We're OK concept is a simple three step tool to remind staff to work safely within the policies and procedures of the organisation by following safe work practices every time they are working in any work place situation.

I am OK

- ✓ I stop and think about the task I am about to undertake.
- ✓ I have considered the hazards and risks, I have conducted a risk assessment, and agreed on the controls for me
- ✓ I am complying with work procedures (ie. task specific procedures).

You are OK

- ✓ I have considered my client's needs, safety and issues of dignity.
- ✓ I have risk assessed my client's needs and negotiated a safe approach.
- ✓ I have checked that the client understands and is ready for the activity we are about to undertake

We are OK

- ✓ We have safe work practices and systems to support our activity.
- ✓ Our activity has agreed 'Not OK' safety actions and responses.
- ✓ All necessary controls/support required are in place.

The Work Health and Safety Act and Regulations require persons who have a duty to ensure health and safety to 'manage risks' by eliminating health and safety risks so far as is reasonably practicable, and if it is not reasonably practicable to do so, to minimise those risks so far as is reasonably practicable.

Risk management is a four step process that involves –

- ✓ Identifying hazards
- ✓ Assessing risks
- ✓ Eliminating or controlling risks
- ✓ Monitoring and reviewing.

A risk management approach will be adopted to prevent incidents occurring. Risk management requires that foreseeable danger (or hazards) are identified; eliminated or controlled; and continuously monitored and reviewed.

Risk management is a proactive process that will help us respond to change and facilitate continuous improvement in the organisation. It will be planned, systematic and cover all reasonably foreseeable hazards and associated risks.

Hazard Identification

A hazard is a situation with the potential to cause harm to life, health or property and is the primary cause of health and safety problems in the workplace. Hazards generally arise from the following aspects of work and their interaction -

- The physical work environment
- The equipment, materials and substances used
- The work tasks and how they are performed
- Work design and management.

Hazards can be identified in a number of ways including –

- undertaking workplace inspections (including inspections of client homes);
- reviewing injury and incident data including near misses;
- investigating complaints and incidents;
- conducting safety audits;
- monitoring worker health and the work environment;
- observing work practices;
- consulting with workers and others, including staff, volunteers, contractors, clients and visitors;
- responding to information contained in hazard report forms;
- consulting with health and safety representatives and WH&S Committee members;
- consulting, cooperating and coordinating activities with other duty holders.

Hazards that affect the Community Care Sector and Community Care Options –
(as identified by the WH&S Committee on 6.12.2020).

- Slips, trips, falls
- Manual handling
- Workplace violence
- Infection Control
- Client behaviour – ie smoking, drug and alcohol use
- Motor vehicles, travel and transport
- Working at external locations
- Infectious Diseases
- Domestic squalor
- Working alone or in isolation
- Drugs and alcohol
- Stress
- Safe food handling

Hazard/Incident Reporting

Hazard – a source of potential harm.

An **INCIDENT** is an instance of something happening, an event or occurrence. This incident could involve staff, clients or others. All Incidents including near misses are to be reported immediately.

Any identified work place hazards and incidents are to be reported immediately. This is the responsibility of all staff members.

Staff will report all hazards and incidents on the CCO WH&S Hazard/Incident Report form. (Attached)

Where staff perceive an immediate imminent and/or serious risk to the health and safety of anyone within the workplace including clients and their families they must immediately phone their Manager. If their line Manager is unavailable then the CEO or another Manager. They should remove themselves and anyone else at risk to prevent injury or illness in the first instance.

Where staff are unable to complete and submit a form themselves on the day of observing a hazard, or experiencing an incident they should phone the local office, the client's Support Coordinator/Care Manager or the Support & Development Manager and report the issue. It is the staff member's responsibility to ensure that the hazard/incident has been managed in some way to reduce risk of harm to others ie. reported, recorded in the client's communication book, drawn to the attention of the client and others in the household, eliminated, reduced, controlled in some way. ie a sign posted over faulty power point, mat removed etc.

Staff receiving a call from Support Workers in relation to a Hazard/Incident will complete a Hazard/Incident report form on their behalf.

Hazard/Incident Reports received in outer offices should be faxed to the CEO's Personal Assistant on the day of receipt.

Once received the PA will register on WH&S Register, scan form and send to relevant Support Coordinator/Care Manager, or Program Manager for action. PA will enter details into TRACCS, and alert Management to WH&S form being received. Forms collated to review at weekly Exec/Management Meetings.

Support Coordinators/Care Managers are responsible for ensuring follow up action is completed and updated on the system as soon as possible, and within 1 week of notification. Including advising all those working in the environment where the hazard/incident was identified, of the action taken to reduce hazard. Where they are unable to address the issue immediately and close the issue on TRACCS they will ensure that they have alerted the Client Services Manager so that additional resources or action may be taken to address the issue.

Office Use Only	
Date Report received	
Staff Incident ☐	
Hazard ☐	No.
Client Incident ☐	

HAZARD & INCIDENT REPORT

A **HAZARD** is anything (including work practices & procedures) that has the **potential to harm the health or safety of a person.** Any identified work place hazards are to be reported immediately.

An **INCIDENT** is an instance of something happening, an event or occurrence. This incident could involve staff, clients or others. All Incidents including near misses are to be reported immediately.

Safety is everyone's responsibility!

Name of person making report	
Position	
Date of Report	
Date of Hazard/Incident	
Time of Hazard/Incident	
Client Name	
Hazard/Incident Location	
Describe the hazard/incident & who was affected & how you responded to it (Attach additional information if insufficient room)	
Name of any witnesses	
Was first aid or medical attention required?	**Yes** □ Details: **No** □
Is further action required?	**Yes** □ Details: **No** □

Possible solutions	(Any suggestions eg. Modification, maintenance, new equipment, lifting aids, training, revised work pressures, etc)

ACTION TAKEN – Office use only

Include action taken at local level and referral to other sources

Date	**By whom** (name and position)	**Action**
	Grace Keys - PA	Hazard/Incident Report Received
	Grace Keys - PA	Recorded on Hazard/Incident Register
	Grace Keys - PA	Recorded in TRACCS & communicated to relevant staff
	Grace Keys – PA	If Staff Injury refer to Operations Manager to assess
	Liz Anscombe - Ops	• Time lost by worker Yes/No
	Liz Anscombe – Ops	• Notification to insurer Yes/No
		If Client Injury refer to relevant Care Manager or Program Manager for follow up with client
	Executive Team	Reviewed & checked action by staff
		Further follow up required ☐
		No further action ☐
Action -		
Date	By Whom (name & position)	
		Feedback to SW

SAFE CARE
Hazard Reporting

What you need to do when you identify a workplace hazard

ASSESS THE HAZARD
What is the likelihood and severity of risk

If it is **safe** to do so – **fix it**
If you can't fix it – make the **area safe**

Report it

HOW? – Complete a hazard report form – located in client communication folder & drop into office asap (same day) and/or
Phone your local office
Speak to the Care Manager/Support Coordinator
Speak to your Manager

Safety is everyone's responsibility

Risk Assessment

CCO risk assessment processes will commence from the point of client referral. The Program Managers where they have contact with the person making the referral, will ask the referrer a range of questions about any risks from the client and/or their environment. Will complete WHS form WH&S Questions to ask at referral.

Where there is no contact with the referrer. The referral will be allocated to a Support Coordinator/Care Manager or Service Assessment Officer who will contact the referrer where there are any identified risk areas on the referral form and complete the above form and/or the client and ask them a range of questions about any risks prior to arranging a visit to the client. Will complete WHS form as above.

The Support Coordinator/Care Manager or SAO will complete the CCO Workplace Health & Safety Risk Assessment form when visiting the client to complete the initial assessment. Support Coordinator/Care Managers or SAO's are to consider how hazards may cause harm, the likelihood of harm occurring and the severity of harm should it occur.
Please refer to risk indicator chart.

Support Coordinators et al, will complete a WH&S Risk Assessment on all client home's before services are commenced. Support Coordinators et al, will ensure that the client's home is as safe a workplace as possible. They will recommend to the owner of the property any changes that are required to make the home a safer work place. It is recognised that due to the nature of the business, some hazards may be out of the control of the organisation. However, services to clients will be provided in such a way as not to endanger the client or the staff member providing the service.

Specifically, Support Coordinators/Care Managers/SAO's will -

- ✓ physically inspect the relevant areas in and around the client's home;
- ✓ identify unsafe areas in the client's home which impact on service provision;
- ✓ make appropriate referrals to occupational therapists and/or physiotherapists to assess problem areas;
- ✓ ensure that appropriate remedial work is carried out and control mechanisms put into place;
- ✓ document hazards, referrals, remedial work and controls in the client's risk management plan and in the client's progress notes prior to support staff commencing work;
- ✓ ensure support staff receive relevant client WH&S information through inclusion in roster alerts.

Support Workers will –

Ensure that where they have identified a hazard that they have reported it.
Update the risk assessment form and provided information about this update in the client communication book.

FIRST HOME VISIT CHECKLIST

Support Coordinators and/or assessors are to consider the following issues and complete this checklist to identify any actual or potential hazards prior to visiting the client's home for the first time. The information will be gathered from referral and assessment data.

Client: Services to be provided:	Client Address:	Client Phone: (H) (M)

Preparing for first home visit I HAVE FOUND OUT IF	YES	NO	Are there any risks now?	YES ✓	NO ✓
The client or others at the home have previously displayed challenging or aggressive behaviours					
The client or others at the home might be under the influence of drugs and/or alcohol.					
There may be a risk of the client or others at the home using a weapon.					
The visit/service is to be provided after dark and outside of normal work hours.					
The client's home is located in a known 'unsafe area'					
Anyone else is expected to be at the home when I visit.					
If there are risks in any of the above areas you must discuss risk control measures with your manager. Do not visit until the risks have been controlled.					

The house and property I HAVE FOUND OUT	YES	NO
What type of accommodation the client lives in		
If the client lives in an isolated area. If yes, I have specific directions and/or location.		
If the road conditions are safe in dry weather/wet weather		
Any special instructions needed to get to the home		
Any special parking arrangements		
Which door is used for entry		

If someone is readily able to open the door		
If there are any WHS risks getting onto the property or into the home eg gates, path, driveway, stairs, lighting		
If there are any animals on the premises		
My safety I AM	YES	NO
Wearing an identification tag that will be visible at all times		
Dressed appropriately and in accordance with the organisations clothing and footwear policy – jewellery is kept to a minimum, with no scarves or neckties worn		
Wearing footwear that is appropriate to my work environment – flat or low heeled footwear, which are fully enclosed and which have non slip durable soles		
Carrying only what I need		
Familiar with any safe work procedures or safety instructions for this client and service		
I HAVE		
A mobile phone and checked that it is fully charged and has reception in the area I am visiting		
Put emergency contact numbers into my mobile phone.		
Filled in the movement board or told my manager of client details, phone numbers and estimated time of return/finish.		
Arranged to call or text my manager (or designated person/On Call) prior to going into the home for the first visit and again when I have left the home.		
Found out what to do in case of an emergency/threatening situation and how to leave a clients home if unsafe.		
Developed code words for use to alert my manager or other staff member if I require urgent assistance e.g. ringing the office and saying “I have left my red folder on the desk” indicates you are in danger and require immediate and urgent assistance.		
Checked that my work car is well maintained and I have checked petrol.		
If you have answered “no” to any of the questions on this checklist you may be at risk of an incident or injury. Please contact your manager so that together you can look at ways these hazards can be addressed so you are not at risk of sustaining a workplace injury.		

Community Care Options

WORKPLACE HEALTH AND SAFETY RISK ASSESSMENT

Client Name:	**File No:**
Address:	**Phone:**
Location: (draw map and attach if needed)	**Parking:**
Location of door to enter: front □ side □ back □ other □ (describe):	

Can the service be performed safely without any modification to the residence or equipment and without any specific safe work practices? YES □ NO □ **If no identify actions required -**

Action Required	**Arranged**	**Date Completed**
Eg Referral to OT		

Should safe work procedures be recorded for any other task in the home and surrounds?

_____

_____

This assessment was carried out in good faith and the results of the assessment are based on what I have observed or been advised by those present on the day of the assessment.

_____	_____	_____
Assessor's signature	Date	Review Date

Client advised of need for risk assessment □ Client consented to risk assessment □

Client advised of changes needed to make environment safe for workers and their own care □

Provide home safety brochure.

	Please tick			
Access to Property	**YES**	**NO**	**N/A**	**Hazard Identified/Comments**
House is in an isolated area				
Property is easy to find, clearly marked with street number/lot number etc				
Road access to the property is safe and in good condition				
The home is clearly visible from the street				
Parking – adequate parking on street				
Gates – easy to open				
Other				
Outside Residence	**YES**	**NO**	**N/A**	**Hazard Identified/Comments**
Pathways are level; non slip & uncluttered				
Steps/stairs are level; non slip; uncluttered and have handrails				
Veranda surface is level; non slip & uncluttered				
Pets – present; restrained and/or separated from worker				
	YES	**NO**	**N/A**	**Hazard Identified/Comments**
Exterior lighting at night is adequate				
Exits are clear of obstruction				
There is evidence of vermin				
Outdoor areas are properly maintained– eg. paths, clothesline, long grass, rubbish.				
Other				
Inside Residence				
Floor surfaces are level; non slip and uncluttered				
Lighting is adequate for walking and adequate for performing work				
Tasks are identified which involve working at a height				
Weapons (eg guns) visible or reported to be present in house				
Emergency exits are visible with easy access				
Smoke detectors are present and working				
Fire equipment (extinguisher) is present and working				
Work areas are suitable; stable & well ventilated				
Other				
Electrical/Gas				
Electrical leads or extension cords are exposed or damaged				
Power points are in good working order (not cracked)				
Power points are located near water				
Gas cylinders are used on site – oxygen				
Heaters are present and safe				
Bedding, clothes, water near heater				
Client and their Family				
Challenging/disruptive behaviours evident or reported				
Infectious diseases evident or reported				
Drug or alcohol abuse evident or reported				
Risk of physical assault or sexual harassment evident or reported				
Risk of the person wandering evident or reported				
Risk of verbal abuse/aggression evident or reported				

Risk of suicide or self harming behaviour evident or reported				
The client displays insight into safe behaviour				
Client is resistant to care				
Client unable to accept instructions				
Special diet required				
The client reports food /or & other allergies				
Assistance with eating is required				
Food and fluid intake is adequate				
The client appears unsteady on their feet/reports frequent falls				
Equipment available/appropriate	**YES**	**NO**	**N/A**	**Hazard Identified/Comments**
Vacuum Cleaner/carpet sweeper in working order				
Broom has an adequate handle length				
Mop & bucket adequate for use				
Washing Machine appears safe with no wiring or moving parts exposed				
Dryer in good working order				
Clothesline has adjustable height and is safe to access				
Laundry basket & trolley available				
	YES	**NO**	**N/A**	**Hazard Identified/Comments**
Iron in working order, ironing board has adjustable height				
Pipes are exposed				
Clearly marked taps				
Step ladder available				
Food preparation equipment is available clean and safe				
Food storage equipment is available				
Shower Chair				
Rails				
Non slip mats				
Bath board				
Hand held Shower				
Mobility aid (specify)				
Toilet chair				
Hoist				
Communication aid				
The client needs an emergency alarm				
Manual Handling				
The client requires physical assistance to transfer/mobilise				
The client has required mobility equipment				
Occupational Therapy Assessment is required				
A Manual Handling assessment is required				
Specific equipment is required				
Specific training is required				
One worker is sufficient				
Other				
Personal Care				
The client has uncontrolled or severely limited body movements				
The client can mobilise without any assistance during personal care routines				

The client can assist with personal care				
Assistance with showering/bathing is needed				
Assistance with hair care is needed				
Assistance with dressing is needed				
Assistance with dental care is needed				
Assistance with menstrual care is needed				
Assistance with bowel/ bladder care is needed				
The bathroom is modified and accessible				
Equipment is required to assist with personal care routines				
Other				
Continence				
Client requires assistance with continence management				
The client has been assessed by a continence advisor or community nurse				
Medication Administration	**YES**	**NO**	**N/A**	**Hazard Identified/Comments**
The client manages medication independently				
The client needs supervision/prompting to take medication				
The client has a webster pack or dosette box				
A family member/carer/friend assists with medication				
Assistance required to collect medication				
	YES	**NO**	**N/A**	**Hazard Identified/Comments**
Client has a variety of medication types eg drops, puffers, tablets				
Medication has been reviewed or monitored recently				
Client has frequently changing medications				
Precautionary information required for medications				
Pathology needed to monitor medications				
Other				
Pet care				
There are pets present				
Pets will be secured before staff arrive and until they leave				
Assistance with pet care is required				
Pet care includes removal of faecal matter				
Pet care includes feeding pets				
Pet grooming is required				
Walking pets is required				
Client has an alternative carer for their pet in case of emergencies				
Other				
Domestic assistance				
Food is stored at appropriate temperature, away from vermin etc				
Suitable cleaning agents available				
Bathroom and laundry have adequate drainage				
Bathroom has adequate space to provide personal care safely				
Electrical equipment used in bathroom				

Other				
Hazardous Substances				
Hazardous substances are present				
Hazardous substances are labelled appropriately				
Substances are in original container				
Stored in safe position				
Used for suitable purposes				
Material Safety Data Sheets (MSDS) available				
Client/family member smokes – advised cannot smoke in house when staff present				
Other				
Social Support				
The worker is required to handle money				
The client requires mobility aids or other items for social outings ie medication, puffer etc				
Client can be transported safely				
The client able to transfer safely in and out of a vehicle independently				
The suggested activity is safe for client and others				
A behaviour management plan is required				
Additional training and information is required				
Other				
An emergency plan/emergency procedures required				

Please complete risk management plan upon completion of risk assessment. Consider any issues highlighted. Risk Management Plan to be printed on yellow paper and placed in Client Home folder with copy of risk assessment.

WORK HEALTH AND SAFETY RISK MANAGEMENT PLAN

Client Name - _____ Client File No. - _____ Date Developed - ___ _____

Risk/Hazard Identified	Risk Category	Actions to be taken to control, minimise risk	Risk Category following Action

Review Date - _____

Risk Indicator Chart

Category 1 – High Risk Category 2 – Medium Risk Category 3 – Low Risk		**LIKELIHOOD**		
		Very Likely	**Likely**	**Unlikely**
		Known to regularly or very likely occur, given existing circumstances or environment	Know to often or fairly likely occur given existing circumstances or environment	Some potential to occur based on previous experience or existing circumstances or environment
SEVERITY	**High** Life threatening or cause serious injury	Category 1(red)	Category 1 (red)	Category 2 (amber)
	Medium Could result in temporary incapacity	Category 1 (red)	Category 2 (amber)	Category 3 (green)
	Low Could result in inconvenience or first aid	Category 2 (amber)	Category 3 (green)	Category 3 (green)

SAFE CARE

Risk Management

Risk management is a simple process making you safer

Identify the hazard

Assess & analyse the risks

Identify & implement controls

Monitor & Review

A **HAZARD** is anything (including work practices & procedures) that has the **potential to harm the health or safety of a person**

A **RISK** is defined as the chance of the hazard causing harm & is measured by its likelihood of happening & its consequences. Together they give a risk ranking.

Safety is everyone's responsibility

Elimination and Control of Risks

Hazards must be controlled using a range of methods.

The hierarchy of hazard controls is a list, which emphasises controlling a hazard at the source. This is the preferred list of control measures, in prioritised order that can be used to eliminate or minimise risk.

The most effective method to deal with a hazard is to eliminate it, but that is not always possible. Some hazards cannot be eliminated.

Such is the case with a hazard like the sun ie. We cannot 'remove' the sun, so therefore we must control the risk that the sun poses to us.

Below is the Hierarchy of Risk Control measures, in order of preference, and with some examples of each.

All staff have a responsibility to ensure that they have implemented an appropriate control measure to manage the risk to themselves and others. If they are unable to control the risk they need to ensure that they have raised the matter with the organisation for support to implement a control measure.

Method of Control	Hazard and Example of Method being used
1. Eliminate the hazard	***Completely remove the hazard from the workplace so that it is not there.***
2. Substitution	***Replace the material or process with a less hazardous one.***
3. Isolate the hazard	***Place a barrier or similar between the hazard and people within the workplace eg a fence surrounding the hazard.***
4. Engineering Controls	***Install or using additional machinery such as local exhaust ventilation to control the risk. Possibly by placing guarding over dangerous items of machinery. eg using a lifter when manual handling risk identified.***
5. Administrative Controls	***Conduct regular safety briefings. Provide training. Perform risk assessments. Increase safety awareness signage.***
6. Personal Protective Equipment	***PPE is seen as a 'last line of defence' to protect a worker if the above measures have failed (in most cases, other than Infection Control). PPE may be used as a temporary control measure until other alternatives are installed. In most cases a combination of the above controls and PPE are chosen to effectively control the risks hazards pose to the workplace and those in it.***

SAFE CARE

Safety is everyone's responsibility

Monitoring and Review

Legislation and good practice requires that risk controls are monitored and reviewed in order to maintain the currency of that particular control. Changes to work practices, work environment or equipment may change the level of risk and require further/less controls to mitigate the changed risk profile.

Managers are responsible for monitoring and reviewing risk assessments and control measures in consultation with staff.

Under the WH&S regulations assessments and control measures will need to be re-evaluated if –

- ✓ when the control measure is not effective in controlling the risk ie an injury or
- ✓ incident results from exposure to the hazard;
- ✓ before a change at the workplace that is likely to give rise to a new or different
- ✓ health and safety risk that the control measure may not effectively control;
- ✓ if a new hazard or risk is identified;
- ✓ if the results of consultation indicate that a review is necessary;
- ✓ if a health and safety representative requests a review.

Support Coordinators and others undertaking risk assessments will ensure that client risk assessments are reviewed annually or more frequently if a change in work practice or the work environment occurs. The Client Services Manager will review client services at least quarterly and ensure that risk assessments and risk management plans are current.

The CEO's Personal Assistant will register and monitor hazard and incident forms as they are submitted to identify if existing control measures are sufficient or if new control measures are required.

The Management Team will review and monitor hazard and incident report forms weekly at the Management Team meeting.

The CEO will report all hazard and incident information to the Board of Management monthly.

All staff are responsible for reporting newly identified hazards and incidents to the organisation as soon as they are aware or occur so that Support Coordinators and Management can review and update risk management strategies.

CCO does and will maintain the following, for the benefit of monitoring, review and continuous improvement planning –

Hazard Register
Staff Incident Register
Client Incident Register
Reportable Incident Register

4.2 Accidents

Prevention - All Staff are expected to take appropriate care and action to prevent accidents by -

- ✓ Being alert and observant;
- ✓ Thinking before acting;
- ✓ Avoiding unreasonable risk taking;
- ✓ Considering the consequences of actions;
- ✓ Considering those working in close proximity;
- ✓ Observing written or implied safety regulations;
- ✓ Properly using all equipment and safety equipment and clothing;
- ✓ Following Community Care Option's policies and procedures and the instructions of supervisors, Support Coordinators and Managers;
- ✓ Keeping work areas tidy;
- ✓ Maintaining tools and equipment including First Aid Kits in a safe condition, and replacing contents when utilised within the workplace, in a timely manner. (Using the replacement form);
- ✓ Adopting an attitude conducive to safe work;
- ✓ Acting safely and with common sense;
- ✓ Not reporting for work if medically unfit; and
- ✓ Not to report for work if affected by alcohol or drugs.

Car accidents
Under the terms of the Workers' Compensation Act, 1987, the organisation's staff are insured for any injury they might sustain in the performance of their duties and, if they are not at fault -

- ➢ while travelling to and from work;
- ➢ on the usual route to and from work;
- ➢ during lunch time; and
- ➢ in the course of work during work hours.

Employees must make sure that they exchange details with the other driver if another car was involved in the accident. Details include -

- ➢ Name
- ➢ Address
- ➢ Telephone contacts
- ➢ Compulsory Third Party (CTP) insurance
- ➢ Insurance companies.

It is a requirement that the Police are notified of all motor vehicle accidents. Staff must not leave the scene of an accident until the Police have attended or have advised that they can leave.
Staff are directed to seek medical assistance if they are injured.

The staff member will complete the Community Care Options' Incident Report Form and relevant Insurance Claim and give them to Community Care Options' CEO's PA as soon as possible after the accident.

A staff member, who has been involved in an accident should seek debriefing from A Senior Manager - CEO, Operations Manager, Client Services Manager. If debriefing is required after hours staff are to call the emergency on call phone to obtain the number of a member of the management team who will provide them with debriefing after hours. Also staff should access Lifeline for debriefing after hours if appropriate.

If necessary, the staff member will obtain a Medical Certificate for any injury related leave required and complete the Register of Injuries.

4.3 Bullying and Harassment Policy

Definitions
Bullying behaviours are repeated, unreasonable and offensive, humiliating or undermining in nature, whether directed towards a person or group of persons.

Bullying behaviour is identified by –

- a repeated pattern of behaviour which may also consist of diverse incidents over time
- inappropriate, unreasonable and possibly aggressive behaviour
- risking physical and/or psychological harm to you.

One-off incidents of bullying may offend or upset people but they are not bullying. However, a single incident can escalate into bullying and should be reported through the Workplace Grievance and Dispute Resolution process.

The following behaviours can upset or offend people but should not be confused with bullying –

- differences of opinion
- poor or bad management practices on their own..

Reasonable managerial actions taken in a reasonable way are not bullying and can include –

- transferring or retrenching a worker
- allocating work in line with systems and policies
- disciplinary actions and performance management processes that are handled constructively, not in a humiliating or threatening fashion.

Bullying can include violence and harassment. Where bullying involves assault, or a threat of assault, it may become a police matter. Some bullying behaviour may also be unlawful under other legislation such as Anti-Discrimination laws.

Harassment behaviour may be a single incident that disadvantages a person and includes intimidating and/or targeting another person's sex, pregnancy, race, age, marital status, homosexuality, disability, transgender (transsexual) status or carers' responsibilities.

Harassment in the workplace is a behaviour targeted in the following way –

- ✓ material that is racist, sexist, sexually explicit, homophobic (anti-gay) that is displayed at work circulated on paper or by email, or put on a computer or fax machine or on the internet, or in your workspace or belongings.

The following behaviours are considered harassment when targeted towards the sex, pregnancy, race, age, marital status, homosexuality, disability, transgender status or carers' responsibilities of a person –

- ✓ verbal abuse, offensive jokes or gestures
- ✓ ignoring, isolating or segregating a person or group
- ✓ staring or leering in a sexual manner;
- ✓ sexual or physical contact or intrusive questions about sexual activity;
- ✓ sexual assault (also a crime under the Crimes Act);
- ✓ wolf whistling or repeated sexual invitations when the person invited has refused similar invitations before; and
- ✓ initiation ceremonies that are sexual, sexist, racist.

If harassment is part of a repeated pattern of behaviour that creates a risk to health and safety, and/or disadvantage, it is considered both harassment and bullying.

Position Statement
Community Care Options will provide a safe workplace free from bullying and harassment. CCO will maximise employee work health and safety through not tolerating bullying and/or harassment behaviour that could harm the physical, mental or emotional health of an employee. The workplace climate at CCO will value all employees as individuals and treat all employees with dignity and respect as a part of normal workplace behaviour.

Legislation

- ✓ *WHS Act and the WHS Regulation*
- ✓ *SafeWork NSW*
- ✓ *WorkCover NSW*
- ✓ *NSW Industrial Relations Act 1996*
- ✓ *Commonwealth Workplace Relations Act 1996*
- ✓ *NSW Anti Discrimination Act 1977*
- ✓ *Commonwealth Human Rights and Equal Opportunity Commission Act*
- ✓ *Commonwealth Racial Discrimination Act 1975*
- ✓ *Commonwealth Sexual Discrimination Act 1984*
- ✓ *Commonwealth Disability Discrimination Act 1992*
- ✓ *Commonwealth Age Discrimination Act 2004*

Responsibilities
CCO will insure all employees are aware of and understand the nature and undesirable effects of bullying and/or harassment throughout the workplace.

The Work Health & Safety Committee will ensure awareness, and prevention processes are in place concerning bullying and/or harassment behaviours and that reporting and resolution processes are fairly managed. The Grievance Resolution Facilitator will insure prompt, confidential and impartial action will be taken in response to reports of bullying and/or harassment and will follow the Workforce Dispute and Grievance Policy in dealing

with issues raised. Employees will not be victimised for reporting complaints.

Approach
As a company and as individual employees, CCO will –

- ✓ model respectful, professional and empowering behaviour through its leadership and management practices.
- ✓ promote an expectation of the above behaviours between all employees.
- ✓ maintain regular checking processes in the workplace environment to identify bullying or harassment behaviours.
- ✓ proactively implement prevention measures against bullying or harassment.
- ✓ support employees through a reporting of complaint and resolution process.

Community Care Options promotes EEO, Anti-Discrimination and Harassment Prevention in the workplace through –

- ✓ Distribution of relevant organisation policies including the EEO & Anti-Discrimination Policy, Harassment Prevention Policy and Workforce Dispute Grievance Policy;
- ✓ Regular training and education for all staff and Managers regarding EEO, Anti Discrimination, Harassment Prevention and Grievance procedures;
- ✓ Prompt, appropriate and effective action taken upon receipt of Discrimination or Harassment complaints; and
- ✓ Regular review of organisation policies and practices to ensure any existing forms of discrimination or harassment in the workplace are identified and removed.

Causes of Workplace Bullying and Harassment
CCO will minimise the causes of bullying and harassment by managing the workplace, workplace conditions, the way that work is organised and the workplace environment according to the CCO Values Statement. This includes –

- ✓ Valuing employees equally and as individuals and team members.
- ✓ Ethical and professional actions from Managers and employees.
- ✓ Encouragement of employee creativity and initiative.
- ✓ Eliciting employee views in general and also through formal consultation.
- ✓ Continuously practicing good communication amongst all employees.

CCO will be especially aware of employee welfare when these situations occur –

- ✓ Restructure or downsizing of the organisation, positions and/or workloads.
- ✓ Increasing demands for efficiency and speed
- ✓ Review of work schedules
- ✓ Defining position and duties descriptions
- ✓ Defining CCO organisational and individual employee goals and targets
- ✓ Negotiating employment conditions

Prevention of Workplace Bullying and Harassment
CCO will establish WH&S measures to prevent Bullying and Harassment in the organisation, including –

- ✓ Maintaining and following a current Bullying and Harassment Policy
- ✓ Raising employee awareness of how to recognise bullying, the possible effects of bullying and where to get further information.
- ✓ Regular communication to employees about bullying and harassment behaviour. This includes using staff meetings, notice boards, WH&S committee meetings, formal training sessions, staff newsletter, the intranet and informal discussion groups.
- ✓ Employment practices of recruitment and induction will include information raising awareness of unacceptable bullying and harassment behaviour.
- ✓ Maintaining a well publicised complaints reporting and resolution process that is free from victimisation.
- ✓ A WH&S annual review of bullying or harassment risk factors.
- ✓ Involvement of employees in assessing workplace behaviour and climate
- ✓ Provide specific training in 'Preventing and Dealing with Workplace Bullying' for managers.
- ✓ Implementing support programs, such as a WH&S Committee work environment monitoring and an Employee Assistance Program (EAP).

Operational Procedures

Reporting and Resolution Processes
CCO will utilise the Workforce Dispute and Grievance Policy for resolving complaints of bullying. In Summary, there will be a prescribed process of approach, formal report, confirmation, investigation, and mediation undertaken by a Grievance Resolution Facilitator.

The alleged bully should be –

- ➢ treated as innocent unless the allegations are proved to be true
- ➢ fully informed of the complaint, including the name of the person making the complaint
- ➢ given an opportunity to explain their version of events.

The resolution process will –

- ➢ treat all reports seriously and act promptly
- ➢ not victimise people who report bullying
- ➢ support all parties, including during interviews
- ➢ be neutral and impartial
- ➢ communicate during the length of the process
- ➢ be confidential
- ➢ be recorded – all meetings and interviews documented.

Any party should be able to make an appeal against the findings of a formal investigation. An external body, an independent third party or an external mediator should hear the appeal.

Disciplinary Action

Should the Grievance Resolution Facilitator believe a complaint of bullying or harassment is founded or involves an allegation of a more serious nature suggesting possible misconduct by a staff member the matter will be immediately referred to the CEO and processes and procedures relating to Conduct Management will be implemented.

Banned Behaviour

In this workplace certain behaviours are not tolerated, are banned and can result in termination of employment. These include –

- Engaging in any sexual activities at work;
- Touching anyone else's sexual parts of the body;
- 'Initiation rites' that are sexual, or could offend, humiliate or intimidate someone;
- Downloading pornography from the Internet;
- Displaying any pornography or sexual or naked pictures anywhere in the organisation where other employees, relatives, clients, contractors or any visitor to the workplace can see them;
- Stalking an employee, relative, client, contractor or any visitor to the workplace.
- Showing of X-rated videos;
- Strip-o-grams, or any other form of striptease, or naked display of sexual parts of your own or someone else's body; and
- Indecent or sexual assault.

Cross Reference or Further Information

- ✓ *CCO Values Statement*
- ✓ *Workforce Dispute and Grievance Policy*

Schedule for Revision of Policy: BULLYING & HARRASSMENT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
September 2009	**Draft for review**	**D Ryan**		
April 2011	**Reviewed**	**D.Ryan**		
August 2014	**Reviewed & Updated**	**D. Ryan**	**December 2016**	
December 2018	**Reviewed/ Updated**	**D. Shipman**	**2020**	
November 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
December 2022	**Reviewed & Updated**	**D. Ryan**	**2024**	

APPENDIX One: Examples of Workplace Bullying

Bullying may include one or more types of behaviour. Some types of bullying behaviour may seem trivial taken on their own, but when they are part of a repeated pattern they can seriously undermine a worker's confidence, self-esteem and health.

Bullying does not necessarily involve intent. Sometimes, 'a bully' may be totally unaware that their behaviour is harmful to others.

Bullying behaviour can be obvious and aggressive, such as –

- ✓ behaviour or language that frightens, humiliates, belittles or degrades
- ✓ loud verbal criticism
- ✓ encouragement to other workers to participate in bullying behaviour
- ✓ malicious rumours, gossip, or innuendo.

Workplace bullying can also be subtle and can include behaviour such as –

- ✓ deliberate exclusion of a worker from normal workplace activities
- ✓ interference with personal property or work equipment
- ✓ intimidation by inappropriate personal comment, belittling opinions or unjustified criticism
- ✓ offensive jokes, whether by spoken word or email.

Behaviour that treats some people less favourably, or is disempowering, is also bullying. Such behaviour includes –

- ✓ assigning meaningless tasks to a worker that are unrelated to their job
- ✓ setting tasks that are unreasonably above or below a worker's ability
- ✓ deliberately changing work arrangements, such as rosters and leave, to inconvenience a particular worker or workers
- ✓ setting timelines that are very difficult to achieve
- ✓ deliberately denying access to information, consultation or other resources
- ✓ unreasonably blocking promotion, training, development or other work opportunities
- ✓ excessive and unreasonable work scrutiny
- ✓ removing areas of responsibility without cause.

Workplace bullying can occur at any time when carrying out work related duties or activities, including at workplace related social events. It can be carried out verbally, physically and by letter, email and text messages or in other forms of writing. Everyone has the potential to bully and anyone can be a target.

APPENDIX Two: Bullying Checklist

The CCO Work Health & Safety Committee will manage the annual review of the workplace environment and report the findings of the review to the Management Team. Guidelines for this review are as follows -

1. Bullying and Harassment Policy

Have workers been consulted in the development of policies and procedures to prevent bullying and/or harassment?	
Does the workplace have a bullying and/or harassment prevention policy as a stand-alone policy?	
Do all workers know that the company does not tolerate bullying?	
Are complaints dealt with independently, in a timely way, and kept confidential?	
Can workers make a complaint without fear of reprisal or victimisation?	
Does the workplace provide awareness and skills training on dealing with bullying and harassment?	
Are the policy and procedures monitored and reviewed on a regular basis, and after every bullying complaint?	

2. RISK identification

Review of Bullying and/or Harassment organisational indicators –

Do managers and team leaders practice appropriate leadership skills?	
Do managers and team leaders use good interpersonal skills?	
Does the workplace have a 'participative' management style that emphasises open communication, support and mutual respect?	
Are there staff shortages or high turnover?	
Are employees leaving CCO reporting dissatisfaction with working relationships?	
Are there employees who are withdrawn and isolated?	
Is there deterioration in relationships between work colleagues, clients or management?	
How regular and meaningful is consultation and good communication practiced?	
Is CCO equipment often damaged or is there poor care of working environment?	
Do workplace injuries indicate stress or constant minor physical injury?	
Has there been recent significant organisational change or restructure, or is such change pending and has consultation occurred with workers about the proposed changes and provided them with an opportunity to influence proposals?	
Has technological change occurred (or pending) and has support or training been sufficient concerning the change?	
Has there been a change in management (or pending) and have employees been provided with information to help them understand the impact of the change?	
Are there any other changes that might lead to high job instability and uncertainty about ongoing employment?	
Is employee morale good and absenteeism low?	

Review of high risk employees/groups –

Are there any workers with different religious or political views, or from different racial backgrounds, compared to the majority of the workforce?	
Are there workers in uncertain employment, such as casual and labour hire workers?	
Are there young workers, such as apprentices and trainees?	
Do all employees understand their role and have the appropriate skills to do their job?	
Is there diversity among employees that is not fully accepted by other employees?	

APPENDIX Three: Advice to Employees for Managing Bullying and/or Harassment

If you think you are a target of bullying

It may be helpful to discuss your feelings with an independent third party. Some people identify the behaviour quickly, others experience the behaviour for some time before realising that it is bullying. Seek advice from an WHS representative, your Manager or a union representative.

Some want the behaviour to cease immediately, others want the bully punished, and still others choose to ignore the situation. As soon as possible, and if you feel capable, firmly tell the person that their behaviour is not acceptable – and ask them to stop. Ask your Manager to be with you, if necessary.

- ✓ Confronting a bully on your own is not easy and may only be effective in the early stages. The longer the bullying goes on, the harder it may become to confront the bully yourself. Remember: some people do not intend to bully and may not be aware how their behaviour affects you.
- ✓ If you cannot confront the bully, try writing a memo or email to make it clear why you object to their behaviour. Keep copies of the memo or email, and any replies.
- ✓ If you are not able to approach the person directly, or if an informal approach has not resolved the situation, formally report the matter to your Manager, as outlined in the Workforce Disputes and Grievances Policy.

Steps you could take when subject to bullying include –

- ✓ logging all incidents of bullying – dates, times, nature of incident, details of slurs, accusations, criticisms. Stick to the facts. Keep all records at home, not at work. It is not just the character of the incidents, but the number, frequency and especially the pattern of incidents that can reveal the bullying.
- ✓ writing down your feelings at the time of the incident, and your response
- ✓ recognising that you may need emotional support and, in some cases, medical support. This should be sought as early as possible.
- ✓ logging the incident in the workplace register of injuries should sick leave be required
- ✓ keeping copies of all annual appraisals, letters, memos and emails relating to your ability to do the job
- ✓ getting a witness to the bullying incidents – avoid situations where you are alone with the bully
- ✓ finding out if you are the only person being bullied, or whether other people are also affected – if others are affected, consider a collective complaint
- ✓ knowing your job description and ensure your responsibilities match it
- ✓ having an independent witness with you at all meetings regarding bullying incidents, official or otherwise.

If you feel that you are being harassed or discriminated against because of sex, race, pregnancy, marital status, transgender (transsexual), homosexuality (actual or presumed), disability, marital status, age or carer's responsibilities, contact the NSW Anti-Discrimination Board.

4.4 Dealing with Challenging Interactions in the Workplace

Definition

In simplest terms a **challenging** conversation is **defined** as an **interaction** between two or more parties characterized by - elevated emotional intensity, differing viewpoints, and perceived high stakes for at least one of the parties.

Also could be termed Behaviours of Concern.

Challenging behaviour is any behaviour that causes significant distress or danger to the person of concern or others. It can include an outburst of aggression, or resistant type behaviour by clients.

Challenging behaviours are difficult for everyone involved. Whilst managing these behaviours may be part of the job, it is not acceptable for workers to be hurt.

Position Statement

CCO recognises that at times staff may face real or perceived physical, emotional or psychological hazards associated with delivering care to clients with challenging behaviour. In some cases, there may be a very real threat of physical violence, in these instances the Support Worker must leave the premises and report the matter to their Support Coordinator, the Client Services Manager or the Support & Development Manager at the first opportunity. When attempting to address these situations a Manager must ensure the safety of the Support Worker is paramount. Once the safety of the Support Worker has been assured the Manager can then address the needs of the client.

At initial assessment of a client, any issues of challenging interaction must be identified and a client risk profile completed.

Legislation

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*
- ✓ *Support Coordination*

DVA Notes for Community Nursing

Operational Procedures

Procedures to be applied when dealing with challenging interactions within CCO.

Report early signs of challenging behaviours. Talk about your concerns with your supervisor or at team meetings. Early reporting enables management to take action.

Prior to agreeing to provide service to a client with known behavioural problems the

Support Coordinator must provide a case management program that sets out –

- ✓ the circumstances that trigger the behaviour;
- ✓ strategies for dealing with the inappropriate/ specific behaviour should it arise;
- ✓ training for Support Workers in dealing with the inappropriate behaviour;
- ✓ crisis protocols.

Service that cannot be delivered safely should be suspended and appropriate alternatives explored. This must be done in consultation with –

- ✓ The client
- ✓ The clients family/carer/advocate
- ✓ Staff
- ✓ Other service providers
- ✓ The Support Coordinator/Care Manager
- ✓ The Client Services Manager.

Advice should also be sought from an expert in the field such as - Community Psychiatric team, Head Injury team, Aged Care Assessment team and/or a Behaviour Consultant.

The person withdrawing from the service must consult with the Support Coordinator prior to taking action.

Preventing challenging behaviours

Any situation or feeling can act as a trigger for challenging behaviour. This is frequently unpredictable when working with those with dementia, brain injury or intellectual disability. However the approach made towards the person is very important.

- Pause – stand back, take a moment before approaching and assess the situation.
- Speak slowly and clearly in a calm voice.
- Explain your care actions.
- Try not to rush the person, act calmly.
- Show respect and treat people with dignity at all times.
- Minimise boredom, social isolation and irritating factors in the environment such as noise, uncomfortable clothing.
- Enhance comfort, exercise, participation in activities, decision making and dignity.

Communication is the key

Avoid harsh aggressive or abrupt statements.

Don’t say things such as “You must….”, “Don’t…..”, “Stop…….”.

Use alternatives and “I’ language like “I would like you to…” It would help me if……”, “ I feel scared when…….”.

When challenging behaviour happens

- Back off where possible.
- Keep calm.
- Call for help.
- Leave the person to calm down, if possible.
- Remove others from the environment, if possible.
- Be aware of body language and tone of voice used to the person.

Employers have a duty of care to do all things possible to prevent or minimise any harm that may occur as a result of challenging behaviours. This includes providing a means of communication for emergencies, an emergency response system and procedures.

Workers must follow reasonable instructions in managing challenging behaviour and protect the safety and health of themselves and others.

4.5 Emergency Management

Emergency and Evacuation Policy

Pertaining to the office

The organisation has emergency evacuation plans identifying exit points for all of it's buildings.

A copy of the Evacuation Procedure and Building Diagram is placed so staff can easily view the information.

On orientation and, at least, annually thereafter, staff will be trained in the evacuation procedure and the use of fire fighting equipment.

Fire fighting equipment is serviced annually.

All exits and routes to the exits are clearly marked as such.

The organisation has appointed a Fire Warden and a Deputy Fire Warden.

The organisation has appointed one member as a First Aid Officer.

Procedures for dealing with Specific Hazards

Fire

Raise the Alarm by calling "Fire"
Where possible, alert the Fire Warden or the Deputy Fire Warden of the hazard.

Names of current Fire Warden, Deputy Fire Warden and First Aid Officer can be found on the staff communication board located in the kitchen at 20 Curacoa St

Evacuation

The Fire Warden or Deputy Fire Warden will give the instruction to evacuate the premises ensuring that the Staff Fire Board is retrieved.

A staff member will be appointed to check that the toilets are not occupied.

Staff must move quickly and calmly to the nearest and safest exit. Personal items should not be taken as retrieving such items can cause delay, and may be hazardous when evacuating.

Where there is heavy smoke, keep low, as smoke is less dense near the floor and the temperature is lower. Take short breaths, if possible cover the lower part of the face with a damp cloth. If vision is impossible crawl along the floor following the walls until you come to a door.

If there is someone who is unable to move without assistance, drag them along the floor on a blanket if possible.

Staff must congregate on the footpath level with the Scout Hall in Curacoa Street. Staff names will be checked against the Staff Fire Board to ensure that all staff are accounted for.

Staff are not to re-enter the building until the Fire Brigade have communicated that it is safe to do so.

Dealing with the Fire
At the same time as commencing evacuation, alert the Fire Brigade by phoning them on 000.

Give clear instructions as to the location of the office building.

Turn off all power at the meter box located on the southern side of the building next to the store room roller - door.

The Fire Warden or Deputy Fire Warden will make a judgement as to whether they will attempt to extinguish the fire by using the appropriate piece of fire fighting equipment, only if safe to do so.

When attempting to put out any fire stay between the fire and an exit door.

Close doors to contain the fire.

If clothing catches fire, a person whose clothes are on fire should be laid on the floor and rolled in a blanket or thick coat. If your own clothing catches fire roll on the floor to extinguish the flames. A fire blanket is located in the kitchen.

Staff must ensure they do not put themselves or others at risk.

Fire at Clients' Premises
Directions will be included in individual client care folders regarding evacuation routes, calling for assistance and in particular, directions to be given to emergency providers regarding specific directions, and the nearest cross street. Client orange emergency card.

Staff are to exit the client's home immediately with the client and any other occupants of the home. Take the orange emergency card. Staff once having left the building will phone 000.

Training of all staff in calling for help will be included in the Workplace Induction Program, Policies and Procedures update sessions and is outlined in the Support Worker Manual.

Bomb Threat
Bomb threats are generally made over the telephone.
Attempt to communicate with the caller, asking where the bomb has been placed. Do not

hang up even if the caller has terminated the call.

At the same time, a member of the management team or delegate will appoint a staff member to alert other staff members to the situation.

The CEO or a delegated staff member will contact the Police.

Evacuation following a bomb threat
The Fire Warden or Deputy Fire Warden will give the instruction to evacuate the premises ensuring that the Staff Fire Board is retrieved.

Staff must move quickly and calmly to the nearest exit. Personal items should not be taken as retrieving such items can cause delay, and may be hazardous when evacuating.

Staff must congregate on the footpath level with the Scout Hall in Curacoa Street; Staff names will be checked against the Staff Fire Board to ensure that all staff are accounted for.

Staff are not to re-enter the building until the Police have communicated that it is safe to do so.

The staff member who received the call should make themselves available to Police to convey information regarding the bomb threat.

Threats by Visitors to the Office
Should a person visiting the premises threaten staff, the following steps should be taken

- ✓ *Do not approach or move toward the person;*
- ✓ *Speak calmly and quietly to the person;*
- ✓ *Attempt to placate the person and respond if possible to their requests. For example, the person demands money or valuables hand it over.*
- ✓ *Staff must NOT attempt to disarm or physically restrain the aggravated person;*
- ✓ *If possible, inform the CEO or delegated person who will continue to deal with the person;*
- ✓ *The CEO or another Manager will ask the person to leave and inform them that the police will be called unless they leave;*
- ✓ *If the person does not leave a staff member will call the police and ask them to attend the premises;*
- ✓ *If staff members feel there is an imminent danger of a physical attack by the visitor, they should attempt to press a Duress Button.*

Duress Buttons are located -

- ✓ *Under the reception desk*
- ✓ *In the client interview room*

Duress alarms will alert the Security Firm responsible for monitoring the premises, who will alert the police.

When the Security Firm rings, confirm that a visit would be appropriate without giving details, which may further upset the visitor. Security will then send a Guard.

If the person is unknown to staff they should try and remember height, hair colour, colour of eyes etc. of the visitor for their report to the police if this is necessary.

If the person departs indicating threats to staff, the CEO or delegated staff member will inform the police. Lock the premises. Alert Support Workers that office is in lockdown.

If a person returns, after having indicated threats on their departure, the CEO or delegated staff member will decide whether it is safe to let the person back into the office or whether to call the police.

4.6 First Aid

Definition - First aid is the immediate care given to a victim of injury or sudden illness until more advanced care can be provided or recovery occurs.

Position Statement

Community Care Options is committed to the provision of first aid facilities and personnel to ensure safety in our workplaces. As an employer, CCO is obliged under New South Wales Legislation and the Work Health and Safety Act to provide a Duty of Care for its employees, including provision of First Aid support in the workplace.

Similarly, as a provider of aged care and disability community services in the home, CCO fulfils its Duty of Care to clients by ensuring its direct support staff have a current First Aid certificate and can assist where able in an emergency situation.

Responsibilities

The CEO is responsible for ensuring that First Aid provisions are adequate and in accordance with legislative requirements and funding guidelines.

Approach

CCO uses a risk management approach to first aid. We have assessed our first aid requirements considering the type of work performed, potential injuries and illnesses, number and distribution of employees, mobility and capability of employees, size and layout of the workplace and the location of the workplace. Assessment included consultation with employees about first aid needs. These will be reviewed regularly.

Following an assessment of the organisations needs in relation to first aid a first aid management plan will be developed and ratified by the Work Health & Safety Committee.

Legislation and Standards

- ✓ *Work Health & Safety Act 2011*
- ✓ *Regulation 648 Employer obligation for provision of First Aid*

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*

DVA Notes for Community Nursing

Operational Procedures

What is First Aid?

First aid is defined as emergency care given to an injured or ill person before regular medical aid can be obtained. It has the following purposes -

- ✓ Preservation of life
- ✓ Protecting the casualty (and yourself) from further harm
- ✓ Providing pain relief
- ✓ Preventing the injury or illness from getting worse
- ✓ Providing reassurance
- ✓ Promoting recovery

The above actions describe the nature of the initial care of a person who has had an accident or is suffering from a sudden illness and needs help until a qualified health care professional, such as a doctor, registered nurse or ambulance officer arrives.

Consent to perform first aid must be sought, unless the person is unconscious or bleeding seriously, and first aid cannot be provided unless consent is given. An injured/ill person, or their legal guardian, has the right to refuse any assistance from a first aid officer, ambulance paramedic, nurse or doctor.

First Aid should be provided responsibly and prudently and in good faith for the best interests of the casualty and undertaken 'to the best of the first aider's ability'.

Recognising an emergency is the first step in responding. An emergency is a situation requiring immediate action. A medical emergency is a sudden illness such as a heart attack, which requires immediate medical attention. An injury is damage to the body, such as a broken arm, which results from a violent force. Some injuries can be serious enough to be considered emergencies. Recognising an emergency may be difficult at times. It is important to be observant of indicators including unusual noises, sights, smells, symptoms or signs or behaviour.

Responding to an emergency – there are many ways to help, but in order to help one must first decide to act. Staff can recognise and respond to emergencies by phoning for help, providing comfort to the victim or family members, giving first aid to victims and helping to keep order at the emergency scene.

Barriers to Action –

- ➢ Presence of bystanders – always ask if help is needed, do not assume that just because there is a crowd, someone is caring for the victim
- ➢ Uncertainty about the victim
- ➢ Nature of the injury or illness
- ➢ Fear of disease transmission
- ➢ Fear of doing something wrong – **the worst thing to do is to do nothing.**

It is the job of the trained first aider to provide initial treatment to injured or ill persons which is consistent with the first aider's level of training and competence.

Under NSW state law a person is not liable for decisions or actions when providing first aid as long as they have gained consent, and have acted in good faith in applying their First Aid training.

First Aid provision required in the workplace of CCO as a provider of support.
As a non government community service provider, CCO is expected by its government funding bodies to have a policy concerning First Aid provision to clients. This policy is to reflect the duty of care and support obligation that CCO has to provide to its clients via its direct care employees.

Support Worker First Aid Qualification Requirement
A current first aid certificate is a CCO employment requirement for all Support Workers.

The Employee's First Aid Duty of Care
Duty of Care can be defined as having some responsibility towards a person due to an inherent relationship. As part of this duty of care relationship one is required to do what a reasonable person in the same position would do to minimise risk of further injury to the injured person.

Support Workers
Under Australian Law a person trained in first aid that has taken responsibility for a client through provision of client services has a legal duty of care requiring them to render assistance to an injured/ill person until such time as an ambulance paramedic, nurse, doctor or other person with better qualifications arrives. It is considered legally negligent to not seek consent to provide first aid when a Duty of Care exists.

First Aid provision required in the workplace of CCO as an employer.
In accordance with legislation and following an assessment of the workplace needs CCO has appointed a qualified First Aid Officer in our Coffs Harbour office where there are more than 25 employees. This First Aid Officer is paid an allowance in accordance with their relevant Award and is fully reimbursed for the cost of first aid certificate renewal.

"**Qualified First Aid Officer**" means

a) *a person who holds a current first aid certificate issued after successful completion of a Work Cover/ SafeWork approved first aid course, or*
(b) *a person who holds a current occupational first aid certificate issued after successful completion of a Work Cover/ SafeWork approved occupational first aid course;*
(c) *a level 3 or greater New South Wales ambulance officer;*
(d) *a registered nurse;*
(e) *a medical practitioner.*

The designated First Aid Officer in the Office
Under Australian Law a trained first aid person has a legal duty of care requiring them to render assistance to an injured/ill person. Where an employee is trained and is designated as a first aider in the workplace, and receives remuneration accordingly, that employee would have an obligation to render assistance as required until such time as an ambulance paramedic, nurse, doctor or other person with better qualifications arrives.

The First Aid Officer is responsible for the maintenance of a fully stocked First Aid Kit (**B**) in the Coffs Harbour Office being readily accessible during working hours, for the provision of first aid as required, and for ensuring that the first aid register is maintained.

The Manager People & Culture will ensure that a person is delegated in each of the outer offices with the responsibility of maintaining first aid kits and replacing stock as needed.

The Manager People & Culture is responsible for ensuring that all organisational vehicles contain a fully stocked First Aid Kit (**B**) as well as a list of emergency telephone numbers and a copy of the procedure on what to do in case of an accident.

A register of injuries is required to be kept under the Workplace Injury Management and Workers Compensation Act 1998, and is the responsibility of the CEO to be kept current.

First Aid Kits to Support Workers
Support Workers will be issued with Personal Protective Equipment, which includes a First Aid Kit. Employees are required to sign that the contents of the kit are in accordance with the contents list. The employee at his or her own cost must immediately replace items from the First Aid Kit, which are used privately.

Support Worker First Aid kits will be checked periodically (at least annually) to ensure that they are adequate and being maintained for the use in an emergency by the employee.

It is an offence to misuse such equipment and fines will be imposed where staff remove inappropriately any part of the contents.

It is the responsibility of all staff to report use of first aid resources and to arrange replacement of contents as soon as possible after use.

Management are responsible for ensuring contents are replaced as soon as notification of use is received.

First Aid assistance when driving and an accident occurs
A driver of a motor vehicle involved in a vehicle accident anywhere in Australia is required to stop and render assistance to any injured person involved in that accident, to the best of their ability. This is regardless of any first aid training that person may or may not have.

Cross Reference and Further Reading
- ✓ *Work Health & Safety Act 2011, Chapter 2 First Aid Regulation 20*

Appendix One: First Aid Kit B Contents

CCO provide all support staff with a first aid kit, it is the responsibility of support staff to ensure that any item used from the kit is replaced immediately. Supplies can be replenished by contacting CCO Reception.

The first aid kit must contain the following items in the quantity (if any) specified:

First Aid Kit	**B**	Safety pins - packet	1
Adhesive plastic dressing strips, sterile, packets of 50	1	Shoe Covers – disposable shoe protectors – 1pkt	1
Adhesive dressing tape	1	Surgical Face Masks	1
Apron – disposable	1	Scissors, blunt	1
Bags, plastic, for amputated parts:	2	Splinter probe	1
Car seat protector	1	Sterile eyewash solution, 10 ml single use ampoules or sachets	2
Conforming Bandage 5.cm x 4.5cm	1	Sunscreen	1
Dressings, non-adherent, sterile, 7.5 cm 7.5 cm	1	Surge Protector – power guard	1
Disposable shoe covers – one pair	1	Swabs, prepacked, antiseptic, packs of 10	1
Dust mask	1	Triangular bandages	1
Eye pads, sterile	2	Wound dressings No. 15	1
Gauze bandages:	1	Wound Wipes	2
Car seat protector	1	Surgical Face Masks	1
Conforming Bandage 5.cm x 4.5cm	1	Safety pins - packet	1
First-aid pamphlet	1	Shoe Covers – disposable shoe protectors – 1pkt	1
Goggles	1	Surgical Face Masks	1
Gloves - cotton (hand protection) + rubber gloves (washing up)	2	Scissors, blunt	1
Gloves disposable – vinyl – food prep and cleaning – 1 box	1	Splinter probe	1
Hand Sanitizing Gel	1	Sterile eyewash solution, 10 ml single use ampoules or sachets	2
Handy Bar	1	Sunscreen	1
Niterile gloves – long cuff – for personal care – 1 box	1	Surge Protector – power guard	1
Labels – for food	30	Swabs, prepacked, antiseptic, packs of 10	1
P1 Respirator (Chemical mask)	1	Triangular bandages	1
Permanent Marker – black	1	Resuscitation Face Shield	1
Rescue blanket, silver space	1	Wound dressings No. 15	1

4.7 Hazardous Substances - Use of chemicals and cleaning products

Definition
Hazardous substances are chemicals that can harm human health. While it might be obvious that some substances, such as acids or poisons, can cause harm, some health effects may not be so readily apparent. For example, in some cases dusts or vapours can also be hazardous substances.

Substances that cause skin irritation, allergies, cancer, birth defects, genetic mutations, and other health effects are also classified as hazardous substances. Health effects may not be immediate and may occur over a long time period. A hazardous substance may be a simple chemical or it may be a mixture of several chemicals.

Chemical hazards are not limited to those substances obtained from a supplier and delivered in a labelled container with an MSDS. Industrial processes such as welding or grinding may cause toxic fumes or dusts. Toxic atmospheres, or atmospheres without enough oxygen to sustain life, may develop in confined spaces or inadequately ventilated spaces.

Examples of some potentially hazardous substances include -

- ✓ paints
- ✓ drugs
- ✓ cosmetics
- ✓ cleaning chemicals
- ✓ degreasers
- ✓ detergents
- ✓ gas cylinders
- ✓ refrigerant gases
- ✓ pesticides
- ✓ herbicides
- ✓ diesel fuel
- ✓ petrol
- ✓ liquefies petroleum gas
- ✓ welding fume.

Some hazardous substances are also classified as dangerous goods. Dangerous goods are those substances or articles with an immediate risk to health or safety. This includes physical risks such as flammability or corrosion.

Legislation

Risk Management and Hazardous Substances

Under the Work Health and Safety Act NSW 2011 and Work Health and Safety Regulation 2011 employers must ensure the health, safety and welfare of employees in relation to the use of hazardous substances.

CCO will ensure that an induction and training program is implemented which incorporates the following elements -

a) Information about hazardous substances to which employees are or may be exposed in the course of their work. Information should include the nature of the hazards, risks to health arising from exposure, the degree of exposure and routes of entry of the hazardous substances into to the body. This includes information on the forms of hazardous substances including dusts, fumes and other atmospheric contaminants.
b) The risk assessment process and how the employee can contribute.
c) The work practices and procedures to be followed in the use, handling, processing, storage, transportation, cleaning up and disposal of hazardous substances.
d) The measures used to control exposure to hazardous substances, including any information that the employee requires for the correct use and maintenance of control measures.
e) The proper use and fitting of personal protective equipment.
f) The procedures to be followed in case of an emergency involving hazardous substances or dangerous goods, including any special decontamination procedures to be followed.
g) First aid and incident reporting procedures to be followed in case of injury or illness.
h) The nature of, and reasons for, any monitoring required and access to the results of monitoring.
i) The employees' rights to be advised of the intention to use a new hazardous substance where they are likely to be exposed in the course of their work and the right to be consulted in the process of risk assessment of a hazardous substance.
j) Duties under the WHS Regulation of suppliers, employers and employees.

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*

DVA Note for Community Nursing

Operational Procedures
For a hazardous substance to have an effect it has to make contact with or enter the body – the way this occurs is called a route of entry. The main routes of entry are -

- swallowing – for example from hand contamination or food contact
- breathing in (inhalation) of atmospheric contaminants
- skin or eye contact –with dust on surfaces, splashes to the skin or eyes.

Some substances are so poisonous that swallowing a small amount will cause harm. Swallowing can occur from airborne dusts and sprays, or during eating or smoking from unwashed hands or contaminated food.

There are three basic physical forms -

- solids (including dusts, fumes and smoke)
- liquids (including mists and vapours)
- gases (including vapours).

The physical form of a substance often depends on how it has been generated or how it is being used.

Dusts
Dusts are generally formed by grinding, abrasion, or crushing of larger solids. They can be generated by processes such as grinding, sanding or polishing. Examples are asbestos, coal, cotton, wood and wheat dust. Most industrial dusts are capable of being drawn into the human respiratory system (ie breathed in).

Some dusts can also be a fire or explosion hazard. In form of a dust some substances become very reactive.

Fumes
Fumes are fine, solid, dust particles that are formed when metal is melted and some of the molten metal turns to vapour (for example by processes such as MIG welding or stick welding).

Smoke
This results from the incomplete burning of materials. Smoke consists of soot, liquid droplets and ash. Smoke particles are usually smaller than dust particles and can easily move deep into the lungs. Carbon particles in smoke can have other chemicals absorbed on to them that may cause lung irritation.

Liquids
Liquids may cause poisoning and/or physical injury if they are swallowed. Some can burn your skin (acute local effect). Many other liquids used in industry, including pesticides, solvents, paints, cutting fluids/oils and liquid fuels are also hazardous substances because they are easily absorbed through the skin into the blood. They can be absorbed more

quickly if your skin is weakened in some way – for example if your skin is cracked, reddened, broken or very dry.

It is important to prevent spillage of liquids since they can rapidly spread. Other risks from liquids arise because they easily change to aerosols and vapours that move even more rapidly through the air. Flammable liquids can be very dangerous if spilt, since flammable vapours result, and can ignite explosively.

Liquids that change easily into gases (eg petrol, alcohol) can spread widely through a workplace if the container has no lid or seal. These vapours can cause both exposure and fire hazards.

Vapours
Vapours can form when a liquid evaporates – ie. moves into the air as a gas. Vapours can be inhaled easily. Vapours are even more hazardous in small enclosed spaces; they can form explosive atmospheres and easily reach toxic levels.

Mists, fogs and aerosols
Mists, fogs and aerosols consist of fine liquid droplets suspended in the air. Steam cleaning spray jets can also produce mists.

Aerosols are often generated when liquids are handled too vigorously or sprayed. Usually the size of the droplets in an aerosol are so small that they remain suspended for long enough to be widely dispersed.

Gases
Gases can be a hazard because they disperse in the air very quickly. Air is a gas made up mainly of nitrogen and oxygen with a small amount of other gases. Gases can be hazardous to your health if they are toxic or take the place of oxygen needed to breathe. Human lungs absorb oxygen, but also can absorb other gases easily. These gases enter the blood stream and are carried directly to other parts of the body with rapid effects. Non-toxic gases can be hazardous if they are allowed to build up to the point that they are taking up the space that would normally be occupied by the oxygen needed to stay alive. This will cause death by asphyxiation. Some gases have no detectable odour or colour thus adding an increased risk because the presence of the gas cannot be detected.

Typical symptoms which can indicate exposure to a hazardous substance are -

- eye irritation
- skin rashes
- difficulty in breathing/shortness of breath
- headaches, confusion, fatigue
- cold or flu symptoms.

However some very serious chemical exposures have no warning symptoms.
The effects of a hazardous substance depend on -

- the toxicity – the capacity to cause harm
- the level of exposure to the chemical – the dose the body actually receives
- individual susceptibility.

The risk of a hazardous substance is determined by a combination of dose and toxicity.

The community care sector is varied and diverse. Chemicals are encountered in a range of work locations including client homes. Not all these chemicals are classified as hazardous according to the legislation but still may have the propensity to affect an individual due to specific sensitivities. The label of the substance should indicate if the substance is potentially hazardous. However, general risk management principles apply to all chemicals and to Hazardous Substances in particular.

Employee Responsibilities:
Employees have a responsibility to maintain safe work practices to the extent that they are capable.

Employees should therefore use the control measures in the way that they are intended to be used, and in particular should carry out the following -

a) Cooperate with their employer in performing the risk assessments of hazardous substances in the workplace.
b) Participate in suitable induction and training programs.
c) Use the control measures provided for hazardous substances, plant and processes.
d) Wear, in a proper manner, the personal protective equipment provided.
e) Store personal protective equipment in the accommodation provided when it is not in use.
f) Remove from their person any protective equipment that could cause contamination, and wash before eating, drinking or smoking.
g) Practice a high standard of personal hygiene, and make proper use of the facilities provided for washing, showering or bathing and for eating and drinking.
h) Report promptly to their employer, through their supervisor, any defects discovered in any control measure, device, facility, label or item of personal protective equipment that may affect compliance with the provisions of the WHS Regulation.
i) Cooperate with their employers in the conduct of appropriate monitoring or health surveillance programs that arise from risk assessments.

Hazardous Substances Safe Work Procedure
Cleaning products and other chemicals can damage your health. Staff have reported that some products have caused them irritation or other difficulties. These are -

- Baygon and other surface sprays;
- Shower cleaning products, especially Shower Power, Big Kevs, Domestos, Exit Mould and other mould removers;
- Caustic Soda, and other caustic substances; and
- Ammonia.

To protect staff from chemicals staff must -

- ✓ staff should read instruction labels on all cleaning products provided by clients;
- ✓ staff should use products only in accordance with instruction labels;
- ✓ staff should not use any substances that are not in their original container or are not labelled;
- ✓ use gloves and if appropriate, goggles and masks (if a substance is likely to splash or produce fumes);
- ✓ stop using chemicals to which they experience an adverse reaction and fill in an incident report. If necessary they must consult their GP;
- ✓ if using cleaning products in an enclosed area such as a bathroom ensure effective venitlation ie exhaust fan, open doors; spray product and allow time for fumes to dissipate before cleaning; and
- ✓ never use 2 chemicals together – you could create a new chemical.

To be used with care and appropriate protection -

- ✓ Domestos, but wear full protective gear including goggles, particularly when cleaning toilets. Do not use Domestos when washing floors;
- ✓ Surface Sprays - but only when wearing full protective gear, including goggles, and face masks. The goggles and masks are to protect from the effects of chemicals.

Cleanliness

Always wash your protective gear and clothing after use in warm soapy water. Dirty aprons and other gear should be put into the “dirties” bag in your personal protection kit.

Emergency Procedures:

In spite of the implementation of all practicable control measures, a leak, spill or uncontrolled release of a hazardous substance could still occur. Established emergency procedures, procedures for safe disposal of the substance and sufficient suitable personal protective equipment should be used, where appropriate, to enable the source of the release to be safely identified and repairs made. All persons not directly concerned with the emergency should be excluded from the area of contamination. Consult the relevant MSDS for advice**.**

4.8 Infection Prevention and Control

Effective infection prevention and control is central to providing high quality healthcare for clients and a safe working environment for those that work in healthcare settings, including community care.

Infections can spread in any environment. Clients may be more vulnerable to infection for a number of reasons, including being older, having been in hospital and having chronic diseases.

Infection prevention and control is an essential part of care and the responsibility of all staff providing care to older people and people with a disability.

Staff may be exposed to Infectious Diseases as part of their work due to the undertaking of personal care or cleaning activities or due to the close proximity to clients.

Definition

Infectious Diseases can be defined as “a disease that can be transmitted from person to person or from organism to organism, and is caused by eg viruses and bacteria.” They may cause a short-term illness such as a cold or a longer term condition such as hepatitis. In either case actions to reduce the risk of transmission through the adoption of suitable work procedures is recommended.

Infection Control is the prevention of the spread of micro-organisms from client to client, client to employee and employee to client. Infections can spread through contact with body fluids that are airborne, ingested, on the skin, or on other surfaces.

Position Statement

Community Care Options is committed to our duty of care to provide and maintain a healthy and safe environment for all staff, and to minimise the risk of anyone in the workplace contracting an infectious disease.

The aim of this policy is to assist all CCO staff, including Support Workers to improve the quality of the care they deliver, and aim to promote and facilitate the overall goal of infection prevention and control. CCO wants to create safe care environments through the implementation of evidence-based practices that minimise the risk of transmission of infectious agents.

CCO’s approach, is underpinned by a risk-management framework, to ensure the basic principles of infection prevention and control are applied in the settings in which we work. CCO will operate within the **Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).**

It is recognised that the level of risk differs according to the health care environment and therefore some recommendations should be justified by risk assessment. When implementing these recommendations CCO need to consider the risk of transmission of

infection and implement according to our specific setting and circumstances.

The Guidelines are based around the following core principles –

- an understanding of the modes of transmission of infectious agents and of risk management
- effective work practices that minimise the risk of transmission of infectious agents
- governance structures that support the implementation, monitoring and reporting of infection prevention and control work practices
- compliance with legislation, regulations and standards relevant to infection control.

Legislation
Aged Care Quality Standards
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

DVA Notes for Community Nursing

Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

NSQHS Standard 2 on Partnering with Consumers.

<u>Management and Clinical Governance</u>
Management and clinical governance can have a positive impact on the effectiveness of infection prevention and control by driving continuous quality improvement and promoting a non-punitive culture of trust and honesty. It is important that CCO Managers and Clinicians effectively collaborate, and involve client's, and other staff as partners in healthcare in order to effect change and achieve the best possible outcomes.

Risk management is the basis for preventing and reducing harm arising from care associated infections and underpins the approach to infection prevention and control throughout this policy. A successful approach to risk management includes action at the organisational level (for example providing support for effective risk management through an organisational risk-management policy, staff training and monitoring and reporting) as well as in clinical practice.

For risk management to be effective, there needs to be appropriate infrastructure and culture; a logical and systematic approach to implementing the required steps; and embedding of risk-management principles into the philosophy, practices and business processes across the organisation, rather than it being a separate activity or focus.

Factors that support risk management across the organisation include - development of a risk-management policy; staff training in risk management; implementation of a risk register, risk treatment schedule and integrated action plans; monitoring and audit; and risk-management reporting.

An infrastructure and environment that encourages two-way communication between management and care workers and among care workers is an important factor in increasing the level of support for and compliance with infection prevention and control programs. Management should –

- provide direction (eg. nominate issues for attention that are relevant to the core business of the organisation, such as respiratory hygiene and cough etiquette, appropriate management of urinary catheters in spinal injury care)
- establish and evaluate periodic goals (ie. nominate reduced rates for performance improvement)
- seek feedback on policy directives particularly in regards to changes in clinical care protocols or new technologies and how clients can be involved in policy formation
- provide information to individuals, self-directed work groups, clients and other stakeholders, with an emphasis on continually improving performance.

Care workers can contribute to the development of risk-management structures, and are integral to the strategies within these.

All the roles described in this section are important for effective infection prevention and control.

Chief Executive Officer
Community Care Options Board and CEO support and promote infection prevention and control as an integral part of the organisation's culture through the following strategies –

- having a performance agreement that includes infection prevention and control outcomes as a key performance indicator
- endorsing the inclusion of specific articulated infection prevention and control roles, responsibilities and accountabilities for relevant staff within the organisation's management plan
- ensuring that the rights of clients, as articulated in the Australian Charter of Rights for Community Care, are integral to the IPC program
- committing to the IPC program vision, mission, priorities, targets and annual infection prevention and control plan with specific, measurable goals for care associated infection risk mitigation and reduction—these should be outlined in an annual business plan which the CEO and the infection control professional jointly develop
- supporting an organisational culture that promotes individual responsibility for infection prevention and control among all staff and values the IPC program's contribution to the safety of clients, care workers and others. This support includes ensuring IPC program staffing levels are sufficient and incorporating responsibility

for infection prevention and control into every staff member's job description
- authorising infection control professionals to -
  - implement IPC program recommendations
  - intervene when clinical or other practices pose infection risks (eg. Cease services during outbreaks and guide client care for isolation or cohorting)
- recommending remedial action when infection prevention and control measures are compromised or breached.

Manager People & Culture/Client Services Manager/Clinical Care Staff - Infection control professionals
Infection control professionals should have the skills, experience and qualifications relevant to their specific clinical setting and be able to –

- develop, manage and evaluate governance of infection prevention and control systems, related programs and services
- provide expert infection prevention consultancy and strategic direction to the CCO and external agencies.

Infection control professionals are primarily responsible for designing, coordinating, implementing and undertaking ongoing evaluation of CCO's infection prevention and control program and policies. This includes compliance with the respective state/territory and/or national accreditation, licensing, policy or regulatory requirements. They are also responsible for equipment and product evaluation.

ALL CCO staff are responsible for following CCO's policy, procedures and practices in relation to infection prevention and control.

Infection prevention and control (IPC) program
The IPC program is the means by which infection prevention and control practice is implemented in every part of Community Care Options.

CCO's IPC program will include –

- the development of infection prevention and control policies and procedures that are multimodal and based on national and state/territory Guidelines
- education and training of care workers to improve their understanding of care associated infection, and antimicrobial resistance, and so they can implement relevant policies and procedures
- the need for infection surveillance which includes timely mechanisms for feedback and reporting to relevant care professionals and senior management
- the use of multimodal strategies to address the prevention of infections
- regular monitoring and review of care practices to ensure that all policies and procedures are being correctly implemented against key performance indicators
- developing policies and procedures related to staff health and safety, including immunisation policies, and strategies to prevent occupational exposure to infection hazards

- evaluation of chemical disinfectants, products and equipment purchase
- ensuring that care environments are clean and appropriate materials and equipment are available to enable appropriate infection prevention and control procedures

Risk Management

In the context of these guidelines, 'risk' is defined as the possibility of microorganism colonisation or infection in client's or care workers arising from activities within a care setting. Risk management is the basis for preventing and reducing harms arising from care associated infection.

A successful approach to risk management occurs on many levels within an organsiation such as CCO -

- Organisation wide — eg providing support for effective risk management through an organisational risk-management policy, staff training, follow-up of outcomes, monitoring and reporting.
- Program based — eg embedding risk management into all policies so that risks are considered in every situation.
- Individual — eg considering the risks involved in carrying out a specific procedure for or with a specific individual and questioning the necessity of the procedure as part of clinical decision-making, attending education sessions (eg. hand hygiene or respirator fit testing).

The Australian/New Zealand Standard on Risk Management **AS/NZS ISO 31000: 2009** outlines a stepwise approach to risk management:

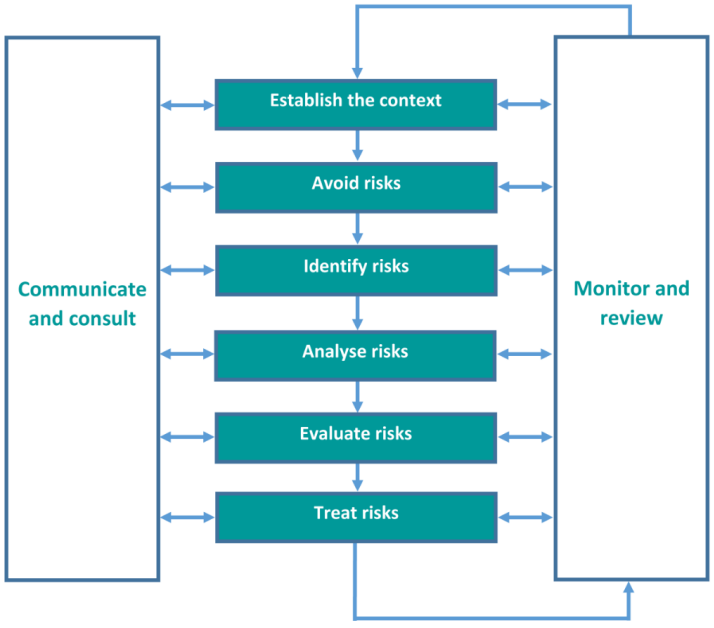


Figure 3. Risk management

Community Care Options adopts a risk management approach to all areas of the organization, including its approach to infection prevention and control.

Establishing context — identifying the basic parameters in which risk must be managed e.g. type of health facility, extent of and support for the facility's infection prevention and control program.

Avoiding risk — establishing whether there is a risk and whether the potential risk can be averted eg. by questioning whether a procedure is necessary.

Identifying risks — a systematic and comprehensive process that ensures that no potential risk is excluded from further analysis and treatment eg. using root cause analysis.

Analysing risks — considering the sources of risk, their consequences, the likelihood that those consequences may occur, and factors that affect consequences and likelihood eg. existing controls.

Evaluating risks — comparing the level of risk found during the analysis process with previously established risk criteria, and assessing available options for ease of implementation and impact resulting in a prioritised list of risks for further action.

Treating risks — implementing appropriate management options for dealing with identified risk eg. modifying procedures, protocols or work practices; providing education; and monitoring compliance with infection prevention and control procedures.

Monitoring and review is an essential component of the risk-management process. This ensures that –

- new risks are identified
- analysis of risk is verified against real data, if possible, and
- risk treatment is implemented effectively.

Communication and consultation are also key elements of clinical risk management. An interactive exchange of information between management, care workers, clients and other stakeholders provides the basis for increased awareness of the importance of infection prevention and control, identification of risks before they arise and prompt management of risks as they occur.

CCO staff and clients are advised to contact CCO immediately they are aware of, have symptoms of, or have been diagnosed with an infectious disease. If you are unsure please check with a CCO RN, or the Executive Team.

The Client Services Manager and Manager People & Culture will be advised immediately of any infection risks identified.

Using a risk analysis matrix may assist with risk analysis and provide input into evaluation and decision making on whether the risks need action, and what the most appropriate risk mitigation strategies and methods may be.

Contact will be made with relevant people potentially affected by such an infection – client, other staff supporting the client, family members.

The Client Services Manager will retain a Register of Infectious Disease Notifications for clients.

The Manager People & Culture will retain a Register of Infectious Disease Notifications for staff.

Managers will seek the advice of the Local Health District Communicable Diseases Unit and advise staff and client's of any further information required or precautions to take.

Likelihood	Consequences				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain	Medium	High	High	Extreme	Extreme
Likely	Medium	Medium	High	High	Extreme
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Low	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Low risk	Manage by routine procedures.
Medium risk	Manage by specific monitoring or audit procedures.
High risk	This is serious and must be addressed immediately.
Extreme risk	The magnitude of the consequences of an event, should it occur, and the likelihood of that event occurring, are assessed in the context of the effectiveness of existing strategies and controls.

Figure 4. Risk analysis matrix

Consider which risks need to be actively managed, why, how this will be achieved, and prioritise which actions to take based on the impacts. Use a risk evaluation matrix (Table 1 below) to determine the ease and impact of possible strategies when deciding which to implement. Note that priority must be given to activities that address risks that are high and which could have a potentially catastrophic outcome.

Table 1. Risk evaluation matrix

Example	Ease	Analysis	Impact
Clean and disinfect surfaces.	Easy	Potential for measles contact transmission if droplets are transmitted indirectly to surfaces.	High
Use of surgical mask and isolation of suspected cases.	Easy	Wearing of correctly-fitted surgical masks by coughing patients prevents dispersal of respiratory secretions into the air.	High
Provide ABHR in waiting, clinical rooms and consultation rooms.	Easy	Shown to improve compliance with hand hygiene, which has an impact on the spread of HAI.	High
Change linen between each patient in consultation rooms.	Hard	Linen not a high risk cause of measles transmission.	Low
Educate infectious patients to report their infectious state prior to attending practice.	Hard	May reduce the incidence of iatrogenic infection.	High

Monitor and review

The number of cases identified should be reported to the local public health unit as a notifiable disease.

Monitor and/or follow up with any known at-risk clients eg. immunocompromised.

Provide feedback to staff.

Operational Procedures

Clients are not required to disclose to us if they have an infectious disease. Staff are to treat all people as if they potentially have an infectious disease and therefore use ‘standard precautions’ – (universal infection control procedures) when dealing with all clients.

Infectious diseases can be airborne, such as meningitis or tuberculosis, blood borne, such as HIV or Hepatitis and faecal-oral borne such as gastroenteritis.

This policy and procedures includes information about standard workplace practices - washing hands, cleaning up spills, sterilizing shared kitchen utensils, wearing protective clothing, disposing of contaminated waste appropriately and reporting of exposure incidents; immunization/vaccination programs; first aid policies and post-exposure procedures.

- Infectious agents (also called pathogens) are biological agents that cause disease or illness to their hosts. Many infectious agents are present in healthcare settings.

- Infection includes six elements - causative agent (pathogen), reservoir, portal of exit, means of transmission, portal of entry, and a susceptible host.

- Clients and Support Workers are most likely to be sources of infectious agents and are also the most common susceptible hosts. Other people visiting and working in client environments may also be at risk of both infection and transmission.

- In community care settings, the main modes for transmission of infectious agents are contact (including bloodborne), droplet and airborne.

Contracting a care associated infection

Most infectious agents are microorganisms. These exist naturally everywhere in the environment, and not all cause infection (eg. 'good' bacteria present in the body's normal flora). Parasites, prions and several classes of microorganism — including bacteria, viruses, fungi and protozoa—can be involved in either colonisation or infection, depending on the susceptibility of the host –

- With **colonisation,** there is a sustained presence of replicating infectious agents on or in the body, without causing infection or disease.
- With **infection**, invasion of infectious agents into the body results in an immune response, with or without symptomatic disease.

Transmission of infectious agents within the community setting requires all of the following elements –

- causative agent (pathogen)
- reservoir
- portal of exit
- means of transmission
- portal of entry
- a susceptible host.

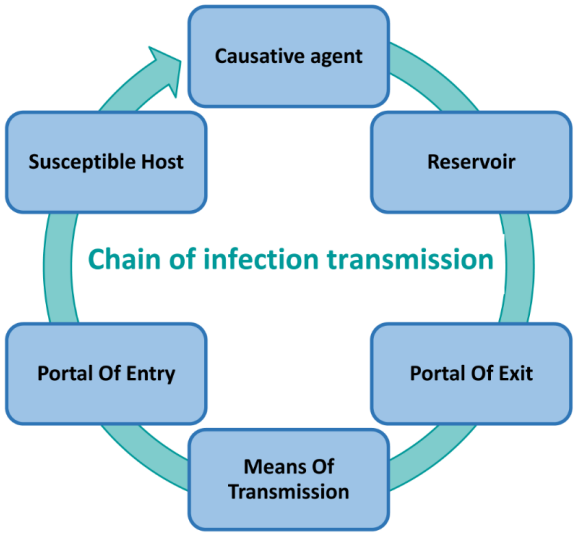


Figure 1. The chain of infection transmission

Infectious agents transmitted during health/personal care come primarily from human sources, including clients, Support Workers and visitors. Source individuals may be actively ill, may have no symptoms but be in the incubation period of a disease, or may be temporary or chronic carriers of an infectious agent with or without symptoms.

Infection is the result of a complex interrelationship between a host and an infectious agent and people vary in their response to exposure to an infectious agent –

- Some people exposed to infectious agents never develop symptomatic disease while others become severely ill and may die.
- Some individuals may become temporarily or permanently colonised but remain asymptomatic.
- Others progress from colonisation to symptomatic disease either soon after exposure, or following a period of asymptomatic colonisation.

Important predictors of an individual's outcome after exposure include –

- his or her immune status at the time of exposure (including whether immune status is compromised by medical treatment such as immunosuppressive agents or irradiation)
- the person's age (eg. neonates and elderly patients are more susceptible)
- their health status (eg. when a client has other underlying disease such as diabetes or is a smoker)
- the virulence of the agent
- other factors that increase the risk of transmission of infection (eg. undergoing surgery, requiring an indwelling device such as a catheter or remaining in hospital for lengthy periods).

Mode of Transmission

Understanding the modes of transmission of infectious organisms and knowing how and when to apply the basic principles of infection prevention and control is critical to the success of an infection control program. This responsibility applies to everybody working in client homes. Infection prevention and control is integral to clinical care and often requires a range of strategies to be successful. It should not be considered as an additional set of practices but as part of standard care.

Successful approaches for preventing and reducing harms arising involve applying a risk-management framework to manage 'human' and 'system' factors associated with the transmission of infectious agents. This approach ensures that infectious agents, whether common (eg. gastrointestinal viruses) or evolving (eg. influenza or multi-resistant organisms), can be managed effectively.

Involving clients and their carers is essential to successful infection prevention and control. Clients need to be sufficiently informed to be able to participate in reducing the risk of transmission of infectious agents.

In community care settings, the main modes of transmission of infectious agents are contact (including blood borne), droplet and airborne. The modes of transmission vary by type of organism. In some cases the same organism may be transmitted by more than one route (eg. norovirus, influenza and respiratory syncytial virus (RSV) can be transmitted by contact and droplet routes).
Common ways infections spread include –

Contact is the most common mode of transmission, and usually involves transmission by touch or via contact with blood or body substances. Contact may be direct or indirect –

- *Direct transmission* occurs when infectious agents are transferred from one person to another—for example, a patient's blood entering a worker's body through an unprotected cut in the skin.

- *Indirect transmission* involves the transfer of an infectious agent through a contaminated intermediate object or person — eg a worker's hands transmitting infectious agents after touching an infected body site on one client and not performing proper hand hygiene before touching another client, or a worker coming into contact with fomites (eg. bedding) or faeces and then with a client.

Examples of infectious agents transmitted by contact include multi-resistant organisms (MROs), *Clostridioides difficile* (*Clostridium difficile* or *C. difficile*), norovirus and pathogens which cause highly contagious skin infections/infestations (eg. impetigo, scabies).

Droplet transmission can occur when an infected person coughs, sneezes or talks, and during certain procedures. Droplets are infectious particles larger than 5 microns in size. Respiratory droplets transmit infection when they travel directly from the respiratory tract of the infected person to susceptible mucosal surfaces (nasal, conjunctival or oral) of another person, generally over short distances. Droplet distribution is limited by the force of expulsion and gravity and is usually no more than 1 metre.

Examples of infectious agents that are transmitted via droplets include influenza virus and *Neisseria meningitidis* (meningococcal infection).

Airborne transmission may occur via particles containing infectious agents that remain infective over time and distance. Small - particle aerosols (often smaller than 5 microns) are created during breathing, talking, coughing or sneezing and secondarily by evaporation of larger droplets in conditions of low humidity. Aerosols containing infectious agents can be dispersed over long distances by air currents (eg. ventilation or air conditioning systems) and inhaled by susceptible individuals who have not had any contact with the infectious person. These small particles can transmit infection into small airways of the respiratory tract.

An example of infectious agents primarily transmitted via the airborne route are *M. tuberculosis* and rubeola virus (measles).

Successful infection prevention and control involves implementing work practices that reduce the risk of the transmission of infectious agents through a two-tiered approach, including –

- Routinely applying basic infection prevention and control strategies to minimise risk to both clients and workers, such as hand hygiene, appropriate use of personal protective equipment, cleaning and safe handling and disposal of sharps (*standard*

precautions).

- Effectively managing infectious agents where standard precautions may not be sufficient on their own—these specific interventions control infection by interrupting the mode of transmission *(transmission-based precautions*; formerly referred to as *additional precautions*).

Standard precautions

All people potentially harbour infectious agents. Standard precautions refer to those work practices that are applied to everyone, regardless of their perceived or confirmed infectious status and ensure a basic level of infection prevention and control.

Implementing standard precautions as a first-line approach to infection prevention and control in the client care environment minimises the risk of transmission of infectious agents from person to person, even in high-risk situations.

Standard precautions are used by care workers to prevent or reduce the likelihood of transmission of infectious agents from one person or place to another, and to render and maintain objects and areas as free as possible from infectious agents.

How standard precautions are implemented –

- Personal hygiene practices, particularly **hand hygiene**, aim to reduce the risk of contact transmission of infectious agents.
- Appropriate use of **personal protective equipment**, which may include gloves, gowns, plastic aprons, masks/face-shields and eye protection, aims to prevent exposure of the healthcare worker and patients to infectious agents.
- Safe **handling and disposal of sharps** assists in preventing transmission of blood-borne diseases to care workers.
- **Environmental controls,** including cleaning and spills management, assist in preventing transmission of infectious agents from the environment to clients.
- Appropriate **reprocessing of reusable equipment and instruments**, including appropriate use of disinfectants, aims to prevent client – to – client transmission of infectious agents.
- Practising **respiratory hygiene and cough etiquette** reduces risk of transmission of infection.
- **Aseptic technique** aims to prevent microorganisms on hands, surfaces or equipment from being introduced into a susceptible site.
- Appropriate handling of **waste and linen** assists in reducing transmission of infectious agents.

Transmission-based precautions

Any infection prevention and control strategy should be based on the use of standard precautions as a minimum level of control. Transmission-based precautions are recommended as additional work practices in situations where standard precautions alone may be insufficient to prevent transmission. Transmission-based precautions are also used in the event of an outbreak (eg. gastroenteritis), to assist in containing the outbreak and

preventing further infection.

Transmission-based precautions should be tailored to the particular infectious agent involved and its mode of transmission. This may involve a combination of practices.

Types of transmission-based precautions –

- **Contact precautions** are used when there is known or suspected risk of direct or indirect contact transmission of infectious agents that are not effectively contained by standard precautions alone.
- **Droplet precautions** are used for clients known or suspected to be infected with agents transmitted over short distances by large respiratory droplets.
- **Airborne precautions** are used for clients known or suspected to be infected with agents transmitted person-to-person by the airborne route.

Hand Hygiene - Washing and Hand Care
Effective hand hygiene is the single most important strategy in preventing the spread of infection. Ease of access to hand washing facilities (soap and water) and alcohol-based hand rubs can influence the transmission of infections. Washing hands with soap and water is required if hands are visibly soiled while either product can be used if hands are visibly clean. If hands are not clean, simple activities such as placing a finger in the mouth, rubbing the nose or eye may transmit enough germs in the body to cause infection. Staff can infect themselves or a client in this manner.

It is recommended that routine hand hygiene is performed -

- ✓ At start and finish of shifts and breaks
- ✓ Before touching a client
- ✓ Before any personal care procedure
- ✓ After a personal care procedure or body substance exposure risk
- ✓ Whenever cross infection from body fluids is possible such as assisting a client with toileting, changing nappies, administering medicines and applying first aid
- ✓ After touching a client
- ✓ Before and after meals, going to the toilet, handling food, coughing, smoking
- ✓ After cleaning or handling soiled equipment, surfaces, or linen
- ✓ After touching animals
- ✓ Before contact with any clients whose immune systems may be compromised
- ✓ After touching a client's surroundings/home environment.

Hand hygiene must also be performed before putting on gloves and after the removal of gloves. Gloves should be worn for ALL client services.

CCO commits to providing staff with alcohol-based hand rubs that meet the requirements of European Standard EN 1500 for all routine hand hygiene practices.
It is recommended that alcohol-based hand rubs that contain between 60% and 80% v/v ethanol or equivalent should be used for all routine hand hygiene practices.

Summary

Standard precautions treat all clients the same way regardless of their infectious status.

Compliance with standard precautions has been shown to significantly reduce the risk of exposure. A high standard of personal hygiene is essential and the following practices will assist hand care -

- ✓ A mild liquid hand wash (with no added substances which may cause irritation or dryness) should be used for routine hand washing
- ✓ To minimize chapping of hands, use warm water and pat hands dry rather than rubbing them
- ✓ Liquid handwash dispensers with disposable cartridges, including disposable dispensing nozzle, are preferable to refillable containers, which may predispose to bacterial colonization.
- ✓ Repeated hand washing and wearing of gloves can cause irritation or sensitivity, leading to dermatitis or allergic reactions. This can be minimized by early intervention, including assessment of hand-washing technique and the use of suitable individual-use hand creams.
- ✓ Aqueous-based hand creams should be used before wearing gloves. Oil-based preparations should be avoided as these may cause latex gloves to deteriorate.
- ✓ Water impermeable gloves must be readily available to all workers and worn when likely to be exposed to blood or other body fluids/substances, or contaminated materials. The wearing of gloves substantially reduces the risk of hands being contaminated with blood or other body fluids/substances.
- ✓ Hands must be washed and dried immediately after removing gloves (gloves cannot be guaranteed to prevent skin contamination and may not remain intact during use).
- ✓ Gloves should be removed and replaced (if needed) once the specific task is finished.
- ✓ Waterproof aprons or gowns should be worn when clothing may be contaminated with blood or other body fluids/substances.
- ✓ Surgical masks and/or protective eyewear should be worn where eyes and/or mucous membranes may be exposed to splashed or sprayed blood or other body fluids/ substances.
- ✓ Cuts or abrasions on any part of a worker's body must be covered with waterproof dressings at all times.
- ✓ Appropriate handling and disposal of sharp instruments and clinical waste
- ✓ Correct cleaning and disinfecting of non disposable equipment
- ✓ Appropriate use of cleaning agents
- ✓ Environmental controls such as design and maintenance of premises, cleaning and spills management.

Staff Training

In the interests of risk management and ensuring that all of CCO's employees understand their responsibilities for practicing standard precautions and other infection control techniques. ALL staff will be trained by a Registered Nurse at Induction in Infection Control policies, procedures and practices, including hand hygiene and use of Personal Protective Equipment.

Infection Control Training for care workers – https://covid-19training.com.au

Staff and Client Immunisation

Community Care Options encourages our vulnerable clients to have a Flu Vaccination each year, particularly those client's aged over 65 years, people with a disability or those with compromised immune systems. We actively promote this through Client Newsletters and Friends of CCO Meetings.

At this point in time it is not compulsory for CCO staff to have specific vaccinations prior to gaining employment.

Support Coordinators working on the Compacks program are required to have specific immunisations as identified by NSW Health prior to accessing the hospital for client assessments.

CCO encourages our staff, particularly front line staff to have a Flu Vaccination each year by organizing their access to a free flu clinic.

CCO currently maintains a register of Infectious Diseases for Staff and Client's –

those undertaking Covid testing required to send through cleared results to CCO.

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

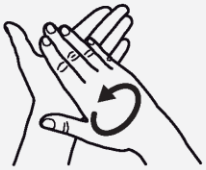
0

Wet hands with water;

1

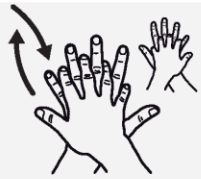
Apply enough soap to cover all hand surfaces;

2



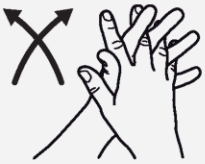
Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4



Palm to palm with fingers interlaced;

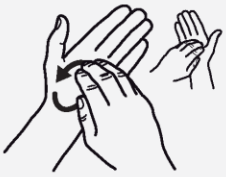
5

Backs of fingers to opposing palms with fingers interlocked;

6

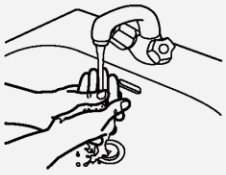
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

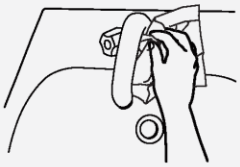


Rinse hands with water;

9

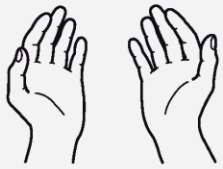
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a 1b

Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

Once dry, your hands are safe.

Clinical Care

Clinical care and health support planning are provided to CCO's clients receiving Home Care Packages (particularly levels 3 & 4), DVA Nursing, NDIS high level supports by Registered Nurses and an Enrolled Nurse – called Clinical Care Managers.

How does client - centred care relate to infection prevention and control?

Infection prevention and control is ultimately about people. Effective infection prevention and control is central to providing high quality client - centred care.

Putting patients at the centre of infection prevention and control and enabling them to participate in the care process is not just about explaining the risks of treatments, but involves considering client's needs at every level. This has to be balanced with the requirement to maintain an environment where care can be delivered in a safe manner which minimises the spread of infection.

This ranges from designing the environment to maximise client comfort and safety to having a range of processes to engage client's in their care. Clinical care managers need to listen to and act on their client's feedback as well as provide the client with education and support so that they can be involved in looking after themselves.

To support a two-way approach to infection prevention and control and encourage the client participation required to minimise cross-infection or transmission, it is important to –

- take client's perspectives into account when developing policies and programs
- familiarise client's with the infection prevention and control strategies that are employed to protect them, the people caring for them and the healthcare environment
- discuss with client's the specific risks associated with their medical treatment
- encourage client's to disclose their health or risk status if there is a potential risk or source of infection to healthcare workers or others within the healthcare environment
- provide opportunities for client's to identify and communicate risks and encourage them to use feedback procedures for any concerns that they have about infection prevention and control procedures
- provide educational materials about infection prevention and control using a variety of media (eg. posters in waiting rooms, printed material and educational videos)
- inform client's about the protocols for protecting their privacy and confidentiality.

Clients and visitors to their home should be informed on what they can do to prevent the spread of infection and keep themselves infection-free. CCO will provide specific information to client's to assist them in becoming involved in identifying and reducing risks related to standard and transmission-based precautions.

Clinical care managers should, where possible –

- explain the processes of infection prevention and control (eg. importance of hand hygiene, reasons for wearing personal protective equipment (PPE), importance of appropriate handling and disposing of sharps) to client's and their carers
- engage client's and their carers in the decision-making process regarding their care and how it is delivered
- ensure all client's and their carers are aware that they can to ask questions of clinical care professionals.

- Written material (such as brochures and posters) can be used to reinforce verbal discussions with client's as part of their care.

Some examples of the types of information that should be provided to clients are below -

Use of personal protective equipment

- Wearing of appropriate PPE such as gowns, gloves and masks is a routine part of infection prevention and control in healthcare—it is used for everybody's safety.
- The use of PPE alone is not enough—care workers should perform hand hygiene before putting on and after removing the protective items.
- PPE is used in the client care area only—care workers remove the equipment before they leave the area to reduce the risk of spreading infection.
- Gowns or aprons are used so that the care worker's clothing or skin does not become contaminated.
- Care workers wear an appropriate mask if there is risk of them inhaling an infectious agent.
- Appropriate masks, eye protection or face-shields are worn by a care worker in situations where the client's body substances may splash onto his or her face.
- Care workers wear gloves when they will have direct hand contact with blood or body substances, mucous membranes or wounds or if there is a chance that touching the client could transmit infection.
- Client's who are sensitive or allergic to latex should tell their care workers so that an alternative glove type can be used.
- It is important to note that it is not unusual for infection prevention and control practices to change over the course of care based on risk assessments made by individual care workers.
- It is okay to question a care worker about whether they should be using protective personal equipment or whether they are using it properly.

Handling and disposing of sharps

- Care workers are at risk of injury and infection when using sharp equipment such as needles and scalpels.
- Care workers take measures to handle sharp devices in a way that prevents injury to the user and to others who may encounter the device during or after a procedure.
- Special containers are used for the disposal of sharp devices.
- It is okay to question a care worker about the way in which they are handling or disposing of sharp devices.
- Client's will be educated about how to safely dispose of sharps used in the home so there is no risk of injury to community members.

Management of outbreak situations

Outbreak situations may require client's to be aware of changes to infection prevention and control activities within Community Care Options services.

- In community settings, staff must respond quickly to an outbreak of an infection to contain the infection and stop it spreading further. Actions may include notifying direct care staff and carers, testing client's or staff to see who may carry the infection.
- Hand hygiene is the most important part of preventing transmission of an infection.
- If infected clients are transported, they will be asked to wear a mask.
- Infected client's should avoid unnecessary movement around their community.
- To minimise transmission of infection, visitors should be kept to a minimum, visitors should perform hand hygiene using an alcohol-based hand rub before entering or exiting the client home. They may also be asked to wear gloves and gowns while they are with the client.
- Staff will take all necessary precautions as instructed by Management, on the advice of NSW Health.

Surveillence of Health Care associated infections and antimicrobial stewardship

CCO's Clinical care managers will be responsible for supporting client's with health care planning, including monitoring of the risk of and type of infections the client may experience. Clinical care managers will also monitor the use by client's of antimicrobial agents to treat infections. It is important for clinical care managers supporting clients with health care and infection prevention and management, to have the consent of the client to liaise with their GPO and or Pharmacist in relation to medications prescribed to treat infections. This is particularly true of those clients, infected with a multi drug resistant organism (MRO).

To minimise MRO transmission and infection, clinical care managers must ensure that infection prevention and control principles, such as standard and transmission based precautions and antimicrobial stewardship are practised during all client care.

Clinical care managers will keep effective records in relation to client infection – including treatment – medication, wound care, infection prevention and control mechanisms for staff and carers. Clinical care managers will seek advice from the client's GP or make contact with the Local Health Network to determine need to notify and any other precautions.

Clinical care managers will ensure that infection risks, including strategies to address/control them are communicated effectively and immediately to CCO's support workers, and other clinicians, health services involved. Respecting of course client privacy and confidentiality.

Clinical care managers will communicate with all care support personnel the processes around evaluating and responding to the infection risks identified. eg new equipment purchase, maintenance and cleaning of equipment. Environmental cleaning processes must be consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

Aseptic Technique

Aseptic technique is a set of practices aimed at minimising contamination and is used to protect the client from infection during procedures. Sterile single use equipment or instruments must be used according to the manufacturer's instructions and in such a way that the sterility of the item is maintained.

The five essential principles of aseptic technique are –

1. **Sequencing** –
   - Performing a risk assessment
   - Pre procedure preparation
   - Performing the procedures
   - Post procedure practice, handover and documentation

When performing a procedure steps must be sequenced to ensure efficient, logical and safe order of procedure and clinicians should be familiar with the sequence of the procedure to ensure asepsis is maintained.

2. **Environmental control** –
   - Prior to aseptic procedure, the clinical care manager must ensure there are no avoidable nearby environmental risk factors, such as bed making, use of fans, cleaning of the nearby environment, pets near the work area.
   - A sterile field should be set up on an adequate surface that has already been cleaned.
   - If a sterile item is dropped on the floor the package integrity is compromised and it MUST be either thrown away (single use) or re-processed (if reusable). It is never appropriate to reuse the item.
   - To prevent accidental contamination, the clinician's hair should be tied back, and lanyards removed or tucked in prior to commencing procedure.

3. **Hand Hygiene -**
   - Perform hand hygiene immediately before and after a procedure or after body fluid exposure, in compliance with the five moments for hand hygiene.
   - Depending on the procedure about to be performed either routine or surgical hand hygiene is required.

4. **Maintenance of aseptic fields** –
   - Cleaning and/or disinfection of key site(s) and key part(s) prior to procedure(s).
   - Establishing an aseptic field
   - Use of sterile equipment
   - Maintainenace of the aseptic field, including protecting the key sites and key parts
   - Use of a non touch technique
   - Gloves must not touch any item or surface outside of the aseptic field.

5. **PPE** –
    - Correct selection and use of sterile and non sterile PPE
    - Sterile gloves should be worn if key sites or key parts need to be touched
    - If key sites or key parts are not touched then non sterile gloves must be worn to protect the clinician from any body substance exposure.
    - Other PPE should be worn in line with standard precautions to reduce the risk of body substance exposure to the clinical care manager such as apron, mask and eye protection.

The Clinical Care Team Leader is to undertake a local risk assessment (six monthly) to identify medium and high risk procedures that require the use of aseptic technique or maximum barrier protection. The Clinical Care Team Leader is to regularly audit (six monthly) the use of aseptic technique and evaluate audit data locally to identify opportunities for compliance improvement.

CCO will maintain a central record describing the aseptic technique education and competencies of its clinical workforce.

Audit information to be made available to the Client Services Manager for discussion at Executive Meetings.

Routine Cleaning

Standard precautions must be implemented when cleaning surfaces and client homes. Employees must wear suitable gloves and other protective clothing appropriate for the task. Protective eyewear must be worn where splashing is likely to occur.
Toilets, sinks, washbasins, baths, shower areas, and surrounding areas should be cleaned regularly or as required. Cleaning methods for these items should avoid generation of aerosols. Although environmental surfaces play a minor role in the transmission of infections, a regular cleaning and maintenance schedule is necessary to maintain a safe environment.

Surfaces should be cleaned on a regular basis using only cleaning procedures that minimise dispersal of micro-organisms into the air.

Floors should be cleaned daily or as necessary with a vacuum cleaner. Alternatively, damp dusting or cleaning with a dust-retaining mop is acceptable.

Routine surface cleaning should proceed as follows -

- ✓ clean and dry work surfaces before and after usage or when visibly soiled.
- ✓ spills should be dealt with immediately;
- ✓ use detergent and warm water for routine cleaning;
- ✓ where surface disinfection is required, use in accordance with manufacturer's instructions;
- ✓ clean and dry surfaces before and after applying disinfectants;
- ✓ empty buckets after use, wash with detergent and warm water and store dry; and mops should be cleaned in detergent and warm water then stored dry.

Standard Cleaning Materials

This should include a mop and cleaning bucket plus cleaning agents should be readily available for spills management and should be stored in an area known to all staff.

1. *A large reusable plastic container or bucket with fitted lid, containing -*
2. *large zip seal plastic bags for waste material;*
3. *sturdy cardboard scraper and pan (similar to a 'pooper scooper');*
4. *sodium hypochlorite (bleach) or other suitable (equivalent acting) disinfectant.*
5. *disposable rubber gloves suitable for cleaning;*
6. *eye protection (disposable or re-usable);*
7. *a plastic apron; and*
8. *a mask (for protection against inhalation of powder from the disinfectant granules, or aerosols from high risk spills which may be generated during the cleaning process).*

With all spills management protocols, it is essential that the area is left clean and dry.

Blood Spills

Small Blood Spills

Ensure the employee is wearing latex/rubber gloves and enclosed footwear. Small blood spills can be easily managed by wiping the area immediately with paper towelling and then cleaning the area with water and detergent or a suitable disinfectant such as sodium hypochlorite (bleach).

Small spots or drops of blood or body fluids can be removed immediately by wiping the area with a damp cloth, tissue or paper towelling. A disposable alcohol wipe can also be used.

Large Blood Spills in a 'Wet' area eg. a bathroom or toilet area

Ensure the employee is wearing latex/rubber gloves and enclosed footwear. The spill should be carefully washed down the sink and the area flushed with water and detergent.

After the area is cleaned and if there is a possibility of bare skin contact with the surface, the area should be disinfected as above with sodium hypochlorite (bleach) or other suitable (equivalent acting) disinfectant.

Large Blood Spills in 'Dry' areas

Ensure the employee is wearing latex/rubber gloves and enclosed footwear. The area should be decontaminated and the area of the spill contained. (no access to clients)
A scraper and pan should be used to remove the absorbed material if required. The area of the spill should then be cleaned with a mop and bucket of water with sodium hypochlorite (bleach) or other suitable (equivalent acting) disinfectant.
The bucket and mop should be thoroughly cleaned after use and stored dry.

Post Exposure Procedures

Where it is believed that an employee has been exposed to potentially infectious material they should follow the following post exposure steps.

Needle-Stick Injuries

If a staff member accidentally pricks themselves with the needle of a used syringe, the following first aid measures must be taken -

- ✓ encourage the puncture point to bleed by gently squeezing around it;
- ✓ wash away any blood or body substances using soap and water (if available);
- ✓ cleanse puncture point with a Medi-Prep antiseptic wipe (first aid kit item);
- ✓ apply a fabric strip (eg band aid) to puncture point;
- ✓ a doctor should be seen as soon as possible for an assessment.

Other Exposures
If a staff member is exposed to (is in direct contact with) blood or body fluids the following first aid measures should be taken -

- Skin – wash with soap and water
- Eyes – rinse eyes with copious amounts of water
- Mouth – spit out and repeatedly rinse with water

Incident Management
Following a needle-stick injury or exposure where there has been a possibility of blood or body fluid entering the body (ie via cut or broken skin, eyes or mouth) –

The responsible Manager must –

- ✓ **immediately accompany the staff member to a doctor – take the needles or syringe if safe to do so for potential testing.**
- ✓ the doctor will assess the risk of disease transmission and discuss what tests and/or treatment may be necessary;
- ✓ inform the staff member about their access to appropriate professional counselling
- ✓ the manager is to notify and investigate the incident
- ✓ the manager is to ensure confidentiality of all investigations and related documents.

Waste Management
- ✓ all waste generated from first aid treatments or the clean up of spills should be handled with care, so as to avoid contact with blood and body substances. Medical latex gloves should be worn when handling contaminated waste.
- ✓ small amounts of contaminated waste should be placed in a sealed, leak-proof bag and disposed of with general waste.

Soiled Clothing
- ✓ latex medical gloves must be worn when handling soiled clothing. Soiled clothing should be identified as such and placed in a leak proof bag separate from other materials.
- ✓ staff should be advised to take home any soiled clothing belonging to them and to wash as soon as possible. Normal washing procedures and detergents are adequate for decontamination of most laundry items.

Hepatitis and HIV Testing and Counselling
Testing for HIV/AIDS/Hepatitis antibodies involves a blood test.
In the case of HIV/AIDS/Hepatitis a positive test indicates the person is infected with HIV/AIDS /Hepatitis. A negative result may mean either the person is not infected or is infected but has not yet developed antibodies to HIV/AIDS/Hepatitis.
It usually takes about three months for HIV/AIDS/Hepatitis antibodies to appear after exposure to HIV/AIDS/Hepatitis, so if a person has recently been at risk, a second test is recommended after three months.

Pandemic Planning

A Pandemic if/when it occurs arises rapidly, spreads quickly and usually comes in waves, each of which can last for months. A Pandemic occurs when a new strain of influenza spreads around the globe, infecting many people at once as there is no immunity. Up to 25-30 percent of the world's population could be infected.

Strategies need to be developed before the Pandemic strikes. Good Hygiene practices and social distancing is one of the key first measures. This means limiting interaction among groups of people. People will be encouraged to stay at home and avoid public places. CCO will determine how we will continue to deliver services without placing staff and clients at extra risk.

Risk Management

Hazard Identification

Staff should identify activities in the workplace that may put them or members of the public at risk of exposure/transmission of an infectious disease as a result of work activities. Sources of infection eg. blood and body fluids/substances and material potentially contaminated with blood or body fluids such as sanitary waste, soiled linen etc. and means of transmission eg. first aid, cleaning toilets, disposal of used syringes etc.

Risk Assessment

The purpose of risk assessment is to evaluate the risks to workers arising from exposure as a result of work activities and the working environment. Risk assessment should take into account -

- ✓ the type and frequency of exposure including the probability, amount of blood or body fluids/substances, type of body fluid/substance encountered, possible routes of transmission, and potential for multiple exposures;
- ✓ volume and frequency of contact with discarded used needles and syringes;
- ✓ factors contributing to exposure and their recurrence;

Risk associated with workplace layout, design and work practices including –

- *poor lighting*
- *crevices that encourage concealment of used needles and syringes*
- *access to relevant medical and first aid services*
- *the level of knowledge and training of employees regarding infectious diseases and safe work practices*
- *the availability and use of personal protective equipment (PPE), including - rubber gloves, eye goggles and face shields,*
- *the suitability of equipment for the tasks*
- *individual risk factors for each worker, such as damaged/broken skin, dermatitis and eczema*
- *the number of workers and other persons at risk of exposure*
- *availability of vaccines and post exposure prophylaxis (PEP)*
- *current risk control measures and the potential need for new risk control measures.*

Risk Control
Practical prevention and control strategies appropriate to the workplace include –

- ✓ Safe work procedures, incorporating standard and additional transmission based precautions where appropriate;
- ✓ Higher level controls such as retractable needles to prevent needle stick injuries and isolation rooms to house infectious clients;
- ✓ Personal hygiene;
- ✓ Post-injury testing, counseling and follow-up;
- ✓ An immunization program for Hepatitis B and flu when relevant;
- ✓ Availability and use of appropriate PPE;
- ✓ Good housekeeping;
- ✓ Appropriate waste management, including sharps handling and disposal
- ✓ Supervision and monitoring
- ✓ Critical incident planning including planning for Pandemics
- ✓ Staff training in risk control measures.

Safe Working Procedures
Following **standard infection control precautions** can minimise the risk of norovirus outbreaks caused by person-to-person transmission in any institution or group setting or by an infected food handler. This requires a basic level of hygiene measures that can be implemented in any setting, regardless of whether a person is infectious or not.

Standard precautions are work practices required to achieve a basic level of infection control. They include –

- hand hygiene and cough etiquette
- the use of personal protective equipment (PPE)
- the safe use and disposal of sharps
- routine environmental cleaning
- incorporation of safe practices for handling blood, body fluids and secretions as well as excretions.

Although standard infection control precautions are intended for use in healthcare settings, the principles can be applied to other institutional and group settings.

Person-to-person outbreaks in semi-closed environments are usually difficult to control because the infectious dose of norovirus is small, infected people excrete large numbers of viable virus particles and widespread environmental contamination occurs.

Norovirus outbreaks in institutional settings may generate public concern and media interest and may cause severe illness and even result in deaths where cases have severe underlying illnesses.

The public health action for different settings may vary but regardless of the type of outbreak setting, three important control measures should be applied in the management

of all outbreaks –

- cleaning and disinfection
- regular handwashing
- exclusion and cohorting of ill people.

The objective of public health management of norovirus outbreaks is to interrupt transmission and prevent further cases. In outbreaks that are spread from **person-to-person**, public health management will be needed to institute immediate infection control measures.

Key measures for controlling outbreaks
The most important generic measures to be implemented in an outbreak setting are described below. **These are recommendations only and may need to be varied according to the circumstances and type of setting for each outbreak.**

The basic principles which support these recommendations can be applied to the management of institutional and community based outbreaks.

Hand hygiene
Transmission of norovirus is usually person-to-person by the faecal-oral route and by contact with contaminated environmental surfaces. Cross-contamination by hands can assist in further propagating norovirus in outbreak settings. Studies have shown that fingers contaminated with norovirus could sequentially transfer virus to up to seven clean surfaces as well as from contaminated cleaning cloths to clean hands and surfaces. Hand hygiene is an effective means of preventing spread of infection.

Hands must be washed with soap and water wherever possible, or decontaminated using an alcohol-based hand rub or gel before and after contact with any person in an outbreak setting and after activities that may result in personal exposure to viruses.

Hand hygiene should be routinely carried out in accordance with Hand Hygiene Australia's **Five moments for hand hygiene –**

1. before touching a client
2. before a procedure
3. after a procedure or body fluid exposure risk
4. after touching a client
5. after touching a client's surroundings.

Where an outbreak has occurred, it is vital that there is a high level of compliance with this guidance. During outbreaks, staff members, visitors and patients should give additional attention to effective handwashing.

Washing and drying
Hands should be washed systematically by rubbing all surfaces of lathered hands vigorously with a mild liquid handwash for 20 seconds under running water. It seems that

time and friction when washing hands are more important aspects than temperature.

When washing is complete, thoroughly rinse hands under running water and then pat dry using a disposable paper towel, a single clean cloth towel or a fresh portion of a roller towel to prevent recontamination. If elbow or foot controls are not available a paper towel or the used towel should be used to turn taps off to prevent the risk of cross infection.

Alcohol-based preparations
Soap and water should be used wherever possible when washing hands during outbreaks. Skin disinfectants formulated for use without water (eg. 70–80% alcohol-based solutions) can be used to decontaminate hands when handwashing facilities are not available. However, they do not replace the importance of handwashing with soap and water during outbreaks. Alcohol preparations are not useful if hands are visibly contaminated with body fluids, faeces or vomit. Hands should then be washed as soon as appropriate facilities are available.

Alcohol-based hand rubs should not be removed from clinical settings or patient care areas during an outbreak, rather hand washing should be promoted above the use of alcohol-based hand rubs during an outbreak.

Personal protective equipment
In outbreak settings, appropriate personal protective equipment (PPE) should be used if possible in each setting of potential norovirus transmission to minimise infection risk. Splashing of faeces or aerosols from vomiting has the potential of suspending norovirus in the air and falling onto food or surfaces. Hand hygiene should be carried out at all times, particularly after removing PPE to minimise spread of viruses.

Gloves
Disposable gloves should be worn if having direct contact with ill persons and when it is likely that hands will be contaminated with faeces or vomit. Hands must be washed before and after using disposable gloves, which should be single use only. If gloves are not available, it is essential that hands be washed immediately after any contact with ill and well people during an outbreak.

Masks
Noroviruses are highly infectious and a small number of particles in aerosolised vomit can cause infection. A mask (surgical type, fluid repellent paper filter mask) should be worn when there is potential for aerosol dissemination. This may occur when attending a vomiting person or cleaning areas or surfaces that are visibly contaminated by vomit or faeces. Surgical face masks provide sufficient protection against droplet transmission of noroviruses. During outbreaks, staff attending vomiting patients or cleaning areas contaminated by vomit or faeces should use surgical masks or other respiratory protection to prevent infection, as this can significantly reduce subsequent illness in staff.

Gowns
Protective, impermeable gowns or plastic aprons should be worn if potential exists for

splashing, splattering or spraying of vomit or faeces. Impermeable gowns and plastic aprons will protect clothing and skin from contamination with faeces and vomit. Ideally, aprons will be single use that can be disposed of, although reusable plastic ones can be washed with detergent and water between uses. If the items have been visibly contaminated with faeces or vomit a bleach solution should be used to decontaminate. Protective clothing contaminated with faeces or vomit should be removed as soon as possible and disposed of without generating aerosols.

Eyewear
Protective eyewear such as face-shields or goggles should also be worn where the potential exists for splashing, splattering or spraying of vomit and faeces. Reusable goggles should be washed with detergent and water between uses. Visible contamination with faeces or vomit should first be washed off with soap and water, followed by cleaning with bleach solution.

Environmental cleaning

Prolonged outbreaks in semi-closed settings suggest that norovirus survives well in the environment and can spread via environmental surfaces. A continuation of outbreaks on consecutive cruise ship trips has demonstrated environmental persistence and led to recommending the need for extensive disinfection measures.

Chemical agents
There is no direct evidence to support the use of particular chemical agents for environmental disinfection as there is no viral culture system available for norovirus.

In order for bleach to be effective at a concentration of 1000 ppm (0.1%) it needs –

- sufficient time to kill the virus – at least 10 minutes contact time
- environmental surfaces to be free of vomit or faeces or any other organic matter
- dilution of bleach to made up fresh, just before using.

Cleaning equipment and agents
Bleach should be applied to hard, non-porous, environmental surfaces at a concentration of 1000 ppm. However, cleaning with bleach should be preceded where possible with a neutral detergent clean, the detergent providing a surfactant to release oils and bio-burden to enable penetration of the chemical. Detergents used for environmental cleaning should remove soil or dirt, suspending this in water, to be followed by rinsing the area free with little or no residue. Neutral pH detergents are best for environmental cleaning because they are less likely than acid or alkali detergents to damage metals such as stainless steel or to cause skin irritation.

Environmental surfaces
To assist in preventing transmission in an outbreak setting, frequently touched environmental surfaces such as door handles, bathroom taps, lift buttons, washrooms, phones and tables should be cleaned more frequently than the routinely recommended

daily cleaning. Particular attention should be paid to toilet seats, flush handles, wash-hand basin taps and toilet door handles. These should be cleaned at least twice a day as well as after any high usage times. Surfaces should be cleaned using detergent and warm water. A bleach solution diluted to 1000 ppm may be used to disinfect surfaces that are visibly soiled. The manufacturer's recommendations for use and occupational health and safety instructions should be followed when using bleach.

Cleaning up vomit or faeces

Vomit can produce aerosols suspended in the air and fall onto food or surfaces. If a person vomits in a public area, all people should be removed from the vicinity and the area cleaned immediately. Persons cleaning vomit or faeces should wear gloves, apron and a mask. Paper towels should be used to soak up excess vomit and faeces and disposed of in a leak proof plastic bag. The area should be cleaned with detergent and warm water using a disposable cloth, and discarded into a leak proof plastic bag. The area should be disinfected with bleach solution, if not subjected to damage by bleach.

Splash incidents

If there has been exposure to faeces or vomitus on body parts other than the hands, the area should be washed with soap and water if on the skin, with water if the eyes are splashed and if in the mouth, the body fluid should be spat out and the mouth rinsed several times with water.

Carpets

Carpets that have been soiled by faeces or vomit are difficult to disinfect. Bleach is not generally recommended as prolonged contact is required and carpet is usually not bleach resistant. Soiled carpets should be cleaned with detergent and warm water and then steam cleaned. Vacuum cleaning carpets has the potential to recirculate norovirus and is not recommended. The cleaner should use PPE (gown, mask and gloves) to prevent norovirus infection.

Soft furnishings

Soft furnishings that may be damaged by bleach should be cleaned with detergent and warm water and if possible steam cleaned. If mattresses have been contaminated they should also be steam cleaned. Contaminated pillows should be laundered in the same way as linen. However, if they are covered with an impermeable cover, pillows should be cleaned with detergent and warm water followed by wiping with a bleach solution.

Laundry

Gloves should be worn when handling soiled linen. PPE may be required if there is potential for contamination by way of splashing, spraying or splattering of faeces or vomit. Soiled linen or clothing should be removed immediately and placed in a collection bag or leak proof plastic bag. There should be minimal handling of soiled linen or clothing to prevent generating further aerosols. Contaminated linen, blankets or clothing should be washed as usual in detergent for the maximum washing cycle.

Food

Ill people should not take part in food handling duties and should not return to their usual food handling duties until 48 hours after their symptoms have ceased. All appliances, work benches and equipment need to be effectively sanitised. All utensils, cutlery, crockery and glassware are to be washed in the usual manner with detergent and hot water. Dispose of any exposed food, that is, food that has been handled by an infected person or food that may have been exposed to someone vomiting in close proximity.

- attention to hand hygiene
- prevention of gross contamination during food preparation
- provision of adequate handwashing facilities for food handlers
- ensuring that food handlers do not work while they have symptoms of gastroenteritis.

In addition to standard precautions for outbreak management, it is recommended that additional contact, droplet and air-borne precautions are adopted to minimise the dissemination of the infectious agent to other people, staff, visitors or volunteers.

In order to reduce the risk of food handling related to norovirus infection and consequent outbreaks, it is essential to maintain **food hygiene standards**. These include –

Exclusion

Ill people should be sent home immediately and excluded from child care, preschool, school or work for 48 hours after all symptoms have stopped. Maximum viral shedding probably occurs 24–48 hours after exposure; therefore it is a reasonable and accepted recommendation that workers be excluded for 48 hours after symptoms have stopped.

Isolation and cohorting

An attempt should be made to separate ill people from well people (‘cohorting’), especially if the outbreak setting is in a semiclosed environment and people are required to live in a household-like situation sharing the same facilities. However, there should be limited moving around of norovirus-infected people. In such settings, common areas should be closed off in an outbreak situation. If this is not possible, unwell people should not use common areas. If unwell people must share a room with others, strict handwashing and PPE procedures should be in place for anyone entering that room. If possible, separate toilet facilities should be allocated for affected people. If possible, ill people should be restricted to their room and for 48 hours after resolution of symptoms. This measure is intended to prevent susceptible individuals from becoming infected as norovirus immunity is known to be strain specific and short-lived.

If the outbreak is confined to one area, people in that area should avoid contact with people in unaffected areas. There should be dedicated people to look after ill persons and they should not be involved in food preparation. If dedicated people are not available, they should observe strict handwashing and use of PPE procedures when moving between ill and well people or affected and unaffected areas.

Training

It would be beneficial for all institutions, community settings and food establishments at risk

of norovirus outbreaks to provide a specific program of education and training for staff about management of such outbreaks. This could be incorporated in induction training programs and also be carried out at times of an outbreak occurring. Workplace education could include the following –

- cleaning and disinfection procedures
- isolation of affected persons
- transfer of ill persons
- exclusion of ill people
- importance of correct hand hygiene covering all hand surfaces for adequate duration, using the appropriate product and carried out at appropriate times
- personal hygiene, proper glove use and correct food handling practices for food handlers
- transmission of viral gastroenteritis and infection control procedures.

Staff should be able to identify the early signs of an outbreak and be prepared and know how to manage the outbreak and also how to minimise the risk of infection to themselves. The local public health agency can provide advice to institutions that are experiencing an outbreak and arrange for assistance from EHO. Equipment, staff and resources must be identified and accessible at all times.

During an outbreak, regular promotion of hand washing is recommended. In order for people to wash their hands during an outbreak they must have access to water, handwash (preferably liquid, not cakes of soap) or alcohol-based hand rubs or gels and disposable paper towels or single cloth towel. Where possible, staff need to have access to PPE and staff need to be trained in how and when to use them. Training on cleaning procedures is important. Employers should ensure that employees are properly trained in food safety as it relates to their assigned duties.

Management should support the recommendation that staff should not return to work for 48 hours after diarrhoea or vomiting stops. Staff should not feel compelled to return to work earlier for fear of losing their employment or due to staff shortages. This is particularly important where staff have a role in handling or preparing food. Many foodborne outbreaks of norovirus are the result of people working while they have symptoms of gastroenteritis.

Sharps

The principal risk of occupational exposure to infection of Hepatitis and HIV for most workers is from sharps injuries. Sharps should only be handled with appropriate designed tongs or similar equipment. If this is not available the sharp should be disposed of by holding the barrel of the syringe with a gloved hand. The sharp should be placed in a sealable rigid-walled, puncture-resistant container and the local council or health service should be contacted for collection/disposal information.

The following principles should also apply to the use and handling of sharps -

- ✓ Containers should be positioned at the point of use
- ✓ The person generating the sharp should be responsible for its safe disposal
- ✓ Sharps should not be passed by hand between workers
- ✓ Disposable sharps should be used when possible

Workers should be instructed not to -

- ➢ Bend, break, recap or otherwise manipulate needles
- ➢ Place their hands into areas where their hands or fingers are not clearly visible (eg. into garbage bags and crevices)
- ➢ Manually compress garbage bags, hold garbage bags close to their body
- ➢ Hold garbage bags by the base of the bag.

4.9 Manual Handling

Definition
Manual handling is any activity to lift, lower, push, pull, carry or otherwise move, hold or restrain a person or object.

Position Statement
Community Care Options is committed to the provision of a safe, healthy and productive workplace. Community Care Options recognises that manual handling tasks increase the risk of injury to staff, volunteers and clients, and will develop a range of procedures to reduce this risk.

Legislation
WH&S Act 2011

Aged Care Quality Standards
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 6 – Service Management*

NDIS Practice Standards
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal Activities*

DVA Notes for Community Nursing Provider

Objectives
The objectives of our Manual Handling policy are to –

- ✓ Maintain a safe and healthy work environment;
- ✓ Reduce the costs of manual handling injuries both to the organisation and
- ✓ individuals;
- ✓ Address any workplace factors which may increase the risk of manual handling
- ✓ injuries;
- ✓ Provide access to information on safe work procedures.

Operational Procedures
Community Care Options assist people with injury, age-related, physical and developmental disabilities to achieve and maintain optimum function. Work is undertaken in a diverse range of locations. Risk control strategies which eliminate or minimise manual handling must be balanced against the duty of care to clients to maintain dignity and develop independence. Clients often have complex care needs that require innovative and well planned approaches and these have to be implemented in ways that ensure workplace safety. Workers in this sector face many physical demands in addition to ‘lifting’ which forms only a small part of the manual handling that workers perform.

The manual handling of people, particularly assisting clients with daily activities such as personal care and mobility tasks constitute a large proportion of the manual handling activities performed by Support Workers in community care services.

Over 50% of all injuries in the health and community services sector 2006/2007 were related to manual handling, this indicates the risks associated with lifting, pushing, pulling, carrying, holding, moving or restraining people and objects during the provision of care are significant and require ongoing management. Most manual handling injuries are preventable through better approaches to managing risks.

The management of these risks is often complex as there are physical risks to the worker and client but also wider risks to the client of loss of independence and autonomy. There is interplay of many factors eg. social, medical, financial, psychological, relational and environmental which affects the level of complexity in managing manual handling risks. A risk control hierarchy needs to be implemented in the context of specific needs of clients. The challenge is to provide essential services to people and simultaneously meet WHS obligations.

Under the Code of Practice for Manual Tasks, organisations are required to manage manual handling risks in a systematic way by identifying hazards, assessing or quantifying the risks (if not known) and applying risk control strategies.

A consultative approach may identify the need for manual handling assessments in the workplace. Many lifting operations, for example the occasional lifting of a small, light object, will involve negligible manual handling risk**.** Risk assessment is an integral part of successful risk management and should take place as part of client assessment processes so that WHS controls are incorporated and implemented as part of clients' support plans.

Manual Handling injuries may result from:

- Moving, transporting, transferring clients
- Repetitive movements
- Lifting and carrying materials and equipment
- Working at incorrect heights
- Lack of physical space
- Heavy physical work
- Poor workplace design
- Poor postures and actions
- Sudden unexpected load bearing
- Fatigue
- Poor physical fitness
- No mechanical aids being used
- No training in manual handling techniques and the use of mechanical aids
- Unpredictable, changing, large loads

When assessing manual handling risks Support Coordinators/Care Managers should consider -

1. *actions and movements*
2. *the workplace and workstation layout*
3. *the worker's posture and position*
4. *the duration and frequency of manual handling*
5. *the load location and distance moved*

6. *weights and forces*
7. *the characteristics of loads and equipment*
8. *work organisation*
9. *the work environment*
10. *the worker's age, skill and experience*
11. *the clothing required*
12. *any special needs of the worker*

CCO will ensure that -

- ✓ all objects are, where appropriate and as far as reasonably practicable, designed, constructed and maintained so as to eliminate risks arising from the manual handling of the objects;
- ✓ work practices used in a place of work are designed so as to eliminate risks arising from manual handling;
- ✓ the working environment is designed to be, as far as reasonably practicable and to the extent that it is within the employer's control, consistent with the safe handling of objects.

If it is not practical to eliminate manual handling risks Support Coordinators/Care Managers must design the work activity to control them and if necessary -

- ✓ engage an Occupational Therapist to assess, recommend and train staff in any specific equipment needs.
- ✓ modify the design of objects or the work environment, taking into account work design and work practices;
- ✓ provide mechanical aids;
- ✓ ensure staff are trained in manual handling techniques, correct use of aids and minimal lifting procedures;

Manual handling injuries may be eliminated or minimised by –

✓ Eliminating the task (for example, use of a wheelchair taxi rather than lifting the client and the wheelchair into a car). ✓ Eliminating the task by the use of engineering controls (for example, changing the equipment or materials used). ✓ Reducing the amount of handling involved (for example, change work practices). ✓ Reducing repetitive work by introducing variations in work activities ✓ Altering the layout of work areas to avoid twisting, sideways bending or excessive reaching.	✓ Carrying smaller loads. ✓ Use of lifting devices. ✓ Maintaining and regularly inspecting all equipment used for manual handling tasks. ✓ Matching skills and abilities of workers with client needs. ✓ If client condition changes, reviewing manual handling procedures. ✓ Providing information and training on risk assessment and safe lifting techniques at induction and during in-service training programs.

✓ Reorganising storage areas so that heavier and frequently used items are stored between knee and shoulder height, ensure weight of products is manageable.	✓ Providing access and encouragement for exercise programs for staff.

Bariatric Clients

Larger clients (weight and/or size) especially when receiving services within the home pose even higher risks. It is essential that services assess the client's size regularly and ensure that equipment available matches the tasks undertaken. There are a number of suppliers who provide specific equipment for bariatric clients and these should be consulted when developing manual handling plans for such clients.

Community Care Options has a 'minimal lift' policy. The implications of this policy are that employees and volunteers are required to avoid manual handling whenever possible and if not possible to avoid, to utilise mechanical assistance whenever possible to undertake manual handling tasks.

The minimal lifting approach includes -

- ✓ providing adequate levels of appropriately skilled staff; consulting with staff on risk assessment and the development of control strategies, not just on the selection of equipment;
- ✓ the trial and purchase of handling equipment; providing appropriate mechanical lifting aids and equipment to assist staff in moving/transferring clients;
- ✓ the assessment of clients to determine their specific manual handling needs and standardising the method of handling;
- ✓ **prohibiting manual lifting (including team lifting) except in emergencies**;
- ✓ educating and training staff in correct use of aids and equipment, manual handling techniques, client assessment and risk assessment;
- ✓ encouraging appropriate client mobility and independence;
- ✓ enforcing the use of equipment, when required, through supervision and post-training support;
- ✓ reviewing work systems and practices to identify risks, eliminate unnecessary manual handling and improve work practices on an ongoing basis; designing facilities to support safe systems of work and safe handling of clients an equipment.

<u>Responsibilities</u>

Managers are responsible for –

- ➢ developing and monitoring this policy;
- ➢ ensuring that manual handling risk assessments are completed for all identified manual handling tasks in consultation with staff undertaking the activities;
- ➢ implementing manual handling risk control strategies;
- ➢ developing safe work procedures;
- ➢ ensuring that equipment is available and well maintained;

- providing adequate information, instruction, training and supervision to staff and volunteers on the risks of manual handling. Safe work procedures developed and the safe use of equipment provided.

Employees are responsible for –

- cooperating with CCO in the identification of any manual handling hazards and implementation of manual handling controls;
- following safe work procedures;
- utilising equipment provided for manual handling;
- attending training as required;
- reporting any manual handling incidents;
- calling an ambulance on 000 for any client's who experience a fall. DO NOT attempt to lift the client. They should be thoroughly examined before being relocated.

Staff Training

All CCO staff working with client's requiring Manual Handling undertake a number of buddy shifts with their Peer Mentor and are then assessed as competent in providing care and support to that client by an RN.
Manual Handling Competencies
OT engagement for assessment and Manual Handling strategies - annually.

Manual Task Guide for Carers - resource
Transferring people safely handbook - resource

CHECKLIST FOR THE MANUAL HANDLING OF PEOPLE

Complete the checklist by circling yes or no for each question. If you circle an answer which is highlighted a control measure is required.

Work Location: ……Date of assessment: …/…/…
People being assessed:
……..
Names of assessor(s): ……..

Working Posture	Circle yes or no		Control Measure
Back & neck – does the people handling action require repetitive movement or prolonged static positions with the back –			
(a) bent forward?	Yes	No	
(b) twisted?	Yes	No	
(c) bent sideways?	Yes	No	
(d) a combination of the above?	Yes	No	
Arms and shoulders – does the people handling action require repetitive movement or prolonged static positions with -			
(a) Extended reach in front?	Yes	No	
(b) Reaching above the shoulders	Yes	No	
Hand and wrist – does the people handling action require repetitive and/or prolonged forceful exertions while gripping equipment?	Yes	No	
Legs – is repetitive or sustained squatting or kneeling performed?	Yes	No	
Other postures – is a standing posture without walking sustained for long periods?	Yes	No	
Repetition & Duration			
Do people handling activities undertaken throughout the shift require frequent or prolonged actions involving the transfer, holding, supporting or restraining of the person?	Yes	No	
Does the worker perform the same or similar people handling actions throughout the shift?	Yes	No	
Is a physically demanding people handling task/action performed frequently during a shift?	Yes	No	
Is one posture required to be maintained for long periods?	Yes	No	
Work Area Design			
Are items of furniture, fittings and equipment on which people are positioned			
(a) At a height, or adjustable to a height, so that workers do not have to bend while handling people?	Yes	No	
(b) Of a width that allows easy access without	Yes	No	

reaching?			
Are items of furniture and fittings – (a) Positioned to allow easy access to people and give workers sufficient space for leg and feet movements and to turn their body when necessary? (b) Easy to move if necessary to allow space? (c) Designed so that workers can get their feet underneath? (d) Too wide for easy access to a person (a trolley or positioning equipment)?	Yes Yes Yes Yes	No No No No	
Have all items and fittings, which allow people to assist themselves been provided?	Yes	No	
Facilities – with regard to the design of areas where people are handled – (a) Is there adequate space in areas where handling aids or wheelchairs are used for easy movement? (b) Is the space around the toilets large enough for two workers to assist if required? (c) Are all doors (e.g. bedroom, bathroom, toilet), corridors and corners wide enough for handling equipment or staff to stand beside person to assist? (d) Is there sufficient room so that equipment can be used as intended? (e) Do all floor areas allow for easy manoeuvring of mobile furniture and equipment?	Yes Yes Yes Yes Yes	No No No No No	
Is handling equipment - (a) Designed for safe use (e.g. trolleys and wheelchairs with locking mechanisms etc)? (b) Easy to manoeuvre? (c) Stored close to where they are used and in an area with good access? (d) Able to fit into/through all necessary spaces?	Yes Yes Yes Yes	No No No No	
Does the vehicle design allow workers assisting people in vehicles – (a) Access from both sides? (b) Internal headroom? (c) Easy access for wheelchairs?	Yes Yes Yes	No No No	
Workplace Environment			
Do people have to be handled over surfaces which are – (a) Uneven underfoot? (b) Slippery or wet? (c) Protective from the weather?	Yes Yes Yes	No No No	

Does flooring on routes over which wheeled equipment and furniture will be pushed/pulled allow easy movement?	Yes	No	
Is the area in which a people handling task is to be performed cluttered or untidy?	Yes	No	
Is the workplace outdoors and requiring people to be handled over difficult terrain?	Yes	No	
Are there extremes of heat, cold, wind or humidity?	Yes	No	
Does noise interfere with communication?	Yes	No	
Is lighting adequate to perform handling actions or tasks?	Yes	No	
The handling procedure			
Is manual lifting or carrying a person required during a transfer procedure?	Yes	No	
Can the person be held close to the worker's body?	Yes	No	
Is a worker required to support all/most of the body weight of a person unaided?	Yes	No	
Is the person located – (a) On the floor or below knuckle height? (b) Above the worker's shoulder?	 Yes Yes	 No No	
Does the worker need to bend over to one side to assist a person?	Yes	No	
Is the person supported by one hand only?	Yes	No	
Is the person located where access or movements are restricted?	Yes	No	
Is the person pushed, pulled or slid across the front of the worker's body?	Yes	No	
Are there excess transfers in a task?	Yes	No	
Is excessive force applied during task?	Yes	No	
Are situations possible where people can fall or collapse to the floor?	Yes	No	
Characteristics of the person being handled			
Is the person – (a) Awkward to handle? (b) Bulky or blocking the view of handlers? (c) Difficult to grip (slippery or wet)?	 Yes Yes Yes	 No No No	
Is the person limited physically, for example - (a) Unable to assist? (b) Unable to weight bear? (c) Has reduced postural control/balance?	 Yes Yes Yes	 No No No	
Does the person have condition (s) which require special handling, for example,			

fractures, skin conditions, impaired motor control?	Yes	No	
Is the person – (a) Uncooperative through cognitive or behavioural problems or medication and likely to move around or go rigid? (b) Unable to communicate and understand when told what is to happen? (c) Unpredictable, likely to make sudden movements or lose their balance?	Yes Yes Yes	No No No	
Is the person – (a) Attached to medical equipment? (b) Positioned on handling equipment (such as wheelchair) which needs to be moved with them?	Yes Yes	No No	
Individual Characteristics of the Worker			
Does the worker(s) have the necessary competency to – (a) Perform heavy people handling tasks/actions? (b) Make decisions about how to handle people with specific problems for example, people unable to help or who are unpredictable? (c) Set up and use mechanical devices? (d) Assist with team handling in the tasks/actions ?	Yes Yes Yes Yes	No No No No	
Do the workers have any ongoing or temporary physical characteristics that indicate a limited capacity to perform the task/action?	Yes	No	
While performing people handling tasks, are workers wearing - (a) Clothing which restricts the worker in using the best working postures? (b) Footwear offering inadequate stability, support and traction with the walking surface?	Yes Yes	No No	
Does the required personal protective equipment increase the demands of the action eg. (a) Gloves interfering with type of trip used? (b) Foot-covers affecting traction with floor?	Yes Yes	No No	
Work Organisation			
Is the work load affected by - (a) Unexpected work load increases? (b) People handling tasks occurring frequently in one part of a shift? (c) Insufficient workers to assist when peak	Yes Yes Yes	No No No	

workloads occur, or to assist other staff with handling people?			
Is organised team handling available when no other alternative is possible?	Yes	No	
Are people handling tasks performed without planned rest breaks or the worker being able to take a short break when necessary?	Yes	No	
Are long shifts (over 8 hours) or overtime undertaken where work involves frequent people handling?	Yes	No	
Are handling aids – (a) Suited to the task and the person's condition? (b) Used on all occasions they should be? (c) Accompanied by adequate procedures on their safe use and introduced with training for casual as well as regular staff? (d) Not working well, or out of action due to needing maintenance? (e) Purchased only after consideration of their health and safety effect on workers during use?	 Yes Yes Yes Yes Yes	 No No No No No	
Are there adequate policies and procedures for- (a) Workers to report or fix unsafe equipment or environmental conditions? (b) Handling people as safely as possible during emergency evacuation?	 Yes Yes	 No No	

Comments:

……

……

Signature of assessor(s): ……..

Supervisor's review: ……Date: …/…/...

Manual Tasks Guide for Carers

Tips for Carers on Preventing Musculoskeletal Injuries from Performing Manual Tasks

WORKSAFE

Moving and Positioning of People

Competencies

Name

.....

4.10 Personal Protective Equipment (PPE)

Definition

Personal protective equipment, or PPE, is any clothing or equipment a worker uses for protection. It includes equipment such as gloves, hand sanitizer, goggles, ear plugs, respirators, safety harnesses, safety shoes, hard hats and sunscreen.

Legislation

WH&S Act
Code of Practice - Personal Protective Clothing and Equipment

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal Activities*

Operational Procedures

There are specific laws about using appropriate PPE in the workplace.

Employers/PCBU must provide PPE to workers and must not charge anyone for using the equipment. If contractors do not have PPE, it needs to be issued by the employer/PCBU.

Personal Protective Equipment (PPE) is a hazard control method and is a very necessary component of CCO's risk management approach to health and safety.

In order to offer support staff maximum safety when working in clients' homes, all support staff are provided with a personal protection kit. Support staff must ensure that the kit is always properly stocked and ask for replacement items in good time.

Staff are required to utilise PPE as per the WH&S Act, regulation, codes of practice and CCO policy and procedures for specific tasks as follows –

- ✓ gloves for the provision of personal care support, cleaning , food preparation;
- ✓ handwash as required – before and after service, before and after the provision of personal care, meal preparation, toileting, cleaning and first aid;
- ✓ masks and goggles if using hazardous chemicals or substances for cleaning;
- ✓ masks if the client or worker has any concerns re infectious disease ie flu like symptoms;
- ✓ apron if concern re transmission of disease through body fluids;
- ✓ sunscreen, hat and long sleeved clothing if working outside.

Contents of the personal protection kit

- ✓ 1 x Sanitary Hand Cleanser
- ✓ 1 x Box of Gloves
- ✓ 2 x Aprons
- ✓ 1 x pair Goggles
- ✓ 1 x Chemical Mask
- ✓ 1 x Large Snap Lock Bag (for dirty aprons/goggles to be placed in)
- ✓ 1 x Large Snap Lock Bag (for clean aprons/goggles to be kept in)
- ✓ 1 x Medium Snap Lock Bag (for chemical mask to be kept in)
- ✓ 1 x Medium Snap Lock Bag with list of Contents, Instructions for Cleaning and Replacement Forms
- ✓ 1 x cleaning instructions for protective equipment
- ✓ 1 x First Aid Kit

Available upon request – Cancer Council approved hat and sunscreen.

Cleaning protective equipment
Support staff are instructed to clean protective equipment regularly. Instructions for cleaning are part of the personal protection kit and also outlined in the Support Worker Manual. These are as follows -

Aprons -
1. Place dirty apron in Lock Bag marked “DIRTY” and seal.
2. Wash apron in mild soapy water.
3. Air dry or wiped dry with clean soft cloth.
4. Keep apron in Lock Bag marked “CLEAN”.

Goggles -
1. Place dirty goggles in lock bag and seal.
2. Thoroughly clean all surfaces with mild soap solution. Do not use any solvents on the lenses.
3. Carefully rinse all traces of soap solutions.
4. Air dry or pat dry with clean soft cloth or tissue.
5. Keep in Lock Bag marked “CLEAN” and seal.

Masks -
1. Must be replaced when filter becomes blocked.
2. Must be kept in Lock Bag provided.
3. Disposable masks to be changed between clients

4.11 Safe Driving Policy

Position Statement
CCO is committed to establishing a culture of safe driving and ensuring that staff and client's are as safe as possible when travelling in CCO or staff vehicles. Awareness of safe driving is important because traffic collisions are expensive. Besides injury and time off from work, there is the high cost of vehicle repairs and replacement. A corporate safe driving policy can reduce the potential for emotional trauma and loss of life.

Safe Vehicle Operated Safely
In order to be properly prepared for the task of driving safely employees should –

- ✓ be appropriately licensed
- ✓ understand the effects of fatigue, alcohol and pharmaceutical preparations
- ✓ know the current road rules
- ✓ understand and adopt safe driving practices
- ✓ respect the rights of other road users, including cyclists and pedestrians.

Safer Vehicles
Management will contribute to safety by ensuring that CCO vehicles encourage and enhance safe operations. This includes –

- ➢ vehicle features such as high visibility colour, airbags, daytime running lights, ABS brakes and extras
- ➢ systematic maintenance of fleet vehicles
- ➢ keeping records and following systems to ensure your compliance with, and effective operation of the organisation's safe driving policy and procedures.

Staff who utilise their own vehicles for work purposes must provide evidence of vehicle road worthiness through the provision of registration and insurance documents annually. Staff vehicles will also be checked at a minimum annually by the organisation to ensure that they are being maintained at an appropriate standard to ensure client and staff safety.

Driver and Passengers
There are four main factors that contribute to crashes and injuries on NSW roads. These factors are –

- ➢ Drink driving
- ➢ Speeding
- ➢ Fatigue
- ➢ Non use of seat belts

There are many other factors but research shows that these four are of greatest significance. To promote safe driving the corporate policy on these issues is as follows -

Drink Driving is Dangerous
A total ban on driving while impaired by alcohol, medications or illegal drugs. Staff must not consume alcohol while on duty or before commencing duties and must not drive while over the legal limit for alcohol.

Speeding: Its Only a Matter of Time
Around one third of fatal crashes in NSW involve speed as a major factor. Travelling faster than posted limits, or travelling faster than appropriate for the road conditions as the time results in crashes. Conditions such as drizzle, rain and heavy traffic are some that require a decrease in speed. Staff schedules should allow adequate time for travel between appointment or work commitments so as to avoid the tendency to speed, particularly in rural areas. The organisation would rather a staff member was late than that they exceed the speed limit. The organisation will not be responsible for fines incurred by staff through exceeding the speed limit.

Avoid Driver Fatigue
Another major contributor to fatal crashes is fatigue. Staff should avoid fatigue by planning schedules realistically, by being rested before departure, and by stopping for appropriate rest breaks. Staff should not drive during normal sleeping hours.

Wearing of Seat Belts
Seat belts should be used at all times by drivers and passengers in all vehicles. The use of seat belts greatly decreases the risk of injury in the event of a crash. The driver of the vehicle is responsible for all passengers wearing seatbelts.

Loss or Suspension of Licence
All personnel who drive on corporate business must hold the relevant, up to date driver's license. If the license of any staff member is ever cancelled or suspended this must be reported to your Manager.

Operating for Maximum Vehicle Safety
All vehicles (organisational and staff) must be maintained in a safe, clean and roadworthy state to ensure the safety of employees as well as other vehicle occupants (clients) and other road users.

Vehicle Presentation
The appearance of corporate vehicles reflects on the staff and the organisation. Therefore vehicles should be kept clean and tidy at all times. There are practical safety benefits to be gained from regular inspections of vehicles. Awareness of tyre conditions, clarity of the windscreen and knowledge of minor body damage can all be learned from keeping in touch with the vehicles condition. Any problems that could affect the safe operation of the vehicle should be reported immediately.

Vehicle Maintenance
Proper maintenance is an important element of the Safe Driving Policy. Brakes, tyres, suspension, lights, electricals, windscreen wipers and exhaust all contribute to safe

motoring. Staff are responsible for ensuring that correct servicing is carried out and all vehicle faults are rectified. It is important that tyre pressures be checked regularly.

Vehicle Operation
In order to operate a vehicle safely at least two important areas need to be considered -

headlights and mobile phones. Having 'lights on' during the daytime improves visibility to other road suers, including pedestrians.

The law requires that only hands free mobile phones be used, as research shows a mobile phone can be a dangerous distraction whilst driving. Staff should pull off the road when safe to respond to mobile phone calls.

Vehicles are an important business tool. The way that the vehicle is kept and the manner in which it is driven reflects on staff professionalism. A vehicle doesn't simply get staff to their job its part of their job.

4.12 Slips, Trips & Falls

Definition
Slips occur when your foot loses traction with the ground surface due to inappropriate footwear or walking on slippery floor surfaces that are highly polished, wet or greasy.

Trips occur when you catch your foot on an object or surface. In most cases people trip on low obstacles that are hard to spot such as uneven edges in flooring, loose mats, open drawers, untidy tools or electrical cables.

Falls can result from a slip or trip but many occur during falls from low heights such as steps, stairs and curbs, falling into a hole or a ditch or into water.

Slips, trips and falls are one of the highest causes of workplace injuries in the disability and aged care sector. Falls are the second most common cause of injury behind manual handling in the community services sector. During 2000/2001 falls accounted for 24% of permanent injuries for workers and 20% of temporary injuries (under 6 months), with falls from the same height accounting for approximately two thirds of those injuries.

Slips can be caused by slippery floors, loose gravel or other small items left on a smooth surface, uncleaned spillages or gripless shoes.

Trips may occur over objects lying on the ground or jutting out into aisles or paths, over pets, getting in or out of vehicles, or due to uneven surfaces, cracked paths or poorly marked or poorly lit steps.

Falls from a height can be from ladders, down stairs, due to insecurely guarded drops/ledges or from standing on chairs to reach an object.

Legislation
WH&S Act

Aged Care Quality Standards
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 6 – Service Management*

NDIS Practice Standards
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal Activities*
- ✓

The causes of such incidents can range from incorrect footwear, inattention, poor lighting or unpredictable work environment.

CCO has implemented a Falls Prevention Procedure to ensure that ‘reasonably foreseeable’ fall hazards are identified and eliminated or controlled in a manner consistent

with legislative requirements in order to reduce the risk of injury or death for all staff, volunteers, clients, visitors and contractors.

Identifying slip and trip hazards

Common slip hazards include -

- spills of liquid or solid material
- wet cleaning methods
- wind-driven rain or snow through doorways
- a sudden change in floor surface, for example joins between carpet and polished timber
- change from wet to dry surface
- dusty and sandy surfaces
- the incline of a ramp
- loose or bumpy flooring
- low light levels
- use of unsuitable footwear.

Common trip hazards include –

- ridges in floors or carpets
- worn floor coverings or broken tiles
- potholes and cracks in floors
- changes in floor level
- thresholds and doorstops
- floor sockets and phone jacks
- cables from power extension units
- loads that obstruct vision
- obstacles in traffic areas.

Selecting control measures— housekeeping

Good housekeeping helps prevent slips and trips. Examples of control measures include - :

- training staff to recognise slip and trip hazards and the importance of good housekeeping
- setting up standards and procedures storage and cleaning
- checking and storing usable inventories, discarding any unwanted items
- implementing safe systems of work and any relevant signage for timely and efficient reporting and clean up of spills
- providing sufficient rubbish or recycling bins
- using appropriate containers for rubbish if it is likely to contain sharp objects
- developing a cleaning schedule that assigns workers to take charge of cleaning workplaces, and

- encouraging workers to clean their workplaces daily before they leave, so far as is reasonably practicable.

Selecting control measures—safety training

All workers share responsibility for housekeeping and cleanliness at the workplace. Work health and safety training not only assists workers to become more aware of slip and trip hazards and the relevant control measures, but also helps to prevent injuries. Training should include:

- awareness of slip and trip hazards
- identifying effective control measures
- duties of workers.

Selecting control measures—personal protective equipment

Personal protection equipment (PPE) including slip resistant footwear should only be used:

- when there are no other practical control measures available (as a last resort)
- as an interim measure until a more effective way of controlling the risk can be used
- to supplement higher level control measures (as a backup).

When selecting and purchasing footwear consider whether it has good slip resistance properties, in addition to any other required safety features. For example:

- in wet conditions—the shoe sole tread pattern should be deep enough to help penetrate the surface water and make direct contact with the floor
- in dry conditions—the shoe sole tread pattern should be flat bottom construction which grips the floor with maximum contact area, and
- urethane and rubber soles are more effective than vinyl and leather soles for slip resistance. Sole materials that exhibit tiny cell like features will provide the added benefit of slip resistance.

Operational Procedures

a. Ensure Safe Access to Places of Work

Managers and supervisors must ensure safe access to all places of work. Workplace WHS inspections and good housekeeping practices must be implemented to eliminate or control potential slip, trip and fall hazards in the workplace.

Floors must be designed and maintained to be safe without risks of slips, trips or falls and with adequate lighting provided to enable safe movement around the workplace. Where any faults are identified they should be reported to management for rectification.

b. Identify Slip and Trip Hazards

Slips usually occur when there is a loss of grip between the shoe and the floor. Trips occur when a persons's foot hits a low object in their path, causing a loss of balance. Some factors that contribute to the risk of slips and trips include -

- tasks that create floor contaminants, either wet (eg water, oil) or dry (eg dust, paper);
- floor surface or illumination level not suitable for activities;
- footwear not appropriate to the task or work environment;
- inadequate cleaning arrangements/procedures/products;
- uneven floor levels, loose floor coverings and joints between flooring materials;
- storage of objects in walkways and traffic routes;
- distractions in the workplace;
- the need to rush tasks;
- environmental factors (e.g. wet weather, frost, heat or cold stress);
- individual factors (e.g. eyesight, medical conditions, certain medications, response to heat/cold/noise/stress).

Managers and supervisors must implement the Workplace's Risk Management Policy to identify, assess, eliminate or control, monitor and review slip and trip hazards in the workplace.

Risk control measures should be implemented in line with the Hierarchy of Controls.

Some possible risk control measures include -

- ✓ Enforce the wearing of rubber soled shoes
- ✓ Provide support workers with torches to use when visiting client homes or on community access when illumination may be low
- ✓ Request that support workers spend time removing any possible trip hazards before commencing work e.g. rug over cord, move boxes from corridors etc.
- ✓ Include the regular cleaning of floor contaminants in safe work procedures and housekeeping practices.
- ✓ Reinforce the need to watch where walking on a regular basis.

c. Prevent Falls from Height

Activities where there is a risk of falling from height (or into depth) include, but are not limited to -

- work on rooftop or ladders;
- climbing rocks, trees or walls;
- cleaning external windows;
- climbing stairs
- entering natural or man-made cavities and shafts, including confined spaces.

Managers and supervisors must implement the Workplaces Risk Management Policy to identify, assess, eliminate or control, monitor and review all such activities. It is essential that risk assessments and safe work procedures (or safe work method statements) are documented and training/instruction is provided.

Risk control measures must be implemented in accordance with legislative requirements

and the Hierarchy of Risk Controls. CCO does not allow its staff to work from heights. Where staff members are requested to complete a task that requires working from a ladder or height approval must be sought from management and an effective risk control measure ie step ladder used to minimise any risk of falls. Staff will decline completion of the task until such measures are in place.

d. Prevent Falling Objects

Activities where there is a risk of falling objects include, but are not limited to –

- raising or lowering plant, material and debris;
- storing objects on high shelves or rooftop;
- demolishing a structure.

Managers and supervisors must implement the Workplace WHS Risk Management Policy to identify, assess, eliminate or control, monitor and review all such activities. It is essential that risk assessments and safe work procedures (or safe work method statements) are documented and training/instruction is provided.

Risk control measures must be implemented in accordance with legislative requirements and the Hierarchy of Risk Controls -

- provide a safe means of raising or lowering objects;
- provide a secure physical barrier to prevent objects falling freely from a building or structure, or if not possible then provide measures to arrest the fall of objects;
- provide appropriate personal protective equipment.

4.13 Smoke Free Environment

To promote the health and safety of all employees, clients and users of Community Care Options' premises.

We all have a legal responsibility to provide a safe workplace. Staff who fail to consider the safety of others at work by not complying with the non-smoking policy may be personally liable to a fine under the Work Health and Safety Act 2011.

Community Care Options recognises the rights of clients and staff to smoke, but will actively support them to quit smoking if this is their choice. Quitline provides assistance and support for people to quit smoking, and can be contacted on 137848 or www.quit.org.au.

The smoke-free policy applies to all buildings and surrounding areas used in the dealings of the organisation, such as office buildings, training venues and clients' homes. It also includes vehicles owned by the organisation or used for organisational purposes.

This means that -

- Smokers are not entitled to smoke in the workplace even if staff in a particular area all want to smoke;
- Clients cannot smoke in their homes when CCO staff are present to provide a service;
- The organisation does not have a designated smoking area or smoking breaks;
- Staff are required to leave the work site if they wish to smoke, and must do so during their usual designated rest breaks;
- Staff cannot be disciplined when they smoke away from the workplace or during their own time.

Where a client is a smoker they will be requested not to smoke during service times. If the client is choosing to smoke whilst CCO staff are present, staff are request the client not to smoke, or to go outside and smoke. If the client is non compliant with this request the staff member should advise the client that they will leave the service and immediately ring the Support Planner or your Manager to advise of same.

NO SMOKING

4.14 Stress

Stress at work is a world-wide problem. Its implications extend beyond health and safety in the workplace, and can seriously disrupt people's lives. The International Labour Organisation (ILO) states that work should leave time for rest and leisure, for service to society, and for self-fulfilment and personal development. It says these goals are unattainable if workers' lives are dominated by occupational stress.

Common causes of work-related stress have been attributed to -

- Communication difficulties between workers and managers – lack of formal or effective communication or consultation structures or procedures with workers feeling unable to voice concerns or problems or feeling insecure if they do.
- Bullying, harassment or intimidation
- Work overload and underload – unreasonable demands, impossible targets,
- Inadequate time to complete jobs satisfactorily leading to a feeling of being overwhelmed or exhausted.
- Job insecurity – fear of redundancy, lack of permanency, short-term or casual contracts, lack of career opportunities, lack of recognition or reward for a job well done, particularly where the pay is low.
- Too much change – restructuring of workplace and the way work is organised.
- Inadequate staff levels – staff leaving and not being replaced with the rest of staff expected to pick up the workload.
- Inadequate resources – or equipment that is continually breaking down because it is poorly maintained or overdue for replacement.
- Unresolved health and safety issues eg. exposure to chemicals, noise, extremes of temperatures, exposure to potential violence whilst working alone.
- Excessive performance monitoring and surveillance
- Poor work organisation – lack of clear job descriptions, conflicting demands, too much or too little work, boring or repetitive work, no job satisfaction
- Insufficient training
- Dangerous hours – required to work overtime or through breaks. Shift rosters that are unpredictable or make it difficult to balance work and family life.
- Difficulty dealing with clients/general public due to abuse and threats of violence.
- Lack of control over how work is done – lots of responsibility but little authority or decision making, little or no say in how work is done.
- Exposure to prejudice regarding age, gender, race, ethnicity, or religion
- No opportunity to utilise personal talents or abilities effectively
- Chances of a small error or momentary lapse of attention having serious or even disastrous consequences
- Any combination of the above.

Stress is a natural reaction to excessive pressure. It's the name we give to the physical or emotional reactions that we experience when we feel unable to cope with the pressures or demands upon us. It isn't a disease, but if stress is excessive and goes on for some time, it can lead to mental and physical ill health.

Health and Safety problems arise when we are continually exposed to stressors at work and feel that we cannot escape or avoid them. Human beings react to the external world through complex physical, biochemical and psychological systems which interact with and affect each other. What happens to the body affects how we feel and think and our mental state can directly affect the way our body functions.

When exposed to external physical or mental demands or threats – or stressors – the human body automatically undergoes a series of physical and biochemical responses. This is sometimes called the 'fight or flight' response. It is a survival mechanism which provides a means of preparing to confront or to run away from threats.
Adrenaline and other hormones, cholesterol and fatty acids, are released into the bloodstream, the heart beats faster and the nervous system 'revs up'. We may perspire more, the muscles tense involuntarily and we breathe faster and more shallowly.
This stress response prepares the body for a short burst of physical activity, such as running. The body then quickly returns to a 'non-stressed' state. The stress response is not meant to be prolonged.

Chronic or prolonged stress results in the physical and biochemical changes being sustained over long periods. This affects our health, and can lead to an increase of cholesterol and fats in the arteries, a significant risk factor for cardiovascular disease. When faced with work related stress which we cannot overcome or run from a common reaction is to suppress our feelings and 'soldier on'.

Some of the physical and psychological symptoms which can be experienced include -

- Headaches
- Backaches and other muscular aches and pains
- Cramps in the neck, shoulders or arms
- Poor memory, difficulty in concentrating
- Feeling frustrated, irritable or angry
- Feeling weepy or tearful
- Loss of energy and motivation
- Feeling anxious, helpless or afraid
- Apathy and hopelessness
- Changes in appetite and weight
- Sleep difficulties
- Generally feeling worn out or run down

Chronic stress can cause or worsen a range of ill health problems which severely affect quality of life. These include -

- Asthma
- Psoriasis
- Peptic ulcers
- Digestive disorders and irritable bowel syndrome
- Sexual problems

- Depression
- Alcohol and drug use.

Over the long term,prolonged exposure to stress has been linked to serious illnesses, including –

- Diabetes
- Heart disease
- Suppression of the immune system cells involved in fighting cancer.

Fatigue
Fatigue is an acute or chronic state of tiredness which affects employee performance, safety and health and requires rest or sleep for recovery. Fatigue may affect physical and mental capacities and increase the risk of workplace incidents. It can also contribute to workplace conflict and absenteeism. Through a build-up of sleep debt, fatigue can result in errors of judgement that may lead to injury or death, affecting not only the employee, but the health and safety of others as well.

The fatigue factors that influence risk include -

- mentally and physically demanding work (very high demands);
- long periods of time awake (eg. long hours of work extended by long commuting times);
- inadequate amount or quality of sleep (eg. when 'on-call');
- inadequate rest breaks (eg. inadequate or poorly timed rest breaks or rest breaks where the environment is not conducive to rest);
- disruption of the body clock (eg. working when we would normally be sleeping);
- environmental stresses (eg. noisy or hot environments); and
- work requirements, work schedules or systems of reward (pay, recognition or promotion) that provide incentives to work longer and harder than may be safe.

Shift work
Research shows there are significant issues associated with fatigue from shift work. Many aspects of human performance are at their lowest levels during the night, particularly between 2:00am and 6:00am. Disruption to the body clock by working during these hours can affect behaviour, alertness, reaction time and mental capacity.
Prolonged night shifts can result in sleep debt, as sleep cycles are usually about two hours shorter when sleeping during the day after working a night shift. Day sleep and sleep during 'on-call' periods at night are usually of a lesser quality than night sleep.
Individuals adjust to shift work in different ways, so it is essential to consult your workers when putting together staffing arrangements and work schedules.

Prolonged fatigue can have detrimental effects on physical and mental health, for example, sleep disorders, mood disturbances, gastrointestinal complaints, headaches, depression, cardiovascular disease and irregular menstrual cycles.

Fatigued individuals in the workplace may complain of feeling drowsy or of headaches, and may show symptoms such as increased irritability, blurred vision, falling asleep at work, making mistakes or having near-misses, yawning, moving off track while driving vehicles or increased absenteeism.

Personal factors can contribute to work-related fatigue, for example, employees with multiple jobs or lack of sleep due to young babies. Not all the factors noted mean there is a risk of fatigue in the workplace, but where the work involves potential for fatigue, the employer must assess the risk to determine whether risk control measures are required.

Employers should ask applicants if they have another job and what it involves. They should also have a provision in the employment contract requiring employees to advise the employer if they take another position so that health and safety issues can be considered.

Management of Work-Related Stress

The majority of work related stress leading to psychological injury claims are not the result of a major traumatic event or critical incident. Most such claims develop over long periods, often in response to the interaction of a number of work related and other factors.

Under the Work Health and Safety Act 2011 a manager has a duty of care to ensure the well-being of its workers. Employees affected by stressors may be more likely to make mistakes that may result in other forms of injury. Action to reduce work related stress can be cost-effective. The effect of unmanaged workplace stressors may show up as high staff turnover, an increase in unplanned absence, workplace conflict, reduced work performance, customer complaints, staff replacement costs, and costly workers' compensation claims.

Psychological injury claims can have a significant impact on workers compensation premiums as they can involve extended periods of time off work, and higher medical, legal and other claim payments compared to other types of claims.

CCO will adopt a risk management approach to work related stress. We will identify sources of potential harm, through employee opinion surveys or data relating to absenteeism or workers compensation claims. We will assess the level of risk through systematically assessing the extent and causes of psychological injury and identify priority areas for action. In consultation with employees, middle and senior managers, we will develop and implement a plan to -

- Address the workplace factors that are risks to psychological injury (primary intervention)
- Minimise the impact of stress on employees by responding to warning signs and intervening early (secondary intervention)
- Provide safe and effective rehabilitation and return to work for individuals once an injury has occurred (tertiary intervention).

Most of the 'things to do' boil down to good management practices -

- staff are taken seriously when people admit to being under too much pressure
- staff have the skills, training and resources they need, so that they know what to do, are confident that they can do it and receive credit for doing it well
- If possible, provide some scope for varying working conditions and for people to influence the way their jobs are done. This will increase their interest in, and sense of ownership of, their work
- Ensure that people are treated fairly and consistently in line with the policies and practices in your agency and that bullying and harassment aren't tolerated at work, and
- Ensure good two-way communication, especially at times of change.

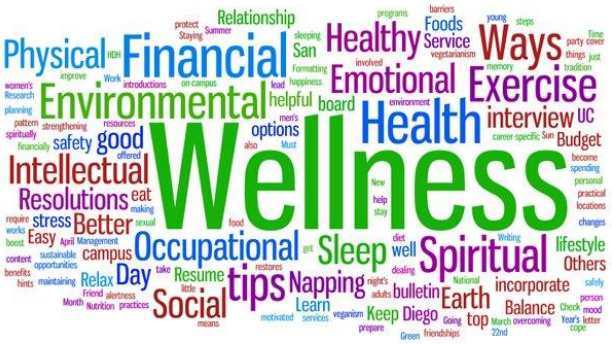
PREVENTATIVE STRATEGIES

Risk Factor or Indicator Identified	**Possible Solutions**
Change Management	*Provide effective leadership during periods of change* *Build the capacity of managers to support their employees through times of change* *Review how the organisation provides employees with information about proposed changes* *Establish consultation and communication process to engage employees in change and provide access to relevant support during changes*
Climate/Culture	*Focus on recruiting and developing supportive leaders with strong people management skills* *Use organisation development programs to improve the quality of leadership and people management practices (focusing on clarity around work expectations and objectives, strong employee engagement processes, good co-worker relations, goal congruence, provision of development-oriented feedback, and transparency and equity of organisational processes and procedures)* *Develop accountability for people-related outcomes at all levels of the organisation*
Communications	*Consider the systems in place for top-down communications (such as newsletter, briefings, regular meetings)* *Consider systems to provide staff feedback and staff involvement in decision-making – such as team and group meetings* *Consider systems to improve cross functional communications – such as forums to discuss common problems and solutions, and shared leadership and governance models.*
Co-worker Relations	*Identify the characteristics of teams that are working well within the organisation to help identify what can be done to improve workgroup interactions in areas with problems* *Establish clear job descriptions and task assignments, supportive*

	supervisory styles, participative decision making and prior agreed mechanisms to reduce conflict. *Don't ignore signs of conflict, and use EAPs or external mediators if help is needed to resolve issues* *Use work team projects to improve interactions, eg. A work-based project with focussed coaching so that new behaviours are integrated into the core business of the team* *Consider short-term secondments to and between work units to improve understanding of the work.*
Critical Incidents	*Develop and implement an organisational policy on critical incident response* *Provide access to practical, emotional and social support* *Provide factual information, monitor employee reactions* *Provide access to early intervention for employees who report distress*
Client-related	*Develop and implement policy and procedures that deal with threatening or inappropriate client behaviour to ensure that employees feel secure during interactions with clients (also see violence below)* *Provide professional role behaviour training to enhance an employee's ability to separate personal emotions from the inherent demands of the job. 'Role separation' may be important to coping with the unique stressors of disability services work.* *Focus on control/autonomy and social support as these have been recognised as important in determining the impact of client-related factors.*
Decision Latitude/Control	*Develop supportive leaders who delegate and encourage participation and initiative* *Encourage leaders to provide support when things go wrong – discourage the development of a 'blame culture'* *Use developmental programs and team projects to encourage initiative and involvement in decision making* *Ensure that regular team meetings are held that provide scope for employees to participate in decisions that concern their work* *Ensure that consultative mechanisms enable participation in broader organisational issues*
Harassment/Bullying	*Promote a supportive leadership culture that will not accept bullying and which encourages and acts on reports of such behaviour* *Develop and implement an organisation policy on harassment/bullying* *Clearly define the complaints process, inform and train managers and employees on their rights and responsibilities* *Develop support during any investigation process*
Performance Capacity and Career Development	*Review recruitment strategies to ensure that individuals are recruited, inducted and trained to have a clear understanding of work expectations, objectives and requirements, the skills and abilities to carry out their tasks competently, and appropriate support to enable them to do so* *Consider using probationary employment to assess suitability*

	Consider using mobility, mentoring and career counselling programs to better match individuals to jobs, broaden the skill base and assist in developing career paths *Use team based projects to broaden skills and develop responsibilities*
Performance Management	*Implement effective performance management systems with clear expectations and procedures that are understood by managers and employees. Aim for a two-way process, covering positive feedback on performance, areas for improvement, future goals and objectives and training needs* *Train* managers *to provide effective development-oriented feedback* *Encourage a culture of continuous feedback, rather than restricting feedback to performance reviews*
Role in Organisation	*Ensure roles and responsibilities are clearly specified, regularly reviewed and modified where necessary, in consultation with staff e.g. as part of the business planning process* *Where role conflicts emerge, review relevant roles and responsibilities. If current roles are appropriate, clarify these in consultation with staff. If not appropriate, establish revised roles in consultation with staff* *Avoid situations where an individual takes on dual roles where conflicts of interests might occur*
Workplace Violence	*Conduct a violence vulnerability audit, considering all the environments in which the organisation operates* *Develop a policy in relation to violence and aggression against employees, including a statement that violence is unacceptable and a commitment to prevention and support strategies* *Develop a control plan for any identified 'at risk' areas (e.g. clients do not have access to dangerous implements or objects that could be used as weapons or missiles, no ready access to cash/valuables/drugs on site). Take into account how staff move between working areas, parking lots etc* *Consider using architectural and engineering designs as part of the control plan for 'at risk' areas (e.g. use of safety glass, good internal and external lighting, escape routes planned to prevent entrapment of employees, duress alarms, communication devices etc)* *Ensure that risk controls cover employees exposed to violence (consider rations of staff to clients, training and experience, use of rotation to reduce exposure, procedures and back up for staff working alone or in areas of isolation, support and supervision).* *Ensure that procedures are in place to manage critical incidents, emergencies and evacuation nd that drills are used to test their effectiveness* *Where risk controls include security devices, ensure periodic servicing, testing and maintenance is carried out* *Investigate and assess all reports and threats, including near misses, and regularly review the effectiveness of controls.*

Boring, Repetitive Work	*Redesign jobs to increase the variety of tasks* *Use job rotation to increase task variety where redesign is not possible*
Shift Work	*Use best practice shift systems to minimise fatigue. Specifically, ensure that rosters permit adequate time between shifts for employees to arrive at work well rested.* *Avoid mandatory night shifts for older employees*
Workload	*Provide supportive leadership – regularly review workloads, prioritise tasks, define performance quality expectations, cut out unnecessary work, give warnings of urgent jobs, meet training needs, and encourage employees to raise and discuss problems so solutions can be developed* *Ensure that staff levels and performance capacities are adequate including to meet periods of peak demand* *Where practicable, give employees some control over the way they do their work* *Avoid unrealistic deadlines* *Where practicable, substitute heavy manual tasks with equipment to reduce physical workloads* *Avoid encouraging employees to regularly work long hours* *Put systems in place to respond to individual concerns. Consider where low morale, unsupportive leadership and poor work team climate are the real issues*
Work Pace	*Set reasonable work rate standards* *Ensure adequate work breaks and, where practicable, allow some flexibility in timing of breaks to match employee's needs* *Use job rotation to enable respite for employees working at fast pace.*



4.15 Sun Protection

Under the Work Health and Safety Act (NSW) 2011, CCO, is required to provide staff working outside with equipment to protect them from exposure to the sun. Employees are obliged to use this equipment safely and appropriately so you are protected.

Most of CCO services are provided in client homes, however there may be times when staff are required to be out with clients and should protect themselves accordingly.

Staff who are working outside can request CCO to provide them with a sun hat and a tube of sunscreen. Hats and sunscreen provided are both endorsed by the Cancer Council or Australia. Staff are required to store the sunscreen according to the directions on the packaging.

Staff are to take all possible care to protect themselves from the effects of exposure to the sun. The NSW Cancer Council recommends that sunscreen be applied when exposed to the sun. This organisation supports the recommendations of the Cancer Council as follows

- ✓ Sunscreen should be applied according to the directions on the tube. Sunscreen is rubbed across the skin, not into the skin. After you have applied sunscreen you should have a thin film of the cream still on your skin.
- ✓ Staff are required to apply sunscreen 5 mins before going out into the sun, as per directions on tube.
- ✓ Sunscreen must be reapplied as and when needed. Staff should refer to the directions on the tube if unsure.
- ✓ Staff are required to store and maintain the hat provided, to ensure that it is presentable and provides adequate sun protection.

Staff are required to wear a hat as follows -

- ✓ while working outdoors, eg taking clients for social support, hanging out washing, sweeping paths etc.

Other recommendations for sun protection
Staff are encouraged to wear a long sleeved shirt while driving, and while working outdoors.

The cancer council recommends that sunglasses be worn while outdoors. You should seek advice from the Cancer Council or your optometrist as to what is appropriate for you.

4.16 Working at External Locations/In Isolation

Working at external locations encompasses two main areas, working in the homes of clients and working in public areas. The information in this section should be read in conjunction with Manual Handling and Workplace Violence sections. Community care workers often confront additional risks when working in public places and in client's homes, as these environments are less predictable than centre-based environments.

Legislation

Work Health & Safety Act

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS Practice Standards

- ✓ *Core Module 1-4*

Working in a Client's Home

Working in a client's home is a common and significant part of services provided by Community Care Options. The homes of clients are workplaces whenever a worker is present during work hours. Consequently CCO and workers have workplace safety obligations under the Work Health and Safety Act and Work Health and Safety Regulation. Unlike centre-based service settings, a client's home is not directly controlled by the employer. Even so, many simple practices can be implemented to ensure the safety of workers.

A home visiting policy is in place as well as procedures for situations where a support worker is trapped in a client's home. The Model Code of Practice on Managing the Work Environment and Facilities recognises remote and isolated workers and provides guidance on risk assessment for such workers. Suggested controls depending on the risk include –

Buddy System – some jobs present such a high level of risk that workers should not work alone, for example working with clients with high manual handling or behaviour issues.

Workplace Layout and Design – workplaces and their surrounds can be designed to reduce the likelihood of violence, for example by installing physical barriers, monitored CCTV and enhancing visibility.

Communication Systems – the type of system chosen will depend on the distance from the base and the environment in which the worker will be located or through which he or she will be travelling. Most staff would have access to a phone in the client's home in the case of an emergency. Mobile phones are relied upon as an effective means of communication in most locations. Coverage in the area where the worker will work should be confirmed before work commences. Geographical features may impede the use of

mobile phones, especially at the edge of the coverage area, and different models have different capabilities in terms of effective range from the base station. Consult the provider if there is any doubt about the capability of a particular phone to sustain a signal for the entire period the worker is alone. If any gaps in coverage are likely, other methods of communication should be considered. It is important that batteries are kept charged and a spare is available.

Movement Records – knowing where workers are expected to be can assist in controlling the risks, for example call-in systems with supervisors or colleagues.

Training, Information and Instruction – workers will receive training to prepare them for working alone and, where relevant, in remote locations. For example, training in dealing with potentially aggressive clients, using communications systems, administering first aid, obtaining emergency assistance driving off-road vehicles or bush survival.

Home Assessment

CCO conducts an off-site check over the phone before an initial home visit. Support Planners to complete the First Home Visit Checklist before visiting client home. Thorough client and home assessments will assist in the identification of risks and minimise the likelihood of injury for workers.

Before commencing services important issues need to be considered such as access to the premises, whether the service user lives alone, and if there are any pets. It is important to ensure all relevant information about the environment in which the service will be conducted has been obtained. Responsibility for this environmental (or home) assessment rests with Support Planners/Care Managers.

Assessments of service user homes are done formally and documented using a consistent checklist. Where risks are identified Support Planners and others are responsible for developing a risk management plan to control the risks.

Support Workers where they observe or experience any risks that have not been identified on the risk management plan should complete a hazard/incident report form and submit immediately so that information can be updated.

A home assessment is a risk assessment to identify health and safety risks found in the physical aspects of the home in addition to the individual client assessment.

When working in a client's home injuries may result from –

Outside Home/Inside Home: *Slips, trips and falls (for example, are pathways level? Are there loose mats?are stairs in good condition?)* *Electrical Safety (for example, is the house fitted with an electrical circuit breaker? Are electrical appliances in good order?)* *Equipment available in home (for example, is the washing machine in good working order?)* *Infection Control (for example, are food preparation areas clean?)* *Chemicals (for example, are household cleaning products stored safely and labelled?)*	*Other areas (this assesses and considers other important aspects of supporting clients in their own homes):* *Do staff skills match client needs?* *Manual Handling (for example, transfers of the client from bed to wheelchair)* *Client initiated violence or violence initiated with others such as family members (for example, is there a known history of aggression?)* *Vehicle suitability if transport is a component of the support being provided.* *Workplace location (for example, is the service to be provided in an isolated location?)*

Once the assessment has identified the hazards and assessed risks in the client's home, the next step is to eliminate or reduce those risks. Hazards should not be seen as barriers to clients receiving services. Often ingenuity and lateral thinking by all concerned is required. Solutions do not always have to be expensive and elaborate. If the likelihood of injury is high, or the risk could cause a severe injury, eliminating or controlling the hazard should be a high priority.

Frequent, simple solutions can be found to control hazards identified in a home assessment. The assessment may identify a number of electrical appliances with frayed power cords. Negotiations about service delivery could include the client replacing or repairing damaged appliances which are required in providing support. It is important to explain safety issues and the need for repair or replacement of damaged appliances to the prospective client.

In situations where home modifications might be needed involving a significant cost to the home owner practical short term solutions need to be considered if a client or the client's carer initially refuses these modifications. In these circumstances, management needs to negotiate with the client and carer and discuss possible consequences of not performing the modifications required.

CCO provides all Support Workers with portable residual current devices (RCD) when working with electrical appliances in hostile environments. These should not replace the need for workers to visually check all electrical equipment for faults such as frayed cords or scorched plugs. If any fault is identified the equipment should not be used and the issue addressed by a supervisor and the client.

Tips for Home Visits

When providing support in an individual's home, irrespective of the support option, there are a number of key points that can be considered as tips for working in the client's home.

Before the Visit

- ✓ Make sure the office knows where you are going – stick to your roster
- ✓ Leave the following information -

  - Name and address of who you are visiting,
  - Time and length of visit
  - Agreed alarm password
  - Any change to your timetable
  - Your proposed route
  - Check the mobile phone is on and working
  - Take PPE if appropriate

Travelling to and from a Client's Home

- ✓ Keep the car doors locked while driving
- ✓ Have enough petrol
- ✓ Do not walk in deserted places or take shortcuts through vacant blocks
- ✓ Walk in the centre of footpaths

Arriving at the Visit

- ✓ Park car the way you will be exiting
- ✓ Do not enter if there are any unrestrained, potentially aggressive animals
- ✓ Be observant
- ✓ Check the locking mechanism on gate
- ✓ Before knocking listen for arguments, or anything that may make the situation unsafe.

After Hours Visit

- ✓ If the office is closed make sure someone knows where you are
- ✓ Always carry your mobile phone, know your non-signal areas and consider alternate communication options
- ✓ Leave if there is any evidence of a threat or serious safety issue for you as a worker
- ✓ If leaving drive your car to a safe area and ring your supervisor.

During the Visit

- ✓ Be cautious entering anyone's home
- ✓ If an unfamiliar person opens the door make sure the client is home before entering
- ✓ Be aware of and plan exit routes
- ✓ Only take into the visit what you really need
- ✓ Keep your keys and mobile phone on your person if there is an identified safety risk due to aggression.

After Visits

- ✓ Report any incident to your supervisor or manager
- ✓ Document incidents in the client notes and complete incident report form
- ✓ Always report to the office regularly
- ✓ Always report “near misses’
- ✓ Ensure your organisation has a procedure if you don’t return on time and call in at designated intervals.

 These steps can become a part of your daily routine, even with clients you know. If at any time a client’s circumstances change you should discuss the changes with a supervisor or manager to have another risk assessment completed. You also need to be aware of the organisation’s policies and procedures regarding high risk clients.

Working in the Community

Working in the community is a regular and significant feature of Community Care Options work. Working with clients in the community, has inherent challenges. When supporting clients to participate in community activities, there is only limited control over the external environment and there is an additional variable of interacting with members of the public. These challenges are heightened when supporting clients with complex or high behavioural support needs.

Location Assessment

There are many variations when working in the community, you may be supporting clients on a one-to-one basis or in group activities. One of the issues for workers in the community care sector is the genuine desire to assist clients integrate and participate in community activities like everybody else.

Any location that is used regularly in service delivery should be formally assessed with some type of documented checklist and preferably by more than one staff member for suitability for your client group. The venue should be reassessed if circumstances change or on a regular basis.

A location assessment is conducted to identify health and safety risks associated with particular venues in which people are supported in the community. These assessments are conducted in addition to individual client assessments.

A thorough location assessment will assist in the identification of risk and minimise the likelihood of injury for workers.

 Remember you may arrive at a location you use regularly to find there has been a substantial change to the location. Flexibility and understanding the basics of risk assessments are the keys to such unexpected dilemmas and may not mean any activity needs to be cancelled if modifications can be made.

Client transport
Working in the community also includes transportation of clients to venues, which adds new considerations regarding safety.

Transport: - how are clients travelling to the venue? Is a Support Worker transporting clients? Are they travelling independently using private or public transport? Transport may be required to support clients attending workplaces, medical or dentist appointments or to go shopping.

An assessment of transport needs and a safe work procedure for client transfers should be undertaken where a hazard exists.

Activities
What is the focus of the activity? Is it predominantly social with a community participation objective or is it a training component of a client's individual plan? An activity risk assessment as part of the venue assessment should be undertaken.

Variables
Variables may include noise or crowds due to school holidays or the time-of-day in which activities take place. Climatic conditions may affect individual client's capacity to manage in the environment. These and similar issues need to be considered in relation to a client's management plan or behaviour support plan, to identify potential triggers and alternate actions if required. Workers regularly identify risk associated with tasks that form part of formal learning activities. Most are familiar with the need to analyse and assess tasks to assist the client to acquire skills and move towards independence. The risk identification process used in formal training processes can be adapted to social activities for clients. This is particularly so when working with clients with an intellectual disability.

Whilst community locations are varied, a number of simple practices can be implemented to ensure the safety of workers. These practices are the same irrespective of the location. The key is to include risk assessment processes as part of everyday practice.

Tips for the Community Visit
When providing support to a client or group of clients irrespective of their support option, there are a number of key points that can be considered as tips for working in the community.

Communication
- ✓ Office knows activity location
- ✓ Workers have mobile phones
- ✓ Phones are checked before starting activity
- ✓ Mobile phones have emergency speed dial numbers

Transport
- ✓ Is the vehicle suitable for the activity?
- ✓ Client safety issues are considered

- ✓ Workers are trained in manual handling
- ✓ Vehicle has sufficient fuel, is in sound condition and has access to roadside assistance
- ✓ Procedures in case of accident are explicit and understood
- ✓ Vehicle is equipped with first aid kit
- ✓ Clients are seated appropriately to minimise aggression or conflict and are not seated directly behind driver.

Location

- ✓ Risk assessment conducted in relation to location.
- ✓ Parking is available
- ✓ Location is accessible to clients and workers
- ✓ Location is suitable for planned activities
- ✓ Emergency exits at location are known and appropriate.

Clients

- ✓ Clients are assessed prior to activities in the community
- ✓ Clients are aware of planned activities
- ✓ Client is willing to participate in planned activities

Staff

- ✓ Staff-to-client ratio matches support needs and planned activities
- ✓ Workers are familiar with client management plans
- ✓ Workers' skills match client support needs
- ✓ Staff are trained in emergency procedures.

Outdoor Work

Outdoor workers can be exposed to high temperatures and humidity. Risk factors for heat-related illness include -

- ➢ high temperature and humidity
- ➢ direct sun exposure (with no shade)
- ➢ limited air movement (no breeze)
- ➢ low fluid consumption
- ➢ physical exertion
- ➢ heavy personal protective clothing and equipment
- ➢ poor existing physical condition or health problems
- ➢ certain medications
- ➢ pregnancy
- ➢ lack of acclimatization to working outdoors
- ➢ previous heat-related illness; and
- ➢ advanced age (>65years).

Heat rash is a skin irritation caused by excessive sweating during hot, humid weather. The rash may appear as clusters of red pimples or small blisters and is more likely to occur on the neck and upper chest, in the groin, under the breasts, and in elbow creases. Powders

can be applied to increase comfort but ointments and creams should be avoided on affected areas.

Heat cramps usually affect workers who sweat profusely during strenuous activity. This sweating depletes the body's sodium and fluid levels. Low sodium levels in muscles can cause painful cramps. Heat cramps, which usually occur in the abdomen, arms, and legs, can also be a symptom of heat exhaustion. Generally, a healthy worker can take a break, drink juice or a sports beverage containing electrolytes, and/or eat a snack with water and the cramps will subside. These workers should avoid strenuous work for the next few hours because heat exhaustion or heat stroke could still occur if the body hasn't had sufficient time to recover. However, if the worker has heart problems or is on a low sodium diet, or if the cramps do not subside within an hour, professional medical care is needed.

Heat syncope is an episode of dizziness or fainting that typically occurs with prolonged standing or from sudden rising from a sitting or lying position when overheated. Dehydration and lack of acclimatization to working outdoors can contribute to heat syncope. Fainting can also be a precursor of heat exhaustion or heat stroke, and workers should take a break and slow down to give their body time to rehydrate and cool down.

Heat exhaustion is the body's response to an excessive loss of water and sodium, usually through excessive sweating. Symptoms of heat exhaustion can include headache, nausea, dizziness, weakness, irritability, thirst, heavy sweating, elevated body temperature, and decreased urine output. Workers affected by heat exhaustion should receive medical attention as it could quickly escalate to a life-threatening heat stroke.

Heat stroke (hyperthermia) is the most serious heat-related health problem. Heat stroke occurs when the body is no longer able to regulate its temperature. The body temperature rises rapidly and the body is unable to cool down. Symptoms of heat stroke include confusion, loss of consciousness, seizures, very high body temperature, and hot, dry skin or profuse sweating. Emergency medical treatment is urgently required.

Prevention is mainly related to maintaining hydration by drinking small amounts of water frequently (before becoming thirsty). If working moderately hard on a moderately hot day a worker should drink about 1 cup of liquid ever 15-20 minutes. If well hydrated urine will be clear or light yellow. Certain medications such as diuretics, antihypertensives and anticholinergic agents can increase the risk of heat-related illness and can result in the body heating up more quickly and taking longer to cool down. Such workers should pay extra attention to how they feel and how much they are exerting.

4.17 Workplace Violence

Definition
Workplace Violence is defined as any incident where an employee or employer is abused, threatened or assaulted in situations related to their work. Client-related violence is described as violence or aggression displayed by a client of a service, towards the workers, when trying to provide support services to the client.

Workplace violence includes acts such as physical assault, including spitting, verbal abuse or threats, threats with a weapon, sexual assault, robbery and vandalism.

Context
Occupational violence can take many forms including -

- client-related violence
- violence that is internal to the organisation involving violence between employees, managers, employers or volunteers
- violence to people in the workplace from the general public, eg, assault or robberies.

In the community services sector, the main threat of violence is from clients or residents.

Violent acts may include -

- ✓ verbal abuse, in person or over the telephone
- ✓ written abuse
- ✓ discrimination
- ✓ bullying and harassment
- ✓ spitting
- ✓ stalking
- ✓ threats
- ✓ ganging up, bullying and intimidation
- ✓ physical or sexual assault
- ✓ armed robbery
- ✓ malicious damage to the property of staff, clients or the organisation.

Under the Work Health and Safety Act (WHS Act 2011) and the Work Health and Safety Regulation 2011 employers must ensure the health, safety and welfare of employees in relation to violence in the workplace. Workplace violence is a significant WHS risk and is specifically referred to in the WHS legislation. Workplace violence should be recognised as a significant workplace hazard. Some of the risks associated with violence in the workplace include physical and emotional trauma, low morale, high staff turnover, financial costs, and lost productivity. WHS legislation requires employers to take all practical steps to eliminate, as far as possible workplace violence risks.

Commitment
CCO has a commitment to violence prevention. Violence should be viewed in the same way as other work health and safety risks. Employees have a duty to report incidents and to comply with organisational procedures to control the risk of violence.

Violence in the Community Services Sector
Community services workplaces have a high potential for violent incidents because they are often working with higher risk client groups and much of the work is carried out in the less predictable environments of home and community settings. Employees/ volunteers in rural and remote areas can be particularly vulnerable due to isolation and limited telecommunication support in some areas.

The term "challenging behaviour" is used to refer to client behaviours that are sufficiently frequent or intense that they may place at risk, the physical or psychological health of others in the in the workplace. Challenging behaviours can range from extreme withdrawal from relationships and activities to aggression directed at self or others. Examples of challenging behaviour include stereotypic behaviour, disruptive behaviour, self-injury and property damage.

Ongoing monitoring of client risk can be done to check the status of a client, not to exclude them. This provides an effective means of protecting staff and ensuring the most positive outcome for clients. A static or inadequate assessment system may stigmatise a client unnecessarily. Workers may be placed at greater risk where they have been advised of a client's risk potential but not provided with sufficient information as to the triggers to that violence.

Factors that may Contribute to Workplace Violence
The following factors may be associated with elevated risk of aggression experienced by employees and volunteers and other clients in the community services sector.

Conditions and disorders -
- poor management of mental illness
- antisocial/borderline personality traits
- delirium
- neurological disorders, head injuries
- confusion, disorientation or dementia
- hypoglycaemia
- epilepsy
- drug and alcohol withdrawal.

Frustration -
- feeling powerless or ignored (eg perceived delays or poor quality service)
- concerns or requests not adequately handled
- difficulty communicating
- humiliation, rejection
- marginalisation.

Fear -

- anxiety
- homophobia
- racism.

Decreased inhibition -

- neurological disorders
- intoxication/disinhibiting medication
- use of illegal drugs
- poor impulse control (eg in some people with a developmental disability & ABI)
- obsessional behaviour.

Stress -

- loss and grief
- frustration or helplessness
- pain
- agitation.

Material gain -

- money, drugs or valuable goods.

Non-material gain -

- power or position
- sexual gratification
- retribution for perceived injustice or inequality.

Violent or aggressive behaviour on the part of a client in the workplace may result from both client and staff related issues -

- Communication difficulties e.g. inability to express needs verbally to carers
- Health problems eg. physical illness, pain
- Fear eg. not being informed of changes
- Environment eg. amount of people, noise levels, room temperatures
- Emotional, psychological, psychiatric eg. feelings of frustration or depression
- Poor self-esteem
- Experience of abuse
- Limited knowledge or lack of information provided to staff about triggers for individual client
- Unsuitable workplace practices eg. often organised for group management rather than individualised activities e.g. set times for meals, activities with little flexibility, no opportunity for client choice
- Poor match between staff skills and client needs
- Behaviour support plan not updated or followed.

Client related violence in the workplace may be minimised by **-**

- ✓ Thorough assessment procedures with new clients
- ✓ Behaviour Support Plans (BSP) where appropriate dependent on the risk assessment
- ✓ Staff trained, supported and following Behaviour Support Plans
- ✓ Client Management/Individual Plans updated and reviewed regularly. Staff informed of changes
- ✓ Reassessment procedures if client circumstances change and review of client
- ✓ management /individual plan on a regular basis
- ✓ Provision to clients and their carers of information about rights and responsibilities including their responsibilities to behave in an appropriate manner
- ✓ Provision to clients and carers of information about the possible consequences of violent and aggressive behaviour eg. restricted support, increased costs due to need for two workers
- ✓ Matching of skills and abilities of staff to client needs
- ✓ Provision of information and training to staff as part of induction and ongoing training programs. This should include identification of precursors to violence and
- ✓ aggression, the role of behaviour support plans and complaint and grievance
- ✓ handling
- ✓ Adequate staffing levels
- ✓ Appropriate client placement.

Know Your Client
When working with a client with behavioural support needs it is important to be very familiar with and consistently implement their behaviour support plan. The goal of the plan is to prevent or minimise the risk of a violent or aggressive behaviour on the part of the client, ie. one client may verbally threaten staff but will never escalate into physical violence, and other clients may threaten and act on the threats. This knowledge assists a worker to make judgements about the seriousness of some client situations.

General Behaviour Identification, Recognising the Basic Signs
It is important as workers that we identify behaviours that may indicate the potential for client related violence or aggression; early identification increases the possibility of de-escalating the situation.

A client may appear to be frowning, agitated or irritable. At other times a client may appear to be clenching their fists and making verbal threats, or a client may be pushing other clients and staff, throwing items or furniture and trying to do physical harm to others.

The behaviours described may not necessarily appear in any order and it is important to be aware of these signs in context with the client and the environment.

Verbal Cues Include -

- Raised voice
- Threats
- Repetitive statements by the client
- Racist, sexist and other types of verbal abuse

Non-Verbal Cues Include -

- Agitated movements
- Threatening gestures
- Eye to eye staring
- Standing very close
- Banging on the furniture
- Clenching the fists
- Towering posture
- Withdrawal

What Action to Take?
The action you take in the event of client related violence will depend on a number of factors such as –

- your knowledge of the client.
- the existence of a management plan and critical incident response plan.
- your level of experience and training.
- the level of violence and your perception of the immediate threat.
- other staff available for assistance.

A useful strategy for assessing a situation is by using the THREAT model

T	Do I feel **T**hreatened?
H	Am I **H**idden?
R	Am I at **R**isk?
E	Is there an **E**scape route?
A	Can I raise the **A**larm?
T	Am I working at a risky **T**ime?

Cooling Down the Situation
Workplace procedures and practices are geared to preventing violence and aggression. It is always preferable to have a pro active approach to preventing violence and aggression, irrespective of the client you are working with. Only a small percentage of the clients have violence and aggression as some component of their behaviour. Like everybody else in the community there is potential, given the right circumstances and stresses, for any client to

become aggressive or violent. In many instances client-related violence does not escalate past verbal aggression and threats.

The background to violent or service users' aggressive behaviour may be many faceted and complex. The reason for a particular behaviour may be difficult to identify and occasionally the cause of behaviours cannot be identified.

If the client is irritable, agitated, verbally threatening, you need to assess the situation to identify the purpose behind the behaviour. The client may be unwell, they may be having difficulty with another client, or they may have had a visit by a family member cancelled. A client behaviour plan should outline the preliminary steps. Use non-aggressive language when talking to the client and take a non-aggressive stance. Continually assess the situation in case it escalates to physical violence.

Remember
It is important to remain as calm as possible and know your options.

You should leave the situation when -

- ✓ you feel you do not have the skill to deal with the situation
- ✓ your deescalating attempts are not working
- ✓ you endanger others by staying
- ✓ when you are alone with an actively aggressive or violent client.

If the situation is moving towards physical violence, without putting your own safety at risk, try to reason with the client using non confrontational language, and utilise the client's behaviour support plan or management plan for the behaviour. Do not try to physically stop them damaging property and do not try to restrain the individual. Be ready to leave if you cannot de-escalate the client's behaviour and there is risk of physical harm or lives are at risk. You may have to call the police.

Remember the busier you are the more at risk you are because -

- ➢ you do not notice the early warning signs of violence
- ➢ you may take less time to clarify a clients problem before acting
- ➢ you may be more vulnerable to taking unnecessary risks.

Workplace violence may also include incidents of bullying and harrassment whether initiated by a client or family members or by another staff member. Such incidents are as unacceptable as actual violence and management has systems in place to prevent where-ever possible and to assist staff who report such incidents.

Hazard identification and risk assessment are pivotal components of a comprehensive behaviour assessment and risk control strategies associated with an identified behaviour should be included in behaviour support plans.

If a violent incident does occur, there are response procedures (such as, giving first aid, supporting persons affected, counselling) in place for those involved to minimise the impact of the event. Reporting and documenting the incident is also a requirement after an incident. Documentation and reporting allows management to review incidents and reassess the controls to eliminate or reduce the likelihood of a reoccurrence of a similar incident. Access to an Employee Assistance Program or trauma debriefing is available if required.

Risk Control Options

This section outlines practical ways to eliminate or minimise violence and aggression in the workplace. The following are some risk control strategies that are in place at CCO.

- ✓ we undertake adequate assessments so that a suitable support plan is developed
- ✓ we develop an Incident Prevention and Response Plan where required
- ✓ we ensure staff receive training in managing challenging behaviours as required
- ✓ we provide a secure work environment -
    - externally, buildings are well lit, and have ready means of access and egress
    - and are maintained to be free of possible hiding places for aggressors;
    - equipment that could be used as a weapon is removed or restricted;
    - business hours are restricted to safe times and locations
- ✓ we have installed and use physical barriers and security systems -
    - we provide a workplace that has service counters that act as a barrier to physical contact between clients and staff;
    - we have duress alarms;
- ✓ we ensure effective management including selecting the right people for the job, fair
- ✓ employment conditions, training, employee consultation and regular supervision.
- ✓ we promote the fact that harassment and bullying will not be tolerated and will result in disciplinary action;
- ✓ we provide effective management and supervision – we know where workers are and what is happening in the workplace, both immediately and in the longer term;
- ✓ we have developed and implemented grievance procedures to allow reporting and
- ✓ action.
- ✓ we change the method of contact between clients and employees to a “remote” service ie use telephone or correspondence instead of face-to-face interaction if the risk warrants this.
- ✓ we ensure that work systems and service do not provoke aggression from clients -
    - provide reasonable waiting times and facilities;
    - ensure staff are trained in violence detection and management including
    - complaint and grievance handling
    - provide clients with information about rights and responsibilities including their
    - responsibilities to behave in an appropriate manner.

4.18 Reportable Incidents

Definition
Section 73Z(4) of the NDIS Act defines a *reportable incident* as –

- the death of a person with disability
- serious injury of a person with disability
- abuse or neglect of a person with disability
- unlawful sexual or physical contact with, or assault of, a person with disability
- sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity
- unauthorised use of a restrictive practice in relation to a person with disability.

Position Statement
Reportable incidents can threaten the health, safety or wellbeing of people with disability, and can have a significant impact on people with disability, workers, families, carers, community members and CCO.

Reportable incidents provide an opportunity for CCO to review our operational practices to improve the quality and delivery of supports and services to NDIS participants and prevent future harm.

CCO are committed to the following objectives promoting -

- timely and effective responses to reportable incidents to address the safety and wellbeing of people with disability.
- effective and appropriate monitoring and investigation of reportable incidents.
- learning from reportable incidents and patterns of incidents, to reduce the risk of harm to people with disability, and improve the quality of supports and services.
- accountability of CCO to people with disability.

Legislation
NDIS (Incident Management and Reportable Incident Rules) 2018
Aged Care Serious Incident Response Scheme

CCO is required by law to have appropriate systems in place to respond to any incidents that occur or are alleged to have occurred in connection with the provision of supports or services to a person with disability. The law also requires that we notify certain types of incidents to the NDIS Commission. These incidents are referred to as ‘reportable incidents’. The incidents defined above.

Principles

CCO adheres to the following principles in dealing with reportable incidents.

Centred on people with disability	Management of an incident is respectful of, & responsive to, a person with disability's preferences, needs & values while supporting the person's safety & wellbeing.
Outcome focussed	Management of an incident should reveal the factors which contributed to the incident occurring, & seek to prevent incidents from reoccurring, where appropriate.
Clear, Simple and Consistent	The process for dealing with reportable incidents is easy to understand, accessible & consistently applied.
Accountable	CCO are responsible for appropriately managing the response to reportable incidents. Everyone involved in the management of a reportable incident understands their role & responsibilities, & will be accountable for decisions or actions taken in regard to an incident.
Continual improvement	The incident management process facilitates the ongoing identification of issues & implementation of changes to improve the quality & safety of NDIS supports & services.
Proportionate	The nature of any investigation or actions following an incident will be proportionate to the harm caused & any risk of future harm to people with disability.

Operational Procedures

For an incident to become a reportable incident it must satisfy the following requirements –

- the incident must involve an act, event or omission defined in section 73Z(4) of the Act and section 16 of the NDIS (Incident Management and Reportable Incidents) Rules 2018.
- the incident must have occurred or is alleged to have occurred in connection with the provision of supports or services by CCO.

CCO must notify ***all*** reportable incidents (including allegations) to the NDIS Commission, even where we have acted and responded appropriately.

A failure to comply with the requirement to notify, investigate and manage reportable incidents is a breach of our conditions of registration and may lead to compliance and enforcement action by the NDIS Commission.

Roles and Responsibilities

All CCO staff are responsible for work health and safety. It is everyone's responsibility. CCO's incident management system sets out the roles and responsibilities of all workers in identifying, managing and resolving incidents and in preventing incidents from occurring.

All staff who are advised that a Reportable Incident may have occurred are to contact the CEO immediately.

The CEO will retain responsibilities for notifying the NDIS Commission that a reportable incident has occurred. The CSM or Operations Manager may report in the CEO's absence.

Categories of Reportable Incidents
The definition of *reportable incident* captures not only confirmed incidents that have occurred, but also allegations of incidents.

In connection with the provision of supports or services
The phrase *'in connection with'* is broad. It covers reportable incidents that may have occurred during the course of supports or services being provided, altered or withdrawn. However, an incident does not necessarily have to occur at the time that the supports or services are being provided to meet the '*in connection with*' requirement.

While not exhaustive, the type of incidents that will be considered to have occurred *in connection with* the provision of supports or services include –

- when a person with disability is receiving a support or service (for example, where a person with disability is receiving care from a worker).
- when a person with disability attends the premises of CCO, or where the support or service is 'off-site', and an incident occurs at the location where those supports or services were provided.
- where a person is receiving funded supports at home.
- where a person with disability is in residential care.

CCO's Incident Management Policy identifies the action steps to be taken in assessing the severity of any reported incident/hazard. The same immediate response is required.

CCO's Response Plan for Incident Management is as follows -

Immediate Action	
Office Staff Member receiving call is to ascertain & record the following -	
Names	That all people present are safe.
	If the staff member is injured.
Injuries	If the client or other parties are injured.
First Aid	If First Aid or Emergency Medical Attention is required
	Whether the staff member left the situation or are still present
	What assistance the staff member may need
	If there are any immediate risks to others because of the incident
	If so who -

Description of incident to be recorded as reported, on CCO's Hazard/Incident Report Form

Other details as per form – date, time, location, witnesses, action taken by the CCO employee

ACTION	**Where the incident fits within the criteria identified as critical in this policy the Receiving staff member will report the situation/incident immediately to a Senior Manager – Client Services Manager, Manager People & Culture, CEO.**
	Reportable incidents are to be advised to the CEO immediately. **The CEO, CSM & Manager People & Culture have delegations for reporting to the NDIS Quality & Safeguards Commission & will complete this action.**

Remedial Action	Both corrective & preventative
Manager receiving Incident /Hazard advice will ensure the following -	
	Follow up with client regarding their health, safety and wellbeing by the CSM, Program Manager, Care Manager, Support Coordinator or Service Coordinator as appropriate & available – same day. Ascertain if any additional supports or services required.
	Follow up with the staff member regarding their health, safety and wellbeing by the Operations Manager, Support & Development Manager, Service Coordinators Support & Development as appropriate & available – same day. Action W/Comp notification if required due to lost time Action any roster changes
	Ascertain any further details that may be required for mitigation of future risks
	Process Hazard/Incident Form for registration, action

Supporting participants in the period after a reportable incident
CCO will play an important role in helping clients after a reportable incident occurs. Workers need to be aware of the impact of trauma on clients, and help to link them to the additional support services they may need. It is important that alleged victims are not repeatedly questioned or told that the impact of their disclosure is that the worker or participant will get into trouble.

Many jurisdictions have Charters or Declarations that set out the rights of all victims of crime, and how government agencies and providers should support victims.

Therapeutic supports
Trauma can be caused by one incident or many incidents. It can result in clients continuing to feel unsafe, even long after the event. Many people with disability experience trauma due to many events over their lives. This includes life-long discrimination and bullying;

separation from their family; lack of control over their life; and experience of abuse and/or neglect. If the person has difficulty communicating, it can be harder to deal with trauma.

Responses to trauma can include that the client –

- is less able to control their emotions and urges, such as anger
- self-harms
- has chronic guilt or embarrassment
- has difficulty trusting others
- is less able to do things for themselves
- increases showering, and
- has more incontinence and smearing.

It is important that CCO delivers support that is 'trauma-informed'. This includes providing a safe environment; communicating openly and respectfully; helping clients to have maximum choice and control; and linking them to trauma services, such as counselling.

CCO Managers will be responsible for finding an appropriate counsellor who has the skills to work with the person. It is important to remember that not all counsellors have experience in working with people with intellectual disability.

Support for participants in the criminal justice system
People with disability are vulnerable in the legal system. They often have limited access to protection and justice as victims and offenders.

While legislation differs in each jurisdiction, when police take someone into custody who they suspect is a vulnerable person, a support person should be contacted. People with intellectual or physical disability are generally considered to be 'vulnerable persons' by police.

One role of the support person is to help them to get legal advice. It is the right of a participant, whether they are a victim, witness or alleged offender, to decline a police interview. You should know which organisations can provide criminal justice support, including giving free legal advice to suspects with intellectual disability.

Record Keeping
CCO must keep records of all reportable incidents that occur or are alleged to have occurred for a period of seven years from the date of notifying the NDIS Commission. A completed reportable incident notification form is sufficient for this purpose, but CCO is aware that we may have other obligations under Commonwealth, state or territory law to keep records about reportable incidents, particularly if they relate to an alleged crime or an incident under work health and safety laws, and so will maintain all records in relation to all reportable incidents.

CCO will also retain records of investigations (including records of interviews, evidence collected, any relevant correspondence, investigation reports and outcomes).

Key personnel, managers or other people specified in CCO's incident management system are the individuals that will be responsible for creating and maintaining incident records, while CCO will be required to retain them.

Minimum requirements for reporting/record keeping include –

- a description of the incident, including the impact on, or harm caused to, any person (including a person with disability, an older person, a staff member, other)
- whether the incident is a reportable incident
- if known, the time, date and place at which the incident occurred or if not known, the time, date and place at which the incident was first identified
- the names and contact details of the persons involved in the incident and any witnesses to it
- the actions taken in response to the incident, including action taken to support or assist a client (person with disability or older person) impacted by the incident
- if an investigation is undertaken by CCO in relation to the incident —the details and outcomes of the investigation, and
- the name, position and contact details of the person making the record of the incident.

Additional data and information may be required in undertaking an investigation/ assessment of a reportable incident. Other parties may be involved and have priority in investigating the situation eg police, coroner. Staff members to ensure that all details recorded accurately.

Categorising for management reporting
Staff Members receiving Hazard/Incident Reports are to assess incident severity eg is it a reportable/critical incident? to identify priority of reporting to Senior Management including CEO.

Any incidents falling into a reportable incident category are to be notified to the CEO immediately on the day of occurrence/notification.

The CEO or delegated Manager will provide advice to staff involved in the incident with regard to the following -

- **notification of police or emergency services if they have not already been advised**
- **notification of next of kin, family, carers, guardian**

Incidents resulting in an injury to a CCO employee are to be notified to the Manager People & Culture immediately on the day of occurrence/notification.

Where the identified Manager is not available for reporting via phone, email or in person, then the staff member is to report the incident to their immediate Manager eg CEO, or another Manager, if the CEO is unavailable.

Notifying the NDIS Commission of a reportable incident
If a worker becomes aware of an incident, they have a duty to notify one of the following as soon as possible –

- a member of CCO's key personnel
- a supervisor or manager of person
- the person specified in the incident management system who is responsible for reporting incidents that are reportable incidents to the NDIS Commission.

This person is the CEO – Deb Ryan.
In her absence the Client Services Manager and Manager People and Culture may carry out this function. The CEO has a duty to take all reasonable steps to notify the NDIS Commission.

Notification Timeframes
All reportable incidents, except for the unauthorised use of a restrictive practice, must be notified to the NDIS Commission within 24 hours of CCO becoming aware of the incident.

Any unauthorised use of restrictive practices must be notified within 5 days.

CCO will be taken to have become aware of an incident once a person employed or otherwise engaged by CCO has notified one of the following -

- a member of CCO's key personnel
- a supervisor or manager of the person
- the person in the incident management system who is responsible for reporting incidents that are reportable incidents to the NDIS Commission.

Notifications
The notification should be made in writing, by completing a form approved by the NDIS Commission and returning it to the NDIS Commission via email. The Department of Social Services has also commenced the development of an online system for notifying the NDIS Commission of reportable incidents.

Information Required by the NDIS Commission
The CCO reporting officer must provide the following information to the NDIS Commission where it can be collected –

- the name and contact details of – CCO
- the person making the notification
- the name and contact details of – the persons involved in the incident (alleged victim and alleged offender)
- a description of the reportable incident – including the nature of any injuries sustained, and details such as time, date and place it allegedly occurred
- a description of the impact on, or harm caused to, the person with disability
- (Note: where the reportable incident is a death this does not need to be provided)

- the immediate actions taken by CCO in response to the reportable incident including – any actions relating to the health, safety and wellbeing of the client, involved in the incident including medical treatment provided, or whether the incident has been reported to the police or any other body.

If particular information described in the form is not available within 24 hours of relevant personnel becoming aware that a reportable incident has occurred, remaining information may be provided to the NDIS Commission within five business days.

CCO has **five business days** to notify the NDIS Commission of –

• the names and contact details of any witnesses to the reportable incident (including workers, participants or third parties)
• any further actions proposed to be taken (by CCO) in response to the reportable incident.

The NDIS Commissioner will acknowledge receipt of the notification within 24 hours of receiving the additional information.

Police or other Sensitive Matters
While a report of an incident is required by the NDIS Commission, CCO is not required to notify the NDIS Commission of certain information if collecting that information would, or could reasonably be expected to, prejudice a criminal or investigation into the reportable incident, or cause harm to a person with disability.

Registered providers are required to investigate reportable incidents
Registered providers are required to appropriately assess and/or investigate all incidents having regard to the views of any person with disability impacted by an incident and including the following –

- whether the incident could have been prevented
- how well the incident was managed and resolved
- what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their impact
- whether other persons or bodies need to be notified of the incident.

The nature and extent of this investigation will differ depending on the circumstances of the incident or allegation.

A police investigation takes priority over a reportable incident investigation. CCO must obtain clearance from police before taking any action that might compromise the investigation. CCO are required to manage any ongoing risk and should maintain an open dialogue with police about any investigation they are conducting.

Investigating reportable incidents is a complex process. Internal and external investigators **must be appropriately trained** in conducting serious workplace investigations, including

investigating serious incidents that may involve a criminal element. The CEO will determine the appropriate person (including external sources) to investigate based on individual circumstances.

Providing the NDIS Commission with a final report
CCO will be required to give details to the NDIS Commission in connection with any internal or external investigation or assessment that has been undertaken in relation to the reportable incident, including –

- the name and position of the person who undertook the investigation
- when the investigation was undertaken
- details of any findings made
- details of any corrective or other action taken after the investigation
- a copy of any report relating to the investigation
- information about whether persons with disability impacted by the incident (or their representative) have been kept informed of the progress, findings and actions relating to the investigation or assessment
- any other information required by the NDIS Commission.

The details outlined above should be included in the final report to the NDIS Commission which must be provided within 60 business days following the intiial notification. The NDIS Commission may extend the period for providing the final report - eg if there is a concurrent police investigation, the reportable incident will be justifiably delayed.

Corrective action
Corrective and restorative measures may be taken following a reportable incident, regardless of whether or not an investigation has occurred.

At a minimum, CCO will consider whether any corrective action would reduce the risk of future reportable incidents. It is acknowledged, that there may be certain incidents that will not require further action, such as the death of a person with disability from natural causes, so long as there were no additional contributing factors (for example neglect or poor quality of care).

Corrective measures may include, but are not limited to –

- disciplinary action
- training or education of workers
- modification of the environment
- development or amendment of a policy or procedure
- changes to the way in which supports or services are provided
- other practice improvements.

Where appropriate, the NDIS Commission may require CCO to take corrective measures. The NDIS Commission will work with CCO to implement the measures, and monitor progress.

Restorative measures may include, but are not limited to –

• providing ongoing support to people with disability impacted by a reportable incident
• giving an apology
• providing compensation - for example, through an enforceable undertaking.

Action by the NDIS Commission
The NDIS Commission can take action or require CCO to do one or more of the following in response to receiving a notification of a reportable incident –

- give information in relation to the reportable incident to police
- refer the reportable incident to another person or body with relevant responsibilities in relation to the reportable incident (eg child protection authorities)
- require or request CCO to undertake specified remedial action in relation to the reportable incident within a specified period, including remedial action to ensure the health, safety and wellbeing of the person with disability affected
- carry out an internal investigation in relation to a reportable incident
- engage to an appropriately qualified and independent expert, at the expense of the provider, to carry out an investigation in relation to the reportable incident
- conduct an inquiry
- take any other action considered appropriate in the circumstances.

The NDIS Commission may provide, or can require CCO to provide, information on the progress or outcome of an investigation to the following people –

• the participant who was involved in the incident (or their representative)
• any person nominated by the participant (or their representative) to receive the information.

Information will be provided to the client in a form that is accessible to them.

In addition, the NDIS Commission can carry its own investigation or inquiry in relation to the reportable incident as it sees fit.

Description of the categories of reportable incidents

Death of a person with disability

All deaths of people with disability that occur in connection with the provision of supports or services must be notified to the NDIS Commission. This includes –

- A death that occurs while a support or service is being provided (for example, in a person's home or supported disability accommodation).
- A death that occurs as a result of, or, in connection with the provision of supports or services.

There are specific requirements in each state and territory in relation to the obligations on providers to notify a death to bodies such as coroners and police. Coroners are responsible for determining the cause of death. Coroners are also responsible for making decisions about whether there will be an autopsy or an inquest in relation to a death. The NDIS Commission will work alongside state and territory coroners and other bodies to examine the circumstances of deaths.

The NDIS Commission's jurisdiction is limited to oversighting deaths that occur in connection with the provision of supports and services by an NDIS provider. The NDIS Commission does not have a function to inquire into the provision of other services, for example, health services and/or other mainstream systems the responsibility of states and territories.

Serious injury of a person with disability

The serious injury of a person with disability must be notified to the NDIS Commission if it occurs or is alleged to have occurred in connection with the provision of supports and services.

In determining, whether an injury is 'serious', consideration should also be given to the level of harm caused. A serious injury includes, but is not limited to:

- fractures
- burns
- deep cuts
- extensive bruising
- concussion
- any other injury requiring hospitalisation.

Abuse or neglect of a person with disability

All incidents of abuse of a person with disability that occur or are alleged to have occurred in connection with the provision of supports and services must be notified to the NDIS Commission. There are many different types of abuse.

The focus is on the nature of the incident or allegation itself, and the impact on the person with disability. Abuse may include -

- behaviour management that is seriously inappropriate or improper
- making excessive and/or degrading demands of a person with disability
- hostile use of force towards a person with disability
- a pattern of seriously inappropriate, degrading comments or behaviour towards a person with disability.

In making a determination regarding abuse, it is important to consider relevant codes of conduct that outline the nature of professional conduct and practice by workers which should occur when working with people with disability.

Psychological abuse includes -

- A pattern of behaviour that is harassing or harmful to a person with disability.
- Verbal abuse, including where it is intended to intimidate, threaten or belittle, gain power and control or where the intent is to cause emotional pain or is demeaning or insulting.

A 'pattern of abuse' occurs where there is repeated physical abuse, ill treatment and/or harassment of a participant.

Abusive conduct includes the following, alone or in any combination -

- abuse of a sexual or non-sexual nature
- physical force or inappropriate physical contact
- threats of physical force or threats of inappropriate physical contact
- conduct that causes physical harm or emotional distress to the person with disability impacted by the incident
- financial abuse.

Financial abuse includes -

- withholding money belonging to a person with disability or using money for purposes not authorised by a person with disability, including NDIS funds
- coercion or misleading behaviour to obtain money or property from a person with disability.

Neglect of a person with disability

Neglect includes an action, or a failure to act, by a person who has care or support responsibilities towards a person with disability. In determining neglect, the nature of the worker's care responsibilities provides the context against which the incident or allegation needs to be assessed.

Neglect can be a single significant incident where a provider or worker fails to fulfil a duty, resulting in actual harm to a participant, or where there is the potential for significant harm to a participant. Neglect can also be an ongoing pattern of repeated failures by a provider or worker to meet a participant's physical or psychological needs.

All incidents of neglect of a participant that are alleged to have occurred in connection with the provision of supports and services must be notified to the NDIS Commission.

Neglect includes grossly inadequate care that involves depriving a participant of the basic necessities of life, such as food, drink, shelter, clothing, medical care/treatment. It also includes more specific categories which are discussed below.

Supervisory neglect

An intentional or reckless failure to adequately supervise or support a participant that *results* in the death of, or significant harm to, the participant, or

An intentional or reckless failure to adequately supervise or support a participant that also:

- involves a gross breach of professional standards
- has the potential to result in the death of, or significant harm to, the participant.

Failure to protect from abuse

An obviously unreasonable failure to respond to information which strongly indicates actual or potential serious abuse of a participant.

A reckless act/ failure to act

- A reckless act, or failure to act, that:
  - involves a gross breach of professional standards
  - results in or has the potential to result in the death of, or significant harm to, a participant.

Unlawful sexual or physical contact with, or assault of, a person with disability

Unlawful sexual contact

Any unlawful sexual contact or assault of a person with disability that occurs, or is alleged to have occurred, in connection with the provision of supports or services must be notified to the NDIS Commission. 'Unlawful sexual contact or assault' encompasses any behaviour of a sexual nature that is an offence under any criminal statute of a state, territory or the Commonwealth.

Sexual offences include, but are not limited to -

- sexual assault
- indecent assault
- acts of indecency.

Sexual assault

The term *sexual assault* refers to -

- Specific offences involving a person having sexual intercourse with another person without their consent (sometimes referred to as rape, depending on the language of the relevant state or territory legislation).

- A situation where a person is forced, coerced or tricked into sexual acts against their will or without their consent.

Indecent assault

Indecent assault usually involves touching (or threatening to touch) a person's body in a sexual manner without the consent of the other person. For example, it can include unwanted touching of a person's breast, bottom or genitals.

Unlawful physical contact

Any unlawful physical contact with, or assault of, a person with disability that occurs, or is alleged to have occurred, in connection with the provision of supports or services must be notified to the NDIS Commission.

Physical assault

A physical assault includes any act by which a person intentionally inflicts unjustified use of physical force against a person. An assault can also occur if a person causes another person to reasonably fear that unjustified force will be used against them. Even if a person who inflicts, or causes, the fear of, physical harm does not intend to inflict the harm or cause the fear, they may still have committed an assault if they acted recklessly (i.e. the person ought to have known that their actions would cause physical harm or the fear of such harm).

Assaults can include hitting, pushing, shoving, spitting, throwing objects, or making threats to physically harm a participant.

When physical contact does not need to be notified to the NDIS Commission

The Rules specify when unlawful physical contact does not need to be notified to the NDIS Commission and that is in circumstances where the contact with, and impact on, the person with disability – is in all the circumstances – negligible.

It is important to consider the context in which physical contact/force is used against a participant to determine whether it is unlawful. For example, where there is use of necessary and reasonable force in the following circumstances -

- restraining a participant when it is in accordance with an approved behaviour support plan authorised by a Restricted Practices Authorisation mechanism
- taking reasonable steps to disarm a participant seeking to harm themselves or others
- separating participants who are fighting
- moving a participant out of harm's way
- restraining a participant from causing intentional damage to property
- self-defence, or the defence of others.

Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity

Sexual misconduct
For sexual misconduct to constitute a reportable incident, the alleged misconduct must have been committed against, with, or in the presence of, a participant by a person, including a worker or another participant, in connection with the provision of NDIS supports or services.

The term sexual misconduct is designed to address conduct of a sexual nature that can, but does not have to, amount to a criminal offence.

Unlawful sexual conduct
Sexual crimes which do not involve physical conduct will constitute sexual misconduct. For example, acts of indecency are sexual offences where a person commits an indecent act with or toward another person, but does not have any physical contact with them. There are a range of non-contact sexual offences in each jurisdiction, which involve conduct that must be notified to the NDIS Commission. These include but are not limited to -

- grooming a child for sexual purposes
- filming a person without consent
- a pornography offence or an offence involving child abuse material.

Some jurisdictions also have specific sexual offences that are designed to prevent the sexual exploitation of people with a cognitive impairment by their carers, or by anyone else who has knowledge of the person's impairment and enters into a sexual relationship with the intent of taking advantage.

Crimes which involve encouraging another person to commit a sexual offence against a person with disability (such as offences involving aiding, abetting, counselling or procuring) would also constitutes sexual misconduct.

Crossing professional boundaries
The support relationship between a worker and a person with disability relies on a high degree of trust. All forms of sexual misconduct constitute a breach of this trust and a breach of the NDIS Code of Conduct.

It is important to distinguish between sexual misconduct and legitimate conversations around a participant's sexual support needs, family planning or that serve to meet a worker's duty of care.

Sexual misconduct includes behaviour that can reasonably be construed as involving an inappropriate and overly personal or intimate relationship with, conduct towards, or focus on, a participant or group of participants.

The crossing of professional boundaries can only occur in the context of a worker-participant relationship.

In the area of 'crossing professional boundaries', particular care should be exercised before making a finding of sexual misconduct. For example, a worker who, on an isolated occasion, 'crosses professional boundaries' in a manner that involves no more than poor judgement could not be said to have engaged in sexual misconduct. Also, in cases where a worker has 'crossed boundaries' in terms of their relationship with a participant, this would not constitute sexual misconduct if there is evidence which shows that the worker did not seek to establish an improper relationship with the involved participant.

However, a single serious 'crossing of the boundaries', or a course of less serious breaches of this type, may constitute professional misconduct – particularly if the worker either knew, or ought to have known, that their behaviour was unacceptable.

The NDIS Code of Conduct, as well as other codes of conduct that might apply in your workplace, outline the expectations of workers in respect of their relationships with participants.

Sexually explicit comments and other overtly sexual behaviour
Sexual misconduct includes a broad range of sexualised behaviour with or towards participants. While it is not possible to provide a complete and definitive list of unacceptable sexual conduct involving participants, the following types of behaviour give strong guidance -

- sexualised behaviour with or towards a participant (including sexual exhibitionism)
- inappropriate conversations of a sexual nature
- inappropriate comments relating to sexual acts
- unwarranted and inappropriate touching of a participant
- personal correspondence and communications (including emails, social media and web forums) with a participant concerning the worker's romantic, intimate or sexual feelings for the participant
- inappropriate exposure of participants to sexual behaviour of others
- watching participants undress in circumstances where supervision is not required and it is clearly inappropriate.

Grooming behaviour
Behaviour should only be seen as 'grooming' where there is evidence of a pattern of conduct that is consistent with grooming a participant for sexual activity, and there is no other reasonable explanation for that pattern.
The types of behaviours that may lead to such a conclusion include, but are not limited to:

- Persuading a participant or group of participants that they have a 'special' relationship with the worker, for example by -
  - inappropriately giving gifts

  - inappropriately showing special favours to them but not other participants, or
  - asking the participant to keep the relationship to themselves.
- 'Testing boundaries', for example by:
  - undressing in front of a participant
  - encouraging inappropriate physical contact (even where it is not overtly sexual)
  - 'accidental' intimate touching.
- Extending a relationship with a participant outside of work (except where it may be appropriate, for example, where there was a pre-existing friendship with the participant's family, or as part of regular social interactions in the community).
- Inappropriate personal communication (including emails, telephone calls, text messaging, social media and web forums) that inappropriately explores sexual feelings or intimate personal feelings with a participant.

A worker or another person in the context of NDIS support provision requesting that a participant keep any aspect of their relationship secret, or using tactics to keep any aspect of the relationship secret, would generally increase the likelihood that grooming is occurring.

Unauthorised use of restrictive practice

Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with disability. These can include restraint (chemical, mechanical, social or physical) and seclusion (keeping someone in isolation).

The NDIS Commission aims to reduce and eliminate the use of restrictive practices in the NDIS state and territory authorisation arrangements are intended to protect participants from being inappropriately treated or controlled. The NDIS (Restrictive Practices and Behaviour Support) Rules also regulate the following restrictive practices through behaviour support plans:

- **Seclusion**, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted.
- **Chemical restraint**, which is the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
- **Mechanical restraint**, which is the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.
- **Physical restraint**, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

- **Environmental restraints**, which restrict a person's free access to all parts of their environment, including items and activities.

The use or alleged use of a restrictive practice in relation to a participant, other than where the use is in accordance with an authorisation (however described) of a state or territory in relation to the person with disability must be notified to the NDIS Commission. This includes the emergency use of a restrictive practice.

In addition, the following use of a restrictive practice is reportable -

- the use of a restrictive practice in relation to a person with disability where the use is in accordance with an authorisation of a state or territory but is not in accordance with a behaviour support plan for the person with disability.

The use of a restrictive practice in relation to a person with disability is not a reportable incident if - :

- the use is in accordance with a behaviour support plan for the person with disability
- the state or territory in which the restrictive practice is used does not have an authorisation process in relation to the use of the restrictive practice

Section Five – Incident Management

5.1 Incident Management Framework

5.2 Policy and Procedures

5.3 Responsibilities

5.1 Incident Management Framework

CCO's Incident Management policy provides an over arching framework for management of all kinds of incidents throughout the organisation. It sets out an eight step incident management process -

1. ***identification and immediate response***
2. ***notification***
3. ***categorising for management reporting***
4. ***assessment***
5. ***investigation and further action***
6. ***follow up and feedback***
7. ***incident data collection and monitoring***
8. ***Continuous Improvement***

All incidents that affect the health, safety or welfare of staff, or the health or safety of clients or visitors to CCO workplaces or sites must be notified, recorded, and investigated in a timely manner, and preventative measures identified and implemented.

5.2 Incident Management Policy and Procedures

The Incident Management policy is supported by the procedures for notifying and investigating incidents involving staff, visitors and CCO Clients. These procedures provide additional guidance on the specific steps to be taken for WH&S and client incident notification, investigation and follow up action.

CCO is a large organisation providing a range of services in a variety of settings. Incidents may occur in any aspect of CCO's business, and they may involve staff, clients or visitors to CCO's workplaces or facilities, or they may affect CCO's property or operations.

CCO is committed to reducing the number of incidents that occur; minimising the harm caused as a result of those incidents and using the lessons learned from incidents to prevent a recurrence of those incidents in the future.

CCO is committed to a workplace that is healthy and safe for our staff, and also committed to the prevention and protection of clients, be they people with a disability, older people or others, from situations, acts, or omissions that put them at risk of harm.

Incident Management

Definition - What is an incident?

An incident includes –

- acts, omissions, events or circumstances that occur in connection with providing supports or services to a CCO client (a person with disability or an older person) which have, or could have, caused harm to the person
- acts by a client (a person with disability or an older person) that occur in connection with providing supports or services to the person and which have caused serious harm, or a risk of serious harm, to another person, and
- reportable incidents that have or are alleged to have occurred in connection with providing supports or services to a CCO client (a person with disability or an older person).

A reportable/notifiable incident includes –

- the death of a client (person with disability or older person)
- serious illness or injury of a client (person with disability or older person) **Infectious**
- a dangerous incident that exposes a person to serious risk, even if no injury occurs
- abuse or neglect of a client (person with disability or older person)
- unlawful sexual or physical contact with, or assault of, a client (person with disability or older person)
- sexual misconduct committed against, or in the presence of, a client (person with disability or older person), including grooming of the person for sexual activity

- the use of an unauthorised restrictive practice in relation to a client (person with disability or older person)
- the denial of any human rights in any way in relation to a client or any person associated with (person with a disability or older person)
- release of hazardous chemicals into the environment

If an incident is a ***reportable incident***, CCO is required to notify the appropriate jurisdictional regulator of the incident and keep them informed of any investigation or actions arising from the incident. This could be the Aged Care Safe Guarding Commission or the NDIS Commission (oversight our responses to *reportable incidents)*. Please reference the Reportable Incidents Policy and Procedures where the above mentioned situations occur.

Legislation
Work Health and Safety Act 2011
Work Health and Safety Regulation 2012
Code of Practice – How to Manage Work Health and Safety Risks
NDIS (Incident Management and Reportable Incidents) Rules 2018

Aged Care Quality Standards
- ✓ *Standard 8 – Organisational Management*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 7 – Human Resources*

NDIS Practice Standards
- ✓ *Standard 6 - Service Management*

DVA Notes for Community Nurses
This Incident Management policy is supported by procedures for notifying and investigating incidents involving staff, visitors and CCO Clients. These procedures provide additional guidance on the specific steps to be taken for WH&S and client incident notification, investigation and follow up action.

This policy should be read in conjunction with the Reportable Incidents Policy and Procedures.

This policy is based on the following principles -

- ✓ Incidents are reported fully and honestly without fear of inappropriate blame or reprisals;
- ✓ Information regarding incidents is treated confidentially and the privacy of those involved in the incident is protected to the extent possible;
- ✓ The purpose of reporting is to learn from incidents and to share this knowledge.

5.3 Responsibilities

All staff are responsible for notifying **any** incident/hazard in which they are involved, aware of, or which they witness to their Manager, and for participating in the investigation of incidents, if necessary.

Office based staff members are responsible for taking calls as required from direct care staff advising of incidents. The staff member receiving such advice regarding an incident are to record on CCO's Hazard/Incident report Form and place in WH&S pidgeon hole. If incident is serious then CEO or other Manager to be alerted immediately.

All Managers are responsible for ensuring all necessary initial care and support is provided to all those affected by an incident – particularly vulnerable clients and staff; ensuring incidents are properly reported, assessed and investigated (within 7 days of notification), and ensuring action has been taken to prevent a recurrence, or mitigation strategies have been implemented.

Incident Reporting and Investigation

This policy is based on the following principles -

- ✓ Incidents are reported fully and honestly without fear of inappropriate blame or reprisals;
- ✓ Information regarding incidents is treated confidentially and the privacy of those involved in the incident is protected to the extent possible;
- ✓ The purpose of reporting is to learn from incidents and to share this knowledge.

Procedure for Reporting Workplace Incidents and Injuries
The staff member experiencing or witnessing the incident/accident is to ensure their own health and safety at all times.
To administer or seek first aid as may be required.
Complete an incident report form and verbally advise supervisor of incident/accident.

Incidents experienced in the work place must be reported to management at the earliest opportunity. The following would be considered critical incidents –

- ✓ Actions by the client or carer, which may endanger the client's or staff safety;
- ✓ Witnessed or experienced abuse to, or by a client; and
- ✓ The unexpected death, or traumatic death of a client whilst in our care.

The above needs to be reported immediately to a Senior Manager.

All staff are also responsible for reporting to management, incidents/accidents and near misses (hazards) promptly so that action can be taken to address them before they result in an illness or injury.

Type of incident/accident	How to report and what form to report on
Accidents - involving the organisation's vehicles	Verbally then on an Incident Report form
Workplace Accidents	Verbally, then written on an Incident Report form
Client Incidents/Accidents	Verbally, then written on an Incident Report form
Safety Issues in the Workplace • ***urgent and major*** • ***minor routine***	Report verbally followed by written report using the Hazard Report form. Written report using the Hazard Report form.
Accidents - requiring support by emergency services, eg Fire, Ambulance or Police	By dialling 000. Make sure you tell the services the total address, including the town, state and nearest crossroad. Advise the office verbally

Incident Investigation Procedures

Management undertakes to –

Report and investigate every accident, near miss or incident involving personal injury, serious damage to property, or illness, to assess the extent of necessary corrective action;

Invite/engage Work Health and Safety Representatives to investigate incidents/hazards with management so that effective consultation occurs;

Report accidents in accordance with our responsibilities under the Work Health and Safety Act 2011; and

Wherever possible, adopt alternative methods, or provide alternative equipment, to control some hazards. These controls will be discussed in depth with the client and staff members.

Procedure for Reporting Workplace Incidents and Injuries

Identification and immediate response

1. Staff Members need to be aware of and alert to any situations which may be escalating beyond normal patterns of workplace/human behaviour. It is important to identify that there is a situation or incident/hazard.

2. The staff member experiencing or witnessing the incident/hazard is to ensure their own health and safety at all times. The staff member is to leave the premises/situation if they feel unsafe at any time.

3. The staff member to administer or seek first aid as may be required by themselves, clients or others following an assessment of whether it is safe to do so.

4. Staff member to contact emergency services if required – ambulance, police, fire -000

Notification

CCO has established clear reporting lines for when incidents occur, including specifying who must be notified when an incident occurs.

5. The staff member involved or witnessing an incident are to contact CCO office immediately they have left the client home and are safe and advise of circumstances.
   CCO Critical Support service to be contacted outside of normal business hours eg 4.30 pm - 8.3o am, weekends.

6. The staff member involved or witnessing an incident are to contact CCO office immediately they have contacted emergency services and advise of circumstances. CCO Critical Support service to be contacted outside of normal business hours eg 5.00 pm – 9.00 pm.

7. The staff member to follow the instructions given by the office or Critical Support in relation to action and response to the situation. eg phone emergency services – police, ambulance, fire, leave the situation etc

8. Incidents and hazards experienced in the work place must be reported to management at the earliest opportunity. The following would be considered critical incidents –

- ✓ actions by the client or carer, which may endanger the client's or staff safety;
- ✓ the death of a client (person with disability or older person)
- ✓ serious injury of a client (person with disability or older person)
- ✓ witnessed or experienced abuse or neglect of, or by a client (person with disability or older person)
- ✓ unlawful sexual or physical contact with, or assault of, a client (person with disability or older person)

- ✓ sexual misconduct committed against, or in the presence of, a client (person with disability or older person), including grooming of the person for sexual activity
- ✓ the use of an unauthorised restrictive practice in relation to a client (person with disability or older person)
- ✓ the denial of any human rights in any way in relation to a client or any person associated with (person with a disability or older person).

The above situations/incidents need to be reported **immediately** to a Senior Manager – Client Services Manager, Operations Manager, CEO, Program Managers.

All staff are also responsible for reporting to management, incidents/accidents and near misses (hazards) promptly so that action can be taken to address them before they result in an illness or injury.

Staff Members can make verbal reports to any of the following office staff – they will record the staff members report of the incident for review by management.

Position	**Staff Member**	**Contact**
Customer Service Officer	Cathy Hawkens	66502000
Service Coordinators	Customer Service Support & Development Aged Care Disability Compacks	66502000
Manager People & Culture	Liz Anscombe	66502000
Support & Development Officer	Grace Keys	66502000
Client Services Manager	Lee Fletcher	66502000
CEO	Deb Ryan	66502003 0418960977

Staff are to complete CCO's Hazard/Incident Report Form as soon as is reasonably practicable following an incident, which ensures that all important information is included for reporting.

Staff members are to also complete a Record of Injury Form for Workers Compensation purposes.

All **staff receiving** incident information should be clear about appropriate response plans to ensure the health, safety and wellbeing of CCO staff and clients.

CCO's Response Plan for Incident Management is as follows -

Immediate Action	
Office Staff Member receiving call is to ascertain & record the following -	
Names	That all people present are safe.
	If the staff member is injured.
Injuries	If the client or other parties are injured.
First Aid	If First Aid or Emergency Medical Attention is required
	Whether the staff member left the situation or are still present
	What assistance the staff member may need
	If there are any immediate risks to others because of the incident
	If so who -

Description of incident to be recorded as reported, on CCO's Hazard/Incident Report Form Other details as per form – date, time, location, witnesses, action taken by the CCO employee

ACTION	Where the incident fits within the criteria identified as critical in this policy the Receiving staff member will report the situation/incident immediately to a Senior Manager – Client Services Manager, Operations Manager, CEO, Program Managers.
	Reportable incidents are to be advised to the CEO immediately. The CEO, CSM & Manager People & Culture have delegations for reporting to the NDIS and/or Aged Care Quality & Safeguards Commissions & will complete this action.

Where the incident is not assessed as urgent - the Hazard/Incident Report Form is to be placed in the WH&S mail box or faxed to Coffs office. Action any remedial issues eg roster adjustments

Remedial Action	Both corrective & preventative
Manager receiving Incident /Hazard advice will ensure the following -	
	Follow up with client regarding their health, safety and wellbeing by the CSM, Program Manager, Care Manager, Support Coordinator or Service Coordinator as appropriate & available – **same day**. Ascertain if any additional supports or services required.
	Follow up with the staff member regarding their health, safety and wellbeing by the Operations Manager, Support & Development Manager, Service Coordinators Support & Development as appropriate & available – **same day**. Action W/Comp notification if required due to lost time Action any roster changes

	Ascertain any further details that may be required for mitigation of future risks
	Process Hazard/Incident Form for registration, action

Minimum requirements for reporting/record keeping include –

- a description of the incident, including the impact on, or harm caused to, any person (including a person with disability, an older person, a staff member, other)
- whether the incident is a reportable incident
- if known, the time, date and place at which the incident occurred or if not known, the time, date and place at which the incident was first identified
- the names and contact details of the persons involved in the incident and any witnesses to it
- the actions taken in response to the incident, including action taken to support or assist a client (person with disability or older person) impacted by the incident
- if an investigation is undertaken by CCO in relation to the incident —the details and outcomes of the investigation, and
- the name, position and contact details of the person making the record of the incident.

Categorising for management reporting
Staff Members receiving Hazard/Incident Reports are to assess incident severity eg is it a reportable/critical incident? to identify priority of reporting to Senior Management including CEO.

Any incidents falling into a reportable incident category are to be notified to the CEO immediately on the day of occurrence/notification.

The CEO or delegated Manager will provide advice to staff involved in the incident with regard to the following -

- **notification of police or emergency services if they have not already been advised**
- **notification of next of kin, family, carers, guardian**

Incidents resulting in an injury to a CCO employee are to be notified to the Operations Manager immediately on the day of occurrence/notification.

Where the identified Manager is not available for reporting via phone, email or in person, then the staff member is to report the incident to their immediate Manager eg CEO, or another Manager, if the CEO is unavailable.

Incidents not requiring an immediate response will be notified to the appropriate staff member for follow up eg Clinical Care Manager, Care Manager, Support Coordinator, Service Coordinator as per CCO's Hazard/Incident Reporting process eg WH&S mail box.

Assessment
The assessment must consider the views of client (persons with disability or older people) impacted by the incident.

CCO will consider the outcome of such assessments to determine what further action should be taken, which could include –

- providing ongoing support to impacted people with disability and/or ensuring the ongoing wellbeing and safety of impacted people with disability
- identifying and implementing practice improvement measures
- notifying the NDIS Commissioner and/or other bodies or agencies, if appropriate
- undertaking further investigations
- identifying and taking corrective action to prevent a reoccurrence of incidents, or
- deciding that no further action is necessary.

Investigation and further action
In some circumstances it may be necessary to conduct an investigation to establish the cause of a particular incident, its effect and any operational issues that may have contributed to the incident occurring.

An investigation into an incident is not necessarily the same as an investigation into a reportable incident and, in general, it may not be as formal or extensive.
For incidents that are not assessed as critical the Hazard/Incident Report Form will be forwarded to the staff member responsible for service coordination for the specific client involved (where the incident involves a client). The Care manager, Support Coordinator or Service Coordinator will follow up with the client involved and the staff member involved to ascertain what action needs to be taken to prevent a reoccurrence of the incident. This could include the client or staff member modifying their behaviour, updating risk assessments and risk management plans, referring for specialist support eg OT, Behaviour Support.

CCO will adhere to the NDIS Commissions Procedural Fairness Guidelines during the course of conducting any investigation into an incident.

Once investigated and resolved the Incident is to be closed on the CCO database.

In deciding whether further details should be recorded about an incident, CCO should consider, but is not limited to, the following factors –

- the nature of the supports or services being provided
- the seriousness of the incident (including where it is not a reportable incident, but is beyond a simple or minor incident), and
- whether it is part of a pattern of incidents.

All Reportable/Critical Incidents will require an investigation.

If police are involved as in death, serious injury, sexual abuse, assault etc then an internal investigation should not commence until the police have completed their inquiries.
The CEO will liaise with all police and media enquiries into any incident and will direct the implementation of any investigation.

CCO Management undertake to –

- Report and investigate every accident, near miss or incident involving personal injury, serious damage to property, or illness, to assess the extent of necessary corrective action;
- Invite/engage Work Health and Safety Representatives to investigate incidents/hazards with management so that effective consultation occurs;
- Report accidents in accordance with our responsibilities under the Work Health and Safety Act 2011; and
- Report incidents considered to be 'reportable' under and according to the NDIS (Incident management and Reportable Incidents) Rules 2018.

Wherever possible, CCO will adopt alternative methods, or provide alternative equipment, to control some hazards. These controls will be discussed in depth with the client and staff members.

Follow up and feedback
CCO will ensure that follow up support and assistance is provided to any person affected by an incident to the extent that we are able, to ensure the person's health, safety and wellbeing. This may include a client (person with disability, an older person), a carer, or a CCO staff member. Follow up will be provided via the relevant line Manager eg Client Services Manager or Manager People & Culture.

The client affected or impacted by any incident will be consulted about the incident and involved in the management and resolution of the incident. They will be asked to provide feedback and input into assessments, investigations and corrective actions proposed or taken. They will be kept informed of all actions taken during the investigation and of the outcome of any investigation by the person delegated to investigate the incident.

Corrective Action
Corrective action will be taken in the following circumstances –

- where an incident may have been prevented (or the severity lessened) by some action (or inaction) by CCO or a worker
- where there is an ongoing risk to clients (people with disability, or an older person); or
- where action by CCO may prevent or minimise the risk of a reoccurrence.

Examples of corrective actions include –

- re-training or further training of workers

- practice improvements including developing or enhancing policies and procedures
- changes to the environment in which supports or services are provided, and
- changes to the way in which supports or services are provided

Incident data collection and monitoring
All hazards/incidents are reported on CCO's Hazard/Incident Registers. Forms are accessed and reviewed daily.

Hazard/Incident Reports are reviewed at weekly Executive/Management Team Meetings to oversight issues/actions and trends.

CSM monitors open incidents at the end of each month.
CEO reports Hazards/Incidents monthly to Board of Directors

WH&S Committee reviews de-identified Hazard/Incident data bi monthly to monitor trends and make recommendations for service improvements in the area of WH&S.

CCO is required to keep records relating to incidents and to provide statistical and other information about incidents to the NDIS Commission upon request.

CCO supports the premise that good record keeping assists in improving accountability and promotes transparent decision-making.

Learning from incidents
Like complaints and other feedback, incidents provide an opportunity to review practices and procedures and identify where improvements in service quality can be made.

Management and WH&S Committee Review of incidents assesses the following issues –

- whether the incident could have been prevented
- how well the incident was managed and resolved;
- what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their impact, and
- whether other persons or bodies need to be notified of the incident.

CCO's Incident Management System will be reviewed following any reportable incidents and policies and procedures reviewed and updated at least bi annually or as determined by any sector reforms. All records must be kept for seven years.

Section Six – Injury Management

6.1 Workers Compensation Acts

6.2 Workers Compensation Regulations

6.3 CCO Return to Work Policy & Procedures

6.1 Workers Compensation Acts

The relevant Acts are -

- ✓ Workers Compensation Act 1987
- ✓ Work Health Safety Act 2011
- ✓ Workplace Injury Management and Workers Compensation Act 1998.

Together, these Acts establish a workplace injury management and workers compensation system that -

- Assists in securing the health, safety and welfare of workers;
- Provides for –
  - prompt treatment of injuries
  - effective and proactive management of injuries
  - medical and vocational rehabilitation following injuries
- Provides injured workers and their dependents with income support during incapacity
- Creates a fair, affordable and financially viable workers compensation system
- Ensures contributions by employers are commensurate with the risks faced in their industry.

6.2 Workers Compensation Regulations

The Workplace Injury Management and Workers Compensation Regulations support the general requirements of the Workers Compensation Acts but provide more detail.

Workers Compensation (Workplace Injury Management) Regulation 2002

The regulation is made under the Workers Compensation Act 1987, including section 280 (the general regulation making power), and Chapter 3 of the Workers Compensation and Workplace Injury Management Act 1998.

Workers Compensation Regulation 2003

The object of this Regulation is to relace, without any major changes in substance and as a consolidated Regulation, the provisions of the Workers Compensation (General) Regulation 1995 and the Workers Compensation (Insurance Premiums) Regulation 1995.

6.3 CCO Return to Work Policy

Demonstrates the commitment to the requirements of the Workers Compensation Acts and Regulations. The organisation's policy and program, has been developed in consultation with employees, through their WH&S Representatives, and relevant unions (if applicable).

Commitments of CCO Work Place

- ✓ To maintain privacy & confidentiality regarding all claims where possible at all times;
- ✓ To prevent injury and illness by providing a safe and healthy working environment;
- ✓ To ensure that injury management activities commence as soon as possible after notification of injury and every effort is made to provide suitable and meaningful duties consistent with the nature of the injury/ illness, after seeking appropriate medical judgement;
- ✓ To provide support throughout the rehabilitation process to minimise the effects of the injury and ensure that an early return to work duties is normal practice and expectation;
- ✓ To provide suitable duties/ employment for injured employees as soon as safely possible, as an integral part of the rehabilitation process;
- ✓ To consult with employees, their doctors, other health professionals and where applicable any union representing them to ensure that our return to work program operates effectively;
- ✓ To ensure that participation in a return to work program will not, of itself, prejudice an injured employee; and
- ✓ To develop Return to Work Plans in conjunction with the staff members job descriptions which may be utilised by management, doctors and rehabilitation providers, in order that duties are selected wherever possible, that reflect the injured workers usual duties when returning to the workplace following injury.

CCO Return to Work Procedures - for action when injury occurs

The Return to Work procedures aim to achieve the commitments under the Return to Work Policy. The procedures recognise that the best possible health outcomes for our injured employees will be achieved through -

1) acting early
2) open communication, and
3) cooperation between key people.

It is the employee's responsibility to notify their Manager, the Manager People & Culture or the CEO of any injury as soon as is practicable.

Once an injury is notified, CCO will ensure that the injured person receives appropriate first aid and/or medical treatment as soon as possible and will conduct an investigation.

CCO will notify the insurer via the online notification process of any injury within 48 hours.

If a notifiable incident occurs, you must notify SafeWork NSW immediately on: 13 10 50

. A ‘notifiable incident’ under the work health and safety legislation relates to:

- ✓ the death of a person
- ✓ a serious injury or illness of a person
- ✓ a dangerous incident

SafeWork NSW may need to conduct an urgent investigation and may be required to preserve the incident site until an inspector attends. SafeWork NSW have a notifying fact sheet with more information about what constitutes a serious injury or illness or a dangerous incident.

You may be able to access counselling and support through SafeWork NSW for those affected by a notifiable incident.

Follow Up After Injury

The designated Return to Work Coordinator is the Operations Manager, who will work with the employee, their Manager, Medical Practitioner, Rehabilitation Provider and the insurer in developing an injury management/return to work plan for an injured worker. The Return to Work Coordinator will maintain a case file and protect the confidentiality of the information on this file.

Finding Suitable Duties

When the injured employee is, according to medical judgment, capable of return to work on suitable duties, an individual return to work plan will be developed offering suitable duties which will be identified after consultation with the relevant parties and will be specified in writing and signed by all parties. Appropriate assistance will be given to workers from non-english speaking background and to those permanently unable to return to pre-injury duties.

Involving a Rehabilitation Provider

The following accredited rehabilitation providers are available to assist when required in the rehabilitation of those employees who suffer a workplace injury or illness -

- ➢ Commonwealth Rehabilitation Services
- ➢ Recovre and;
- ➢ Baringa Rehabilitation Services

Injured employees will however, retain the right to nominate their treating doctor, and accredited provider of their own choice.

Consultation

Employees will be informed of their rights and responsibilities and of company policies on rehabilitation. Such consultation will be effected through The Return to Work Coordinator and Work Health and Safety Representatives and relevant Unions of the organisation.

Flow Chart of Process:

Workers who suffer a work related injury/accident
MUST

Notify IMMEDIATELY
Their Supervisor, Manager People & Culture - 66502004 / 0415687798 or CEO

The Worker's Manager will:

- ✓ **On notification of the injury/accident, ensure that the employee receives appropriate first aid and/or medical treatment asap.**
- ✓ **Conduct an investigation to prevent any recurrence**

The Manager People & Culture will:

- ✓ **Establish the extent of the injury/accident**
- ✓ **If required lodge notification of Injury with the Insurer within 48 hours**
- ✓ **If required lodge notification of Injury to Safe Work NSW**
- ✓ **Request the employee to complete a Resister of Injuries Form**
- ✓ **Request the worker to complete a Hazard/Incident Form**

The injured worker will (if required)

- ✓ **Attend a medical practitioner for diagnosis of Injury**
- ✓ **Obtain a WORKCOVER MEDICAL CERTIFICATE from the medical practitioner**
- ✓ **The worker must deliver, fax/ email the WorkCover Certificate to the Manager P&C**

The Manager People & Culture will:

- ✓ Lodge the Workcover Medical Certificate with Icare (EML) Employers Mutual
- ✓ Contact the Medical Practitioner to advise organisational support for the Worker.
- ✓ Advise the medical practitioner of suitable duties to enable the worker to return to work asap

The Manager People & Culture will:

- ✓ Continue to work with the employee, medical practitioners and Insurance company until the worker is **FIT FOR PRE INJURY DUTIES**

Injury Dispute Resolution

The Rehabilitation Coordinator
Will ensure that the injured worker is provided with all the relevant documents needed to apply for reassessment by the Icare Injury resolution department.

The Injured Worker
Must make all reasonable effort to comply with the return to work (RTW) program developed by the Return to Work Coordinator, in conjunction with the nominated medical practitioner.
.

The Return to Work Coordinator
Is responsible for developing the Return to Work Program in which the most important member of the team is the injured person, allowing them to be enabled to return to suitable duties as soon as possible and to resume to pre injury duties as soon as is possible following injury.

The Return to Work Coordinator

Will undertake all aspects of the role as per requirements of SafeWork NSW.

Workplace First Aid
Staff members giving First Aid in an emergency will not be subject to potential liability if responding to emergencies as a member of the public in the “Good Samaritan” term of First Aid Provision.

Staff members will provide First Aid to the level of training received.