Core Module

Policy and Procedure Manual

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CM.National. 07.06.22.V2.10

ABN: 49213343957

Version: 1.0

Approval date: 13/06/2022

Review date: 13/06/2023

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Section 1: Rights and Responsibilities

Topic	Policy and Procedure
1.1 Person-Centred Supports	• Aboriginal and Torres Strait Islander People Policy and Procedure • Person-Centred Supports Policy and Participant Service Charter of Rights • Preferred Method of Communication Policy and Procedure • Person-Centred Supports Linkage Policy and Procedure • Advocacy Support Policy and Procedure - Victoria
1.2 Individual Values and Beliefs	• Individual Values and Beliefs Policy and Procedure
1.3 Privacy and Dignity	• Privacy and Dignity Policy and Procedure • Management of Data Breach Policy and Procedure
1.4 Independence and Informed Choice	• Independence and Informed Choice Decision-Making Policy and Procedure

1.5 Violence, Abuse, Neglect, Exploitation and Discrimination	• Violence, Harm, Abuse, Neglect, Exploitation and Discrimination Policy and Procedure
	• Working with Children Policy and Procedure
	    - Victoria
	• Risk Assessed Role Policy and Procedure
	    - Transitional Requirements:
	        ○ Victoria
	• Zero Tolerance Policy and Procedure

1.1 Person-Centred Supports

Aboriginal and Torres Strait Islander People Policy and Procedure

1.0 Purpose

Strength In Care wishes to recognise the Traditional Owners of the Land and the Aboriginal communities served by our organisation.

Strength In Care will provide services and supports that meet the needs of Aboriginal and Torres Strait Islander people.

Strength In Care will ensure all staff are trained in culturally appropriate actions and requirements and that they work collaboratively with local Aboriginal and Torres Strait Islander people.

2.0 Scope

This policy applies to all individuals who have contact with our participants.

3.0 Policy

It is the policy of Strength In Care to create a safe and welcoming environment for everyone. This policy intends to ensure that participants have the right to engage with Aboriginal and Torres Strait Islander community members and to access the support required to meet their individual needs.

Staff are required to:

- listen to the individual's story about their needs and values before asking questions

- check with the participant on how to act in a culturally respectful manner
- determine how to communicate effectively (verbal and non-verbal)
- ask the participant how they want to be connected to their community and respect the importance I attach to my family and kinship system
- establish rapport and engage with those the participant considers important in their life, such as Elders, family members, or other community members
- recognise that my connection to culture may evolve
- accept when the participant prefers to be supported by their family and community. Work collaboratively to build their confidence and capacity to do so.
- Be aware that their experience, attitudes and beliefs related to identity are not a "norm". Staff must not make assumptions or impose their personal views on me.
- recognise the complexity of working in a cross-cultural context and be aware of how their judgements and biases may affect their behaviour
- Identify and listen to those with cultural knowledge who can help staff better understand the culture, kinship system and community
- accept and be comfortable with "not knowing" how things are perceived from an Aboriginal and/or Torres Strait Islander perspective.

If required, front-line workers will collaborate with Aboriginal and Torres Strait Islander community members to support participants in developing and reviewing their support plans and activities.

4.0 Procedure

Our inclusive approach will promote the cultural safety of Aboriginal and Torres Strait Islander people through engagement with the participant, their community and all relevant stakeholders. Our processes are designed to meet the needs and requirements of the participant.

A variety of procedures may be implemented, including:

- incorporating symbols and images that reflect the indigenous culture in our marketing material, on our website and in our environment
- acknowledging the stigma, discrimination and exclusion experienced by people who identify as Aboriginal and/or Torres Strait Islander, and how this may intersect with discrimination faced with a disability
- displaying a Statement of Traditional Owners
- clarifying if participants identify as Aboriginal and Torres Strait Islander
- contacting and maintaining networks with local Aboriginal and Torres Strait Islander communities
- working with community networks for the benefit and support of the participant
- contacting the participant's family, extended family and community
- establishing communication processes for maintaining an individual's indigenous supports
- working with other services in a coordinated manner to enhance support for the participant
- planning actions that promote cultural safety and connectivity while respecting the cultural and spiritual identity of Aboriginal and Torres Strait Islander communities
- researching and supporting community events for the participants, and then sharing this information with all staff
- accepting the participant's preference to be supported by family and community
- working collaboratively to build family and community confidence and capacity
- identifying how, when, and why to source and work with different types of interpreter services in a culturally appropriate way
- collaborating with local communities to provide services, referrals, consortia involvement and memorandums of understanding.

4.1 Advocacy information

A file review of all Aboriginal and Torres Strait Islander participants enhances our inclusive approach obligations. The review will determine if:

- service access and support strategies are relevant for Aboriginal and Torres Strait Islander people
- service involvement and links with the Aboriginal community and Aboriginal services are being provided, as relevant
- cultural needs of the participants are documented in their support plans
- strategies and supports are implemented as per individual plans
- Aboriginal and Torres Strait Islander people should be given opportunities to voice their opinions and provide feedback on all aspects of their service. Staff should support the participant in voicing their opinions and knowledge in meetings. Participants must be allowed to discuss ideas and provide input to management to improve our services to meet their requirements.

4.2 Staff and volunteer training

Strength In Care will train all staff and volunteers so that all front-line workers can capably implement Aboriginal or Torres Strait Islander cultural competence strategies. The training aims to increase access to the service by Aboriginal and Torres Strait Islander people.

Training may include:

- variability in Aboriginal and/or Torres Strait Islander cultures, beliefs, practices, languages, kinships and ways of living
- impact of European arrival, including inter-generational distrust of non-indigenous and government
- stigma, discrimination and exclusion that may be experienced and how this may intersect with discrimination faced from having a disability

5.0 Related documents

- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house

- Training Register
- Easy Read Documents

6.0 References

- Disability Discrimination Action 1992 (Commonwealth)
- Human Rights and Equal Opportunity Commission Act 1986 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Racial Discrimination Act 1975 (Commonwealth)
- Sex Discrimination Act 1984 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework

Person-Centred Supports Policy and Participant Service Charter of Rights

1.0 Purpose

The NDIS Quality and Safeguards Commission aims to uphold the rights of people with disabilities, including the right to dignity and respect and to live free from abuse, exploitation, and violence; this is in keeping with Australia's commitment to the United Nations Convention on the Rights of Persons with Disabilities. Our organisation has used this statement as the basis of our policy.

This policy aims to empower people with disabilities to exercise choice and control in their support services. Whilst ensuring appropriate protections are in place; and building the capacity of people with disabilities, their families, and their carers to make informed decisions about National Disability Insurance Scheme (NDIS) providers.

2.0 Scope

This policy applies to all staff members and participants; the policy aims to assist participants in understanding their rights.

3.0 Policy

Strength In Care will provide supports that promotes, upholds and respects individual rights to freedom of expression, self-determination and decision-making.

The Participant Service Charter outlines the rights of participants, how participants will be treated and the obligations of Strength In Care. This charter also sets out participant responsibilities and feedback options on any service aspect.

Strength In Care takes a person-centred, evidence-based approach to any services that we provide where the participant, family or their advocate/s is primary to any decisions made.

Strength In Care exists to work with our participants, their advocates, family members and other service providers, as relevant, to provide the services to meet our participants' needs within the scope of our services.

We will provide support and work with other community groups or education programs directly or partner with other services. Information regarding our services is located on our website, Strength In Care or by asking a staff member.

Strength In Care will work with other groups, services and programs, either directly or in partnership, to ensure the provision of relevant support.
Our Service Charter of Rights will be provided to participants in a Participant Handbook using simple terminologies such as your rights, responsibilities, and responsibilities.

Our organisation works to meet the NDIS Workforce Capability Framework objectives (written from the participant's perspective).

1. Our Relationship
    - Set up our relationship for success
2. Your Impact
    - Know your capabilities, role and impact
3. Support Me
    - Support me in pursuing what is important to me
4. Be Present
    - Be present and provide the support I need
5. Check-in
    - Work with me to evaluate and act on what is working and what is not.

Note:

All five objectives apply to workers who work directly with the participant to deliver general or advanced support, such as support workers, allied health assistants and health and allied health practitioners. The first three objectives also apply to ancillary workers, such as cleaners and receptionists.

4.0 Charter of Rights

4.1 Participants' rights

Participants have many individual rights. We understand these rights and work towards informing, supporting and assisting participants to achieve their goals and exercise their rights. Strength In Care adopts a policy of non-discrimination in the provision of our support services to individuals and the eligibility and entry to these services.

Participants have the right to:

- access supports that promote, uphold and respect their legal and human rights
- exercise informed choice and control
- freedom of expression, self-determination and decision-making
- access supports that respect culture, diversity, values and beliefs
- access a service that respects their dignity and right to privacy
- support access to make informed choices to maximise their independence
- access supports free from violence, abuse, neglect, exploitation or discrimination
- receive supports that are overseen by strong operational management
- access services which are safeguarded by caring carers who work within a well-managed risk and incident management system
- receive services from workers who are competent, qualified and have expertise in providing person-centred supports
- consent to the sharing of information between providers during transition periods
- select to opt-out of providing information, as required by NDIS.

4.2 Participants' responsibilities

Participants using our support services have responsibilities to Strength In Care. We ask that they:

- respect the rights of our staff to ensure a workplace that is safe, healthy and free from harassment
- abide by the terms of their agreement with us
- understand that their needs may change and, correspondingly, services provided may need to change to meet their needs
- accept responsibility for their actions and choices, even though some decisions may involve risk
- inform us if they have any problems with our staff or the services received
- share appropriate information to develop, deliver and review their support plan
- care for their health and wellbeing (as much as they can)
- provide information that will help us better meet their needs
- provide us with a minimum of 24-hours' notice if they will not be home for their service
- understand that our staff are only authorised to perform the agreed number of hours and tasks outlined in their service agreement
- contribute and participate in the safety assessments of their home
- control pets during service provision
- provide a smoke-free working environment
- pay the agreed amount for the services provided
- inform us in writing (where able) and provide appropriate notice before terminating our service
- advise our staff when asked if they wish to opt-out of a service.

4.3 Participant's right to provide feedback

Strength In Care values all feedback, positive and negative. We ask participants to speak up and not be silent; we want to know when a service has been exceptional or when

individuals are unhappy with the service received or believe they have not been treated fairly.

The participants will be offered the opportunity to provide input into our organisation's management. The participant can voice their opinions by attending meetings with management or other relevant persons and writing guiding feedback and emails. All options are open as we wish to hear how to improve their service.

Feedback can be provided in the following ways, including:

- completing a Complaints and Feedback Form
- talking directly to a staff member
- attending management meetings as a representative
- asking to speak to a more senior manager or supervisor
- contacting the office via the phone
- sending an email
- contacting us anonymously or completing the Anonymous Complaints and Feedback Form.

	Details
Complaints Manager	Olivier Vles
Email	ollie@strengthincare.com.au
Phone	03 7064 4003
Postal address	3J/19 Bruce Street, Mornington VIC 3931

We will acknowledge the complaint by responding within one working day. Strength In Care will resolve complaints openly, honestly and quickly. (See our Complaints and Feedback Policy and Procedure for further details).

If not satisfied with the resolution of a complaint, we recommend individuals contact the NDIS Quality and Safeguards Commission on 1800 035 544 (free call from landlines) or TTY 133 677.

Alternatively, individuals can lodge a complaint via the NDIS Quality and Safeguards Commission website. To view, go to forms.business.gov.au/smartforms

4.4 NDIS Code of Conduct

Our team will provide support or quality services to participants, their families, and advocates. To enable us to do this, we request that all participants:

- provide complete and accurate information about themselves and their situation
- explain any changes in their health
- inform their staff if they cannot keep an appointment or commitment
- complete consent forms so that we can work with an advocate (if applicable)
- act respectfully and safely towards other people using the service and towards our front-line worker
- provide feedback about the service and advise how services could be improved
- report back to us if you are unhappy with our services or if there is any matter of concern.

4.5 Our commitment to participants

Strength In Care takes a strengths-based, person-centred, holistic approach to care and support, where the participant or their advocate is primary to the decision-making process. Our team will ensure that services are managed with respect and that we consult participants. When dealing with our stakeholders, we will:

- treat people with respect
- treat individuals courteously, fairly and without discrimination
- inform participants of their rights and responsibilities through our orientation process, Easy Read documents and handbooks
- protect personal information
- involve participants in any decisions regarding the services they access
- assist participants in connecting with other services, if needed

- inform how to provide feedback on our services
- ensure participant safety and undertake practices that prevent injury
- assist participants in accessing and using our services
- comply with signed service agreements
- inform participants of their rights and responsibilities
- arrange for an interpreter or other language services, if required
- respect individual views, opinions, personal circumstances and cultural diversity
- provide advice and options regarding other supports and services that may be available
- ensure staff have the appropriate skills and competencies to meet participants' needs
- treat everybody with dignity, fairness and respect, without discrimination or victimisation
- advise how complaints can be made and provide information on how we will respond to that complaint
- provide support and care that recognises and acknowledges individual preferences, choices, interests and capability
- support the right for participants to receive quality care in an appropriate environment, which promotes participation
- give participants a voice in all aspects of their services
- listen and respond to the participant as per the NDIS Workforce Capability Framework
- provide services that meet, or exceed, relevant industry standards such as the NDIS practice standards and quality indicators, NDIS rules, and their charter of rights.

5.0 Related documents

- Participant Handbook
- Complaints and Feedback Form
- Anonymous Complaints and Feedback Form
- Complaints and Feedback Policy and Procedure

6.0 References

- NDIS Code of Conduct Rules 2018
- NDIS Workforce Capability Framework
- NDIS (Complaints Management and Resolution) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- United Nations Convention on the Rights of Persons with Disabilities

Preferred Method of Communication Policy and Procedure

1.0 Purpose

All participants have the right to access support that promotes, upholds and respects their legal and human rights and enables them to exercise choice and control. There is a variation in the modes of communication that each participant will require due to individual needs. This policy is designed to ensure that our employees understand each participant's preferred method of communication. This preferred method of communication will then be embedded in the support and services provided to the participant.

2.0 Scope

At all stages of service provision, staff must understand the participant's preferred method of communication and put that preference into practice wherever possible. The Director will inform the staff of each participant's communication requirements and will always endeavour to place staff that can communicate effectively with a participant.

3.0 Definitions

Term	Definition
Interpreter	A person who interprets and translates speech orally or in sign language. An interpreter translates the spoken words based on whatever grammatical knowledge of the language they interpret, and their interpretation is based on their expertise in the subject.

Translator	A translator is a professional person who translates one language into another language. A translator must be equipped with excellent linguistic skills. They must have a sound knowledge of grammar and express the thoughts presented in the language to a participant.
Mode of communication	This term is an expressive medium or channel of communicative intent expression - natural speech, facial expression and gesture. Exceptional communication modes include the use of graphic symbols or synthetic speech.
Easy Read documents	Easy Read documents simplify information, so it is easy to understand by the participant. It uses simple text and pictures to explain text and has lots of white space.

4.0 Policy

The participant's best means of communicating is determined at the initial contact and recorded and used from that point forward. Staff are required to treat all participants with respect and use their preferred mode of communication wherever possible. Variations in the mode of communication may include:

- written documents with no adjustments
- verbal explanations
- demonstration
- Easy Read documents – explanations and forms
- interpreters (oral)
- translators (written).

Participants may use their interpreters and access their advocate to assist them.

5.0 Procedure

At the initial contact meeting, staff will consult with the participant and their family or advocate to determine the most preferred mode of communication.

5.1 Initial Meeting

The Director will undertake the following steps:

1. Determine the best means of communication via discussion or assessment.
2. Record this mode of communication in the support plan.
3. Inform all staff who work with the participant.
4. Match staff with these skills, or train and support staff to communicate.
5. Prepare the relevant form of information for provision to participant
6. Arrange for an interpreter or translator (if required).

5.2 Provision of Information

Staff are to use the information gained in the initial meeting to provide information to the participant in their mode of communication, where information must be discussed with the participant. Methods that will be used may include:

- providing information in written Form without any adjustments
- providing information in written form using Easy Read Documents
- explaining the information orally to those with issues with reading or comprehending written documents
- demonstrating information (if able to do so)
- accessing an interpreter via Translating and Interpreting Services, Department of Home Affairs.

5.3 Communicate effectively

Staff are required to review information to determine how best to communicate with the participant. All communications must be:

- clear, inclusive and respectful
- adapted to suit the participant's age, culture and cognitive ability.

Staff must monitor their verbal and non-verbal communication style as they will be different to the participant and find ways to communicate effectively. The participant and staff member must be persistent and patient to work out the best communication means.

Communication techniques that should be used include:

- using plain English
- speaking clearly
- checking for understanding
- using body language
- keyword signing\

To enhance independence, staff may need to use tools and adaptive techniques such as:

- alphabet and/or word boards
- communication charts or cards

5.4 Documentation

Record the following in the participant's file and support plan:

- best means of communication
- type of information method used to inform the participant
- verbal explanation – by whom, when, and how
- list of information supplied
- how the participant agrees that they had been informed (verbal, signature, guardian or advocate)

6.0 Related documents

- Participant Intake Form
- Support Plan
- Support Plan – Easy Read
- Participant Handbook
- Easy Read Documents and Forms

7.0 References

- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- NDIS Act 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- United Nations Convention on the Rights of Persons with Disabilities

Person-Centred Supports Linkage Policy and Procedure

1.0 Purpose

People with disabilities have the same right as other members of Australian society to realise their full potential. They should be supported to participate in and contribute to social and economic life. This policy aims to ensure the inclusion of and access for people with disabilities to mainstream and community-based activities and other government initiatives.

2.0 Scope

This policy applies to all front-line staff.

3.0 Policy

Strength In Care will access links between other service systems, e.g. social activities, which will improve and support the varying needs of people with disabilities, their families and advocates.

Strength In Care's commitment is to make sure people with disabilities are connected to their communities by:

- providing information on mainstream services and community activities which will benefit participants
- contributing to developing links and networks within the community
- working in partnership with community organisations to provide opportunities for active participation in local activities
- supporting key workers to build their capacity so that they can sustain their role, which could involve linking them into direct-carer support services

- linking the participant and their families to social and recreational activities that provide the family with a break from their caring role and connect them with the community
- sourcing activities that promote the participant's wellbeing, e.g. personal development, peer support and mentoring.

4.0 Procedure

Strength In Care will follow this policy to allow participants to maintain their ability to participate in and contribute to society. Front-line workers are required to ensure that participants are:

- connected within their community
- informed about relevant activities to allow for the participant to make decisions and choices
- provided with the necessary skills to participate confidently and contribute to the community and protect their rights
- assisted to use and benefit from mainstream services
- assisted to participate in, and benefit from, community activities
- supported to contribute to leading, shaping and influencing their community.

5.0 Related documents

- Agency Referral Form
- Participant Information Consent Form

6.0 References

- NDIS - Framework for Information Linkages and Capacity Building
- NDIS Practice Standards and Quality Indicators 2021

Advocacy Support Policy and Procedure - Victoria

1.0 Purpose

Strength In Care recognises the importance of ensuring the participant's right to use an advocate or representative of their choice is maintained. All actual and potential participants can select and involve an advocate or a chosen representative to participate or act on their behalf.

2.0 Scope

This policy applies to all participants, staff, volunteers and stakeholders.

3.0 Definition

Advocacy is the active support for a cause or position, and, in this context, it is an expression of support for a person who may find it difficult to speak for him or herself. It may include achieving social justice, improving a person's wellbeing, preventing abusive, harmful and discriminatory treatment, or stopping unjust and unfair treatment from meeting their fundamental needs and interests.

Below is a list of six types of advocacies:

Type of Advocacy	Description
1. **Individual advocacy**	The advocacy aims to prevent or address instances of discrimination or abuse using a one-on-one approach
2. **Systemic advocacy**	They are working to influence or secure long-term changes to ensure the collective rights and interests of people with disabilities.

3. **Family advocacy**	A family member advocates to provide a voice on behalf of another family member.
4. **Citizen advocacy**	Matches people with disabilities to volunteers.
5. **Legal advocacy**	Upholds the rights and interests of people with disabilities by addressing the legal aspects of discrimination, abuse and neglect.
6. **Self-advocacy**	Supports people with disabilities to advocate for themselves or as a group

4.0 Policy

All participants have the right to use a chosen advocate to represent their interests and speak on their behalf.

Our staff will work cooperatively with the participant's nominated advocate and show the same respect to the advocate as shown to the participant. When the participants cannot advocate for themselves, it is Strength In Care's policy to ensure that the participant's interests are represented and supported using a substitute decision-maker.

4.1 Advocacy principles

- Strength In Care will ensure that all staff receive training in the use of advocates.
- Strength In Care will maintain printed material on advocacy and advocacy services.
- Strength In Care will maintain local advocacy resource/contact lists.
- Strength In Care will work cooperatively with any nominated advocate chosen by the participant and show the same respect to the advocate as is shown to the participant.
- Strength In Care will utilise a governance system to enable Strength In Care to identify where a participant needs advocacy.

5.0 Procedure

5.1 Initial assessment (participant without an advocate)

- Strength In Care will work cooperatively with any nominated advocate chosen by the participant and show the same respect to the advocate as is shown to the participant.
- Provide the participant with advocacy information.
- Explain to the participant their rights regarding advocacy as per the Strength In Care's Service Agreement and Charter of Rights and the NDIS Practice Standards and Quality Indicators 2021.
- Advise the participant that if they wish to utilise advocacy services, Strength In Care can assist them in contacting any of these services.
- Provide the Authority to Act as an Advocate Form to the participant if they decide to utilise the services of an advocate. The completed and signed Form is stored in the participant's file.
- Provide the Third-Party Information Release Consent Form to the participant. The completed and signed Form is stored in the participant's file.
- Discuss and document any specific communication issues or protocols between the service and the advocate (email, phone, or other methods).
- Inform the participant that they can add and withdraw approval for an advocate to act on their behalf.

5.2 Initial assessment (participant with advocate/representative)

Before initial assessment

- Ensure during initial contact with the participant that they are informed of their right to an advocate and record the advocate's details if they have one.
- Advise the participant of the need to complete the Authority to Act as an Advocate Form and provide the appropriate form.

- Contact the nominated advocate to ensure they are aware they are nominated and confirm they agree to advocate.
- Place the completed Authority to Act as an Advocate Form in the participant's file.
- Ensure the potential participant is aware of their advocacy rights, including the right to have an advocate present for all assessments, meetings and communication between themselves and Strength In Care.
- Schedule the participant's initial assessment at a time and date to allow the advocate to be present.
- Arrange for an identified advocate to be present at the assessment.

At initial assessment

- Request the completion of the Authority to Act as an Advocate Form if it has not yet been provided. Explain to the participant that the form must be completed for Strength In Care to recognise the nominated person as the participant's advocate formally.
- Gather information about the advocate, such as contact details and methodology.
- Explain that the participant has the right to change their advocate. The participant should document changes using the Authority to Act as an Advocate Form in writing (Easy Read form available).

5.3 Working with advocates

- Identify the existence of an advocate on the participant's file.
- Discuss and document any specific communication issues or protocols between the service and the advocate.
- Communicate with a participant's advocate and involve them in goal setting, planning service responses, and referrals for additional or alternative services.
- Provide the advocate with ongoing information regarding the health and well-being of the participant, as agreed.
- Ensure that all on-call staff are aware of the participant's advocate.

5.4 Continuing work with advocates

- During reassessments, visits, or meetings, provide participants with written and verbal information that reminds them of their right to have (or change) an advocate.
- Remind participants of their right to have (or change) an advocate during each annual review of services or written communication.
- Communicate and work cooperatively with advocates.
- Refer participants assessed as 'not able to manage their service' (and who have no other advocate) to the Victorian Government Office of the Public Advocate, as appropriate.

Note: A web link accessing disability advocacy services is available. As a postcode, town or suburb is required to be entered to access services, Strength In Care will guide and assist participants. Go to Disability Advocacy Finder on the Department of Social Services website.

6.0 Related documents

- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Authority to Act as an Advocate Form
- Third-Party Information Release Consent Form

7.0 References

- Disability Act 2006 (VIC)
- Disability (NDIS Transition) Amendment Act 2019 (VIC)
- Information Privacy Act 2000 (VIC)

- Privacy and Data Protection Act 2014 (VIC)
- Human Rights and Equal Opportunity Commission Act 1986 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- National Disability Strategy 2010-2020
- NDIS Practice Standards and Quality Indicators 2021

8.0 Advocacy information

Organisations	Websites
Australian Centre for Disability Law	disabilitylaw.org.au
Autism Asperger's Advocacy Australia (A4)	a4.org.au
The Autistic Self Advocacy Network of Australia and New Zealand	asan-au.org
Blind Citizens Australia	bca.org.au
Brain Injury Australia	braininjuryaustralia.org.au
Children and Young People with Disability Australia	cyda.org.au
Deaf Australia	deafaustralia.org.au
Deafness Forum of Australia	deafnessforum.org.au
Disability Advocacy Network Australia (DANA)	da.org.au
First Peoples Disability Network (FPDN)	fpdn.org.au
Human Rights Council of Australia	hrca.org.au
Inclusion Australia (National Council on Intellectual Disability - NCID)	inclusionaustralia.org.au
Intellectual Disability Rights Service	idrs.org.au
Mental Health Australia	mhaustralia.org

National Disability Services	nds.org.au
National Ethnic Disability Alliance (NEDA)	neda.org.au
People With Disability Australia	pwd.org.au
Physical Disability Australia (PDA)	pda.org.au
Short Statured People of Australia	sspa.org.au
Women with Disabilities Australia (WWDA)	wwda.org.au

8.1 Victorian advocacy providers

Advocacy Providers	Website
Action on Disability in Ethnic Communities (ADEC)	adec.org.au
Action for More Independence & Dignity in Accommodation (AMIDA)	amida.org.au
Association for Children with a Disability (aCD)	acd.org.au
Blind Citizens Australia	bca.org.au
Communication Rights Australia (CAUS)	caus.com.au
Deaf Victoria	deafvictoria.org.au
Disability Justice Advocacy (DJA)	justadvocacy.com
Disability Discrimination Legal Service (DDLS)	communitylaw.org.au
Disability Resources Centre (DRC)	drc.org.au
Independent Mental Health Advocacy (IMHA)	imha.vic.gov.au
Office of the Public Advocate	publicadvocate.vic.gov.au
STAR Victoria	starvictoria.org.au
Valid	valid.org.au

Victorian Mental Illness Awareness Council - VMIAC	vmiac.org.au
Women with Disabilities Victoria (WDV)	www.wdv.org.au

1.2 Individual Values and Beliefs

Individual Values and Beliefs Policy and Procedure

1.0 Purpose

People with disabilities have the same right as other members of Australian society to realise their full potential. They should be supported to participate in and contribute to social and economic life and voice their opinions and needs about their services.

We support inclusion and access for people with disabilities to mainstream and community-based activities and other government initiatives (National Disability Strategy 2010-2020).

To meet the identity capabilities of the NDIS Workforce Capability Framework, as it relates to culturally and linguistically diverse; Lesbian, Gay, Bi-sexual, Transgender, Intersex, Queer/questioning and Asexual (LGBTIQA) participants.

To inform the community of Strength In Care's service provision capacity, including the priority of access process and eligibility criteria requirements, we will encourage and manage requests for service from potential participants and referrals to and from other agencies.

Strength In Care commits to cultural diversity and supports our participants by respecting their culture, values and beliefs. We will recognise and value the multicultural nature of Australian society and provide specific acknowledgement and support to the customs of Australian Indigenous people.

2.0 Scope

The Individual Values and Beliefs Policy focuses on the inclusiveness of all community groups and freedom from discrimination that belongs to all people, irrespective of their sexual orientation, gender identity, disability, race, sex, cultural and linguistic diversity, age, and stage development.

The policy applies to Strength In Care staff and management engaged in working with participants.

3.0 Policy

Strength In Care will deliver flexible services that are designed to meet the needs of diverse peoples. We will actively provide a work environment that supports, values and encourages cultural diversity by training our staff to develop their cultural and LGBTIQA understandings.

Strength In Care will identify any real or potential barriers for the participant to access our services. Our strategies to ensure equity for all people may include:

- treating all people equally according to their human rights
- encouraging inclusion of all people regardless of their background, ethnicity, culture, language, beliefs, gender, age, sexual orientation, socioeconomic status, level of ability, additional needs, family structure or lifestyle
- promoting inclusive practices and ensuring the successful involvement of participants in the community to enable them to reach their goals and aspirations.

Strength In Care will collaborate with the participant to identify their culture, diversity, values and beliefs. Strength In Care acknowledges the participant's right to practice their cultures, values and beliefs. Strength In Care will work with the participant to ascertain how and when they wish to participate in any religious or cultural practices. The team must respond sensitively to the participant's requirements and work with them to access their vital support.

Strength In Care recognises, respects, promotes and celebrates the value of cultural diversity. Our team will adopt and implement inclusive and culturally diverse policies and strategies.

Strength In Care is committed to social inclusion and community participation in both the delivery and expansion of services for disadvantaged participants. Our team will partner with the community, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, and people with different sexual orientations and disabilities.

To improve and support the varying needs of people with disabilities, their families and advocates, we will access links between other service systems. We will:

- consult with our participants to facilitate the provision of fair, equitable and transparent services
- seek participant input into our governance so we can modify our policies and practices to meet participants' needs and aspirations through meetings, verbal and written feedback or anonymously if they so wish.
- work with services in the community to ensure our participants are provided with relevant contacts to other services and community networks to enable the development of their personal goals, outcomes and aspirations in line with their support plan
- actively encourage and support our participants to maintain personal networks and community connections and participate in their community
- use networks and community engagement feedback to inform management processes.

Strength In Care will gather information about participants' cultural beliefs, values and diversity. Participants' decisions and choices regarding their beliefs and cultural practices are supported and recorded in their support plan.

Strength In Care's commitment is to make sure people with disabilities are connected to their communities by:

- providing information on mainstream services and community activities which will benefit people with disabilities, as well as their families and advocates
- contributing to relevant links and networks within the community
- encouraging participation and inclusion of people with disabilities by working in partnership with community organisations.

Strength In Care is committed to identifying and liaising with other stakeholders. Stakeholder identification and contact are dependent on the participant and may include local community support organisations, job networks, training organisations and housing agencies.

Strength In Care will uphold and promote the legal and human rights of all people and abide by the United Nations Convention on the Rights of People with Disabilities.

Strength In Care will treat all people with courtesy and dignity and will recognise their human rights to self-determination and privacy.

4.0 Procedure

Strength In Care will ensure that all participants are treated fairly and in a non-discriminatory manner. This intent incorporates both intake and service delivery processes. Information provided will be in an Easy Read format, but we will arrange relevant support in the home language or an interpreter. For any participant who has an information reading or understanding barrier, a support person will be provided to assist the participant in understanding what is said to them.

Our team assists the participant in decision-making about their level of participation in their relevant support. Strength In Care will support the participant to access supports linked to their culture, diversity, values and beliefs. The type of support and responses will be determined through consultation with the participant and will follow the choices made by the participant. Below are guidelines to assist staff in the process:

- pursue contacts that the participant has chosen
- contact local communities, e.g. cultural, religious, sexual orientation groups or spiritual groups, including Aboriginal and Torres Strait Islander communities
- contact government agencies to seek support for individual participants
- source community members and groups to provide input into the service
- contact advocates to assist with the development of community support plans for the participants
- support the participant's rights to seek contact with those in the community relevant to their wishes, goals and aspirations. The participant will be encouraged to join with related community links, as required
- follow the participant's aspirations and needs to participate in the community actively.

Strength In Care will make relevant contacts for the participant to assist in initial involvement with their selected group or individual.

Strength In Care will work with Aboriginal and Torres Strait Islander people and culturally diverse groups to actively engage with their communities. Support provided by their community is incorporated within the participant's support plan. This support will be assessed, monitored and reviewed to ensure that the goals and aspirations of participants are met using the relevant community supports.

Strength In Care will provide services that meet the aspirations and goals of the participant for inclusion in the community.

Our organisation will work with the community to actively encourage participants to participate in various activities, including employment, education, sporting activities, cultural events, and relevant activities.

We are committed to building relationships with and between key stakeholders, including governments, organisations and communities, to obtain the best result for their participants.

Strength In Care will ensure that their services are tailored to meet their participant's needs flexibly, acknowledging that each person's needs are different.

Strength In Care will place a high priority on providing early intervention and prevention in each participant's case. By understanding the root causes of any issues and intervening early, problems can be effectively managed. Strength In Care will undertake cultural competency training for staff to increase knowledge and build strategies on how to work inclusively.

Strength In Care promotes inclusion by:

- working closely with a network of health and allied health professionals to be able to support the holistic needs of our participants
- building effective partnerships with the participants and their families, advocates and support people to discuss and foster shared priorities and understand the participant's individual needs and goals
- focusing efforts on building social inclusion and participation opportunities within the range of services provided
- providing information on community events and other relevant networks that meet participants' needs and identified goals
- working within a participant's networks and supports, e.g. childcare, kindergarten, school or home environments, to allow Strength In Care to assist the participant foster relationships and increase participation in familiar surroundings
- instigating a Person-Centred Supports Linkage Policy and Procedure outlining how Strength In Care will work with other communities for the betterment of their participants
- operating in a manner that ensures all people can access our services.

4.1 Understanding individual responsiveness – cultural and linguistically diverse

Staff (role-dependent) are required to:

- ask the participant about appropriate cultural and linguistic protocols
- following the participant's cultural and linguistic protocols
- check with the participant on culturally appropriate ways to reflect and assess current practices
- seek information about how they want to connect with their community
- not put their own experience, attitudes and beliefs related to identity as 'normal'
- recognise the complexity of working in a cross-culture context and be aware of their judgements and biases affect their behaviour
- understand that they may not be able to perceive the participant's cultural perspective
- support the person to access an interpreter or similar to ensure safe, accurate and meaningful communication
- seek feedback from family and other community members to understand how to build on or adjust current practices
- assist the participant in accessing culturally and linguistically appropriate channels to provide feedback and complaints.

4.2 Understanding individual responsiveness - LGBTIQA+ identity

Staff (role-dependent) are required to:

- ask and respect the participant's sexual expression and orientation
- respect and protect the participant's privacy about with whom they share their sexual orientation, gender identity and/or expression
- ask what is relevant to support sexual orientation, gender identity and/or expression and respect their right not to provide this information
- ask how to refer to the participant, such as personal pronouns - he
- use inclusive language

- support the participant to connect with chosen community(s) and family and acknowledge them as part of the support team
- not put their own experience, attitudes and beliefs related to identity as 'normal'
- understand that they may not be able to perceive the participant's perspective
- find spaces that are safe for me to explore and share my sexual orientation, gender identity and expression, as required
- connect to community groups and peer networks that can broaden support options and minimise safety risks
- work with the participant to improve experience and confidence in accessing support and service
- check on the preferred way of reflecting and assessing the service provided
- provide support to find and access safe and inclusive channels to raise concerns, complaints and incidents

5.0 Related documents

- Aboriginal and/or Torres Strait Islander Policy and Procedure
- Person-Centred Supports Linkage Policy and Procedure
- Participant Information Consent Form
- Staff Training Record
- Staff Training Plan
- Support Plan

6.0 References

- Disability Discrimination Action 1992 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- National Disability Strategy 2010 - 2020
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- United Nations Convention on the Rights of People with Disabilities

1.3 Privacy and Dignity

Privacy and Dignity Policy and Procedure

1.0 Purpose

Strength In Care provides our participants with access to services and supports that respect and protect their dignity and right to privacy.

2.0 Scope

This policy applies to all participants and staff of Strength In Care and other service agency representatives.

3.0 Policy

Strength In Care is committed to protecting and upholding all stakeholders' rights to privacy and dignity, including participants, staff, management and representatives of other service agencies.

Strength In Care is committed to protecting and upholding the participants' rights to privacy and dignity as we collect, store and handle information about them, their needs and the services provided to them.

Strength In Care requires staff and management to be considered and consistent when writing documents regarding a participant and when deciding who has access to this information.

Strength In Care is subject to NDIS Quality and Safeguards Commission rules and regulations. Strength In Care will follow the guidelines of the Australian Privacy Principles in its information management practices.

Strength In Care will ensure that each participant understands and agrees to the type of personal information collected and the reasons for collection. If the material is to be recorded in an audio or visual format, the participant must agree to their involvement in writing before any material can be collected. The participant must also be informed when the material is recorded in an audio or visual format.

Strength In Care will advise each participant of our Privacy Policy using the language, mode of communication and terms that the participant is most likely to understand (Easy Read documents are made available to all participants).

Strength In Care will ensure that:

- it meets its legal and ethical obligations as an employer and service provider concerning protecting the privacy of participants, and organisational personnel
- participants are provided with information about their rights regarding privacy and confidentiality
- participants and organisational personnel are provided with privacy, and confidentiality is assured when they are being interviewed or discussing matters of a personal or sensitive nature
- all staff, management and volunteers understand the requirements to meet their obligations
- participants are informed of Strength In Care's confidentiality policies using the language, mode of communications and terms they are most likely to understand
- Strength In Care will attempt to locate interpreters and use easy-read materials.

This policy conforms to the *Federal Privacy Act (1988)* and the *Australian Privacy Principles*, which govern personal information collection, use, and storage.

This policy will apply to all records, whether hard copy or electronic, containing personal information about individuals and interviews or discussions of a sensitive personal nature.

4.0 Procedure

4.1 Dealing with personal information

In dealing with personal information, Strength In Care staff will:

- ensure privacy for the participants, staff, or management when they are being interviewed or discussing matters of a personal or sensitive nature
- collect and store personal information that is only necessary for the functioning of the organisation and its activities
- use fair and lawful ways to collect personal information
- collect personal information only with consent from the individual
- ensure that people know of the type of personal information collected, the purpose of keeping the information, the method used when information is collected, used or disclosed, and who will have access to the information
- ensure that personal information collected or disclosed is accurate, complete, and up-to-date and provide access to the individual to review information or correct wrong information about themselves
- take reasonable steps to protect all personal information from misuse, loss and unauthorised access, modification or disclosure
- destroy or permanently de-identify personal information no longer needed or after legal requirements for retaining documents that have expired
- ensure that participants understand and agree with the type of personal information being collected and the reason/s for the collection
- ensure participants are advised of any recordings in either audio or visual format. Before collecting material, the participant's involvement in any recording format has been agreed to in writing.

4.2 Participant records

Participant records will be kept confidential and only handled by staff directly engaged in delivering service to the participant. Information about a participant may only be made available to other parties with the consent of the participant, or their advocate, guardian or legal representative. A written agreement providing permission to keep a recording must be stored in the participant's file.

All hard copy files of participant records will be kept securely in a locked filing cabinet in the office of the Director.

4.3 Responsibilities for managing privacy

All staff members are responsible for managing personal information to which they have access. The Director is responsible for the content appearing in Strength In Care publications, communications, and on our website and must ensure:

- appropriate consent is sought and obtained for the inclusion of any personal information about any individual, including Strength In Care personnel (see Consent Policy and Procedure)
- information provided by other agencies or external individuals conforms to our privacy principles
- our website contains a Privacy Statement that clearly outlines the conditions regarding any collection of personal information from the public captured via their visit to the website.

The Director is responsible for safeguarding personal information relating to Strength In Care's staff, management and contractors. The Director will be responsible for:

- ensuring that all staff members are familiar with the Privacy Policy and administrative procedures for handling personal information
- providing participants and other relevant individuals with information about their rights regarding privacy and dignity

- handling any queries or complaints about a privacy issue.

4.4 Privacy information for participants

During the first interview, participants are notified of:

- the information being collected about them,
- how their privacy will be protected, and
- their rights concerning this data.

Information sharing is part of our legislative requirements. Participants must consent to any information sharing between our organisation and government bodies. The participant is informed they can opt-out of any NDIS information sharing during audits.

4.5 Privacy for interviews and personal discussions

To ensure privacy for participants or staff when discussing sensitive or personal matters, Strength In Care will only collect personal information which is necessary for the provision of support and services and which:

- is given voluntarily
- will be stored securely on the Strength In Care database.

When in possession, or control, of a record containing personal information, Strength In Care will ensure that the record shall be protected against loss, unauthorised access, modification or disclosure by such steps as is reasonable in the circumstances. In cases when a record must be provided to a person in connection with the provision of a service to Strength In Care, everything reasonable will be done to prevent unauthorised use or disclosure of that record.

Strength In Care will not disclose any personal information to a third party without an individual's consent unless that disclosure is required or authorised by, or under, law.

5.0 Related documents

- Code of Conduct Agreement
- Easy Read Privacy Document
- Privacy and Confidentiality Agreement
- Consent Policy and Procedure

6.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Australian Privacy Principles (Commonwealth)

Management of Data Breach Policy and Procedure

1.0 Purpose

To meet legislative compliance requirements as a mandatory reporter of eligible data breaches to the Office of the Australian Information Commissioner (OAIC) and any individuals potentially affected by a data breach. Our organisation must inform relevant authorities of any breach, limit and reduce risks to the business, and ensure continuous improvement in the maintenance of data held by our organisation.

2.0 Scope

All staff members must maintain the confidentiality of all data relating to participants and other staff members. This policy relates to all personal data regarding both participants and team members.

3.0 Definitions

Term	Definition
Data breach (Eligible data breach)	Unauthorised access to or unauthorised disclosure of personal information or lost personal information in circumstances where unauthorised access to or unauthorised disclosure of the information is likely to occur.
Likely (likely to result in serious harm)	To be interpreted to mean more probable than not

Reasonable person	A reasonable person is a person who is adequately informed, based on information immediately available or following reasonable enquiries or an assessment of the data breach. OAIC's guidance states that: *the reasonable person is not to be taken from the perspective of an individual whose personal information was part of the data breach or any other person. Generally, entities are not expected to make external enquiries about the circumstances of each individual whose information is involved in the breach*.
Likely to result in serious harm	An assessment as to whether an individual is likely to suffer 'serious harm' because of an eligible data breach depends on, among many other relevant matters: ● the kind and sensitivity of the information subject to the breach ● whether the information is protected and the likelihood of overcoming that protection ● if a security technology or methodology is used concerning the information to make it unintelligible or meaningless to persons not authorised to obtain it - the information or knowledge required to circumvent the security technology or methodology ● the persons, or the kinds of persons, who have obtained, or could obtain, the information ● the nature of the harm that may result from the data breach.

Potential forms of serious harm	It could include physical, psychological, emotional, economic and financial harm and harm to reputation.
Remedial action	There are several exceptions to the notification obligation. An entity can take effective remedial action to prevent unauthorised access to or disclose information when it is lost or prevent any serious harm resulting from the data breach. An entity takes such remedial action; an eligible data breach will not be taken to have occurred. Therefore an entity will not be required to notify affected individuals or the OAIC.
Suspicion of an eligible data breach	If Strength In Care merely suspects that an eligible data breach has occurred, but there are no reasonable grounds to conclude that the relevant circumstances amount to an eligible data breach; we must undertake a "reasonable and expeditious assessment" of whether there are reasonable grounds to believe that an eligible data breach has occurred.
Assessment time frame	Within 30 days after the day, it became aware that the grounds caused it to suspect an eligible data breach.

Personal Information	Personal information includes a broad range of information, or an opinion, that could identify an individual. Personal information will vary depending on whether a person can be identified or identifiable in the circumstances. For example, personal information may include: ● an individual's name, signature, address, phone number or date of birth ● sensitive information ● credit information ● staff member record information ● photographs ● internet protocol (IP) addresses ● voiceprint and facial recognition biometrics (because they collect characteristics that make an individual's voice or face unique) ● location information from a mobile device (because it can reveal user activity patterns and habits).

4.0 Policy

Strength In Care views data breaches as having severe consequences, so the organisation must have robust systems and procedures in place to identify and respond effectively.

Strength In Care will delegate relevant staff members with the knowledge and skills required to become a Data Breach Response Team member.

Staff are required to inform the Director or their delegate of the potential, or suspected, data breach immediately. Within forty-eight (48) hours, the Director is to complete a Data

Breach Process Form. Plus, ensure that, as a regulated entity, they notify the particular individuals and the Commissioner about eligible data breaches as soon as practicable (no later than thirty (30) days after becoming aware of the breach or suspected breach).

If a staff member becomes aware that there are reasonable grounds to believe that there has been an eligible data breach, Strength In Care is required to promptly notify any individuals at risk of being affected by the data breach and the OAIC.

Strength In Care will undertake the following when an eligible data breach has occurred:

1. Prepare a statement that, at a minimum, contains:
    a. Strength In Care contact details:
        i) If relevant, the identity and contact details of any entity that jointly or simultaneously holds the same information, the eligible data breach has occurred, e.g. due to outsourcing, joint venture or shared services arrangements. If information of this sort is included in the statement, the other entity will not need to report the eligible data breach separately.
    b. a description of the data breach
    c. the kinds of information concerned
    d. the steps it recommends individuals take to mitigate the harm that may arise from the breach (while the entity is expected to make reasonable efforts to identify and include recommendations, it is not expected to identify every recommendation following a breach).
2. Provide a copy of the prepared statement to the OAIC using the online Notifiable Data Breach Form.
3. Undertake such reasonable steps to notify affected or at-risk individuals of the contents of the statement. Individuals will be notified by email, telephone or post, depending on the situation; if direct notification is not practicable, Strength In Care will publish the statement on its website and take reasonable steps to publicise its contents.

5.0 Procedure

5.1 Stage 1. Assess and determine the potential impact

- Once notified of the potential data breach, the Director must consider whether a privacy data breach has (or is likely to have) occurred and made a preliminary judgement as to its possible severity.
- Advice on managing the data breach should be sought from appropriate managerial staff.
- Criteria for determining whether a privacy data breach has occurred:
  - Is personal information involved?
  - Is the personal information of a sensitive nature?
  - Has there been either - unauthorised access to personal information or unauthorised disclosure of personal information or loss of personal information in circumstances where access to the information is likely to occur?
- Criteria for determining the severity of the breach:
  - type and extent of personal information involved
  - the number of individuals that have been affected
  - if the information is protected by any security measures (password protection or encryption)
  - type of person/s who now have access
  - whether there is (or could be) a real risk of serious harm to the affected individuals
  - if there could be media or stakeholder attention due to the breach/ suspected breach.
- Concerning the above, serious harm could include physical, physiological, emotional, economic/financial or harm to reputation and is defined in *Section 26WG* of the *National Data Breach Act*.

The Director and relevant staff will take a preliminary view as to whether the breach (or suspected breach) may constitute a Notifiable Data Breach. Accordingly, the Director will issue pre-emptive instructions as to whether the data breach should be managed at the local level or escalated to the Data Breach Response Team (Response Team); this will depend on the nature and severity of the breach.

5.2 Stage 2. Select the appropriate data breach management option

Option 1 - Data breach managed at a local level by managerial staff

1. The Director will ensure the implementation of immediate corrective action if this has not already occurred. Corrective action may include retrieving or recovering personal information, ceasing unauthorised access, and shutting down or isolating the affected system.
2. A Data Breach Process Report must be completed within 48 hours of receiving instructions. The report will contain a:
    - description of the breach or suspected breach
    - summary of action taken
    - summary of outcomes from the action taken
    - outline of processes implemented to prevent a repeat situation
    - the recommendation that outlines why no further action is necessary.
3. The Director will sign off, confirming that no further action is required.

Option 2 - Data breach managed by the Data Breach Response Team

1. When the Director instructs that the data breach be escalated to the Response Team, the Director will convene the Response Team and notify any relevant managerial staff.
2. The Response Team will consist of:
    - Director
    - Human Resource nominee
    - Information Technology nominee
    - Marketing and external relations nominee

- Other people nominated by the Director.

5.2.1 Primary role of the Data Breach Response Team

There is no single method of responding to a data breach. On a case by case basis, each incident must be dealt with by assessing the circumstances and associated risks to inform the appropriate course of action. The following steps may be undertaken by the Response Team, as appropriate:

1. Immediately contain the breach if this has not already occurred. Corrective action may include retrieving or recovering personal information, ceasing unauthorised access, and shutting down or isolating the affected system.
2. Evaluate the risks associated with the breach, including collecting and documenting all available evidence regarding the information outlined above.
3. Call upon the expertise of, or consult with, relevant staff members in specific circumstances.
4. Engage independent cybersecurity or a forensic expert, as appropriate.
5. Assess whether serious harm is likely (with reference above and Section 26WG of the National Data Breach Act).
6. Make a recommendation to the Director whether this breach constitutes an NDB for mandatory reporting to the OAIC and the practicality of notifying affected individuals.
7. Consider developing a communication or media strategy, including the timing, content and method of any announcements to participants, staff members or the media.
8. The Response Team must undertake its assessment within 48 hours of being convened.

5.2.2 Secondary role of the Data Breach Response Team

Once the data breach has been dealt with appropriately, the Response Team should turn its attention to the following steps:

1. Identify lessons learnt and remedial action that can be taken to reduce the likelihood of a recurrence; this may involve a review of policies, processes and refresher training.
2. Prepare a report for submission to senior management.
3. Consider conducting an audit to ensure that the necessary outcomes are affected and effective.

5.3 Stage 3. Notify the Office of the Australian Information Commissioner

- Taking into consideration the Response Team's recommendation, the Director will determine whether there are reasonable grounds to suspect that a Notifiable Data Breach has occurred.
- If there are reasonable grounds, the Director must prepare a prescribed statement and provide a copy to the OAIC as soon as practicable (and no later than 30 days after becoming aware of the breach or suspected breach).

6.0 Related documents

- Staff Training Record
- Staff Training Plan
- Data Breach Process Form

7.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Privacy Amendment (Notifiable Data Breaches) Act 2017 (Commonwealth)

1.4 Independence and Informed Choice

Independence and Informed Choice Decision-Making Policy and Procedure

1.0 Purpose

Strength In Care policy is underpinned by international, national and state obligations concerning the human rights of people with disabilities; Article 12 of the *United Nations Convention on the Rights of Persons with Disabilities* is the critical driver behind supported decision-making.

We wish to support all participants in making informed choices, exercising control, and maximising their independence relating to the support provided.

Quality decision-making will underpin the long-term effectiveness of participant support and agreements. It facilitates the achievement of strategic goals, maximises participant involvement, enhances participant outcomes and encourages the wellbeing and productivity of our staff.

2.0 Scope

This policy applies to all Strength In Care staff and participants accessing our services.

3.0 Policy

This policy assumes that each participant has decision-making capacity, unless proven otherwise, and acknowledges that each participant's capacity varies for each decision and situation. All participants have the dignity of risk to make their own decisions.

In instances where a participant's decision-making capacity is in doubt, this policy provides direction regarding determining capacity and consent, supporting and facilitating decision-making, and deciding on behalf of the participant.

This policy will eliminate the risk of a participant's life decisions without their involvement or against their actual or anticipated wishes. Decisions are only to be made with the consent of the participant.

Strength In Care puts choice and control squarely in the hands of people with disabilities, their families and carers. Our organisation will collaborate with the participant, family, carers and advocates to determine the participant's capacity.

Director will designate the relevant staff to determine a participant's capacity through:

1. Always assuming the participant has the capacity
2. Never basing the capacity assessment on appearances
3. Identifying the decision to be made.
4. Assessing the participant's decision-making ability and not the decision being made - A participant cannot be assessed as lacking capacity simply because they make a decision that is considered unwise, reckless or wrong.
5. Using a substitute decision-maker as a last resort
6. Documenting the process and reasons, as required

Strength In Care will provide information in an Easy Read format for participants who require this communication style.

4.0 Definitions

Term	Definition
Decision-making	Process of identifying and choosing alternatives based on the decision-maker's values, preferences, and beliefs.

Informed choice	A person chooses services based on diagnostic tests or treatments, knowing the details, benefits, risks and expected outcomes.
Capacity	Capacity is decision specific – it depends on the particular decision being made. Everyone has the right to make their own decisions or have the right to have support to make their own decisions. In some situations, this right must be balanced against the need to protect a person who cannot make a particular decision from harm to themselves or from exploitation by others.
Dignity of Risk	The dignity of risk is the right to take risks when engaging in life experiences and the right to fail in taking these.
Advocate	An Advocate is a person who puts a case on someone else's behalf.
Autonomy	The capacity to decide for oneself and pursue a course of action in one's life, often regardless of moral content.

5.0 Procedure

5.1 Advocate

Strength In Care will inform all participants from their first contact with Strength In Care that they have the right to access an advocate (including an independent advocate) of their choosing. They will be advised that it is their right to have the advocate present at any time that they are in contact with Strength In Care.

5.2 Decision-making and choice

During the development of the service agreement and all ongoing interactions with each participant, Strength In Care staff must:

- always assume that the participant can undertake decisions
- inform the participants, and their advocate, of their options regarding their supports
- advise the participants, and their advocate, of any risks to themselves or others regarding their options
- consult and collaborate with the participant, and their advocate, by providing current and relevant information to allow the participant to make decisions
- allow the participant enough time to absorb and understand all relevant information before and during the decision-making process
- provide information in an Easy Read format
- assess the participant's service requirements against their NDIS plan, plan and provide proper support and design appropriate strategies with the participant, family and advocate
- undertake review meetings where the participant, family and advocates have input
- plan with the participant, family and advocates when the participant decides to exit from Strength In Care.

The development of the support plan incorporates input from participants and their relevant networks. Each support service requires the participant to be part of the decision-making process. Strength In Care will:

- accept all decisions made unless there is a risk to the health and safety of the participant. In these cases, then Director or their delegate will:
    - inform the participant that if they wish to continue, it is their choice
    - undertake a risk assessment for the support (e.g. Risk Assessment Form – High-Risk Activity or Event)
    - consult with the participant and their relevant networks about the potential risks
    - discuss the participant's dignity of risk
    - create a risk management plan related to their activity choice

    - record details of discussion and outcome in the support plan
- identify any lifestyle risk factors as per the Lifestyle Risk Factors Policy and Procedure
- create an emergency plan (Emergency and Disaster Management Policy and Procedure), test and adjust the plan in consultation with the participant
- train and inform staff on the support plan strategies and documentation
- allow staff access to the support plan so they can undertake strategies and inform participants when questioned.

Strength In Care recognises that participants have the right to dignity of risk in their decision-making. Participants will be advised of the following:

- various relevant options that may support their needs before any decisions are made
- benefits of each relevant option
- risk, if any, linked to each relevant option.

Participants will be provided time to absorb information and make the appropriate decisions based on the risks involved.

5.3 Autonomy

All participants have the right to autonomy, and all staff will respect this. Participants can make decisions for themselves and pursue the actions that they determine. Participants have the right to make choices based on who they are and what they want to do. Front-line workers must allow the participant their right to intimacy and sexual expression (in the context of lawful behaviour).

5.4 Time

Strength In Care recognises that the participant may require time to make some decisions so they can review the various options available to them. Participants may also need to

seek advice from their networks and relevant stakeholders. Staff must not rush participants during the support provision and decision-making process.

5.5 Documentation

Strength In Care requires staff to record all information and options provided to each participant. Decisions will be recorded in the participant's file.

6.0 Related documents

- Access to Supports Policy and Procedure
- Easy Read Rights Document
- Participant Notes
- Responsive Support Provision and Support Management Policy and Procedure
- Risk Management Plan
- Service Agreement
- Support Plan
- Support Planning and Service Agreement Collaboration Policy and Procedure
- Transition or Exit Policy and Procedure
- Participant Information Consent Form

7.0 References

- NDIS Practice Standards and Quality Indicators 2021
- United Nations Convention on the Rights of Persons with Disabilities

1.5 Violence, Harm, Neglect, Exploitation and Discrimination

Violence, Harm, Neglect, Exploitation and Discrimination Policy and Procedure

Important note: Information regarding our organisation reporting harm or risk of harm against children refer to the Working with Children Policy and Procedure.

1.0 Purpose

Strength In Care recognises the right of all participants to feel safe and to live in an environment that protects them from assault, neglect, exploitation, discrimination or any other form of harm or abuse. People with disabilities, children and young people are some of the most vulnerable groups in our society. Strength In Care must identify, consult and respond to instances where persons with disabilities, children or young persons are being harmed or at risk of significant harm.

Common reasons for people with disabilities, children and young people to be at risk of significant harm include:

- domestic and family violence
- physical harm, sexual abuse and emotional harm
- neglect.
- Vulnerability due to living with disability

This policy aims to prevent and mitigate the effects of harm, risk of harm, violence, abuse and neglect on participants through training and implementing processes to inform staff and protect participants who are at risk of significant harm.

2.0 Scope

Strength In Care will encourage and support any person who has witnessed the abuse of a service user or, who suspects that harm or abuse has occurred, to make a report and be confident of doing so without fear of retribution.

3.0 Definitions

Term	Definition
Abuse and neglect	Any behaviour outside the norms of conduct entails a substantial risk of causing physical or emotional harm to a person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e. neglect) and commission (i.e. abuse).
Discrimination	Discrimination is the treating or proposing to treat someone unfavourably because of a personal characteristic protected by the law, including bullying someone because of a protected characteristic.
Exploitation	Exploitation is the action or fact of mistreating someone to benefit from their work or the action of making use of and benefiting from resources.
Violence	Violent behaviour by a person towards another can include abusive behaviour that is physical, sexual, intimidating and forceful.
Harm	Harm will be taken to be a reference to physical harm or psychological harm (whether caused by any act or omission) and includes such harm caused by sexual, physical, mental or emotional abuse or neglect

3.1 Types of abuse

Term	Signs and symptoms	Causes

Physical harm	Bruising, lacerations, welts, rashes, broken or healing bones, burns, weight loss, facial swelling, missing teeth, pain or restricted movements, crying, acting fearful, agitation, drowsiness, hair loss or poor physical well-being	Hitting, slapping, pushing, punching or burning entails an incident that is non-accidental, resulting in pain or injury.
Psychological/ emotional harm	Loss of interest in self-care, helplessness, withdrawal, apathy, insomnia, fearfulness, reluctance to communicate openly, choosing not to maintain eye contact, paranoia and confusion.	Intimidation, humiliation, harassment, threatening, sleep deprivation, withholding affection, or not allowing them to maintain their decision-making powers leads to a repeated pattern.
Sexual abuse	Unexplained sexually transmitted disease, vaginal/ anal bleeding, fear of specific people or places, bruising to genital areas, inner thigh or around breasts, anxiety, torn or bloody underclothes, difficulty walking or sitting, sleep pattern changes, repeating nightmares.	Rape (penetration or oral-genital contact), interest in older person's bodies, inappropriate comments and sexual references, inappropriate (possibly painful) administration of enemas or genital cleansing, indecent assault, and sexual harassment are mainly about violence and power over another person, rather than sexual pleasure.

Neglect	Neglect is poor hygiene or personal care, unkempt appearance, lack of personal items, absence of health aids, weight loss, agitation, inappropriate clothing or lack of food.	Neglect is the intentional failure to provide basic life necessities.
Domestic and family abuse	Any controlling, bullying, threatening or violent behaviour between people in a relationship, including emotional, physical, sexual, financial or psychological abuse.	Many experts believe in psychopathology. Witnessing abuse as the norm, or being abused, destroys the child's ability to trust others and undermines their ability to control emotion.

Financial harm	Unexplained money loss, lack of money to pay for essentials such as rent, bills and food, Inability to access or check bank accounts and bank balance, changes or deterioration in standards of living, e.g. not having items or things they would usually have, Unusual or inappropriate purchases in bank statements, Isolation and withdrawal from friends and family, Lack of things you'd expect someone to be able to afford, e.g. TV, grooming items, clothing	Financial abuse is when someone takes away access to money, manipulates their financial decisions, or uses their money without consent. It occurs when someone uses money or things relating to money to hurt, scare or control someone.
Grooming	Being very secretive about how they're spending their time, including when online, having money or new things like clothes and mobile phones that they can't or won't explain, depression and or anxiety, underage drinking or drug taking	Grooming is when someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them.

4.0 Policy

This policy aims to:

- take a preventative, proactive and participatory approach to participant safety
- value and empower the participant to contribute to decisions that affect their lives
- foster a culture of openness that supports all persons to disclose the risks of harm to participant safety
- respect diversity in cultures and child-rearing practices while keeping the participant's safety paramount
- provide training to staff on appropriate conduct and behaviour towards participants
- engage only the most suitable people to work with participants and ensure superior quality staff, volunteer supervision and professional development
- ensure participants know who to talk to if they are worried or feeling unsafe and that they are comfortable and encouraged to raise any issues
- report suspected abuse, neglect or mistreatment promptly to the appropriate authorities
    - children to Police on 000 if there is a serious immediate risk, and to the state reporting body
    - adults to Police on 000 if there is a serious immediate risk
- share information appropriately and lawfully with other organisations where the safety and wellbeing of the participants are at risk
- value the input of families and advocates and communicate regularly with them.

A participant's harm, abuse and neglect are defined as a reportable incident; therefore, the Reportable Incident, Accident and Emergency Policy and Procedure will apply.

4.1 Statement of commitment to safety

Strength In Care is committed to the safety and wellbeing of all participants. This commitment is the primary focus of our support and decision making. Strength In Care is committed to providing a safe environment where participants are safe, and their voices are heard and included in decisions that affect their lives. Attention is paid to the cultural safety of participants from culturally or linguistically diverse backgrounds.

All staff members have a responsibility to understand the critical and specific role they play, both individually and collectively, to ensure the wellbeing and safety of all participants and young people are at the forefront of all they do and every decision they make.

4.2 Safe Code of Conduct

Strength In Care is committed to the safety and wellbeing of participants. Our business recognises the importance of, and responsibility for, ensuring our environment is a safe, supportive and enriching environment that respects and fosters the dignity and self-esteem of all people, enabling them to thrive.

The Safe Code of Conduct protects our employees and participants and reduces abuse or harm opportunities. It also assists in understanding how to avoid or better manage risky behaviours and situations. It is intended to complement child protection legislation, disability legislation, policies and procedures, and professional standards and codes of ethics apply to all staff.

Strength In Care management supports the implementation and monitoring of the Code of Conduct. We will plan, implement and monitor arrangements to provide inclusive and safe environments.

All staff, volunteers, and other community members involved in participant-related work must comply with the Code of Conduct by observing appropriate and acceptable behaviour (see '4.3 Acceptable behaviours' below). The Code of Conduct applies in all situations, including planned activities, digital technology, and social media.

4.3 Acceptable behaviours

Staff or any other persons involved with participant-related work are responsible for supporting and promoting the safety of participants by:

- upholding Strength In Care's Statement of Commitment for the participant's safety
- treating the participant, their family and advocates with respect within the environment and during outside activities as part of everyday social and community activities
- listening and responding to the participant's views and concerns, particularly if:
    - they are reporting that they or another person have been abused; or
    - that they are worried about their safety or the safety of another participant
- promoting cultural safety, participation and empowerment of Aboriginal and Torres Strait Islander people through interactions with their community leaders and members
- promoting the cultural safety, participation and empowerment of people with culturally or linguistically diverse backgrounds through engagement with the community accessing the service
- promoting the safety, participation and empowerment of people with disabilities
- reporting any allegations of harm, risk of harm and abuse or personal safety concerns to management, who must contact the relevant state authority (for children, see *Working with Children Policy and Procedure*)
- understanding and complying with all reporting or disclosure obligations (including mandatory state reporting), as they relate to protecting the participant from harm or abuse
- maintaining the right to live in a safe environment by promoting and informing the participants of their rights
- ensuring participants are safe and protected from harm as quickly as possible once harm, risk of harm or abuse is suspected
- identifying themselves to the participant upon entering premises and showing any required identification.

4.4 Unacceptable behaviours

As front-line workers, volunteers and community members involved in participant-related work, our staff will not:

- ignore or disregard any concerns, suspicions or disclosures of abuse
- develop a relationship with any participant that could be viewed as favouritism or grooming behaviour, e.g. offering gifts
- exhibit behaviours, or engage in activities with participants that can be interpreted as abusive, harmful and unjustifiable in an educational, therapeutic or service delivery context
- ignore behaviours by other adults toward young participants when they are overly familiar or inappropriate
- discuss the content of an intimate nature or use sexual innuendo with participants, except where it occurs relevantly in the context of parental/advocate guidance or a therapeutic setting
- treat a participant unfavourably because of their disability, age, gender, race, culture, vulnerability, sexuality or ethnicity
- communicate directly with an underage participant through personal or private contact channels, e.g. social media, email, instant messaging or texting, except where that communication is reasonable in all the circumstances related to work or activities, safety concerns or other urgent matters.

4.5 Screening, supervising, training and human resource practices to reduce risk

Our staff will be required to undertake checks, including disability worker checks, relevant police, and working with children checks and the mandatory NDIS Worker Orientation Module. All records will be maintained in their personnel file.

5.0 Procedure

Figure 1 Steps in Incident Management (Incident Management Systems – detailed guidance for NDIS Providers June 2019. Please note: any harm or reasonable suspicion of

harm, abuse or neglect to children must be reported to the state authorities (see Working with Children Policy and Procedure)

Worker providing services identifies an incident or an allegation of an incident is reported to the worker

Worker provides immediate response to ensure the safety and wellbeing of impacted person

Worker follows incident manageme nt system processes

Relevant personnel undertake assessment of incident

Relevant personnel determine if incident is a reportable incident

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This includes:

- Reporting incident to relevant personnel
- Protecting evidence
- Notifying an impacted person's support person or family
- Contacting police or other relevant authorities

Relevant personnel make a notification to the NDIS Commission and comply with reportable incident process

Provider initiates action in response to incident

For reportable incidents keep NDIS Commission updated and respond to requests and directions

5.1 Strategies to identify and reduce or remove the risk of harm

Strength In Care recognise that creating a safe organisation begins with a clear understanding of the potential risks to the participant and staff in our organisation's setting. Strength In Care will identify possible issues and problems and plan to reduce or remove these risks.

To reduce the likelihood of harm, Strength In Care will consider, define and act against its organisational risks. These strategies include:

- considering the organisation, activities and services provided to participants
- reviewing and planning how to make all activities as safe as possible
- developing a safety plan for participants who require additional supports
- supporting participants with disabilities to understand plans and safety procedures using appropriate communication methods
- informing participants that they have the right to live in a safe environment
- acting proactively to reduce the likelihood of any risks.

5.2 Reporting violence, abuse, neglect, exploitation and discrimination

A report must be made if:

- a participant shows a change in behaviour or mood, which may indicate they are being abused
- someone is observed behaving toward a participant in a way that makes others feel uncomfortable
- a participant advises another person is abusing them
- a person advises that they are abusing another participant
- a participant or visitor informs that they have observed abusive or harmful acts
- a participant advises that they feel discriminated against, e.g. language and actions
- a participant presents as unkempt or seeking food
- there is evidence of unexplained bruising or similar

- an action or inaction is witnessed that may be considered abusive, harmful or at risk of harm
- when an individual, for any reason, believes a participant is being abused.

Failure to report an abusive, harmful or risk of harm situation may result in a criminal offence. Reporting procedure below relates to:

- abuse or neglect of a person with a disability (including harm and risk of harm for under 18s)
- unlawful sexual or physical contact with, or assault of, a person with a disability
- sexual misconduct, committed against, or in the presence of, a person with a disability, including grooming for sexual activity
- Unauthorised use of restrictive practices to a person with a disability.

5.3 Assault identification and response

Step 1. Identified potential or real risk of harm to a participant

- Inform management of the identified or actual risk of violence, abuse, neglect, exploitation and discrimination.
- If a real risk has occurred, Strength In Care will follow the reporting procedure listed below in 5.4 How to report (for more information, refer to the Reportable Incident, Accident and Emergency Policy and Procedure listed below).
- Steps 2 to 4 (below)will be followed as part of our prevention strategies if a real risk has not occurred.

Step 2. Response to a potential or real risk of harm to a participant

- Delegated management officer will contact police or governing state body, or in case of emergency, we will call 000 (follow the reportable incident process listed below)
- Support the participant by offering to contact relevant support persons (e.g. family member or advocate)

- If the risk of harm has not occurred, then management should review the Incident Report and determine prevention strategies

Step 3. Documentation

- Reporting staff member to complete the Incident Report.
- The Director will complete the Incident Investigation Form and the Incident Investigation Form Final Report (as required).

Step 4. Follow up

- The Director will check on the participant after the event to ensure that they are receiving any required support.
- Strength In Care will review our incident management system to identify if any additional preventative measures could be introduced to improve organisational practices.
- Strength In Care will train our staff as required to prevent harm to the participant.

5.4 Reporting roles

The organisation will establish the following roles and ensure that allocated staff are aware of their responsibilities:

1. Approved Reportable Incident Approver responsibilities:
    - the authority to review reports before submission to the NDIS Commission.
    - submits new reportable incidents
    - views previous reportable incidents submitted by their organisation.
2. Authorised Reportable Incidents Notifier responsibilities:
    - supports the Authorised Reportable Incident Approver to collate and report the required information
    - creates new reportable incident notifications to be saved as a draft for review and submission by the Authorised Reportable Incident Approver.
3. Mandated notifier responsibilities for children (see Working with Children Policy and Procedure)

5.5 How to report

The Director will review the information and contact the police immediately to inform them of the suspected abuse.

For Module 2A implementing providers, unauthorised use of a restrictive practice constitutes a reportable incident. The provider must notify the NDIS Commission within five business days of becoming aware of the use.

Reportable incidents are submitted via the NDIS Commission Portal - My Reportable Incidents page as follows:

1. Complete an **Immediate Notification Form** and submit it within 24 hours:
    - Approved Reportable Incident Notifier will create for approval.
    - Approved Reportable Incident Approver will approve and submit.

   Note: Approved Reportable Incident Notifier may create and submit as required by the circumstance of the incident. The participant's valid NDIS Number must be entered.

2. The **5-day Form** is to be completed within five days of key stakeholders being informed of an incident:
    - Approved Reportable Incident Notifier will create a form for approval.
    - Approved Reportable Incident Approver will approve and submit.
        - Note: Approved Reportable Incident Notifier may create and submit as required by the circumstance of the incident.
3. A final report will be submitted if requested by the NDIS Commission.
    - Approved Reportable Incident Notifier will create for approval.
    - Approved Reportable Incident Approver will approve and submit.
        - Note: Approved Reportable Incident Notifier may create and submit as required by the circumstance of the incident.

5.5.1 Timeframes for notifying the NDIS Commission about reportable incidents

When a reportable incident occurs or is alleged in connection with the NDIS supports or services you deliver, you must notify us using the NDIS Commission Portal within the required timeframes (set out below). The timeframes are calculated from when a registered NDIS provider became aware that the incident occurred or was alleged to have occurred.

Reportable incident	Required timeframe
death of a person with disability	24 hours
serious injury of a person with disability	24 hours
abuse or neglect of a person with disability	24 hours
unlawful sexual or physical contact with, or assault of, a person with disability	24 hours
sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity	24 hours
the use of the restrictive practice to a person with disability if the use is not following a required state or territory authorisation and/or not under a behaviour support plan.	Five business days

5.6 Details to provide

The Director will give the following information to the authorities:

- participant's name, age, date of birth and address
- description of injury, harm, risk of harm, abuse and neglect (outline current and previous)
- participant's current situation
- location of the participant and alleged perpetrator, if known

- explanation of when and how harm, risk of harm or abuse was discovered and by whom.

Note: NDIS forms must be submitted to the NDIS Commission. The required police contact will also use the above information if investigating an incident.

5.7 Investigating allegation or incident

An investigation is guided by relevant authorities such as the Police, NDIS and state reporting body for children (refer to Working with Children Policy and Procedure) to ensure that the internal investigation does not inadvertently affect the outcome of their investigation.

The Director undertakes a review of the allegation or incident by:

- gathering data from the relevant person/s
- analysing the situation to determine what occurred, how it occurred, and the parties involved
- determining the effect on the participant/s
- consulting with relevant stakeholders; never seek information that may guide the participant as this requires a specialist. Appropriate authorities will conduct any questioning once the incident is reported
- informing the participant or their family that they have access to a support advocate
- reviewing the outcome against practices
- undertaking action to prevent the incident from being repeated.

5.8 Support the participant

Reported allegations or incidents require the Director to gather all the relevant information and make a report to the relevant authority such as the police or via each state's reporting process.

Support will be provided to the participant relevant to the allegation or incident. The participant will be provided with an appropriate advocate if required.

5.9 Documentation

- Record all allegations and incidents in the Incident Register.
- Complete Incident Report and Incident Investigation Form
- Complete Incident Investigation Form, if required.
- All reports are to be included in the participant's file.
- Complete Immediate Notification Form and 5-Day Form, and NDIS Report, as required.
- Maintain records for seven years.

6.0 Related documents

- Authority to Act as an Advocate Form
- Code of Conduct Agreement
- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Report
- Incident Register
- Participant Notes
- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Reportable Incident, Accident and Emergency Policy and Procedure

- Working with Children Policy and Procedure
- Zero Tolerance Policy and Procedure

7.0 References

- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- The National Framework for Protecting Australia's Children
- United Nations Convention on the Rights of the Child 1989

Child Safe Environment Policy and Procedure

1.0 Purpose

Strength In Care recognises the child's right to feel safe and to live in an environment that protects from assault, neglect, exploitation or any other form of harm or risk of harm. This policy specifically looks at the requirements when working with children under eighteen (18) years. This policy has been designed to meet the Children & Young People (Safety) Act 2017 and the Child Safety (Prohibited Persons) Act 2016 to create a safe environment.

Director is responsible for:

- Ensuring all staff are trained, understand and sign that they have read and understood this policy and the Code of Conduct.
- Actively seek input and give children and young people, families, staff and relevant others a voice in this policy and our practices through:
    - Seeking feedback during support provision
    - Face to face meetings
    - Annual surveys
    - Feedback and complaints process
    - Annual staff performance reviews
- Ensure and confirm that all staff working with children hold the relevant Working with Children Check and NDIS Screening Check
- Review this policy at least every five years
- Monitor and manage the currency of all screening and compliance checks
- Ensure that contractors hold current checks and agree to our policy and Code of Conduct
- Ensure all children and young people have a support plan designed to suit their requirements
- Risk Assessment and management strategies are undertaken and reviewed
- Hold current checks – Working with Children and NDIS Screening
- Supply a copy of this policy upon request

Management, staff and volunteers are required to:

- Read, understand, seek clarification (as required) and agree to this policy and the Code of Conduct
- Hold current checks – Working with Children and NDIS Screening
- Comply with their job descriptions
- Follow all policies and procedures
- Provide feedback on policies and practices
- Report all risks or potential risks of harm to children and young people immediately to the Child Abuse Report Line.
- Communicate any complaints and incident information to management
- Always comply with National Principles for Child Safe Organisations and all state legislative requirements

Contractors are required to:

- Read, understand, seek clarification (as required) and agree to this policy and the Code of Conduct
- Hold and provide copies of current checks – Working with Children and NDIS Screening
- Comply with their contract
- Follow all policies and procedures
- Provide feedback on policies and practices
- Report all risks or potential risks of harm to children and young people immediately to the Child Abuse Report Line.
- Communicate any complaints and incident information to management
- Always comply with National Principles for Child Safe Organisations and all state legislative requirements

2.0 Scope

This policy applies to all staff and stakeholders linked to our organisation, including:

- Staff
- Contractors
- Volunteers
- Management
- Children
- Young people
- Families
- Networks

3.0 Definitions

Term	Definitions
Child or young person	persons under 18 years of age.
Complainant	a person who makes a complaint
Harm	Section 17 of the Safety Act defines 'harm' to mean physical or psychological harm (whether caused by any act or omission), including harm caused by sexual, physical, mental or emotional abuse or

National Police Check	a summary of an individual's offender history in Australia and a record of their criminal history relating to convictions, finding of guilt or pending court proceedings. They are available from South Australia Police (SAPOL) or organisations accredited by the Australian Criminal Intelligence Commission. It is an organisational decision if a National Police Certificate (NPC) is required for workers or volunteers. However, the organisation can no longer use the NPC to assess if a person is suitable to work or volunteer with children in South Australia; this must be determined by a valid, not prohibited Working with Children Check
Working with Children Check	People working or volunteering with children in South Australia must, by law, have a valid, not prohibited, Working with Children Check. A Working with Children Check assesses whether a person poses an unacceptable risk to children. As part of the process, the Screening Unit will look at criminal history, child protection information and other information.

4.0 Policy

This policy uses National Child Safe Standards and aims to create an environment where children and young people can feel safe by:

- taking a preventative, proactive and participatory approach to child well-being and safety issues
    - all staff are required to hold a Not Prohibited Working with Children Check and NDIS worker screening
    - training staff in safety measures to prevent and identify harm or risk of harm

  - provide children and young people with information about their rights, complaints and incidents
  - seek feedback and input from children, young people, their families and staff to ensure that our policies and practices encompass all aspects of child safety. Feedback and input mechanisms may include:
    - Seeking feedback during support provision
    - Face to face meetings
    - Annual surveys
    - Feedback and complaints process
    - Annual staff performance reviews
  - Management, staff, and contractors must read, understand, and sign that they have read, agreed, and complied with this policy and the code of conduct.
- value and embrace the opinions and views of children and young people
  - provide opportunities for children and young people to provide feedback through communication – email, phone, discussion,
  - documenting children and young people's voice
  - reporting input to management so we can improve and design services to meet their needs.
- assist children and young people in building skills that will assist them in participating in society
  - design a support plan to meet individual needs
    - identify areas to build skills
    - create strategies
    - implement strategies
    - review and monitor skill development
    - update and adjust as required.
- are focused and take action on protecting children and young people from harm.
  - staff must report any harm or risk of harm identified
  - risk management strategies must be actions (see *3.1 Risk Management*)

Strength In Care will encourage and support any person who has witnessed the harm or risk of harm to a child or young person or who suspects that harm or risk of harm has occurred to make a report and be confident of doing so without fear of retribution.

Staff are required to engage with children and young people and develop a relationship where the child and the young person feel safe. Staff must listen, acknowledge and respond to each child or young person, so they know the staff member will act positively to their needs and any information they share. By developing this trusting relationship, children or young people can give feedback or complain (Refer to Appendix B Child Safety Standards for details on approaching each standard).

Relevant handbooks are provided to staff and families, and the Child and Young Person's Handbook and Staff Handbook have information about mandatory reporting. Staff are trained at induction and ongoing in child safety requirements and their obligation under the *Children & Young People (Safety) Act 2017* and have access to our policies to review any procedures or requirements as required.

Strength In Care, as a mandatory reporting body, is required to report any indicators. Under Section 30 (3) of the Children and Young People (Safety) Act 2017, *employees of, or volunteers in, an organisation that provides health* are mandated reporters; therefore, our staff who perform the duties of which include direct responsibility for, or direct supervision of, the provision of services to children and young people (whether or not those duties constitute child or young person-related work under the Child Safety (Prohibited Persons) Act 2016).

This policy is supported by our Core NDIS Policy and Procedures, including:

- Zero Tolerance Policy and Procedure
- Aboriginal and Torres Strait Islander Policy and Procedures
- Human Resources Management Policy and Procedure
- Risk Management Policy and Procedure
- Working with Children Check Policy and Procedure

- Violence, Harm, Abuse, Neglect, Exploitation and Discrimination
- Complaints and Feedback Policy and Procedure
- NDIS Worker Screening and Risk Assessed Roles Policy and Procedure
- Individual Values and Beliefs Policy and Procedure

4.1 Risk Assessment

Strength In Care acknowledges that prevention is the best protection from harm or risk of harm and recognises their duty of care obligations to implement prevention strategies. Each child or young person has completed an Individual Risk Profile and Home Safety Checklist. This information allows us to create a Support plan designed to provide support and care for the child or young person, including physical safety and the child or young person's well-being

Identified risks may include:

- Our culture is not child-safe focussed
- The organisation's current code of conduct is not role-related, targeted to our organisation, or is not circulated to or understood by staff and volunteers
- Children/young people do not feel included
- Children/young people and their families are not supported to report concerns, complaints and feedback
- Children/young people are physically touched by staff/volunteers to correct techniques (physiotherapy, occupational therapy)
- Children/young people have access to an unsafe online environment
- Organisational staff (including employees and volunteers) harm children/young people
- Third-party contractors (while delivering services for the organisation) harm children/young people
- Children/young people are not supported when harm occurs

- Recruitment of a 'prohibited person' within the organisation or contracting with a third party that does not have a Not Prohibited Working with Children Check (WWCC) or a child-safe environments compliance statement (see Appendix A)
- Allowing a person to work with children or young people while the WWCC is being processed
- Organisational staff (including employees and volunteers) do not understand their obligations to report harm and risk of harm to the Child Abuse Report Line and SA Police if a child/young person is at immediate risk or requires an internal reporting process before meeting legal obligations to report to CARL
- Use of power to hurt, scare or control children/young people
- Not allowing children/young people to participate in spiritual or religious practices that are important to them
- Children/young people are provided with unsupervised services
- The organisation holds overnight and/or offsite activities with children/young people Child safe environments compliance statement is not lodged with the Department of Human Services
- Taking images of children and young people
- Supervision of children and young people
- Physical environment
- Online communications between staff/volunteers and children/young people
- Protecting privacy and confidentiality
- Procedures for dealing with situations where a member is being investigated for or is charged with a serious criminal offence

Risk minimisation actions

- Child-focused Code of Conduct is in place that sets the behavioural standards expected, including what happens when a breach occurs, is circulated to staff and volunteers and is displayed in public places
- Meet the requirements of the *Children and Young People (Safety) Act 2017* (which mandates child safe environments) and the *Child Safety (Prohibited Persons) Act 2016* (which mandates Working with Children Checks)

- Strategies are in place to make sure that child safety (through the National Principles for Child Safe Organisations) is embedded across the organisation
- The organisation uses inclusive, developmentally- appropriate language and resources to help children/young people to feel valued, respected and included
- Strategies to embed a child safe organisational culture are reviewed and updated regularly
- The Child Safe Environments Policy is reviewed at least once every five years. When this happens, a new child safe environments compliance statement is lodged with the Department of Human Services.
- Support through training and supervision is provided to organisational staff (including employees and volunteers) through
  - Quarterly reviews
  - Seeking feedback from supervisors
  - Induction training - understanding of harm and risk of harm and how to report effectively
  - regular supervision meetings are conducted to review practice and update where appropriate, and training provided that increases
- Working with Children Checks (WWCC) ensures that people working with children and young people are assessed as suitable. Those who are not suitable ('Prohibited' WWCC) cannot work with children and young people in our organisation.
- Recruitment processes, including undertaking referee checks to ensure the suitability of persons before they are employed/volunteer with our organisation, are completed
- When taking images of children and young people, must have the consent of the child or young person and parent/guardian consent required
- Complaints processes are in place and promoted to children, young people and their families to make sure that they feel safe reporting to the organisation
- Cyber safety and social media guidelines are in place and provided to all staff and volunteers
- Appropriate supervision is provided for all online activities

- Children and young people are to be supervised by parents/guardians at all times
- Our child-safe environments policies and procedures (including Code of Conduct) are made available to staff, volunteers, children, young people and their families by <insert options here – could include welcome/induction packs, website, Facebook>
- Children, young people and their families are encouraged to participate in our organisation and provide feedback through surveys, questionnaires, and feedback opportunities during sessions
- If children and young people are harmed, we support them and their families by delivering supports – could include following your organisation's reporting and responding to harm/risk of harm procedure which sets out the process for reporting to CARL and connecting those impacted with appropriate support services)
- Staff, volunteers and contractors undertake training to understand their obligations to report harm and risk of harm (see 4.2 below)
- All staff, volunteers, and contractors must read the Child Safe Environments Policy, Code of Conduct, Child Safe Environments Mandatory Notification Information Booklet and undertake child safe e-learning modules in the first week of working with the organisation (see 4.2 below)
- Where physical contact is required, this is undertaken safely by explaining why contact is required and what will happen and asking the child/young person for their permission (or their family if this is more appropriate) before proceeding
- Staff, volunteers and contractors working with children and young people with disability must hold a valid Not Prohibited Working with Children Check (WWCC) even if they are working with children and young people less than seven days a year

According to our internal reviews of policies and procedures, this policy must be reviewed every five years.

Staff should guide children and young people who require assistance to Kids Helpline on 1800 55 1800 and Youth Helpline on 1300 13 17 19 for support, as required.

4.2 Staff requirements, support and training

The legislative requirement is that staff engaged in a risk-assessed role must have the required South Australian clearance checks. We will meet the requirements of the *Child Safety (Prohibited Persons) Act 2016* and ensure that staff and volunteers have a valid, 'not prohibited' Working with Children Check issued by the Screening Unit of the Department of Human Services.

All staff must undergo an interview before a job offer is made. This interview will include:

- overview experience working with children and young people
- behaviour management techniques, e.g. questions such as:
    - Tell me about when you had to manage a child or young person with behavioural problems
    - How would you respond if a child or young person started yelling at you?
    - What if they started to throw items?

Screening post-interview of the suitable candidate is essential, and this process includes at least two (2) reference checks and qualification checks. All hired staff will have buddying to two (2) shifts, be allocated a supervisor and have a probationary period.

During their onboarding process, all staff and volunteers are trained in child and young person's safety and must undertake annual training to ensure they are current with standards and requirements. Staff must read and agree to comply with the Code of Conduct (see Appendix B). We will use the Mandatory Reporter Guide as part of the training. Our staff annual performance review will review current knowledge of standards and reporting. This information will be used to create relevant training against SA requirements. All information will be recorded in the person's Staff Training Record; note contractors will have this form to record their training to ensure compliance.

Staff will be trained in:

- The real or potential risk of harm indicators
- Mandatory reporting obligations
- Internal requirements for informing management
- Completing Incident Investigation so management can review the information
- Not asking leading questions
- Code of Conduct
- Commitment to the safety of children and young people
- Record keeping and information sharing
- Job description

Our mandated notifiers to attend a 'Safe Environments: Through Their Eyes' training course. Management meetings will include child and young person's safety on their agenda. Staff, contractors, and volunteers must:

- read and understand the Mandatory Notification Information Booklet (see: https://dhs.sa.gov.au/__data/assets/pdf_file/0003/103179/CSE-Mandatory-notification-information-booklet.PDF)
- complete the online SMART (Strategies for Managing Abuse Related Trauma) training (see: https://professionals.childhood.org.au/prosody/2015/07/smart-online)
- view the resources Keeping our kids safe developed by SNAICC at https://www.snaicc.org.au/policy-and-research/child-safety-and-wellbeing/keeping-our-kids-safe/
- be provided with professional development opportunities to build knowledge and skills regarding the well-being and development of children and young people
- how regularly they complete the specific training, e.g. every three years (mandatory reporting, Keeping our kids safe)

All staff have quarterly supervision and support meetings or visits, allowing us to determine the current knowledge and skills of the worker, therefore, allowing us to create

additional support and guidance as required. Staff reporting any risk of harm will undertake a debriefing session, and this session will determine additional support required, e.g. professional support.

Before employment, staff must undergo the Working with Children Check and NDIS worker screening process. Results are recorded in their personnel file. Employees performing within a child or young person-related role have been determined as a risk-assessed and require NDIS Worker Screening. It is the responsibility of the employee to apply to the state Worker Screening Unit (WSU), provide the relevant application information and pay the fee.

It is then the responsibility of the Director to verify all risk-assessed roles and maintain appropriate records using the Contractor Risk Assessed Check Form, Risk Assessed Role Register and the Risk-Assessed Role – Employee Register. Staff cannot work with children and young people unless their worker's screening has been verified.

Staff, volunteers, contractors, or other relevant parties must comply with child-safe standards, legislation, and regulations. At any stage, a person breaches any of these compliance requirements; the Director will advise the Screening Unit regarding this person, including any serious criminal offence, child protection information, or disciplinary or misconduct information. The informing method will vary according to the current issue but will usually be via phoning the Screening Unit.

5.0 Procedure

5.1 Communication

We have developed a Child and Young Person's Handbook and Staff handbook that informs children and young people and staff about rights and their right to participate in decisions affecting them. We will always take input seriously as per National Principle 2.

During the initial intake, development of a support plan and reviews, our team informs and involves families in promoting the safety of the child or young person. We work with the child or young person's community to ensure information is provided and they are involved in the child or young person's safety and well-being (National Principle 3).

To comply with Chapter 8 (Section 114(5)) of the *Children and Young People (Safety) Act 2017*), children, young people, their families, networks, staff, and contractors can request a copy of the organisation's child-safe environments policies and procedures. We will make this information available on our website for easy access. To request a copy:

1. Email info@strengthincare.com.au
2. Telephone 03 7064 4003
3. Director or their delegate will forward the policy within 2 working days

5.2 Listening to children and young people (National Principle 2)

Our organisation will

- communicating using age and developmentally-appropriate language)
- feedback and concerns can be reported by children, young people and their families or carers by:
  - Email info@strengthincare.com.au
  - Telephone 03 7064 4003
  - Anonymously self-addressed envelope provided at intake
  - Staff or contractors who will record and inform management
- Design consultation methods suited to our clientele and that consider the child or young person's age, developmental level and cultural backgrounds
- using a survey (hard copy or online)
- invite formal or informal feedback from children and young people about their experiences with us
- invite children and young people to be represented on a board or committee or organise a youth committee or focus group

5.3 When to report a real or potential risk of harm situation

For any child and young person at immediate and real risk, staff must call 000 Police immediately, then inform management. The individual's safety must be at the forefront of all actions.

It is important to always search for the cause of a change in a child or young person's behaviour or unexplained physical symptoms. If a child or young person shows one or more of the possible signs of harm or risk of harm, it must be reported immediately, even though this does not automatically mean harm has taken place.

Possible signs of harm or risk of harm are when:

- a child or young person shows a change in behaviour or mood that may indicate they are at risk of real or potential harm
- someone is seen behaving inappropriately towards a child or young person
- a child or young person tells staff another person is abusing them
- a person tells staff they are abusing a child or young person
- a child, young person or visitor advises staff that they have observed abusive or harmful acts
- someone observes an action or inaction towards the child or young person that may be considered abusive
- a person suspects or has reason to believe a child or young person is at risk of real or potential harm.

The Director will then report to the South Australian Government's Department of Child Protection. Failure to report an abusive, harmful or at risk of harm situation may result in a criminal offence.

5.4 How to report

The Director will use the online child or young person protection reporting system to report a less serious concern(s):

Department of Child Protection

Website: https://www.childprotection.sa.gov.au/reporting-child-abuse/report-child-abuse-or-neglect

The staff member will use their professional understanding and knowledge of child and young person protection to determine when to contact the required reporting body. The Director will undertake the following:

- At the time it is determined there is a risk of harm, they will report a suspected case of a child or young person's harm or risk of harm via a phone call to:
    - ***Child Harm or risk of harm Report Line*** (CARL) - Phone: 13 14 78
    - if at immediate risk, report to South Australia Police (SAPOL) on 000.
    - In cases involving Aboriginal children and young people, support is provided by Yaitya Tirramangkotti - an Aboriginal team, via the CARL number.
- All serious concerns are reported via the Child Harm or risk of harm Report Line and *not via the website's online reporting system.*

The individual who identifies the harm or risk of harm is the person who makes the report to CARL/SAPOL and is required to report internally, so Director can determine if it is a reportable matter.

In all cases, we will be guided by the relevant authority (Department for Child Protection/ SA Police) about how to proceed after a notification.

5.5 Details to provide

The staff member will provide the following information to the Child Harm or risk of harm Report Line:

- Child or young person's name, age, date of birth and address

- description of injury, harm or risk of harm (outline current and previous)
- child or young person's current situation
- location of the child, young person, parent or caregiver and alleged perpetrator
- when and how the manager found out about the harm or risk of harm.

5.6 Child identification details and context

Strength In Care will need to provide enough detail to identify the child or young person and give context to your report, including:

- child or young person's full name
- date of birth or age
- current address
- contact number
- school/kindergarten/childcare centre
- ethnicity, i.e. cultural background, aboriginal kinship group, non-English speaking
- who are the parents; do they all live in the same house; are there siblings in the house?
- alleged perpetrator's name, age, address, relationship to the child or young person, and current whereabouts
- current whereabouts of the child or young person of concern
- details of when the next expected contact with the alleged perpetrator will occur
- If in place, family court orders, apprehended violence orders, and domestic violence orders.

5.7 Supporting a child, young person, family and staff

Our management will put support strategies for the child, young person and their family. Strategies will vary according to the situation, and staff will be informed, trained, and supported in implementing strategies.

Strategies may include:

- Inform the child/young person/family that they are believed. One of the most helpful things you can do following disclosure of harm or risk of harm is to believe the child or young person.
- Reassure the child or young person that they have done the right thing by telling someone about the harm and that they are not in trouble. Provide them with age-appropriate information regarding what will happen next, ensuring that the adults take care of things (contact Kids Helpline or Youth Helpline). Be careful not to make promises you can't keep, such as not telling anyone else.
- Act protectively
- Take immediate steps to ensure the child or young person's safety and the safety of other children or young people who may be exposed to harm, risk or harm or abuse.
- Provide adequate support to meet the needs of the individual circumstances, e.g. cultural support and advocacy support.
- Provide staff with debriefing and other supports to ensure that their health and well-being are supported.

5.8 Defining child maltreatment, harm or risk of harm and neglect

Children and young people at risk of real or potential harm are related to any behaviour by parents, caregivers, other adults or older adolescents outside the norms of conduct and entail a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e. neglect) and commission (i.e. harm or risk of harm).

5.8.1 Physical harm or risk of harm

- *Signs and symptoms*: Bruising, lacerations, welts, rashes, broken or healing bones, burns, weight loss, facial swelling, missing teeth, pain or restricted movements, crying, acting fearful, agitation, drowsiness, hair loss or poor physical well-being.

- *Causes*: Hitting, slapping, pushing, punching or burning, which involves an incident that is non-accidental, resulting in pain or injury.

5.8.2 Psychological and emotional harm or risk of harm

- *Signs and symptoms*: Loss of interest in self-care, helplessness, withdrawn, apathy, insomnia, fearfulness, reluctance to communicate openly, choosing not to maintain eye contact, paranoia and confusion.
- *Causes*: Intimidation, humiliation, harassment, threatening behaviour, sleep deprivation, withholding affection, and not allowing a person to maintain their decision-making powers which lead to a pattern when repeated over time.

5.8.3 Financial harm or risk of harm

- *Signs and symptoms*: Unpaid accounts, withholding funds, loss of jewellery and personal belongings, removal of cash from wallet/purse, a person becomes agitated when discussing money, not providing money for outings and personal items, or a person taking over the care of someone's money without their permission.
- *Causes*: Misuse of a person's money, valuables or property, forced changes to legal documents (such as a will), denying access to or control of personal funds, stealing, fraud, forgery, embezzlement, misuse of power of attorney, removing decision-making powers of a person.

5.8.4 Sexual abuse

- *Signs and symptoms*: Unexplained sexual transmitted disease, vaginal/anal bleeding, fear of specific people or places, bruising to genital areas, inner thigh or around breasts, anxiety, torn or bloody underclothes, difficulty walking or sitting, change in sleep patterns, repeating nightmares.

- *Causes*: Rape (penetration or oral-genital contact), interest in older person's bodies, inappropriate comments and sexual references, inappropriate (possibly painful) administration of enemas or genital cleansing, indecent assault, sexual harassment, which is mainly about violence and power over another person rather than sexual pleasure.

5.8.5 Neglect

- *Signs and symptoms*: Poor hygiene or personal care, unkempt appearance, lack of personal items, absence of health aids, weight loss, agitation, inappropriate clothing, and lack of food.
- *Cause*: Intentional failure to provide basic life necessities.

5.8.6 Social harm or risk of harm

- *Signs and symptoms*: Sadness and grief due to people not visiting, anxiety after a specific person's visit, withdrawal, low self-esteem, appearing ashamed, passivity, and listlessness.
- *Causes:* Prevention of contact with friends or family, preventing access to social activities.

5.8.7 Grooming

- *Signs and symptoms*: Being very secretive about how they're spending their time, including when online, having money or new things like clothes and mobile phones that they can't or won't explain, depression and or anxiety, underage drinking or drug taking
- *Causes:* Grooming is when someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them

5.9 Complaints and Feedback

This section does not relate to a reasonable belief that a child or young person has been harmed or is at risk of harm. Any complaint about staff, volunteer or contractor that identifies and is found to be real may lead to disciplinary measures and their employment being ceased. Any validated complaint related to child protection will lead to the termination of employment.

Complaints and suggestions can be made by:

- using the Complaints and Feedback Form or the Anonymous Complaints and Feedback Form
- contacting a member of staff, verbally or in writing, our staff must offer to document the complaint on behalf of the participant if required and refer the matter to the Director
- contacting the Complaints Manager, verbally or in writing
- responding to questionnaires and surveys
- sending an email to our contact email
- attending meetings/care conferences
- contacting external complaint agencies, e.g. NDIS Quality and Safeguards Commission
- communicating orally, in writing, or any other relevant means.

Contacts for making a complaint are listed below:

Complaints Manager	Olivier Vles
Email address	ollie@strengthincare.com.au
Phone Number	03 7064 4003
Postal Address	3J/19 Bruce Street, Mornington VIC 3931

Complaints may be made by:

- staff
- participants (adults, children, and young people)
- public
- advocates
- family members
- carers
- anonymous person/s.

Results are recorded in the Complaint, Compliment and Feedback Register, allowing input into our continuous improvement processes. The Continuous Improvement Register will record improvements established after finalising the complaint management process.

If a complaint is about:

- **Support or services**: The Complaints Manager will deal with the complaint.
- **Staff member/s**: The Complaints Manager will deal with the complaint
- **CEO/Manager:** An external person or body may be approached, e.g. NDIS Quality and Safeguards Commission.

All staff, participants, family and advocates, visiting health professionals, and visitors are informed of our complaints process via:

- participant welcome information
- initial access to supports
- staff orientation, induction and training
- Meetings, reviews and assessments
- participant agreements
- contractor agreements.

5.9.1 Complaint management process

The investigation process must adhere to impartiality, privacy, confidentiality, transparency and timeliness. Complaints will not be discussed with anyone who does not have responsibility for resolving the issue. Strength In Care must take into consideration any cultural and linguistic needs of a participant and provide the relevant support mechanism, such as an interpreter or similar.

Complainants are provided with access to our Complaints and Feedback form. These may be accessed via staff or management. The Complaints Manager will review the individual's needs and assist them via the best means appropriate to suit them. The variance between individuals requires a personal approach but may include:

- offering an advocate
- providing text telephone (TTY) service to people with a hearing impairment
- ensuring the meeting site is wheelchair accessible
- offering independent assistance to read and write to formulate and lodge a complaint
- seek information from the complainant to determine any special requirements (e.g. access or communication).

The resolution outcomes from a complaint will recognise that people who make a complaint are generally seeking one, or more, of the following outcomes:

- Acknowledgement:
    - genuinely listening without interruption
    - empathising
    - ensuring the complainant feels comfortable (e.g. being aware that staff may be defensive and consider how this is perceived)
    - acknowledgement of the effect of the situation on the individual
    - resolving to a good outcome
    - notifying regularly and promptly on steps undertaken.
- Answers:
    - clear explanations relevant to the issue are provided ONLY once all the facts are known.

- Actions (Action Plan):
    - what will be done?
    - who will do it?
    - action plan completion date
    - how progress will be communicated to all parties involved
    - oversight of actions.
- Apology:
    - consider the form of the apology and the managerial level of response
    - consider timeliness, sincerity
    - be specific and direct
    - accept responsibility if appropriate and provide information on the cause and impacts
    - explain without excuses
    - provide a summary of key actions agreed on to move forward and resolve the issue.

6.0 Related documents

- Code of Conduct Agreement
- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Report
- Incident Register
- Child Notes
- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Reportable Incident, Accident and Emergency Policy and Procedure
- Violence, harm or risk of harm, Neglect, Exploitation and Discrimination Policy and Procedure
- Zero Tolerance Policy and Procedure
- Aboriginal and Torres Strait Islander Policy and Procedures
- Human Resources Management Policy and Procedure
- Risk Management Policy and Procedure
- Working with Children Check Policy and Procedure
- Complaints and Feedback Policy and Procedure
- NDIS Worker Screening and Risk Assessed Roles Policy and Procedure
- Individual Values and Beliefs Policy and Procedure

7.0 References

- Children's Protection Act 1993 (SA)
- Children's Protection (Miscellaneous) Amendment Act 2005 (SA)
- Children and Young People (Safety) Act 2017 (SA)
- Child Safety (Prohibited Persons) Act 2016 (SA)
- NDIS (Practice Standards - Worker Screening) Rules 2018
- NDIS (Quality and Safeguards) Commission 2018

- The National Framework for Protecting Australia's Children
- United Nations Convention on the Rights of the Child 1989

Appendix A Commitment to the safety of children and young people

Strength In Care is committed to the safety and well-being of all children and young people who will be the primary focus of our care and decision-making. We have zero tolerance for children and young people being at harm or risk of harm

We are committed to providing a child-safe environment where children and young people are safe and feel safe, and their voices are heard about decisions that affect their lives. Particular attention will be paid to the cultural safety of Aboriginal children and children from culturally and/or linguistically diverse backgrounds and the safety of children with a disability.

All people working for or with us have a responsibility to understand the important and specific role they play individually and collectively to ensure that the well-being and safety of all children and young people are at the forefront of all they do and every decision they make.

In our planning and practices, we will

- Children and young people's safety and protection are our priority
- Children and young people are valued, respected and encouraged to participate. Their voice is essential to providing appropriate and safe support.
- Take a preventative, proactive and participatory approach to child safety;
- Value and empower children to participate in decisions that affect their lives;
- Foster a culture of openness that supports all persons to disclose harm or risks of harm to children safely
- Respect diversity in cultures and child-rearing practices while keeping child safety paramount;
- All children and young people are embraced regardless of their abilities, sex, gender, or social-economic or cultural background and equity is upheld

- Engage only the most suitable people to work with children and have high-quality staff, supervision and professional development;
- Ensure children and young people know who to talk with if they are worried or are feeling unsafe and that they are comfortable and encouraged to raise such issues;
- Assist children and young people in building skills that will assist them in participating in society
- Focus and take action on the protection of children and young people at risk of harm
- Value the input from children, young people and their families in our policies and practices.
- Report suspected harm or risk of harm, neglect or mistreatment promptly to the appropriate authorities;
- Share information appropriately and lawfully with other organisations where the safety and well-being of children are at risk; and

Child and Young Person's Handbooks and accessible display areas include information about services that can assist children and young people

- Kids Helpline on 1800 55 1800
- Youth Helpline on 1300 13 17 19)

Appendix B Child Safe Standards

Standard 1. Child safety is embedded in our organisational leadership, governance and culture

- Commitment to safety.
- Staff are trained in:
    - child or young person's safety
    - Codes of Conduct
    - behavioural standards when interacting with children and young people
    - reporting obligations and record keeping.
- Risk management plans are undertaken for each child.
- Comply with the NDIS Code of Conduct, our organisation's Code of Conduct and the Statement of Commitment to Safety (See Appendix A).

Standard 2. Children participate in decisions affecting them and are taken seriously

- Children and young people can express their views and are provided opportunities to participate in decisions that affect their lives:
    - upon commencement with our organisation
    - on an ongoing basis (they are asked regularly for their thoughts and ideas)
    - at the review of their plan.
- The importance of friendships is recognised, and support from peers is encouraged, helping children and young people feel safe and be less isolated.
- Work with the child, young person and the family to determine how best to assist with these linkages.
- Children and young people can access harm or risk of harm prevention programs and information.
- We provide links to relevant organisations such as Kids Helpline, as needed.
- Age-appropriate information that describes how adults should behave towards the child or young person is provided.
- Staff are attuned to signs of harm and facilitate child-friendly ways for children and young people to communicate and raise their concerns:

  - staff trained to work with each child and young person
  - knowledge and skills are assessed to determine training to ensure skills and knowledge are evident.

Standard 3. Families and communities are informed and involved

- All levels of our organisation encourage families to take an active role in keeping children and young people safe.
- Our policies and procedures (including the Code of Conduct) are communicated to parents and carers (e.g. Welcome Pack including Child and Young Person's Handbook)
- Families and community members are encouraged to provide feedback on how well the organisation keeps children and young people safe, and this information is acted upon where necessary: Feedback can be provided via:
  - a Complaint and Feedback Form
  - meetings are held about a child and young person.

Standard 4. Equity is upheld, and diverse needs are considered

- The Director and our staff understand the type of barriers that prevent children and young people from disclosing harm or risk of harm or adults from recognising a child or young person's disclosure.
- The Director and our staff identify and respect the diverse needs, abilities and backgrounds of children and young people and understand the value of treating them fairly.
- Our organisation reviews each child or young person's cultural needs at intake.
- We provide relevant, culturally sensitive, age-appropriate activities to children.
- All staff are trained and provided information about the factors that may increase a child or young person's vulnerability to harm.
- The Director ensures that our workforce reflects the diversity of the children and young people we provide services to, where possible.
- The Director and staff adapt activities and services to ensure all children and young people feel included, and we undertake the following for each child:

- risk management plan
- strategy planning.

Standard 5. People working with children are suitable and supported

- When recruiting, Strength In Care does not solely rely on the Working with Children Check. We also provide ongoing staff training opportunities for all staff, including:
    - induction
    - annual training
- When recruiting, Strength In Care is aware of and implements child and young person safe recruitment practices.
- All vacant position advertisements identify that we value the child and young person's safety.
- Recruitment processes involve a range of interview questions to establish staff suitability.
- Background and reference checks are recorded (see Human Resource Management Policy and Procedure).
- Supervision includes regular reviews to check whether staff follow Codes of Conduct and other child-safe policies.
- The Director monitors all aspects of supervision and undertakes employee supervision at least quarterly.

Standard 6. Processes when responding to complaints of child abuse (or other concerns) are child-focused.

- The Director builds a culture where complaints are taken seriously, and all employees take responsibility for the safety of children and young people using our induction process and cultural staff training.
- During a new employee's induction, the Director clearly explains that the Code of Conduct breaches will result in disciplinary action. Staff are also informed of this ongoing through internal training sessions.

- Staff are given support and information on what and how to report, including external bodies.
- Accessible procedures enable children, young people, staff and others to make complaints. These procedures include potential time frames, review processes and potential outcomes of complaints.
- Complaints are handled confidentially (see Complaints and Feedback Policy and Procedure).
- Processes are reviewed at regular intervals and after a complaint is received by Strength In Care.
- Documents are treated confidentially, as required.

Standard 7. Staff are equipped with knowledge, skills and awareness to keep children safe through continual education and training

- The Director provides ongoing education and training opportunities for all staff, including:
    - knowledge, skills and confidence to prevent and identify real or potential harm, and
    - how to respond to and report complaints.
- Additional training is provided when higher risks towards a child or young person are involved, e.g. behaviour management
- The Director is our Child Safety Officer and is responsible for all staff training.
- Training is regularly reviewed in response to emerging best practices.

Standard 8. Physical and online environments minimise the opportunity for abuse or other kinds of harm to occur

- The Director sets expectations regarding behavioural standards for staff when interacting with children and young people in physical and online environments.
- Risk assessments identify areas where staff have opportunities to interact with children and young people unsupervised, including one-off events and overnight accommodation.

- Physical environments are altered to increase natural sightlines while respecting a child and young person's right to privacy.
- Higher-risk areas such as cars, boarding facilities and offsite locations are managed using specific safety measures, such as spot checks.
- Children and young people are provided information regarding online safety and are regularly encouraged to tell staff about negative experiences.
- Staff and parents are provided information about risks in the online environment (e.g. online grooming, cyberbullying and sexting).

Standard 9. Implementation of Child Safety Standards is continually reviewed and improved

- The Director maintains a culture of continuous improvement to ensure that policies and procedures are implemented and routinely reviewed even though staffing may change.
- The Director understands the value of continuous monitoring, open conversations and exploring new ways to keep children safe.
- Our child-safe policies and practices are reviewed annually.
- Staff refer to the Child Safe Standards when creating, reviewing or evaluating child-safe policies and procedures.
- Critical incidents are used to identify the root cause of a problem, identify risks to children and young people's safety, and improve (e.g. Incident Report and Incident Investigation Form and Continuous Improvement Register).
- Children and young people are supported to provide feedback which we will act on if required.

Standard 10 Policies and procedures document how the organisation is child safe

- The Director will ensure that policies and procedures and reviewed and compliant.
- Strength In Care acknowledges that we will be held accountable for our policies and procedures.
- Staff are trained and knowledgeable about organisation procedures, especially how they relate to child and young person's safety

- Staff, parents and carers are informed and have access to Strength In Care Child Safe Environments policies and procedures and complaint policy and procedure.

Appendix C Code of Conduct

I will

- Act following our child and young persons' safety and well-being policies and procedures.
- Behave respectfully, courteously, and ethically towards children, young people, families, and other staff.
- Listen and respond to the views and concerns of children and young people, particularly if they communicate (verbally or non-verbally) that they do not feel safe or well.
- Promote the human rights, safety and well-being of all children and young people in the service.
- Demonstrate appropriate personal and professional boundaries.
- Consider and respect the diverse backgrounds and needs of children and young people.
- Create an environment that promotes and enables children and young people's participation and is welcoming, culturally safe and inclusive for all children, young people and their families.
- Involve children and young people in making decisions about activities, policies and processes that concern them.
- Contribute, where appropriate, to policies, discussions, learning and reviews about child and young person's safety and well-being.
- Identify and mitigate risks to children and young person's safety and well-being as required by our risk assessment and management policy or process.
- Respond to any concerns or complaints of the child or young person's harm or abuse promptly and in line with our services policy and procedure for receiving and responding to complaints.
- Report all suspected or disclosed child and young person harm or abuse required by *Children & Young People (Safety) Act 2017* and our policy and internal and external reporting procedure.
- Comply with our protocols on communicating with children.

- Comply with *Children & Young People (Safety) Act 2017* and these policies and procedures on record keeping and information sharing.
- Adhering to our Child Safe Environment Policy at all times and taking all reasonable steps to ensure the safety and protection of children and young people
- treating everyone (this includes staff, volunteers, students, children, young people and parents), including those of different race, ethnicity, gender, gender identity, sexual orientation, age, social class, physical ability or attributes and religious beliefs with respect and honesty and ensure equity is upheld
- being a positive role model to children and young people in all your conduct with them
- setting clear boundaries about appropriate behaviour between yourself and the children and young people in your organisation – boundaries help everyone to understand their roles
- listening and responding appropriately to the views and concerns of children and young people
- ensuring another adult is always present or insight when conducting one to one coaching, instruction or other activity
- being alert to children and young people who are or may be at risk of harm, and reporting this quickly to the Child Abuse Report Line (13 14 78)
- responding quickly, fairly and transparently to any serious complaints made by a child, young person or their parent/guardian
- encouraging children and young people to 'have a say' on issues that are important to them

I will not

- Engage in any unlawful activity with or concerning a child and young person.
- Engage in any activity that is likely to physically, sexually or emotionally harm a child or young person.
- engage in rough physical games
- develop any 'special' relationships with children and young people that could be seen as favouritism, such as the offering of gifts or special treatment

- do things of a personal nature that a child or young person can do for themselves, such as toileting or changing clothes
- discriminate against any child or young person because of age, gender, cultural background, religion, vulnerability or sexuality.
- Be alone with a child or young person unnecessarily.
- Arrange personal contact, including online contact, with children and young people I am working with for a purpose unrelated to our activities.
- Disclose personal or sensitive information about a child or young person, including images of a child or young person, unless the child, young person and their parent or legal guardian consent or unless I am required to do so by our policy and procedure on reporting.
- Use inappropriate language in the presence of children or young people, or show or provide children and young people with access to inappropriate images or material
- Work with children and young people while under the influence of alcohol or prohibited drugs.
- Ignore or disregard any suspected or disclosed child or young person's harm or abuse.

If I notice or consider any person has breached this Code of Conduct, then I will

- Act to prioritise the best interests of children and young people.
- Take action promptly to ensure that children and young people are safe.
- Promptly report any concerns to my manager or Child Safety Officer, the Chief Executive Officer or another manager or leader in Strength In Care.
- Follow policies and procedures for receiving and responding to complaints and concerns.
- Comply with SA requirements if relevant and with policy and procedure on internal and external reporting

I have read the Child Safe Environments Statement, Child Safety Standards, and this Code of Conduct and agree to abide by these requirements during my employment. I

understand that breaches of this Code of Conduct may lead to disciplinary action or termination of my employment.

Name	
Position	
Date	

Adapted from Child Safety Organisations National Principles

Working with Children Policy and Procedure – Victoria

1.0 Purpose

Strength In Care recognises the participant's right to feel safe and live in an environment that protects from assault, neglect, exploitation, or any other form of abuse. This policy specifically looks at the requirements when working with participants under eighteen years.

As part of our risk strategy, this policy has been devised to ensure that Strength In Care is compliant with Commonwealth and Victorian state requirements and linked to the United Nations Declaration on the Rights of Disabled Persons and the United Nations Convention on the Rights of the Child.

2.0 Scope

This policy applies to all staff and positions identified in our Risk-assessed Role Register. These procedures and policy requirements encompass employees, volunteers and subcontractors. The Working With Children Check is for working directly with children in work specified as child-related work or work in a designated role as stated in the state legislation.

3.0 Policy

Strength In Care complies with the Victorian Government's Safety Screening Policy. Strength In Care verifies that support worker safety screening is current and in compliance with NDIS worker screening and the Department of Health and Human Services requirements. All staff and subcontractors' roles are risk-assessed to determine employees required to hold relevant clearances, i.e. working with children checks. Strength In Care are aware of and comply with the Commission for Children and Young People's Child Safe Standards.

Strength In Care will encourage and support any person who has witnessed the abuse of a participant or suspects that abuse has occurred to make a report and be confident of doing so without fear of retribution.

As a mandatory reporting body, Strength In Care is required to report any indicators.

Strength In Care acknowledges that prevention is the best protection from abuse and neglect and recognises their duty of care obligations to implement prevention strategies. Staff are required to read and be trained in working and protecting children and young people and must sign a Code of Conduct (Appendix B) kept in their personnel file.

It is a legislative requirement that staff engaged in a risk-assessed role have Victorian clearance checks. Safety screening will include verifying that the worker's name is not on the Disability Worker Exclusion List (DWEL). Staff must undergo the NDIS worker screening process before employment, and results are recorded in their personnel file.

Strength In Care will maintain a record of employee \ Working with Children Checks to ensure they are current (valid for five years). The Director will confirm employees' WWCC status by using the Working With Children Check Victoria online portal.

Within 21 days of commencement with Strength In Care, new employees must inform Working with Children Check Victoria that they are now working for Strength In Care. Strength In Care will file the letter of confirmation and a photocopy of the worker's card in the employee's personnel file.

Strength In Care will access and check all required staff through the Disability Worker Exclusion Scheme via the Department of Health and Human Service's online portal on the DWES website.

Staff will guide children who require assistance to **Kids Helpline on 1800 55 1800** for support.

4.0 Procedure

4.1 When to report an abusive situation

Strength In Care will report a possible abusive situation if we have a reasonable belief (see below 4.1.1) that a child is harmed or at risk of harm. It is important to always search for the cause of a change in a participant's behaviour or unexplained physical symptoms. If a participant shows one or more of the possible signs of abuse, the Director will report it immediately, even though Strength In Care understands that this does not automatically mean abuse has taken place.

4.1.1 Reasonable belief

A reasonable belief is formed if a reasonable person doing the same work would form the same belief on those grounds based on the same information. Grounds for forming a belief are matters that the person has become aware of and any opinions concerning those matters. For example, a 'reasonable belief' might be formed when:

- a child states that they have been physically or sexually abused
- a child states that they know someone who has been physically or sexually abused (sometimes the child may be talking about themselves)
- someone who knows the child informs Strength In Care that the child has been physically or sexually abused
- professional observations of the child's physical condition, behaviour or development leads a professional to form a belief that the child has been physically or sexually abused
- signs of physical or sexual abuse led to the belief that the child has been physically or sexually abused
- other circumstances lead Strength In Care to suspect that a child has been abused.

Failure to report an abusive situation may result in a criminal offence.

4.2 How to report

The Director will use their professional understanding and knowledge of child protection to determine when to contact the **Child Protection Intake Service**.

To make a report, the Director will contact the Child Protection Intake Service covering the local government area (LGA) where the child normally resides.

- During business hours Monday to Friday (8.45 am - 5.00 pm), call:
    - North Division intake: 1300 664 977
    - South Division intake: 1300 655 795
    - East Division intake: 1300 360 391
    - West Division intake - metropolitan: 1300 664 977
    - West Division intake - rural and regional: 1800 075 599
- Outside of business hours Strength In Care will contact:
    - Child Protection Emergency Service: on 13 12 78.

4.3 Details to provide

The Director will provide the following information to the child abuse report line:

- child's name, age, date of birth and address
- description of injury, abuse and neglect (outline current and previous)
- child's current situation
- location of the child, parent or caregiver and alleged perpetrator
- when and how the manager found out about the abuse.

4.4 Child identification details and context

Strength In Care will need to provide enough detail to identify the child or young person and give context to the report, including:

- child's full name
- date of birth or age
- current address
- contact number
- school/kindergarten/childcare centre
- ethnicity, i.e. cultural background, aboriginal kinship group, non-English speaking (Who are the parents? Do they all live in the same house? Are there siblings in the house?)
- alleged perpetrator's name, age, address, relationships to the child and current whereabouts
- current whereabouts of the child of concern
- details of when the next expected contact with the alleged perpetrator will occur
- If in place, family court orders, apprehended violence orders, and domestic violence orders.

4.5 Defining child maltreatment, abuse and neglect

Child abuse and neglect are related to any behaviour by parents, caregivers, other adults or older adolescents outside the norms of conduct and entail a substantial risk of causing physical or emotional harm to a child or a young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e. neglect) and commission (i.e. abuse).

The following descriptors cited are from "*Protect – Identifying and Responding to All Forms of Abuse in Victorian Schools*" and are used by Strength In Care to provide guidance relating to abuse indicators.

4.5.1 Physical abuse indicators

Physical indicators include (but are not limited to):

- bruises or welts on facial areas and other areas of the body, e.g. back, bottom, legs, arms and inner thighs
- bruises or welts in unusual configurations or those that look like the object used to make the injury, e.g. fingerprints, handprints, buckles, iron or teeth
- burns from boiling water, oil or flames or burns that show the shape of the object used to make them, e.g. iron, grill, cigarette
- fractures of the skull, jaw, nose and limbs (especially those not consistent with the explanation offered or the type of injury possible at the child's age of development)
- cuts and grazes to the mouth, lips, gums, eye area, ears and external genitalia
- bald patches where hair has been pulled out
- multiple injuries, old and new
- effects of poisoning
- internal injuries.

Behavioural indicators of physical child abuse include (but are not limited to):

- disclosure of an injury inflicted by someone else (e.g. parent, carer or guardian)
- an inconsistent or unlikely explanation or inability to remember the cause of injury
- unusual fear of physical contact with adults
- aggressive behaviour
- disproportionate reaction to events
- wearing clothes unsuitable for weather conditions to hide injuries
- wariness or fear of a parent, carer or guardian
- reluctance to go home
- no reaction or little emotion displayed when being hurt or threatened
- chronic absences from school without reasonable explanation
- overly compliant, shy, withdrawn, passive and uncommunicative
- unusually nervous, hyperactive, aggressive, disruptive and destructive to self or others
- poor sleeping patterns, fear of the dark or nightmares and regressive behaviour, e.g. bed-wetting

- drug or alcohol misuse, suicidal thoughts or self-harm.

4.5.2 Psychological and emotional abuse indicators

Indicators may include (but are not limited to):

- speech disorders such as language delay, stuttering, or selectively being mute (only speaking with certain people or in certain situations)
- delays in emotional, mental or physical development.

Behavioural indicators of psychological and emotional abuse include (but are not limited to):

- overly compliant, passive and undemanding behaviour
- extremely demanding, aggressive and attention-seeking behaviour or anti-social and destructive behaviour
- low tolerance or frustration
- poor self-image and low self-esteem
- unexplained mood swings, depression, self-harm or suicidal thoughts
- behaviours that are not age-appropriate, e.g. overly adult or overly infantile
- fear of failure, overly high standards, and excessive neatness
- poor social and interpersonal skills
- violent drawings or writing
- lack of positive social contact.

4.5.3 Sexual abuse indicators

Indicators of sexual abuse include (but are not limited to):

- injury to the genital or rectal area, e.g. bruising, bleeding, discharge, inflammation or infection
- injury to areas of the body such as breasts, buttocks or upper thighs
- discomfort in urinating or defecating
- presence of foreign bodies in the vagina or rectum

- sexually-transmitted diseases
- frequent urinary tract infections
- pregnancy, especially in very young adolescents
- anxiety-related illnesses, e.g. anorexia or bulimia.

Behavioural indicators of sexual abuse include (but are not limited to):

- disclosure of sexual abuse, either directly (from the alleged victim) or indirectly (by a third person or allusion)
- persistent and age-inappropriate sexual activity, e.g. excessive masturbation or rubbing genitals against adults
- drawings or descriptions in stories that are sexually explicit and not age-appropriate
- fear of home, specific places or particular adults
- poor/deteriorating relationships with adults and peers
- poor self-care or personal hygiene
- complaining of headaches, stomach pains or nausea without a physiological basis
- sleeping difficulties
- regressive behaviour, e.g. bed-wetting or speech loss
- depression, self-harm, drug or alcohol abuse, or attempted suicide
- sudden decline in academic performance, poor memory and concentration
- engaging in sex work or sexual risk-taking behaviour
- wearing layers of clothing to hide injuries and bruises.

4.5.4 Neglect indicators

Indicators of neglect include (but are not limited to):

- appearing consistently dirty and unwashed
- being consistently inappropriately dressed for weather conditions
- being at risk of injury or harm due to a consistent lack of adequate supervision from parents
- being consistently hungry, tired and listless

- having unattended health problems and lack of routine medical care
- having inadequate shelter and unsafe or unsanitary conditions.

Behavioural indicators of neglect include (but are not limited to):

- gorging when food is available or inability to eat when extremely hungry
- begging for or stealing food
- appearing withdrawn, listless, pale and weak
- aggressive behaviour, irritability
- involvement in criminal activity
- little positive interaction with a parent, carer or guardian
- poor socialising habits
- excessive friendliness toward strangers
- indiscriminate acts of affection
- poor, irregular or non-attendance at school
- staying at school for long hours and refusing or being reluctant to go home
- self-destructive behaviour
- taking on an adult role of caring for a parent.

4.5.5 Family violence indicators

Indicators of family violence in children include (but are not limited to):

- speech disorders
- delays in physical development
- failure to thrive (without an organic cause)
- bruises, cuts or welts on facial areas and other parts of the body, including the back, bottom, legs, arms and inner thighs
- any bruises or welts (old or new) in unusual configurations or those that look like the object used to make the injury (e.g. fingerprints, handprints, buckles, iron or teeth)
- fractured bones, especially in an infant where a fracture is unlikely to have occurred accidentally

- poisoning
- internal injuries.

Behavioural indicators of family violence may include (but are not limited to):

- violent/aggressive behaviour and language
- depression and anxiety, and suicidal thoughts
- appearing nervous and withdrawn, including wariness or distrust of adults
- difficulty adjusting to change
- psychosomatic illness
- bedwetting and sleeping disorders
- acting out, e.g. cruelty to animals
- extremely demanding, attention-seeking behaviour
- participating in dangerous risk-taking behaviours to impress peers
- overly compliant, shy, withdrawn, passive and uncommunicative behaviour
- taking on a caretaker role prematurely, trying to protect other family members
- embarrassment about family
- demonstrated fear of parents, carers or guardians and of going home
- disengagement from school (absenteeism, lateness or school refusal) or poor academic outcomes
- parent-child conflict
- wearing long-sleeved clothes on hot days in an attempt to hide bruising or other injuries
- becoming fearful when other children cry or shout
- being excessively friendly to strangers.

4.5.6 Grooming

- Being very secretive about how they're spending their time, including when online,
- having money or new things like clothes and mobile phones that they can't or won't explain,
- depression and or anxiety,

- underage drinking or drug taking
    - *Causes:* Grooming is when someone builds a relationship, trust and emotional connection with a child or young person so they can manipulate, exploit and abuse them.

5.0 Related documents

- Incident Investigation Form
- Incident Register
- Participant Notes
- Risk Assessment Form
- Risk-assessed Role Register
- Risk-assessed Employee Register
- Risk Management Plan
- Risk Register
- Violence, Abuse, Neglect, Exploitation and Discrimination Policy and Procedure
- NDIS Worker Screening and Risk-assessed Roles Policy and Procedure

6.0 References

- Child Safe Standards
- Child Wellbeing and Safety Act 2005 (VIC)
- Children, Youth and Families Act 2005 (VIC)
- Department of Health and Human Services DEWS Portal
- Protect – Identifying and Responding to All Forms of Abuse in Victorian Schools
- United Nations Convention on the Rights of the Child
- United Nations Declaration on the Rights of Disabled Persons
- Department of Health and Human Services Mandatory Reporting website: www.providers.dhhs.vic.gov.au
- Department of Health and Human Services - Safety Screening Policy
- Working with Children Act 2005

- Working with Children Check website
- Commission for Children and Young People's Child Safe Standards

Appendix A Child Safe Standards

Child Safe Standard 1 – Organisations establish a culturally safe environment in which the diverse and unique identities and experiences of Aboriginal children and young people are respected and valued

Our organisation will ensure:

- a child's ability to express their culture and enjoy their cultural rights is encouraged and actively supported.
- We embed strategies that equip all members to acknowledge and appreciate the strengths of Aboriginal culture and understand its importance to the well-being and safety of Aboriginal children and young people.
- adoption measures to ensure racism within the organisation is identified, confronted and not tolerated. Any instances of racism are addressed with appropriate consequences.
- active support and facilitation, participation and inclusion within it by Aboriginal children, young people and their families.
- Our policies, procedures, systems and processes together create a culturally safe and inclusive environment and meet the needs of Aboriginal children, young people and their families.

Child Safe Standard 2 – Child safety and wellbeing is embedded in organisational leadership, governance and culture

Our organisation will ensure:

- Our information has a public commitment to child safety.
- A child safe culture is championed and modelled at all organisation levels from the top-down and bottom-up.
- Governance arrangements facilitate the implementation of the child safety and wellbeing policy at all levels.

- Code of Conduct provides guidelines for staff and volunteers on expected behavioural standards and responsibilities. Staff working with children are required to read and sign the Code of Conduct (Appendix B)
- Risk management strategies focus on preventing, identifying and mitigating risks to children and young people.
- Staff and volunteers understand their obligations to information sharing and recordkeeping.

Child Safe Standard 3 – Children and young people are empowered about their rights, participate in decisions affecting them and are taken seriously

Our organisation will ensure:

- Children and young people are informed about their rights, including safety, information, and participation (*See Children and Young People Handbook*).
- The recognition, encouragement and support of peer friendships to assist children and young people feel safe and less isolated.
- Where relevant to the setting or context, children and young people are offered access to sexual abuse prevention programs and relevant related information in an age-appropriate way.
- Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children and young people to express their views, participate in decision-making and raise their concerns.
- strategies are in place to develop a culture that facilitates participation and is responsive to the input of children and young people.
- opportunities for children and young people to participate and are responsive to their contributions, thereby strengthening confidence and engagement.

Child Safe Standard 4 – Families and communities are informed and involved in promoting child safety and wellbeing

Our organisation will ensure :

- Families participate in decisions affecting their children.
- We engage and openly communicate with families and the community about its child-safe approach, and relevant information is accessible.
- Families and communities have a say in developing and reviewing the organisation's policies and practices.
- Families, carers and the community are informed about the organisation's operations and governance.

Child Safe Standard 5 – Equity is upheld, and diverse needs respected in policy and practice

Our organisation will ensure:

- All staff and volunteers understand children and young people's diverse circumstances and provide support and respond to those who are vulnerable.
- Children and young people have access to information, support and complaints processes in ways that are culturally safe, accessible and easy to understand.
- We pay particular attention to the needs of children and young people with disability, children and young people from culturally and linguistically diverse backgrounds, those unable to live at home, and lesbian, gay, bisexual, transgender and intersex children and young people.
- we pay particular attention to the needs of Aboriginal children and young people and provide/promote a culturally safe environment for them.

Child Safe Standard 6 – People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice

Our organisation will ensure:

- Recruitment, including advertising, referee checks and staff and volunteer pre-employment screening, emphasise child safety and wellbeing.
- Relevant staff and volunteers currently work with children checks or equivalent background checks.

- All staff and volunteers receive appropriate induction and are aware of their responsibilities to children and young people, including record keeping, information sharing and reporting obligations.
- Ongoing supervision and people management are focused on child safety and wellbeing.

Child Safe Standard 7 – Processes for complaints and concerns are child focused

Our organisation will ensure:

- an accessible, child-focused complaint handling policy outlines the roles and responsibilities of leadership, staff and volunteers, approaches to dealing with different types of complaints, breaches of relevant policies or the Code of Conduct and obligations to act and report.
- Effective complaint handling processes are understood by children and young people, families, staff and volunteers and are culturally safe.
- Complaints are taken seriously and responded to promptly and thoroughly.
- policies and procedures address complaints and concerns to relevant authorities, whether or not the law requires reporting, and co-operates with law enforcement.
- Reporting, privacy and employment law obligations are met.

Child Safe Standard 8 – Staff and volunteers are equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training

Our organisation will ensure :

- Staff and volunteers are trained and supported to implement the organisation's child safety and well-being policy effectively.
- Staff and volunteers receive training and information to recognise indicators of child harm, including harm caused by other children and young people.
- Staff and volunteers receive training and information to respond effectively to child safety and well-being issues and support colleagues who disclose harm.

- Staff and volunteers receive training and information on building culturally safe environments for children and young people.

Child Safe Standard 9 – Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed

Our organisation will ensure:

- Staff and volunteers identify and mitigate risks in the online and physical environments without compromising a child's right to privacy, access to information, social connections and learning opportunities.
- The online environment is used following the organisation's Code of Conduct and child safety and wellbeing policy and practices.
- Risk management plans consider risks posed by organisational settings, activities, and the physical environment.
- Organisations that contract facilities and services from third parties have procurement policies that ensure the safety of children and young people.

Child Safe Standard 10 – Implementation of the Child Safe Standards is regularly reviewed and improved

Our organisation will ensure:

- regular reviews (annual), evaluation and improvements in child safe practices.
- Complaints, concerns and safety incidents are analysed to identify causes and systemic failures to inform continuous improvement
- reports on the findings of relevant reviews to staff and volunteers, community and families and children and young people.

Child Safe Standard 11 – Policies and procedures document how the organisation is safe for children and young people

Our Organisation will ensure:

- Policies and procedures address all Child Safe Standards.
- Policies and procedures are documented and easy to understand.
- Best practice models and stakeholder consultation informs policies and procedures development
- Leaders champion and model compliance with policies and procedures.
- Staff and volunteers understand and implement policies and procedures.

Appendix B Code of Conduct

I will

- Act following our child and young persons' safety and well-being policies and procedures.
- Behave respectfully, courteously, and ethically towards children, young people, families, and other staff.
- Listen and respond to the views and concerns of children and young people, particularly if they communicate (verbally or non-verbally) that they do not feel safe or well.
- Promote the human rights, safety and well-being of all children and young people in the service.
- Demonstrate appropriate personal and professional boundaries.
- Consider and respect the diverse backgrounds and needs of children and young people.
- Create an environment that promotes and enables children and young people's participation and is welcoming, culturally safe and inclusive for all children, young people and their families.
- Involve children and young people in making decisions about activities, policies and processes that concern them.
- Contribute, where appropriate, to policies, discussions, learning and reviews about child and young person's safety and well-being.
- Identify and mitigate risks to children and young person's safety and well-being as required by our risk assessment and management policy or process.
- Respond to any concerns or complaints of the child or young person's harm or abuse promptly and in line with our services policy and procedure for receiving and responding to complaints.
- Report all suspected or disclosed child and young person harm or abuse required by *Child Wellbeing and Safety Act 2005* and our policy and internal and external reporting procedure.
- Comply with our protocols on communicating with children.

- Comply with *Child Wellbeing and Safety Act 2005* and these policies and procedures on record keeping and information sharing.
- treating everyone (this includes staff, volunteers, students, children, young people and parents), including those of different race, ethnicity, gender, gender identity, sexual orientation, age, social class, physical ability or attributes and religious beliefs with respect and honesty and ensure equity is upheld
- being a positive role model to children and young people in all your conduct with them
- setting clear boundaries about appropriate behaviour between yourself and the children and young people in your organisation – boundaries help everyone to understand their roles
- listening and responding appropriately to the views and concerns of children and young people
- ensuring another adult is always present or insight when conducting one to one coaching, instruction or other activity
- alert to children and young people who are or may be at risk of harm, and report this quickly to the local government area.
- responding quickly, fairly and transparently to any serious complaints made by a child, young person or their parent/guardian
- encouraging children and young people to 'have a say' on issues that are important to them

I will not

- Engage in any unlawful activity with or concerning a child and young person.
- Engage in any activity that is likely to physically, sexually or emotionally harm a child or young person.
- engage in rough physical games
- develop any 'special' relationships with children and young people that could be seen as favouritism, such as the offering of gifts or special treatment
- do things of a personal nature that a child or young person can do for themselves, such as toileting or changing clothes

- discriminate against any child or young person because of age, gender, cultural background, religion, vulnerability or sexuality.
- Be alone with a child or young person unnecessarily.
- Arrange personal contact, including online contact, with children and young people I am working with for a purpose unrelated to our activities.
- Disclose personal or sensitive information about a child or young person, including images of a child or young person, unless the child, young person and their parent or legal guardian consent or unless I am required to do so by our policy and procedure on reporting.
- Use inappropriate language in the presence of children or young people, or show or provide children and young people with access to inappropriate images or material
- Work with children and young people while under the influence of alcohol or prohibited drugs.
- Ignore or disregard any suspected or disclosed child or young person's harm or abuse.

If I notice or consider any person has breached this Code of Conduct, then I will

- Act to prioritise the best interests of children and young people.
- Take action promptly to ensure that children and young people are safe.
- Promptly report any concerns to my manager in Strength In Care.
- Follow policies and procedures for receiving and responding to complaints and concerns.
- Comply with Victorian requirements if relevant and with policy and procedure on internal and external reporting

I have read the Child Safety Standards and this Code of Conduct and agree to abide by these requirements during my employment. I understand that breaches of this Code of Conduct may lead to disciplinary action or termination of my employment.

Name	Olivier Vles
Position	Managing Director
Date	25/06/2022

Adapted from Child Safety Organisations National Principles

NDIS Worker Screening and Risk Assessed Roles Policy and Procedure

1.0 Purpose

Registered NDIS providers must ensure that key personnel and other workers in certain types of roles have appropriate worker screening clearances that meet the requirements of the NDIS Practice Standards and Quality Indicators. Appropriate clearances ensure that the key personnel and employees in risk assessed roles do not pose an unacceptable risk to the safety and wellbeing of our NDIS participants. Compliance with the NDIS Practice Standards and Quality Indicators 2021 is a condition of registration for all registered NDIS providers.

The risk assessed role is linked to the NDIS requirements. All roles identified as risk assessed by Strength In Care must meet all NDIS worker screening requirements.

2.0 Scope

The Director must identify and record information regarding each role in the organisation to determine all risk assessed roles within Director. The Director determines and identifies all employees who meet the performing in risk-assessed roles criteria.

Employees performing within a role that has been determined as a risk-assessed role require NDIS Worker Screening. It is the responsibility of the employee to apply to the state Worker Screening Unit (WSU), provide the relevant application information and pay the fee.

It is then the responsibility of the Director to verify all risk-assessed roles and maintain appropriate records using the Contractor Risk Assessed Check Form, Risk Assessed Role Register and the Risk-Assessed Role – Employee Register.

3.0 Definitions

Term	Definition
A risk assessed role	A key personnel role (person or an entity) as defined in s11A of the National Disability Insurance Scheme Act 2013 (e.g. a CEO or a Board Member) as: ● a role for which the regular duties include the direct delivery of specified supports or specified services to a person with a disability ● a role for which the regular duties are likely to require 'more than incidental contact with people with disability, which includes: ○ physically touching a participant ○ building a rapport with a participant is an integral and ordinary part of the performance of normal duties ○ Contact multiple participants as part of the direct delivery of a specialist disability support or service or in a specialist disability accommodation setting.
Contractor	When the NDIS provider engages another organisation or individual to perform work on their premises (or otherwise) as part of their support and services provision. The organisation or individual is considered a contractor engaged by the registered NDIS provider.

Exceptions/exemptions	A registered NDIS provider may engage a person in a risk-assessed role, who does not have an NDIS Worker Screening clearance, only if the registered NDIS provider is subject to the transitional and unique arrangements and the registered NDIS provider is complying with those arrangements. A registered NDIS provider can also allow secondary school students on a formal work experience placement to engage in risk assessed roles without having an NDIS Worker Screening clearance or an acceptable check under the transitional and special arrangements, provided the students are directly supervised by another worker who has an NDIS Worker Screening clearance or acceptable check under the transitional and special arrangements.
Worker Screening Check	The WSC is an assessment of whether a person who works, or seeks to work, with participants poses a risk. The worker screening check assessment determines whether a person is cleared or excluded from working in specific roles with participants.
Worker Screening Unit (WSU)	The Worker Screening Unit conducts the NDIS Worker Screening Check in **the state or territory** where a person applies. The Worker Screening Unit also decides whether a person is cleared or excluded. Registered NDIS providers must ensure that they only engage workers who have been cleared in specific roles, called risk assessed roles.

National NDIS Worker Screening Database	The National NDIS Worker Screening Database: • holds a register of cleared and excluded workers • supports ongoing national monitoring of the criminal history records of workers with NDIS Worker Screening clearances • means NDIS providers across the country can use a single online portal to verify their workers' Worker Screening Check applications and review the NDIS Worker Screening clearances of prospective workers without needing to contact individual state and territory Worker Screening Units • helps NDIS providers with record-keeping requirements.

4.0 Policy

As a registered NDIS provider, Strength In Care will comply with the requirements relating to worker screening, as per the National Disability Insurance Scheme (Practice Standards – Worker Screening) Rules 2018. The Director must verify that risk-assessed role workers have applied for and hold the appropriate worker screening clearances (as determined by the Worker Screening Unit) by reviewing the details recorded in the National Worker Screening Database (NWSD). The Director or an authorised delegate will manage, record and verify worker screening.

The Director will identify risk assessed role positions and ensure all workers in the positions have an NDIS Worker Screening Check or an acceptable check under the transitional and unique arrangements. The following table lists the NDIS registration groups that may have risk assessed roles.

Table 1. Supports and services that may have risk assessed roles as described by the NDIS

Descriptor
Assistance to access and maintain employment or higher education
High intensity daily personal activities
Assistance in coordinating or managing life stages, transitions and supports
Assistance with daily personal activities
Assistance with travel/transport arrangements, but only if the services are concerning specialised transport to school/educational facility/employment/community (does not include public services, i.e. taxi, bus and train)
Specialist positive behaviour support
Community nursing care
Assistance with daily life tasks in a group or shared living arrangement
Innovative community participation
Development of daily living and life skills
Early intervention supports for early childhood
Specialised hearing services
Interpreting and translating
Participation in community, social and civic activities
Exercise physiology and personal training
Management of funding for supports in participant plans
Therapeutic supports
Specialised driver training
Specialised support coordination
Specialised supported employment
Hearing services
Customised prosthetics
Group and centre-based activities

Only employees who work in risk assessed roles require worker screening clearances. Strength In Care is not required to verify that employees, who do not work in risk assessed roles, have an NDIS worker screening clearance or an acceptable check under the transitional and unique arrangements.

However, Strength In Care or a self-managed participant may (as a safety measure) require staff to undergo an NDIS worker screening clearance or have an acceptable check under the transitional and special arrangements before engaging them for a role that is not a risk assessed role.

5.0 Procedure

5.1 Risk assessed role

The Director will determine whether the regular duties of a role involve more than incidental contact with a participant; this may include:

- physical contact
- face-to-face contact
- oral communication
- written communication
- electronic communication.

The Director will undergo a review of every role within Strength In Care and identify and record all risk assessed roles in the Risk Assessed Role Register. Staff identified as working in a risk-assessed role will undergo the appropriate worker screening checks, and all clearance check details are recorded in the Risk Assessed Role – Employee Register.

Roles determined as not risk-assessed are not required to hold worker screening clearances.

5.1.1 Documenting a risk assessed role

The Director will complete the Risk Assessed Role Register for each risk assessed role and will document:

- risk assessed role tile
- description of the role
- type of risk assessed role (as contained in the NDIS (Practice Standards - Worker Screening) Rules 2018)
- date risk assessed role determined
- employees who are role assessed
- the name and title of the person who made the assessment.

5.1.2 New reclassification of risk assessed role

When a new risk assessed role is identified (or a current role is reclassified as a risk assessed role following a review), the Risk Assessed Role Register must be updated within 20 business days of the identification (or review) of the risk assessed role.

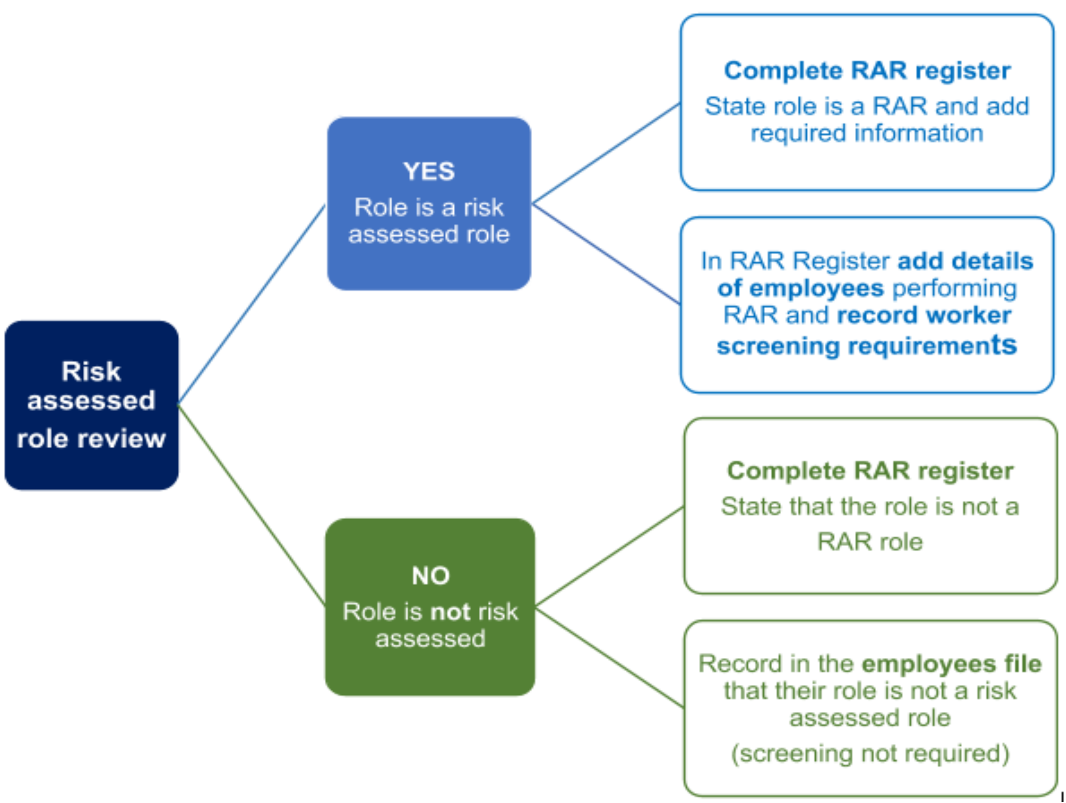
5.1.3 Worker risk assessed role checks

For each employee working in a risk-assessed role, the Director or their authorised delegate will document all relevant details in the Risk Assessed Role – Employee Register. Information documented includes:

- the full name, date of birth and address of the employee
- the risk assessed role or roles in which the employee engages
- if the worker may engage in a risk-assessed role without an NDIS worker screening clearance:
    - the basis on which they may do so (refer to sections below regarding the exemptions to the requirement for a worker to have an NDIS Worker Screening clearance)

  - the start and end date of the period in which the exemption that allows them to work in a risk-engaged role applies
- the name of the staff member who supervises the worker during this period
- the worker's NDIS Worker Screening Check application reference number
- the worker's NDIS Worker Screening Check the outcome expiry date
- whether the worker's NDIS Worker Screening Check is subject to any decision which affects that Strength In Care may not allow the worker to engage in a risk-assessed role, and the nature of any such decision (i.e. interim bar, suspension, exclusion)
- records relating to an interim bar, a suspension, an exclusion, or any action taken by the provider concerning these kinds of decisions concerning any worker
- allegations of misconduct against a worker with a check and the registered NDIS provider's action in response to that allegation.

Table 1. Internal review process



5.1.4 Engaging contractors

When engaging contractors, Strength In Care will work with the contractor to ensure that any contractor workers (including individual contractors) have the required worker screening checks and clearances.

When working with contractors, the Director or their delegate will complete a Contractor Risk Assessed Check Form.

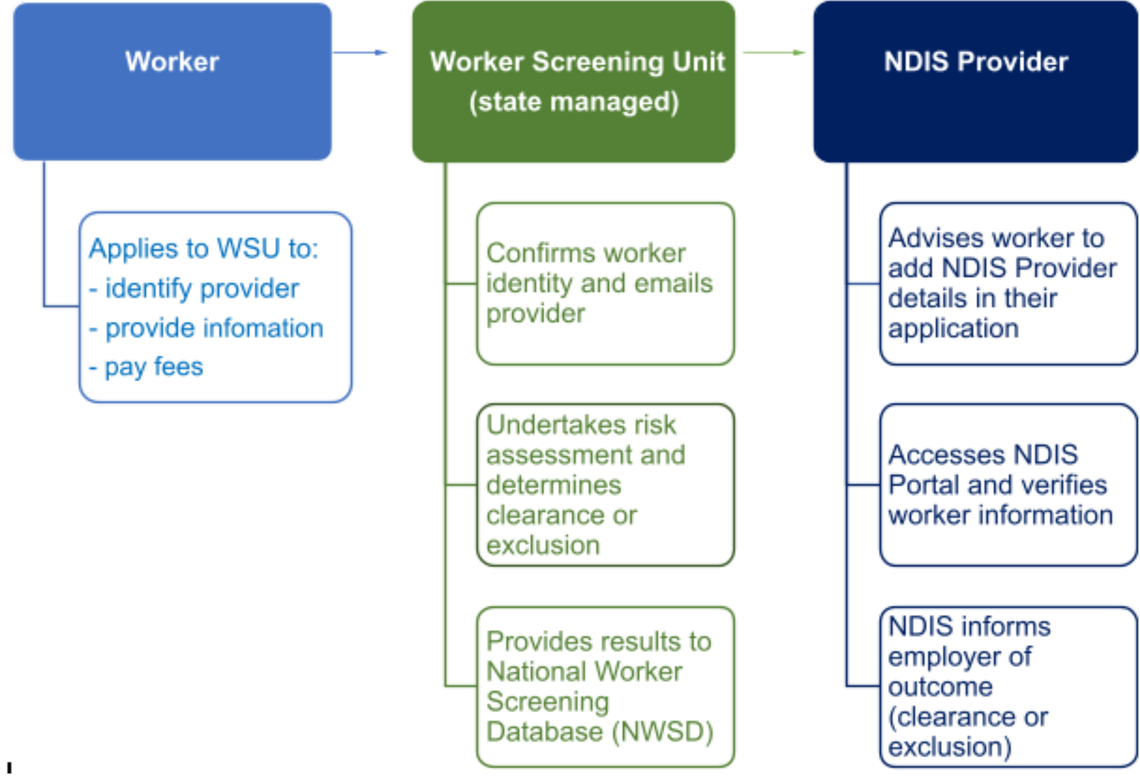
5.2 NDIS Worker Screening

All workers employed in a risk-assessed role must apply for an NDIS Worker Screening Check with the state's Worker Screening Unit. The Worker Screening Unit manages the application process and collects the required fee.

The Director or a delegated staff member will access the NDIS Portal and validate the worker screening checks. The National Worker Screening Database (NWSD) will advise Strength In Care via email of a worker's clearance or exclusion.

The Director, in turn, will inform the staff member of the results. In the case where NWSD advises of exclusion or provides negative advice regarding a worker, it is the Director's responsibility to withdraw that particular worker from the risk assessed role immediately.

Diagram 2. Risk Assessed Role - NDIS Worker Screening Process



In addition to the National Police Check, some staff may require a Working with Children Check if they work with participants under 18 years.

For more information regarding worker screening, refer to Appendix 1. Worker Screening Unit and Transitional Requirements or Appendix 2. NDIS Worker Screening Application Overview.

5.3 Risk management

As a registered NDIS provider, Strength In Care is required to develop, implement and maintain risk management strategies to ensure our participants' safety. Risk management strategies for risk assessed roles will be recorded in our Risk Management Plan.

Strength In Care's Risk Management Plan will:

1. Identify the risks relating to:
    - non-supervision of a worker during the delivery of services or supports

- safety of our participants
- a participant is injured or not receiving the necessary support they need.

2. Outline actions to be taken by our organisation to address risks, which may include the Director:
    - identifying if the employee has any current worker screening clearances
    - allocating an appropriate supervisor to the employee to monitor their work until worker screening clearances are received
    - checking references and seeking additional information about employees working a risk assessed role to confirm they understand and perform safe work practices.

5.4 Document records

Strength In Care will keep all documents up to date. Records will be kept for seven years from the date they were made. Records will be stored by Strength In Care on a secure, password-protected server in an organised, accessible and legible manner.

Information relating to workers engaged in a risk-assessed role will be kept in an easily accessible manner to the NDIS Commission or a quality auditor. Information will include workers engaged on any day over the previous seven years.

6.0 Related documents

- Risk Assessed Role Register
- Risk Assessed Role – Employee Register
- Contractor Risk Assessed Check Form
- Personnel File Contents Checklist
- Risk Management Plan
- Human Resource Management Policy and Procedure

7.0 References

- NDIS (Practice Standards – Worker Screening) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021

Appendix 1: State Worker Screening Units and Transitional Requirements – Victoria

1.0 State worker screening units

For information about how to apply for a Worker Screening Check, visit the WSU webpage for the relevant state or territory via the link:

State	State Worker Screening Unit (Web Link)
Victoria	Department of Justice and Community Safety

2.0 Risk assessed role transitional requirements as of 1 February 2021

NDIS workers in a risk-assessed role	Transitional arrangements
Victoria	
Workers who hold a valid: • police check • Disability Worker Exclusion Scheme (DWES) Check.	Workers have until 31 July 2021 to get an NDIS Worker Screening Check Clearance (NDIS Clearance).
Workers who hold a valid: • police check • DWES Check • Working with Children (WWC) Clearance.	Workers have until their WWC Clearance expires to get an NDIS Clearance

Workers who meet the transitional arrangements for providing Early Intervention Supports for Early Childhood (ECIS) and community mental health services in Part B of the Department of Health and Human Services (DHHS) Safety Screening Policy for registered NDIS providers operating in Victoria	Workers have until 31 July 2021 to get an NDIS Clearance If they have a WWC Clearance, they will have until it expires to get an NDIS Clearance.

Appendix 2 NDIS Worker Screening Application Overview

Victoria
How to apply Workers can apply for an NDIS Check online at Service Victoria. To apply: ● register or login to the Service Victoria account ● verify identity ● submit identification documents for their police check and any other background checks ● enter work details ● review and provide consent for the checks ● pay for the application. The application will then be sent to the NDIS Worker Screening Unit in Victoria, which will assess the application. The NDIS Worker Screening Unit will send the worker an email confirming that their application has been received and explaining what will happen next.

What is needed for an application

- The worker will need at least three different identity documents for an application. Including at least one commencement document, for example, a full birth certificate (not an extract), an Australian passport, an ImmiCard, or a foreign passport linked to a valid Australian visa.
- Other documents may include a Medicare card or credit card.
- If the name on the documents does not match, the worker will need an additional document showing the name change.
- They will also need to use a smartphone with a camera to confirm they are the person in their identity documents. The Service Victoria application process will guide the applicant through this process.

After the worker has verified their identity, they move on to the next step in the application process. They will also be able to save their application and come back to it later.

Note: A Working with Children Check may be required if working with children under 18 years of age.

Zero Tolerance Policy and Procedure

1.0 Purpose

We are committed to meeting the requirements of the Disability Abuse Prevention Strategy. We will always endeavour to understand, promote and enhance safeguards to prevent abuse from occurring.

2.0 Scope

This policy is relevant to all staff, volunteers or stakeholders.

3.0 Definition

Term	Definition
Zero tolerance	It aims to provide an evidence-based, nationally applicable and contemporary approach to preventing and responding to abuse of people with disabilities. The aim is to assist service providers in developing positive organisational cultures and practices and robust safeguarding mechanisms relevant to the National Disability Insurance Scheme (NDIS).

4.0 Policy

Strength In Care is committed to all elements of the National Disability Insurance Scheme (NDIS) Code of Conduct. Strength In Care will train staff in all areas of the NDIS Code of Conduct to ensure a zero-tolerance approach is adhered to across all practices.

To follow the Code and guidelines, we will:

- refuse to tolerate any form of harm, risk of harm or abuse towards people with disabilities by workers or other people with disabilities, and promotes zero tolerance for abuse
- provide staff with training and information to correctly apply the obligations of the NDIS Code of Conduct
- assist staff in undertaking their role, e.g. keeping support plans up-to-date; provide training opportunities which will include formal training, mentoring and on-the-job supervision
- act on all reported cases of harm, risk of harm, abuse or suspected abuse
- agree never to take adverse action against any staff member or volunteer if they report harm, risk of harm, abuse or neglect
- base all necessary disciplinary actions on the principle of procedural fairness if a staff member violates the obligations of the NDIS Code of Conduct
- respect and value the diversity of people and cultures to create an inclusive environment where it is safe for people with disabilities to express their cultural identity
- actively maintain a working environment that minimises the risks of abuse
- create and maintain a positive complaints culture, where people are not afraid to speak up
- foster a culture of zero tolerance for harm or abuse towards people with disabilities.

Strength In Care informs their front-line staff (who impose the obligations) that they must:

- provide services without engaging in abuse, exploitation, harassment or neglect
- report any form of harm, risk of harm, abuse or suspected abuse
- never engage in sexual abuse or misconduct and report any such conduct by other workers, participants, family members, carers or community members
- show respect for cultural differences when providing services
- act ethically, with integrity, honesty and transparency.

5.0 Procedure

Strength In Care will train staff to be able to understand and act on a zero-tolerance approach and ensure that staff appreciate participants are people first, who have needs, aspirations, preferences and feelings.

All staff must listen to participants to determine their preferences, aspirations, needs, and supports (where it is safe).

Strength In Care will ensure that staff are informed that people with disabilities tend to face significantly higher risks of sexual assault and exploitation than the general population and that this is particularly true for women with a disability. Also, there can be barriers to disclosure that make it difficult for a person with a disability to report sexual abuse and misconduct.

5.1 Reporting abuse or harm

Strength In Care acknowledges that the reporting of harm, risk of harm or abuse is critical to prevent abusive or harmful situations from escalating and recurring among participants.

Strength In Care staff who work with participants will report any form of harm and abuse (zero tolerance) following the reporting procedures outlined in the Violence, Harm, Abuse, Neglect, Exploitation and Discrimination Policy and Procedure. Staff will refer to the reporting procedures outlined in the Reportable Incident, Accident and Emergency Policy and Procedure when reporting a reportable incident.

6.0 Related documents

- Code of Conduct Agreement
- Incident Investigation Form
- Incident Register

- Incident Report
- Incident Register
- Participant Notes
- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Violence, Harm, Abuse, Neglect, Exploitation and Discrimination Policy and Procedure
- Reportable Incident, Accident and Emergency Policy and Procedure
- Working with Children Policy and Procedure

7.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Disability Discrimination Action 1992 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- Privacy Act 1988 (Commonwealth)

Section 2: Provider Governance and Operational Management

Topic	Policy and Procedure
2.1 Governance and Operational Management	• Corporate Governance Policy and Procedure • Conflict of Interest Policy and Procedure • Work Health Safety and Environmental Management Policy and Procedure • Manual Handling Policy and Procedure • Continuous Improvement Policy and Procedure
2.2 Risk Management	• Risk Management Policy and Procedure
2.3 Quality Management	• Quality Management Policy and Procedure
2.4 Information Management (see '3.2 Support Planning')	• Information Management Policy and Procedure • Consent Policy and Procedure • Social Media Policy and Procedure
2.5 Complaints and Feedback Management	• Complaints and Feedback Policy and Procedure
2.6 Incident Management	• Reportable Incident, Accident and Emergency Policy and Procedure

2.7 Human Resource Management	• Human Resource Management Policy and Procedure • Delegation of Responsibility and Authority Policy and Procedure • Drug and Alcohol Policy and Procedure • Non-Smoking Policy and Procedure • Workplace Aggression and Violence Procedure • Dress Code Policy
2.8 Continuity of Supports	• Continuity of Supports Policy and Procedure • Telehealth Policy • Business Continuity Policy and Procedure
2.9 Emergency and Disaster	• Emergency and Disaster Policy and Procedure

2.1 Governance and Operational Management

Corporate Governance Policy and Procedure

1.0 Purpose

Corporate governance is a performance driver of our company. Governance refers to the framework of rules, relationships, systems and processes by which an enterprise is directed, controlled and held to account and through which authority is exercised and maintained.

The Strength In Care is committed to providing a high-quality service to participants and maintaining business practices that demonstrate high standards of corporate governance. The purpose of this policy is to:

- ensure the organisation's business operates following legal, regulatory and company standards
- establish a framework for corporate governance that promotes transparency and safeguards against individual's unethical or unlawful practice
- outline control measures that govern the internal and external actions of managers, staff, contractors or any person who is conducting business with Strength In Care.

2.0 Scope

Principal accountability and approaches to corporate governance include:

- fulfilling our duty to all Strength In Care's stakeholders, including participants, participants representatives, advocates, staff, contractors and any person conducting business with our organisation

- providing services of value to our participants
- providing meaningful employment for our staff
- contributing to the welfare of the community.

3.0 Company details

3.1 Strength In Care business details

Business name	Strength In Care
Date registered	28/04/2021
ABN	49213343957
Domain name	www.strengthincare.com.au
Licences and permits	NDIS Registered Service Provider
Products/services	0102 Assist Access/Maintain Employ 0106 Assist-Life Stage, Transition 0107 Assist-Personal Activities 0108 Assist-Travel/Transport 0115 Daily Tasks/Shared Living 0125 Participate Community 0132 Support Coordination
Premises	3J/19 Bruce Street, Mornington VIC 3931

Are these premises rented or owned?	Rented

3.2 Insurance

Workers compensation	EML
Public liability insurance	Vero
Professional indemnity	Vero

3.3 Business focus

3.3.1 Commitment to quality

Strength In Care is committed to providing high-quality services to its participants in a supportive environment in line with National Disability Insurance Service requirements.

Strength In Care will use information from the management of continuous improvement, complaints and feedback, incidents, work health and safety, information feedback and risk management to adjust our policies and practices so that we meet participant and community requirements.

Strength In Care will seek feedback, listen, and action information gained from the voice of participants and the community to ensure that we are meeting their requirements and to provide high quality, responsive service. Information and feedback gained through meetings, surveys and consultation with the community and stakeholders will be collated and forwarded to management to review and make recommendations about any adjustments to policies and practices. Organisational meetings will document discussions and outcomes, and this data will be fed back into our continuous improvement cycle. Participant and community input may lead to the following:

- policy changes

- practice improvements
- strategy review and adjustments
- governance review and adjustments
- human resource review and adjustments
- relevant changes related to the current situation

3.3.2 Target group

There are two (2) target groups within the community in which we work:

1. ***Participants*:** Individuals with special needs who require support.
2. ***Service providers:*** Disability services organisations that seek support for their participants.

3.3.3 Services provided

Strength In Care provides the following support services for participants with a disability:

- ${Registration Groups}.

3.4 Management and reporting structure

All reporting is based on the management structure as outlined in the organisation chart.

3.5 Key personnel

Key Personnel refers to individuals who hold management, key executive or operational positions in an organisation, such as directors, managers, board members, chief executive officer or chairperson. You must disclose the requested information to all key personnel. The NDIS Commission considers and decides on the suitability of key personnel. Management will provide the following information to NDIS Commission as required during the audit process. This information may include information related to:

- a banning order has ever been in force

- conviction of an indictable offence against a law of the Commonwealth or a State or Territory
- insolvency under administration (is or has been)
- being the subject of adverse findings or enforcement action by a Department of, or an authority or other body established for a public purpose by, the Commonwealth, a State or a Territory, including one with responsibilities relating to the quality or regulation of services provided to people with disability, older people and children
- being the subject of adverse findings or enforcement action following an investigation by any of the following:
    (i) the Australian Securities and Investment Commission;
    (ii) the Australian Charities and Not-for-profits Commission;
    (iii) the Australian Competition and Consumer Commission;
    (iv) the Australian Prudential Regulation Authority;
    (v) the Australian Crime Commission;
    (vi) AUSTRAC;
    (vii) a body of a State or Territory that is equivalent to a body mentioned in any of subparagraphs (i) to (vi);
    (viii) a work health and safety authority of a State or Territory
- being the subject of any findings or judgment about fraud, misrepresentation or dishonesty in any administrative, civil or criminal proceedings, or is currently party to any proceedings that may result in the member being the subject of such findings or judgment
- being disqualified from managing corporations under Part 2D.6 of the Corporations Act 2001

The following staff are employed/contracted by our organisation:

- ${KeyPersonnel Name}

We also engage specialist consultants and contractors to support business functions and assist with a range of participant support services.

Knowledge, skills and experiences of all partners and key personnel, who influence the company, are reviewed to ascertain if additional training is required to address any identified gaps.

Key personnel names:

Olivier Vles (Managing-Director)

Giselle Vles (Relations Manager)

Rebecca Green (Office Administrator)

Lemalie Laumua (Team Leader)

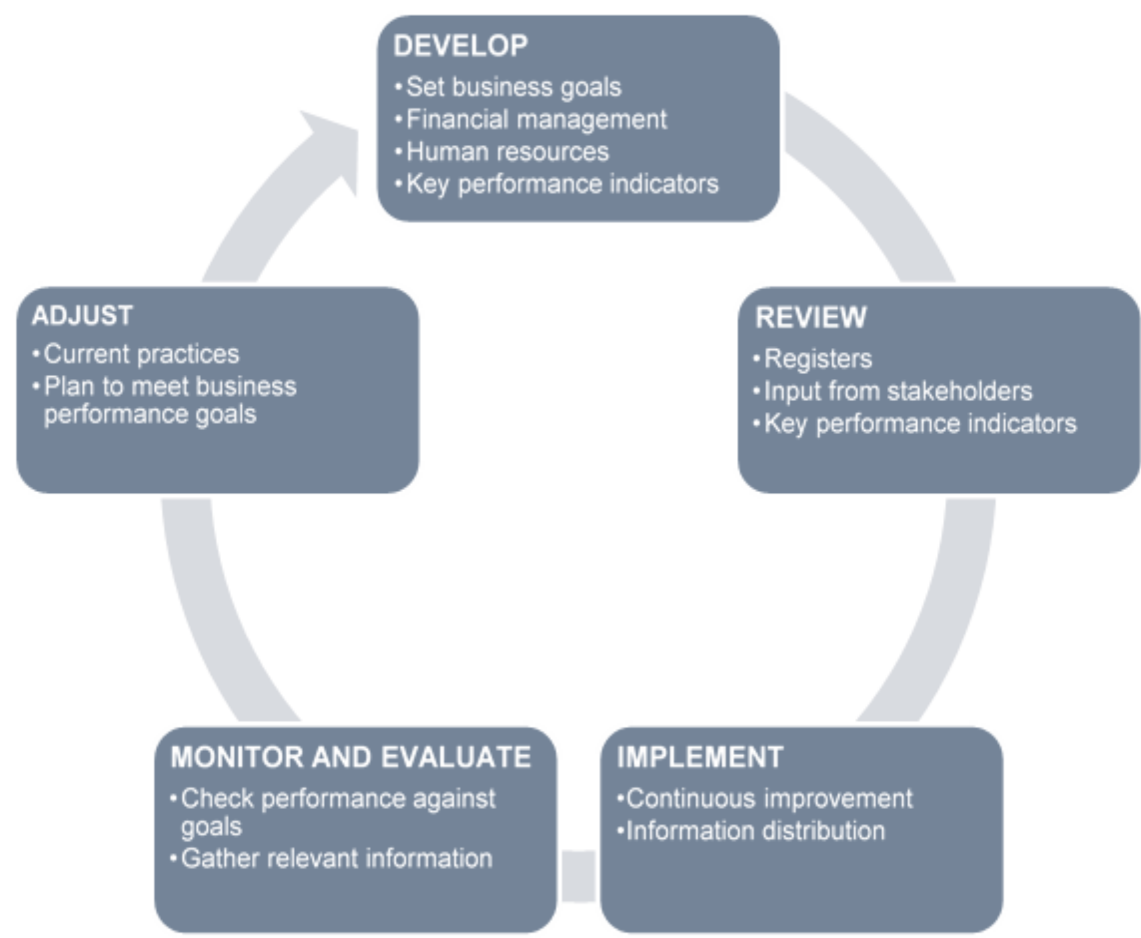
Takudzwa Chaparadza (Team Leader)

3.6 Performance planning and review

The planning and review process are included in the Human Resource Management Policy and Procedure. Strength In Care will monitor and review the performance of employees on an annual basis to:

- determine staff member performance matches the current role description
- evaluate if the staff member's performance is meeting the needs of the participants
- review participant input on current strategies
- establish additional training to meet changes in contemporary practices
- provide support to staff to meet the required level of support
- match skills and knowledge to the target audience.

3.6.1 Business planning and review



3.7 Conflict of interest

All key personnel and staff must inform Strength In Care's management regarding any situation in which they will derive personal benefit from actions or decisions made in their official capacity. The person concerned must complete a Conflict of Interest Declaration.

4.0 Procedure

4.1 Corporate governance principles

Strength In Care will be governed to ensure the best interests of all stakeholders and to remain viable and productive. Our corporate governance principles include, but are not limited to, the following:

- services are regularly monitored, reviewed and improved
- risk management reviews are conducted regularly
- implement policies, procedures and systems for effective health and risk management so that workers know their roles and responsibilities, look out for their safety, and balance dignity of risk with the duty of care when supporting participants.
- continuous improvement strategies are undertaken and implemented
- implementation of necessary reviews and audits of all systems, policies and procedures
- planning processes incorporate community engagement
- supporting and modelling a culture that promotes the principles of NDIS – upholding rights, celebrating diversity and respecting the voice of those with lived experience
- effective management of human resource requirements, so all services meet the requirements of the participant and community
- additional training and supervision will be provided to our workers as needed
- set clear expectations of what best practice looks like, provide access to support and coaching, and develop worker awareness and capabilities to deliver quality supports and services
- contractual obligations are always to be met
- participant and community input is reviewed and actioned
- effective organisational emergency and disaster planning, effective management, and implementation of appropriate financial and funding arrangements.

4.2 Financial management

The Strength In Care will undertake all requirements linked to NDIS contractual arrangements and other business practices. Financial management is one of your main

avenues to judge our success in making a profit and managing our funds. The information provides the tools to plan for overall business growth, diversify your services, or reach new markets. It assists in decision-making to expand or reduce our products, services, and markets. Effective financial management allows us to chart your course into the future, adjust your direction when needed, and help you find your way through challenging times.

An Asset Register will be maintained with a list of all current assets, allowing for additional purchases as required. Building and property will be reviewed to ensure that premises meet the current requirements of our business. If additional sites are required, an analysis of costing will be undertaken.

4.2.1 Business financial management - roles and tasks

- Financial roles and responsibilities are determined by Strength In Care.
- An accountant will be used to complete the required financial compliance and obligations.
- Financial decisions are the responsibility of Strength In Care.

4.2.2 Business financial management practices

The following practices apply to financial management, including recording business earnings and documentation of the company as a legitimate enterprise with a clear revenue stream and records of deductible business expenses.

Documentation and organisation of information regarding company transactions will be used to facilitate financial management for tax purposes.

4.2.2.1 Bank accounts

All bank accounts are maintained, and separate bank accounts are always used for business and private purposes.

For monies withdrawn from any bank account, whether by EFT or other online payment method, approvals are required by the Director to authorise each payment.

Each payment made must be supported by an invoice, receipt or other appropriate documentation, and the authorisations must be attached to this documentation before payment.

Any variations to banking arrangements can be made or varied by the Director who will delegate the responsibility for updating the financial system or bank account register with the new information.

4.2.2.2 Credit cards

The business credit card can only be used for travel, authorised entertainment and purchases of small value expenses or equipment up to $ 500.

No cash advances are to be taken using the business credit card unless authorised by the Director.

Where a business credit card is lost or stolen, then the owner of this card is to notify the Director who is responsible for notifying the issuing agency and ensuring the card is cancelled.

A business credit card is not to be used for personal expenses.

All holders of business credit cards are required to attach all receipts for payments made on the credit card. Upon completion and authorisation of the monthly expense statement,

these documents are to be forwarded to the Director for payment of the credit card statement.

All business credit cards are to be returned when the person is requested to by the Director or where they cease employment with the business.

4.2.2.3 Budget

Strength In Care develops an annual budget with the support of a financial adviser. Our budget is a list of expenses organised in categories and will assist us to:

- Track all business expenses
- Plan for the future
- Economise as required
- Plan for expansion
- Make a profit

The budget will include:

- time frames
- fixed costs – salaries, rent, insurance and any other known costs
- variable costs – utilities, cost of materials, staff wages
- income – over the budget period.

4.2.2.4 Books of accounts

Strength In Care is responsible for maintaining accounts, assisting the financial adviser in the preparation of the annual budget and preparing monthly, quarterly and annual financial reports. Bookkeeping is a critical component of financial management, assisting us in better business decisions regarding financing, funding and taxes.

Accounts are reconciled monthly. Allowing Strength In Care to track services provided, manage cash flow, run profit and loss and make future projections (e.g. the number of services, staff increases, the timing of expenses, buying inventory).

The $ [Manager Position} delegate handles financial queries regarding participant fees are handled by the $[Manager Position} delegate. Strength In Care or their delegate is responsible for processing all receipts and payments and forwarding information to participants and relevant others. This delegate must check all information before providing relevant financial data, and staff providing services must never be informed of the financial status of a participant.

4.2.2.5 Issuing petty cash

Petty cash is approved by the Director. Each payment made must be supported by an invoice, receipt or other appropriate documentation. The authorisations must be attached to this documentation before payment before any cash is taken from the petty cash float. Only up to $50 can be disbursed at any one time.

Once the petty cash is spent, a receipt or invoice should be attached to the voucher and returned to petty cash with any balance of money unspent.

Petty cash float is to be reconciled with a delegated staff member.

4.2.2.6 Income

Business income is any income realised as a result of Strength In Care operations. In its simplest form, our net profit or loss is calculated as revenue from all sources minus the costs of doing business. All monies received are receipted and recorded in the electronic financial system and recorded in our profit and loss to management review and analysed against our budget.

All money received is deposited in our bank account. Unallocated direct deposits of more than one week will be investigated fully to determine the source of deposit. The source cannot be identified; the deposit will be allocated to a separate bank account until the source is recovered.

Income is matched against invoices to determine when payments have been received and when additional actions are required. Payments are usually made directly into our bank account unless other arrangements have been confirmed.

4.2.2.7 Payments

All payments (except petty cash) are made by electronic transfer. Payments must be accompanied by an invoice and matched against services or equipment received before authorisation. All payments must be recorded in the profit and loss information and managed against the budget. Payments are authorised by the Director.

Management meetings must review payments, income, profit and loss, budget and other financial management issues.

4.2.2.8 Recurrent payments

Recurrent payments, wherever possible, are made electronically. All recurring payments must be approved by the Director who will delegate the arrangement for the payment to be authorised by the bank.

The Director or their delegate is responsible for carrying out the following duties regarding payment stop on a payment:

- ensuring the payment has not already been made
- getting authorisation to activate the stop payment using appropriate forms from the bank
- ensuring the bank receives the notification of the stop payment notice

- receiving confirmation of action from the bank of the stop payment
- ensuring the details of the stop payment are kept.

4.2.2.9 Supplier accounts

When purchases are charged to the accounts of established suppliers, the account will be paid in full, upon receipt of the statement or invoice, within the required terms of payment. The information must be recorded and used to inform Management Meetings about the current status of the debt and payments of these accounts. Information should be reviewed against the budget, cash flow and payments.

4.2.2.10 Asset register

The Asset Register records all the fixed assets of a business. Fixed assets refer to assets that a business regularly uses to produce its income, and unlike assets like inventory, these assets are not considered products to be sold. The register allows our organisation to quickly retrieve information on an asset, including its description, purchase date, location, purchase price, current price, and location.

The register will show the quantity and value of office equipment, motor vehicles, furniture, computers, communications systems and equipment.

4.2.2.11 Reconciliations and ATO reports

The following reconciliations and Australian Taxation Office (ATO) reports are completed at the end of each month:

- Bank accounts are reconciled against bank statements.
- The Instalment Activity Statement is completed and forwarded to the ATO.

The following reconciliations and ATO reports are completed at the end of each quarter:

- The Business Activity Statement (BAS) is completed and forwarded to the ATO.

- Superannuation Guarantee contributions are reconciled, and payments are made.

The following reconciliations and ATO reports are completed at the end of each year:

- Books of accounts are balanced and closed off.
- Wages are reconciled, and Payment Summaries are completed and forwarded to the employee and the ATO.
- Audit reports are prepared.

4.2.2.12 Audit

Annual acquittal statements and audited financial reports will be forwarded, as per contractual requirements, to the relevant government bodies. An annual audit is undertaken each year by a qualified external auditor. Feedback from the audit is provided to management meetings to review budgets and financial management.

4.2.2.13 Participant - payments and pricing (NDIS)

- Strength In Care must adhere to the NDIS Price Guide or any other agency pricing arrangements and guidelines as in force from time to time.
- Strength In Care must declare relevant prices, any notice periods or cancellation terms to participants before delivering a service. Participants are not bound to engage the services of Strength In Care once our prices have been disclosed.
- Strength In Care can make a payment request once that support is delivered or provided.
- No other charges can be added to the support cost, including credit card surcharges or any additional fees, including any ‘gap’ fees, late payment fees or cancellation fees. These requirements apply to all Strength In Care participants whether the participant self-manages their funds or a plan manager or the agency manages it.
- A claim for payment is to be submitted within a reasonable time and no later than sixty (60) days from the end of the service booking to the participant or the NDIS.

- Strength In Care will not charge cancellation fees except when provided explicitly in the NDIS Price Guide.
- Strength In Care and participants (except for those that are self-managing) cannot contract out of the Price Guide.
- Where there are any inconsistencies between the Service Agreement and the NDIS Price Guide, the NDIS Price Guide prevails.
- As required, Strength In Care will obtain a quote for services which the participant is required to approve before the commencement of the service.

4.3 Monitoring, evaluation and reporting

Strength In Care exhibits a continuous improvement culture to facilitate the development of its services and processes; we seek stakeholder input and review immediately upon receipt.

All Strength In Care's policies are reviewed annually and consider the input from all stakeholders. Policy reviews also consider any changes in legislation and the results attained through monitoring and evaluation practices.

4.4 Strategic plan

The planning process involves:

Planning activity	Notes	When

Evaluation	• Review plan to determine future services or products required for NDIS participants and their families. • Review against the vision of creating a unique cultural environment, community environment with genuine care and support, focusing locally, and developing staff. • Review using participant and community input. • Review the current political climate and its influence on business practices and planning. • Organisation's performance, including risk and continuous improvement. • Undertake situational analysis as per risks and continuous improvement.	Every three years.

	• Set goals for business, participants, and stakeholders. • Create a framework that may include: ○ development of participants ○ professional staff development ○ improvement of services ○ safety and security for all. • Problem identification and problem resolution processes identify key organisational challenges, goals, strategies, timeframes, responsible persons, and evaluation methods. • Consultation is undertaken with the community, and community priorities are considered in line with the organisation's vision and mission. • Consultation with participants will inform future planning against the organisation's vision and goals. • Use evaluations to adjust planning - political, social, and financial continuous improvement recommendations are to be fed into the plan. • Ensure that any planning and future planning matches our mission of creating a unique cultural and community environment with genuine care and support, focusing on locally developing staff.	Every three years.

Development	• The plan is developed by Strength In Care. • Feedback is obtained from stakeholders, including community members, employees, participants, advocates and networks. • The use of feedback to improve services and develop new services based on the needs of the community and individuals.	Every three years.
Approval	• Plan approved.	Every three years.
Implementation	• The plan's details are shared with staff and other stakeholders (as relevant).	Ongoing.
Review	• Achievements against the plan are reviewed monthly. • Strength In Care documents achievements and timeframes completed within the plan.	Monthly.

4.5 Risk management

Strength In Care will review risks and ensure that they are either eliminated or reduced. Possible potential risks are identified below:

Risk	Likelihood	Impact	Strategy
Non-compliance with NDIS	Likely	High	Internal review of policies, procedures, financial structures and staff training.
Competitors	Likely	High	Provide high-quality service that encourages loyalty.

Key personnel risk	Likely	High	Identify and train a support person in managing and implementing business needs.

4.6 Marketing

4.6.1 Target markets

- Participants.
- Individuals.
- Legal guardians.
- Plan managers.
- Small organisations who are seeking reliable support for their participant/s.

4.6.2 Marketing strategy

- Raise brand awareness through the use of social media and websites
- Actively communicate with participants and community members
- Provide clear communication and messages
- Inform participants and the community of our brand, mission and goals – focus on our Point of Difference
- Promote our services and products by focusing on the quality of our services
- Develop high-quality services, staff and products, then promote these via media
- Provide an environment where staff wish to work – using staff retention as a selling point
- Contact local networks and communities to provide information about the services we provide.
- Work with the community and other coordinating participant services; advise details of services provided and associated fees.
- Incorporate community languages into all marketing collateral and on our website.

- Provide a single point of contact for enquiries (someone who can provide clear, relevant and accurate information)
- Consult with and listen to participants using their voices to promote the organisation
- Provide documents that demonstrate quality.

5.0 Related documents

- Asset Register
- Conflict of Interest Declaration
- Conflict of Interest Register
- Continuous Improvement Policy and Procedure
- Business Plan and Strategy Plan
- Meeting Agenda
- Meeting Minutes
- Participant Handbook
- Quality Management Policy and Procedure
- Reportable Incident, Accident and Emergency Policy and Procedure
- Risk Management Policy and Procedure
- Offer of Employment Letter
- Staff Handbook
- Staff Orientation Checklist
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Service Agreement

6.0 References

- NDIS Practice Standards and Quality Indicators 2021

- Disability Discrimination Action 1992 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- Suitability Assessment Process Guide – Information for NDIS Providers and their 'key personnel' July 2018
- Financial Management for small business

Conflict of Interest Policy and Procedure

1.0 Purpose

Strength In Care aim is to ensure that actions and decisions are informed, objective and fair. A conflict of interest may affect how a person acts, their choices, or the way they vote on group decisions.

Strength In Care proactively manages any perceived and actual conflicts of interest through the development and maintenance of organisational policies. This management will ensure that corporate and ethical values do not impede participants' right to choose and control their support and services.

Identified conflicts of interest require action to ensure that personal or individual interests do not impact the organisation's services, activities, or decisions.

2.0 Scope

All management, staff and contractors must act in the organisation's interests and notify the organisation when conflicts with other interests or commitments.

3.0 Policy

The Director requires declarations and management of conflicts of interest as part of their legal responsibilities as the controlling member of the organisation.

This policy requires management and staff to disclose any outside interests and workplaces that conflict with the organisation's interests. The Director must act impartially and without prejudice. Gifts or benefits are not accepted due to the potential influence of any decision relating to Strength In Care. Examples may include:

- close personal friends or family members involved in decisions about employment, discipline or dismissal, service allocation, or awarding of contracts
- individuals, or their close friends or family members, who are gaining financially or gaining some other form of advantage
- an individual engaged by another organisation offering services that are in a competitive relationship with Strength In Care (the individual may have access to commercially sensitive)
- information, plans or financial information that conflict with Strength In Care
- prior agreements or allegiances that are binding an individual to other individuals or agencies, requiring them to act in the interests of another party or to take a position on an issue that will conflict with Strength In Care.

4.0 Procedure

4.1 Registration of known conflicts of interest

A Conflict of Interest Register will be maintained, and management and staff will be asked to declare:

- potential or actual conflicts of interest that exist when a person joins the organisation
- conflicts of interest that arise during their involvement with the organisation, which will be recorded in the register maintained by the Director or their delegate.

All potential and actual conflicts will be recorded in the register to provide sight of the identified and declared conflicts.

All management and staff must declare any potential or actual conflicts of interest that become evident during their involvement with the organisation. Management must disclose potential conflicts before the commencement of any meeting.

All management and staff must speak with the Director when a conflict becomes apparent and provide formal notification in writing to the Director of the conflict.

4.2 Management of conflicts of interest

Where a conflict of interest is declared or identified by a staff member:

- the immediate supervisor and the Director will assess the conflict
- if a conflict of interest exists (or there is a perception that a conflict exists), the staff member may be asked to:
  - contribute to the discussion but abstain from voting or taking part in a decision on the matter
  - observe but not take part in the discussion or decision-making
  - leave the meeting during the discussion and before a decision has been made.

4.3 Staff involvement in external activities

Strength In Care encourages and supports staff to become involved in community activities and volunteer work in their personal lives. However, the staff member may undertake volunteer or professional roles outside the organisation, leading to a conflict of interest or a perception of conflict, e.g., consultancy work for member organisations or government agencies.

As a result, Strength In Care expects that all staff members declare their involvement in external work-related activities to allow for discussion and management of the potential conflicts of interest with the Director. Staff members who undertake other (new) work outside of the organisation need to inform the Director.

4.4 Contractors

All contracts with external consultants engaged by the organisation will include a Conflict of Interest Declaration confirming that no conflict of interest exists.

5.0 Related documents

- Code of Conduct
- Conflict of Interest Declaration
- Conflict of Interest Register
- Privacy and Confidentiality Agreement

6.0 References

- NDIS Act 2013 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Australian Privacy Principles(Commonwealth)

Work Health Safety and Environmental Management Policy and Procedure

1.0 Purpose

Work Health and Safety (WHS) regulations place an obligation on decision-makers of the service to take reasonable steps to understand the hazards and risks associated with working and support activities and allocate appropriate resources and processes to eliminate or minimise these risks to health and safety.

These legal requirements extend to eliminating risks to staff members, participants, subcontractors, and volunteers whenever it is practical; if it is not feasible to eliminate all risks, they will be minimised wherever possible.

2.0 Scope

Staff members, participants, volunteers and sub-contractors are also obligated to protect their own and other people's health and safety. Their responsibilities include identifying hazards and risks and managing work health and safety risks. Infection control measures and applying appropriate treatments. They should also consult with other people, including supervisors or management, about these risks.

3.0 Policy

Strength In Care aims to promote and maintain the highest degree of physical, mental and social well-being of all individuals in the workplace. The organisation will comply with all relevant federal and state legislation to ensure a safe workplace. All personnel are responsible for ensuring a safe workplace by implementing safe work systems.

Strength In Care will provide the resources required to comply with relevant acts and regulations associated with workplace health and safety to ensure that the organisation's workplaces are safe and without health risks.

Strength In Care will undertake regular reviews and take steps to enhance workplace health and safety on a continuous improvement basis.

3.1 Statement of injury management and return to work

Strength In Care is committed to:

- establishing and reviewing the return-to-work program that is consistent with the injury management program to ensure injured workers return to work in a timely and safe manner
- managing all claims and the return to work of employees injured in the workplace
- establishing individualised injury management plans according to legislative requirements, as outlined in the policy and procedures
- consulting with employees and other stakeholders on health and safety issues
- complying with relevant work health and safety legislation and regulations and other associated legislation
- providing and maintaining equipment and appropriate personal protective equipment for the safety of our employees
- providing employees with information, training and supervision, as necessary, to enable them to work in a safe manner and without risks to health
- documenting, investigating and reviewing incidents
- displaying, documenting and distributing this Work Health Safety and Environmental Management Policy and Procedure and all other associated documentation in the workplace, including the return-to-work program
- maintaining the required insurance cover
- appointing a designated person to manage all claims for workers' compensation, occupational rehabilitation and return to work programs

- outlining the roles and responsibilities of all relevant parties in the return-to-work process
- regularly reviewing workers' compensation claims.

3.2 Environmental management

Management will endeavour to minimise our environmental impact in the following areas:

- reduction of waste generated
- unnecessary energy consumption.

Strength In Care will actively take part in:

- identifying waste streams and options for effective waste management
- reviewing purchasing behaviour, e.g. buy recycled materials; reduce waste; use less harmful/volatile chemicals
- improving storage, e.g. reducing the quantity of waste and spills, reducing odours by keeping containers closed
- conserving energy, e.g. installing eco-friendly lights, turning lights off when not needed, purchasing energy-efficient emergency equipment and using greener fuel sources
- conserving water, e.g. installing water-saving accessories, repairing leaks
- preserving waterways, e.g. mark and protect storm-water drains
- creating an emergency plan and spill response
- improving education and awareness
- notifying relevant authorities in the event of a major environmental impact.

3.3 Incident management

Incident management is an integral element of the Strength In Care's planning processes. All stakeholders are encouraged to raise any concerns regarding risk, incidents or safety. Support delivery issues, and their contributing factors, are identified and utilised as Strength In Care’s performance measures:

- Strength In Care management is ultimately accountable for incident management throughout our service and support provision.
- Our organisation reinforces our accountability by using governance structures, including policy, performance management and delegations, and defines the acceptable level of risk for the organisation.

The Director is responsible for:

- overseeing the incident management system, including monitoring, reviewing and reporting on its effectiveness
- managing, reviewing and implementing the contingency disaster plan, including establishing and maintaining all service agreements
- implementing incident management processes
- advising results and analysis of incident investigations
- evaluating and documenting actual and potential risks with a formal risk assessment
- ensuring all staff within Strength In Care have a responsibility to identify and engage in the minimisation of risks that may exist in service delivery.

Figure 1. Incident management process

3.3.1 Responding and reporting obligations

- Strength In Care has a responsive risk management hazard, incident and accident reporting system in place.
- All incidents of any nature are a matter of concern and, as such, should be recorded using incident and hazard reports.
- All notifiable incidents are reported to state WorkCover authorities, Coroner (if required) and the NDIS Commission through the portal as per regulatory requirements.
- Details of incidents will be documented through the incident management system.

3.3.2 Documentation

- All information is gathered regarding privacy and confidentiality, recorded comprehensively and stored securely.
- The incident report is for the use of the Director only, as it will contain identifying information. Minimum information required includes a description of the event, damage, injuries, reporting requirements, parties/persons involved and recommendations. Reportable Incidents documentation will be held for seven (7) years. Where children are involved, records will be kept as per state requirements.
- When discussing the incident findings and recommendations in a meeting, care must be taken not to minute any identifying information.

3.3.3 Evaluation and feedback

- Staff involved in the incident will be advised of the findings and recommendations of the incident investigation.
- Information will be reported through the meeting system.
- Strength In Care may trend incidents, accidents and critical events.
- Reviews of policy, procedure and equipment may occur because of an incident or accident.

3.3.4 Support for stakeholders

- Any staff member, participant or visitor involved in or affected by an incident is offered support.

3.4 Manual handling

- Strength In Care has a Manual Handling Policy and Procedure, and all staff are instructed in this procedure at induction and as required.
- Maintenance of the participants' independence by encouraging mobility is a priority.
- The manual handling needs of participants are assessed and documented on entry to Strength In Care.
- Manual handling is a component of the education and training program.
- Staff members have instruction on the correct manual handling and lifting techniques.
- All staff members are assessed on their manual handling techniques during induction and then regularly.
- All manual handling injuries and incidents are reviewed, risk assessments are conducted, and strategies are implemented to control risks.
- Risk identification, assessment and control are carried out in consultation with staff.

- Incidents, accidents and hazards identified from manual handling activities are reported through the communication meeting and other associated meetings, as deemed by management as required.
- Appropriate equipment is provided so manual handling activities can be safely executed.
- According to infection control guidelines, personal manual handling equipment such as 'slide sheets'.
- The Director will ensure that the general layout of the workplace is conducive to the safe handling of participants and the safe use of equipment.

3.5 Infection Control

Strength In Care will follow and inform staff of any health orders (e.g. use of PPE – gloves and masks). Staff must train in how infectious agents spread, including

- breathing in airborne germs – coughs or sneezes release airborne pathogens, which are then inhaled by others
- touching contaminated objects or eating contaminated food – the pathogens in a person's faeces may be spread to food or other objects if their hands are dirty
- skin-to-skin contact – the transfer of some pathogens can occur through touch or by sharing personal items, clothing or objects
- contact with body fluids – pathogens in saliva, urine, faeces or blood can be passed to another person's body via cuts or abrasions or through the mucus membranes of the mouth and eyes (better health)

Staff must follow infection control guidelines set out in our practice guides and policies, including

3.6 Work health and safety consultation

Strength In Care will establish and maintain systems for work health and safety consultation to enable staff to contribute to the decision-making process regarding

matters that affect their health, safety and welfare at work. The intended outcomes of this policy include:

- prevention of risk of injury to workers and others
- consultation with workers regarding the risk management process
- reduction of social and financial costs of work health and safety hazards
- establishment and maintenance of safe systems of work
- regulatory compliance maintenance
- prompt consultation on work health and safety matters, taking into consideration the level of risk involved in any specific issue
- training is updated according to current work health and safety regulatory requirements and made available to staff.

3.6.1 Nature of consultation

The purpose of the work health and safety consultation with staff is to:

- share health and safety information
- provide a reasonable opportunity to:
    - express their views
    - raise work health and safety issues
    - contribute to the decision-making process
- consider the opinions of staff members
- promptly inform staff of any future outcomes.

3.6.2 When a consultation is required

Consultation is required when:

- identifying and assessing risks to health and safety
- deciding ways to eliminate or minimise those risks
- deciding on the adequacy of facilities for worker welfare
- proposing changes that may affect the health and safety of workers.

3.6.3 Work health and safety resolution

- Staff are to be consulted on proposed changes to the work environment, equipment, policies, protocols and procedures that may affect their health and safety.
- Information on hazards, work health and safety activities, and achievements will be disseminated to staff through staff meetings, memos, etc.
- A staff member may approach the Director to bring forward issues in the workplace.
- The Director will attempt to resolve the issue locally.
- Strength In Care will always make a reasonable effort to achieve a timely, final and effective resolution of work health and safety matters.

Work-related problems, concerns or complaints concerning work health and safety will be managed following our Human Resource Management Policy and Procedure.

Only after reasonable efforts have been made to resolve the issue can the parties seek the assistance of an appropriate workplace health and safety inspector. This right arises whether all or only one party has made reasonable efforts to resolving the work health and safety issue; this means that a party's unwillingness to resolve the issue would not prevent an inspector from being called in.

The inspector's role is to assist in resolving the issue, which could involve the inspector providing advice or recommendations or exercising any of their compliance powers, e.g. issuing a notice.

Even if an inspector has been requested to assist in resolving a work health and safety issue, a worker's rights to cease unsafe work remain under the *Work Health and Safety Act 2011* model.

When an issue is resolved, the issue's details and resolution will be written and recorded to all parties' satisfaction as soon as reasonably practicable:

- Worker/s affected by the issue will be informed of the agreement's details between the parties.
- A copy of the issues' resolution agreement may be forwarded by any of the parties involved or Strength In Care that represents the party.

3.7 Workplace incidents

Strength In Care will:

- hold current workers' compensation insurance policy that covers all workers
- notify a worker of any workplace incidents, as per legislative requirements
- make suitable duties available to injured workers
- maintain a record of wages according to regulatory requirements
- maintain a register of workplace-related injuries and illnesses
- forward any workers' compensation payments to injured workers
- avoid dismissing an injured worker because of their injury within six months of the injury or illness occurring and the injured worker's incapacity to work
- maintain a register of acceptable modified duties
- prepare an offer of modified duties in writing and provide these to the injured worker and healthcare practitioner
- educate staff about the causes of the injury and subsequent risk
- keep associated records as required
- ensure all staff are aware of responsibilities and rights concerning return to work through training and education
- manage disputes according to regulatory requirements.

3.7.1 Notification of injuries

- The Director will be notified of all injuries as soon as possible.
- All injuries are to be recorded.

- The workers' compensation agent will notify any injuries within 48 hours.
- Workers will be notified immediately of any serious incidents involving a fatality or a serious injury or illness.

3.7.2 Recovery

- The Director will ensure that the injured worker receives appropriate first aid and medical treatment as soon as possible.
- The injured worker must nominate a treating doctor responsible for the medical management of the injury and plan a return to work.

3.7.3 Return to work

The Director will:

- arrange a suitable person to explain the return to work process and the injury management plan to the injured worker
- ensure the injured worker's right to the confidentiality of medical information
- ensure no information will be used to discriminate against the injured worker
- provide mechanisms to communicate across cultures, including ethnicity, gender and age
- ensure all return to work plans are completed within the legal time frames
- prepare the return to work plans based on the advice of the staff member's own treating health practitioner/doctor and the workplace rehabilitation provider
- follow the relevant legislation and the agreed consultation procedures
- create availability of suitable work where possible when a staff member's injury does not allow a return to immediate pre-injury duties (these suitable duties shall be made available temporarily)
- maintain contact and communication with an injured staff member during the period of incapacity and absence from work
- ensure the confidentiality of the injured staff member's information and records.

3.8 Work health and safety management program

The work health and safety management program consists of a set of activities, policies and procedures that are updated, as required, which relate to all aspects of work health and safety, including:

- work health and safety training and education
- work design, workplace design and standard/safe work procedures
- emergency procedures
- provision of work health and safety equipment, services and facilities
- workplace inspections and evaluations
- reporting, recording and reviewing incidents, accidents, injuries and illnesses
- hazard identification activities
- equipment assessment procedures and practices
- participant risk assessment procedures and practices
- staff risk assessment procedures and practices
- provide information on work health and safety to staff, participants and their families
- implement safe manual handling procedures and safe work procedures.

3.9 Education/training

Every staff member will receive emergency training at least annually. Education/training will always be conducted by appropriately authorised and skilled personnel. Within seven days of commencing employment, each new employee will be provided instructions regarding:

- identification and minimisation of hazards in/around a participant's home and workplace
- procedures to be followed in an emergency.

3.10 Hazard identification and risk management

Management actively encourages the reporting of hazards and promotes a positive and timely response; staff and contractors are informed of hazard identification mechanisms. On identification and reporting of a hazard, staff members and subcontractors will:

- take immediate action to minimise the hazard(s), where possible
- report immediately to the person in charge when the action is beyond role limitations, and the hazard poses a high risk
- record the hazard according to the organisation's hazard reporting requirements.

Identified hazards are reported and reviewed using Strength In Care's continuous improvement and risk management processes (see the Risk Management Policy and Procedure and the Continuous Improvement Policy and Procedure).

3.11 Risk management

Strength In Care considers risk management to be fundamental to good management practice. Effective management of risks will provide an essential contribution to the achievement of Strength In Care's strategic and operational objectives and goals. Risk management must be an integral part of Strength In Care's decision-making and must be incorporated within the strategic and operational planning processes, at all levels, across Strength In Care.

Strength In Care will maintain strategic and operational risk management plans. Management is committed to ensuring all staff are provided with adequate guidance and training on risk management principles and their responsibilities to implement risk management effectively.

Strength In Care will regularly review and monitor the implementation and effectiveness of the risk management process, including the development of an appropriate risk management culture across our organisation.

4.0 Definitions

Term	Definition
Bullying	Bullying can be defined as "unreasonable and inappropriate workplace behaviour that may intimidate, offend, degrade, insult or humiliate an employee (or another person), in front of others, including physical or psychological behaviours."
Clinical risk management	Clinical risk management is an approach to improving the quality of care that emphasises identifying circumstances that put participants at risk of harm and then acting to prevent, control or accept those risks. The aim is to improve the quality of care for participants and reduce risks for care providers.
Dangerous goods	Those substances that give rise to an immediate physical effect, such as fire, explosion, and vapour release, are defined under Work Health Safety legislation.

Dangerous incident	A dangerous incident means an incident in a workplace that exposes a worker or any other person to a serious risk to a person's health or safety emanating from immediate or imminent exposure to: (a) an uncontrolled escape, spillage or leakage of a substance (b) an uncontrolled implosion, explosion or fire (c) an uncontrolled escape of gas or steam (d) an uncontrolled escape of a pressurised substance (e) electric shock (f) the fall or release from a height of any plant, substance or thing (g) the collapse, overturning, failure or malfunction of, or damage to, any plant that is required to be authorised for use following the regulations (h) the collapse or partial collapse of a structure (i) the collapse or failure of an excavation or of any shoring supporting an excavation (j) the inrush of water, mud or gas in workings in an underground excavation or tunnel (k) the interruption of the main system of ventilation in an underground excavation or tunnel (l) any other event prescribed by the regulations but does not include an incident of a prescribed kind.

Due diligence	Where a PCBU (person conducting a business or undertaking) has a health and safety duty, an officer of the PCBU is required to exercise 'due diligence' to ensure the PCBU meets that duty. Due diligence means taking a reasonable step to: ● gain and update knowledge of WHS matters ● understand the nature of the business, undertaking's operations and the general hazards and risks involved ● ensure the PCBU has appropriate resources for eliminating/minimising risks and that these resources are used ● ensure the PCBU has processes for receiving, reviewing and responding to information about incidents, hazards and risks ● ensure the PCBU implements processes for complying with their duties, such as: ○ consultation ○ provision of training and instruction ○ reporting of notifiable incidents.
Environment	Components of the earth, including: ● land, air and water ● any layer of the atmosphere ● any organic or inorganic matter and any living organism ● human-made or modified structures and areas and includes interacting natural ecosystems.
Hazard	Hazards are something with the potential to cause injury, illness or disease.

Hazardous substances	Those substances can cause detrimental health effects, such as damage to the respiratory tract, skin, and eyes (including carcinogens) and are defined as such under WHS legislation.
Health and Safety Representative (HSR)	Members of a workgroup elect the HSR person within the PCBU or across several businesses (e.g. multiple workplaces) to represent that workgroup during consultation on work health and safety issues.
Health and Safety Committee (HSC)	A PCBU must establish an HSC requested by the HSR or a minimum of 5 or more workers at the workplace or the PCBUs own initiative. The HSR can be a member of the HSC if they consent.
Incident	Incidents can be either an event or a near miss, including care complications, accidents, and side effects. A common feature is that incidents are potentially harmful.
Notifiable incident	A notifiable incident is defined as: ● death of a person ● serious injury or illness of a person ● dangerous incident ● abuse or neglect of a person ● unlawful sexual or physical contact or assault of a person ● sexual misconduct committed against, or in the presence of, a person. ● unauthorised use of a restrictive practice concerning a person.
Person conducting a business or undertaking (PCBU)	A person or entity that conducts the business or undertaking alone or with others, whether or not the business or undertaking is conducted for profit or gain.

Officer of the PCBU	A person who makes or participates in making decisions that affect the whole, or a substantial part, of the business or undertaking.
Personal protective equipment (PPE)	Personal protective equipment (PPE) is defined as safety clothing or equipment for specified circumstances or areas where the nature of the work involved or the conditions under which people are working requires wearing or using for personal protection to minimise risk.
Reasonably practicable	Taking all steps, a duty holder reasonably considered the cost of eliminating or minimising the risk and whether this cost far exceeds the level of risk reduction.
Risk	The chance of something happening that will have an impact upon the services Strength In Care provides—measured in terms of likelihood and consequences.
Risk analysis (Incident)	Analysing the seriousness of the event's consequences and its likelihood or frequency of occurring again provides a Category Code (CAT), generating a numerical rating that guides appropriate action.
Risk identification	Data sources that assist identification of risk include Coroners' reports, clinical indicators, variance analysis, incident reporting, complaints and other feedback.
Risk register	All levels of Strength In Care are responsible for the continual monitoring of the strategic risk profile. A risk register identifies major risks for Strength In Care, including an indication if existing controls or management systems are in place to manage that risk.

Risk treatment	Risk can be avoided, controlled, retained or eliminated. Two major approaches to control risk are reducing risk before it arises (in essence, proactive system design, e.g. Work Health Safety Risk Management Site for Safe Work Method Statement, equipment maintenance) or reducing the risk after the problem arises (countermeasures or barriers such as increased training).
Safety Data Sheet (SDS)	Information containing data regarding the properties and effects must be provided by the manufacturer, supplier or importer of the hazardous substance/dangerous goods. SDS must be current – within five years of the issue date and meet specific legislated format requirements.
Serious injury or illness	Serious injury or illness of a person means an injury or illness requiring the person to have: (a) immediate treatment as an in-patient in a hospital (b) immediate treatment for: (i) the amputation of any part of his or her body (ii) a serious head injury (iii) a serious eye injury (iv) a serious burn (v) the separation of his or her skin from an underlying tissue (vi) a spinal injury (vii) the loss of a bodily function (viii) serious lacerations (c) medical treatment within 48-hours of exposure to a substance, and any other injury or illness prescribed by the regulations but does not include an illness or injury of a prescribed kind.

Worker	Anyone who is carrying out work, in any capacity, for a PCBU, including direct employees, contractors and subcontractors and their employees, labour-hire employees engaged in working in the business or undertaking, outworkers, apprentices, trainees and students on work experience and volunteers.
Work group	A workgroup is the group of people represented by the HSR, such as a specific department, shift (e.g. day/night shift), location or type of worker. Workgroups are determined by negotiation between the PCBU and workers (and their representatives if required).
Work health and safety	The main objective of the model *Work Health and Safety Act* is to '*provide for a balanced and nationally consistent framework to secure the health and safety of workers and workplaces*'.
Workplace	A ***workplace*** is where work is carried out for a business or undertaking, including where a worker goes or is likely to be while at work.

5.0 Related documents

- Complaints and Feedback Form
- Anonymous Complaint and Feedback Form
- Complaints Register
- Continuous Improvement Policy and Procedure
- Emergency Plan
- Emergency Plan - Waste
- Hazard Report Form
- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Report

- Incident Register
- Position Descriptions
- Return to work program documents
- Staff Training Record
- Staff Training Plan
- Risk Management Policy and Procedure

6.0 References

- NDIS (Quality and Safeguards Commission) 2018
- Safe Work Australia National Code of Practice
- Work Health and Safety Act 2011 (Commonwealth)

Manual Handling Policy and Procedure

1.0 Purpose

Most work roles involve performing some type of manual task using the body to move or hold objects, people or animals. Manual tasks cover a wide range of activities, including stacking shelves, cleaning, gardening, moving people and entering data into a computer.

Manual handling relates to any activity that requires effort, e.g. lifting, lowering, pushing, pulling, supporting, carrying and moving loads by hand or by bodily force. Some manual tasks are hazardous and may cause musculoskeletal disorders (MSD). These are the most common workplace injuries across Australia.

The *Work Health and Safety Act 2011* and the *Work Health and Safety Regulations* provide a framework for safeguarding the health, safety and welfare of those who participate in manual handling activities.

This document is provided as a guide for staff to ensure safe manual handling practices. All workers are responsible for following the steps detailed in this procedure for any manual handling activity. The procedure should be read in conjunction with the Work Health Safety and Environmental Management Policy and Procedure.

2.0 Scope

2.1 Organisation

Strength In Care has a responsibility for ensuring that manual handling practices are current and that best practice information is provided to staff regarding managing the risk of musculoskeletal injuries associated with hazardous manual tasks. Strength In Care takes all reasonable steps to use appropriate resources and processes to eliminate or minimise risks in our organisation caused by hazardous manual tasks.

2.2 Staff

Staff and participants must take reasonable care of their health and safety and not adversely affect the health and safety of others. Staff must comply with any reasonable instructions, as far as they are able, and must also cooperate with any reasonable health and safety policies or procedures that they have been provided by Strength In Care to mitigate risk.

3.0 Definitions

Term	Definition
Manual handling	Any activity that involves lifting, pushing, pulling, carrying, moving, holding or restraining. It also includes sustained and awkward postures or repetitive movements.
Hazardous manual task	A task requiring a person to lift, lower, push, pull, carry or otherwise move, hold or restrain any person, animal or thing involving one or more of the following: ● repetitive or sustained force ● a high or sudden force ● repetitive movement ● sustained or awkward posture ● exposure to vibration. These hazards directly stress the body and may lead to an injury.

Musculoskeletal disorder (MSD)	An MSD may include: ● sprains and strains of muscles, ligaments and tendons ● back injuries, including damage to the muscles, tendons, ligaments, spinal discs, nerves, joints and bones ● joint and bone injuries or degeneration, including injuries to the shoulder, elbow, wrist, hip, knee, ankle, hands and feet ● nerve injuries or compression (e.g. carpal tunnel syndrome) ● muscular and vascular disorders as a result of hand-arm vibration ● soft tissue injuries, including hernias ● chronic pain. An MSD can occur in two ways, including: ● gradual wear and tear to joints, ligaments, muscles and intervertebral discs caused by repeated or continuous use of the same body parts, including static body positions ● sudden damage caused by strenuous activity or unexpected movements such as when loads being handled move or change position suddenly ● Injuries can also occur due to a combination of the above mechanisms.
Workplace	Any place where work is carried out for a business and includes any place where a worker goes, or is likely to be, while at work, including a participant's home.

4.0 Policy

Strength In Care will manage risks to health and safety relating to a musculoskeletal disorder associated with hazardous manual tasks by following the recommendations of SafeWork Australia's Hazardous Manual Tasks Code of Practices.

A Work Health and Safety Officer, delegated by the Director, will manage risks to:

- identify and assess reasonably foreseeable hazards that could give rise to manual handling risk
- eliminate the risk, as far as is reasonably practicable
- minimise the risk, as far as is reasonably practicable, by implementing control measures (e.g. use of appropriate mechanical aids, the provision of training, support and communication with all who may be exposed to the risks and hazards)
- maintain the implemented control measure, so it remains effective
- review, and if necessary, revise risk control measures to maintain a work environment without risks to health and safety, as far as practicable.

Strength In Care will ensure it provides:

- appropriate equipment and related training that promotes safe manual handling practices
- education specific to manual handling on an annual basis to guarantee staff knowledge is up to date and in line with the current safe work standards
- induction training and instruction to workers that are suitable and adequate for their work role, incorporating:
    - the nature of the work carried out
    - the nature of the risks associated with the work at the time of the information, training and instruction
- control measures implemented
- review and monitor the manual handling practices of employees who directly and actively participate in the delivery of care to participants

- assessment of participants for manual handling risks and where risks are identified, ensure these are documented in their clinical record, as well as procedures/ practices to be carried out to reduce the risk (to be undertaken upon initial assessment of the client and in the home risk assessment procedures)
- support for consultative and collaborative improvement processes regarding safe manual handling
- annual reviews of the individual participant that include the assessment of equipment or processes relating to manual handling to ensure that these are still valid
- carry out reassessment immediately if there are changes in the participant's condition that may alter the work environment concerning manual handling
- investigate all incidents and accidents which result in physical or musculoskeletal injury to employees
- review risk assessments and systems of work in light of any incidents
- report all incidents and complete the Incident Investigation Form as soon as practical.

Our staff will ensure they take personal responsibility for reducing the potential risk of injury to themselves, participants and others by:

- understanding the principles of manual handling and being able to identify potential hazardous risks
- familiarising themselves with the Safe Work Australia Hazardous Manual Tasks Code of Practice
- consistently using safe work practices when undertaking any manual handling activity, following the manufacturer's operational instructions on the use of equipment and procedures documented in the participant's notes relating to specific manual handling
- adhering to our organisation's policies and procedures regarding manual handling as outlined in this policy and the following procedures.

5.0 Procedure

5.1 Managing manual handling risks

All new staff undertake work health and safety training and are provided with relevant documentation at their induction/orientation. The Staff Orientation Checklist records this.

New staff will be assessed for their competency in manual handling on their initial buddy shift/s and any later shift observations.

All staff will be provided annual refresher training in manual handling relevant to their role, as per mandatory training outlined in the Staff Development Policy and Procedure.

5.2 Participant care procedures

Participant assessment, planning and ongoing revision will include:

- an initial assessment of manual handling risks and appropriate control strategies, documented in the Participant Initial Assessment Form
- notes of manual handling risks in the Risk Assessment Form
- ongoing assessment of manual handling risks and strategies annually or as required.

5.3 Continuous improvement procedures

The Quality and Risk Committee will:

- ensure all musculoskeletal injuries are investigated
- review policies and procedures in the light of such incidents
- enter review and outcomes in the Incident Register and Continuous Improvement Register
- periodically review all employee incidents to identify musculoskeletal injuries and manual handling patterns.

5.4 Employee procedures

Employees are expected to:

- take part in all training and assessment provided concerning manual handling
- adhere to manual handling policies and procedures
- consult with all key persons to reduce manual handling risks, i.e. participant, family, carer, management and allied health professionals
- use and operate equipment following manufacturer instructions and only for its intended use
- report to the Director as soon as possible:
    - potential hazards and faulty equipment (e.g. commode chair difficult to manoeuvre, malfunctioning hoist batteries, frayed/worn slings, harnesses and broken buckles)
    - incident/accident, injury or dangerous occurrence relating to manual handling
    - changes in the participant's condition and environment may increase the risk of injury from manual handling issues.

5.5 Risk management process for manual tasks

<table>
<tr><td rowspan="2">IDENTIFY</td><td colspan="4">What is the manual task?
Using the body to lift, lower, push, pull, carry or otherwise move, hold or restrain any person, animal or thing.
Is the manual task hazardous?</td><td rowspan="2">CONSULT</td></tr>
<tr><td>Application of force:
- repetitive
- sustained
- high
- sudden</td><td>Posture:
- sustained
- awkward</td><td>Movement:
- repetitive</td><td>Exposure to vibration</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">ASSESS</td><td colspan="4">What is the risk of MSD?
• How often and how long are specific postures, movements or forces performed or held?
• What is the duration of the task?
• Does the task involve high or sudden force?
• Does the task involve vibration?
What is the source of risk?</td><td rowspan="3">CONSULT</td></tr>
<tr><td>Work area design and layout</td><td>Systems of work</td><td>Nature, size, weight and number of persons, animals or things handled</td><td>Work environment</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">CONTROL</td><td colspan="4">Is the task necessary?
• Can the source of risk (work area layout, environment, etc.) be changed?
• Can mechanical aids be used to perform the task?
• What training is needed to support the control measures?</td><td rowspan="2">CONSULT</td></tr>
<tr><td colspan="4"></td></tr>
</table>

REVIEW	**Conduct a review:** • when the control measure is no longer effective • 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 the new hazard or risk is identified • if consultation results indicate that a review is necessary • if a health and safety representative at the workplace requests a review.	CONSULT

6.0 Related documents

- Incident Report
- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Register
- Continuous Improvement Register
- Continuous Improvement Plan
- Staff Orientation Checklist
- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Hazard Report Form
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Human Resource Management Policy and Procedure
- Work Health Safety and Environmental Management Policy and Procedure

7.0 References

- Work Health and Safety Act 2011 (Commonwealth)
- Work Health and Safety Regulations 2019 (Commonwealth)
- SafeWork Australia - Hazardous Manual Tasks Code of Practices

Continuous Improvement Policy and Procedure

1.0 Purpose

Strength In Care is committed to continuous service improvement. Continuous improvement requires a deliberate and sustained effort and a learning culture. It is results-driven with a focus not only on strengthening service delivery but also on individual outcomes.

This policy supports Strength In Care to apply the National Disability Insurance Service Practice Standards and Quality Indicators.

Strength In Care actively pursues and demonstrates continuous improvement in all aspects of business operations.

2.0 Scope

All staff, whether permanent or casual, contractors, volunteers or business partners, are responsible for monitoring how well Strength In Care services and supports are functioning.

3.0 Definitions

Term	Definition

Continuous improvement	Continuous improvement is a formal, cyclical series of steps designed to improve processes that lead to better outcomes for participants and other stakeholders. The steps usually include identifying opportunities for improvement, collecting data, analysing data, deciding on a new approach based on the data analysis, developing and implementing changes and evaluating
Internal auditing	Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve the organisation's operations. It helps the organisation to accomplish its objectives by bringing a systematic and disciplined approach to evaluating and improving the effectiveness of its quality management system.
Corrective action	Correction action is an action, or a plan, created by management to address a non-conformance.

Performance measures	Performance measures (or 'indicators') evaluate outcomes or results. They measure how well the service provider is carrying out its work and achieving its aims. They are expressed as numbers rather than as descriptions. They can tell a service provider: • how much it has done (numbers of people using a service, numbers of activities provided) • how well it has done something (levels of satisfaction by numbers of people, timeliness or efficiency of activities) • the effect it has had (outcomes for numbers of people receiving service, changes in social well-being or social policy) • sound corporate governance • the financial health of the organisation • participant satisfaction levels • achievement of positive outcomes for participants • level of staff morale • provide a positive profile for the service provider among stakeholders.

4.0 Policy

This policy guides the design and delivery of services and ensures Strength In Care maintains high standards, improves systems and processes, adapts to changing needs and demonstrates organisational improvement.

4.1 Continuous improvement process

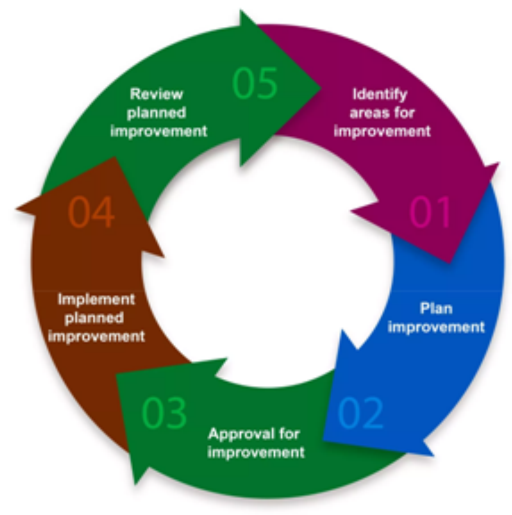
The basis of Strength In Care's quality system is a cycle of self-improvement that follows a basic model involving planning, acting and checking to improve and standardise our processes. This model is used at an organisation level to determine, measure, analyse and improve performance. At a process level, this approach involves:

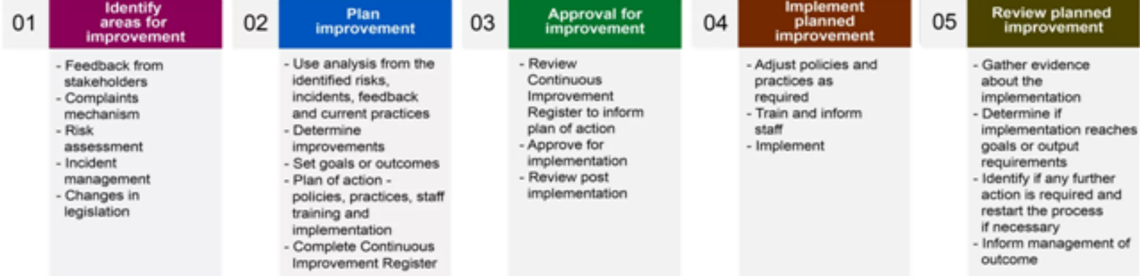
- identifying problems or improvement opportunities, then investigating and determining the root cause
- developing and implementing an action plan, listing tasks, setting target dates, nominating responsibility and tracking progress through continuous management
- checking that the improvement has led to growth through performance measures and identifying any new or additional measures needed
- standardising improvements made through policies or other documents.

4.2 Principles

- All services, processes and procedures undertaken are the best they can be.
- Services are regularly reviewed and measured for quality and effectiveness.
- All staff and participants are encouraged to provide feedback on improving service delivery.
- The participants are to be involved in all decision-making processes that affect them.
- Participants, family and advocates can provide valuable insights about the effectiveness of services, highlight any gaps or issues that arise and provide ideas for improvements and innovation.
- A quality learning culture within the organisation ensures that all people contribute to service quality and quality management regardless of their role.
- Planning, resource allocation, risk management and reporting are critical for continuous improvement and are part of an integrated approach that supports Strength In Care's mission and vision.
- Strength In Care is committed to innovation, high quality, continuous improvement, contemporary best practices and effectiveness in the provision of support to people with disabilities.

Diagram 1. Continuous Improvement Cycle Process





4.3 Measurements of quality

Strength In Care uses survey and audit results to measure outcomes required under the NDIS Practice Standards and Quality Indicators, in addition to other legislative requirements.

4.4 Sources of data for continuous improvement

4.4.1 Changes in legislation/regulation and best practice

Strength In Care's management is informed of regulative and legislative changes via structured access to government, industry and association information channels and

through attendance at industry conferences, networking events and ongoing training/ education. Information of this type is used to improve practices and approaches in our operations and services, including implementing service improvements.

Policies and procedures will be reviewed on an ongoing basis to ensure compliance with legislation. Version control will ensure that current documents are available to staff and participants.

4.4.2 Feedback and evaluation of data

Strength In Care will conduct formal surveys annually, at a minimum, to obtain opinions and feedback from participants as well as from their families and advocates, where possible. Participants and the community are supported and encouraged to provide feedback through meetings and reviews.

Such feedback will assist Strength In Care in assessing the quality of services accurately and in making any improvements necessary to develop our corporate governance policies and practices.

Strength In Care will collate the feedback from its surveys, meetings and reviews and advise participants of any proposed improvements to service delivery. Surveys, focus groups, and individuals may also be targeted to review specific aspects of performance, e.g. information provision or ensuring participants are involved in planning and decision-making for themselves and our organisation.

Staff surveys will be conducted annually and during our annual performance reviews. These will be used to measure morale, understanding of Strength In Care's policies and procedures, operating environment satisfaction, roles within the organisation, training and information needs and our commitment to our values. Feedback analysis is incorporated into a Continuous Improvement Plan.

4.4.3 Internal/external audits

Strength In Care will conduct periodic internal audits to determine whether the quality management system conforms to the requirements of the relevant quality standards. The internal audits will check all processes and documents to ensure that the quality management system has been effectively implemented and maintained.

Internal and external audits will ensure that legislation, industry standards, and operational processes are correctly understood and implemented per organisational policy (see Appendix 1: Internal review and external audit schedule).

Data obtained from audits will be stored and used to ensure corrective actions are recorded, verified and closed out. The data collected from internal audits and corrective actions will be integrated into the continuous quality improvement system.

4.4.4 Complaint management

All complaints will be investigated to determine the root causes and required improvements. All improvements will be tracked to capture and evaluate corrective actions and progress through management systems (meetings and reports).

All staff will be responsible for promoting the development of a positive complaint handling culture. Management will review complaints every six months (at least) to ensure that the complaint handling process follows our policy and procedures.

The Director or their delegate will annually review the entire complaint handling system to ensure changes to policy and practice are implemented when necessary. The complaint data will be analysed to determine any trends or patterns of ongoing concern; such analysis will be incorporated into the continuous improvement system and corporate governance.

4.4.5 Incident reporting

The Director or their delegate will be responsible for reviewing incidents, including incidents recorded under the Incident Register. This register allows for collating and analysing data from incident reports to determine issues, trends, or patterns of ongoing concern; such analysis will be linked to the continuous improvement system.

4.4.6 Unsolicited feedback

Every participant and staff member has the right (and is encouraged) to provide feedback and suggestions that they believe can lead to improvements in the overall operation of

Strength In Care. They may use the Complaints and Feedback Form to put their thoughts and ideas in writing to the Director. Alternatively, feedback can be provided via email or phone.

All suggestions will be fully considered, and appropriate improvements implemented wherever possible. This feedback information is linked to our corporate governance to instigate changes in policies and procedures to improve practices on an ongoing basis.

4.5 Communication of improvements

An outline of any improvements is provided via:

- staff meetings
- emails
- subcontractor meetings
- updated policies and procedures
- providing information to participants.

4.6 Monitoring continuous improvement processes and systems

As part of our audit program, continuous improvement processes and systems are regularly audited. All staff, participants and other stakeholders are encouraged to provide ongoing feedback on any issues and areas where improvements are possible.

Continuous improvement should include feedback from participants and stakeholders to ensure that Strength In Care meets the needs of the community in which it functions.

Continuous improvement ideas and strategies will be used to inform our corporate governance. Document and version control measures are documented in the Document Control Register, and new documents are distributed as outlined in this document.

5.0 Related documents

- Asset Register
- Complaint and Feedback Form
- Anonymous Complaint and Feedback Form
- Complaints Register
- Continuous Improvement Register
- Corporate Governance Policy and Procedure
- Document Control Register
- Hazard Report Form
- Incident Register
- Incident Report
- Incident Investigation Form Final Report
- Internal Audit Schedule
- Risk Management Plan
- Risk Assessment Form
- Risk Register
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register

6.0 References

- Disability Services Act 1986 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021

Appendix 1: Internal review and external audit schedule

Audit Focus	Technique	Responsibility	Review Schedule
Policies and Procedures	• Evaluate effectiveness and currency (practices match policy) • Merge, develop or repeal policies and procedures • Address non-conformances • A delegate staff member to review, adjust and train staff in new practices and policies • Review against compliance requirements (NDIS and legislation)	Director or delegated officer	Three-year cycle or when legislation changes. High-risk policies – annually (all Governance)

Audit Focus	Technique	Responsibility	Review Schedule
NDIS Audit Certification or Surveillance	• Review previous report • Review all policies and procedures against standards • Inform participants and staff • Policy matches practice • Rectifications allocated to relevant staff and used as training and	Director and NDIS Approved External Auditor	Three-year cycle (Annual surveillance and renewal audits)
Service Delivery	• Review each practice for improvement and compliance • Preparation and submission of reports required under any contractual arrangements • Review input from participants and community • Errors or non-conformances will be actioned to ensure compliance	Director or delegated officer	As per contractual arrangements

Audit Focus	Technique	Responsibility	Review Schedule
Legislative	• Preparation of annual report • Review current legislative requirements (NDIS, Tenancy, general business) • Non-compliances – Director to manage	Director or delegated officer	Annually following the end of the financial year (if relevant)
Financial	Financial year reporting: • quarterly • end of Financial Year Review budget and profit and loss information	Director or delegated officer	**Quarterly** (March, June, September and December) **Annually** (July)
Asset Management	• Review Assets Register • Update warranty and depreciation details • Building and assets review • Audit maintenance schedules for continuing value and usefulness	Director or delegated officer	Annually

Audit Focus	Technique	Responsibility	Review Schedule
Risk Management	• Review of risk management and risk treatment plans • Review participant practices to ensure individual risk management • Review continuous improvement register for sign-offs and actions • Action non-actioned items in the Continuous Improvement Register	Director or delegated officer	Quarterly
Complaints	• Review Complaints Register • Review Continuous Improvement Register for sign-offs and actions • Action non-actioned items in the Continuous Improvement Register	Director or delegated officer	Half-yearly

Audit Focus	Technique	Responsibility	Review Schedule
Continuous Improvement	• Review current Continuous Improvement Plan, Incident Register, Risk Management Plans, and Complaints Register for trends and plan of action. • Action non-actioned items in Continuous Improvement Register	Director or delegated officer	Quarterly
Incident Review	• Incident Register review for risk identification linked to continuous improvement • Action non-actioned items in the Continuous Improvement Register	Director or delegated officer	Quarterly

Audit Focus	Technique	Responsibility	Review Schedule
Operational and Environmental Safety	• Building safety reviews • Internal and external inspections incorporating physical & digital access audits • Check all aspects of the building for safety, privacy and security • Review of waste management • Actions completed rectifying non-conformances	Director or delegated officer	Annually
Work Health Safety Requirements	• Safety compliance audits against documented work procedures, e.g. fire safety, electrical equipment, participant safety • Actions are undertaken to rectify non-conformances by a delegated officer	Registered professional	Annually

Audit Focus	Technique	Responsibility	Review Schedule
Provision of Support	Participant surveys review • service satisfaction • staff satisfaction • rights upheld • Improvement ideas Action review outcomes	Director or delegated officer	Annually
Human Resource Management	• Staff performance reviews • Staff working requirements – screening • Staff satisfaction surveys and analysis for improvements • analyse input for trends • Action trends to improve outcomes for staff • Risk-Assessed Role register review	Director or delegate	Annually
Subcontractors or suppliers	• Review supplier contract details, performance, costs and service quality • Adjust suppliers and contractors if not meeting requirements	Director or delegated officer	Annually

Audit Focus	Technique	Responsibility	Review Schedule
Personnel File Audit	• KPIs reviewed to ensure meets current job role • Adjust job descriptions • Training records current • Review of relevant registrations and currency	Director or delegate	Annually
Information Management	• Random file selection for accuracy and compliance • Check privacy and confidentiality requirements • Ensure passwords systems are current • Advice management if any issues	Director or delegate	Annually

2.2 Risk Management

Risk Management Policy and Procedure

1.0 Purpose

Strength In Care is actively working to identify, address and monitor potential risks to promote a safe environment for participants, staff and visitors and to maintain adequate and viable business operations to:

- support effective decision-making that is guided by our mission and vision
- ensure a consistent and effective approach to risk management
- formalise our commitment to the principles of risk management and incorporate these into all areas of the business
- foster and encourage a risk-aware culture, where risk management is understood to be a positive attribute of decision-making rather than a corrective measure
- manage health orders and implement relevant organisational strategies
- align the planning, quality and risk management systems and integration into all areas of our operations
- implement robust corporate governance practices to manage risk while allowing innovation and development.

2.0 Scope

Risk management is built into all areas of our operations, including service delivery and corporate governance. Risk management is the responsibility of all staff members and all areas of the organisation. It is the responsibility of the Director to carry out risk management analyses for the organisation and to take appropriate measures.

3.0 Policy

Strength In Care recognises the importance of managing risk and ensuring that all stakeholders are aware of their role in identifying, analysing, evaluating, treating, monitoring and communicating risk in a systematic risk management approach.

Strength In Care understands the organisation may be at risk when:

- a well-functioning governance structure is not in place
- management plans, policies and processes are inadequate
- staff member roles and responsibilities are unclear
- participants are not required to sign consent forms or waivers
- staff practices do not meet participant and health standards
- participant input into governance and practices is not actioned
- equipment and facilities are not safe for the intended use
- child safe standards are not met to meet compliance requirements
- implementation of a comprehensive risk management plan has not occurred.
- finances are managed inappropriately, resulting in inadequate financial sustainability and cash flow
- insurance is inadequate or inappropriate
- operations are not evaluated regularly.

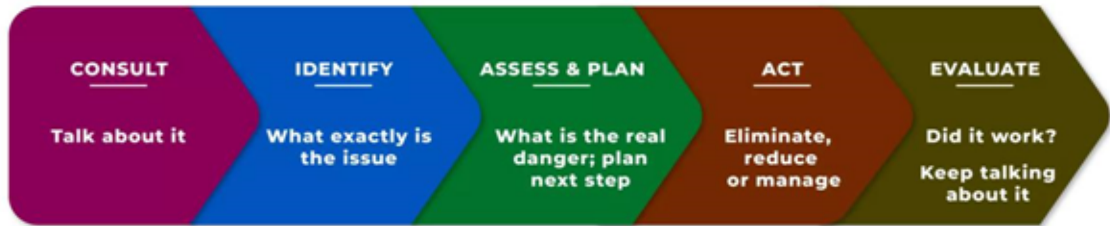
4.0 Definition

Term	Definition
Risk	The possibility of something occurring that will impact the service's objectives. Often risks involve constraints, failures, obstacles and losses that may arise in the future. Risk is measured in terms of consequences and if the risk will have a positive or negative impact.

5.0 Procedure

5.1 Identification

Figure 1. Risk identification process



Our organisation implements processes to manage risk, such as:

- analysing hazard data
- conducting risk assessments, including participant, environmental and equipment assessments
- review of health orders and current practice requirements
- reviewing incident/accident information
- seeking staff, participant, family and visitor feedback/complaints
- maintenance of log items
- ongoing review of all policies and procedures
- seeking input from staff during staff meetings
- seeking input from participants
- incorporating appropriate strategies identified during planning days, e.g. strategic and operational planning sessions
- incorporating new information obtained via education and training into the business
- conducting risk reviews against standards – NDIS, Child Safe
- conducting financial audits
- conducting internal and external audits.

5.2 Planning

Strength In Care has established and maintained a Risk Management Plan. The plan identifies and addresses:

- **Risks to Strength In Care** - Including loss of funding, inability to deliver funded outcomes within budget, embezzlement of funds, lack of suitably qualified staff, extended staff illness, damage to reputation and relationships, changes in compliance requirements and eligibility, decisions by the Director and loss of data due to natural disasters.
- **Risks to staff** - Including lack of suitably qualified staff, extended staff illness, staff member injury due to WHS risks, changes in training and education compliance requirements, and impacts of natural disasters and infection.
- **Risks to participants** - Including environmental, natural disasters, falls, transport, burns, choking, complex health needs, staff working in a participant's home, changes in the consistency of performance of activities, interruptions to service delivery and exit plans (transitioning services to another service provider).

The Risk Management Plan includes:

- details of the risk
- the date the risk was identified
- risk rating and the possible consequence/s of the risk
- actions required to eliminate, mitigate or control the risk
- review dates, new controls and changes to existing controls.

The Director reviews the Risk Management Plan every two (2) months, or more frequently as required, in response to information received via work health and safety reviews, audits and continuous improvement systems.

Figure 2: Risk management process

5.3 Managing risks

5.3.1 Controls

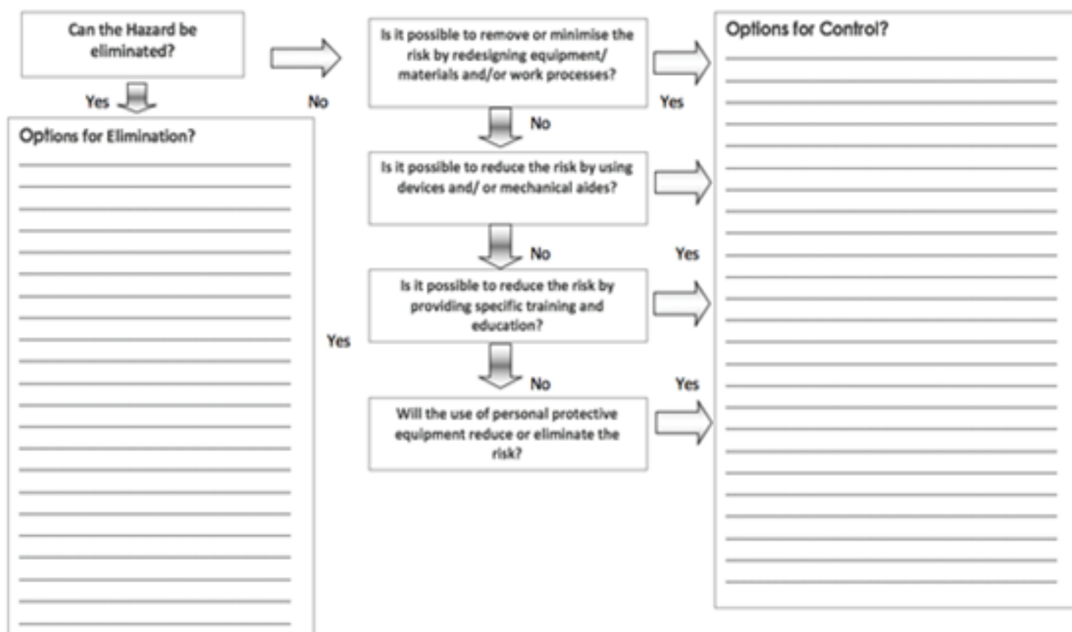
Controls are strategies used to manage risk. Identified risks are balanced against the cost and inconvenience of the control to the organisation before implementation. Controls used by Strength In Care to manage risks include:

- implementation of a Strategic Plan
- implementation of a Risk Management Plan
- implementation of Emergency and Disaster Management plans for participants
- implementation and review of participant risk assessment within support plans
- thorough staff orientation, education and training
- implementation of new processes identified during a risk assessment
- effective internal and external information systems, including meetings and memos
- strict adherence to policies, procedures and work instructions by all staff
- the utilisation of position descriptions
- staff supervision and reviews
- establishing participant support plans that identify risks and record strategies
- participant reviews of support and environment
- ongoing capital maintenance and setting appropriate equipment budgets and plans
- maintaining all current registrations and insurances.

Risk matrix

	CONSEQUENCE				
LIKELIHOOD	**Insignificant (1)** Participant – potential injury Staff – lost time or illness of < 5 days Visitors – no treatment or refused treatment Services – minimal disruption Financial – loss of <5K Environmental – fire alarm from faulty equipment	**Minor (2)** Participant – first aid attention by RN Staff – lost time or illness of 5-10 days Visitors – first aid attention by RN Services – disruption to some users Financial – loss of < $10K &> 5K Environmental - small fire from faulty equipment	**Moderate(3)** Participant – medical attention by GP required Staff – lost time for > 11 days or restricted duties Visitors – medical intervention by GP Services – disruption to all users Financial – loss of > $10K but < $50K Environmental – fire contained in a room	**Major (4)** Participant – permanent loss of function or disfigurement; absconding resident; sexual assault Staff – permanent loss of function or disfigurement; sexual assault Visitor – as for staff Service – major loss of service Financial – financial loss of > $50K &< $100K Environmental – fire that grows larger than one room	**Extreme (5)** Participant – death or hospitalisation Staff – death or hospitalisation Visitors – death or hospitalisation Services – complete loss of service Financial – financial loss > $100K Environmental – fire requiring evacuation (5)
Rare (1) – Unlikely to reoccur – may occur in exceptional circumstances	Low (1)	Low (1)	Low (1)	Low (1)	Low (1)
Unlikely (2) – possibly could reoccur at some time in 2 – 5 years	Low (1)	Low (1)	Low (1)	Medium (2)	Medium (2)
Possible (3) – possibly will reoccur, might occur at some time (may happen every 1 – 2 years)	Low (1)	Low (1)	Medium (2)	Medium (2)	Medium (2)
Likely (4) – will probably occur in most circumstances (several times a year)	Low (1)	Medium (2)	Medium (2)	High (3)	High (3)
Highly Likely (5) – is expected to occur again either immediately or within a short period of time (Likely to occur most weeks or months)	Low (1)	Medium (2)	Medium (2)	High (3)	Extreme (4)

***Risk Control Process is** used to remove or minimise associated risks.*



5.3.2 Improvement committee

Members of the improvement committee are representatives of our workforce. The committee functions to identify risks by reviewing information (see '5.0 Procedure' and '5.1 Identification'). The committee meets every quarter.

Separate from the committee review, all risks will be reviewed independently by Strength In Care's Director.

Where risks are ongoing, they will be included in the Risk Management Plan and Continuous Improvement Plan. It is the Director's role to ensure all actions required to manage identified risks are undertaken within the nominated time frames.

5.3.3 Hazard identification

Where a hazard or potential hazard is identified,

1. staff must complete in detail a Hazard Report Form
2. provide the Hazard Report Form on the same working day to the Director
3. Director reviews, analyses, identify the level of risk and creates a plan of action to deal with the hazard.

When consequences of hazards are assessed as high or extreme:

1. a staff member must contact Strength In Care
2. inform the Director immediately, or as soon as it is safe to do so
3. the Director takes steps to address extreme or high hazards **immediately**.

The documentation of the hazard includes:

1. the staff member must complete Step 1 Report the Hazard and Step 2 Assess the Risk Note: the staff member does not have to complete Step 2 if they do not feel that they can.
2. Director review and analyse Hazard Report Form

3. Complete the Control the Hazard section in detail
4. Add information into the Continuous Improvement Plan, as required

All Hazard Report Forms are provided to the Strength In Care Improvement Committee for review.

5.3.4 Monitoring

Risk management processes and systems are audited regularly as part of the audit program. Management must review registers and plans – risk, incident, complaints and feedback, and continuous improvement. Data gained from monitoring registers and plans will lead to knowledge of risks in the organisation, and a formulation of organisation plans to reduce or eliminate risks for all parties – staff, participants and the organisation.

5.3.5 Reporting

Strength In Care will use the data gained from the risk management process to inform decisions and plans to improve practices continuously. The analysis will assist changes in services, policies and procedures. The analysis will include, but is not limited to:

- complaints and feedback
- financial risk
- staffing issues
- participant satisfaction
- risks to participants and staff
- amendments to legal or compliance requirements
- training and education.

Strength In Care will review our risks management systems through:

- seeking feedback from participants, families, networks and staff
- risk assessment of participants at intake and at least annually.
- annual practice and strategy review of each participant

- management meetings where the following topics are discussed, analysed and acted upon:
    - incident management register
    - complaint register – review feedback, resolutions and outcomes
    - operational and governance management
    - human resource management
    - information systems – participant, staff, networks, technology and distribution of information
    - work health and safety – safe practices
    - emergency and disaster management – using input from participant's plans, situational changes (including prevention and control of infections and outbreaks)
    - financial management such as cash flow, compliance, contracts, insurances
    - safe environments – children and young people, adults

5.4 Consequence Rating Table

Insignificant	Minor	Moderate	Major	Extreme
The participant				

Less than first aid injury or a brief emotional disturbance	First aid injury or emotional disturbance impacting more than two days but does not require treatment.	Substantial injury resulting in medical treatment. Temporary impairment or development/ exacerbation of mental illness requiring treatment Some cases of abuse/ neglect of the person	Significant injury causing permanent impairment. Severe, long-lasting or significant exacerbation of mental illness requiring long-term treatment. Significant faults were allowing significant abuse/neglect of people receiving support.	Avoidable death of a person. Systemic faults allowing widespread abuse or neglect of a participant.

Support Worker and others				
Nil or minor first aid injury or a brief emotional disturbance	First aid injury or psychological injury impacting more than two days but does not require treatment.	Substantial injury resulting in medical treatment. Temporary impairment or development or exacerbation of psychological injury requiring treatment.	Significant injury causing permanent impairment. Severe, long-lasting, or significant exacerbation of mental illness requiring long-term treatment.	Preventable fatality

6.0 Related documents

- Emergency Plan
- Emergency Plan – Waste
- Complaints and Feedback Policy and Procedure
- Complaint and Feedback Form
- Anonymous Complaint and Feedback Form
- Continuous Improvement Policy and Procedure
- Hazard Report Form
- Risk Assessment Form
- Risk Indemnity Form
- Risk Management Plan
- Risk Register
- Continuous Improvement Plan
- Continuous Improvement Register
- Documentation, including meeting minutes, agendas and memos
- Personal Emergency Preparation Plan
- Position Descriptions
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Capital maintenance and equipment budgets and plans
- Maintenance of current registrations and insurances

7.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)

2.3 Quality Management

Quality Management Policy and Procedure

1.0 Purpose

The quality management system has been established to provide focus and direction within Strength In Care to have a positive impact on operational effectiveness, resulting in a high-quality service. The policy is developed to ensure:

- alignment of people and resources with our mission and vision
- alignment of planning, quality and risk management systems and the integration of these systems into all areas of operations
- fostering collaboration and exchange of 'best practice' information with all stakeholders to allow us to conduct critical self-evaluation
- providing a whole-of-service approach, reflecting our governance and organisational structure, which outlines responsibilities and accountabilities
- continuous improvement.

2.0 Scope

The Quality Management Policy and Procedure supports the development of a culture in which all staff assume responsibility for quality work performances while engaging with high performing management at all levels and within areas of the organisation.

It is the responsibility of the Director to oversee the quality management system and to implement appropriate strategies. It is the responsibility of staff members engaged in service delivery to follow our quality management policies.

3.0 Policy

Strength In Care recognises the importance of implementing and maintaining a quality system (outlined below is an overview of our system). The quality management system is designed to support our service delivery and ensure that all services meet the requirements of the NDIS Quality Standards and Practice Indicators 2020. Strength In Care's quality management system includes:

- using data gained from complaints/feedback to improve services and procedures (see Complaints and Feedback Policy and Procedure)
- managing the continuous improvement system to determine areas of improvement, including input from:
    - Complaints and Feedback Policy and Procedure
    - Risk Management Policy and Procedure
    - Reportable Incident, Accident and Emergency Policy and Procedure
    - Continuous Improvement Policy and Procedure.
- incorporating all relevant improvements identified in the Continuous Improvement Register into management and corporate governance processes
- highlighting risks through the Risk Management Policy and Procedure to reduce hazards and improve practices
- managing human resources; including training staff on how to deliver quality support to meet the individual needs of participants
- providing participants access to quality services and allowing them to have input via complaints and feedback
- devising and implementing an internal audit schedule to ensure our organisation continues to:
    - review legislation that directly affects service provision
    - audit and review policies and procedures to meet NDIS Standards, Rules and Guidelines using the Internal Audit NDIS Policy Review Form.
- delivering services that meet best-practice standards; including evidence-based, person-centred support plans designed for individual participants
- reviewing policies and procedures, in conjunction with our feedback strategies, allows for quality management of all services.

4.0 Quality plan

4.1 Monitoring the quality plan

- Strength In Care will hold regular managerial meetings with relevant stakeholders (may include, but are not limited to, managerial staff, participant representative, staff representative, accountant or bookkeeper, and community members).
- Monitoring strategies include a review of the following data:
  - Participant's risks.
  - Environmental risks.
  - Working with participants' risks (work health safety).
  - Feedback from participants, staff and community.
  - Complaints from participants, staff and community.
  - Incidents (both non-reportable and reportable).
  - Accident information.
  - Compliance changes (including legal).
  - Human resources (requirements, vacancies, potential adjustments).
  - Financial (NDIS income, outgoings).
  - Technology issues.
  - Continuous Improvement Register (new and ongoing).
  - Building maintenance and safety issues.
- Managerial meetings will use an agenda that will include the following items:
  - Financial report
  - Director's report
  - Ratification of executive decisions
  - Funding and compliance
  - Organisational risk management
  - Continuous Improvement
  - Complaints, compliments, concerns
  - Human Resources (issues, people, planning)
  - Work health and safety

- Risk management
- Information management
- Incidents (if applicable)
- General business

4.2 Review

1. Management meetings and input from various sources are used to determine any adjustment to the following:
    - strategic or business plans
    - policies and procedures
    - current practices.
2. Review the Continuous Improvement Register to:
    - sign off actions
    - reallocates responsibilities if required.

4.3 Update

After monitoring and reviewing current information, the Director or their delegate will:

- ensure that staff are trained in new practices
- record training in staff files
- adjust policies and procedures and implement versioning control
- inform participants of changes.

5.0 Related documents

- Complaints and Feedback Policy and Procedure
- Complaint and Feedback Form
- Anonymous Complaint and Feedback Form
- Continuous Improvement Policy and Procedure
- Corporate Governance Policy and Procedure

- Continuous Improvement Plan
- Continuous Improvement Register
- Documentation including meetings, agendas and memos
- Hazard Report Form
- Internal Audit Schedule
- Internal Audit NDIS Policy Review Form
- Board Meeting Agenda
- Board Meeting Minutes
- Position Descriptions
- Reportable Incident, Accident and Emergency Policy and Procedure
- Risk Assessment Form
- Risk Indemnity Form
- Risk Management Policy and Procedure
- Risk Management Plan
- Risk Register
- Service Agreement
- Staff Training Record
- Staff Training Plan
- Business and Strategy Plan

6.0 References

- NDIS (Quality and Safeguards) Commission 2018
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Act 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)

2.4 Information Management

Information Management Policy and Procedure

1.0 Purpose

Strength In Care actively works towards implementing and operating effective communication processes and information management systems. We strive to maintain all information systems and practices following legislative, regulatory compliance and organisational standards.

2.0 Scope

It is the policy of Strength In Care that all participants, staff, volunteers and contractors will have records established upon entry to the service and maintained while actively engaging with Strength In Care.

3.0 Policy

- Strength In Care will maintain effective information management systems that keep appropriate controls of privacy and confidentiality for stakeholders.
- Strength In Care will abide by the Australian Privacy Principles (APP), including
    - Consideration of personal information privacy
        - APP 1 – Open and transparent management of personal information
        - APP 2 – Anonymity and pseudonymity
    - Collection of personal information
        - APP 3 – Collection of solicited personal information
        - APP 4 – Dealing with unsolicited personal information
        - APP 5 – Notification of the collection of personal information

- Dealing with personal information
  - APP 6 – Use or disclosure of personal information
  - APP 7 – Direct marketing
  - APP 8 – Cross-border disclosure of personal information
  - APP 9 – Adoption, use or disclosure of government related identifiers
- The integrity of personal information
  - APP 10 – Quality of personal information
  - APP 11 – Security of personal information
- Access to and correction of personal information
  - APP 12 – Access to personal information
  - APP 13 – Correction of personal information

- Strength In Care's policies and procedures are stored as read-only documents in the Policies and Procedures folder on the shared drive.
- Strength In Care is responsible for maintaining the currency of this information with assistance from the Director and other staff members, as required.
- The involvement of all staff members is encouraged to ensure Strength In Care's policies and procedures reflect best practices and to foster ownership and familiarity with the material.
- A copy of each form our organisation uses is maintained in the shared drive in the sub-folder titled Forms.
- All staff can access the policies and procedures at Strength In Care's office in a paper-based or electronic format.
- At a minimum, policies and procedures are reviewed every three (3) years.
- All superseded policies and procedures are deleted from Strength In Care's Policy and Procedure folder and electronically archived by the Director or a delegate.

4.0 Procedure

4.1 Strength In Care information management system

4.1.1 Participant documentation procedure

- Participants are informed of the following:
    - reasons for collecting personal information
    - use and disclosure of personal information
    - security of their information
    - the management of their information
    - government requirements, e.g. opt-out
    - access to their information
    - how to change any details
- Confidentiality of participant records is maintained.
- All Strength In Care staff and volunteers responsible for providing, directing or coordinating participant support must document their activities.
- Participant files will provide accurate information regarding their services and support and will contain, but are not limited to:
    - participant personal details
    - referral information
    - assessments
    - support plans and goals
    - personal emergency preparation plan
    - participant reviews
    - details regarding service responses.
- Original participant documentation is stored in the participant's central file.
- Information relating to a participant's ongoing situation, including changes to their situation (e.g. increased confusion, deteriorating health, increased risk), must be documented in their notes.
- All staff are appropriately trained in documentation and record-keeping
- Staff must clearly understand the participant’s requirements, goals, and strategies, including information within the support and emergency plans.
- Individuals are not permitted to document on behalf of another person.

- Participant records will be audited regularly to ensure thorough, appropriate, and high quality.
- Participant records will be stored in a safe and secure location with access available to authorised persons only.
- Service agreements must be maintained as per the participant's NDIS plan and provided according to the participant's communication needs.
- Agreements with brokerage agencies will include a requirement for brokerage workers to document their activities regularly.
- Staff must enter notes and observations into the participant's file in a factual, accurate, complete and timely manner.
- Staff members must only use information collected from a participant for the purpose it has been collected.
- Participants should be advised that data that has been collected but which does not identify any participant may be used by the organisation for service promotion, planning or evaluation.
- Participants, families and advocates have a right to access their personal information collected, and staff will support such persons to access their personal information as requested.

4.1.2 Entering Strength In Care's service

Upon a participant entering our service, all initial information will be collected using Strength In Care's Participant Intake Form. Only personal information necessary to assess and manage the participant's support needs will be collected.

The Strength In Care's Assessment Report will be used to document the participant's assessment information. An Individual Risk Profile will be undertaken to develop the Support Plan and the Personal Emergency Preparation Plan.

Strength In Care's Director will work with the participant, their advocate/s and any other family or service providers/individuals to develop and document a participant support plan; this will be documented using Strength In Care's Support Plan.

A participant file will be created to act as the central repository of all participants' service information and interactions. A unique identifier may be assigned to each participant for documentation and record-keeping purposes.

The participant's file will only contain material relevant to the management of services or support needs, including, but not limited to:

- copy of the signed agreement
- assessments
- risk assessment – individual and environment
- health reports
- the Support Plan
- the Participant Intake Form
- communication notes
- the Participant Information Consent Form
- the Personal Emergency Preparation Plan
- complaint information.

4.1.3 Ongoing documentation procedures

Strength In Care’s ongoing documentation procedures include:

- maintaining participant information in the electronic participant management system, following system practices
- documenting participant information and service activities only on Strength In Care's approved forms or tools
- updating of documents at review and during any emergency or disaster

- ensuring other service agencies and health professionals involved with the care or support of Strength In Care's participant provide adequate documentation of their activities and the participant's wellbeing or condition.

The type of detailed information documented includes:

- outcomes of all ongoing participants assessments and reassessments
- changes or redevelopment of a participant's support plan, including revised goals or preferences
- critical incidents or significant changes in the participant's health or wellbeing
- emergency or disaster considerations (e.g. health order, natural disaster)
- conversations, in person or via telephone, with a participant, family members, their representative or advocate
- conversations regarding the participant, with any other providers, agencies, health/ medical professionals, family members or other individuals with interest in the participant
- activities associated with the participant's admission and exit, including referrals.

4.1.4 Setting up and maintaining files for participants

Once a personal file for a participant is established, staff must maintain that file to ensure that all information is accurate, up-to-date and complete:

- relevant staff must document significant issues and events that arise during their work with the participants as the events and problems occur
- non-current (information that no longer has any bearing on the services provided to the participant), staff will establish an archival file and progressively cull non-current information into that file for secure storage.
- regular file audits by Director ensure that:
    - files are up-to-date
    - forms are being used appropriately
    - non-current information is being culled and stored in the archival file

  - progress/file notes are factual, accurate, complete and in chronological order
  - risk plan is current
  - a personal emergency preparation plan is relevant, trialled and used to inform management.
- exiting the service – all files - personal and archival will be stored in a secure place such as a locked area or password-protected folder on a computer under the control of Strength In Care.

4.1.5 Participant file formats

- The files of participants will be established and maintained in the following format:
  - a standard manila folder, or another similar folder, or
  - held in a secure electronic format with password access.
- The forms must be based on the current formats approved by Strength In Care.
- Archival files may be:
  - in lever-arch folders or archive boxes and multiples as required
  - electronically in the approved forms/domains and formats
- For ease of access, materials in the archival file should be listed chronologically, with each page numbered in order and groups of similar forms.

4.1.6 Security of files and participant information

- All current hard copy files for participants must be kept in a secure area, such as a lockable filing cabinet at the service, ensuring only authorised personnel can access a participant's personal information.
- Authorised personnel include Strength In Care's staff members who are employed to provide support to the participants. If files cannot be stored at the service, then alternative arrangements will need to be made by the participant and the Director to ensure confidentiality and security.

- All electronic files must be password protected to ensure confidentiality and security.
- If stored at the service, current files of participants can only be taken from the service by relevant staff members from Strength In Care to provide the participant's information or access to another service, such as a doctor.
- Non-current files should not be removed from the service unless:
    - they are being moved to a more secure archival storage unit
    - permission has been sought from the Director to do so.
- Staff must not undertake any of the following actions without the express approval of the Director:
    - photocopying any confidential document, form or record
    - copying any confidential or financial computer data to any other computer, USB or storage system such as Google Docs
    - communicate any confidential data to any unauthorised staff member or any other person/s.

4.1.7 Transporting a participant's hard copy files

When a participant's hard copy files need to be transported from one location to another (e.g. from their usual site to a doctor), they must be carried in a locked document container (e.g. a briefcase or attaché case). Strength In Care will provide the staff with a locked case, as required.

4.1.8 Communication/file notes for participants

- Communication/file notes for participants must include the following components:
    - the date the entry is made
    - the time when the entry is being made
    - the time when the event occurred
    - nature of the event in a factual, accurate, complete and timely manner
    - signature of the person making the entry

    - the surname of the person making the entry (printed in brackets)
    - person's position of employment.
- Staff must ensure that all relevant information about the participant is entered into the person's file notes in a factual, accurate, complete and timely manner.
- The file notes for each participant should be written when a significant event occurs or to record the type of support provided while working with a participant. The definition of a significant event will vary from person to person and should be determined in consultation with the Director and should relate to the support required by the person-centred plan.
- It is required that staff make an entry in the file notes on each workday, even when the person's day has gone according to plan and without unusual or extraordinary events.
- All entries made into file notes should be placed on the next available line. Under no circumstances should blank spaces be left on the file notes sheet.
- On behalf of another staff member (e.g. dictating over the phone), all file note entries made by staff members must be signed by the person dictating the notes on their next shift. It is that person's responsibility to check the entry for accuracy and, if required, note any corrections that need to be made on the next line available.
- The participants should be aware of what has been recorded in their progress/file notes whenever required.

4.1.9 Working from home

Staff who work from home must sign the Privacy and Confidentiality Agreement. The security requirements for working from home include:

- only the staff member can access any documents, both written and electronic
- the computer must have a firewall to protect information
- all information linked to the server must be uploaded at the end of the day.
- start and finish times are to be recorded and sent to the supervisor
- report current work status at least weekly.

4.1.10 Access to participants' files

- Participants/guardians are provided access to their records on request. The Director should approve and control the way participants access their files to ensure the security of other non-related information is maintained.
- Access to a participant's file is the direct responsibility of the Director. When access is requested by anyone other than Strength In Care staff, Director will grant permission when satisfied the policies and procedures have been followed, and access to the file is in the best interest of the participant. Such access will only be granted when the appropriate person has given consent.
- All participants' files are the property of Strength In Care and, although a participant and their guardian can access the file, it cannot be taken by a participant or guardian; or be transferred to any service external to Strength In Care without permission of the Director.
- Copies of legitimately released files for any reason shall be recorded on an appropriate letter, which shall be signed as a receipt by the service recipient or their legal guardian. The proper procedure for releasing information about a participant to persons or services that are external to Strength In Care is outlined in our Consent Policy and Procedure.
- Any students on placement at Strength In Care may only access files with the consent of the participant or their guardian. Students will always be required to provide a written undertaking to maintain confidentiality and only use non-identifying information. This agreement is to specify what information is to be used for and advise that any written compositions containing information are to be provided to the Director for approval before dissemination.

4.2 Staff records

Staff files are kept in a filing cabinet in the Director’s office and are available only to the Director. The filing cabinet is locked when the office is unattended.

- The staff files will be established and maintained in the following format:
  - a standard manila folder, or another similar folder, or
  - held in a secure electronic format with password access.

4.3 Minutes of meetings

Minutes of meetings are maintained on the shared drive in an identifiable folder, e.g. Management Meetings. The minutes must be identified:

- with meeting title, e.g. Management Meeting
- by date, e.g. Management Meeting/12/0X/YY
- saved as Management Meeting (date)

4.4 Other administrative information

Individual staff members are responsible for organising and maintaining the filing of general information following their position descriptions.

Administrative information, including funding information, financial information and general filing, is maintained in the filing cabinets in the Director's office. The cabinets are locked when the office is unattended for a lengthy period, and all electronic files are password secured.

4.5 Electronic information management

4.5.1 Data storage

- All data is stored in the shared drive of the server.
- The Director is the only person who can add new data folders to the shared drive of the server.

4.5.2 Backup

- All computer data (including emails) is backed up every night to a remote server.
- Periodic testing of backed-up data is undertaken to check the system's reliability.

4.5.3 External programs

No programs, external data or utilities are installed onto any workstation without the permission of the Director.

4.5.4 Log-in credentials

Log-in credentials are assigned by the Director or their delegate.

4.5.5 Email

- Staff should not send and receive personal emails unless approved by Director
- All emails are filed in the appropriate folders set up by the Director.
- Pornographic, sex-related or spam email received is to be deleted immediately. Under no circumstances are staff allowed to open or respond to spam emails.

4.5.6 Internet access

- Internet access is restricted to work-related purposes.
- Internet access reports are maintained on the server and are regularly reviewed by the Director.
- Under no circumstances are staff allowed to access pornographic or sex-related sites.

4.5.7 IT Support

- Our organisation maintains an ongoing IT support agreement.
- If staff experience problems with a program, computer, or any other piece of IT equipment, they can, in the first instance, contact the Director.
- If necessary, the Director will arrange for the IT consultant/s to assist.

4.5.8 Social media

- Our organisation is aware that social media, e.g. social networking sites such as Facebook, Twitter or similar, video and photo-sharing sites, blogs, forums, discussion boards and websites, promote communication and information sharing.
- Staff are required to ensure the privacy and confidentiality of the organisation, participants and their information.
- Staff must not access inappropriate information or share any information related to their work through social media sites.
- All staff are required to seek clarification from the Director if in doubt as to the appropriateness of sharing any information related to their work on social media sites.

4.6 Monitoring information management processes and systems

We regularly audit information management processes and systems as part of our audit program. Staff, participants and other stakeholders are encouraged to provide ongoing feedback on issues and areas where improvements are possible.

4.7 Archival and storage

After their active period, all records must be kept in the archive files for an additional time. Regulatory, statutory, and legislative requirements determine the retention period, or as

defined by Strength In Care as a best practice (refer to Attachment 1: Disposal and archiving of documents).

Archived records must be identified and stored to allow easy access and retrieval when required. Archived records, in hard copy, must be stored in an environment that minimises deterioration and damage, i.e. not exposed to direct sunlight, moisture, extremes of temperature, pests, dust and fire hazards.

4.8 Destruction of records

The following procedures apply for the destruction of records:

- Junk mail and instructional post-it notes may be placed in recycling bins or other bins as required.
- All other records or documents requiring destruction are to be:
  - shredded and then placed in recycling bins
  - sent off-site to be securely pulped
  - deleted from the network.

5.0 Related documents

- All electronic and hard copy documentation
- Complaints Register
- Service Agreement
- Privacy Statement - Website
- Participant Intake Form
- Participant Information Consent Form
- Personal Emergency Preparation Plan
- Support Plan
- Consent Policy and Procedure

6.0 References

- Disability Discrimination Action 1992 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021

Attachment 1: Disposal and archiving of documents

Function or Activity	Description	Retention/ disposal action	Custody
Aboriginal and Torres Strait Island participant information	Documents relating to Aboriginal health	Lifetime	Office
	Standard operational documents	7 years after the person's last contact with the service	
Business information	Name Address Telephone number Compliance notices Financial records	7 years	Office
Internal audits	Audit schedule Audit questions Audit reports	2 years	Office

Participant records	Name Address Telephone number Emergency Contact Application Complaints about the non-delivery of services Incident Records Complaint Records BSP Records Service Agreement Personal Emergency Preparation Plan	7 years If the participant is a child, records must be stored until the child turns 25 years of age.	Office
Contracts/leases	Properties	7 years	Office
Corrective action	Corrective action Requests	2 years	Office
Financial	Audits Budgets Receipts Cheques Petty cash documents Other financial records	7 years	Office
Management review	Minutes of meetings Agendas Monthly reports	2 years	Held on PCs according to the type of meeting

Consent Policy and Procedure

1.0 Purpose

Strength In Care must gain consent from the participant before sharing any information with family, advocates, other providers and government bodies.

Children under the age of eighteen (18) will need consent from their family/advocate/guardian to share information with other providers and government bodies. It is the responsibility of all staff to inform participants about their rights regarding the provision of consent.

2.0 Scope

All efforts should be made to obtain consent. When there are language or communication barriers, staff members will ensure that all reasonable efforts have been made to overcome these, using available communication skills and technology, interpreters, relatives/carers and friends.

Relatives may be consulted about the best ways to communicate or may be requested to establish the participant's values and preferences if a participant cannot express these themselves.

Initial consent will be undertaken during the participant's registration with the service. The prime responsibility for obtaining consent lies with the front-line worker who is to carry out the service. Consent can be sought from another individual, but only if they have enough knowledge to correctly provide the right information and answer the participant's questions. Consent is equally valid whether it is expressed verbally, non-verbally (implied), or is written:

- **Implied consent** is adequate for most of the support provided by the organisation.

- **Oral consent** is enough for most doctors and other health professionals (e.g. commencing a manual handling process or use of complex medical procedures).
  Oral consent should be recorded in the support plan with relevant discussion details, the date and time of the entry, and the staff member's name legibly written. Oral refusal of consent for any intervention must also be recorded in the support plan in the same manner.
- **Written consent** should be gained to use an advocate or share information by the participant and the healthcare professional. Note: Participants automatically opt-in and must request to opt-out of NDIS audit requirements.
- **Taking a photograph** requires written consent from any participant whose photo is being taken.

3.0 Policy

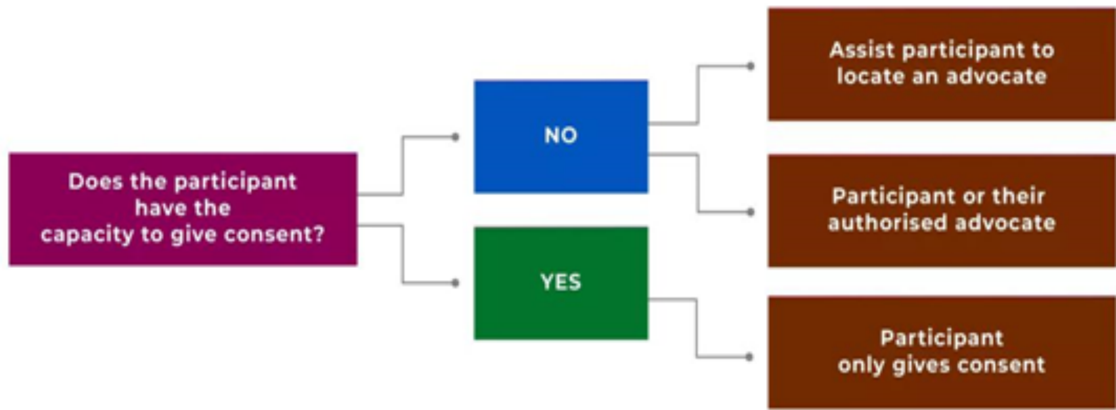
- Strength In Care recognises the importance of maintaining the privacy and confidentiality of all participants; however, there are times when it is essential to share information with other parties, such as government bodies and other service providers.
- Strength In Care will not provide any information to a person or authority without the participant's consent unless the disclosure is a legal requirement.
- Strength In Care will inform all participants, upon entry into the service, about their rights to privacy and confidentiality.
- Strength In Care will notify all participants that they have an opt-out option if their information is requested for audit purposes.

3.1 Guiding principles

- Participants have the right to make decisions about things that affect their lives.
- It is presumed that participants can make their own decisions and provide consent when it is required unless there is evidence otherwise.

- Participants are supported to make informed decisions when their consent is required.
- Consent is obtained from the participant, or a legally appointed guardian, for life decisions such as accommodation, medical treatment, forensic procedures and behaviour support.
- Consent for financial matters is obtained from the participant, a legally appointed financial manager or the person appointed under a Power of Attorney.
- Participants are supported to identify opportunities to make decisions about their own lives and build confidence in their decision-making skills.
- When a participant wants or needs support to make decisions, it is provided in ways preferred by the participant and a supporter of their choice.
- Support with decision-making must respect the person's cultural, religious and other beliefs.
- If a participant wants support from family and friends, this is encouraged and facilitated.
- Support is provided in ways that uphold the participant's right to self-determination, privacy and freedom from harm, abuse and neglect.
- Decision-making and self-determination are not limited by the interests, beliefs or values of those providing the decision-making support.
- The amount or type of support a participant requires to make decisions will depend on the specific decision or the situation.
- Participants are supported to make decisions that affect their own lives, even if others do not agree with them or regard the decisions as risky.
- Participants are supported to access opportunities for meaningful participation and active inclusion in their community when they want this.
- Information is provided in formats that everyone can understand and enables the participant, their supporters and others, such as legally appointed guardians, to communicate effectively.

Diagram 1. Participant consent process



4.0 Procedure

If a participant wishes to provide consent so another person or organisation can access their personal information, then the following procedure is to be undertaken:

1. The participant is informed that written or verbal consent is required before sharing any personal information.
2. The participant is advised that their consent can be withdrawn at any time.
3. Information about the consent is communicated in a relevant method to the participant.
4. The participant completes a Participant Information Consent Form.
5. A signed Participant Information Consent Form is placed at the front of the participant's file.
6. All relevant staff members are informed about consent approval.

Diagram 2: Participant consent process

5.0 Related documents

- Participant Information Consent Form

6.0 References

- Disability Services Act 1986 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021

Social Media Policy and Procedure

1.0 Purpose

The purpose of this policy is to outline the issues and responsibilities of Staff staff, including management, volunteers and contractors, to meet legal requirements with privacy and confidentiality laws relating to the parameters of employment, service operations and confidentiality agreements with participants, work colleagues and our service. Failure to do so may result in disciplinary action.

This policy will assist Strength In Care staff when they use social media in the following capacities:

- Adding content to official Strength In Care social media pages.
- Creating online support groups or providing information sharing as a representative of Strength In Care programs.
- Making references to Strength In Care within a personal capacity on a social media platform.

This policy does not apply to Strength In Care staff in their personal use of social media platforms where the staff member does not refer to Strength In Care and or current services.

2.0 Scope

This policy applies to all Strength In Care staff members and any future contractors.

3.0 Definition

Term	Description

Social Media tools	Social media platforms allow users to share and upload media content such as photographs and videos (with comments) to the internet quickly and easily. Social networks are one of the fastest-growing areas in modern communications technology and effectively encourage a two-way conversation with stakeholders. Some examples are: ● Social Networking sites such as Facebook, Twitter, Skype, Google ● Blogs such as Tumblr, e-news and so on ● Video and photo sharing sites such as Flickr and YouTube ● Micro Blogs such as Twitter ● Weblogs ● Forums, discussion boards and webinars ● Encyclopaedias such as Wikipedia ● Online communities

4.0 Policy

Strength In Care will host online social media platforms, online groups and online communities, such as Facebook, Twitter, Skype, blogs and websites.

Staff members of each program of Strength In Care are encouraged to contribute to the organisation's social media platforms and online communities.

4.1 Principles

The following principles apply to the professional use of social media on behalf of Strength In Care as well as personal use of social media when referencing Strength In Care, staff and participants.

1. Staff must adhere to the Strength In Care Code of Conduct, Staff Handbook, and other organisation's policies when using social media about Strength In Care.
2. Staff must be aware of the effect their actions may have on their reputation, as well as the reputation of Strength In Care. The information that staff post or publish may be public information for a long time.
3. Staff must observe content and information made available by management through social media. Staff should use their best judgement in posting material that is neither inappropriate nor harmful to Strength In Care its staff and or participants.
4. Although not an exclusive list, some specific examples of prohibited social media conduct include posting commentary, content, defamatory images, pornographic, proprietary, harassing, libellous, or that can create a hostile work environment.
5. Staff are not to publish, post or release any information that is considered confidential or not public. If there are questions about what is considered confidential, staff should check with the Director or their immediate supervisor.
6. Social media networks, blogs and other types of online content sometimes generate press and media attention or legal questions. Staff should refer these inquiries to authorised Strength In Care spokespersons/senior management.
7. Staff encountering a situation while using social media that threatens to become antagonistic, then they should disengage from the dialogue politely and seek the advice of management.
8. Staff must seek appropriate permission before referring to or posting images of current or former staff, participants, vendors or suppliers. Additionally, staff should get appropriate permission to use a third party's copyrights, copyrighted material, trademarks, service marks or other intellectual property. Use of participant and staff images requires written consent before publication
9. Social media use must not interfere with staff responsibilities. Strength In Care technology and computer systems are to be used for business purposes only by management and or designated people. When using Strength In Care computer systems, the use of social media for business purposes is permitted.
10. Personal use of social media networks or personal blogging of online content is

prohibited, and disciplinary action is undertaken.

11. Subject to applicable law, after-hours online activity that violates Strength In Care Code of Conduct or any other company policy may subject staff to disciplinary action and or termination.

4.2 Purpose of Social Media

When posting social media content to social networking sites, it is helpful to remember the reasons for doing so. When using Strength In Care pages, the aims should be to:

- promote the values and beliefs of Strength In Care
- reach a wider, more diverse audience, with a focus on the organisation and current/prospective participants in a more diverse setting
- Educate, inform and entertain
- connect with local services that will assist members of the Strength In Care social media community
- create a local network of services that will assist in instantaneous information sharing and provide instantaneous access to support for carers
- promote and implement online support groups
- provide access and support to the Strength In Care website
- learn about Strength In Care and the community needs
- lift statistical data that will assist in navigating Strength In Care through instantaneous feedback on local issues being discussed monthly
- promote events by creating event pages and inviting the participants and volunteers of Strength In Care to attend.

4.3 Staff Responsibilities

When using social media sites, staff should:

- be aware of privacy and anti-discrimination acts and laws
- adhere to the organisation's values and Code of Conduct policy that applies in the work environment

- promote the values and goals of our organisation
- Educate / Inform / Contribute
- respect all stakeholders
- withhold confidential information
- respect the privacy of fellow staff and colleagues
- agree the content and contact information remain the property of Strength In Care
- reflect the mission and goals of Strength In Care
- provide positive feedback, and the Director will be informed of any correspondence or negative feedback
- be transparent, admit to mistakes
- protect yourself - be judicious when writing on social media platforms. Once the material has been made public, it can be quickly disseminated and very difficult to reclaim.
- show respect for your audience
- identify these as your own when making comments or opinions, not those of Strength In Care or its programs. Consider using a disclaimer where appropriate, for example, "The views expressed in this blog are my own and not those of Strength In Care".

4.3 Moderation

After management consultation, all defamatory postings will be removed by the Director or their delegate on behalf of Strength In Care.

Defamatory postings include, but are not limited to, those that are: racist, sexist, prejudicial in any way, threatening, insulting, unlawful and threatening to another's privacy.

4.4 Maintenance

The Relations Manager will assign responsibility for maintaining an online social presence and analysing results, including:

- training and assisting staff and volunteers in the benefits of social media
- training and assisting participants, upon request, to use social media, with special consideration to privacy issues
- assisting in setting up and developing an online presence, enabling other services to connect online
- sharing and distributing by adding "email this to a friend" links or "add to Facebook" links, and other means available
- submitting to social media sites
- tracking blog and social media page mentions
- responding to posts and comments, particularly to negative feedback, in consultation
- recording and management of statistics for events
- uploading new content for information share, photos, podcasts and film regularly.

4.5 Implementation, Monitoring and Review

The Director delegate is responsible for the implementation and monitoring of this policy which will be reviewed annually from the date of its endorsement unless a review is required earlier for auditing purposes.

4.6 Role of the Directoror their delegate

- manage the day to day running of the social media pages, blogs, and support groups' pages, and track/update all event and information posts.
- Ensure all content posted is in line with the core beliefs and values of Strength In Care.
- Seek input from staff and relevant others in the community
- Advertise local events, groups or information after seeking approval from management

- check social media pages daily and throughout the day to manage pages effectively
- monitor feedback posted in comment feeds, lifting data that will assist with navigation of the organisation
- answer any negative feedback upon consultation with the management
- removed immediately, all defamatory material, comments, and links posted that are deemed inappropriate
- create support group pages that complement current programming and promote self-management within the groups to assist with the enabling and wellness approach
- answer queries sent by users after liaising with the Director.

4.7 Service Specific Social Media Site

The use of service-specific social media sites, e.g. Facebook page:

- The page will not be branded using the Strength In Care logo to avoid confusion with the official Strength In Care Facebook page but will use reference to "Strength In Care" as part of the name of the page.
- Any comments that could not be said at a conference or media should not be posted online. If you are unsure about posting something or responding to a comment, ask the Director for guidance

4.8 Guiding Principles of Posting on Social Media Sites

Only those who are authorised may speak on behalf of Strength In Care. Authorised speakers must adhere to the following principles and those already listed above.

- **Acknowledge who you are:** If you are representing Strength In Care when posting on a social media platform, you must acknowledge this.
- **Have a plan:** You should consider your message, audience and goals, as well as a strategy for keeping information on social media sites up-to-date in line with all of Strength In Care's strategies for online communication and public awareness.

- **Protect Strength In Care's reputation:** Posts on social media sites should remain professional in tone and good taste.
- **Accuracy:** Ensure that any content you publish is factually accurate and complies with relevant company policies, particularly confidentiality and disclosure—review content for grammatical and spelling errors.
- **Area of responsibility/influence:** Only offer advice, support or comment on topics that fall within your area of expertise and responsibility at Strength In Care.
- **Respect:** Be respectful of all individuals and communities you interact with online. Be polite and respectful of others' opinions.
- **Consider the future:** What sounds great to the audience today could reach an unintended audience tomorrow with unexpected consequences.
- **I didn't mean it that way:** Remember that others, including the media, may use your material for their purposes and completely different from what you intended.
- **Using other people's materials:** When using social media, assume that all music, videos, photographs, articles, logos, brand names and other content you did not create are protected by copyright laws. If you would like to use any of these materials, you need to obtain the necessary permissions or licenses from the copyright owner. Instead, consider creating a link to the website where the content is hosted.

4.9 Social Media Daily Checklist

1. Check social media by 9 am. Make changes to any feeds approved from the previous day, look at feedback and comments from social media site users
2. Remove derogatory material and make a note of all informal and informal feedback and or complaints
3. Forward complaints to the Director, Upload any information approved from the previous day
4. Upon receiving feedback from the management, the Director delegated officer will manage informal feedback and or complaints directly

5. Check social media at lunchtime and make changes or upload approved items as necessary
6. Collaborate and consult with the Director or their delegate for the following day's social media updates.
7. Compile updates for the following day and seek approval from the Director or their delegate
8. Final afternoon check of social media sites, collation of day's feedback and distribution to relevant stakeholders

4.9 Social Media Training

The Director's delegate will:

- develop training packages to present to participants wishing to learn how to access and use social media and its sites.
- assist staff in linking into the Strength In Care support page
- link staff into social media support groups
- develop appropriate support groups to assist with the individual staff member's needs
- develop social media strategies to assist with the enablement of the staff to develop a support network using social media.

5.0 Related Documents

- Human Resource Management Policy and Procedure
- Information Management Policy and Procedure

6.0 References

- Communications Council Best Practice Guide: http://www.webindustry.asn.au/documents/Social_Media_Code_of_Conduct.pdf
- Australian Government Office of the Privacy Commissioner:

- Voices of the Staff Guidelines for the Use of Social Media:
  http://voices.umich.edu/docs/Social-Media-Guidelines.pdf

2.5 Complaints and Feedback Management

Complaints and Feedback Policy and Procedure

1.0 Purpose

This policy is intended to ensure that complaints are handled fairly, efficiently and effectively. The resolution of complaints will be consistent with a rights-based principle fundamental to the United Nations Convention on the Rights of Persons with Disabilities.

The complaint and feedback management and resolution system intend to:

- provide a well-handled system that values the participant's opinions and takes all feedback seriously, with the intent to improve the relationship between our organisation and our participants
- empower all employees and participants to feel free to voice their complaints or provide feedback
- allow us to respond to issues raised by individuals making complaints in a timely and cost-effective way
- boost participant confidence in our administrative processes
- seek a resolution that meets all parties' expectations, where possible
- provide Strength In Care with information that will help us deliver quality improvements in our services, supports, roles, and complaints handling process.

2.0 Scope

Our Complaints and Feedback Policy is Strength In Care's commitment to a positive complaints culture within our organisation, from the highest management levels to our frontline staff. The policy provides the foundation for all other quality complaints

management and resolution framework components. The policy also guides our staff and participants (who may wish to make a complaint or provide feedback).

A designated Complaints Manager will handle all complaints and feedback received by Strength In Care. All staff are bound by the National Disability Insurance Scheme (NDIS) Code of Conduct.

3.0 Policy

Strength In Care will create an environment where complaints and concerns, compliments and suggestions are welcomed and viewed as an opportunity for acknowledgement and improvement. This process ensures that individuals have the right to make complaints and are encouraged to exercise their right in a blame-free and resolution-focused culture, respecting an individual's right to privacy and confidentiality.

Strength In Care will appoint a staff member to be the designated Complaints Manager. The Complaints Manager is responsible for coordinating and handling complaints and feedback and ensuring the complaint or feedback is properly managed.

It is acknowledged that Strength In Care views all comments and complaints as a vital contribution to our internal review of performance and processes, which assists in developing the continuous improvement of our services as we work towards achieving our care commitment.

A person does not necessarily have to expressly state that they wish to make a complaint to have the issue or concern dealt with as a complaint. Regardless of whether an issue is big or small, it will be treated seriously, and Strength In Care will ensure the person is advised on how valuable their opinion is to our organisation. We will use such information to improve our service delivery continuously.

Participants, families, advocates or other stakeholders may submit a Complaint and Feedback Form regarding Strength In Care's supports, services, staff, or contractors. The participants can be provided information in Easy Read format if required.

The Complaints Manager will ensure that the complainant can physically access all meetings to resolve the complaint by reviewing the environment to ensure that the meeting site is accessible for those with mobility issues.

It is our policy to follow the principles of procedural fairness and natural justice and comply with the requirements under the National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018 and NDIS (Procedural Fairness) Guidelines 2018, including:

- informing a person if their rights or interests may be adversely or detrimentally affected in a direct and specific way
- giving notice of each prejudicial matter that may be considered against them
- giving a reasonable opportunity to be heard on those matters before adverse action is taken
- putting forward information and submissions in support of an outcome that is favourable to their interests
- ensuring that the decision to take adverse action should be soundly based on the facts and issues that were raised during that process, and this should be apparent in the record of the decision
- ensuring that the decisionmaker should be unbiased and maintain an unbiased appearance.

Strength In Care ensures complaints and feedback are managed effectively through:

- implementing an open and transparent complaint handling system
- observing the principles of natural justice and compliance with relevant mandatory reporting under Australian law
- committing to the right of stakeholders to complain either directly or through a representative

- undertaking procedural fairness to reach a fair and correct decision
- taking reasonable steps to inform the complainant of the NDIS commission complaints process, including the use of various communication means, e.g. oral and written
- maintaining complete confidentiality and privacy
- abiding by the NDIS Code of Conduct
- training staff in our complaint process and the rights of all stakeholders to complain
- considering all complaints seriously and respectfully
- advising participants and staff members of their right to complain
- staff will be trained in complaint handling during assessments and orientation
- guidance regarding the complaint process is outlined in the welcome information provided to our participants
- provision of support for people who may need assistance to make a complaint
- protection of complainants against retribution or discrimination
- prompt investigation and resolution of complaints
- communicating and consulting with participants, family and advocates during the complaints process and providing feedback and resolutions
- interpretation and application of policies and processes
- providing opportunities for all parties to participate in the complaint resolution process
- ensuring that complainant is involved in the resolution of the complaint
- keeping complainant informed of the progress of the complaint:
    - actions taken
    - the reasons the decisions are made
    - options to have decisions reviewed
- ensuring that the decisionmaker or advocate is included and recognised in the process
- accepting Strength In Care and staff accountability for actions and decisions taken due to a complaint

- committing to resolving problems at the point of service or through referral to alternatives
- committing to use complaints as a means of improving planning, delivery and review of services through our continuous improvement processes
- referring complaints and feedback into our continuous improvement cycle
- annually auditing the Complaints and Feedback Policy and Procedure.

4.0 Definitions

Term	Definition
Complaint	Expressing dissatisfaction with an NDIS support or service, including previous complaint handling, for which a response or resolution is explicitly or implicitly expected.
Resolution	The official decision to solve or end a problem or contentious matter. A resolution includes finding a way to improve a difficult situation.

Role	Role requirements

Complaints Manager	The role of the Complaints Manager is to: • manage the complaint process • manage reviews and make recommendations for continuous improvement using the information gained from the issue of the complaint • stand independently from the management to allow participants and staff members to be able to make a complaint about the management of the organisation • provide feedback and advice, as required • review the complainant's needs to ensure that their mode of communication is managed (e.g. Easy Read, large print, translated documents, etc.) • collaborate with the complainant and their advocate • keep all parties informed during all stages of the complaint management process • seek a resolution that benefits all parties, if feasible • handle all appeals related to the outcome of the complaint • complete all necessary reports and documents, including providing information to complainants and management • record all information into the Complaint, Compliment and Feedback Register • review the Complaint, Compliment and Feedback Register at monthly management meetings.

5.0 Procedure

5.1 Complaint process

Complaints and suggestions can be made by:

- using the Complaints and Feedback Form or the Anonymous Complaints and Feedback Form
- contacting a member of staff, verbally or in writing, our staff must offer to document the complaint on behalf of the participant if required and refer the matter to the Director
- contacting the Complaints Manager, verbally or in writing
- responding to questionnaires and surveys
- sending an email to our contact email
- attending meetings/care conferences
- contacting external complaint agencies, e.g. NDIS Quality and Safeguards Commission
- communicating orally, in writing, or any other relevant means.

Contacts for making a complaint are listed below:

Complaints Manager	Olivier Vles
Email address	ollie@strengthincare.com.au
Phone Number	03 7064 4003
Postal Address	3J/19 Bruce Street, Mornington VIC 3931

Complaints may be made by:

- staff
- participants
- public
- advocates

- family members
- carers
- anonymous person/s.

Results are recorded in the Complaint, Compliment and Feedback Register, allowing input into our continuous improvement processes. The Continuous Improvement Register will record improvements established after finalising the complaint management process.

If a complaint is about:

- **Support or services**: The Complaints Manager will deal with the complaint.
- **Staff member/s**: The Complaints Manager will deal with the complaint
- **CEO/Manager:** An external person or body may be approached, e.g. NDIS Quality and Safeguards Commission.

All staff, participants, family and advocates, visiting health professionals, and visitors are informed of our complaints process via:

- participant welcome information
- initial access to supports
- staff orientation, induction and training
- Meetings, reviews and assessments
- participant agreements
- contractor agreements.

5.2 Complaint management process

The investigation process must adhere to impartiality, privacy, confidentiality, transparency and timeliness. Complaints will not be discussed with anyone who does not have responsibility for resolving the issue. Strength In Care must take into consideration any cultural and linguistic needs of a participant and provide the relevant support mechanism, such as an interpreter or similar.

Complainants are provided with access to our Complaints and Feedback form. These may be accessed via staff or management. The Complaints Manager will review the individual's needs and assist them via the best means appropriate to suit them. The variance between individuals requires a personal approach but may include:

- offering an advocate
- providing text telephone (TTY) service to people with a hearing impairment
- ensuring the meeting site is wheelchair accessible
- offering independent assistance to read and write to formulate and lodge a complaint
- seek information from the complainant to determine any special requirements (e.g. access or communication).

The resolution outcomes from a complaint will recognise that people who make a complaint are generally seeking one, or more, of the following outcomes:

- Acknowledgement:
    - genuinely listening without interruption
    - empathising
    - ensuring the complainant feels comfortable (e.g. being aware that staff may be defensive and consider how this is perceived)
    - acknowledgement of the effect of the situation on the individual
    - resolving to a good outcome
    - notifying regularly and promptly on steps undertaken.
- Answers:
    - clear explanations relevant to the issue are provided ONLY once all the facts are known.
- Actions (Action Plan):
    - what will be done?
    - who will do it?
    - action plan completion date
    - how progress will be communicated to all parties involved
    - oversight of actions.

- Apology:
  - consider the form of the apology and the managerial level of response
  - consider timeliness, sincerity
  - be specific and direct
  - accept responsibility if appropriate and provide information on the cause and impacts
  - explain without excuses
  - provide a summary of key actions agreed on to move forward and resolve the issue.

5.2.1 Non-investigation complaint process

All complaints, where possible, will be managed directly and quickly at the point of service unless the complaint requires investigation (see the procedure outlined below). The non-investigation complaint process is as follows:

1. Issue reviewed by the Complaints Manager.
2. The complainant will be consulted and discussed to determine the actions required to resolve the issue. During this process, Strength In Care will offer the complainant support from an independent advocate to reduce stress and anxiety.
3. All available options will be discussed with the complainant and their advocate.
4. Where possible, a collaborative decision is finalised (i.e. acknowledgement, answer, action or apology).
5. The complainant is informed of the decision and the reasons for the outcome.
6. The complainant can review the decision if they are not happy with the resolution, implementing the complaint investigation process.
7. If a complainant seeks a review, a review of the decisions may be resolved quickly by the Complaints Manager completing the above points (2 to 5) again.

5.2.2 Complaint Investigation Process

Step 1. Acknowledge

1. Acknowledge all complaints quickly, within one working day, where possible.

Step 2. Review of the complaint

1. Before any consultative meeting, inform the complainant that their advocate or support person can be present throughout the process.
2. Offer to locate an independent advocate for the participant, if required.
3. Involve the complainant and their advocate using a consultative process to ensure their voice, views and preferred outcomes are heard and discussed.
4. Determine the type of outcome that the complainant seeks (i.e. acknowledgement, answers, actions or apology). Information will be used to ensure that the complainant's feedback and requirements are at the core of the complaint investigation and management process.
5. Inform the complainant of:
    - their right to an advocate and interpreter
    - the stages of the complaint management and decision-making process
    - mechanisms implemented to protect the complainant's privacy
    - their right to complain to the NDIS Quality and Safeguards Commission at anytime
    - actual progress and outcomes of the investigation.
6. Determine the type of complaint (i.e. service, support or process).
7. Notify the complainant and their advocate at each investigation stage and seek their feedback.
8. If a consultative meeting is required, it will be held in a safe environment determined by the complainant and at a time relevant to the participant. The complainant is a recipient of disability services under the NDIS; the participant's record will be checked for a preferred contact for complaints. The participant will also be asked if they would like to nominate a staff member from Strength In Care who is assigned to handle complaints.

Step 3. Assessing the complaint

1. When assessing a complaint, the Complaints Manager must prioritise the complaint and determine a resolution pathway (where required).
2. After the pathway is established, the complaint will be investigated.
3. Feedback from the complainant or their advocate must be used as part of this process (e.g. consultation meeting data).

Step 4. Investigation and decision making

1. When the complaint is lodged, the Complaints Manager should determine if it is practicable to find an immediate resolution (see 5.2.1 Non-investigation complaints process).
2. During the investigation and decision-making process, the Complaints Manager will:
    - keep the complainant informed about each stage of the investigation process
    - consult with the complainant to gather information about the underlying issue/s
    - analyse antecedents and underlying issues when determining a decision
    - review and approve all written reports and documents before them being sent out to all parties
    - respond to the complainant with a clear decision and any next actions (if any)
    - inform the complainant that they have the right to reject the outcome
    - inform the complainant of their right to make a complaint directly to the NDIS Commission by:
        i) phoning 1800 035 544 (free call from landlines) or TTY 133 677 (interpreters can be arranged).
        - using a National Relay Service and asking for 1800 035 544.
        - completing an online complaint contact form.

Step 5. After the decision

1. After investigation and a satisfactory response has been documented, the Complaints Manager will:
    - inform the complainant and their advocate of the decision, including the reason for the decision, and they will provide options for how the complainant can review the decision
    - ensure that the complaint investigation is satisfactorily completed
    - determine if the complainant is satisfied with the outcome
    - follow-up and consult with the complainant/s about any concerns
    - close out the complaint.

5.3 Review and improvement

Strength In Care takes a systematic approach to incorporate a review of all issues raised by a complaint to identify and address any possible systemic issues and determine any continuous improvement actions identified during the complaints process.

The review and improvement process includes:

- ascertaining preventative actions and continuous improvement
- considering if any systemic issues require addressing
- recording the information regarding the complaint in the Complaint, Compliment and Feedback Register
- recording the details of the improvement stemming from a complaint in the Continuous Improvement Register (if required)
- training staff in any new systems or actions
- adjusting policies and procedures
- monitoring the complaint resolution according to the internal audit schedule
- providing feedback to the complainant personally to inform them of the outcomes and influences their issue raised within our organisation.

5.4 Documentation

All employees are provided training regarding the complaints process during orientation and given the Staff Handbook, which includes information on the complaints process (see 5.6 Staff Training).

The complaints process is available for participants, families, carers and advocates via the information provided in our Participant Handbook and through the provision of Easy Read documents (as required).

Documentation of the complaint process is as follows:

- All complaints will be recorded in the Complaint, Compliment and Feedback Register, and information in the register will include the following:
    - complaint details
    - identified issues
    - actions are undertaken to resolve the complaint
    - the outcome of the complaint.
- All documents, including the Complaint and Feedback Forms, are uploaded into the computer system.
- Copies of any information provided to the complainant are stored in their relevant file.
- All documents are kept confidential, and access is only permitted to employees relevant to the complaint. The Complaints Manager determines who is relevant.
- A copy of all complaint documents will be retained in the file for seven years from the record date. If the documents relate to a participant under 18 years of age, the documents will be retained until the participant turns 25 years of age.
- Statistical and other information will be collected to:
    - review issues raised
    - identify and address systemic issues
    - report information to the Commissioner if requested by the NDIS Quality and Safeguards Commission.

- A policy review will occur if there are legislative changes or when determined by a regular or annual internal audit review.

5.5 Unresolved complaints

Unresolved complaints will be referred to the Complaints Manager for investigation and resolution. Should the complaint not be resolved to the complainant's satisfaction, the complaint will be escalated to a person nominated by the complainant (with the complainant's permission).

When complaints cannot be resolved internally, the complainant may be referred to the following:

NDIS Quality and Safeguards Commission
Phone: 1800 035 544 (free call from landlines) or TTY 133 677
National Relay Service and ask for 1800 035 544.
Interpreters can be arranged.

An NDIS Complaint Contact Form can be completed online at business.gov.au

5.6 Staff orientation and training

The staff orientation process includes training all employees in the complaints and feedback process, including the NDIS Commission requirements. Our in-house training includes:

- NDIS reporting requirements and contacts details
- providing information regarding Strength In Care's complaint and feedback process and procedures (e.g. forms to complete and how to assist participants wishing to make a complaint)
- identifying our Complaints Manager
- encouraging employees to have a positive attitude towards complainants and a commitment to resolving all complaints

- creating an understanding of how feedback and complaints inform and guide our continuous improvement cycle
- understanding timeframes for reporting and resolving complaints.

Additional training will occur when practices and policies are changed due to a complaint or if staff are still not sure how to handle a complaint upon commencing work at Strength In Care.

6.0 Related documents

- Complaint and Feedback Form
- Anonymous Complaint and Feedback Form
- Complaints Process Checklist
- Complaint, Compliment and Feedback Register
- Continuous Improvement Policy and Procedure
- Continuous Improvement Register
- Continuous Improvement Plan
- Participant Handbook
- Staff Handbook
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register
- Risk Management Policy and Procedure
- Service Agreement

7.0 References

- NDIS (Complaints Management and Resolution) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Act 2013 (Commonwealth)
- NDIS (Procedural Fairness) Guidelines 2018

- Privacy Act 1988 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)

2.6 Incident Management

Reportable Incident, Accident and Emergency Policy and Procedure

1.0 Purpose

Strength In Care will comply with the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018.

It is our objective to maintain an incident management system that covers incidents that consist of acts, omissions, events or circumstances that:

- occur in connection with the provision of supports or services to a person with a disability
- has, or could have caused harm to a person with a disability.

Important note: Information on how Strength In Care reports harm, risk of harm, and abuse against children can be found in our Working with Children Policy and Procedure.

2.0 Scope

All staff members are responsible for ensuring the safety of all participants who access our services. All incidents must be reported as per this policy. Management is responsible for ensuring that staff are trained and undertake the NDIS Worker Orientation training module.

3.0 Definitions

Term	Definition

Incident	Acts, omissions, events or circumstances that occur in connection with providing support or services to a person with a disability and have, or could have, caused harm to the participant.
Reportable incident	A reportable incident is any of the below: • The death of a person with a disability. • Serious injury of a person with a disability. • Abuse or neglect of a person with a disability. • Unlawful sexual or physical contact with, or assault of, a person with a disability. • Sexual misconduct is committed against, or in the presence of, a person with a disability, including grooming the person with a disability for sexual activity. • Use of restrictive practice to a person with a disability where the restrictive practice use is not following an authorisation (however described) of a state or territory concerning the person, or if it is used according to that authorisation but not following a behaviour support plan for the person with a disability.

Incident management system	Incorporates all items listed below: ● Acts, omissions, events or circumstances that occur in connection with providing support or services to a person with a disability; and have or could have caused harm to the person with a disability. ● Incidents consist of acts by a person with a disability that occur in connection with providing support or services to the person with a disability and have caused serious harm or a risk of serious harm to another person. ● Reportable incidents allegedly occurred to provide support or services to a person with a disability.

4.0 Policy

Strength In Care recognises that many of the participants using Strength In Care services are at risk of incidents and accidents. Staff are required to encourage participants to report incidents to allow the organisation to improve practices and inform authorities following this policy.

Strength In Care's Reportable Incident, Accident and Emergency Policy and Procedure seeks to:

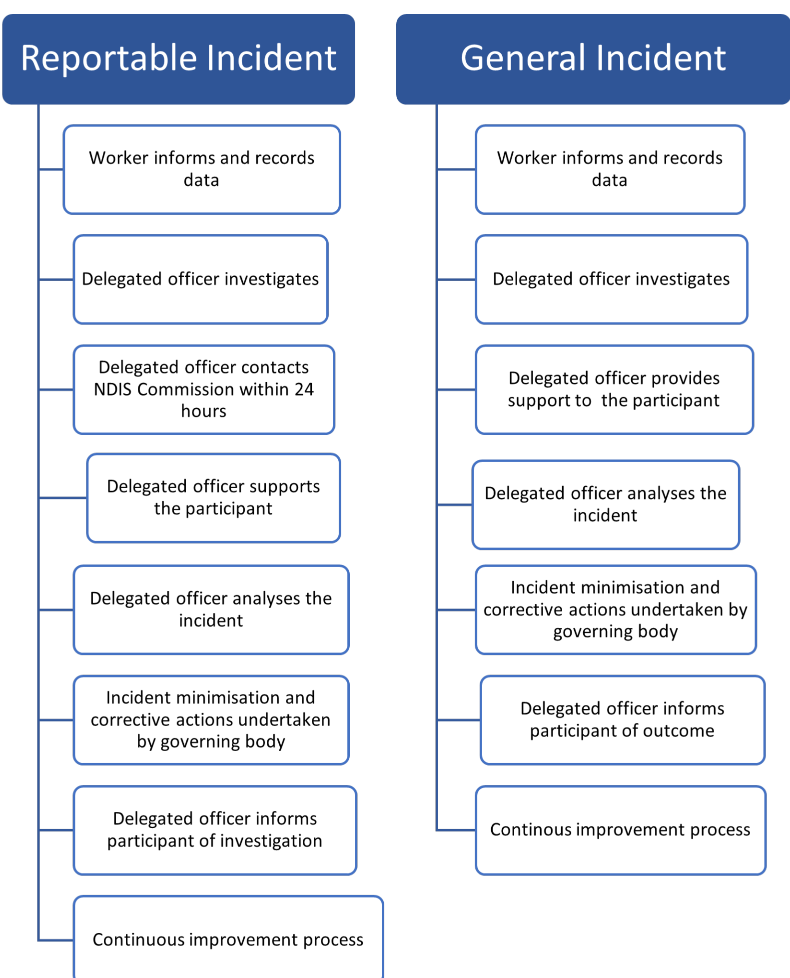
- minimise risk and prevent future incidents through the development of appropriate participant-centred plans, staff training, assessment and review
- ensure that there is immediate management of an incident, accident or emergency and that each of these events is prioritised, managed and investigated appropriately
- identify opportunities to improve participant support quality by ensuring that the incident system is planned, coordinated, and linked to the quality and risk management systems.

Participants will be provided information in Easy Read format, as required.

The Director is the delegated officer listed in this policy and will manage, investigate and report all incidents as required. Within this process, the Director will ensure procedural fairness when dealing with an incident. Our organisation will follow all procedural fairness guidelines as required by the Commissioner.

5.0 Procedure

5.1 Incident management procedure



Strength In Care will establish a procedure that identifies, manages and resolves incidents, as follows:

Step 1. Inform of incident

1. The worker to report the incident to the Director.
2. The worker completes an Incident Report that identifies and records details relating to the incident, i.e. people, place, time and date.

Step 2. Investigation

1. The Director will determine, from the information provided, if the incident is classified as a reportable incident by the NDIS Quality and Safeguards Commissioner or a different type of incident:
    - A reportable incident must comply with the reportable incident reporting process.
    - Strength In Care will comply with the National Disability Insurance Scheme (Incident Management and Reportable) Rules 2018.
    - A general incident is an accident with non-reportable injuries.
2. The Director will review the details of the incident:
    - People involved.
    - Location.
    - Circumstances.
    - The outcome, e.g. injury.
3. The Director will investigate the incident/accident following the process outlined in the Incident Investigation Form to determine the required information:
    - Primary reasons for the event.
    - Underlying reasons for the event.
    - Immediate actions are required to fix the cause of the event.
    - Preventative actions are required for the future.
4. Any information learned from incidents/accidents will be incorporated into our continuous improvement cycle to prevent the same incident/accident from recurring.
    - The analysis and investigation of each incident will vary based on the seriousness of the incident.

Step 3. Support participant

1. The Director ensures that the affected participant is supported and assisted:
    - informing them that they have access to an advocate; if the participant does not have an advocate, the Director can help access an independent advocate
    - reviewing their health status to assist and support
    - assessing the environment to ensure their safety and to prevent any recurrence
    - ensuring their well-being and assisting in developing the participant's confidence and competence so they do not lose any function/s.
2. The Director or their delegate will review the incident with the participant and collaborate with the person/s involved to manage and resolve the incident.

Step 4. Analyse incident

1. As part of our continuous improvement process, the information gained from an incident is used to amend or implement new practices:
    - we will establish the incident cause/s and the effects and any operational issues that may have contributed to the incident occurring and the nature of the investigation
    - if an incident requires the implementation of corrective action, an appropriate plan will be developed to adjust practices according to the nature of the action required.
2. The Director or their delegate will undertake an appropriate analytical process to:
    - determine the cause of the incident
    - ascertain if the incident was an operational issue
    - consider the participant's perspective, including:
        - whether the incident was preventable
        - how the incident was managed and reviewed
        - determining any remedial action required to minimise future impacts and prevent a recurrence.

- identify why the incident occurred, e.g. environmental factors, participant health
- ascertain if current strategies or processes require review and improvement.
- devise new strategies or procedures, if required
- plan staff training for any new strategies
- implement new strategies
- evaluate the success of new strategies.

All Incident Investigation Forms, including the Final Report, must be closed out by the Director or their delegate and one other Strength In Care staff member.

Step 5. Incident/accident minimisation and corrective action

1. Strength In Care will risk-assess all participants in conjunction with our Risk Management Policy and Procedure.
2. During staff orientation and regular ongoing training sessions, incidents and emergency minimisation and procedures are taught.
3. Risks will be identified, and control mechanisms agreed upon with participants.
4. Strength In Care will consult with participants, and relevant stakeholders, to design specific risk control mechanisms to reduce risk to participants and their environment.
5. The effectiveness of mechanisms will be evaluated via:
    - participant review processes, including support plan review
    - participant feedback
    - case conferencing.
6. Internal and external risk audits.
7. Reviews of policies and procedures.

Corrective actions

Upon completing the incident analysis procedure, any corrective action will be implemented. Each corrective action identified will be evaluated to ascertain the action's effectiveness, as per our Continuous Improvement Policy and Procedure, i.e. Plan, Do, Check, Act.

Step 6. Informing participants

Strength In Care will inform participants or their advocate of the incident outcome/s, either in writing or verbally, dependent on the participant and the situation. Collaborative practice will ensure the participant and their advocate are involved in the incident's management and resolution.

5.2 Staff training

Strength In Care recognises the importance of prevention to ensure our staff and participants' safety. Our orientation process includes training in risk and safety practices, including manual handling, infection control, safe environments, and risk and hazard reduction.

Upon commencing employment with Strength In Care, all staff are trained in organisational incident management processes, including how to report an incident and who to report an incident to the Director). All staff are given full access to our organisational policies and procedures to provide guidance. A Staff Incident Reference Card is provided to all staff as a guide.

5.3 Reportable incidents

Staff must report any reportable incident immediately that it becomes evident.

The Director is responsible for reporting all reportable incidents to the NDIS Quality and Safeguards Commission. Reportable incidents are serious incidents or allegations that harm any NDIS participant.

As a registered provider, Strength In Care is required to report serious incidents (including allegations) arising from the organisation's service provision to the NDIS Quality and Safeguards Commission. Reportable incidents involving NDIS participants include:

- the death of a person with a disability
- serious injury of a person with a disability
- abuse or neglect of a person with a disability (n
- unlawful sexual or physical contact with, or assault of, a person with a disability (excluding, in the case of unlawful physical assault, contact with, and impact on, the negligent person)

- sexual misconduct committed against, or in the presence of, a person with a disability, including grooming the person for sexual activity
- the use of a restrictive practice to a participant, other than where the restrictive practice use follows an authorisation (however described) of a state or territory concerning the person or a behaviour support plan.

5.3.1 Reporting roles

The organisation will establish the following roles and ensure that allocated staff are aware of their responsibilities:

1. Approved Reportable Incident Approver responsibilities:
    - Authority to review reports before submission to the NDIS Commission.
    - Views previous reportable incidents submitted by their organisation.
2. Authorised Reportable Incident Notifier responsibilities:
    - Supports the Authorised Reportable Incident Approver to collate and report the required information.
    - Creates new reportable incident notifications to be saved as a draft for review and submission by the authorised Approver.

5.3.1.1 Timeframes for notifying the NDIS Commission about reportable incidents

When a reportable incident occurs or is alleged in connection with the NDIS supports or services you deliver, you must notify us using the NDIS Commission Portal within the required timeframes (set out below). The timeframes are calculated from when a registered NDIS provider became aware that the incident occurred or was alleged to have occurred.

Reportable incident	Required timeframe
death of a person with disability	24 hours

serious injury of a person with disability	24 hours
abuse or neglect of a person with disability	24 hours
unlawful sexual or physical contact with, or assault of, a person with disability	24 hours
sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity	24 hours
the use of restrictive practice concerning a person with disability if the use is not following a required state or territory authorisation and/or not under a behaviour support plan.	Five business days

5.3.2 Reportable incident procedure

The Director will review the information and contact the police immediately to inform them of any suspected abuse.

The Approver submits reportable incidents via the NDIS Commission Portal's My Reportable Incidents page. https://www.ndiscommission.gov.au/providers/ndis-commission-portal:

1. Complete an **Immediate Notification Form** and submit it within 24 hours:
    - Approved Reportable Incident Notifier will create for approval.
    - Approved Reportable Incident Approver will approve the report and submit it.

      Note: Approved Reportable Incident Notifier may create and submit as required by the incident's circumstance.
2. **5-day form** to be completed within five days of key stakeholders being informed:
    - Approved Reportable Incident Notifier will create a form for approval.
    - Approved Reportable Incident Approver will approve and submit the form.

      Note: Approved Reportable Incident Notifier may create and submit as required by the incident's circumstance.

3. **Final Report** will be submitted on the due date if requested by the NDIS Commission:
    - Approved Reportable Incident Notifier will create a report for approval.
    - Approved Reportable Incident Approver will approve the report and submit it.

      Note: Approved Reportable Incident Notifier may create and submit as required by the incident's circumstance.

Assessment of the incident by the Director, or their delegate, will involve:

- assessing the incident's impact on the NDIS participant
- analysing and identifying if the incident could have been prevented
- reviewing the management of the incident
- determining what, if any, changes are required to prevent further similar events from occurring
- recording all incidents and responsive actions taken.

5.4 Documentation

- All reportable incident reports and registers must be maintained for seven (7) years.
- This policy is to be reviewed annually or when legislation changes occur.
- All participants, families and advocates are informed of this policy.
- All staff are trained in the procedures outlined in this policy.
- Training details are recorded in each employee's personnel file.

6.0 Related documents

- Continuous Improvement Policy and Procedure
- Final Report (NDIS form)
- 5-day form (NDIS form)
- Incident Report

- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Register
- Immediate Notification Form (NDIS form)
- Participant Handbook
- Participant Orientation Checklist
- Reportable Incident, Accident and Emergency Policy and Procedure
- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Risk Management Policy and Procedure
- Staff Incident Reference Card
- Support Plan Review Report
- Staff Training Record
- Staff Training Plan
- Training Attendance Register – In-house
- Training Register

7.0 References

- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)

Reportable deaths (coroner) - Victoria

Not all deaths need to be reported to the Coroner's Court of Victoria. Reportable deaths include deaths:

- that are unexpected, unnatural or violent or resulted after an accident or injury
- that unexpectedly occur during or after a medical procedure
- where the identity of the person or their cause of death is not known
- where the person was in custody or care.

A person who can report a death to the Coronial Admissions and Enquiries

- Persons who must advise the coroner of a reportable or reviewable death include *any person who had care or custody of a person placed in care*.
- Anyone who thinks a reportable death has occurred and that the court has not been advised should report the death without delay.
- The immediate family of a person who has died might report the death to the coroner if the person who has died was discharged from an approved mental health service within three months of the death occurring.

Procedure to report a death

In the event of a reportable death, the Director will undertake the following steps:

1. Contact Coronial Admissions and Enquiries on phone number: 1300 309 519.
2. Complete a Medical Deposition online, if requested by Coronial Admissions and Enquiries.
3. Advise the participant's family that they can request access to coronial documents by contacting the Registry on 1300 309 519

References

- Coroners Act 2008 (VIC)
- Coroners Court of Victoria (information sighted - 9:12 am on 17/11/20)

2.7 Human Resource Management

Human Resource Management Policy and Procedure

1.0 Purpose

Strength In Care's policy objective is to safely and effectively manage our staff. Our goal is to create a structured, fair, safe and supportive environment that supports our staff to meet organisational requirements and facilitate high levels of participant service and satisfaction.

2.0 Scope

Human resources are used to describe both the people who work for our organisation and the management of resources related to our staff members. This policy is designed to incorporate many aspects of human resources and to comply with the *Fair Work Act 2009* and NDIS Quality and Safeguards Commission requirements.

3.0 Policy

3.1 Human resource management principles

Our human resource management principles are as follows:

- recruit and employ staff with appropriate qualifications, skills and competence
- employ staff who hold the NDIS Worker Screening Check, NDIS Worker Orientation Program, and other state requirements before commencing work
- maintain adequate levels of staff members to ensure quality support that meets the assessed needs of participants and organisational requirements
- support workers to understand capability expectations at different levels,

- provide constructive feedback, and create informal and formal opportunities for them to develop their capabilities and build a career
- improve staff skills and competency levels through ongoing supervision and support combined with the implementation of comprehensive training programs and annual performance reviews
- ensure staff hold current legislated work checks, professional registrations, licences, insurances and any other employment requirements (as needed).
- performance manage poor staff performance or allegations of misconduct
- continually review and improve human resource management procedures
- access expert external advice and information on human resource management when required.
- comply with relevant legislation and be comparable with industry standards and working conditions
- create annual performance reviews and develop training plans, including the annual training in reporting disclosures or risk of harm
- set clear expectations of what best practice looks like, provide access to support and coaching, and develop worker awareness and capabilities to deliver quality supports and services
- inform staff that they may be selected to undertake an interview as part of our NDIS audit compliance, and seek consent for any NDIS interview
- Strength In Care will apply the following principles to all aspects of our relationship with our employees:
    - equity and fairness
    - respect for individuals, their privacy and confidentiality
    - accountability for actions and performance
    - encourage and support professional development
    - workplace flexibility and understanding of personal needs.

3.2 Corporate governance management

A review of all persons who influence our governance is instigated. All these key personnel will be assessed using the Suitability Assessment Process Guide – Information for NDIS Providers and their 'key personnel' July 2018 to ensure that they meet the required NDIS standards.

All key personnel knowledge and skills will be:

- analysed to confirm they hold the relevant experience and knowledge to undertake their role
- analysed against the suitability assessment process
- undertake a gap analysis if there are areas of knowledge and skills that require additional training and education
- arrange for the relevant education or training necessary
- record analysis and training provided.

3.3 Staff recruitment

Individuals are appointed based on their ability to meet criteria consistent with their role and position description. We employ staff who offer a range of skills and experience to manage our organisation effectively, and our services meet the needs of all participants. Roles are outlined in the organisational structure within Strength In Care's Corporate Governance Policy and Procedure.

To ensure that we select the correct person, we have clear position descriptions that identify the skills and experience required to fill the position. We will review the NDIS Workforce Capability Framework to ensure that staff employed understand their role and work with participants.

According to our Equal Employment Opportunity Policy (see below - 3.4. Equal Employment Opportunity Policy). All permanent vacancies are advertised externally and internally. Only those who successfully pass the NDIS Worker Screening Check and NDIS

Worker Orientation Program will be employed by Strength In Care The Director is responsible for the recruitment and administration of all employees.

3.4 Equal Employment Opportunity (EEO) Policy

Strength In Care commits to:

- providing equal employment opportunities to all prospective and current employees
- promoting a fair and equitable work environment
- complying with all relevant anti-discrimination legislation
- creating and maintaining an environment in which diversity is valued, human dignity is respected, and people are treated with equity and tolerance
- ensuring staff and visitors are free from discrimination, harassment or victimisation.

Our organisation chooses the best person for the job, regardless of:

- race
- nationality or ethnic origin
- disability (physical, intellectual or psychological)
- gender
- age
- sexual orientation
- marital status
- family status and responsibility (including pregnancy)
- religious or political beliefs
- activities or practices.

3.5 Code of Conduct

All employees who are engaged by Strength In Care must abide by both the NDIS Code of Conduct and Strength In Care's Code of Conduct and, if relevant, the Child Safety Code of Conduct.

3.5.1 NDIS Code of Conduct

- Act with respect for individual rights to freedom of expression, self-determination and decision-making, following applicable laws and conventions.
- Respect the privacy of people with disabilities.
- Provide support and services safely and competently and with care and skill.
- Act with integrity, honesty and transparency.
- Promptly take steps to raise and act on matters that may impact the quality and safety of supports and services provided to people with disabilities.
- Take all reasonable steps to prevent and respond to violence, harm, risk of harm, exploitation, neglect and abuse against people with disabilities.
- Take all reasonable steps to prevent and respond to sexual misconduct against people with disabilities.

3.5.2 Strength In Care Code of Conduct

- Abide by the philosophy of our organisation.
- Observe all the rules of our organisation.
- Provide support to participants in a safe, ethical manner with care and skill.
- Work safely and competently, following the policies and procedures of our organisation.
- Respect the dignity, culture, values and beliefs of all individuals.
- Do not discriminate against participants on any basis.
- Respond in flexible and innovative ways to support participant decision-making.
- Do not discuss confidential issues with people outside the organisation; regard all information provided by a participant as confidential, and never disclose personal information to a participant.
- Do not harass other staff members of our organisation.
- Do not alienate participants from their families or representatives.
- Do not smoke whilst at work.

- Do not take illegal drugs or consume alcohol on duty or at the organisation or participant's premises.
- Never accept gifts or purchase items from participants.
- Do not engage in sexual misconduct with participants.
- Staff are never to take a participant to their (staff member's) home or engage in a relationship with a participant outside of a professional association.
- Always positively represent our organisation.
- Always wear clean and appropriate work clothes, or uniform, while at work.
- Adhere to all our record keeping and accounting procedures.
- Provide quality services.

3.6 Emergency and Disaster Planning

Staff with relevant skills and capabilities to assist in responding to an emergency or disaster are identified. These capabilities may include the capability to:

- Assist with contingency planning:
    - Collaborating with relevant management or staff about crisis management
    - Participant emergency plan review and adjustments
    - Adjusting any contingency plan to suit changing circumstances
- Train and supervise staff in infection prevention measures:
    - Use and disposal of personal protective equipment
    - Cleaning environment to remove infectious agents
    - Hygiene practices
- Work with management in controlling staff infection practices
    - Reviewing and adjusting controls to manage the current situation

Strength In Care governance includes planning and emergency and disaster management. Emergency or disaster planning requires management staff to:

- Identify the emergency or disaster (e.g. flood, epidemic)
- Review the needs of current participants

- Use this data to determine staffing numbers, qualifications and experience required
- Identify any gaps in service provision due to a lack of numbers
- Start a recruitment process to source staff (see 4.1 Process for filling a vacant position)
- Ensure that recruiting staff are supported and assist in the onboarding and induction process to allow staff to be ready quickly.

4.0 Procedure

4.1 Process for filling a vacant position

4.1.1 Review the position

1. Clarify the role and the need for the position.
2. Develop or review the position description.
3. Review position against requirements for the relevant registration group.
4. Develop essential and desirable selection criteria as per the position description.
5. Determine how each selection criteria is assessed (e.g. written application and interview).

4.1.2 Advertise the position

1. Positions are advertised internally and externally.

4.1.3 Interview applicants

1. The Director conducts the interviews and uses the appropriate interview form.
2. All applicants will be asked the same questions. The questions will explore the applicant's relevant skills and experience to perform the required duties.
3. Interview questions may include:

a. Relevant experiences
b. Behaviour management questions, if relevant to the position
c. Time management
d. How to work with participants
e. Qualifications

4. When interviews are completed, the preferred applicant will be selected.
5. Recruitment decisions and reasons for decisions made are documented.
6. Pre-employment/reference checks take place.
7. The successful applicant will be notified, and unsuccessful applicants will provide feedback.
8. An offer of employment will be made to the successful applicant, conditional on pre-employment checks:
    a. reference checks (at least two referees and qualification checks, if the position is a risk assessed role)
    b. mandatory worker screening (i.e. worker screening and working with children check as per state requirements)
    c. registration check (as applicable to the role)
    d. insurances (as applicable to the role)
    e. licences (as applicable to the role)
    f. NDIS Worker Orientation Program Certificate
9. Once appropriate checks are completed and satisfactory, an offer of employment will be sent to the applicant for signing before commencing employment. This document will include a probationary period.

4.2 Procedure for a new employee

1. The Director will complete an orientation procedure with all new employees that include:
    a. Codes of Practice

   b. NDIS Rules and Practice Standards (such as NDIS principles – human rights, celebrating diversity and respecting the voice of those with lived experience)
   c. Risk management strategies and procedures – all areas, i.e. environment, work role, working with participants of different age ranges
   d. Incident management procedures
   e. Complaint management procedures
   f. Emergency and Disaster practices
   g. Infection prevention and control training
   h. Workplace task procedures
   i. Documentation procedures
   j. Participant's rights, including United Nations Rights
   k. Reporting violence, abuse, neglect, discrimination and exploitation
   l. Professional development
2. A Staff Orientation Checklist will be completed by the new employee and signed off by the Director.
3. All forms and documents signed by the employee are filed in a personnel file with copies provided to the employee, as appropriate.

4.3 New Staff Supervision

- New staff members are inducted into their roles and supervised appropriately.
- New senior staff members are monitored by the Director.
- New staff are allocated a supervisor who will support and train them in our practices.
- The orientation process will vary according to the experience of the new staff member but is usually for a minimum of two (2) shifts.
- Supervisors must discuss the progress, knowledge and skills of the new staff member with the Director to confirm that they are ready to work unsupported.

4.4 Position descriptions

- All employees are provided with a position description that specifies their roles and responsibilities.
- Position descriptions are reviewed and updated regularly.
- Before commencing employment and if there is a position description change, a copy of the position description is provided to the staff member
- Position descriptions are used as part of performance management and will be reviewed and adjusted due to changes in work practices, as required
- Position descriptions for staff working directly with participants refer to the NDIS Workforce Capability Framework and Child Safe Standards
- Position descriptions are used as part of the Risk Assessed Role determination.

4.5 Code of Conduct and Privacy and Confidentiality Agreement

All staff must comply with the Code of Conduct, which encapsulates the respectful, safe, and professional delivery of support to our participants, representatives, community, and other stakeholders.

Employees must sign a Code of Conduct Agreement and a Privacy and Confidentiality Agreement on employment commencement. Disciplinary action will be taken if employees do not abide by these agreements.

4.6 Staff information

Strength In Care's policies and procedures contain critical information that all staff must know to complete their roles safely and effectively. Staff are informed on how we will use their information as per Information Management Policy and Procedure.

New employees are provided the time to read all policies and procedures and are reminded during staff meetings and through communication with the Director to do so. A Staff Handbook is provided to all new employees as a reference guide only.

4.7 Staff uniform

All staff representing Strength In Care are required to wear our uniform or other provided form of identification (e.g. name tags), so participants easily identify themselves as belonging to our organisation. Staff uniforms must be clean and neat before commencing work.

4.8 Recordkeeping

An employee personnel file is maintained and may include:

- employment application
- criminal record check
- working with children check
- worker screening record
- professional registrations
- a signed offer of employment
- photocopy of driver's licence, car registration and insurance (wherever applicable)
- signed Code of Conduct Agreement
- signed Privacy and Confidentiality Agreement
- training offered
- training provided
- mandatory training attendance record
- evaluation of training events
- annual refresher training (Child Protection), as required
- mandatory NDIS worker screening check
- mandatory NDIS Worker Orientation Certificate
- COVID 19 Infection control training
- Annual infection control training.

All employees are entitled to view their file at any suitable time; this can be arranged directly with the Director.

Strength In Care must never employ a person as a staff member unless satisfied that all regulatory checks are current and in place.

The following details must be kept current for each worker:

- Contact details
- Details of any secondary employment (if any)

4.9 Staff supervision and support

Supervision and support are essential to making our employees feel supported in their work and ensuring they perform satisfactorily. Strength In Care will supervise work performance issues at our office/s, in participants' homes and within the community. Participants will be contacted to determine if the worker is fulfilling their role professionally and safely. Additionally, supervision sessions allow a follow-up on development issues noted in an employee's development and performance reviews.

Upon employment, all employees are provided with Strength In Care's contact details. The Director is available to be contacted over the phone by the employee. Alternatively, the Director is available to meet with an employee if they require time to discuss any issues or concerns.

Employee supervision relates to monitoring employee work practices against the expectations, needs, and support services identified in the Service Agreement and our policies and procedures. The supervision requirements are determined by the employee's role and current work knowledge and skills. The observation timeframe can vary from fortnightly, monthly, quarterly, half-yearly, or annually per our Staff Supervision Roster.

Our organisation will use a variety of data gathering methods, including but not limited to:

- observing using a Staff Observation Checklist:
- contacting and gaining feedback from participant
- speaking with our supervisors
- speaking with relevant providers who work with our participants
- undertaking performance reviews

A staff member's annual competency assessment, education and training, and performance appraisal provide other avenues for our organisation to provide staff support and supervision. All staff can attend meetings and care conferences to ensure they are aware of participant support changes and to take the opportunity to provide input and feedback.

4.9.1 Stress in the workplace

Work-related stress can lead to illness, injury and decreases in performance. Stress can come from many sources, both work and non-work. Our organisation has a legal obligation to minimise workers' exposure to work-related factors that can increase the risk of stress. This obligation is the same for self-employed people and contractors.

We aim to eliminate or minimise staff members' risk of harm from potential stress at work. Our strategies include:

- informing staff that if feeling stressed to inform their supervisor
- allocating a staff member to support the person
- monitoring staff for stress
- training any supervisor or management personnel in how to handle a person who seeks assistance and how to refer the stressed staff member to the delegate support person
- actively listening to the person and devising a plan of action to eliminate or minimise their stress
- determine if the stress is a result of work or home:

    - if work-related, then formulate a plan of action to eliminate or minimise their stress
    - if home-related, consult with the person to identify if there are any ways to support the individual

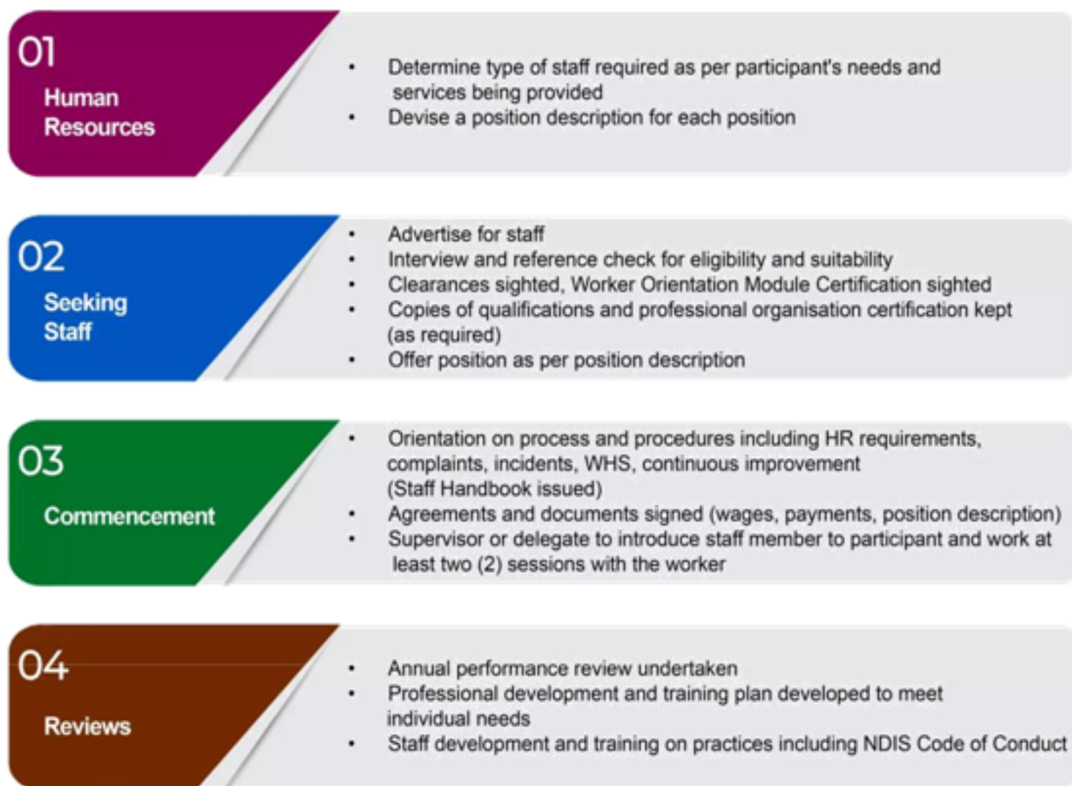
4.10 Performance development reviews

- Strength In Care is committed to supporting staff to improve their efficiency and effectiveness. All staff members are expected to perform their duties to the best of their ability and show a high level of personal commitment to always providing quality and professional service.
- Performance development reviews are conducted annually in consultation with individual staff members.
- Performance development reviews are based on the position description and an agreed work plan.

The aims of the review are to:

- conduct an honest and confidential discussion regarding work performance and the workplace between the staff member and the Director
- discuss job performance in the context of a position description
- discuss work problems and develop appropriate solutions
- discuss possible ways of improving work performance, including identifying training and development needs or changes to work practice.

Diagram 1. Staff recruitment and management process



4.11 Staff education and training

Our organisation will set and meet high-quality service standards that promote lifelong learning and development and supports career development for workers in disability and the wider care sector.

Strength In Care provides appropriate training and development opportunities for all staff; this includes:

- establishing what high-quality standards look like for the staff member
- promoting learning opportunities relevant to the position
- establishing processes to measure and adjust services
    - training staff in outcome from continuous improvement
    - updating staff skills due to the changing nature of their work
    - providing staff with clear practice guidelines on what is required

    - using our performance reviews to determine additional training requirements
- identifying training needs through annual performance development reviews and ongoing staff and management input
- providing appropriate training to meet identified needs
- providing mandatory training as per state requirements (e.g. Child Protection)
- providing training opportunities for all staff
- providing refresher infection prevention and control training for staff working directly with participants, at least annually or more frequently as required
- evaluating training to ensure it meets the needs of the staff member and assists in improving our operations and services
- completing a training needs analysis
- devising appropriate training plans to meet staff performance requirements.

4.12 Staff development opportunities

Strength In Care creates staff development opportunities, as follows:

- Staff attendance (for up to three (3) days per year) at workshops, seminars and conferences.
- Flexible working hours, so staff can participate in accredited study courses at recognised educational institutions.
- Provision of learning resources for staff education, e.g. videos and research literature.
- Each staff member will discuss training needs upon recruitment during annual performance reviews and supervision sessions.

4.13 Staff performance dispute procedure

Outlined below is the procedure used to deal with a staff performance dispute not involving misconduct. Misconduct is an action by a staff member that results in instant dismissal.

4.13.1 Verbal warning

The staff member is quickly informed of any complaint concerning their work performance and is provided with an opportunity to discuss the complaint.

The Director, in consultation with the employee, will outline how the employee must improve their performance. Any assistance needed by the employee to improve their performance is identified and provided wherever possible.

A date to review the employee's performance will be set, considering adequate time to resolve the issue and reduce risk to the organisation.

4.13.2 First written warning

Further discussion will occur if the employee's performance is still unsatisfactory at the second review. This review will include the employee, a representative of their choice (optional), and the Director.

The complaint against the employee and plans for improvement will be put in writing and will clearly state that a lack of development by a given date will result in a final written warning being issued. A copy of the first written warning will be provided to the employee.

4.13.3 Final written warning

Further discussion will be conducted if the employee's performance has not improved at the given date set. This review will include the employee, a representative of their choice and the Director.

The complaint against the employee and plans for improvement are recorded in writing, clearly stating that a lack of growth by a given date will result in termination of employment. A copy of the final written warning will be provided to the employee.

4.13.4 Termination of employment

If the problem persists, the staff member's employment may be terminated after the date set in the final written warning. The Director must approve the termination.

If the termination is not approved, an alternative process for managing the performance issue will be developed. Detailed notes of performance dispute management are recorded and kept in the employee's personnel file.

4.14 Staff grievance procedure

If a staff member has a grievance related to their employment or concerning another staff member, the following processes apply:

4.14.1 Discussion

The staff member may approach the Director to discuss the issue and seek advice on the issue. The consultation will be confidential. The staff member may write the matter to their supervisor and request that the issue is raised with management. A decision on the issue and a discussion with the staff member will occur within seven (7) business days.

If the staff member considers that the discussion has not addressed their concerns adequately, they can seek external advice (e.g. union representative or another independent body).

4.14.2 Misconduct

Misconduct includes severe breaches of our policies and procedures or unacceptable behaviour that warrants the immediate dismissal of a staff member. Examples of misconduct include:

- theft of property or funds from our organisation
- wilful damage of property belonging to our organisation
- intoxication through alcohol or other substances during working hours
- verbal or physical harassment or discrimination of any other staff member or participant
- disclosure of confidential information regarding the organisation to any other party without prior permission
- disclosure of participant information, other than information that is necessary to assist participants and to ensure their safety
- conducting a private business from our premises or using the organisation's resources for private business without permission
- falsification of any records belonging to the organisation
- failure to comply with the organisation's Code of Conduct.

4.14.3 Seek advice

The Director must be informed immediately following receipt of an allegation of misconduct. If necessary, the Director will obtain external professional advice. The staff member should consider seeking advice from their union or another independent body.

4.14.4 Suspension of duties

A staff member is informed, as soon as possible, of any allegation of misconduct. The staff member may be suspended, with full pay, pending an investigation of the claim. A letter outlining the time, date and alleged misconduct will be provided to the staff member.

4.15 Leave

4.15.1 Application for leave

Any staff member taking leave must complete an Application for Leave Form. If the application form is not completed, payment will not be made for leave taken.

The application must be completed and approved before annual, long service, or unpaid leave.

4.15.2 Sick leave

A doctor's certificate is required for more than two consecutive days of sick leave. When sick leave is required, the Director should be informed as soon as possible and, at a minimum, at least two hours before the staff member's usual start time. An Application for Leave Form must be completed immediately upon the employee returning to work after sick leave.

The Continuity of Support Policy and Procedure will be implemented to support participants during staff absences.

4.15.3 Personal/carer's leave and compassionate leave

Personal/carer's leave and compassionate leave are defined in the relevant award (this only applies if staff are under an award). To qualify for personal leave, an individual's reason for leave must meet the definition of personal/carer's leave and compassionate leave within the award.

An Application for Leave Form must be completed immediately after a staff member returns to work. When leave is required, staff should inform the Director at least two hours before the usual start time of the staff member.

4.15.4 Recording annual leave

Our accounting system software tracks annual leave taken and owing to staff.

4.15.5 Timesheets

Each staff member is required to maintain up-to-date timesheets. Timesheets must be submitted to the Director, as per the work agreement. The Director or their delegate will check timesheets against the roster hours to determine accuracy before forwarding them to the administration office for payment.

4.16 Workers compensation

When a staff member suffers an injury or suffers from a disease, and work is a substantial contributing factor to that illness or injury, Strength In Care ensures that financial benefits and other assistance are provided, as required by the relevant state legislation and regulations.

4.17 Employee exit procedure

When an employee leaves Strength In Care, the following procedure applies:

1. The Director conducts the exit interview, and the employee is asked to provide useful feedback.
2. The exit interview is documented.
3. Completed documentation is viewed as relevant and used, if appropriate, to be integrated into the organisation’s continuous improvement process.

5.0 Related documents

- Application for Leave Form
- Code of Conduct Agreement

- Complaints and Feedback Form
- Human Resource Management Policy and Procedure
- Job Candidate Interview Form
- Delegation of Responsibility and Authority Policy and Procedure
- Delegation of Responsibility and Authority Form
- Offer of Employment Letter
- Employment Check Register
- Personnel File Contents Checklist
- Performance Management Template
- Employee Performance Appraisal
- Privacy and Confidentiality Agreement
- Staff Handbook
- Staff Observation Checklist
- Staff Orientation Checklist
- Staff Supervision Roster
- Training Needs Analysis
- Staff Training Record
- Staff Training Plan
- Warning Letter

6.0 References

- Disability Discrimination Act 1992 (Commonwealth)
- Australian Human Rights Commission Act 1986 (Commonwealth)
- Fair Work Act 2009 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Safety, Rehabilitation and Compensation Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- Workplace Gender Equality Act 2012 (Commonwealth)
- NDIS (Practice Standards - Worker Screening) Rules 2018
- NDIS (Code of Conduct) Rules 2018

- NDIS Practice Standards and Quality Indicators 2021

Delegation of Responsibility and Authority Policy and Procedure

1.0 Purpose

Delegations of responsibility and authority are the mechanisms by which Strength In Care enables the staff of Strength In Care to act on behalf of Strength In Care.

The purpose of this policy is to establish a framework for delegating responsibility and authority within Strength In Care in a manner that facilitates efficiency and effectiveness and increases accountability levels of our staff and volunteers' performances.

Delegations are a crucial element in effective governance and management of Strength In Care and provide formal authority to staff and volunteers to commit to the organisation and incur liabilities on behalf of the organisation.

Delegations of responsibility and authority within Strength In Care are intended to achieve four objectives to ensure:

1. the efficiency and effectiveness of the organisation's administrative processes
2. the appropriate officers have been provided with the level of authority necessary to discharge their responsibilities
3. the most suitable and best-informed individuals exercise delegated authority within the organisation
4. the internal controls are adequate.

2.0 Scope

The policy applies to all staff and volunteers who have delegated responsibility or authority to act and sign documents on behalf of Strength In Care.

3.0 Policy

This policy sets out the circumstances under which the Director may delegate their responsibilities.

The Director is responsible for the management of the organisation and can delegate any of its functions. However, the Director may not delegate its power to adopt the following:

- strategic plan
- business plan
- annual budget.

The Director is:

- charged with the duty of promoting the interests and furthering the development of Strength In Care
- responsible for the administrative, financial, and other business of Strength In Care
- responsible for exercising general supervision over the staff and volunteers of Strength In Care.

The Director may delegate any function, power, or duty conferred or imposed upon them, subject to this policy, to any member of the staff of the organisation.

Strength In Care is committed to the highest standards of integrity, fairness and ethical conduct, including full compliance with all relevant legal requirements. In turn, requires that all managers, staff, volunteers and contractors acting on our behalf meet those same standards of integrity, fairness and ethical behaviour, including compliance with all legal requirements.

There is no circumstance under which it is acceptable for Strength In Care or any of its staff or contractors to, knowingly and deliberately, not comply with the law or to act unethically in the course of performing or advancing Strength In Care's business.

4.0 Procedure

The overarching policy applies to Strength In Care as a whole. Units within the organisation must align their delegation of authority and responsibility policies with the central strategy. Delegations must be exercised to ensure that delegated staff hold the requisite qualifications and skills.

4.1 Delegations to the Director

Delegations are attached to the position occupied, not to the occupant of the position. The responsibilities of a position appear in a duty statement, role statement, or statement of responsibility appropriate to the position.

Delegations reflect Strength In Care's organisational structure. Levels of authority are hierarchical through relevant lines of responsibility, up to and including the Director. Formal authorities held by any delegate are included in those held by that delegate's supervisor or line manager; a delegate who sub-delegates authority remains responsible and accountable for the decision or action.

The Director may, at any time, vary or terminate any delegation, subject to confirmation by the Board at its next meeting.

A delegation cannot be exercised where the officer holding the delegation has a conflict of interest or where the delegation will directly or indirectly result in any tangible benefit to the delegate. In such cases, a transfer of the function to another appropriate position must be arranged by the Director.

Permanent changes to delegations, either permissive or restrictive, require written authority from the Director. The Board must approve any significant variation to the standard delegations.

This policy applies only to formal delegations. Delegations of an informal nature, where no commitment or liability is incurred on behalf of Strength In Care, are carried out in the normal business of the organisation without the requirement of written authority.

A staffing delegation can only be actioned by the delegate who holds management responsibility for the individual staff member. A staffing delegation example follows:

Position	Authority to ensure staff replacement	Authority to authorise contracts	Authority to access My Place	NDIS Compliance
Director	Yes	Yes	Yes	Yes
Financial Officer	No	No	Yes	Yes

Position	Corporate Governance - Quality, risks, complaints	Reporting and recording risks, complaints	HR Management	Work with participant	NDIS Compliance
Director	Yes	Yes	Yes	No	Yes
Supervisor	Yes	Yes	Yes	Yes	Yes
Support workers, including allied health	Yes	Yes	No	Yes	Yes

5.0 Related documents

- Delegation of Responsibility and Authority Form

- Corporate Governance Policy and Procedure
- Human Resource Management Policy and Procedure

6.0 References

- NDIS Quality Standards and Practice Indicators 2020

Drug and Alcohol Policy

1.0 Purpose

This policy's focus is to ensure that all employees are aware that drug use or possession and the consumption of alcohol or intoxication at the workplace will not be tolerated.

Strength In Care has a duty of care to ensure that the workplace is free from hazards and unnecessary risk. Staff have a responsibility to ensure the safety of:

- themselves,
- their fellow workers,
- participant,
- contractors and
- visitors.

The effects of alcohol and other drugs on a person's ability to work safely must be understood. The effect of a range of substances, including alcohol, cannabis, opiate analgesics, hallucinogens, volatile substances and stimulants, is detrimental to the safety standard. Prescription and over-the-counter medication may affect a person's ability to work safely, as can combining different drugs or mixing drugs with alcohol.

Our strategy is to ensure workplace hazards and risks associated with alcohol and other drugs are eliminated or reduced as far as practicable.

2.0 Scope

This policy applies to management, staff, contractors, volunteers and visitors. It will outline the disciplinary procedures, employee assistance programs and counselling services available to those employees who experience problems with drugs and alcohol.

3.0 Policy

Strength In Care is committed to providing a safe and healthy workplace. Alcohol and Drugs (whether used during private life or at the workplace) are factors that reduce a person's ability to work safely by impairing a person's ability to exercise judgement, coordination, motor control, concentration and alertness.

Staff and contractors under the influence of alcohol and or drugs become a workplace health and safety liability by increasing the risk of injury and illness to themselves and others. Staff and contractors must:

- not work while under the influence of alcohol, illegal drugs or drugs taken for non-medicinal purposes, which would affect their ability to perform their work safely and efficiently.
- report to work in a condition they are fit to perform their duties safely
- be taken home or not work when intoxicated - Strength In Care will arrange for transport
- monitor their alcohol consumption when representing the organisation or at an Strength In Care event. The Director may ask them to cease if they are unable to represent the organisation or are at any risk.

3.1 Possession and sale of alcohol

- Possession or distribution/sale of alcohol or illegal drugs during work hours or being under the influence of alcohol or drugs whilst working on behalf of Strength In Care will result in disciplinary action up to and including termination, depending on the severity of the incident.
- Provision of alcohol at Strength In Care events will be at the discretion of the management, considering the nature of the event, time and the likely number of attendees.
- The sale of alcohol is prohibited.
- A staff member or sub-contractor on the job for Strength In Care is involved in unauthorised possession or use of alcohol or under the influence of alcohol and will be subject to investigation. If the initial finding is substantiated, disciplinary action up to and including termination will apply.

3.2 Controlled substances and alcohol

A staff member on the job involved in the manufacture, distribution, dispensing, possession or used a controlled substance, or is under the influence of such, will be suspended from work immediately, pending further investigation.

3.3 Employee Responsibility

As employers, we are responsible for providing a safe workplace; staff work safely and within certain safety guidelines set out by our organisation and work health and safety legislative requirements. Staff must ensure that they do not jeopardise their safety, the safety of their colleagues or any visitors.

Staff use of drugs and alcohol impacts their ability to fulfil their work health and safety obligations. Staff under the influence will jeopardise their safety and the safety of all others in the workplace.

Failure to encompass the duty of responsibility by staff can impact their worker's compensation entitlements, state fines linked to Safe Work, or internal disciplinary procedures.

Staff members' responsibilities include:

1. Immediately and honestly reporting any accident and/or injury on the prescribed forms;
2. Visiting a medical practitioner if required to have accident symptoms recorded and treated;
3. Continuing to visit medical practitioner when and as required until a full or partial clearance has been given to return to work;

Compensation will not be paid if the employee:

- was under the influence of alcohol and drug addiction
- was not using protective clothing or equipment as required by the employer
- committed an act of serious or willful misconduct.

- false claims will be refused, and the employee may be liable for prosecution for fraud.

3.4 Employee Assistance Program

Our organisation will endeavour to offer assistance to any employee experiencing performance-related problems at work. Where appropriate, the Director will be available to discuss any difficulties a staff member is experiencing, which directly impact their ability to work efficiently and safely.

Where required, the Director may refer staff to the appropriate medical services or counselling services. In particular, performance issues related to drug and alcohol use will be referred to a medical centre for professional assistance.

3.5 Confidentiality

All procedures regarding drug and or alcohol counselling shall remain confidential between the staff and the management of Strength In Care unless the information is needed for workers' compensation purposes. Should the evidence of drug use by an employee be bought to the attention of Strength In Care by another employee, the evidence will be investigated further.

The accusation may require further staff questioning; however, no personal information shall be revealed to co-workers unnecessarily.

3.6 Safeguards for Medications

When a staff member's ability to work safely may be affected due to medication, the staff member should inform the Director or relevant managerial staff member of the effects of the medication. The staff member doesn't need to disclose the illness for which they are taking medication.

It may also be appropriate for the staff member to provide some means of verification as to the side effects of the medication, such as a medical certificate if medication is to be taken over an extended period.

If an employee can perform their usual work duties safely, an appropriate person should monitor their safety performance.

If staff cannot perform their usual work tasks safely, they should not be assigned those usual tasks. Where practicable, an employee should be given reasonable alternative work until consumption of the medication ceases.

When a staff member is:

(a) unable to complete usual work duties safely for an extended time, and

(b) there is no alternative work available for the staff member, and consultation between the staff member concerned and the Director will discuss steps that can be taken until the staff member can resume duties. The consultation process also needs to address transport issues away from the workplace, and staff should only recommence normal duties when they can work safely.

3.7 Third Persons at the workplace

Responding to a hazard presented by alcohol and other drugs may also include a situation where a third person enters the workplace affected by alcohol and other drugs. When this situation occurs, the employer and staff members must respond by minimising the risk of an impaired third-person presenting a hazard at the workplace.

4.0 Procedures

4.1 Dealing with an impaired third person

The procedures outlined below should be followed if a third person at the workplace appears to be impaired by alcohol and other drugs.

- Director should approach the impaired person (where applicable)
- if any other person identified the impaired person, they must immediately report the intoxication to the Director
- if the person is aggressive or appears unpredictable, the Director may request the assistance of more than one person for the initial approach. The initial approach should be quietly assertive and not aggressive, argumentative or threatening.

4.1.1 Dealing with substance-impaired persons in the workplace

1. avoid using terms such as *You're drunk*
2. be brief, firm and calm
3. advise the ${Manager Position)
4. Use the affected person's name, speak slowly and clearly and repeat your message if necessary (*I am instructing you to leave our premises. If you do not leave, I will contact the police*)
5. do not argue or debate; repeat your message;
6. try to persuade them not to drive their o vehicle.

4.1.2 Impaired Person Refuses to Cooperate

1. Ensure that the Director has been contacted;
2. Assess dangers;
3. Evacuate all surrounding people at risk from the location of the impaired person or isolate the impaired person;
4. Contact the police and advise them of your circumstances. If necessary, request police assistance to escort the person off the premises.

4.2 Disciplinary Procedures

4.2.1 Policy infringement

Strength In Care has a *no-tolerance* approach to the use of drugs and alcohol in the workplace. Our organisation will not tolerate the possession of or intoxication by drugs or alcohol at the workplace. Should an employee test positive for any illicit or contraband drugs or show a positive blood alcohol test, they will be seen by Strength In Care to be under the influence of intoxication.

Should an employee be shown to be under the influence, it will be viewed by Strength In Care as a direct infringement of this policy. Any infringement of this policy will result in disciplinary procedures against the staff member.

Disciplinary procedures may result in the termination of an employee from their position

4.2.2 Positive results

Staff will be counselled about their drug or alcohol abuse and whether they are prepared to undergo counselling, warn them of the dangers of being under the influence in the workplace and warn the staff member that further violation of our policy will result in dismissal.

5.0 Related Documents

- Human Resource Policy and Procedure

6.0 References

- Work Health and Safety Act 2011
- Safe Work Australian Act 2008

Non-Smoking Policy and Procedure

1.0 Purpose

Strength In Care aim is to improve health by creating a culture that reduces exposure to tobacco and other smoking products and secondhand smoke, supports smokers to quit and discourages people from taking up the habit.

Each state has smoking bans where people spend time with family and friends or part of every day.

Under the smoking laws, it is an offence to smoke:

- in an enclosed workplace (with limited exceptions)
- at patrolled beaches
- at outdoor areas of public swimming pools
- at and within 5 metres of public transport waiting points such as bus stops, taxi ranks
- at and within 10 metres of outdoor children's playground equipment and outdoor skate-parks
- at outdoor sporting venues during organised underage sporting events and training sessions
- in cars carrying children at underage functions at train stations (including platforms)
- on public transport
- at outdoor pedestrian malls
- on school grounds
- within prisons and anywhere on prison grounds
- in eating and drinking establishments
- on the grounds of, and at and within four metres of an entrance to, all childcare centres, kindergartens or preschools, and primary and secondary schools (including public and private schools)

- at government precincts (including buildings such as Parliament, courts, public service bodies and various hospitals and health services).)

2.0 Scope

This policy applies universally to all staff, participants, volunteers, visitors and contractors.

3.0 Definitions

Term	Description
Passive smoking	Passive smoking inhales second-hand tobacco smoke, a combination of side-stream smoke from a burning cigarette and mainstream smoke exhaled by a smoker.
Smoke	Smoke means to smoke, hold, or otherwise have control over an ignited tobacco product
Smoke-free	Smoke-free means that no smoking is permitted
Smoking products	Smoking products can include tobacco products, herbal cigarettes, loose smoking blends, personal vaporisers (electronic or e-cigarettes, e-cigars, vape pens), personal vaporiser-related products (e-liquids and e-cigarette parts), and smoking-related products or packages or cartons of these items.

4.0 Policy Statement

Strength In Care recognises the health risk to non-smokers who are in contact with second-hand smoke. Smoking is prohibited on our premises, in company vehicles used and in private vehicles if a resident is transported. This policy applies to staff, contractors, participants, and others.

Participants are not able to smoke:

- in a car where staff are present
- at their home when staff are present

Staff must not smoke:

- in the participant's environment (e.g., home, car, outings and activities)
- before entering a participant's environment
- during outings with the participant
- with the participant (including with their permission)

This smoke-free policy will not infringe upon smokers' rights, and it does not ban cigarettes but limits their use in certain areas.

5.0 Procedures

During the initial participant assessment, the designated staff member will explain to the prospective participant that they are not to smoke whilst staff provide a service to them

- Staff who find that the participants are smoking whilst with them should inform their supervisor.
- Supervisors will contact the participant and remind them of their safe obligations to the staff member.
- Staff are to notify the Director if they feel participants may be at risk of burning themselves or their home. (e.g., falling asleep with a cigarette, etc.)
- Staff must not smell second-hand smoke upon the arrival of their shift. Participants have the right to complain if this occurs. Management will contact the staff member to discuss the issue and advise them not to smoke before the commencement of the shift. Director may escalate this discussion if the staff member continues to smell smoke before supporting participants (refer to Human Resource Management Policy and Procedure).
- Staff must not smoke during their work with the participant, including transporting, visiting community sites, shopping and any outside activity.

6.0 Related Documents

- Participant Handbook
- Staff Handbook
- Human Resource Management Policy and Procedure

7.0 References

- Work Health and Safety Act 2011
- Safework Australia
- Going Smokefree – A guide to workplaces.

Workplace Aggression and Violence Policy

1.0 Purpose

Strength In Care is committed to preventing or minimising risk relating to acts of aggression and violence from/to participants, staff, volunteers and others. As such, Strength In Care will not accept anyone into the organisation who displays signs of aggressive or violent behaviour.

2.0 Scope

The policy applies to all staff, management, participants and others.

3.0 Definitions

Term	Description
Aggression:	A tendency toward unprovoked offensives; quarrelsome or belligerent
Violence	Physical attack on an individual or property by another individual or group
Violent acts	For example: • threats of violence; • threats of a sexu.al nature; • emotional abuse; • verbal abuse, in person or over the phone; • "ganging up" on an individual by a group.

4.0 Responsibility

- Management is responsible for ensuring policies, procedures, and systems are in place to prevent or reduce the risk of aggression/violence.
- The Director is responsible for taking all practical measures to ensure that the organisational workplace is safe from the risk of aggression/violence and must take prompt remedial action to eliminate aggressive/violent behaviour. Measures taken should include:
  - identifying, assessing and controlling risks of aggression/violence
  - regular consultation with staff and volunteers to review and monitor procedures to ensure effectiveness
  - the provision of adequate resources to effectively implement control measures and prevention
  - the provision of adequate and appropriate post-incident support for participants, staff, volunteers and others
  - training staff and volunteers to develop the ability to anticipate and manage critical or violent incidents.
- All staff and volunteers must cooperate with this policy to ensure health and safety.
- Staff and volunteers are to report all aggressive/violent incidents to the Director who will, in turn, inform the management.

5.0 Procedure

5.1 Participant assessment and conduct

The Director is required to minimise aggression/violence risks by letting participants know what is expected. Staff involved in the participant's initial assessment must be appropriately trained and are required to:

1. Verify all information received during the initial interview before accepting the participant into the organisation.
2. Make eligibility criteria clear to participants, including providing information that participants who display aggressive or violent behaviour will be excluded from Strength In Care services.

3. Make the code of behaviour for participants clear, i.e. verbalise the required code of behaviour, which includes:
   - participants should act in a manner that respects the rights of other participants, staff, volunteers, and persons outside the organisation
   - participants to play their part in helping the organisation provide everyone with safe services.
4. Outline the consequences of failure to comply with the required code of behaviour (i.e. possible exclusion from Strength In Care services).
5. Inform participants they have a right to be protected from harm or abuse by other participants, staff, volunteers and persons outside the organisation. That action will be taken if this occurs.
6. Refer participants who need psychiatric treatment, detoxification and drug and alcohol rehabilitation to other services as appropriate.

5.2 General Procedures

5.2.1 Controlling violence:

Control procedures should be put in place whenever risks of violence are identified and assessed. Violence control measures should be:

- a part of standard workplace procedures and designs
- implemented following a review of a violent incident.

5.2.2 Staff and volunteers:

On commencement of service, staff and volunteers must have explained that the organisation will not tolerate aggressive or violent behaviour. Any evidence of this type of behaviour from any participant, carer, staff or volunteer will result in appropriate action being taken with every possibility of them being requested to leave.

Volunteers who feel threatened should, if at all possible, remove themselves from the situation immediately and notify the relevant supervisor. If this is not possible, they must

notify the police immediately and let them handle the situation. Volunteers should not put themselves in danger.

5.2.3 Identifying and assessing the potential for aggression/violence:

The Director should attempt to identify where aggression/violence may occur and the impact it could have. To achieve this, they need to carry out the following on an annual basis:

- consultation with other staff and volunteers;
- review of previous Incident Reports where violence was involved.

The organisation must keep records of all Incident Reports to assess the potential for aggression/violence. Any aggressive/violent incident (actual or implied) should be checked against previous incidents to establish a trend.

5.2.4 Initial assessment interview/home visits:

Before the initial assessment is conducted in a person's home, as much information as possible regarding their potential for aggressive/violent behaviour should be obtained. In the event where an individual has potential for aggressive or violent behaviour, then one of two decisions must be made:

a) the individual will be refused service based on the information already received;

   OR

b) an assessment will be conducted to verify the information conducted with two staff and the following procedures strictly adhered to:
   - inform an appropriate person, the address of where they are going and expected arrival and return times. An appropriate person is someone who is:
     - available during all working hours;
     - able to monitor departure and return times; and

    - able to respond appropriately if the employee does not meet those expected times.
- Staff must carry a charged mobile phone.
- On arrival at a participant's home or at a place that the staff is unfamiliar with, they should look around to establish exit points and any potential dangers. There should be two exits from rooms where visits or interviews are being conducted if at all possible.
- If staff feel concerned for their welfare, they should cease what they are doing and immediately leave the premises.
- If there has been a serious threat, call the police and let them handle the situation. Staff/volunteers, under no circumstances, are to put themselves in danger.
- Staff must be contacted if the expected return time is exceeded and set a new return time.
- If the employee is more than half an hour late and cannot be contacted, the police should be notified immediately.

5.3 Post-incident procedures

5.3.1 Minor aggression:

Following a minor incident such as a verbal attack;

- The Director is to be alerted immediately.
- The Incident Form must be completed.
- The parties involved are to be individually interviewed by the Director.
- Any staff or volunteer involved should be disciplined as appropriate.
- Participants will be advised of the consequence of their actions (i.e. possible withdrawal of services).

5.3.2 Major aggression/violence:

Following a major aggressive/violent incident, particularly where physical harm has occurred, the following procedure must be followed:

- immediately call the police, and if necessary, the ambulance service
- alert the Director without delay
- provide first aid and comfort to those who are injured/traumatised
- leave the scene undisturbed for the police
- request witnesses to remain until the police arrive, and if this is not possible, obtain their names and contact phone numbers,
- document everything that has occurred on the Incident Form
- provide critical incident stress debriefing and give relief from duties for Staff/ volunteers involved
- reportable incidents must be reported as per Reportable Incident, Accident and Emergency Policy and Procedure
- An investigation must be carried out (see Reportable Incident, Accident and Emergency Policy and Procedure
- The family of participants, staff and volunteers are contacted by the Director

5.4 General guidelines for dealing with aggression/violence

Staff and volunteers will receive training on how to recognise the possibility of aggression/violence occurring and how to respond in the event of verbal and physical attacks. No employee or volunteer is expected to physically defend themselves against a violent physical attack, although they can use a reasonable level of force to protect themselves.

5.4.1 Verbal threats

Volunteers who are being verbally attacked should leave the situation immediately and contact the relevant Director. Staff who are verbally attacked should:

- assess the emotional/mental state of the participant (i.e. frustrated, disturbed, under the influence of drugs or alcohol);

- try to accommodate their needs;
- use assertive, non-aggressive language;
- assess the potential for the situation to become physically violent;
- seek the presence of another employee/volunteer if at all possible;

5.4.2 Physical violence

When confronted with physical violence:

- **Do not attempt to physically stop the person** by stepping in between them and the person/property they are attacking.
- **Do not attempt to restrain anyone** unless it is a life-threatening situation and there are no other options.
- **Calmly try to reason** with anyone attacking others
- or property and ask them to stop.
- Ensure that you use **soothing words** and body language and **speak quietly but firmly**.
- If all attempts to diffuse the violence have failed and there is a real threat of physical harm or lives at risk, ***LEAVE IMMEDIATELY AND CALL THE POLICE.***
- Contact the Director.

5.4.3 Post Traumatic Stress

Participants, carers, staff and volunteers will be offered counselling following a violent incident. Senior Management should be trained in recognising signs of post-traumatic stress syndrome.

5.4.4 Training

All staff and volunteers will be required to attend appropriate training in dealing with aggressive behaviour or violent situations.

6.0 Related Documents

- Incident Report
- Incident Investigation Form
- Work Health and Safety Policy and Procedure
- Human Resource Management Policy and Procedure
- Reportable Incident Accident and Emergency Policy and Procedure

7.0 References

- Work Health and Safety Act 2011
- NDIS (Reportable Incident Management) Rules 2018

Dress Code Policy

1.0 Purpose

Strength In Care requires that staff, volunteers and subcontractors dress neatly and appropriately at all times and that they maintain adequate personal hygiene. This policy has been developed to guide staff on our work dress standard requirements. Every staff member must follow our professional standards and appear well-groomed, clean and tidy.

2.0 Scope

This dress code applies to all staff, volunteers and contractors whenever they represent our organisation in the workplace or elsewhere.

3.0 Policy

Staff are required to maintain a professional appearance and adhere to safety standards, including:

- Being appropriately attired, tidy and neat in appearance.
- Always wear footwear:
    - appropriate for their role
    - in good repair, and
    - clean.
- Identification must be visible and worn at all times.
- Wearing personal protective clothing as provided where work health and safety is an issue.
- All clothing should be clean, ironed and in good shape. Desist from opting for clothes that display discernible tears, rips or holes, even if it is the current fashion.
- Staff should maintain an acceptable level of bodily hygiene to ensure that interactions with participants and other staff remain positive and pleasant.
- Work clothes should be professional and should not be too revealing or casual.

- Staff may wear jewellery, but we urge that staff, please remove visible body piercings during work hours (see 3.8 Jewellery below)
- All clothing should be clean, comfortable and non-restrictive to allow freedom of movement. The examples below guide staff, volunteers and contractors on our dress code.

3.1 Female example

- Shirt – collar and short-sleeved
- Pants - dress shorts, ¾ length pants or long pants (no jeans)
- Jacket, windcheater or cardigan.
- In summer, dress shorts to the knee are acceptable.
- Footwear
    - enclosed
    - lace-up or slip-on
    - non-slip soles.

3.2 Male example

- Shirt – collar and short-sleeved
- Pants - slacks, trousers, or dress shorts (no jeans)
- Footwear
    - enclosed
    - lace-up or slip-on
    - non-slip soles.

3.3 Inappropriate clothing examples

The following items specifically are not to be worn:

- Track pants
- Jeans (of any colour)

- Bike pants
- Hipster pants
- Sportswear
- Sleeveless tops or singlets
- Short, tight skirts or dresses
- Thongs
- Gumboots
- Crocs

3.4 Footwear

We aim to meet our work health and safety obligations and protect our staff. Footwear must be professional appropriate, incorporate a non-slip sole, and be fully enclosed. In some roles, ankle protection may be required. Check with the Director if unsure.

Staf must **never** wear open-toed, sling-back shoes, thongs, gumboots or crocs.

3.5 Personal Hygiene/Grooming Overview

Due to the nature of our work with vulnerable participants, high hygiene standards are expected. Staff, volunteers and contractors are to be made aware of poor hygiene's negative impact on our participants, particularly offensive odours including stale cigarette smoke and strong perfumes. Staff must not smoke near or before working with participants to prevent offensive odours.

3.6 Make-up

Staff must keep make-up to a minimum and be applied neatly.

3.6 Hair

- Hair must always be clean
- Long hair must be tied back off the face if it reaches below collar length.
- Long loose hair is considered a hazard as it can be caught in machinery or pulled by participants.

3.7 Nails

- Nails are to be kept short and clean to avoid:
    - Scratching or damaging participants
    - Bacteria gathering and potentially spreading
- Clear nail varnish is permitted.
- Remove chipped nail polish as this could be a health risk.

3.8 Jewellery

For staff, volunteers or contractors working directly with participants, minimal jewellery should be worn; if possible, remove all jewellery whilst at work.

Jewellery is to be minimal and not interfere with any tasks of the role. Some jewellery may cause damage to a participant, such as scratching or tearing their skill. Participants may accidentally pull at necklaces and earrings, causing staff skin and tissue damage.

Non approved jewellery

- Dangling earrings or other sharp jewellery
- Body piercing jewellery must be removed when in attendance at work or covered.
- Necklaces are to be tucked away inside blouses/shirts.

The Director determines the acceptability of jewellery and has the right to enforce the removal of any jewellery during work hours based on safety, acceptable appearance and clear communication.

2.8 Continuity of Supports

Continuity of Supports Policy and Procedure

1.0 Purpose

Continuity management is an integral part of our organisation's operating plans, risk management and decision-making. Continuity of care to our participants falls within this remit. Continuity of care planning contributes to improved quality and safety of care, increases the satisfaction of the participant, staff and our organisation, and maximises the use of resources to provide the appropriate level of care and access.

The participant's NDIS Plan incorporates reasonable and necessary supports. Any informal supports already available to the individual, i.e. informal arrangements that are part of family life or natural connections with friends and community services and other formal supports, such as health and education. Strength In Care will ensure that the participant has consistent supports or services to allow them to undertake daily activities and supports to maintain their life choices.

2.0 Scope

This policy applies to Strength In Care staff managing and working with participants.

3.0 Policy

The Director will arrange schedules to ensure that participants know who will be attending to their needs and supports. The Director will pair a participant with a worker who holds appropriate skills and knowledge. Our participant requests are matched with their preferred staff wherever possible. Examples of meeting a participant's wishes may

include accessing a staff who speaks the participant's first language, shares the same cultural background or meets specific criteria that have been requested.

Staff will be placed with participants whose locations are close to their homes (where possible) to reduce travel time and increase staff satisfaction and retention.

Continuous support will be planned by allocating a consistent staff to a participant. All supports and strategies are recorded in the participant's plan. The staff will use them when supporting a participant's preferences and needs (see Responsive Support Provision and Support Management Policy and Procedure).

In the case of an Emergency or Disaster, staff should refer to the Personal Emergency Preparation Plan for strategies and relevant information. This document is reviewed during any emergency or disaster and will provide the relevant information, and staff should contact management if unsure.

4.0 Procedure

To ensure participants have timely and appropriate support, without interruption, Strength In Care's staff will:

- access, read and comply with the participant's plan, including the Personal Emergency Preparation Plan
- review strategies listed in the support plan before the provision of support
- provide quality services as per the participant's plan
- document all the participant's preferences and needs to allow for a consistent care approach
- list all appointments and tasks related to the participant's needs
- allow allocation according to a participant's requirements
- inform the Director of any absences in advance to allow time to allocate a replacement who meets the participant's criteria and, preferably, is known to the participant

- contact participants if there are any changes, or potential changes, in their care
- undertake emergency procedures, as required.

No appointments are ever double booked. When travelling to participants' homes, our staff factor in enough travel time and must ensure the correct arrival time.

4.1 Disruptions and changes

Strength In Care notifies participants when an unavoidable interruption occurs. The staff will attempt to inform the participants, via telephone and email, before any unavoidable disruptions to services or participant appointments. When it is impossible to contact the participant, they will be briefed on arrival at the next meeting or scheduled service.

The Director will contact a participant to:

- inform and explain that there is an unavoidable change
- seek the participant's agreement and ensure that they are entirely aware of any changes
- explain, in detail, alternative arrangements.
- ask the participant if they agree with the proposed arrangement
- participant to confirm their agreement or refuse the alternative arrangement
- record details of agreed arrangement or non-agreement in the participant's records
- confirm that the delivered services were appropriate to their needs, preference and goals

In the case of an emergency, when a worker cannot attend work due to circumstances out of their control (e.g. illness or family emergency), Strength In Care will attempt to place a worker who is known to the participant. However, if this is not possible, we will send the best match available to the participant. Strength In Care will contact the participant and advise them of the situation and provide details of the replacement worker.

4.2 Absence or vacancy

When a staff member is absent, or a vacancy becomes available, then the Director will:

- contact a staff who is a suitable replacement (e.g. a person with the relevant qualifications or language requirements)
- provide, where possible, a staff who has worked with the participant previously and is aware of the participant's preferences and needs
- select an appropriate replacement worker who will be sensitive to the participant's requirements, ensuring care is consistent with the participant's expressed preferences
- inform the participant of the replacement's details, where possible
- upon completion of the service, gather feedback from the participant on the replacement staff member.

A staff who is unable to work is required to contact the Director. If there is an intended absence (e.g. vacation or appointment), then the staff member must inform the Director at the earliest opportunity to allow time to prepare the participant.

4.3 Service agreement

Strength In Care ensures arrangements are in place so that support is provided to the participant, without interruption, throughout their service agreement. These arrangements are relevant and proportionate to the support scope and complexity.

4.4 Critical supports

Contingency plans are drawn up and adhered to, allowing for the participant's continuity of care throughout their time with us. In a disaster, planning will incorporate strategies that enable continual support before, during, and after the disaster. Critical planning will be undertaken for participants who have complex needs.

5.0 Related documents

- Support Plan
- Service Agreement
- Contingency Disaster Plan Template
- Access to Supports Policy and Procedure
- Responsive Support Provision and Management Policy and Procedure

6.0 References

- NDIS 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021

Telehealth Policy

1.0 Purpose

In the Australian healthcare setting, Telehealth can be defined as videoconferencing technologies to conduct a consultation where audio and visual information is exchanged in real-time. Telehealth can be conducted between a Strength In Care clinician and a participant in a supported or unsupported format.

2.0 Scope

Strength In Care clinicians will review participants, then only undertake telehealth consultation with participants who can participate in a videoconference to ensure appropriate provision of support and access.

3.0 Policy

This policy has been designed to allow Strength In Care to meet the needs, interests and goals of our participants during natural disasters, pandemics, or when specific circumstances warrant this approach. During events of this type, changes and adjustments to our service providers may occur, requiring adapting current practices to meet government or participant requirements.

In the overall participant management, the role of telehealth is determined by the clinician and other relevant providers. The implementation of telehealth will depend on the clinician's specialty and the participant's requirements and location. Clinicians should be mindful of the limitations of telehealth and communicate these limitations to all video conference participants.

3.1 Participant selection

Clinicians should determine which participants are suitable for telehealth based on available resources, technology and care requirements. Strength In Care will determine whether a telehealth consultation is the most appropriate type of consultation for each participant. The decision to use telehealth incorporates the following factors:

- **Clinical:** Continuity of support and the best support model for the individual.
- **Practical:** Availability of appropriate technology and participant-end support. The quality of the technology at a remote site will play a significant role in the information received during the clinical consultation.
- **Participant needs:** Ability to travel, and consideration will be given to their family, work and cultural situation. Clinicians should also consider the participant's participation capacity (e.g. a video consultation may be inappropriate for participants with vision or hearing impairments).

3.2 Before a telehealth consultation

The clinician will advise the participant on how the consultation will proceed by:

- providing the participant with plain language information about telehealth
- informing the participant of the other available support options (if available)
- informing the participant of any charges for telehealth consultations in comparison to other available options
- indicating the length of the telehealth consultation.

Clinicians will ensure that the participant has been given adequate information regarding the telehealth consultation. They will liaise with the participant-end worker to ensure the participant is sufficiently informed.

3.3. Seeking participant consent

Strength In Care clinicians should be satisfied that participants have consented to participate in the telehealth consultation.

In cases where the participant is not competent and cannot provide consent, consent should be obtained from an advocate in the same way as for a face-to-face consultation, using a Telehealth Consent Form. The clinician will arrange for a Telehealth Consent Form to provide the advocate with the requisite legal authority (e.g. enduring guardianship) to consent on the participant's behalf.

While it is not Strength In Care's standard practice to record a video conference, on occasion, the participant will record the telehealth consult; therefore, their consent applies to this recording. Where a recording is made by Strength In Care for assessment purposes, the participant will be informed before any recording occurs. The participant must provide verbal approval to record the consultation and agree to the planned use of the recording at the start of the telehealth consultation.

3.4 Consultation

Telehealth is no different from any other type of consultation and should be conducted similarly to a face-to-face consultation. A telehealth consultation of high quality is one in which the participant has a voice, screens are shared, and listed supports action. Active listening is undertaken as per current best practice models.

A support worker is present with the participant for some video consultations in supported consultations. The support worker should confirm their identity and that of the participant to the clinician.

For unsupported consultations, the participant may be alone or elect to have a family member present. For the first unsupported consultation, the clinician and participant introduce themselves, and the clinician provides some background information, including their credentials and experience.

3.5 Privacy and confidentiality

Telehealth consultations should be private and confidential. Clinicians should have processes to facilitate this as per standard face-to-face consultations. The participant's privacy and confidentiality should always be maintained.

Strength In Care reviews privacy and confidentiality risks associated with telehealth consultations and develops procedures to mitigate such risks, which include, but are not limited to:

- implementing an appropriate system to prevent interruptions during a consultation (at both clinician and participant end)
- requesting that participants join a telehealth consultation in a quiet room where they will not be interrupted
- alerting other staff that a telehealth consultation is being conducted and requesting not to be disturbed
- storing all recorded telehealth conversations securely, so the participant's privacy and confidentiality are maintained
- selecting telehealth video conferencing technology (hardware and software) that offers appropriate security features
- storing all reports provided for, or generated from, the telehealth consultation securely online with password access
- informing the participant if there is a valid and clinically appropriate reason for recording a consultation and requesting and receiving their verbal consent.

3.6 Technology

3.6.1 Basic requirement of telehealth

- The basic requirement of telehealth is the transfer of audio and visual data in real-time between the clinician and the patient.
- Only specific telehealth technology (hardware and software) appropriate for participants will conduct telehealth consultations.

- Encryption, ease of use, and access are considered part of the software selection (e.g. Zoom has encryption storage capacity and is accessible from home computers and tablets).

3.6.2 Adequate performance

The information and communications technology used for telehealth should fit the consultation's clinical purpose. Specifically:

- the equipment is reliable and works well over the locally available internet network and bandwidth
- the equipment is compatible with the technology used by the patient-end health worker
- the equipment and the network are secure, so privacy and confidentiality are assured during the consultation
- the equipment is of a high enough quality to facilitate clear communication with all participants and transfer accurate clinical information.

3.6.3 Risk management

Strength In Care will conduct a risk analysis to determine the likelihood and magnitude of foreseeable problems using telehealth consultations. The analysis will include:

- identifying the limitations of technology being used
- developing procedures for detecting, diagnosing and repairing equipment and repairing connectivity issues
- availability of equipment and connections
- software support services are available.

Table 1. Possible risk management strategies

Issue	Strategy

Computer breakdown	• Contact technician to repair • Purchase a new computer • Have a spare computer available
Privacy and confidentiality	• Consent in writing • Verbal consent at the beginning of each consultation • The encrypted video is kept in the participant's file • Secure encrypted server
Internet failure	• Phone participant • Reschedule
Encrypted end-to-end software	• Locate encrypted software • Determine if accessible via participant systems • Inform participant of any breach
Zoom	• Encrypted storage • Review for end-to-end encryption (currently being developed) • Use of waiting room

4.0 Related documents

- Telehealth Consent Form
- Privacy and Confidentiality Policy and Procedure
- Risk Management Policy and Procedure

5.0 References

- NDIS Practice Standards and Quality Indicators 2021
- NDIS Act 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Australian Privacy Principles (Commonwealth)

Business Continuity Policy and Procedure

1.0 Purpose and scope

Our organisation is focused on meeting regulatory compliance, achieving best practice standards and providing continuous quality supports to our participants.

We continuously work towards building our organisation's resilience and business capability to effectively manage change (e.g. legislative, emergencies) to ensure continuity of service.

Our organisation plans to ensure the business can:

- manage crises effectively (within our control)
- provide service and business continuity to participants
- provide reassurance to staff and participants during times of uncertainty
- implement our review and compliance structures and policy and procedures.

We will develop strategies to examine the risks and methodology of the business and implement changes required to address the risks identified.

2.0 Procedure

Our organisation acknowledges that our staff and key personnel are essential to providing support and business continuity. Our business is not reliant on a small group of individuals to provide service provision.

If key personnel are unable to fulfil their duties, the business will still operate using workers who have the appropriate skills and experience to meet the needs of our participants. These workers may include:

- staff trained to undertake the role of others in their absence
- staff who are mentored and trained to increase their skills and knowledge

- agency staff who we employ when required
- regular casual staff.

Also, we will conduct appropriate risk assessments to mitigate risk and understand priorities for risk management actions. We will identify strategic priorities and assist in preparing for effective recovery after an emergency or disaster. We will monitor and comply with government directives and keep our participants and staff informed. All records and plans will be kept updated to ensure the information available is precise and current.

Our organisation engages with all key stakeholders to ensure we receive diverse input to inform our business plan, policies and procedures, which may include, but not be limited to, working with community members, participants, other service providers, IT professionals, health professionals, government bodies and staff

We have a policy and procedure review structure in place that is linked to our organisational risk management practices. With government legislation continually changing, we will, on an ongoing basis, implement changes required to the actions of our business and our employees.

The Director will determine if there is a threat to the business and the way that it currently functions, which may require an analysis of current work practices, a review of our services and price structures in comparison to our competitors.

3.0 Crisis management

Information obtained from various sources will be used to determine if our business model is appropriate. Our organisation will review our crisis management processes and implement appropriate and necessary structures to address emergencies and natural disasters, including ensuring that computer data is securely backed up regularly to ensure that all data is recoverable if the system crashes.

We will ensure the following documents are regularly updated to provide current information to staff in the event of an emergency:

- participant support plans
- emergency plans, including Personal Emergency Preparation Plan
- contact details
- medication lists
- critical supplies
- critical suppliers.

In the case of an emergency, we will implement the Emergency and Disaster Management Policy.

3.1 Training

Training of staff and management is essential to business continuity. The Director will advise staff and participants of all training requirements, e.g. scenario training to inform staff of possible emergencies and the relevant procedures to follow.

3.2 Reviews and updates

We will use their risk management and continuous improvement policies and procedures to review current practices and determine an improvement plan. Improvements are likely, to ensure that our business continues to grow and develop. Our organisation will use all appropriate data to determine threats or risks to the business, staff, and participants.

Implementing best-practice standards is the key to ensuring that the business moves forward with positive outcomes. Our staff will be trained to ensure that they are knowledgeable and professional, and staff will be kept up to date with any required changes to the service.

We will ensure that all required business insurances are current and our government regulatory requirements are met.

4.0 Related documents

- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Internal Audit Schedule
- Continuous Improvement Policy and Procedure
- Continuous Improvement Register
- Continuous Improvement Plan
- Human Resource Management Policy and Procedure
- Business Plan and Strategy Plan
- Staff Training Record
- Staff Training Plan
- Contingency Disaster Plan Template

5.0 References

- NDIS Act 2013 (Commonwealth)

2.9 Emergency and Disaster

Emergency and Disaster Management Policy and Procedure

1.0 Purpose

The purpose of the Emergency and Disaster Management Policy and Procedure is so our participants feel safe in the event of a disaster (natural or pandemic); knowing Strength In Care will provide them with continuity of service. Strength In Care focuses on maintaining service delivery to our participants in times of stress and uncertainty.

Though disasters and emergencies may be infrequent, we acknowledge our services are especially important before, during, and after such events, as many participants are beyond the reach of other services, and Strength In Care provides them with an essential support lifeline.

Strength In Care recognises that preparedness for disasters and emergencies is a priority for our organisation and a requirement to ensure the safety of our participants.

Strength In Care will endeavour to provide an adequate level of service to our participants before, during and after all types of emergencies.

2.0 Scope

The scope of this policy includes our participants and staff. Our participants will be informed of our emergency procedures to assist them in preparing for an emergency, building their resilience, and maintaining their confidence in Strength In Care.

Our staff will be well informed and prepared to assist participants in coping in an emergency within the community and in strengthening Strength In Care's disaster resilience.

3.0 Policy

Strength In Care places the safety and care of our participants at the forefront of our operational procedures. During a disaster, our team will adhere to this policy framework and work within any additional guidelines and instructions provided by state and federal government authorities to our organisation.

During any disaster, our senior management will undertake the following actions:

1. Follow all relevant government guidelines and instructions.
2. Review continuity of support plans and ensure the safety, health, and wellbeing of each participant – **before**, **during** and **after** an emergency or disaster.
3. Communicate Strength In Care's response to staff, participants and any other relevant parties.
4. Prepare participants (before any possible actions are taken) by informing them how the current situation may affect their services.
5. Brief our entire staff on any possible or real action steps required by them.
6. Attempt to keep key workers allocated to the same participants.
7. Work towards maintaining continuity of support for each of our participants.

4.0 Procedure

4.1 Preparing for disasters and emergencies

A disaster is any phenomenon, natural or human-made, that has the potential to cause extensive destruction of life and property. An emergency is a grave risk to health, life or the environment. The mere mention of either of these two words makes the community, particularly our participants, extremely nervous. The key to being ready for any disaster is

having all parties know and understand the plan. Our organisation management will consult with participants and support networks, and staff to periodically review plans so their management is relevant to the current situation.

Some disasters and emergencies Strength In Care may face include:

- flood
- fire
- heatwave
- snowstorm
- storms or cyclones
- pandemic.

Strength In Care will:

- consult with participants to create a Personal Emergency Preparation incorporating all aspects - before, during and after any emergency and disaster
- stay informed regarding all state/territory and federal government directives and act upon these directives appropriately
- advise other organisations who work with Strength In Care of our disaster procedures and processes
- communicate with participants and relevant networks in a manner determined in the support plan
- identify personnel who are critical in the delivery of essential frontline services
- identify Strength In Care participants and their stakeholders, whose services may be impacted by the situation
- train staff in the implementation of any strategies
- implement this policy in conjunction with our Risk Management Policy and Procedure, our Information Management Policy and Procedure and our Human Resource Policy and Procedure
- ensure Personal Emergency Preparation Plan explain and guide how the organisation will respond to and oversee the response to an emergency or disaster

- develop Personal Emergency Preparation Plan through consulting with participants and their support networks to create plans for preparing for and responding to disasters that may include
    - making changes to participant supports
    - adapting, and rapidly responding to changes to participant supports and other interruptions
    - communicating changes to participant supports to workers and participants and their support networks.
    - informing participant and their support network in the manner set out in their plan
    - exit strategies (e.g. disaster)
    - continuity of supports, including potential staff replacements and options (e.g. disaster or emergency)
    - supports during emergency or disaster
    - actions to be taken by staff
    - actions to be taken by management
- implement the Personal Emergency Preparation Plan as per the consultation if required
- attach any Personal Emergency Preparation Plan on the service agreement and add them to the participant's file.
- Test and adjust the Personal Emergency Preparation Plan in the context of a particular disaster by:
    - undertaking a trial run of the Personal Emergency Preparation Plan, where the plan will be:
        - acted out
        - reviewed with participants, networks and staff
        - adjusted to meet the needs, preferences and goals of the participant
        - documented strategies in the plan made, and staff informed
    - reviewing each plan when a potential disaster is evident (e.g. fire, pandemic)

- adjusting plan due to changes in circumstances
- ensuring continuity of supports is in place
- communicating with the participant and support networks in a manner that allows for an understanding of what will occur before, during and after the emergency or disaster

- review the Personal Emergency Preparation Plan in consultation with the participant and relevant support networks during the annual risk assessment of the support plan review to enable adjustments due to the changing nature of any disaster or emergency
- gain oversight of participants' plans during management meetings to gain a whole of organisation strategy.

4.2. Supporting the supporters

Vicarious trauma is a real and grave health concern for staff and volunteers of community service organisations such as ours, mainly when working with disaster-affected individuals and communities.

Our Strength In Care will determine the best means to support our staff in a disaster situation and will implement all appropriate measures as detailed in our Human Resource Management Policy and Procedure.

4.3 Consumer preparedness

Strength In Care understands that it is more likely that our participants will be adversely impacted by an emergency or disaster than others in the community.

We acknowledge that we may not provide the same level of service to our participants during or immediately after an emergency or disaster situation. All participants must be supported by Strength In Care to prepare for changes due to a disaster or an emergency.

Strength In Care will:

- inform participants of the current situation and how the provision of their services and workers may be impacted
- Consult with participants and support networks on the plan's development and any adjustments or changes in circumstances. Always ensuring that they are informed of what will occur before, during and after any disaster or emergency.
- continue to provide participants with the same key workers if they are available
- replace key workers with experienced workers who have the knowledge and skills to provide appropriate care to the participant
- inform the participant of any service changes and outline the reason/s for these changes
- communicate with participants to ensure that their needs, preferences and goals are met
- seek support within the local care community if our staff are unavailable, and ensure that any new workers are appropriately experienced, trained and hold all relevant checks required.

4.4 Staff preparedness

Our team is our greatest asset; our focus is that they and their loved ones remain safe during an emergency or disaster.

Strength In Care will help prepare our staff for an emergency or disaster by implementing the following:

- inform staff of the situation and what is required by them via email, online messaging, Zoom meetings or similar
- train workers in all required measures and strategies identified in the plan, e.g. infection control, social distancing and evacuation
- seek feedback from participants regarding their services to adjust information distribution, if necessary

- seek feedback from staff about actions undertaken, any issues or concerns, and what worked well.
- inform staff of our participant's requirements outlined in their support plan
- test each plan to ensure that it will function before implementation
- adjust the plan accordingly
- inform management of the changes to plans to allow for organisational management adjustments.

5.0 Related documents

- Contingency Emergency and Disaster Plan Template
- Business Continuity Policy and Procedure
- Risk Management Policy and Procedure
- Information Management Policy and Procedure
- Human Resources Management Policy and Procedure
- Work Health and Environmental Policy and Procedure

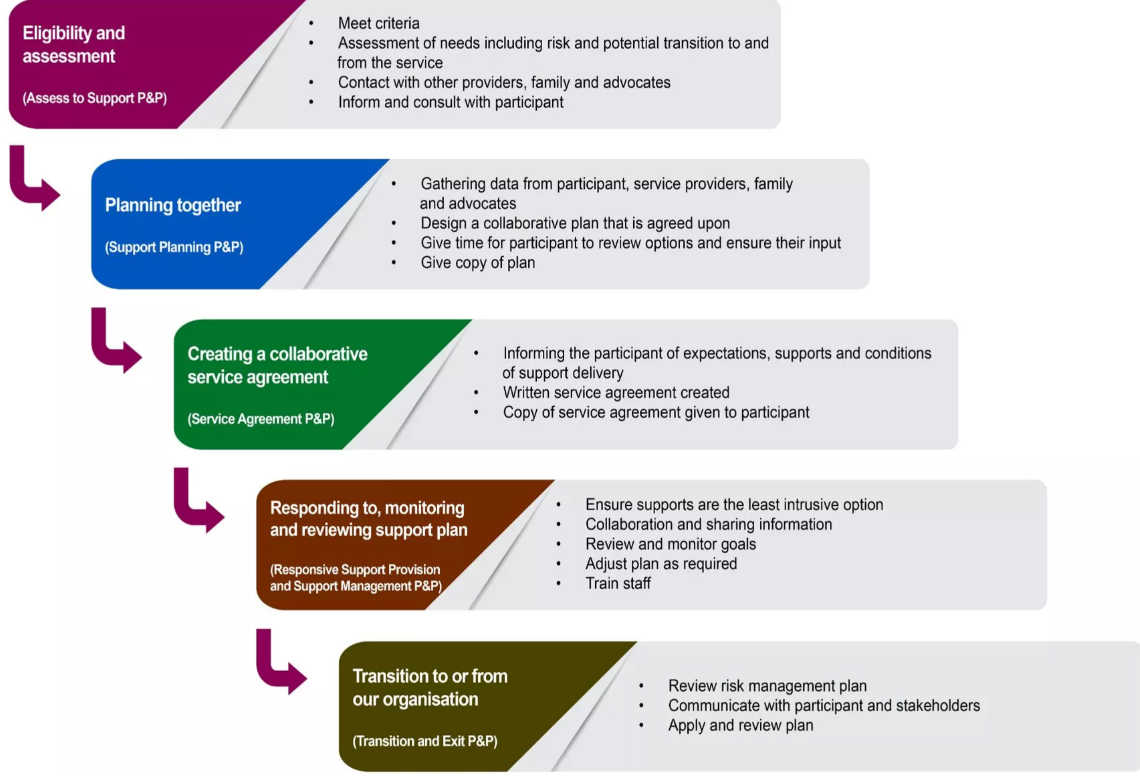
6.0 References

- Work Health and Safety Act 2011 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021
- National Disability Insurance Scheme (Provider Registration and Practice Standards) Amendment (2021 Measures No. 1) Rules 2021

Section 3: Provision of Supports

Topic	Policy and Procedure
3.1 Access to Supports	• Access to Supports Policy and Procedure
3.2 Support Planning	• Support Planning and Service Agreement Collaboration Policy and Procedure • Support Planning Policy and Procedure
3.3 Service Agreement with Participant	• Service Agreement with Participant Policy and Procedure
3.4 Responsive Support Provision	• Responsive Support Provision and Support Management Policy and Procedure • Lifestyle Risk Factors Policy and Procedure • Comprehensive Health Assessment Policy and Procedure • Oral Health Policy and Procedure • Supported Independent Living Policy and Procedure • Daily Personal Activities (Sole Carer) Policy and Procedure
3.5 Transition to or from the Provider	• Transition or Exit Policy and Procedure • Transition to care between Disability Services and Hospitals Policy and procedure

Provision of Supports



3.1 Access to Supports

Access to Supports Policy and Procedure

1.0 Purpose

Strength In Care understands that it is important to provide our participants with the dignity of risk, so our team respects all participants' autonomy and self-determination (or dignity) when making choices.

Our assessment process provides relevant, reliable and valid data to identify a participant's strengths and care needs.

2.0 Scope

Participants contribute to the appropriate and considerate assessment of their individual needs. The support delivery environment is designed to incorporate reasonable adjustments to ensure that the participant's plan and environment are fit for purpose to allow the participant to have a quality of life and independence.

3.0 Policy

The Director or their delegate must seek eligibility information from the participant before commencing any assessment process. This information is used to determine if we can support the participant as required in their plan.

Inform the participant of their rights and how we will maintain their privacy and information. Strength In Care will provide the participant with entry criteria and inform

them of the associated costs. Easy Read documents are available to inform a participant of their right to have a voice in their support requirements.

Participants must be part of the decision-making process with their needs at the core of service delivery and planning. Furthermore, the participants will be given a voice in our policy and practices as they desire.

Strength In Care will be supported to understand the circumstances in that supports can be withdrawn. Supports will not be withdrawn or denied solely based on the dignity of risk choice that the participant has made.

Assessments must be undertaken before the commencement of the Strength In Care's service. Staff must determine the need for an interpreter before starting an assessment to ensure that correct data is gained from the participant. The information obtained during the evaluation, such as areas of independence and identified needs, forms the basis of discussion with the participant to create their support plan.

4.0 Procedure

4.1 Access to supports

The Director will inform the participant of the eligibility criteria to access our support services and associated costs for each service. Eligibility criteria for our NDIS services require the participant to currently hold an NDIS plan that lists access to our registration groups. We will review their NDIS plan to determine if synergy exists between the plan registration groups and our registration.

The Director will determine if the participant requires our Easy Read documents, which outline details on the participant's rights, their voice in the development of their service agreement, how to make a complaint and how we will maintain their privacy. An interpreter will be provided if required by the participant.

Assessment will ensure that our organisation can supply the participant's services in the manner required.

4.2 Reasonable adjustment

The NDIA devises an NDIS plan to address the participant's reasonable and necessary supports.

During the Strength In Care's assessment process to develop a Participant Support Plan, the Director, or their delegate, will consult with the participant, their family, or advocate to make reasonable adjustments to the participant's support delivery environment. The reasonable adjustments are made to determine that the service provided is fit-for-purpose and that the change will support the participant's health, privacy, dignity, quality of life and independence. Any modifications must be discussed and negotiated with all parties and recorded in the service agreement.

4.3 Withdrawal of services

Strength In Care will not withdraw or deny support based solely on the dignity of risk made by the participant. Our organisation may withdraw support if:

- the participant fails to meet their requirements under their service agreement terms
- the participant fails to comply with our policies and procedures
- the participant fails to communicate and provide information about changes to support needs
- workplace health and safety considerations are ignored
- communication has broken down between the Strength In Care and the participant, family or advocate
- payment for support or expenses has not been received as per the Service Agreement.

Under the National Disability Insurance Scheme Terms of Business for Registered Providers, withdrawal or termination of services must be fourteen (14) days.

Strength In Care will always work in the best interest of the participant to achieve a safe transition to a new provider of services (see the Transition or Exit Policy and Procedure).

Upon termination of the service agreement by either party, Strength In Care will take steps to ensure:

- cancellation of the service has been reported to the National Disability Insurance Agency
- services that have been provided under the terms of the service agreement have been claimed
- alternative support solutions are in place for the participant's safety and well-being.

During the withdrawal process, our organisation will follow the Transition and Exit Policy and Procedure requirements and ensure that:

- risks are reviewed to ensure the safety of the participant
- supports relevant to the participant are provided (such as the continuation of support services until transfer is arranged, an advocate, and new provider communication)
- clear withdrawal reasons are detailed
- communication strategies are developed with the new provider
- information is shared with the participant's consent.

4.4 Assessment principles

- Assessment tools used are validated or considered 'best practice'.
- The assessor understands and applies the principles of flexibility, validity and relevance to the assessment process.

The assessment process promotes independence, including the following principles:

- determining the participant's abilities and difficulties
- setting expectations to create a balance between the participant's abilities and their need for support
- acknowledging the participant's support needs and their ability to foster independence and goals in the service agreement.

4.5 Undertaking assessments

Assessment interview time is negotiated with the participant, family and advocate. The designated staff members are to:

- invite the participant's representative/advocate to be present, if required or desired
- identify any special needs (e.g. provision of an interpreter or information in the participant's first language will be sourced)
- inform the participant of their rights, privacy, reporting mechanisms, communication methods, information management and access to their information,
- provide Easy Read documents, if required
- Contact the Director to arrange an interpreter.

During the assessment process, the staff member will inform the participant of their rights and responsibilities regarding:

- collection and use of personal information
- risk assessment processes and strategy development
- privacy and confidentiality considerations
- opt-out options from data collection
- complaints and feedback process
- incident management process
- advocacy options

- how to voice their opinions to management
- information-sharing requirements of the organisation.

The assessment addresses the participant's health, privacy, dignity, risks, quality of life and independence needs. Information is recorded in the participant's records for future reflection. The Director reviews all completed assessments.

4.6 Responsibility for assessments

Only trained professionals can conduct the assessment of a participant. The Director will determine and delegate this responsibility.

Delegated staff must:

- review the intake form
- arrange for a risk assessment of individual and environment
- gain consent to speak to other professionals, family or carers
- seek input and feedback from the participant
- actively listen to participants and record their input
- work with the participant to determine goals, interests, needs and activities

4.7 Recording assessment information

The assessment is documented in a participant's file and management system. The interview and write-up times must be recorded against the participant in the management system.

Record data such as Participant Intake Form, Participant Intake Checklist, Participant Information Consent Form, Individual Risk Assessment and Safe Environment Checklist

5.0 Related documents

- Risk Assessment Form
- Individual Risk Assessment Profile
- Easy Read Documents
- Participant Intake Form
- Participant Intake Checklist
- Support Plan
- Participant Information Consent Form,
- Safe Environment Checklist

6.0 References

- Disability Services Act 1986 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- Equal Opportunity (Commonwealth Authorities) Act 1987
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021

3.2 Support Planning

Support Planning and Service Agreement Collaboration Policy and Procedure

1.0 Purpose

Strength In Care's aim is to work with participants, families, advocates, communities and other providers to achieve the best outcome for the participant. This collaboration allows all parties to share ideas and knowledge to ensure that the supports are relevant, appropriate, and in line with the service agreement.

2.0 Scope

Strength In Care is committed to ensuring that our staff understand the beneficial aspects of a collaborative approach for the participant.

3.0 Policy

Support plans place the participant's voice and requirements at the centre of developing their successful outcomes. Staff will be persistent and patient in building relationships with participants. Our team will promote a shared understanding of the participant's preferences, expectations and needs across the mainstream, community, and formal and paid supports. Support plans will include:

- strategies to actively engage and build relations with participants who interact with multiple programs and supports
- guardianship and supported decision-making, and compulsory treatment orders
- strategies in navigating complex, ambiguous or conflicting service demands, ethical and regulatory environments

This collaborative approach requires staff to work with relevant parties when:

- locating key workers with a family and another provider
- working with other providers in the supply of supports or services
- assisting the participant in transitioning and exiting the service
- work with the participant and their network to develop relevant and proactive strategies
- building the participant's capacity
- planning with supports for the participant
- setting participant goals
- developing person-centred strategies
- developing service agreements.

Staff must cooperate with other agencies in the delivery of service. This collaboration may include initial contact, sharing ideas and input from the participant, their families and advocates, following through on the ideas of a provider, and actively listening to discussions.

We will collaborate with all relevant parties to allow participants to access a service network that meets the full range of needs. The Director will establish communication with the relevant service provider, so our organisation can maintain collaborative relationships and protocols and participate in networks with relevant agencies.

Information, knowledge and skills are communicated and shared between the participant, family, advocate, provider, and other collaborating providers. Strength In Care will work with the participant, their family and advocate to ensure that the participant maintains functionality.

4.0 Procedure

4.1 Keyworker

Participants and families may require assistance in locating the right person to work with the participant. To do this, our team will undertake the following process:

1. Discuss the participant's requirements with the participant, family and advocate.
2. Gain formal written consent to share and gather information with other providers.
3. Contact other service providers working with the participant to collaborate and determine the criteria.
4. Identify at least one (1) key support worker to contact participants, family and advocate, and the other providers.
5. Inform the participant, family, and advocate of the identified person for their approval.
6. Record the process undertaken and results in the participant's service agreement.

4.2 Supporting participants

Staff creating the support plan must understand the participant and their requirements and undertake the following:

- Work with the participant to make sense of my NDIS plan, and understand how I can use it and how it links to other services or plans in my life.
- Build an understanding of participants' capabilities and support them to maintain and build their capacity and resilience to achieve my goals.
- Support the participant to be creative and think outside the box to find and negotiate solutions that meet my goals.
- Provide information and tailored opportunities for the participant to explore and expand their vision for their future and what it means to have a good life.
- Share current best practices to support the participant in making connections and find information about support options.
- Alert the participants to real or potential conflicts of interest when planning and selecting supports, and work with them to make informed choices.
- Encourage the participant's specialised and mainstream service providers to recognise and challenge prejudice or lack of vision in service offerings and attitudes.

- Involve participants in understanding and designing safeguards to keep them safe while supporting their right to take risks and build independence.
- Seek input into our corporate governance to ensure our policies and practices reflect the needs of our participants and community
- Work with participants to develop an agreed way to respond to emergencies, crises and foreseeable life events.

4.3 Risk Management

All participants must have the following risk documents completed and recorded in their files:

- Individual Risk Profile,
- Safe Environment Checklist and
- Personal Emergency Preparation Plan
- Support Plan

The aforementioned forms must be reviewed annually to safely encapsulate the participant's needs, preferences, and goals. Note: The Personal Emergency Preparation Plan must be trialled, adjusted (as required) and recorded.

Staff undertaking risk assessments must be approved by the Director. The risk assessment includes:

- Consideration of the degree to which the participant relies on our services to meet their daily needs
- The extent to which the participant's health and safety are affected due to disruption

4.4 Collaborating with other providers

The Director or their delegate will make initial contact with other providers after obtaining consent from the participant, their family and advocate. Various methods will be used to

maintain contact, e.g. email, phone and networking. All records of contact are kept in the participant Service Agreement.

4.5 Transition and exit

The participant's needs, interests or aspirations may change during the delivery of their supports. These changes may lead to a need to transition to or exit from their current service. If this occurs, with the consent of the participant, we will contact the relevant service provider to:

- collaborate with providers and the participant to develop a plan of action
- request or send documents relevant to the participant
- confirm current supports, practices and needs to enable the participant to transfer or exit smoothly
- identify risks and develop a risk management plan
- develop a transition/exit process for the participant and confirm details with the participant
- work with the participant during the process
- review the effectiveness of the transition upon completion
- document the process in the participant support plan.

Risks associated with each transition to or from Strength In Care are identified, documented and outlined in our Transition or Exit Policy and Procedure and Risk Management Policy and Procedure.

4.6 Capacity building

The participant's capacity building process is designed to improve and retain their skills and knowledge to maintain and improve their functionality.

To build and support the participant's functional capacity, Strength In Care will collaborate with:

- a participant, their family, and advocate to affirm, challenge and support

- other providers to develop the participant's skills further and to improve practice and relationships.

4.7 Participant outcomes

Collaboration with a participant, their family, and their advocate is the basis for ensuring functional outcomes focused on the participant's needs, priorities, and skills. This process includes:

- listening to every person
- analysing the information from each person
- determine relevant participant outcomes
- consult with all parties to reach an agreement on outcomes
- record the information in the support plan
- set a review date to ascertain if the participant to reach the outcome required
- detail collaborates in the service agreement

4.8 Support planning

During the assessment and support planning process, collaboration is undertaken with a participant, their family or advocate to:

- complete a risk assessment (see 4.3 Risk Management)
- document a risk assessment
- plan appropriate strategies to manage/treat known risks
- create an emergency plan
- train staff in strategy implementation
- implement appropriate strategies to manage/treat known risks
- conduct an annual review, or earlier, according to the participant's changing needs/circumstances.

4.8.1 Support Plan document

Staff completing the support plan must identify the participant's communication needs. This information will determine how they will present and inform the participant about their support plan. Staff must explain and provide the support plan in a mode of communication that suits the participant.

4.9 Service agreements

Strength In Care will collaborate with the participant to develop a service agreement that establishes the following:

- expectations of both parties
- supports to be delivered
- conditions associated with the delivery of supports, including details of why particular conditions are attached.

With the consent or direction from the participant, Strength In Care collaborates in the development of the support plan with other providers to:

- develop links
- maintain links
- share information
- meet the needs of a participant.

5.0 Related documents

- Participant Information Consent Form
- Participant Support Plan
- Privacy and Confidentiality Agreement
- Risk Management Policy and Procedure
- Service Agreement
- Support Plan
- Transition or Exit Policy and Procedure

6.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)

Support Planning Policy and Procedure

1.0 Purpose

This policy aims to outline the legislative requirements and practice procedures for undertaking support services for NDIS participants. Our organisation will comply with the requirements of NDIS Practice Standards and Quality Indicators.

Compliance with this policy is a condition of appointment for all persons engaged in providing services on behalf of Strength In Care.

2.0 Scope

To instruct our team on developing a support plan to incorporate the participant's wants, needs and aspirations. Support Plans include the type of staff and the time and length of the service linked to the registration group on an NDIS Plan.

3.0 Policy

All participants and their support networks are aided to collaborate and participate in developing a goal-oriented support plan. The support plan will reflect an individual's goals and aspirations and review the participant's strengths and functionality. The plan is based on the presumption of capacity and will safeguard the risks and needs of the participant.

The support plan incorporates both the participant's supports (described as the nature of a coordination, strategic or referral service or activity) and reasonable and necessary supports funded under NDIS (activities that support goals to maximise independence, allow to live independently and undertake mainstream activities).

The support plan will provide transparent written information to the participant outlining the services and type of support/s they will receive from Strength In Care. The amended support plan will communicate changes in the participant's needs, preferences, or goals. This document must be readily accessible to the participant and their workers.

Participants are provided with the support plan in a mode of communication that has been noted in their file. The support plan must be discussed and explained in detail to the participant to implement adjustments and feedback.

Staff must be screened, trained, and qualified in their roles; all staff must hold current worker screening.

3.1 Support planning principles

- The support planning process is consultative, where the participant, family, friends, carer or advocate work together to identify strengths, needs and life goals, focusing on choice and decision-making.
- The participant's preferences, values and lifestyle choices should be supported (wherever possible).
- Support plans should promote the valued role of people with disabilities that is of their choosing.
- Strength In Care promotes functional and social independence and quality of life.
- Support plans will contain goals.
- Agreed service choices should reflect the participant's personal goals.
- Support plans should be creative, flexible and not restricted to set patterns or methods of service delivery.
- The plan's activities and supports must include the participant's chosen communities and maintain connections with their community to allow active participation.
- If a participant identifies as Aboriginal or Torres Strait Islander, their community will be contacted to engage and support services.

- The support plan is reviewed regularly (at least annually) and amended to respond to participants' needs and preferences.
- The support plan should be strength-based, seeking to maximise independence and build on the participant's existing networks.
- The support plan should be provided to the participant in their first language or Easy Read, where appropriate or requested.
- Staff working with a participant must have access to and understand the support plan and Personal Emergency Preparation Plan
- Support plan must include preventative health measures, including vaccinations, dental check-ups, comprehensive health assessments and allied health services
- The participant or their advocate may request a review of the support plan.
- The staff developing the support plan will have the necessary skills and competence to undertake this function.
- The support plan be linked to the Personal Emergency Preparation Plan
- A participant with a disability will be facilitated to assist in the comprehension of their NDIS Plan, including:
  - understanding and self-directing their NDIS Plan
  - understanding the supports in their NDIS Plan
  - understanding funded support budgets
  - purchasing general funded supports
  - purchasing stated funded supports
  - managing and paying for their supports
  - choosing their providers
  - making agreements with their preferred providers.

4.0 Procedure

4.1 Support plan development

4.1.1 Planning

- Explain the support plan development process for the participant.
- Arrange a meeting time with the participant and, if applicable, their advocate or family.
- Develop the support plan with as much input, choice and decision-making from the participant as they want. Document the reasons for the decisions made (should a participant choose to have minimal input into their support plan).
- Staff creating the support plan must understand the participant and their requirements and undertake the following:
    - Work with the participant to make sense of their NDIS plan, and understand how to use it and how it links to other services or plans in my life.
    - Build an understanding of participants' capabilities and support them to maintain and build their capacity and resilience to achieve my goals.
    - Support the participant to be creative and think outside the box to find and negotiate solutions that meet my goals.
    - Provide information and tailored opportunities for the participant to explore and expand their vision for their future and what it means to have a good life.
    - Share current best practices to support the participant in making connections and find information about support options.
    - Alert the participants to real or potential conflicts of interest when planning and selecting supports, and work with them to make informed choices.
    - Encourage the participant's specialised and mainstream service providers to recognise and challenge prejudice or lack of vision in service offerings and attitudes.
    - Involve participants in understanding and designing safeguards to keep them safe while supporting their right to take risks and build independence.
    - Work with participants to develop an agreed way to respond to emergencies, crises and foreseeable life events

  - Be proactive in supporting preventative health measures, including vaccinations, dental check-ups, comprehensive health assessments and allied health services
  - Support and build participants' capacity and confidence
  - Negotiate with support and service providers, make transitions or adjust my plan, if relevant to their role, and inform the supervisor otherwise
  - Encourage the participant to navigate complexity, resolve issues and, maintain continuity and integration of supports, refer to the supervisor as required
  - Create opportunities for the participants to practice and develop their capacity to manage and direct their supports
  - Support participants to coordinate different and often disconnected services and support into an integrated experience.
  - Identify breakdowns in support arrangements and work with participants and other service providers to adapt in response
  - Identify emergencies and disasters through linking to the Personal Emergency Preparation Plan
- Before meeting with the participant, review the following:
  - Participant Intake Form
  - participant assessment information
  - referral documents
  - other relevant notes or data available that will assist in understanding the participant as an individual.

4.1.2 Providing information to the participant

- Emphasise to the participant why they must identify their personal goals and aspirations.
- Use the appropriate support plan as a prompt to assist the participant in identifying areas where Strength In Care services may help them realise their goals.

- Outline the prompts on the plan, including a discussion of the participant's physical, emotional, spiritual, cultural, community, social and financial needs.
- Provide the participant with a clear understanding of their choices and service options available to make informed decisions about their choices and priorities.
- Explain to the participant any information-sharing requirements with other parties.
- Provide the participant with examples and suggestions of how Strength In Care services may be able to help them achieve their goals.

4.1.3 Facilitating the development of participant-centred goals

- Work with the participant and their advocate/s to identify their personal goals.
- Ask the participant to identify the types of help or assistance that would be most important to them.
- Help the participant recognise their strengths and capabilities.
- Transform the participant's goals into SMART (i.e. Specific, Measurable, Attainable, Realistic and Timely) goals, e.g.
  - Simple goal: To be able to collect the mail.
  - SMART goal: To walk to the letterbox, without assistance, every day to collect the mail.
- Set a time frame for each goal, so progress can be measured, e.g. walk to the letterbox without assistance to collect the mail and achieve this by November 30.
- Use the participant's expressed goals, priorities, and agreed-upon actions in developing their support plan.

Consideration will also be given to:

- financial resource capacities and any limitations of Strength In Care services or specific programs to be utilised
- capacities, expertise and appropriateness of current Strength In Care staff to provide services
- availability of specialised subcontracted staff or services, if applicable

- other services or individuals who will provide services, as designated by the participant
- volunteer supports available
- determining (with the participant) how each goal will be measured so progress can be recorded
- identifying (with the participant) any potential barriers to achieving their goals and then developing strategies to alleviate those barriers
- working with the participant to prioritise their goals if many goals are identified. Each goal lists actions, responsibilities, frequency and duration of services to be coordinated or supplied on behalf of the participant. Document all the information in the support plan
- identifying and documenting a support plan, all stakeholders (e.g. participant, family, advocate/s, community engagement links and other services or agencies) will undertake to assist the participant in achieving each goal.

4.2 Support plan delivery and review

- Negotiate specific days for services/supports and document them in the participant support plan.
- Where possible, agree upon time ranges to build flexibility into the service roster, e.g. start time between 1:00pm and 1:30pm and provision of one (1) hour of domestic assistance.
- If not finalised, negotiate service fees and record these in the participant's service agreement and the support plan.
- Ask the participant to sign the support plan to acknowledge their agreement.
- Ensure access to support plan by both the participant and their worker
- Agree on the criteria to evaluate the effectiveness of Strength In Care service responses and document this in the support plan.
- Ensure that all involved stakeholders have copies of the agreed support plan.
- Explain to the participant that the Director will monitor the progress of the support plan

- Explain that the participant can request a support plan review at any time
- Explain to the participant that they are part of the review process (see Responsive Support Provision and Support Planning Policy and Procedure).

5.0 Related documents

- Risk Assessment Form
- Individual Risk Assessment Profile
- Participant Intake Form
- Participant Intake Checklist
- Participant Information Consent form
- Personal Emergency Preparation Plan
- Service Agreement
- Support Plan
- Support Plan Review Report

6.0 References

- NDIS - Developing your first NDIS Plan
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)

3.3 Service Agreement with Participant

Service Agreement with Participant Policy and Procedure

1.0 Purpose

Strength In Care undertakes the development of a service agreement during the access to support and assessment process and with the collaboration of relevant parties.

We will ensure that all parties are aware of and have agreed to all aspects of the provided services.

2.0 Scope

It is the responsibility of the Director, or their delegate, to undertake the development of a service agreement with the participant and to ensure it is designed specifically to meet their individual needs.

3.0 Policy

Strength In Care collaborates with each participant to develop a service agreement which:

- establishes expectations
- explains the supports to be delivered
- specifies any conditions attached to the delivery of supports, including why these conditions are attached.

The participant is supported to understand their service agreement and conditions using the language, mode of communication and terms that the participant is most likely to follow. We will supply Easy Read documents as required.

The participant must provide their consent or direction to develop and maintain links with other providers to collaborate and share information to meet their needs. The service agreement includes emergency and disaster management plans for individuals.

4.0 Procedure

Strength In Care undertakes the following procedure to develop a service agreement with each participant:

1. Collaborate with the family, advocate or representative to ensure that the service agreement meets the requirements and links to needs, interests and aspirations.
2. Use appropriate communication methods to explore, explain and determine what is provided within the agreement.
3. Keep appropriate records explaining the process undertaken, including consent/direction to collaborate with other providers and to share information to enable the team to meet the participant's requirements.
4. Provide the participant with a copy of their service agreement. When the participant wishes not to keep a copy of the agreement, the circumstance under which the participant did not receive a copy must be documented and kept on the participant's file. It is good practice to have the participant note that a copy was not required on the agreement.
5. The Service Agreement must outline the party or parties responsible and their roles, where applicable, for the following issues:
    a. How the participant will communicate their concerns about a dwelling.
    b. How potential conflicts involving participant(s) will be managed.
    c. As agreed, changes to participant circumstances or support needs will be disclosed.
    d. How vacancies are filled in shared living and how each participant has the right.
    e. Are their needs, preferences and situation being considered?

f. How behaviours of concern are managed may put tenancy at risk if relevant to the participant
g. management of emergencies and disasters.

5.0 Related documents

- Code of Conduct Agreement
- Easy Read Documents
- Personal Emergency Preparation Plan
- Service Agreement

6.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Work Health and Safety Act 2011 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)

3.4 Responsive Support Provision

Responsive Support Provision and Support Management Policy and Procedure

1.0 Purpose

This policy ensures that every participant has access to responsive, timely, competent and appropriate supports that meet their needs, desired outcomes, and goals.

Strength In Care will provide program design, individual planning, coordination and support management to all participants.

2.0 Scope

Strength In Care will ensure our staff are trained to act professionally and appropriately when developing plans that empower the participant to achieve their needs, goals and aspirations.

We will keep each participant informed of their plan while undertaking a holistic approach that incorporates strength-based and person-centred strategies.

3.0 Policy

All services and support plans are developed and delivered in collaboration with the participant and their advocate. All participants, family members, representatives or advocates must be included in any decision-making process, selection of strategies or activities, and approval of all aspects of their support plan. Support management will promptly consist of delivery, monitoring, review, and reassessment.

The Director or their delegate will ensure that the least intrusive options are planned using contemporary evidence-informed practices.

Reasonable efforts will be made to match the participant's key worker requirements to our current frontline workers.

Strength In Care will collaborate with all relevant parties, including other service providers, and only share information with the consent of the participant. Our team will consult to ensure that we meet individual needs.

The Director will ensure that only appropriately trained staff work with the participant. The allocation process will incorporate a skill and knowledge review of a potential frontline worker.

Strength In Care will utilise this policy to ensure the organisation maintains a contemporary approach to support management services.

4.0 Procedure

4.1 Support management principles

Support management includes screening, comprehensive assessment, support planning and support plan implementation, monitoring, review and case closure. Staff must keep up to date with best practices and collaborate and develop strengths-based techniques to build and develop the participant. The participant's support members must be kept informed as per their requirements.

4.1.1 Consulting with participants

Staff must be aware of the power imbalance between the participant and our organisation; therefore, our staff must communicate and inform them about all aspects of

their support. Our staff who are working with the participant in the development of their plan are required to:

- ask the participant about what they need and learn about their other supports to understand how they interact with each other
- be alert to participants' general state of health and challenge assumptions that could result in their health needs not being identified or adequately addressed
- explain clinical information, terminology and prepare reports in ways that participants and others in the support team can understand
- support others in the participant's support team to understand their support plan, how it supports goals and to check their capacity to implement it
- find ways to allow the participant to contribute to the coaching and supervision of their supports
- identify and discuss with participants the specific health or allied health support that could be appropriate to achieve goals combined with other plans and supports
- assist the participant in understanding and co-design health and allied health supports
- provide the participant with current information and be open to new approaches during service provision
- provide opportunities to practice and build my capacity to make informed choices
- seek opportunities to build health and allied health supports that fit day-to-day routines and preferences and are least restrictive or intrusive
- consider participant's circumstances, networks and the support context when identifying options and designing my supports
- involve participants in understanding and designing health and allied health-related safeguards to keep them safe while supporting their right to take risks and build independence.
- consult about developing an agreed way to respond to health and allied health-related emergencies and crises
- support participants to communicate with their team about what to do to manage health and allied health-related problems and respond to a crisis

4.1.2 Creating a support plan

The Director or their delegate will:

- verify that consent was received for assessment and services and is recorded in the participant's file
- review the participant's referral information and confirm eligibility and suitability for a Strength In Care service
- contact the participant and arrange a suitable time for a comprehensive assessment
- arrange interpreters, advocates, guardians, or other service providers, with the participant's consent, to attend the assessment
- determine, if possible, whether a clinical assessment of the participant's health condition is required and arrange for the appropriate staff to attend the assessment, i.e. registered nurse or allied health professional
- ensure representatives identified by the participant (e.g. family, advocate and carers) are contacted and, if necessary, participate in the assessment
- assess as per the organisation's appropriate policies and procedures and base the assessment on the participant's needs and situation
- contact the referrer and any existing providers, within five (5) days after a comprehensive assessment, for further information that may be required
- arrange additional specialised assessments, if indicated
- collaborate with the participant and their supports (refer to 4.1.1 Consulting with participants)
- match available resources (i.e. staff to the needs of the participant)
- work across service boundaries to ensure that participants with complex care needs are provided access to a full range of required support services such as allied health, health and social support services
- provide a single point of contact for participants who require a complex range of services or require intensive levels of support

- ensure Strength In Care's service is screened for eligibility and suitability as per the applicable program guidelines and our Access to Supports Policy and Procedure
- investigate potential options for sourcing support, including the availability of Strength In Care staff/resources and the use of brokerage resources
- arrange, if necessary, a case conference with relevant services and individuals to discuss the participant's situation
- ensure outcomes from support management are documented within the support plan
- inform the participant that their coordinator will continually review and assess their services for effectiveness
- provide the support plan, where appropriate, to the participant's general practitioner or representative, with the participant's consent
- develop a support plan that includes a plan of action that meets the participant's needs, requirements and aspirations and includes:
    - participant information, e.g. personal and health details, cultural and spiritual requirements, sexual identification, Aboriginal and Torres Strait Islander, etc.
    - participant goals
    - advocate details
    - interpreter requirements
    - consent forms
    - active engagement planning
    - strategies to develop, sustain and strengthen independent life skills
    - integrated health therapeutic and other supports are part of the natural routine
    - medical information, including conditions, doctors, medications, use and management
    - risks to participant and staff (include management of the risk if required)
    - emergency and disaster plan - Personal Emergency Preparation Plan
    - any financial budget requirements (if applicable)

    - details of the participant's involvement in any planning and decision-making process
- provide a copy of the support plan to the participant to review and agree to the provided strategies and service.
- monitor the support plan's relevance through regular contact with the participant and other representatives and service providers involved in the participant's wellbeing (refer to 4.1.1 Reviewing the support plan)

The support review is an essential element in providing focused and relevant supports, occurring at various points in the support continuum, depending on the needs of the participant or family, urgency and complexity of the family's needs, and changes in family circumstances.

Support plan reviews may be held to:

- determine if the current roles and responsibilities of our staff and organisation are meeting the needs of the participant
- assess if the frontline workers are meeting participant's goals
- review the purpose, intent, and direction of the intervention
- evaluate the service currently being supplied against the participant's strengths, needs, goals and aspirations
- consider previous assessments and determine if any more are required
- reassess the participant using the relevant assessment tool
- re-evaluate using evidence gathered during work with the participant
- review the current risks and Personal Emergency Preparation Plan
- examine the status of the support plan
- make decisions relevant to the participant; ensure all parties are informed
- review goals and actions
- offer opportunity to have input into policies and practices
- schedule a case conference with the participant and all relevant stakeholders to ensure their active involvement and to discuss any changes in service
- plan towards transfer or closure, if relevant

- record any changes to a support plan in the participant's notes or file
- assess the need to change the service agreement.

4.1.3 Reviewing the support plan

Consulting with the participant is an essential element of the support plan review. During the review process, staff will:

- work with the participants to identify meaningful outcome measures and support them to monitor their progress against their goals and expectations
- support participants to review their crisis management and safeguarding arrangements and request adjustments as needed (e.g. Personal Emergency Preparation Plan
- support the participant to navigate NDIS supports and report to the NDIA on implementation, as required
- support in identifying opportunities for increased independence and reduced reliance on service systems at the participant's pace
- support participants to make sure their views and interests are heard in formal and informal review processes
- ascertain the current risk levels and adjust plan and strategies to suit the current status
- Support participants to find and access channels they are comfortable with to raise concerns, complaints and incidents when they arise.

4.2 Exiting the service

When the participant's needs begin to exceed program resources, or should the participant change to another service provider, the Director will:

- refer to the transition and exit notes in the Participant Support Plan
- follow the guidance of the Transition or Exit Policy and Procedure
- inform the participant of any potential risk of transferring or exiting
- negotiate participant handover arrangements with the new service provider

- advise participants of risks related to leaving the service.

5.0 Related documents

- Risk Assessment Form
- Risk Management Plan
- Risk Register
- Individual Risk Assessment Profile
- Service Agreement
- Support Plan
- Support Plan Review Report
- Support Plan Progress Report
- Access to Supports Policy and Procedure
- Consent Policy and Procedure
- Transition or Exit Policy and Procedure

6.0 References

- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- Work Health and Safety Act 2011 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)

Lifestyle Risk Factors Policy and Procedure

1.0 Purpose

Participants are more likely to have poor physical and mental health, including cardiovascular disease, respiratory disease, cancer, diabetes, oral diseases, depression and anxiety. These health conditions may be a direct result of, or made worse, by lifestyle risk factors such as poor nutrition, obesity, smoking, alcohol intake and lack of exercise. This policy aims to support participants in their lifestyle choices to reduce their risks.

2.0 Scope

Staff working with participants and designing support plans must be mindful of lifestyle risk factors and support the participant in becoming more active within their community.

3.0 Policy

Participant planning must improve health, nutrition, physical activity, adequate sleep, stress, anxiety, alcohol intake, and stop smoking. Loneliness and isolation are also lifestyle risk factors. For instance, the lack of a job, friends or hobbies can lead to many hours spent alone without purpose or connection.

Management must ensure that staff are trained in healthy eating, exercise, stress reduction, and a positive lifestyle, so information and support can flow to the participant.

This policy is linked to the NDIS Practice Standards, including:

- **Support planning:** Participants are actively involved in developing their support plans. Support plans reflect participant needs, requirements, preferences, strengths, and goals regularly reviewed.

- **Independence and informed choice:** Strength In Care supports participants in making informed choices, exercising control, and maximising their independence relating to the supports provided.
- **Access to supports:** Participants access the most appropriate supports that meet their needs, goals and preferences.
- **Incident Management:** Participants are safeguarded by the incident management system, ensuring that incidents are acknowledged, responded to, well-managed and used as part of our continuous improvement.
- **Information Management:** Participants' information is managed to ensure that it is identifiable, accurately recorded, current and confidential. Each participant's information is easily accessible to the participant and appropriately utilised by relevant workers.
- **Human resource management:** Participant's support needs are met by competent workers holding relevant qualifications and who have relevant expertise and experience to provide person-centred support

4.0 Procedure

Lifestyle risks can be addressed by eating healthy food, increasing exercise, reducing stress, and connecting. For instance,

- reducing the amount of takeaway food eaten,
- choosing food and drinks low in added sugar,
- increasing movement throughout the day and
- becoming involved in a community activity that will create a connection with others.

Participants may not have had the opportunity to access or control their living environments, such as food, daily activities, exercise and community participation.

Lifestyle changes happen through:

- raising awareness,

    - provision of information about how everyday activities can affect health.
    - raising health awareness and giving ideas on how to make lifestyle changes that will address risks such as obesity, high blood pressure and stress management
- setting goals for change,
    - Setting small achievable goals for change, such as walking short distances and not taking sugar in coffee or tea, will gradually build to bigger goals.
- Learning with peer support to increase connections, such as
    - friends, physical training with a group
    - joining a community garden
    - water aerobics or participating in a walkathon or fun run
    - joining an art class, music or dancing lessons.
- changes to the living environment and learning the new skills that may be needed;
    - making changes to the environment that can support goals
    - changes can be small such as having healthy food choices available, planning, shopping and cooking healthy meals.
- encouraging physical activity, including
    - encouraging positive ideas of physical activity and self-esteem
    - increasing movement through normal daily activities is a way to feel more positive about our bodies and movement
    - increasing physical activity improves health and influences other lifestyle risks such as nutrition, stress, and smoking; positive outcomes are lower blood pressure, improvement of self-esteem and mental health.

4.1 Supporting participants

Strength In Care will monitor participants' health, safety and wellbeing, support participants to maintain their health and access appropriate health services. Our organisation will support participants to be empowered to live a healthy lifestyle and understand why it is important.

Below are means that we may support participants in the following ways:

- incorporate health promotion and ways to live a healthy lifestyle into support planning
- link actions for a healthy lifestyle to the participant's annual comprehensive assessment
- provide support to make informed decisions regarding their lifestyle support to:
    - understand any risks arising from their present lifestyle
    - understand how they can improve their lifestyle to match their own health goals
    - talk to their GP about their health and what lifestyle changes are needed to optimise their health
- facilitate choice in lifestyle changes and understanding about their health, using accessible tools and resources
- engage the participant with encouragement and highlight their achievements so that they are motivated to develop a healthy lifestyle
- provide information about healthy lifestyles and different ideas to improve health, such as walking instead of driving, learning to cook a new healthy dish or taking up an exercise class
- suggest and support access to new activities or choices that link to the participant's goals and dreams and how a healthy lifestyle may help them achieve this goal
- provide information about and support access to new interests and community activities in the local area, such as a community garden, amateur theatre, starting a walking group, cooking lessons or arts and crafts
- support the participant to make changes to their living environment that will support their goals, increase incidental exercise around the house, keep healthy food choices in the cupboard, and walk to places when possible
- support to access both information or professional assistance such as dietitians or exercise physiologists where the person's lifestyle choices are inconsistent with their own health goals.

4.2 Referrals to other professionals

Lifestyle changes can involve changes across different aspects of a participant's life. A multi-disciplinary approach can assist the participant in developing new skills or identifying a support need and, for instance, identifying an appropriate level and type of exercise or learning how to cook.

The types of professionals that may assist in lifestyle change include dieticians, physiotherapists, occupational therapists, exercise physiologists, counsellors and NDIS behaviour support practitioners.

4.3 Training and development

As part of our training program, staff may receive training and skills in areas such as:

- healthy lifestyles, nutrition and menu planning and exercise
- positive communication skills to engage with participants and empower change.

4.4 Strength In Care obligations

As part of our obligations to the NDIS Code of Conduct, staff must provide NDIS supports or services to participants to:

- act with respect for individual rights to freedom of expression, self-determination and decision-making following applicable laws and conventions
- provide supports and services safely and competently with care and skill
- promptly take steps to raise and act on matters that may impact the quality and safety of supports provided.

Our organisation will comply and demonstrate compliance with the National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 related to delivering safe, quality support and services and managing risks associated with the supports you provide to participants.

4.5 Resources

Below are some resources to assist staff in providing information to participants.

- Five-booklet toolkit developed by Inclusion Melbourne to assist people with a disability make choices about their life my choice tool kit
- Healthy eating for adults Australian Government Department of Health brochure
- Australian dietary guidelines, website links to a range of information and resources eat for health
- Physical activity and exercise guidelines for all Australians, Australian Government Department of Health, include tips and ideas for fitting more activity into your day-to-day life.
- Link for information, initiatives and resources for healthy lifestyles Preventative Health, Australian Government Department of Health
- Council for Intellectual Disability Health Fact sheets, including healthy lifestyles
- Healthy Mind e tool for people with intellectual disability Blackdog Institute
- First Nations People, a resource for planning, dreams, goals and lifestyle. First Peoples Disability Network Australia our way planning resources

5.0 Related Documents

- Support Plan
- Support planning Policy and Procedure
- Independence and informed choice Policy and Procedure
- Access to Supports Policy and Procedure
- Incident Management Policy and Procedure
- Information Management Policy and Procedure
- Human Resource Management Policy and Procedure

6.0 References

- NDIS Code of Conduct Rules 2018

- NDIS Practice Standards and Quality Indicators 2021
- NDIS Lifestyle risk factors Practice Alert July 2021

Comprehensive Health Assessment Policy and Procedure

1.0 Purpose

Participants are at a high risk of poor health, chronic disease and premature death from potentially preventable causes. Completing a regular comprehensive health assessment for participants improves detection of health needs, enables active management of those needs, and significantly reduces health risks and poor health outcomes.

Participants have a right to maintain optimal physical, oral and mental health. Our organisation must monitor participants' health, safety and wellbeing, support participants to maintain their health and access appropriate health services.

2.0 Scope

This policy and procedure guide all staff who develop and implement support plans.

3.0 Policy

All staff must follow the NDIS Code of Conduct and undertake the following:

- act with respect for individual rights to freedom of expression, self-determination and decision-making following applicable laws and conventions
- provide supports and services safely and competently with care and skill
- promptly take steps to raise and act on matters that may impact the quality and safety of participants' support and services.

Strength In Care is committed to demonstrating compliance with the National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018. This policy is linked to the NDIS Practice Standards, including:

- **Support planning:** participants are actively involved in developing their support plans. Support plans reflect participant needs, requirements, preferences, strengths, and goals regularly reviewed.
- **Access to supports:** participants access the most appropriate supports that meet their needs, goals and preferences.
- **Responsive Support Provision:** participants access responsive, timely, competent and appropriate supports to meet their needs, desired outcomes and goals.
- **Incident Management:** participants are safeguarded by our incident management system, ensuring that incidents are acknowledged, responded to, well-managed and part of our continuous improvement regime.
- **Information Management:** participants' information is managed to ensure that it is identifiable, accurately recorded, current and confidential, with information being easily accessible to the participant and appropriately utilised by relevant workers

4.0 Procedure

4.1 Risks of health problems for people with disability

Participants are at risk of poor health and conditions that are not yet diagnosed and are at an increased risk of potentially avoidable deaths. Many people were experiencing multiple health problems at the time of death, including epilepsy and poor nutritional, oral and mental health.

Risks are more likely for participants due to a combination of the following:

- Some participants may be unable to communicate when they feel unwell or experience pain and may communicate in ways that are specific to them and not well understood by others
- A person's symptoms or behaviours are attributed to their disability, and as a result, they do not receive appropriate health assessments or treatments

- A mix of individual, medical, communication and social problems due to disability, health conditions that run in the family, poor nutrition, inappropriate accommodation, harm, abuse and neglect, homelessness, inadequate preventative health care or treatment
- Lifestyle factors include obesity, physical inactivity, isolation, smoking, and alcohol intake.

4.2 Addressing health risks

Health risks can be addressed through the following interventions.

4.2.1 Identify symptoms early

Staff must be informed of and know how to communicate with each participant to develop trust, informing staff when unwell. Early identification of changes in a participant's health and wellbeing means that the participant can access medical services earlier and prevent illness from progressing. It is important to know the participant's usual health to observe changes. Obvious changes would include:

- unexpected weight loss or gain,
- a sudden change in eating habits,
- sudden breathlessness,
- a drop in activity due to fatigue,
- expressions of pain and apparent sudden changes in behaviour.

4.2.2 Promptly visit a general practitioner (GP)

Staff must inform Director promptly of any changes in their usual health so the participant can access a GP when unwell.

4.2.3 Undertake a regular comprehensive health assessment resulting in a healthcare plan

A comprehensive health assessment involves the participant and GP discussing and reviewing the participant's medical history, current health problems, medications and any lifestyle risks. Regular comprehensive health assessments have been shown to prevent illness and maintain the health and wellbeing of participants. These outcomes result from identifying unmet health needs, preventing disease, engaging in regular health care and improving communication with the GP.

Based on health information and physical examination, the GP will recommend what the participant requires for good health and wellbeing. The GP will also recommend and refer the participant for appropriate preventative health care, such as regular screening for serious conditions. For example:

- skin cancer checks;
- breast or bowel cancer screening.

The participant, GP and Strength In Care can then develop a healthcare plan based on the recommendations from the comprehensive health assessment.

4.2.4 Be proactive with chronic illness

Both the medical practitioner and the participant can proactively manage chronic illness by:

- monitoring symptoms that might indicate a change in health status,
- making changes to lifestyle if needed, attending regular medical appointments, and
- managing chronic illness and disease, for example, regular blood tests for diabetes, blood pressure monitoring and medication reviews.

Strength In Care will work with all parties to assist the participant in attending medical appointments and support them in any processes that are required as part of being proactive.

4.3 Supporting participants

Strength In Care will monitor participants' health, safety and wellbeing, support participants in maintaining their health and accessing appropriate health services and support the participant in accessing annual comprehensive health assessments.

4.3.1 Support participants in understanding their own health needs and making informed health decisions

Organisation will:

- talk to participants about their health and develop a healthcare plan
- support participant's understanding of health through the provision of accessible health information; see the resource section below for ideas and tools
- facilitate informed decision making regarding health care using the participant's preferred communication methods. Where appropriate, involve the participant's family, independent support person or guardian in the decision-making process.

4.3.2. Support participants in communicating with healthcare providers

- If required, work with a speech pathologist to create or expand a personal communication system for the participant to have a way of saying when they are unwell, including:
    - words/signs/symbols that can describe pain, nausea and fever, anxiety, and emotional distress.
- Determine the level of support the participant requires to make and attend a medical appointment with the GP or have blood tests, scans or other procedures.
- Support participants to build a relationship with their GP through regular contact.

- Assist the participant in using their preferred communication method with the GP or healthcare provider during appointments.

4.3.3 Support participants to access healthcare

Strength In Care will:

- encourage the participant to let you know if they do not feel well using their preferred communication methods
- have a good understanding of the participant's health and potential symptoms to watch out for; this includes when there are changed behaviours or function
- support the participant to attend the GP if they are unwell.
- support participants with chronic illness to understand their symptoms, treatment plans, recommended lifestyle changes, and regularly visit their GP
- Refer to Practice Alert: Transitions of care between disability services and hospitals to assist hospitalisation.

4.3.4 Support participants to access preventative healthcare

Strength In Care will:

- support the participant to follow their healthcare plan
- undertake preventative healthcare such as regular medical and dental check-ups in between annual comprehensive health assessments
- Refer to The Practice Alert: Lifestyle Risk Factors to improve health outcomes.

4.3.5 Plan and support participant's health appointments

Strength In Care will

- support the participant to make a GP appointment or, with consent, make the appointment on their behalf

- arrange transport, telehealth facilities, and parking if required. Workers should familiarise themselves with the health facility/GP office to support the participant's access to appointments,
- consider if it will be a difficult day for the participant, are there likely to be long waiting times, will they experience fatigue, and how is that best managed?
- communicate with the GP about the participant's triggers for distress, communication aids or physical access requirements
- Time the health assessment on a day when it is likely to less busy in the general practice. Talk to the general practice and make a time that works for both the participant and the GP.

4.3.6 Maintain participant health and medical information

Strength In Care will:

- ensure relevant support staff have access to important health information, including current health problems, medications, allergies, adverse effects from medications, and reports from medical specialists and allied health professionals
- ensure that a record of each visit to a health professional is kept in the participant's file, and this is made available each time the participant sees a health professional
- ensure that any healthcare recommendations are documented and actioned following appointments with healthcare professionals
- implement regular and timely reviews are undertaken on participant medical and health records and in time for comprehensive health assessments (at least annually or more regularly due to changes in health)
- before a comprehensive health assessment (at least annually), a full review of participant records should be undertaken to identify concerns, risks, or any information about potentially undiagnosed symptoms that may not have been followed up
- maintain participants' health records in line with privacy and confidentiality requirements.

5.0 Related Documents

- Support Plan
- Access to Supports Policy and Procedure
- Support planning Policy and Procedure.
- Responsive Support Provision Policy and Procedure
- Independence and informed choice Policy and Procedure
- Incident Management Policy and Procedure
- Information Management Policy and Procedure

6.0 References

- NDIS Practice Alert Comprehensive health assessment (July 2021)
- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021

Oral Health Policy and Procedure

1.0 Purpose

Participants are at risk of poor oral (or dental) health, such as gum disease, tooth decay, loss of teeth and subsequent illnesses leading to detrimental effects on the person and their health, wellbeing and quality of life. This policy's purpose is to ensure that the staff are aware of the participant's oral health.

Participants are at a higher risk of poor oral health because, over their lifetime, they are more likely to have experienced poor nutrition, poor dental hygiene and lack of access to oral health care services. As a result, they may have tooth decay, gum inflammation and damage, ulcerations, and mouth infections. If not treated, oral health conditions can lead to loss of teeth, inability to eat certain food or drinks, acute and chronic pain, illness and hospitalisation. Diseases of the mouth can also impact the health of the whole body. Other risks include dysphagia (difficulty swallowing food and drink) refer to *Mealtime Preparation Policy and Procedure.*

2.0 Scope

This policy applies to all staff working with participants or developing and reviewing support plans.

3.0 Policy

Strength In Care is aware that good oral health includes twice-daily brushing using fluoride toothpaste and flossing of teeth and gums. Also important are good nutrition, annual dental checkups and treatment.

Strength In Care must monitor participants' health, safety and wellbeing, support participants to maintain their health and access appropriate health services, including oral health services.

Oral health problems can be addressed by taking care of the whole mouth, including:

- teeth, gums, lips and cheeks,
- through regular dental checkups,
- brushing teeth,
- flossing, clearing food from the mouth after eating,
- good nutrition,
- staying hydrated,
- reducing sugar, alcohol and
- quitting smoking.

Our organisation encourages regular dental checkups to allow early detection and treatment of oral health issues. Participants are urged to see a dentist if gums bleed, are puffy or lumpy, or inflamed, and if a participant complains of or demonstrates oral pain. We will provide Easy Read Oral Care information as relevant.

Staff must follow the NDIS Code of Conduct to:

- act with respect for individual rights to freedom of expression, self-determination and decision-making following applicable laws and conventions
- provide supports and services safely and competently with care and skill
- promptly take steps to raise and act on matters that may impact the quality and safety of participants' support.

Strength In Care will comply and deliver safe, quality supports and services and the management of risks associated with the supports you provide to NDIS participants following the NDIS Practice Standards and Quality Indicators.

This policy is linked to the NDIS Practice Standards, including:

- **Support planning:** participants are actively involved in developing their support plans. Support plans reflect participant needs, requirements, preferences, strengths, and goals regularly reviewed.
- **Independence and informed choice:** participants are supported to make informed choices, exercise control and maximise their independence relating to the supports provided
- **Access to supports:** participants access the most appropriate supports that meet their needs, goals and preferences.
- **Incident Management:** participants are safeguarded by the incident management system, ensuring that incidents are acknowledged, responded to, well-managed and used are part of our continuous improvement.
- **Information Management:** participants' information is managed to ensure that it is identifiable, accurately recorded, current and confidential. Each participant's information is easily accessible to the participant and appropriately utilised by relevant workers.
- **Human Resource Management:** The participant's support needs are met by competent workers with relevant qualifications, expertise

4.0 Procedure

4.1 Supporting participants

Relevant staff must monitor participants' health, safety and wellbeing, support participants to maintain their health and access appropriate health services, including oral health services. Participants are supported to take care of their oral health, improve their oral health care knowledge, and access dental services.

4.1.1 Plan access to oral health care

Staff are required to:

- talk with the participant about their mouth and ask if they have any worries or pain

- ensure that the participant's support planning includes caring for their oral health, for instance, brushing teeth twice daily and regular dental checkups
- assist the participant in forming a partnership with their dentist and participating in a person-centred planning process with the dentist
- develop a knowledge base about the participant and work with an NDIS behaviour support practitioner to determine if adaptive sensory processes are needed to facilitate a successful dental visit
- be aware that a change or increase in a participant's behaviours of concern may result from dental pain
- use accessible tools and resources, such as social stories, to prepare and plan a visit to the dentist.

4.1.2 Visit, the dentist supports

- the participant in accessing dental care for regular (at least 12 monthly) checkups
- to facilitate informed decision making regarding oral health care and treatment using the participant's preferred communication methods. Involve the participant's family, independent support person or guardian in the decision-making process where appropriate.
- involve the participant's family and informal supports to assist the participant in attending a visit to the dentist, where appropriate,
- support the participant before, during and after a visit to the dentist, including assisting them to communicate with the dentist and following up on the dentist's recommendations after the visit
- use available tools and resources to understand more about good oral health care, how to assist someone brushes their teeth, eligibility for public dental health care, what information the dentist needs and what happens at the dentist visit.
- ensure that any information is provided to the participant in accessible formats, including Easy English and Easy Read, where required.

4.1.3 Follow up on oral health care

- after a dentist visit, support the participant to follow up with:
    - recommended care or changes to daily brushing routines
    - referrals to specialist dental, medical or allied health professionals.
- Ensure participants access regular (at least 12-monthly) dental checkups and that records include any changes or need for dental health assessments. Recommendations are communicated to all relevant staff, and follow up actions are undertaken.
- Ensure the dentist's recommendations are documented in the participant's oral health care plan, support plans and other relevant documents.

4.1.4 Assist daily oral care

- encourage, educate and motivate participants to look after their teeth and gums.
- ensure participants have the items they need to care for their teeth, such as a toothbrush; dental flossing aids; fluoride toothpaste; and any other items recommended by the dentist
- ask the participant what help they need to brush their teeth and rinse after eating a meal
- ensure arrangements are in place to support person-centred participation and supported decision making in oral health care activities for the regular care of teeth, including the type of food eaten, twice-daily brushing with fluoride toothpaste, flossing and rinsing.

4.1.5 Referrals to other professionals

Consider and act on whether the participant needs any of the following referrals:

- a **speech pathology** when gagging when brushing teeth, unable to clear food after eating and chewing, difficulty eating certain foods, swallowing problems, weak or absent cough or drooling.

- an **occupational therapist** to assist participants with handling a toothbrush, flossing, using dental cleaning aids recommended by the dentist, and supporting learning oral hygiene skills.
- an **NDIS behaviour support practitioner** may assist the participant with strategies to manage anxiety and plan reasonable adjustments for a successful dental visit.

4.1.6 Training and development

Strength In Care will review our training program to increase staff training and skills in areas such as:

- knowing where and how to access dental services provided through local health districts and how to access emergency dental services in the local area
- knowing whether there are specialist dentists who are skilled in working with people with disability
- training in oral health care and development of oral health literacy
- how to support tooth brushing, flossing and rinsing food from the mouth after eating, especially for participants on soft foods. For instance, encouraging regular drinks of water throughout the day
- working with a dental practitioner to develop an oral health plan for a participant that includes: risks or problems; dental work they have had before; support needed to brush teeth; the participant's dentist; whether they need a specialist dentist
- training on ways to support participants who are reluctant to engage in oral health care and services, including training in positive behaviour support, supported decision-making or motivational interviewing techniques.

5.0 Resources

5.1 Preparing and supporting participants to visit the dentist

- The Australian Dental Association and Designlab Inclusion Melbourne have developed a series of videos about going to the dentist, teeth brushing and oral care for people with intellectual disabilities. There are also oral health planning forms for the dentist and participant.
- Your Dental Health Guide for people with disability was developed by the Australian Dental Association Western Australia and Inclusion Melbourne. This resource includes practical information for dentists, participants, their families, guardians and NDIS providers.
- Maggie goes to the dentist is an example of a social story that can be customised to assist a participant prepare for a dental visit.
- Going to the dentist is a guide for families and carers of people with Autism, WA Health.
- IDEAS Dentists and Disability website have oral health information and resources for people with disability.
- The Australian Dental Association also has a range of oral health resources available for the general community.

5.2 General Information f

- VicHealth Everysmile has tools, resources and ideas to improve the oral health of people in supported accommodation services.
- Dental Practice Education Research Unit, Adelaide University, has information sheets for Dentists and Carers.
- Health Direct has a guide to accessing oral health services in Australia.

(Resources above are from the NDIS Oral health practice alert)

6.0 Related Documents

- Easy Read – Oral Health
- Support Plan

- Support planning Policy and Procedure.
- Independence and informed choice Policy and Procedure
- Access to Supports Policy and Procedure
- Incident Management Policy and Procedure
- Information Management Policy and Procedure
- Human Resource Management Policy and Procedure

7.0 References

- NDIS Practice alert: Oral Health
- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021

Daily Personal Activities (Sole Carer) Policy and Procedure

1.0 Purpose

Participants living in their own homes have the right to be safe and live as autonomously as possible within their environment. It is Strength In Care's objective to effectively manage professional carers to ensure that they are providing services and supports to meet the requirements of the participant.

2.0 Scope

Strength In Care's management team are responsible for ensuring our professionally trained staff are appropriately supervised and determining they are providing high-quality services that meet the NDIS (Provider Registration and Practice Standards) Rules 2018.

Personal care supports relate to assistance with daily personal activities, including assistance with, or supervision of, personal tasks of daily life, including:

- personal hygiene (e.g. showering, bathing, oral hygiene, dressing and grooming)
- toileting, bladder and bowel management and menstrual care
- eating and drinking
- attending appointments
- use of aids and appliances, hearing and communication devices
- mobility and transferring (e.g. moving in and out of bed and on or off the toilet)
- application of splints, basic first aid due to injuries sustained due to a participant's disability.

3.0 Policy

During the development of the support plan and service agreement, staff are required to actively listen to the participant and their support network to determine the goals,

interests, and needs of the participant. Information is gathered and used to design the supports and services within the support plan to:

- maximise the independence and functional skills of the participant
- suit the participant's age and circumstances
- meet a participant's needs in a less intrusive manner.

Participant's choices and decisions are incorporated into the support plan, including:

- the type of care worker preferred
- specific activities and supports needed (e.g. showering, dressing, eating, toileting, appointments)
- timeframe for activities
- overnight supports (if required).

4.0 Procedure

For participants who live in their own home and request a sole carer, Strength In Care will undertake the following steps:

Step 1. Design daily personal activities

- Detail and record all activities required as per the service agreement.
- Gather details on how the participant wants activities undertaken (e.g. how they like to be showered, what time of day, etc.).
- Determine hours and timeframes for each activity.

Step 2. Identify preferred carer/s (initial consultation)

- Listen to the participant to determine requirements (e.g. male/female, language preferences, cultural requirements, etc.).
- Identify the skills that the carer/s require.
- Review current care workers to determine possible matches.
- If no matches in our current workforce, then the Director will locate appropriate care workers.

- The Director will locate at least two to three carers for each participant.

Step 3. Complete the Safe Environment Checklist and Individual Risk Assessment Profile

- The Director will delegate a staff member to visit the home environment to determine the safety of the environment for both the participant and staff. The Safe Environment Checklist will be completed during this visit.
- All information gained from the visit is documented within the participant's support plan.
- The Individual Risk Assessment Profile will be completed with the participant. Information will be used to develop appropriate risk strategies in the support plan.
- The Director will develop, finalise and detail support plan strategies and objectives in collaboration with the participant, their family or advocate.

Step 4. Staff training

- Staff selected by the participant will be trained in all aspects of their care.
- The Director or their delegate will train the staff.
- A buddy system (of at least two shifts) is implemented to ensure staff are fully trained in all aspects of the role to meet the participant's requirements.

Step 5. Supervision

- The Director will determine an appropriate supervisor.
- The supervisor will visit the participant's home environment at least every two months.
- The supervisor will complete the Participant's Home Monitoring Visit Report during these visits.
- The supervisor will meet with management to report their findings after each home visit. The meeting will identify risks or issues and inform continuous improvement required (e.g. additional training, staff change, etc.).

Step 6. Participant feedback

- The Director will seek the participant's feedback regarding the performance of the staff at least every two months.
- The participant may provide feedback verbally, via email/letter, or through the Complaints and Feedback Form or complete the Annual Participant Survey.

5.0 Related documents

- Support Plan
- Service Agreement
- Participant Home Monitoring Visit Report
- Annual Participant Survey
- Individual Risk Assessment Profile
- Risk Management Plan
- Risk Register
- Safe Environment Checklist
- Training Attendance Register – In-house
- Training Register
- Staff Training Record
- Staff Training Plan
- Complaints and Feedback Form

6.0 References

- NDIS Charter of Rights
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- NDIS (Quality Indicators) Guidelines 2018
- NDIS Act 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Human Rights and Equal Opportunity Commission Act 1986 (Commonwealth)

- Work Health and Safety Act 2011 (Commonwealth)
- Disability Discrimination Action 1992 (Commonwealth)
- United Nations Convention on the Rights of Persons with Disabilities

3.5 Transition to or from the Provider

Transition or Exit Policy and Procedure

1.0 Purpose

Strength In Care's Transition or Exit Policy and Procedure complies with *the National Disability Insurance Scheme Act 2013*, which promotes access, inclusion and choice for people with disabilities. This policy aims to define the processes required to assist and support participants to transition to or exit from services.

2.0 Scope

This policy applies to all participants receiving supports and services from Strength In Care. This policy aims to define a transition or exit process for participants, family and advocate/s, where applicable. The policy provides direction for Strength In Care's staff when considering the exit of a participant from the organisation or working with other providers during the transition to the organisation.

3.0 Policy

Strength In Care is committed to providing participants with information and support through the process of transition into, or exiting from, the organisation's services:

- All participants are provided with the necessary information and explanation in the appropriate communication formats concerning their transition into or exit from the service.
- Participants are provided with information and support through the transition into or exit from the organisation's service.

- Participant transition strategies and exit planning will be documented in the participant's service agreement and support plan.
- The participant entry and exit process for programs are transparent; the organisation adopts fair and non-discriminatory practices when a participant chooses or is required to leave the service.
- To collaborate with other providers for a planned transition to, or from, our service.
- Staff must document, communicate and effectively manage transitions and exits to benefit participants.
- Risk assessments must be undertaken, documented, and acknowledged with each transition.
- Strength In Care delegated staff members must identify processes for the participant and ensure application and review.
- Strength In Care will record if a participant:
    - has met their goals,
    - chooses to leave or cease the services,
    - wishes to transfer to another service provider,
    - moves location and cannot access the service,
    - is no longer eligible for services.

For temporary transition and exit to a hospital or similar, refer to Transitions of Care between Disability Services and Hospitals Policy and Procedure. For other temporary transitions and exits, use this policy.

4.0 Definition

Term	Definition
Transition	Transition requires the preparation for and support of the participant to enter or exit the service. Or referral from another service or to another service or program where appropriate.

Exit (or discharge)	The process through which participants transition out of our organisation The exit process occurs when they have reached their goals outlined in the participant's support plan. For some participants, there may be a period of transition to exit or some form of continuing care.

5.0 Procedure

Strength In Care will implement a collaborative approach when undertaking all decision-making processing regarding transition and exit to allow for an informed approach. This approach must be recorded in the support plan and include the following:

- reasons for the transition
- details of the provider transitioning to/from
- outline of collaborative communication
- summary of communication methods and details of information provided to relevant parties
- the feedback that is received from participants, families, advocates and stakeholders
- transition time frames
- transition process incorporating details of the process, application and communication process relevant to the participant
- identification of risks to the participant and risk management strategies
- review of the process and adjustments made, as required.

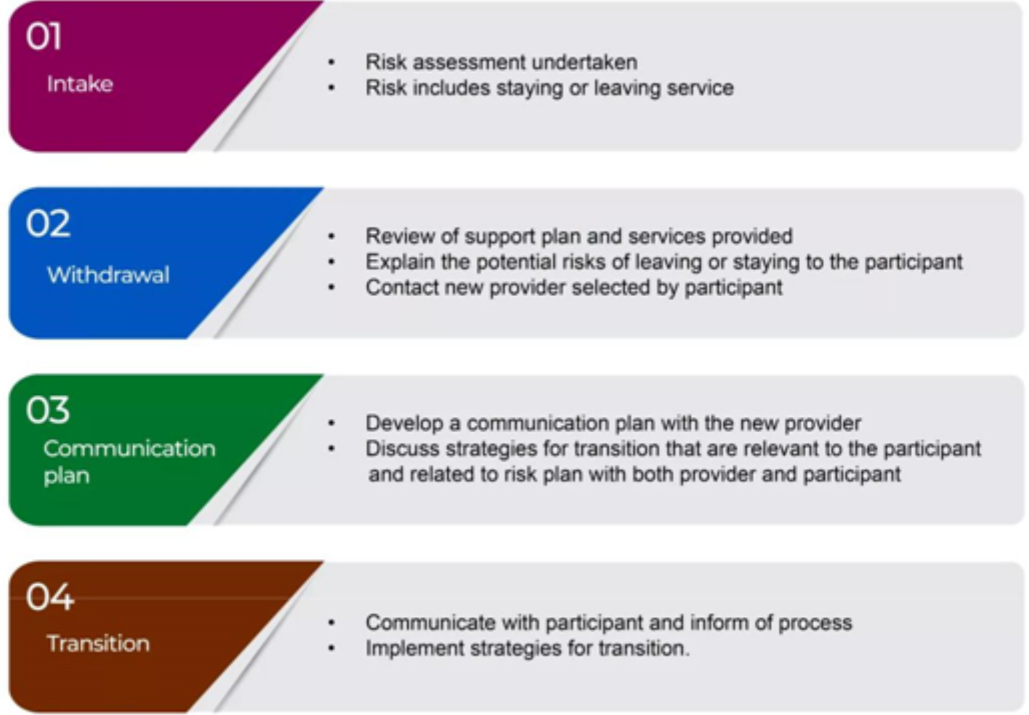
All participants must be advised how and when a process of transition or exit can occur at the time of development of their Service Agreement and Support Plan.

5.1 Service agreement

As per the Service Agreement, a minimum notice of no less than 14 days, or a more extended period, is required to enable the participant, family, and advocate or Strength In Care to have adequate time to nominate an alternative registered provider to deliver support services.

Strength In Care will give notice of intent to withdraw/terminate services to a participant as per their Service Agreement, which states no less than 14 days' notice, or longer, as required.

Figure 1. Transition or exit process



5.2 Transition or exit plan

- A transition or exit plan will be developed at the entry into the service.
- The transition or exit plan is discussed during the participant's reviews.
- The participant will be informed of any risks involved with transitioning into, or exiting from, the service.
- The plan will include a seamless time frame, offer flexibility and provide reliable support from the other service provider.
- The plan will support participants to transition into our service, exit to other services, or cease services.

5.3 Interviews

An entry interview is part of the transition plan; participants wishing to make a complaint regarding their transition into the service will be provided with details on the complaint process.

An exit interview is part of the exit plan; participants wishing to make a complaint regarding their exit will be provided with details on the complaint process.

5.4 Risks

Risks associated with the transition or exit process are identified during the planning stage, documented in the participant's plan and responded to immediately. This risk assessment will be held in the support plan.

5.4.1 Transition

- Identify the participant requiring transition into our organisation
- Identify the service(s) transition from
- Undertake Individual Risk Profile
- Work with the participant and relevant stakeholders to eliminate or minimise risk
- Monitor during the transition process and offer relevant options
- Create a Transition and Exit Plan

5.4.2 Exit

- Participant informs our organisation that they are exiting our service
- Liaise with the new provider and provide relevant risk information and reports
- Work with the participant and new service to eliminate or minimise risk
- Monitor during the exit process and offer relevant options
- Create a Transition and Exit Plan

Strength In Care will aim to minimise the impact of change that is occurring for the participant by creating a transition support schedule that meets the participant's goals, needs and requirements appropriately.

6.0 Related documents

- Transition or Exit Plan
- Code of Conduct Agreement
- Complaints and Feedback Form
- Complaint, Compliment and Feedback Register
- Individual Risk Assessment Profile
- Risk Assessment Forms
- Risk Management Plan
- Risk Register
- Support Plan
- Service Agreement

7.0 References

- NDIS Practice Standards and Quality Indicators 2021
- NDIS Scheme Act 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)

Transitions of Care between Disability Services and Hospitals Policy and Procedure

1.0 Purpose

Transitions of care refer to participants' movement between places or services providing care, such as people moving between disability support services and hospitals. There is a risk of harm to participants. In Australia, the transition of care problems has been associated with risks of harm to people who have a disability. The safe transition of care requires clear communication about participant care between providers, health care staff, participants, and their support network.

2.0 Scope

Staff are required to support participants in the transition process under the guidance of management and this policy.

3.0 Policy

Transitions of care are priority areas for improving medication safety and reducing avoidable harm. During transitions to and from different healthcare settings, a lack of clear communication about a participant's healthcare needs and current treatments can increase the risk of harm.

Safe transitions of care require clear communication and coordination between the participants, their carers, health care and our service. Our organisation will ensure that the communication and coordination between our organisation and the participant's support network about the participant's health needs, potential risks and current health care are not lost during care transitions, including:

- going to hospital from home or supported accommodation

- leaving the hospital to return home or to supported accommodation

Staff must follow the NDIS Code of Conduct and ensure that they:

- provide supports and services safely and competently with care and skill
- promptly take steps to raise and act on concerns about matters that might impact the quality and safety of supports provided.

Under the NDIS Practice Standards, our obligations are related to delivering safe, quality supports and services and managing risks associated with the supports you provide to NDIS participants. This policy is linked to the NDIS Practice Standards, including:

- **Risk management**: Risks to participants are identified and managed.
- **Quality management:** Participants benefit from a quality management system where we continuously use information and feedback to improve support delivery.
- **Information management:** Management of each participant's information ensures it is identifiable, accurately recorded, current and confidential. Each participant's information is easily accessible to the participant and appropriately utilised by relevant workers.
- **Incident management:** Participants are safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, responded to, well-managed and used as part of our continuous improvement
- **Management of medication:** Participants requiring medication are confident that we administer, store and monitor the effects of their medication and work to prevent errors or incidents.

4.0 Procedure

Strength In Care will undertake the following:

- Prepare for potential hospital admissions by keeping participants' health-related information and documentation up-to-date and accurate to be readily communicated to hospital staff.
- Support participants in preparing for hospital admission by coordinating a pre-admission meeting with hospital staff and the participant's support network.
- Plan transitions out of hospital as early as possible based on professional medical advice to ensure that any changes in care are considered.
- Work with hospital staff and the participant's support network to ensure you can provide any additional health-related support the participant may require after leaving the hospital.

4.1 Supporting the participant

Strength In Care will prepare for possible transitions of care by:

- keeping the participant's health and medication information accurate and up-to-date
- communicating with other services during transitions of care
- helping participants understand and communicate information about their health.

4.2 Prepare for a planned hospital admission

To support participants in preparing for planned hospital admissions, we will arrange a pre-admission meeting with hospital staff to:

- coordinate the transition of care with the participant, relevant hospital staff, our staff, and, if possible, the participant's support people such as family or friends
- inform hospital staff about the participant's communication requirements, mobility and physical support needs, nutrition and mealtime management, and behaviour support strategies.

4.3 Information to provide to hospital staff

Providing information to hospital staff requires Strength In Care to have consent from participants, guardians or carers to share information; make the following available to hospital staff on admission:

- My Health Record (if used by the participant)
- Hospital Support Plan– based on the participant's specific needs and requirements
- List of current medications
- Webster packs and other required medications
- Health Care Card
- Medicare Card
- Behaviour Support Plan
- Communication plan/profiles and any related communication aids/tools.

For an emergency visit to the hospital, you may need to arrange for a disability support worker familiar to the participant to stay with them during the admission.

4.4 Support when the participant leaves the hospital

4.4.1 Plan for discharge from the hospital

Plan for the participant's hospital discharge in consultation with health professionals as early as possible, including:

- estimated date of transfer
- destination of transfer
- transportation
- referral services
- home assessments for equipment, modifications
- re-assessing support risks (e.g. wound management, tube feeding).

4.4.2 Understand the participant's ongoing support needs and assess your capacity to meet them

Work with hospital staff to understand the participant's ongoing needs after they leave the hospital, including obtaining the following:

- Transfer of Care summary:
    - summary of the medical care the participant received in the hospital.
- Care plan:
    - follow-up appointments with medical specialists,
    - care recommendations for the participant's regular health care providers, such as their GP, and
    - any other required health or social requirements.
- Medications summary:

    - list of current medications, including information about any new or changed medications.
- Risk Assessment review
    - Review Individual Risk Profile and complete new document, as required
    - Adjust support plan, as required
    - Train staff, as required

Director or their delegate must ask about and understand any changes to the participant's ongoing care needs that have occurred during their hospital stay and assess whether you can provide for these (for example, if the participant now requires specifically trained staff or equipment). If our organisation cannot provide these new care requirements, then we must communicate this to hospital staff as soon as possible.

Director or their delegate must undertake early and ongoing communication with hospital staff, the participant, and support people such as carers (and, if required, the participant's NDIS plan manager) to prevent delays in leaving the hospital and reduce risk to participants after their discharge.

Strength In Care will provide the participant with information about their follow-up care when they leave the hospital. If required, make this available in Easy English.

5.0 Related Document

- Support Plan
- Individual Risk Profile
- Support planning Policy and Procedure.
- Independence and informed choice Policy and Procedure
- Access to Supports Policy and Procedure
- Incident Management Policy and Procedure
- Information Management Policy and Procedure
- Human Resource Management Policy and Procedure
- Risk Assessment Policy and Procedure
- Continuous Improvement Policy and Procedure
- Quality Management Policy and Procedure

6.0 References

- NDIS Practice Alert Transitions of care between disability services and hospitals (November 2020)
- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021

Section 4: Provision of Environmental Supports

Topic	Policy and Procedure
4.1 Safe Environment	• Safe Environment Policy and Procedure • Infection Management Policy and Procedure • Cleaning Policy and Procedure • Hot Water Policy and Procedure • COVID-19 Response Policy and Procedure
4.2 Participant Money and Property	• Participant Money and Property Policy and Procedure
4.3 Management of Medication	• Management of Medication Policy and Procedure • Medication Management (swallowing difficulty) Policy and Procedure • Polypharmacy Policy
4.4 Mealtime Management	• Mealtime Management Policy and Procedure • Practice Guidelines – Food Preparation • Practice Guidelines – Choking
4.5 Management of Waste	• Management of Waste Policy and Procedure

4.1 Safe Environment

Safe Environment Policy and Procedure

1.0 Purpose

Safety for our participants is pivotal to providing high-quality supports and services. This policy is designed to ensure that all participants have access to services and supports that are:

- free from violence, abuse, neglect, exploitation or discrimination
- located in safe environments appropriate to their needs
- risk-averse; risks to participants are identified and managed effectively
- implemented by staff who are competent concerning their role, hold relevant qualifications, expertise and experience in providing person-centred, needs-based support
- transparent; where incidents are acknowledged, responded to, managed effectively, and any key learnings recorded.

2.0 Scope

All staff members must ensure that they focus on the safety of every participant. Staff must also be responsible for their safety within the workplace.

3.0 Policy

Strength In Care ensures that participants can identify our front-line workers.

Strength In Care reviews the participant's environment to ensure that it is safe for both the participant and our staff. A collaborative approach to risk assessment is undertaken to ensure that appropriate strategies are planned and implemented to treat known risks to

the participant. This collaboration is participant dependent and may include health care and allied health providers) to identify and manage risks to participants and correctly interpret participant needs and preferences.

The mode of communication identified by the participant is recorded in the support plan. Staff will use this method to assist the participant in expressing their emerging health concerns. Medical emergency protocols and responses must be recorded in the support plan.

4.0 Procedure

4.1 Risk Assessment

Staff designated to undertake risk assessments must complete a Participant Safe Environment Risk Assessment for non-home environment services. A Safe Environment Checklist – Home is utilised for services provided in the home environment. Collaboration with other services may be undertaken to gain full insight into the potential and real risks.

4.2 Medical emergencies

The information gained from the participant and their family or supports will be used to create a Medical Emergency Plan within the support plan. Staff will be trained on what constitutes an urgent and non-urgent medical situation, and staff must undertake an immediate response in emergencies.

The Medical Emergency Plan will include:

- immediate response
- what constitutes a point of escalation
- to whom to escalate
- identified staff member to contact

4.3 Staff identification

Participants in all environments must be able to identify a staff member easily. Staff identification could be in the form of a uniform or identification tags or badges. The staff must introduce themselves at the beginning of each service delivery.

4.4 Home supports

All staff must use the identification provided by Strength In Care upon entering a participant's environment. The staff will greet the participant and introduce themselves at the beginning of the service, and our staff will inform the participant when they are leaving the environment.

Physical identification will be worn in a uniform or identification tags when staff undertake home supports.

At access to the service and during the initial support planning design, the Director will determine if the participant's home environment (where the supports are undertaken) is safe.

Strength In Care will work with the participant, family and advocate to ensure that the home is safe for the participant and others. As required, the service will assess the premises using a Safe Environment Checklist.

4.5 Establishing a safe environment

If the participant accesses other providers, our team will work with these providers to:

- identify any environmental risks (see Participant Safe Environment Risk Assessment)
- ascertain how to treat the risks
- review the environment to ensure safety
- undertake removal/avoidance of any hazards

- devise a risk management plan to prevent and manage injuries.

The Participant Safe Environment Risk Assessment must be completed for each site where the participant attends and must include infection control.

4.5.1 Infection prevention and control

All staff must follow our Infection Management Policy and Procedure in all service provision settings. Routine environmental cleaning must be conducted where service occurs (not just in the home environment), and cleaning must occur on frequently-touched surfaces.

Management will resource staff to allow them to clean environments when not located in a participant's home. Every staff member is trained in infection prevention and control and PPE use. All staff will undertake a refresher course at least annually. Training will include:

- hand hygiene practices
- respiratory hygiene
- coughing etiquette (using elbow when coughing

5.0 Related documents

- Employment Check Register
- Food Hygiene Check
- Position Descriptions
- Medical Emergency Plan
- New Employee Details
- Participant Intake Form
- Participant Safe Environment Risk Assessment
- Personal Emergency Preparation Plan
- Privacy and Confidentiality Agreement
- Risk Management Policy and Procedure

- Safe Environment Checklist – Home
- Safe Food Storage Check
- Staff Orientation Checklist
- Staff Personal Protective Equipment (PPE) Provision
- Training Attendance Register – In-house
- Training Register
- Staff Training Record
- Staff Training Plan
- Supporting Planning and Service Agreement Collaboration Policy and Procedure
- Support Plan (Easy Read available)
- Training Needs Analysis
- Work Health Safety and Environmental Management Policy and Procedure

6.0 References

- NDIS Practice Standards and Quality Indicators 2021
- Work Health and Safety Act 2011 (Commonwealth)
- NDIS Scheme Act 2013 (Commonwealth)
- Privacy Act 1988 (Commonwealth)

Infection Management Policy and Procedure

1.0 Purpose

This policy aims to prevent cross-infection between participants, carers, staff and contractors so participants maintain their health and well-being. By managing infection, Strength In Care can more effectively manage the cost of health care to both the organisation and our participants.

It is imperative that our staff and contractors understand and follow our protocol concerning infection control and implement our processes as part of their essential work practices and during all care activities to stop the spread of infectious agents.

2.0 Scope

This policy applies to all Strength In Care staff and contractors. Appropriate training will be implemented to assist staff in understanding the causes of infection and how infections spread.

3.0 Definitions

Table 1. Definitions

Term	Definition
Infection	A disease or illness is caused when an organism inside a person multiplies to levels where it causes harm.
Colonisation	An infectious agent establishes itself on or in the body but does not cause disease.
Contamination	When infectious agents spread to a surface or item, creating risks for the spread of infection.

Source	The origin of the infectious agent; most sources are other people, but they can also be air, water, food or equipment that has become contaminated.
Susceptible host	This host is a person exposed to an infectious agent vulnerable to infection.
Multi-resistant organism	A multi-resistant organism (MRO) is an infectious agent resistant to several antibiotics typically used in its treatment. Because treatment options are limited, it is especially important to stop the spread of MROs.
Standard precautions	A minimum level of practice for infection control.
Additional precautions	Put in place when staff know they will be in contact with cases of certain infections.
Common modes of transmission	
Transmission	The spread of infectious agents from one person to another.
Contact	Infectious agents are transferred directly (e.g. contact with infected blood or body fluids) or indirectly (e.g. touching a contaminated surface and then another person without hand hygiene).
Droplet	Droplets made by coughing or sneezing transfer to someone's eyes, nose or mouth.
Airborne	Tiny particles containing infectious agents travel through air currents (e.g. air conditioning) and are breathed in by a person.
Vehicle	Food contaminated with an infection is the "vehicle" to carry the infection to a person when they eat the contaminated food.
Vector-borne	An animal or insect carries a disease and bites a person who then becomes infected.

Outbreak	The occurrence of more disease cases than expected in an area among a specific group, e.g. two or more linked cases of the same illness.

Infectious agents

Organisms that cause infections are infectious agents and are sometimes referred to as germs; most are microorganisms – bacteria, viruses, fungi and parasites. Infectious agents spread from one person to another, and it colonises or establishes themselves in the exposed person who may become infected.
https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/workplace-safety-infection-control

Infectious agents can be spread in a variety of ways, including:

- breathing in airborne germs – coughs or sneezes release airborne pathogens, which are then inhaled by others
- touching contaminated objects or eating contaminated food – the pathogens in a person's faeces may be spread to food or other objects if their hands are dirty
- skin-to-skin contact – the transfer of some pathogens can occur through touch or by sharing personal items, clothing or objects
- contact with body fluids – pathogens in saliva, urine, faeces or blood can be passed to another person's body via cuts or abrasions or through the mucus membranes of the mouth and eyes.

4.0 Policy

4.1 General management

Strength In Care will maintain high standards of infection control through the following measures:

- maintaining and reviewing our infection control policy and procedures regularly and responding to new legislation and best practice guidelines
- maintaining service agreements with appropriately qualified and licenced organisations for the following:
    - removal of waste
    - regular monitoring and removal of pests when required (e.g. termites, spiders)
    - supply of food
    - cleaning and laundry equipment and services
    - monitoring and maintenance of air handling systems (where installed)
    - supply of personal protective equipment
    - pharmaceuticals and medical supplies.
- providing infection control training to all staff
- displaying information and directions within the home to help staff and visitors maintain infection control practices
- completing relevant hazard and risk management processes, as required
- auditing infection control practices, investigating problems, checking for trends and fixing problems.

4.2 Standard precautions

Standard precautions are practices that are applied by all staff and include:

- hand hygiene
- respiratory hygiene/cough etiquette
- personal protective equipment
- handling of medical devices
- cleaning and managing spills
- handling of food, waste and linen.

Standard precautions will always be used for all:

- participants

- work practices.

5.0 Responsibilities

The Director or their delegated officer will undertake the following:

1. Coordinate, monitor, and review the infection control program following Strength In Care's care governance program.
2. Identify and monitor any trends in infection and then formulate and monitor action plans to address these.
3. Monitor staff compliance with infection control requirements and address any issues as identified.
4. Provide infection control reports as required to the Board.
5. Ensure service practices and procedures include and comply with infection control requirements.
6. Participate in selecting and providing equipment and supplies to ensure infection control requirements are met.
7. Support the staff vaccination program in consultation with our staff.
8. Coordinate and evaluate infection control education for all staff, including orientation of new staff members.
9. Ensure that plans are in place to identify and manage infections.
10. Provide information and feedback to management and staff regarding infection control activities and related matters, including actions taken and outcomes achieved.
11. Facilitate the collection of data and necessary reports for infection control clinical indicators.
12. Undertake ongoing professional development in infection control to maintain up-to-date skills and knowledge.
13. Conduct a range of infection control audits as required, and formulate and monitor action plans to address identified issues.
14. Coordinate the management of occupational exposures to blood and body fluids.

15. Ensure that additional precautions are implemented when required to prevent the spread of infection.

6.0 Procedures

Strength In Care must provide care to our participants to assist them in maintaining their well-being and health, as:

- children and older people are often more vulnerable to infections, as their immune systems may not be developed or may be compromised
- participants with chronic diseases may spend time in hospitals where they will be exposed to infectious agents
- surgical wounds and invasive devices, e.g. catheters, increase the risk of infection.

6.1 Risk Management

The Board and the Director ensure implementation of the following processes to manage risks associated with infection control as outlined in the diagram following:

6.2 Surveillance

Surveillance is an integral part of our infection control program, and it encompasses outcome surveillance, process surveillance and critical incident surveillance.

6.2.1 Outcome surveillance

Infection control data is collected by the Director or their delegate and other staff members (as requested by management) from documents, e.g. participant notes/charts, audits, etc.

Data on the following infections may be collected for review:

- skin and mucous membrane infection
- respiratory tract infections
- urinary tract infections
- gastrointestinal

- eye, ear, nose and mouth infections
- skeletal connective tissue
- systemic.

Specific surveillance may be carried out and reported as decided by the Board in consultation with the Director.

6.2.2 Process surveillance

Reports related to surveillance are submitted by the Director to the Board as required. The reports may come from various sources, including clinical information, health issues and other relevant sources.

6.2.3 Critical incident surveillance

The delegated officer will collect data for each critical incident. Investigation of critical incidents is undertaken by the Director or their delegate with the help of staff and external agencies as required.

6.3 Standard and additional precautions

Overview

A two-tier system of infection control precaution is in place. The two tiers are standard precautions and additional precautions. The precautions are designed to control the spread of infection that occurs through the following modes of transmission:

- direct physical contact
- indirect physical contact
- droplet
- airborne
- vehicle

- vector-borne.

6.3.1 Standard precautions (Tier 1)

Standard precautions help reduce the risk of transmitting microorganisms from both known and unknown sources of infection and are always undertaken.

Standard precautions include:

- safe work practices, e.g. hand hygiene and hand sanitising
- use of protective barriers, e.g. gloves, gowns/aprons, masks and eye protection
- appropriate management of contaminated sharps, clinical waste, participant care devices and linen
- respiratory hygiene/cough etiquette.

Standard precautions must be used when staff are likely to encounter:

- blood (including dried blood)
- all body substances, secretions and excretions (except sweat)
- non-intact skin
- mucous membranes.

6.3.2 Additional precautions (Tier 2)

Staff will use additional precautions when they know they will be in contact with certain infections. There are three types of additional precautions. Precautions include:

- **Contact precautions:** Used to reduce the risk of transmitting microorganisms by direct or indirect contact (e.g. contact with skin or surfaces contaminated with MRSA, scabies or gastroenteritis).
- **Droplet precautions:** Used where a participant may have an infection transmitted by droplets (e.g. mumps, rubella, influenza and SARS).

- **Airborne precautions:** Used for participants known or suspected to be infected with pathogens that can be transmitted through the air (e.g. tuberculosis or chickenpox virus).
- **Standard precautions are ALWAYS used with additional precautions**. Additional precautions are used by all staff members when the Director or their delegate instructs staff to use them.

The following table details staff requirements when undertaking standard precautions and when instructed to take additional precautions.

Requirement	Standard Precautions	Additional Precautions		
		Contact precautions	Droplet precautions	Airborne precautions
Signage	No	Yes	Yes	Yes
Hand hygiene	Yes	Yes	Yes	Yes
Gloves	Yes, if there is a risk of contact with blood or body substances.	Yes, for direct contact with a participant or their environment.	No	No
Impervious apron/gown	Yes, if there is a risk of splash or contamination with blood or body substances.	Yes, for direct contact with a participant or their environment.	No	No

Mask	Yes, if there is a risk of splash, splatter, or risk of blood or body substances spraying into the air.	No	Yes. Staff to use a surgical mask when coming within one (1) metre of the participant. Staff to remove the mask after leaving the	Yes. Staff to use a P2 mask. Staff to remove the mask after leaving the room.
Protective eyewear	Yes, if there is a risk of splash, splatter or risk of blood or body substances spraying into the air.	No	Yes. Staff to use when coming within one (1) metre of the participant.	No
Equipment	Yes, when handling equipment contaminated with blood or body substances. Remove gloves when finished handling the equipment and wash hands.	Single-use or dedicated equipment where possible. Reprocess reusable items to the required level before reusing them on other participants.	No	No

Cleaning	Yes, standard cleaning.	Standard cleaning depends on the organism. Director to advise staff of specific cleaning needed.	Standard cleaning depends on the organism. Director to advise staff of specific cleaning needed.	Standard cleaning depends on the organism. Director to advise staff of specific cleaning needed.
Transport of participants	Yes. Cover all open wounds.	Surgical mask if coughing/ sneezing and an infectious condition known or suspected. Director to advise precautions to transport staff and the receiving area.	Surgical mask for the participant when leaving the room. Use a mask over the top of nasal oxygen prongs (if used). Advise transport staff and receiving area of precautions.	Surgical mask for the participant when leaving the room. Use a mask over the top of nasal oxygen prongs (if used). Advise transport staff and receiving area of

Visitors	Yes. Hand hygiene before and after the participant visit.	Yes, as directed by the Director.	Yes. Use a surgical mask when coming within one (1) metre of the participant. Remove mask after leaving the room.	Yes. Use a P2 mask. Remove mask after leaving the room.
Other	Respiratory hygiene for coughing/ sneezing participants.	Do not take medical records into the room.	Do not take medical records into the room.	Do not take medical records into the room.

6.3.2.1 Visitors

The Director will determine if visitors need to use Personal Protective Equipment to protect themselves and others from infection. The requirements and the reasons for this should be clearly explained to the visitors by staff.

Visitors who do not wish to comply with requirements should be referred to the Director for further discussion and explanation.

6.3.2.2 Participants requiring the use of additional precautions

When a participant requires additional precautions, the policies and procedures in this manual will be implemented.

6.4 Hand hygiene and hand care

6.4.1 Situations requiring hand hygiene

- when starting and finishing work
- before and after a meal or other breaks
- before starting a new task or activity.
- after going to the toilet
- after using a handkerchief or tissue, coughing, or sneezing
- after touching hair or any other part of the body
- after handling rubbish
- whenever staff can see dirt on their hands, or when staff are requested to stop the spread of microorganisms.
- before and after direct contact with a participant and their surroundings
- before wearing, and after removing, any personal protective apparel, including gloves, mask/face protection, or impervious apron/gown.
- after any contact with blood or body fluids, non-intact skin and abnormal risk, e.g. rash
- after handling unwashed linen or clothing
- before handling or preparing any food or drinks for participants or staff, including assisting participants with their meals
- after contact with any surface, environment or object that may be contaminated.

6.4.2 General rules for hand hygiene

- hands must be cleaned with soap and water when there are dirt\substances on hands
- staff must wash their hands before and after using gloves
- artificial nails, nail extensions and nail enhancements (varnish or nail art) are not to be worn by staff while providing direct care to participants. These types of nails cause microorganisms to increase.
- hand and wrist jewellery are to be kept to a minimum for staff providing direct participant care

- rings (other than a plain wedding band) are not to be worn
- bangles, wrist bands or bracelets are not to be worn
- hands must be dried after washing, as the residual moisture left on the hands may harbour bacteria
- paper towels or single-use cloth towels must be used to dry hands.

6.4.3 Types of hand hygiene

Routine: Removes transient microorganisms

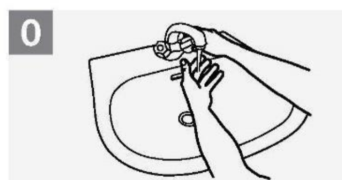
Product	Duration	Technique
Alcohol-based hand cleanser	10-20 seconds	Rub over all surfaces until dry without wiping.

Product	Duration	Technique
Liquid soap and water	30 seconds	Wet hands. Apply one measured dose of solution, lather well overall surfaces, rinse and pat dry with a disposable towel.

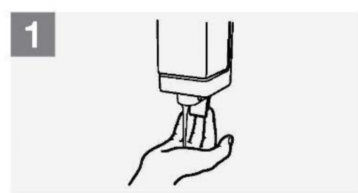
How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

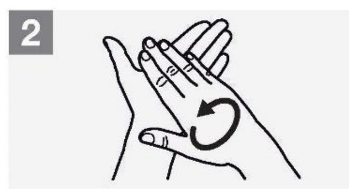
Duration of the entire procedure: 40-60 seconds



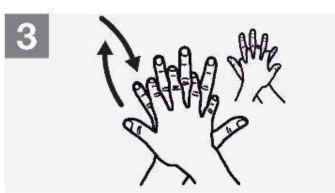
Wet hands with water;



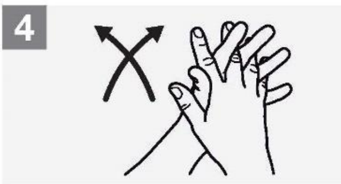
Apply enough soap to cover all hand surfaces;



Rub hands palm to palm;

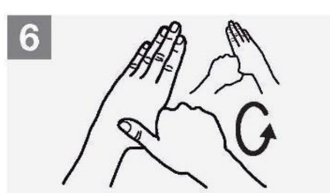


Right palm over left dorsum with interlaced fingers and vice versa;

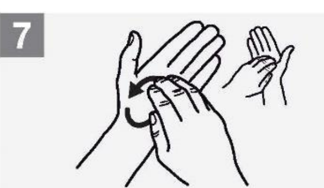


Palm to palm with fingers interlaced;

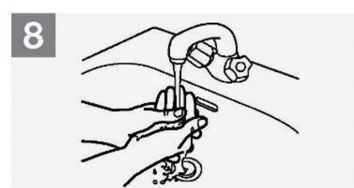
Backs of fingers to opposing palms with fingers interlocked;



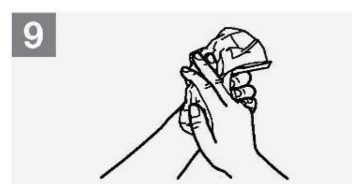
Rotational rubbing of left thumb clasped in right palm and vice versa;



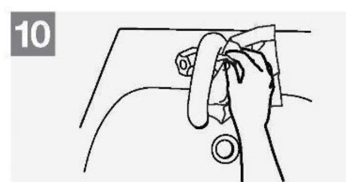
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



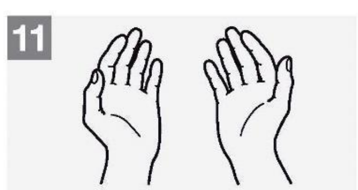
Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;

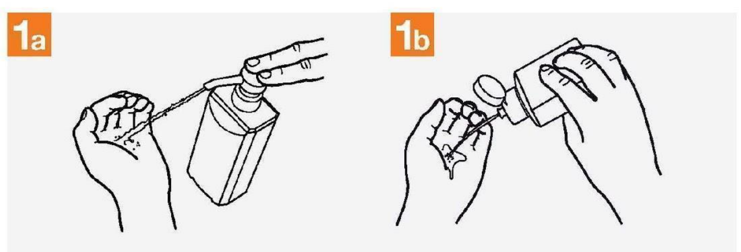


Your hands are now safe.

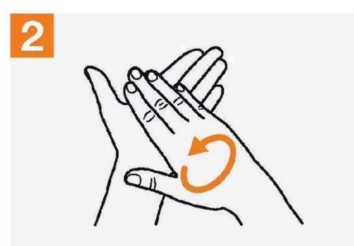
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

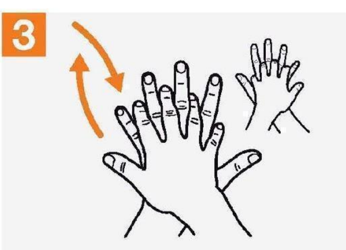
Duration of the entire procedure: 20-30 seconds



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

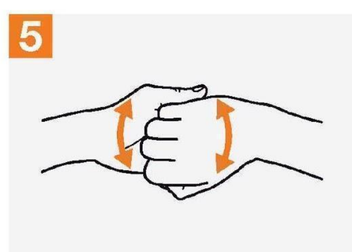


Rub hands palm to palm;



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

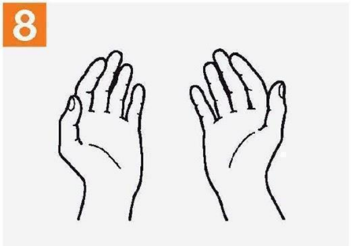
Palm to palm with fingers interlaced;



Backs of fingers to opposing palms with fingers interlocked;

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

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



Once dry, your hands are safe.

6.4.4 Procedural (clinical/non-surgical)

Use before aseptic procedures (e.g. catheterisation).

Product	Duration	Technique
Antimicrobial liquid soap and water	30-60 seconds	Wet hands, apply one measured dose of the solution, lather well over all surfaces, rinse and pat dry with a disposable towel. Use technique as per Diagram 1: How to Handwash; however, the duration must be 30-60 seconds.
Alcohol-based hand cleanser with known residual effect	30 seconds minimum	Rub over all surfaces until dry without wiping. Use technique as per Diagram 2: How to Hand Rub; however, the duration must be a minimum of 30 seconds.

6.4.5 Safety, storage and use of non-water cleansers (alcohol-based hand rub)

Alcohol-based hand rub will be made available in Strength In Care vehicles and offices.
A safety data sheet (SDS) for alcohol-based hand rub is available in areas where alcohol-based hand rubs are stored.

Alcohol-based rubs can ignite and catch on fire when they reach 21° to 24° Celsius or a large volume in one area. These rubs must be stored away at temperatures less than 21° Celsius.

6.5 Personal Protective Equipment (PPE)

6.5.1. Gloves

- **Sterile gloves**: Used for procedures where there is contact with susceptible sites (e.g. catheterisation, where an aseptic technique is required for wound care or managing a tracheotomy).
- **Non-sterile gloves:** Used for procedures that involve contact with non-intact skin and mucous membranes (e.g. emptying a catheter bag) and personal care activities (e.g. assisting with toileting).
- **Reusable utilised gloves:** Used for non-care activities (e.g. general cleaning, cleaning contaminated surfaces).

Gloves are used when:

- changing a colostomy bag or urinary drainage bag
- dressing wounds or touching broken skin
- assisting with toileting
- giving mouth or eye care
- oral suctioning
- touching equipment or surfaces that may encounter blood or body substances
- blood glucose monitoring
- touching broken skin
- preparing food.

Gloves are not used instead of hand hygiene; staff must always:

- perform hand hygiene before and after using gloves
- remove gloves when a care activity is finished
- change gloves before starting a different care activity
- dispose of used gloves immediately.

Staff must not use multiple gloves at the same time.

6.5.2 Aprons or gowns

Impermeable (waterproof) gowns or aprons stop staff clothes and skin contamination. Gowns and aprons are used when there is a risk of blood or body fluids (e.g., vomiting or diarrhoea). Gowns/aprons are worn during the care of participants who have an infection spread by the contact, droplet or airborne route.

Hand hygiene must be performed before and after using gowns or aprons.

The gown/apron must fully cover the torso from neck to knees, arms to end of wrists and adequately wrap around the back. All fastenings on the gown/apron must be tied and fastened at the back. The gown/apron will be removed and disposed of as soon as care is completed.

Plastic aprons can be used:

- when clothes may be exposed to blood or body fluids, and there is a low risk that arms will be contaminated
- when the staff member's clothes might get wet (e.g. when showering a participant)
- only once and then must be disposed of as soon as care is completed.

6.5.3 Face masks

Face masks protect a care worker's nose and mouth from exposure to infectious agents. They are used when there is a risk of:

- droplets or aerosols (e.g. from coughs or sneezes)
- splashes or sprays of blood or body fluids (e.g. when emptying wound or catheter bags).

Masks are worn during the care of participants who have an infection spread by the droplet or airborne route.

Masks may also be placed onto participants who are coughing, especially if they cannot cover their mouths. Before doing this, consider whether wearing a mask will cause distress (e.g. if the participant cannot understand the purpose of wearing the mask).

Types of mask

- Surgical masks are appropriate for most situations.
- Other types of masks may be required.
- The supervisor will inform staff of the appropriate mask, if necessary.

Procedure

1. Check manufacturer's instructions before use.
2. Do not touch the front of the mask with your hands once the mask is in place.
3. Use each mask for the care of one person only and change if a care activity is taking an extended time.
4. Do not leave a mask dangling around the neck.
5. Discard mask after use and perform hand hygiene after discarding

6.5.4 Protective eyewear

Protective eyewear protects a care worker's eyes from exposure to infectious agents. It is used when there is a risk of:

- droplets or aerosols (e.g. from oral suctioning)
- splashes or sprays of blood or body fluids (e.g. when emptying catheter bags).

Eyewear is worn during the care of participants who have an infection spread by the droplet or airborne route. Staff are trained to understand that the outside of the eyewear is contaminated and to:

- remove eyewear using the headband or earpieces
- clean eye shield after each use with detergent and water and allow it to dry
- dispose of single uses eyewear on completion of the care activity.

6.5.5 Handling medical devices

Indwelling medical devices, such as urinary catheters and intravenous catheters, allow infection to enter the body. When handling these devices, staff are at risk of exposure to blood and body substances.

Essential work practices to be followed by staff:

- perform hand hygiene before any contact with the device or where the device enters the body
- select personal protective equipment (e.g. wear gloves and a mask and gown if there is a risk of exposure to blood or body fluids)
- touch the device as little as possible.
- the longer the device is in place, the higher the risk of infection
- medical devices designed for single-use must not be used multiple times, and the manufacturer's instructions should be followed.

6.5.6 Respiratory hygiene and coughing procedure

Respiratory hygiene and coughing etiquette are particularly important for infections spread by droplets. All participants accessing our service must cover sneezes and coughs to prevent them from dispersing droplets into the air and infecting others. Participants are requested to:

- cover nose and mouth with a tissue when coughing, sneezing, wiping or blowing the nose, and dispose of the tissue immediately after use
- cough or sneeze into your elbow (if they do not have a tissue), not their hand
- perform hand hygiene immediately.

Staff must support participants by:

- encouraging them to use tissues when they sneeze or cough
- putting a plastic garbage bag near them, so used tissues can be disposed of immediately

- encouraging hand hygiene
- providing alcohol-based hand rub within easy reach.

6.5.6.1 Staff health requirements

- Staff who have symptoms of a respiratory illness must seek medical advice to check if there is a risk of infecting others.
- Staff who are ill should take sick leave.
- Staff who have a cough must practice the above procedure.
- Staff who have a cough must see their doctor immediately.
- Staff must follow the instructions of Strength In Care to report any illness, including coughs, to prevent the spread of any virus or bacteria.

6.5.7 Sharps management

- Staff members who use a sharp are responsible for its safe disposal:
- Always place the whole disposable needle and syringe in the sharps container unless there are instructions to do otherwise, e.g. insulin pen.
- DO NOT put the lid back on the needle.
- Place sharp in a hard plastic or metal tray when passing to another person.
- Any reusable sharps must be placed in hard plastic or metal containers immediately after use.
- Containers are only to be filled to the level as marked on the container. DO NOT force items into a sharps container (this can damage the container or cause injury).
- Full containers must have the lid firmly locked in place for collection by waste management.

6.5.8 Management of blood and body substance spills

If blood or body substance spills, staff must:

- put on protective clothing; this always includes gloves but may also include an impervious apron and nose/mouth and eye protection
- use brush and pan to remove any broken glass or sharps
- clean up the bulk of the spill with a paper towel and discard it in the bin
- use a mop and bucket to clean the spill (checking first with the participant as they may have specific cleaning equipment).

When finished cleaning, staff will:

- dispose of single-use items
- place reusable items (e.g. sheets, towels) in a washing receptacle for washing and drying
- clean reusable items such as goggles with a neutral detergent and then dry.
- clean the mophead and bucket with detergent and place upside down to drain and dry
- inform the Director or their delegate
- complete or assist with completing the Incident Report.

6.5.9 Multi-Resistant Organisms (MRO)

The issue of multiple resistant organisms (MROs) (also known as "superbugs") can be a source of real anxiety for staff and participants. It can cause inappropriate social and physical isolation and excessive infection prevention actions. It is finding a balance between infection prevention strategies and not inadvertently limiting a participant's activity level and engagement with the residential care community.

Staff will notify the Director IMMEDIATELY that they are aware a participant is infected or suspected to be infected with a multi-resistant organism.

Standard precautions are used in this situation, and staff will follow appropriate policies and procedures.

6.5.10 Notification of infectious diseases

The Director will report any of the following diseases as applicable to relevant state and national legislative requirements. The Communicable Diseases Network Australia (CDNA) has agreed that the following list of communicable diseases is to be notified nationally and provided to the Commonwealth's National Notifiable Diseases Surveillance System (NNDSS).

Bloodborne diseases

- Hepatitis (NEC)
- Hepatitis B (newly acquired)
- Hepatitis B (unspecified)
- Hepatitis C (newly acquired)
- Hepatitis C (unspecified)
- Hepatitis D
- Gastrointestinal diseases
- Botulism
- Campylobacteriosis
- Cholera
- Cryptosporidiosis
- Haemolytic uraemic syndrome (otherwise known as HUS)
- Hepatitis A
- Hepatitis E
- Listeriosis
- Paratyphoid fever
- Salmonellosis
- Shiga Toxin-producing E. Coli or Vero toxin-producing E. Coli (otherwise known, respectively, as STEC or VTEC)
- Shigellosis
- Typhoid fever

Listed human diseases

- Human influenza in humans with pandemic potential
- The Middle East Respiratory Syndrome Coronavirus (otherwise known as MERS-CoV)
- Plague
- Severe acute respiratory syndrome (otherwise known as SARS)
- Coronavirus (COVID-19)
- Smallpox
- Viral haemorrhagic fevers
- Yellow Fever
- Sexually transmissible infections
- Chlamydia
- Donovanosis
- Gonococcal infection
- Syphilis-congenital
- Syphilis-less than two years duration
- Syphilis-more than two years duration or unspecified duration

Vaccine-preventable diseases

- Diphtheria
- Haemophilus influenza (Type B)
- Influenza (laboratory-confirmed)
- Measles
- Mumps
- Pertussis
- Pneumococcal disease-invasive
- Poliovirus infection
- Rotavirus
- Rubella
- Rubella-congenital
- Tetanus

- Varicella-zoster infection - Chickenpox
- Varicella-zoster infection - Shingles
- Varicella-zoster infection - Unspecified

Vector-borne diseases

Note Vector-borne means transmitted by an insect or other organism.

- Barmah Forest virus infection
- Chikungunya virus infection
- Dengue virus infection
- Flavivirus infection (unspecified)
- Japanese encephalitis virus infection
- Kunjin virus infection
- Malaria
- Murray Valley encephalitis virus infection
- Ross River virus infection

Zoonoses

Note: Zoonoses refer to diseases transferable to humans from another animal species.

- Anthrax
- Australian bat lyssavirus infection
- Brucellosis
- Leptospirosis
- Lyssavirus infection (NEC)
- Ornithosis (otherwise known as Psittacosis)
- Q fever
- Rabies
- Tularaemia
- Other bacterial diseases
- Legionellosis

- Leprosy
- Meningococcal disease-invasive
- Tuberculosis

7.0 Related documents

- Incident Report
- Incident Register
- Incident Investigation Form
- Incident Investigation Form Final Report
- Training Attendance Register – In-house
- Training Register
- Staff Training Record
- Staff Training Plan
- Continuous Improvement Policy and Procedure
- Continuous Improvement Plan
- Continuous Improvement Register

8.0 References

- Australian Human Rights Commission Act 1986 (Commonwealth)
- World Health Organisation - How to Handwash Poster
- World Health Organisation - How to Hand rub Poster
- Department of Health - Australian Guidelines for Prevention and Control of Infection in Healthcare 2019 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021

Cleaning Policy and Procedure

1.0 Purpose

Strength In Care will provide cleaning services for home care participants safely and effectively to ensure participants' environments support infection control, dignity and personal choice. Correct and timely floor cleaning is a major part of reducing slips

2.0 Scope

Strength In Care will assist participants in undertaking and developing cleaning skills to maintain their home environment and staff to clean the participant's homes as required.

3.0 Policy

Cleaning is undertaken as part of our care and services. Both participants and staff are always to be safe, so risk assessment is undertaken, and we will ensure that:

- floors are fully dry and can be accessed
- spills and contaminants are attended to
- a build-up of cleaning product residues does not occur
- cleaning equipment and cords are clear of walkways
- cleaning is planned and active
- good quality, appropriate or cleansed equipment used
- correct cleaning products and procedures.
- maintain the slip-resistant properties of the floor/surface (if non-slip flooring)
- are based on advice from the flooring supplier
- are tailored to the specific flooring and contaminants – i.e. type and concentration of chemicals etc. For example, the time detergent is on the floor has significantly affected cleanliness. It is also noted that slip-resistant flooring can be cleaned to be as hygienic as other floorings

All cleaning activities are to be undertaken professionally and in a manner that ensures no cross-contamination. The support plan directs cleaning activities for each participant. Any equipment issues - lack of or faulty must be reported to Director.

4.0 Procedures

Different colour cloths will be used for each area, e.g. pink for the bathroom, green for the kitchen, yellow for laundry. At no stage are these to be mixed, and clothes must be washed at the end of each use.

4.1 Safety Procedures

- A review of the environment is undertaken before any cleaning activity and recorded in the Support Plan.
- Risks are identified, and strategies put in place to reduce risk or harm to a participant or staff member through cleaning activities
- Activities required/ requested are placed in the participant support plan, and the participant/advocate will sign off to ensure they approve of the cleaning schedule
- Strength In Care will ensure that chemicals are handled safely through training, proper storage, use, personal protective equipment and safety data sheets information available to staff
- Equipment or chemicals that cannot be handled safely, e.g. decanted chemicals or broken equipment, will not be used by staff
- Staff are also responsible for maintaining safe resources and must:
- Report any dangerous equipment
- Use the correct equipment.
- Report alterations or additional aids that are needed to the Director
- Not use any appliances that have faulty connections or worn or frayed cords (see Equipment Maintenance and Safety)

4.2 First Aid

- In the event of an injury or illness, the injured or sick staff member is to contact the Director immediately
- Call 000 in an emergence
- If non-urgent medical treatment is required and safe to do so, seek assistance from the General Practitioner.

4.3 General Cleaning Procedures

4.3.1 Internal Areas

- Prepare all equipment and take it to the area to be cleaned
- Empty all bins, replace bin liners and place rubbish in the garbage bin.
- Pick up any large litter from the floor and return it to the correct place
- Straighten all furniture to prevent trips and falls
- Remove cobwebs
- Damp dust
- The last surface to be attended to should be the floor.

4.3.2 Bed Cleaning

- Gather cleaning products
- Collect clean linen
- Remove soiled linen
- Wash over both sides of the mattress
- Clean all surfaces using warm detergent water and disposable cloth
- Ensure all bed surfaces and the underneath frame have been washed and wiped over thoroughly
- Dry all surfaces thoroughly.

4.3.3 Dust Control

- Vacuum cleaners must be fitted with dust bags and the exhaust filter
    - Bags must be changed when full or after use
    - Filters changed according to the manufacturer's instructions
- Damp dusting is permitted only
    - Use a damp cloth, rinsing frequently
    - Dust all pipes and other fixtures

    - Wipe over window sills, ledges, tops of doors, bedside tables and wardrobes, picture frames, cabinets, cupboards, chairs etc.
    - Wipe over fans and curtain rails
    - Check work to ensure all areas have been covered
    - Remove, clean and store equipment
- Avoid dry sweeping.

4.3.4 Wet Mopping

- Mops and mop-heads must be stored dry
- Wash mop at the end of cleaning work
- All equipment used for wet mopping should be cleaned with warm detergent water daily and stored dry
- Participant's bedrooms and other areas must be wet mopped using warm water and detergent (if vinyl or wood flooring)
- Make sure floors are dry before leaving or used by participants.
- Never leave mops standing in buckets of solution
- Mop the 'cleaner' areas first or use separate mops for 'dirty areas (bathrooms, toilets etc.)
- Change the water frequently.

4.3.5 Bathrooms and toilets

- Wear gloves and boots
- Bowl cleaner is acid-based – USE WITH CARE AND WITH PROTECTIVE EYEWEAR.

Check

- Toilets are working
- Taps are working
- Drains are clean and free of collected lint and debris
- Empty and clean waste bins and dispose of rubbish in the garbage bin.
- Mop floors, toilet floors
- Clean mirrors
- Spot clean walls
- Clean doors
- Clean shower recess, wipe over pipes, and clean plugs and drains; shower wall and floor tiles are scrubbed

4.3.5.1 Hand Basins

- Clean out and disinfect
- Ensure that underneath the basin, all plumbing connections are washed simultaneously.

4.3.5.2 Baths

- Ensure that the outside walls of the bath and tiled areas remain clean
- Wipeout bath and surrounds
- Closely inspect grout edges to ensure there is no mould growing
- Ensure that soap containers are clean
- Ensure that handheld connections are clean.

4.3.5.3 Shower Recesses

- Ensure soap containers are clean
- Ensure that handheld shower connections are clean
- Closely inspect grouted edges to ensure that they are stain-free and there is no mould growing
- Inspect rubber mats for wear – ensure they are clean.

4.3.5.4 Equipment stored in the bathroom

- Clean with neutral detergent
- Shower chairs must be cleaned and stored in the shower recess away from the doorway. Ensure to clean the walkway.
- Ensure that it is safely placed to prevent injury to the person(s) entering the bathroom.

4.3.5.5. Toilets

- A clean toilet does not smell
- Brush the surface of the pan
- Thoroughly clean both sides of the seat cover with neutral detergent; use stain remover as required
- Toilet brushes must not be used to clean the seat; use disposable cleaning cloths, ensuring to dispose of each after use on each toilet, e.g. paper towel
- Wipe the seat and cover; dry with a cloth
- Take care to thoroughly clean all edges, corners and plumbing pipes behind and under the cistern.

4.3.5.6 Bathroom Floors

- Clean grout with a hand brush if necessary
- Check the drains to ensure there is no accumulation of lint or debris
- Rinse and dry the floor
- Mop the floor with neutral detergent
- Allow drying
- Thoroughly clean all equipment used.

4.3.6 Dining Areas

- Must be swept and mopped
- Chairs are to be wiped over daily.
- Ensure that chairs are stored under the table

4.3.7 Light fittings

Light fittings are to be cleaned six-monthly or as required with water and detergent:

- Turn off the electrical current. (Water is a conductor of electricity, and serious accidents
  may result from contact with an exposed circuit)
- Use equipment with an extendable handle
- If reaching up is necessary, a ladder must be used
- Remove loose dirt with a clean cloth
- If it is necessary to remove shade or glass sections, carefully loosen screws while supporting the underside of the bowl with one hand
- Wipe the bowl inside and outside
- Dry and polish with a clean cloth
- Remove the dust from the light bulb with a dry cloth – ensure the bulb is cool before handling
- Replace the bulb, bowl and glass sections – ensure they are secure.

4.3.8 Fans and permanent fixtures and fittings

Fans, permanent fixtures and fittings are to be cleaned every six months or when required with water and detergent:

- Turn off electrical current (water is a conductor of electricity, and serious accidents may result in contact with exposed circuits)
- Remove any loose dirt with a damp cloth
- Wipe blades or fixtures with a clean cloth dampened with detergent
- Dry and polish with a damp cloth.

4.3.9 Telephones (Landlines)

- The body of the telephone and the handset are to be cleaned with a damp cloth soaked in detergent and warm water
- The mouth and earpiece must be cleaned with a damp cloth making sure the cloth is only damp to prevent water from entering the holes and damaging the telephone.

4.4 Outside Areas

All outdoor bins are to be emptied at least weekly (check for the day of collection)

- Place bin at the front of the house on the day before rubbish collection occurs
- Collect bins to the front of the house after the rubbish collection service
- Using correctly diluted detergent, clean the inside of the bins
- Hose bins out, removing all dirt and debris
- Turn bins upside down and allow them to dry
- Return bins to their allocated areas.

4.4.1 Paved Areas

- Use a straw broom to sweep paved areas weekly or more frequently if required
- On a rotational basis, all paved areas should be hosed down; all areas should have been hosed by the end.

4.4.2 Grassed Areas

- All grassed areas are to be attended to on a rotational basis; main access areas may require more frequent attention
- Using a plastic bag or bin, collect all litter and remove it to the main collection bin.

4.4.3 Cobweb Cleaning

- Cobwebs are to be removed as regularly as required
- Using a cob webber or broom, remove cobwebs from windows, doors, walkways, lights, and buildings.

4.5 Windows

- Windows are to be attended to on a rotational basis.

- Clean windows using window cleaner and cloth
- Dry with a drying cloth.
- Monitor self for work health and safety.

4.6 Documentation and Reporting

- Records are to be maintained by cleaning staff to record the cleaning activities for each participant accurately, including a file note and logging of hours spent at the participant's home
- Issues regarding broken equipment must be placed on the maintenance log
- The Director will check with each participant or their representative regarding steps to replace or repair broken equipment and supply of detergents, cloths etc.

5.0 Related Documents

- Support Plan
- Support Planning Policy and Procedure
- Work Health and Safety Policy and Procedure
- Risk Management Policy
- Continuous Improvement Policy and Procedure
- Risk Management Policy

6.0 References

- Privacy Act 1988
- Work Health and Safety Act 2011

Hot Water Safety Policy and Procedure

1.0 Purpose

Hot water safety is a major issue for people with disability. Strength In Care acknowledges risks and detrimental consequences to participants who may be burnt or scalded by hot water. This policy is structured to enlighten staff on the risks, prevention strategies, and response requirements.

2.0 Scope

Staff must be aware of any issues and complete training related to participants' safety, including the practices to prevent the risks of burns and scalds.

3.0 Policy

Participants are at a high risk of scalding, often occurring in the bathroom, resulting in infection and death. Hot water can cause scalding burns within seconds without an installed temperature control device. Our organisation will review the hot water temperature as part of the participant's initial safe environment assessment. Staff must be trained in the risks, potential outcomes and reduction strategies related to hot water safety, incorporating the following information:

- Very hot liquids or steam can cause a scald type of burn.
- Scalding is the second highest cause of burns apart from fire and is a preventable injury that can lead to scarring, painful treatment, infection and death.
- More than 90% of scalding occurs from showers or baths in the bathroom. At a water temperature of
    - 50°C, it can take five minutes to scald the skin and
    - at 68°C, it can take only one second to cause third-degree burns

Staff must be aware of serious health consequences related to the burn depth and their

related consequences:

- **First-degree burns** are superficial burns and affect only the outer layer of the skin (e.g. sunburn).
- **Second-degree burns** look red, blistered, wet, swollen, and often painful. These scalds are at risk of infection.
- **Third-degree burns:**
    - destroy the outer and inner layer of the skin and
    - could damage muscles, tendons and ligaments.
    - may require skin grafts, surgeries, and extensive hospitalisation.
    - leading to an increased risk of infection and sepsis, leading to organ failure and death.

All environments must be checked because of the risks of hot water to staff and participants. The Australian Standards have regulations for new hot water installations in facilities where people with disability receive services (AS3500.4 1.11). The maximum recommended water temperature at fixtures used primarily for personal hygiene purposes is 45°C (Australian Standards 2018); the maximum temperature before scalding becomes a serious risk to staff and participants (refer to state requirements).

To ensure our compliance with the NDIS Code of Conduct, we will:

- provide supports and services safely and competently with care and skill; and
- promptly take steps to raise and act on matters that may impact the quality and safety of participants' support and services.

This policy is designed to meet NDIS Practice Standards, including:

- **Risk Management:** Strategising risks associated with the provision of support are identified, analysed, prioritised, and treated. Participants, their supports and the environment are risk-managed involving hot water safety (checklists implemented, staff trained)
- **Incident Management:** A systematic approach is undertaken to ensure that each participant is safeguarded through our incident management system, ensuring that

incidents are acknowledged, responded to, learned from and well-managed.

- **Emergency and Disaster Management:** Our hot water safety strategy provides prevention and response training and guidance in responding to hot water safety incidents.

4.0 Procedures

All staff working with participants must be aware of the risks surrounding burns and scalds and respond if the situation arises. We aim to protect the safety of participants, and all participants will be assessed against our Safe Environments Checklist – Home, Individual Risk Assessment and Participant Safe Environment Risk Assessment, as relevant.

4.1 Safety Procedures

- A review of the environment is undertaken and recorded in the Support Plan.
- Risks are identified, and strategies put in place to reduce risk or harm to a participant or staff member
- Activities required/ requested are placed in the participant support plan, and the participant/advocate will sign off to ensure they approve
- Strength In Care will ensure that hot water is handled safely through training and review of the participant's environment
- Staff are also responsible for ensuring that the water temperature will not injure the participant and checking the temperature level before bathing or showering.
- Staff must check the environment for the risk of hot water spills and steam.

4.2 Prevention Strategies

Our organisation will train staff to reduce the risk of scalds in the bathroom by:

- Always run the cold water in the bath or shower first before the hot water
- Always run the cold water through the tap before the participant enters the bath
- Always check the temperature of the bath, shower or other hot water before a

participant enters the water

- Do not leave the plugin while a participant showers if the shower is a combined bath and shower.

4.3 First Aid

- Apply cool running water to the site of the scald for 20 minutes
- Do not touch the burn
- Do not apply any lotions or ice to the area
- Remove any clothing or jewellery near the scald

4.4 Call an Ambulance

Staff are required to call an ambulance if:

- the burn/scald is larger than a 20 cent piece
- the burn is deep
- the burn has blisters, pus or discharge
- the skin appears leathery
- the burn is to the face, airways, hands or genitals
- there are patches of brown, black or white
- the person also has a fever
- the person is having trouble breathing

4.5 Supported Disability Accommodation (SDA) and Supported Independent Living (SIL) housing

Our organisation will:

- Ensure that all **new** heated water installations use a thermostatic mixing valve or thermostatically controlled tap to deliver hot water not exceeding 45°C at fixtures used primarily for personal hygiene purposes (Australian Standards 2018, AS3500.4 1.11)

- For **older** heated water installations, consider installing a temperature control device such as a thermostatic mixing valve set to a maximum of 45°C (as per state requirements)
- Engage a licenced plumber to test and maintain any temperature control devices at least yearly (ABCB 2015)
- Ensure bathroom fixtures such as showerheads limit maximum water flow

4.6 Documentation and Reporting

- Any hot water safety incident must be recorded and actioned as per our Reportable Incident, Accident and Emergency Policy and Procedure
- Staff must inform their supervisor and complete relevant documents
- Management must use each incident as part of our Continuous Improvement Policy and Procedure.

5.0 Related Documents

- Support Plan
- Individual Risk Profile
- Safe Environment Checklist – Home
- Participant Safe Environment Risk Assessment
- Support Planning Policy and Procedure
- Work Health and Safety Policy and Procedure
- Risk Management Policy
- Reportable Incident, Accident and Emergency Policy and Procedure Continuous Improvement Policy and Procedure
- Risk Management Policy
- Emergency and Disaster Management Policy and Procedure

6.0 References

- Practice Alert – Hot water safety (February 2022)
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Code of Conduct Rules 2018

COVID-19 Response Policy and Procedure

1.0 Purpose

As an NDIS service provider, Strength In Care will fulfil our obligations to deliver safe, quality supports and services while also managing risks associated with the supports we provide to our participants.

Our COVID-19 Response Policy and Procedure is in line with the Australian Federal Government and NDIS guidelines regarding outbreak preparedness, prevention and management of COVID-19 within Strength In Care. This policy aims to avoid or minimise the transmission of COVID-19 within our organisation and the community.

Throughout the pandemic, Strength In Care will endeavour to maintain full-service capacity and will continue to provide supports that are critical to the wellbeing, health and safety of our participants while complying with both state and federal regulatory requirements. We acknowledge that due to COVID-19, we may have to tailor our services or apply limitations to the provision of our non-essential services.

We are focused on preserving the health and safety of the people we are responsible for, including our participants, employees and their families. However, we acknowledge that at some point, a participant or employee may contract COVID-19.

2.0 Scope

This policy intends to guide our employees on taking reasonable precautions to protect themselves and participants from contracting COVID-19. The policy outlines preparations for an outbreak of COVID-19 and response and management of confirmed or suspected cases of COVID-19.

3.0 Description

Coronaviruses are a large family of viruses known to cause respiratory infections. These can range from the common cold to more severe diseases. This new coronavirus is named COVID-19.

COVID-19 is transmitted from person-to-person, usually when an infected person coughs or sneezes. Common signs of novel coronavirus are:

- fever
- coughing
- sore throat
- fatigue
- loss of smell and taste
- shortness of breath.

It is important to note, to raise awareness and not spread fear, that while COVID-19 exhibits symptoms similar to the flu, it is not as simple as contracting seasonal flu. Most people have immunity to the flu, there is a vaccine, and the flu spreads more slowly through the community. Vaccines against COVID-19 are now available, but it is still highly unpredictable, with conditions changing daily nationally and globally.

4.0 Definitions

Term	Definition

Close contact	More than 15 minutes of face-to-face contact in any setting with a confirmed (or probable) case in the period from 24 hours before the onset of symptoms in the confirmed (or probable) case. Sharing a closed space with a confirmed (or probable) case for a prolonged period (more than two hours) in the period extending from 24 hours before the onset of symptoms in the confirmed (probable) case.
Outbreak	The Australian Government Department of Health considers an outbreak when two people in three days become sick with symptoms, and at least one of these three has a positive COVID-19 test.

5.0 Policy

Strength In Care will implement our COVID-19 Response Policy and Procedure to ensure all participants, staff members and external contractors are supported if a COVID-19 case is identified within, or connected to, our organisation.

State government health orders frequently change in response to COVID-19 outbreaks. On an ongoing basis, our organisation will identify and implement any revisions required to the practices and supports undertaken by our business to meet all requirements of the NDIS Commission and the state and federal government.

Strength In Care will identify threats that may require further analysis of our current work practices and supports. The review of current practices will inform our organisational risk management and continuous improvement systems.

As a registered NDIS provider, our organisation will notify the NDIS Quality and Safeguards Commissioner of specific changes and events. The notification is primarily

when our organisation may have difficulty providing supports and services as per Section 13 and 13A of the NDIS (Provider Registration and Practice Standards) Rules 2018 using Notification of Event for – COVID 19 or phoning 1800 035 544.

Our organisation will notify the NDIS commission

- if a support worker or NDIS participant is confirmed to have COVID-19
- if there are changes to the scale of their operations
- any other changes related to COVID-19.

Staff are encouraged to seek the relevant vaccination to protect themselves and our participants. We will record their vaccination in our staff records.

6.0 Procedure

6.1 Preparing for an outbreak

As community transmission of COVID-19 occurs within Australia, our organisation will plan and prepare for possible cases involving our participants or employees.

A COVID-19 Safe Plan and COVID-19 Outbreak Management Plan will be developed to identify risks to participants, employees and our organisation. Strength In Care will review current work practices, services offered, and employee functions and will implement any relevant changes (as and when required) to ensure our organisation is appropriately prepared for a COVID-19 outbreak.

The Outbreak Management Plan will assist Strength In Care to help our employees identify, respond and manage a potential outbreak. It also assists in protecting the health of our employees and participants and reducing the severity of the duration of outbreaks if they occur.

The COVID-19 Safe Plan and the Outbreak Management Plan are reviewed regularly by management. Oversight of the plans is the responsibility of the Director.

6.2 Precautions relating to staff

6.2.1 Signs of symptoms and COVID-19 testing

All Strength In Care staff will take reasonable precautions so that we can safely provide supports and services. Our staff have been instructed to immediately contact the Director and not attend work if they have:

- symptoms of a respiratory illness (even mild symptoms) including a fever, cough, shortness of breath, sore throat, runny nose or congested nose, tiredness, loss of smell or appetite
- returned from overseas or interstate within the last 14 days, consistent with the state's public health directions
- been in contact with someone who has been diagnosed with COVID-19.

If a staff experiences any of the above symptoms while at work, they must:

- leave work immediately
- report symptoms to the Director
- get tested for COVID-19
- self-isolate at home until test results are received.

If the COVID-19 test is negative, the worker may return to work once they are well.

If the test is positive, the state public health unit will contact the worker and inform them what they must do. Public health officials will undertake a close-contact investigation to provide advice on self-quarantine and testing for other workers or participants.

In the event a Strength In Care participant or staff member is diagnosed with COVID-19, our organisation will follow all appropriate and current government procedures. We will

instruct all staff members who have been in contact or have been in the same area as the participant or staff member with COVID-19 to seek appropriate medical advice, be tested for COVID-19, and self-isolate for 14 days.

Strength In Care will advise all appropriate personnel to work from home for 14 days in the following instances:

- Strength In Care staff member has been diagnosed with COVID-19.
- A confirmed case of COVID-19 has been identified in a participant or staff member.
- A confirmed case of COVID-19 has been identified in the local area of Strength In Care's head office location or a caring environment (including a participant's home).

A staff member will also be asked to work from home for 14 days if a confirmed case of COVID-19 has been identified in the staff member's home, suburb or local area as a precaution.

Strength In Care will ensure that all staff members can continue their work remotely, if necessary.

6.3 Staff training

Employees will be instructed to complete the Australian Department of Health's online COVID-19 Infection Control Training. The Director records training details in the Staff Training Record filed in the employee's personnel file and the Training Register.

During staff meetings, employees will be trained in using PPE correctly and provided an update on infection control procedures (including standard and transmission-based precautions content).

6.4 Personal protective equipment (PPE)

During a COVID-19 pandemic, we will stay updated with the latest advice from our state's public health unit regarding when and where to use PPE while supporting participants to remain compliant with government orders.

All existing and new employees will be shown by the Director how to wear PPE correctly.

When purchasing PPE, the Director or their delegate will consult the Australian Department of Industry, Science and Energy and Resources Personal Protective Equipment Buyers Guide to determine how to purchase appropriate PPE.

When unable to access necessary PPE supplies, the Director will request assistance by emailing the National Medical Stockpile at NDISCOVIDPPE@health.gov.au

6.5 Responding to a participant with a suspected or confirmed case of COVID-19

Strength In Care employees are instructed to monitor for symptoms of COVID-19 in participants or their families. If a participant or family member is showing symptoms, the Outbreak Management Plan will be implemented by the Director immediately.

Support to the participant who is suspected or confirmed to have COVID-19 may still be provided. However, our employees must correctly wear all appropriate PPE as per state government orders. The Director will seek instruction from the department of health before commencing any support with a participant suspected or confirmed of having COVID-19.

When responding to a participant with a suspected or confirmed case of COVID-19, the support our workers will offer may include:

- assisting the participant in seeking medical advice if they have symptoms
- identifying essential supports for the maintenance of the participant's health, well-being and safety and determining if they can be delivered differently
- ensuring good communication with the participant and their family, so everyone understands disruptions and changes to supports
- always wearing appropriate PPE as per the state's public health guidelines.

Strength In Care workers will not enter the home of a participant who is unwell unless correctly wearing appropriate PPE to provide supports to maintain the participant's health, wellbeing, health or safety. An unwell participant will not be able to enter our premises until their COVID-19 status is confirmed.

For participants, their families, and carers who require information, we will guide them to the Disability Gateway helpline, which is free, private and fact-checked. Below are the ways to contact the Disability Gateway

- Phone (free call): 1800 643 787
- If you are deaf or have a hearing or speech impairment, call the National Relay Service at 133 677.

The Disability Gateway is available Monday to Friday from 8 am to 8 pm (AEST), and it is not available on national public holidays.

6.6 Visitor management

Strength In Care will regularly review our COVID-19 Workplace Attendance Register or COVID-19 Check-In App to determine if there have been suspected or confirmed cases of COVID-19 within our workplace.

In a confirmed or suspected case within our workplace, we seek guidance from public health officials to assist with confirmed or suspected outbreaks.

Our employees, participants and families will be informed by the Director of the steps we will be taking to prevent infection, including visitor management practices.

Strength In Care will manage visitors to our organisation using the following practices:
Inform all visitors regarding social distancing and hand hygiene.

Ask all visitors to check into our workplace by completing the Workplace Attendance Register or using a Check-In App. The information they must provide includes:

- first name
- phone number
- date and time entered and exited our workplace.

Strength In Care will provide a hand sanitiser at the entry/reception area of the workplace.

6.7 Good respiratory and hand hygiene

Strength In Care will ensure that standard infection control precautions are in practice throughout all work environments (see Infection Control Management Policy and Procedure).

There are preventative measures staff can take to protect themselves from infection and help prevent infections and viruses from others. These measures include practising good respiratory and hand hygiene, such as:

- cleaning hands with soap and water or alcohol-based hand rubs or sanitisers
- avoiding touching your face
- avoiding handshaking and other physical greetings
- covering your nose and mouth with a tissue or flexed elbow when coughing or sneezing
- avoiding contact with anyone who has symptoms such as fever, a cough, sore throat, fatigue and shortness of breath
- staying home if you are unwell
- wearing appropriate PPE when caring for participants
- regularly clean shared high-touch surfaces, e.g. tables, benches, doorknobs.

6.8 Social distancing in the workplace

Social distancing is critical as COVID-19 is most likely to spread from person to person. The following actions taken by our staff will help reduce risk in our work environment:

- staying at home if they are sick
- stop handshaking and other physical greetings
- all meetings are to be held via video conferencing or phone call
- deferring large face-to-face meetings
- holding essential meetings outside in the open air if possible

- eat lunch outside, rather than in the office if possible
- professional cleaners will regularly clean the office
- clean and disinfect shared high touch surfaces regularly and use hand sanitiser
- open windows and adjust the air conditioning to allow for more fresh air.

7.0 Managing an outbreak

The state public health unit may declare (or assist you in deciding whether to declare) an outbreak. The public health department will guide Strength In Care on how to manage the outbreak.

If an outbreak is suspected or confirmed in our workplace, the Director will:

- confirm standard infection control precautions are in place
- commence transmission-based precautions (if not already in place)
- convene the Outbreak Management Team
- implement Outbreak Management Plan
- isolate suspected or confirmed cases and, if necessary, assign a dedicated support worker to them
- liaise with the public health department and follow their instructions
- schedule regular environmental cleaning and disinfection of all areas
- put up signage at the entrance or workplace to inform visitors
- suspend all non-essential services and supports
- suspend all non-essential visitors to the workplace.

8.0 Vaccination

All vaccinations are voluntary, and participants must be allowed to provide informed consent for any medical treatments or procedures, including the COVID-19 vaccine. Our organisation will collaborate with and assist the Australian Department of Health contracted COVID-19 vaccination providers by providing relevant healthcare information

or behaviour support plans and rostering support staff to enable the safe administration of the vaccine.

Strength In Care will engage and communicate regularly with participants about the COVID-19 vaccination. Informing participants about the purpose of the COVID-19 vaccination and, where appropriate, it will be useful to have a person that a participant is most familiar with or trusts (such as a family member/guardian, a participant's friend or a particular staff member) to be involved in informing the participant.

Our organisatoion will:

- construct strategies to assist participants who are averse to injections and pain
    - bring comfort items
    - play favourite music
    - iPad
    - rehearse in advance
    - book support person for the visit
- use anxiety-reducing strategies by seeking advice from:
    - family member
    - guardian
    - local general practitioner
    - NDIS behaviour support practitioner
    - Trusted staff members
- Seek advice from a medical practitioner if there is an allergic reaction history or pain to identify risks ad benefits
- Explain side effects

Staff will work with participants in advance of receiving the COVID-19 vaccine and assist vaccination providers in administering the vaccination as appropriate.

During the administration of the COVID-19 vaccine, if a regulated restrictive practice is used that is not in a participant's behaviour support plan and/or does not have current authorisation from the state or territory, it is a reportable incident to the NDIS Commission.

COVID-19 Safe Plan

Our COVID-19 Safe Plan sets out the following:

- Actions to help prevent the introduction of coronavirus (COVID-19) in the workplace.
- Workplace requirements - the level of face-covering or personal protective equipment (PPE)
- The procedure on how we will prepare for and respond to a suspected or confirmed coronavirus case (COVID-19) in our workplace.
- Details of how Strength In Care will meet all of the requirements set out by the state government (some higher-risk industries or workplaces have additional requirements for employers and employees).

A COVID-19 Workplace Attendance Register is maintained (see visitor management).

The Director will ensure our COVID-19 Safe Plan meets the state government's orders and action requirements at all times.

9.0 Related documents

- Training Register
- Staff Training Record
- Risk Register
- Risk Assessment Form
- COVID-19 Outbreak Management Plan
- COVID-19 Safe Plan
- COVID-19 Workplace Attendance Register

- Notification of Event form – COVID 19
- Infection Management Policy and Procedure
- Emergency and Disaster Management Policy and Procedure
- Business Continuity Policy and Procedure
- Risk Management Policy and Procedure
- Work Health Safety and Environmental Management Policy and Procedure

10.0 References

- NDIS Practice Standards and Indicators 2020
- NDIS Code of Conduct
- Australian Department of Industry, Science and Energy and Resources - Personal Protective Equipment Buyers Guide
- Australian Government Department of Health Video - Coronavirus: Wearing personal protective equipment for disability workers.
- Australian Government Department of Health's website
    - https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert
    - https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-information-on-social-distancing.pdf
- NDIS Coronavirus information and support webpage:

4.2 Participant Money and Property

Participant Money and Property Policy and Procedure

1.0 Purpose

The purpose of this policy is to:

- maximise each participant's control of their funding and finances
- provide participants with the opportunity to manage their NDIS funding personally
- ensure that financial management of NDIS services, and any government programs, are undertaken in an orderly manner, as per appropriate legislation and regulations
- support participants to access and spend their own money as they determine
- inform participants of costs and the payment process for all services provided
- provide participants with technical assistance to increase their capacity to direct their support and teach them how to self-manage.

2.0 Scope

To ensure that our staff members do not give financial advice or information other than that would be required under a participant's plan. If Strength In Care staff are involved with handling a participant's money, strict procedures contained in this policy will always be followed to protect the participant from financial abuse.

3.0 Policy

We will ensure that all financial transactions and procedures are implemented to meet the requirements of all legislation and contracts. The procedures outlined in this policy will be strictly followed to safeguard all participants and our staff.

The participant's money, or other property, is only used with the participant's consent and for the purposes intended by the participant. A staff member must not provide participants with financial advice or information.

All participants requiring financial assistance must approve the arrangement and sign a Service Agreement and Consent Form. The participant's family or advocate must also sign the agreement. All documents will be kept on file and included in the Participant Support Plan.

We will undertake annual audits and provide required documentation. We will ensure the business is financially viable and inform participants of costs and payment procedures.

4.0 Procedure

4.1 Home visits

Staff must only use and touch the participant's property to deliver a service (i.e. the use of equipment to complete tasks, e.g. sweeping, assisting in dressing). A record of the participant's property that is to be used should be listed in the participant's support plan.

A staff member must never access the participant's money. If the participant requests the purchase of an item, then the Director must be informed and records kept in the notes in the participant's records.

If a participant asks for financial assistance, the Director is to be informed immediately.

The Service Agreement must identify details of any money handling undertaken on the participant's behalf.

4.2 Financial management guidelines

At times, participants may require assistance with their finances, e.g. paying bills, banking or shopping. Staff must follow the guidelines and procedures outlined below when financially assisting a participant:

- Staff are never allowed access to a participant's Personal Identification Number (PIN) or to use an automatic teller machine (ATM) on the participant's behalf.
- Financial assistance may only be offered if documented in the participant's support plan and provided by the appropriate staff.
- If a participant requests financial assistance, and it is not documented in their support plan, the staff member must contact the Director for approval.
- Transaction receipts must be obtained and given to the participant for the following:
    - money received
    - money spent
    - money returned
- Staff must count the money in front of the participant on receipt and return.
- The staff must record all financial transactions carried out for a participant in the Financial Transaction Register (FTR) (if in use) and in the participant's progress notes. Records must be documented clearly, accurately and immediately.
- A staff member must not give financial advice to participants or their companions or act as witnesses for any legal documents.
- A staff member must not accept money or gifts from participants.

4.3 Staff procedure

1. The staff must immediately record the amount of money received from the participant (cash, cheque, voucher) in the FTR or record details in the participant's progress notes.
2. The staff must count any cash carefully in front of the participant.
3. Both the staff and the participant sign the entry, confirming the correct details have been recorded.
4. The staff is to complete the transaction and obtain transaction receipts.

5. The staff must carefully count out and return any money to the participant and provide all transaction receipts to the participant.

4.4 Financial assistance procedure

If the participant makes a request for financial assistance, and there is no record of a financial assistance agreement in the participant's support plan, the following steps are taken:

1. If the service is conducted on behalf of another agency, approval must first be sought from the on-call coordinator for the agency.
2. If there are no other agencies involved, then the request must be considered based on the following:
    a. participant agreement
    b. need/urgency
    c. participant safety
    d. time available.
3. All participant request details and final decisions must be documented in the participant's notes and service agreement.

4.5 Suspected financial abuse

Our staff are trained to look for signs of financial abuse when working with participants. Staff are also trained to discuss preventative measures with participants, including:

- ensuring participants are aware of their rights to confidentiality and privacy
- encouraging them to have networks beyond their family circle
- informing them not to relinquish control of their finances if they can confidently manage them
- advising them not to make significant financial decisions following a major event, e.g. loss of a partner
- ensuring that participants are aware of their right to refuse people access to their funds

- encouraging them to make plans while they are still independent
- encouraging them to ask for help if they are overwhelmed, taken advantage of or confused.

If any staff member suspects that a participant is financially abused, then the following steps are to be taken:

1. The staff member is to gather evidence and record it in the participant's notes.
2. The staff member must contact the Director to discuss the evidence gathered.
3. The Director will gather the details of the harm or abuse and author a report of the situation.
4. The Director will inform the relevant authorities and obtain support for the participant.

4.6 Participant fees and payments

Payments and pricing (NDIS)

- Strength In Care must adhere to the NDIS Price Guide or any other agency pricing arrangements and guidelines, as in force from time to time.
- Strength In Care must declare relevant prices, any notice periods or cancellation terms to participants before delivering a service. Participants are not bound to engage the services of Strength In Care after their prices have been disclosed.
- Strength In Care can make a payment request once support has been delivered or provided.
- No other charges are to be added to the support cost (including credit card surcharges) or any additional fees, including any 'gap' fees, late payment fees or cancellation fees. These requirements apply to all participants, whether they self-manage their funding or whether a plan manager or the agency manages it.
- A claim for payment is to be submitted within a reasonable time (and no later than sixty (60) days from the end of the service booking) to the participant or the NDIS.
- Strength In Care will not charge cancellation fees, except when provided explicitly in the NDIS Price Guide.

- Strength In Care and participants (except for those that are self-managing) cannot contract out of the Price Guide. Where there are any inconsistencies between the Service Agreement and the Price Guide, the Price Guide prevails.
- Where required, Strength In Care will obtain a quote for services and have this approved by the participant.

4.7 Monitoring, evaluating and reporting

Strength In Care exhibits a continuous improvement culture to facilitate the refinement of our services and processes. The stakeholder's input is pursued and, when received, reviewed immediately.

All Strength In Care's policies are reviewed annually and consider the input from all stakeholders. Policy reviews also consider the results attained through monitoring and evaluation and changes in legislation.

5.0 Related documents

- Participant Information Consent Form
- Participant Money and Property - Financial Transaction Register
- Participant Money and Property - Consent Form
- NDIS Price Guide
- Service Agreement
- Training Attendance Register – In-house
- Training Register
- Staff Training Record
- Staff Training Plan
- Support Plan

6.0 References

- Australian Securities Industry Council (financial abuse)
- Corporations Act 2001 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021
- NDIS - Provider Registration Guide to Sustainability
- NDIS - Terms of Business for Registered Providers

4.3 Management of Medication

Management of Medication Policy and Procedure

1.0 Purpose

Strength In Care is committed to providing a high standard of care and excellence in supports and service. Strength In Care participants may take medications to support and improve their health conditions. Many participants will manage and take their medications independently, while others may ask for support or assistance.

2.0 Scope

For this commitment to be achieved, the Director is responsible for ensuring that all medications are correctly managed following this policy.

We will also correctly supervise documentation management, including safe/secure storage and handling, support or administration by appropriately trained, qualified or certified staff.

3.0 Policy

Strength In Care encourages participants to maintain their independence for as long as possible, including managing their medications safely and effectively. When a participant requests help with their medications, the nature of this help will be recorded in detail, and the participant's consent will be confirmed. Strength In Care has processes for the reporting and investigation of medication errors.

Participants, carers and advocates can be confident that Strength In Care will ensure quality outcomes for its participants through a safe and correct medication management policy.

This policy follows the twelve (12) Guiding Principles for Medication Management in the Community, developed by the Australian Pharmaceutical Advisory Council (June 2006, updated January 2012).

4.0 Definitions

Term	Definition
Medication support	Involves: • reminding, or prompting, a participant to take medication • assisting with opening medication containers • providing other assistance, not involving medication aid.
Medication assistance	Involves: • storing of medicines • opening medicine container/s • removing the prescribed dosage (from an approved container) • giving the medication as per instructions.

5.0 Roles and responsibilities

Strength In Care:

- has policies and procedures in place for medication administration, storage, errors and incidents
- will provide the necessary training to the staff, which includes the effects and side-effects of medications and the safe and secure methods for medication storage, in addition to medication safety
- will document the staff member's level of skill and knowledge of medication safety, storage and administration through a yearly competency assessment
- ensures a trained staff is available to perform tasks that are within their knowledge, skills and experience

- issues clear instructions (with the participant's consent) that outline steps required to help the participant with their medication. These instructions will include, but are not limited to:
    - medication name and strength, where applicable
    - form of medication, e.g. tablets, suppositories, liquid
    - dose, route, frequency
    - allergies/adverse drug reactions participant is aware of
    - prescriber's name printed on medication, date and signature.

Strength In Care's qualified delegate will:

- undertake responsibility for medication management
- conduct and facilitate training sessions for qualified staff concerning medication support, assistance and administration
- provide annual training incorporating:
    - safe and timely medication administration
    - recording and monitoring medication
    - safe storage of medication
    - prevention of errors or incidents
- ensure staff follow professional guidelines in the delivery of medications.

The staff will:

- follow the Management of Medication Policy and Procedure and all other related medication policies
- participate in annual training
- provide services that are consistent only with their level of training and competence
- seek advice from the Director where doubt exists
- follow the instructions from the Director or their qualified delegate and as per support plan requirements
- seek instruction from the Director when a medication requires refilling.

6.0 Procedure

Strength In Care will (with the participant, carer or advocate's consent) liaise with the family or support network, general practitioner, pharmacist, registered nurse or an enrolled nurse to clarify aspects of the medication management.

The staff providing medication support will make sure to:

- identify the participant
- note the medication is current, and the label correctly identifies the participant
- administer oral medication, either from a:
    - dosage administration aid (DAA)
    - 'box' medication device filled by a pharmacist, doctor or dentist or Strength In Care's Director
    - participant's labelled pharmacy container
- record the service in the participant's support plan
- monitor the participant for any adverse side effects of the medication.

6.1 Safety considerations

The participants are observed for any changes to their health status, and changes are reported to the Director.

Where a participant refuses the administration of medication, the Strength In Care's Director is to be advised. Relevant health professionals (i.e. doctor, registered or enrolled nurse) will be consulted.

A staff member shall not decide to withhold a participant's medication unless certain about the participant's health status. The staff must consult with the Director before withholding medication and follow the Director's decision in consultation with relevant health professionals (e.g. doctor, registered or enrolled nurse).

Medications are to be stored to maintain the quality of the medicine and safeguard the participant, family, and visitors in their home. Strength In Care may assist a participant, carer or advocate in obtaining and using a locked box, another suitable container, or cupboard.

6.2 Documentation

The staff is to record the date and time of medication administration and their signature and printed name on our medication chart or the pharmacy-generated medication chart.

The staff is to record in the participant's health record any change in the participant's health status or medication incidents.

6.3 Adverse drug reactions

- Adverse drug reactions must be reported immediately to the Strength In Care's Director.
- The Director will inform the general practitioner/nurse immediately and document actions taken in the participant's health record.
- An adverse drug reaction is an incident and must be recorded on a Medication Incident Form and in the participant's health record, including symptoms and actions taken.

6.4 Medication errors

Staff who detect an error (including an error in dosage, time, frequency or type of medication administered to, or taken by, a participant) must:

- identify the nature of the error
- notify the Director and the qualified delegate
- follow the advice from Director or the qualified delegate
- complete an Incident Investigation Form

- monitor the participant for any adverse events that the error may cause.

6.5 Staff training for medication assistance

The qualified delegate and health practitioners train staff to assist or support the participants in medication procedures. A Registered Training Organisation (RTO) will deliver all necessary registered training following the Australian Qualification Framework (AQF) Standards (e.g. first aid).

Strength In Care ensures that appropriate staff hold current first aid and cardiopulmonary resuscitation (CPR) qualifications. This training will allow them to correctly respond when monitoring any adverse reactions that require action, intervention and escalation. An Strength In Care support staff has relevant skills and experience and a level of competency to provide appropriate and safe support to a participant.

Our staff participate in regular supervision by a qualified delegate to strengthen their understanding of medication procedures and affirm their knowledge and practice.

Strength In Care conducts an annual competency in medication management and administration practices for their support staff. Details will be recorded in the staff files, where appropriate. Strength In Care's annual training will include, but will not be limited to, high-risk medication education as outlined below.

6.6 High-risk medication

Appropriate staff members will be trained and educated on the specific hazards and risks associated with high-risk medications that participants may be consuming. The PRN Protocols will be followed by staff at all times.

As required, staff will be trained to complete a PRN Care Plan and PRN Intake Checklist.

Strength In Care training will incorporate the following topics for their support workers, where necessary for each participant's individual needs and specified in their support plans:

- PRN psychotropic medications
- Schedule 2 medicine *(over the counter pharmacy medicine)*
- Schedule 3 medicine *(pharmacist only medicines)*
- Schedule 4 medicine (*prescription-only medicines)*
- Schedule 8 medicine (*controlled drugs)*
- Cytotoxic medications.

6.6.1 Schedule 8 (controlled drugs)

Doctors and pharmacists have strict guidelines and reporting requirements related to issuing any Schedule 8 drug (e.g. number of tablets, number of treatment days, specific personal details on the participant and reporting requirements). We will gain any permits to treat a person with Schedule 8 drugs if legislation requires.

Staff who care for (or are assisting in the care of) a participant who has prescribed and dispensed medicine is authorised to possess that medicine for the specific purpose for which it was supplied.

A participant must not direct or incite a registered health practitioner to do anything in the practitioner's practice of the health profession that amounts to unprofessional conduct or professional misconduct. Staff must only give medication as prescribed.

A registered nurse may only delegate medicine administration to someone appropriately qualified to administer medicine. The registered nurse may use their professional judgment about administering a medicine themselves or delegate the administration to another nurse or personal care worker with appropriate qualifications or scope of practice to administer the medicine by the specified route.

Enrolled nurses (who do not qualify for medicine administration approved by the Nursing and Midwifery Board of Australia) and personal staff (with appropriate medicine administration training) may, in some circumstances, be competent to administer medicine under the delegation of a registered nurse. If a registered nurse judges that an enrolled nurse or personal care worker is not appropriately qualified to administer the medicine to a particular resident, they should administer the medicine themselves or delegate the administration to appropriately qualified personnel. Appropriate supervision must be provided.

6.6.1.1 Storage

Schedule 8 poisons must be stored in a lockable room and/or in a lockable storage facility firmly fixed to a floor or wall. A steel drug cabinet is not mandated because of the prevalence of dose administration containers. However, a steel drug cabinet:

- is strongly recommended for the storage of Schedule 8 poisons in original containers
- is strongly recommended for the storage of Schedule 8 poisons that cannot be packed into dose administration containers
- is required for the storage of Schedule 8 imprest medicine, where health services permit is held
- maybe required (for example, for larger quantities of Schedule 8 poisons), if directed.

6.6.1.2 Procedure

The registered nurse must check for the following:

- written instruction of a medical practitioner or another authorised practitioner (the most common option)
- oral instructions of a medical practitioner or another authorised practitioner if, in the opinion of the practitioner, an emergency exists (for example, telephone orders)

- a written transcription of the emergency instructions by the person who received them
- directions for use on a container supplied by a medical practitioner, pharmacist or authorised practitioner (meaning administration of a person's own lawfully supplied medicine)

A registered nurse and witness remove stock from a drug safe and make the drug register entry according to the dose required on the medication chart. Both persons then witness the supply to the different registered nurses who may administer the medication without a second person checking at the bedside.

The trained and qualified administrator must:

- confirm the identity of the participant
- administer the correct medication and fluid (if relevant)
- check the calculations are correct and appropriate for the dose
- make the correct dosage settings and adjustments to a rate-limiting device such as an infusion pump
- countersign the administration on the medication administration chart by the registered nurse who supplied the medication against that of the administering registered nurse occurs
- countersigning of the amount of any medication discarded by the registered nurse in the room occurs.

7.0 Related documents

- Authority to Act as an Advocate Form
- Code of Conduct Agreement
- Complaints and Feedback Policy and Procedure
- Complaints and Feedback Form
- Consent Policy and Procedure
- Doctors Medication Order Form

- Drug Register for Controlled Drugs
- Incident Report
- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Register
- Management of Medication Policy and Procedure
- Medication Incident Form
- Self-Medication Assessment
- Participant Medication Plan and Consent Form
- PRN Care Plan
- PRN Intake Checklist
- PRN Protocols
- Support Plan
- Service Agreement
- Privacy and Confidentiality Agreement
- Reportable Incident, Accident and Emergency Policy and Procedure
- Risk Assessment Form
- Risk Indemnity Form
- Risk Management Plan
- Risk Register
- Risk Management Policy and Procedure
- Staff Orientation Checklist
- Service Agreement with Participants Policy and Procedure
- Training Attendance Register – In-house
- Training Register
- Staff Training Record
- Staff Training Plan
- Training Needs Analysis

8.0 References

- ACIA Administration of Non-Oral and Non-Injectable medications in the Community by Support Staff 2015 (Commonwealth)
- ACIA Administration of Oral Medications in the Community by Support Staff 2017 (Commonwealth)
- Australian Pharmaceutical Advisory Committee (APAC) Guidelines July 2006 (Commonwealth)
- The Medication Management Framework (Poisons Regulations 95AA January 2018)
- Twelve (12) Guiding Principles for Medication Management in the Community developed by the Australian Pharmaceutical Advisory Council (June 2006 updated January 2012)
- NDIS Quality and Safeguards Commission 2018
- NDIS Provider and Registration and Practice Standards 2020

Medication Management (swallowing difficulty) Policy and Procedure

1.0 Purpose

Choking is a major cause of participants' preventable deaths. These deaths can be prevented by reducing exposure to the risk of choking factors. Certain medicines can increase the risk of choking by causing swallowing problems (dysphagia) and drowsiness (sedation).

2.0 Scope

All staff working with participants who administer medication must follow this policy and procedure. Management is to ensure staff are trained and aware of the requirements of this policy and procedure.

3.0 Policy

Strength In Care upholds the rights of and promotes the health, safety and wellbeing of participants receiving supports.

Management must ensure a qualified and experienced person can train and support medicines associated with swallowing problems. Staff are trained to be aware of preventing choking risks associated with medicines. If a person's swallowing problems persist while taking these medicines, speak to the prescribing medical practitioner to get a medical review.

4.0 Procedure

Staff must be aware that people taking **antipsychotic medicines** may be at particular risk of muscular reactions that can affect swallowing:

- in the first few days after starting the medicine
- after an increase in the dosage of antipsychotic medicine or
- when they have been taking antipsychotic medicines for a long time or taking combinations of antipsychotic medicines or antipsychotic medicines in combination with other drugs that can affect swallowing.

Director or their delegate will review any medication that may cause swallowing problems within the first week, after increases in medication and at least annually during support plan review.

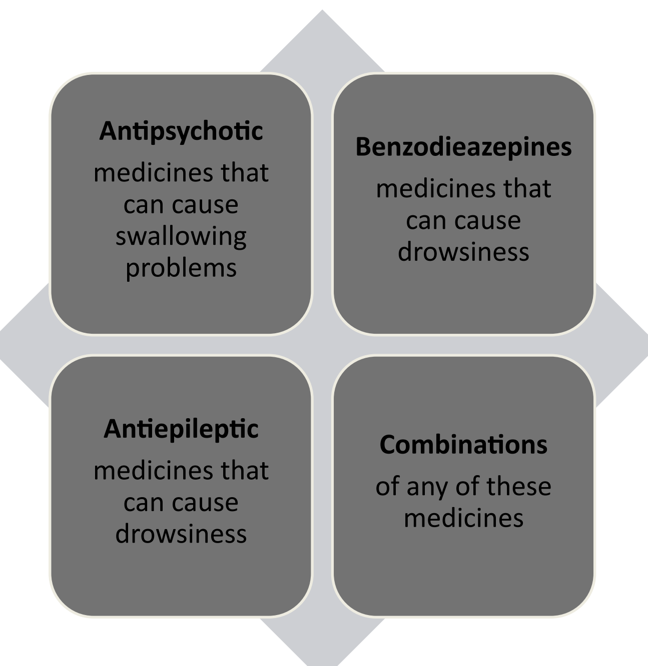
When a person's swallowing problems persist while taking these medicines, then staff must inform Director or their delegate, who will speak to the prescribing medical practitioner to get a medical review.

The Director or their delegate must also consider:

- whether the medicine should **continue** to be prescribed to the person
- whether the current medicine could be **changed** to another medicine of the same type
- if the medicine is to continue - whether the **dose** can be reduced, or if dividing the dose over the day may reduce swallowing problems
- whether to seek an independent medical review, particularly if the person requires medical attention for aspiration pneumonia, experiences frequent coughing or sounds 'gurgly' or chesty during or after meals.

4.1 Medications associated with swallowing problems

The major types of commonly prescribed medicines that have the potential to affect swallowing and cause problems while eating or drinking are:



4.1.1 Antipsychotic medicines associated with swallowing problems

The antipsychotic medicines listed below can cause swallowing problems.

- Aripiprazole (e.g. Abilify)
- Asenapine (e.g. Saphris)
- Chlorpromazine (e.g Largactil)
- Flupentixol (e.g. Fluanxol)
- Haloperidol (e.g. Haldol, Serenace)
- Lurasidone (e.g. Latuda)
- Olanzapine (e.g. Zyprexa, APO-Olanzapine)
- Paliperidone (e.g Invega)
- Quetiapine (e.g. Seroquel)
- Risperidone (e.g. Risperdal, Rixadone)
- Trifluoperazine (e.g. Stelazine)
- Ziprasidone (e.g. Zeldox)

4.1.2 Benzodiazepine medicines associated with drowsiness

The benzodiazepines listed below can cause drowsiness and influence swallowing by association, especially during eating.

- Alprazolam (e.g. Alprax, Kalma, Xanax, Zamhexal)
- Bromazepam (e.g. Lexotan)
- Clobazam (e.g. Frisium)
- Clonazepam (e.g. Rivotril, Paxam)
- Diazepam (e.g. Ducene, Valpam)
- Flunitrazepam (e.g. Hypnodorm)
- Lorazepam (e.g. Ativan)
- Midazolam (e.g. Hypnovel)
- Nitrazepam (e.g. Mogadon, Alodorm)
- Oxazepam (e.g. Alepam, Murelax, Serepax)
- Temazepam (e.g. Normison, Temaze, Temtabs)

4.1.3 Antiepileptic medicines associated with drowsiness

The antiepileptic medicines listed below can cause drowsiness and influence swallowing by association, especially during eating.

- Carbamazepine (e.g. Tegretol, Teril)
- Clonazepam (e.g. Rivotril, Paxam)
- Gabapentin (e.g. Neurontin, Nupentin, Pendine, Gabaran, Gantin)
- Lamotrigine (in combination with other medicines; e.g. Elmendos, Lamictal, Lamidus, Lamitrin, Lamogine)
- Phenobarbital (e.g. Phenobarb)
- Pregabalin (e.g. Lyrica)
- Valproate (in combination with other medicines; e.g. Epilim, Valpro)
- Vigabatrin (e.g. Sabril)

4.1.4 Commonly prescribed medicines that can affect swallowing

Preliminary data has identified that the three most commonly prescribed medicines used for behaviour support are associated with swallowing problems. These medicines are:

- Risperidone (antipsychotic)
- Sodium valproate (antiepileptic)
- Olanzapine (antipsychotic)

5.0 Related Documents

- Support Plan
- Mealtime Management Plan
- Medication Management Policy and Procedure

6.0 References

- NDIS Practice Alert – Medicines associated with swallowing problems (November 2020)
- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- United Nations Convention on the Rights of Persons with Disabilities

Polypharmacy Policy

1.0 Purpose

Polypharmacy increases the risk of medication-related adverse effects and poorer health outcomes. The policy's purpose is to ensure that participants taking multiple medications have their medications reviewed every 3 to 6 months by a medical practitioner or pharmacist.

2.0 Scope

Director must ensure that review dates are identified within the participant's support plan. Staff are to support the participant in seeking this medication review.

3.0 Definitions

Term	Description
Polypharmacy	Polypharmacy is the concurrent use of multiple medications (often defined as five or more medications) to treat one or multiple concurrent conditions. It includes using all prescription medicines, over-the-counter medicines, and complementary medicines. Polypharmacy use is significantly higher in people with disability. It is partly because people with a disability are more likely to have multiple health conditions, such as epilepsy, diabetes, stroke, heart problems, high

Psychotropic polypharmacy	Psychotropic polypharmacy refers to the concurrent use of two or more medications that can affect the brain's function. Psychotropic medications are 'any drug capable of affecting the mind, emotions, and behaviour.' The three main classes of psychotropic medicines are antidepressants, anti-anxiety agents (mostly benzodiazepines to manage anxiety and insomnia) and antipsychotics. Psychotropic polypharmacy is common in people with autism or an intellectual or developmental disability. Although people with these disabilities are more likely to receive medications because of co-existing mental health problems, medications are often prescribed without a diagnosis of a psychiatric disorder. Antipsychotics are also frequently prescribed to manage behaviours of
Home Medicines Review (HMR)	A Home Medicines Review (HMR) is a collaborative medication review for people in the community. It aims to maximise the patient's benefit from their medication regimen and prevent medication-related problems. A referral from a GP or medical specialist is required. An accredited pharmacist interviews a participant, reviews their medications, and reports to the participant's doctor. It is fully subsidised by Medicare for eligible patients and is available every 24 months to any person at risk of or experiencing medication-related adverse

4.0 Policy

Staff will provide supports and services in line with the NDIS Code of Conduct:

- safely and competently with care and skill

- promptly take steps to raise and act on concerns about matters that might impact the quality and safety of supports provided

This policy relates to the *Medication Management Policy and Procedure* that guides staff in administering participants' medication. We aim to provide participants with confidence that our strategies for administration, storage and monitoring of the effects of their medication are effective and appropriate, and we work to prevent errors or incidents. Our strategies will include:

- maintaining records that identify the medication and dosage required by each participant
- identifying the participant correctly and administering the medication safely
- training staff to understand the effects and side-effects of the medication and the steps to take in an incident involving medication
- storing medication safely and securely, so it can be easily identified and differentiated and is only accessed by appropriately trained workers.

4.1 Home Medicine Review

If clinically necessary, a Home Medicines Review can occur more frequently than 24 months in the following scenarios:

- a significant change to a participant's medication regimen in the past three months
- change in medical condition or abilities (including falls, cognition, physical function)
- prescription of a medicine that may be more likely to cause harms
- symptoms that suggest an adverse drug reaction
- inadequate response to medications
- suspected non-compliance or problems with managing medications.

4.2 Risks associated with polypharmacy

Participants are among those most at risk of polypharmacy due to comorbid health conditions and the common use of several medicines of the same class (e.g. antipsychotics). A medical practitioner should conduct a medication review every 3–6 months or when requested by the participant, their carer or other health or disability professionals.

The use of multiple antipsychotics can increase the risk of:

- movement disorders
- hormone disorders
- sexual dysfunction
- obesity
- diabetes
- stroke and heart attack
- memory issues
- falls
- sedation.

Despite the risks associated with polypharmacy, it may be the most appropriate treatment, particularly for people with multiple conditions.

To ensure participants receive the correct medications, a medical practitioner and pharmacist review all medications allowing each drug to be assessed in need, current and recommended dosages, the benefit versus risk of potential adverse effects or other side effects, and possible interactions between medications.

5.0 Procedure

If participants receive multiple medications, Strength In Care will:

- arrange for a medical practitioner or pharmacist to review these every 3 to 6 months as a participant may experience adverse effects when they take multiple medications

- arrange to have their medications reviewed by a pharmacist through the HMR program if participants take five or more medications (or two or more antipsychotics)
- keep a record of when participants last had their medications reviewed
- ensure that participants, carers and support staff have ready access to a full list of the participant's current medicines. Information can be accessed via NPS MedicineWise App or electronic medication records such as My Health Record
- make an appointment with a medical practitioner if staff suspect that a participant may be experiencing adverse effects due to medications, particularly if there has been a recent change in medication
- support participants during the review in a manner that suits their needs
- document the review and its outcomes in the support plan
- management to review the outcome and retrain staff, as required.

6.0 Related Documents

- Management of Medication Policy and Procedure
- Medication Incident Form
- Self-Medication Assessment
- Participant Medication Plan and Consent Form
- PRN Care Plan
- PRN Intake Checklist
- PRN Protocols
- Support Plan
- Privacy and Confidentiality Agreement
- Reportable Incident, Accident and Emergency Policy and Procedure
- Risk Assessment Form
- Risk Indemnity Form
- Risk Management Plan
- Risk Management Policy and Procedure
- Training Attendance Register – In-house

- Training Register
- Staff Training Record
- Staff Training Plan
- Training Needs Analysis

7.0 References

- NDIS Practice Alert – Polypharmacy
- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- United Nations Convention on the Rights of Persons with Disabilities
- ACIA Administration of Non-Oral and Non-Injectable medications in the Community by Support Staff 2015 (Commonwealth)
- ACIA Administration of Oral Medications in the Community by Support Staff 2017 (Commonwealth)
- Australian Pharmaceutical Advisory Committee (APAC) Guidelines July 2006 (Commonwealth)
- The Medication Management Framework (Poisons Regulations 95AA January 2018)
- Twelve (12) Guiding Principles for Medication Management in the Community developed by the Australian Pharmaceutical Advisory Council (June 2006 updated January 2012)

4.4 Mealtime Management

Mealtime Management Policy and Procedure

1.0 Purpose

This policy is developed to ensure that each participant requiring mealtime management receives nutritious meals of a texture that is appropriate to their individual needs, appropriately planned and prepared in an environment and manner that meets their individual needs and preferences, and delivered in a way that is appropriate to their individual needs and ensures that the meals are enjoyable

2.0 Scope

This policy and procedure will be used for participants who require mealtime management.

3.0 Policy

A participant who requires mealtime management will be identified during the assessment and intake process. Any identified participant will have a Mealtime Support Plan created to suit their circumstances. Strength In Care collaborates with the relevant speech pathologist and other relevant practitioners to assess and develop a mealtime management plan that includes:

a) undertaking comprehensive assessments of their nutrition and swallowing; and
b) assessing their seating and positioning requirements for eating and drinking; and
c) providing mealtime management plans which outline their mealtime management needs, including swallowing, eating and drinking; and
d) reviewing assessments and plans annually or following the professional advice of the participant's practitioner, or more frequently if needs change or difficulty is observed.

When participants consent, they will be involved in assessing and developing their mealtime management plan. Staff are trained in the requirements of the individual plan.

4.0 Procedure

A mealtime management plan is recommended when a person has trouble swallowing. A mealtime management plan will incorporate the following information, details and practices.

4.1 Staff training

- staff training of mealtime management needs of the participant to ensure:
    - their capabilities to deliver support and
    - stay alert to ensure safe eating and drinking
    - steps to take if safety incidents occur during meals, such as coughing or choking on food or fluids.
    - preparing and providing safe meals with participants that would reasonably be expected to be enjoyable
    - proactively managing emerging and chronic health risks related to mealtime difficulties, including seeking help to manage such risks.
- Mealtime management plans are accessible to staff providing these services.

4.2 Planning mealtime management plans

- Mealtime management plans planning include:
    - nutritious meals provision that would reasonably be expected to be enjoyable, reflecting their preferences, their informed choice and any recommendations by a Speech Therapist that are reflected in their mealtime management plan; and

    - proactively risks management if the participant has chronic health risks (such as swallowing difficulties, diabetes, anaphylaxis, food allergies, obesity or being underweight)
- providing the participant with information about the mealtime management plan and the consequences of not following this plan
- when the person should be assessed, monitored and reviewed by a speech pathologist for mealtime and swallowing safety and support needs
- whether the person should be supervised or assisted during mealtimes
- communication with the participant about supports during the plan implementation
- changing the foods offered to the person, such as foods and drinks that are easy to chew and swallow, or other food and drink modifications as recommended by a speech pathologist
- how the person is positioned during and after mealtimes
- the amount of food and pace of each mouthful during mealtimes

4.3 Mealtime provision

Staff are required to ensure the following:

- consider who the participant wants to share their meal with (sitting with them)
- establish a positive environment during mealtimes, for example, avoiding a noisy environment which can be distracting
- seek the participant's input in exploring ways to enjoy their mealtime
- support the participant to understand how to prepare or request preferred meals and to learn basic food safety
- store meals safely and as per health standards
- label each meal to allow differentiation between participants
- match the meals to the individual's plan
- who to report any signs of complications or difficulties.
- Respond as per the Mealtime Support Plan if having problems eating and swallowing

4.4 Documentation

- complete documentation on implementation strategies and how they are functioning through identifying:
    - barriers and challenges
    - when supports are no longer required
    - strategies that are working
- regularly reviewing mealtime management plans, especially if there are ongoing issues with aspiration.

5.0 Related Documents

- Support Plan
- Mealtime Management Plan

6.0 References

- NDIS Code of Conduct Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- United Nations Convention on the Rights of Persons with Disabilities

Practice Guidelines - Food Preparation

Definition

Food hygiene refers to the conditions and measures necessary to ensure food safety from production to consumption. Food hygiene measures are intended to prevent the hazards caused by cross-contamination, biological contamination and allergens.

Cross-contamination

Cross-contamination is when bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effects. Cross-contamination between raw and cooked food is the cause of most infections.

Biological hazards

Microbial hazards in food include bacteria such as salmonella, viruses such as Norovirus, and parasites such as trematodes (flukes) and prions (e.g. mad cow disease).

Diarrhoeal diseases are the most common illnesses resulting from the consumption of contaminated food, causing 550 million people to fall ill and 230,000 deaths globally every year (WHO).

Allergens

A food allergy is when the immune system reacts to a food substance (allergen), resulting in the production of allergy antibodies (proteins in the immune system) that identify and react with foreign substances.

An allergic reaction happens when a participant develops symptoms following exposure to an allergen. Symptoms may include hives, swelling of the lips, eyes or face, vomiting or a wheeze.

The most common triggers are egg, cow's milk, peanut, tree nuts, sesame, soy, fish, shellfish, and wheat. Some food allergies can be severe, causing life-threatening reactions known as anaphylaxis. About two per cent of adults have food allergies.

Principles

The key elements of food hygiene are:

- **Personal hygiene:** This includes handwashing, protective clothing, illness procedures, and other duties (e.g. avoiding smoking).
- **Preventing cross-contamination:** This includes preventing bacterial, physical, chemical, and allergenic contamination, particularly by having appropriate equipment (such as separate cutting boards).
- **Cleaning procedures:** Thorough cleaning of the kitchen, equipment, and kitchenware (including plates and cutlery).
- **Allergen control:** All providers must clearly explain which foods contain allergenic products and prevent allergens from cross-contaminating other food.
- **Safe food storage:** This includes storage locations and containers, using a first in, first out system, appropriate labelling and temperature control.
- **Cooking temperatures:** Providers must ensure they cook and hold food at appropriate temperatures to prevent bacterial risks.

Mealtime support plan

Dietary requirements, including any allergies, will be documented in the participant's Mealtime Support plan. Ensure you check the support plan for any known allergies.

Participants with food allergies

Check the participant's plan for any known food allergies. It can be valuable to check again with the participant and their family. Foods that may cause an allergic reaction are called allergens, and even a tiny amount of an allergen can cause a reaction.

If the participant lives alone, it can be possible to eliminate all food allergens from home by carefully reading labels on packaging and taking necessary precautions during cooking.

If the participant does not choose to eliminate all food allergens from home, or you are preparing food in an environment away from home (where there is a potential for allergens to come into contact with the allergic participant's food), the following steps should be taken:

- Read all labels on cans, jars and packaging.
- Label foods as "safe" or "not safe" (perhaps using red/green stickers).
- Designate particular shelves for 'safe' foods rather than putting similar foods next to each other.
- Avoid contamination by:
    - washing hands
    - not allowing allergen covered utensils to touch "safe" foods
    - confine all eating to limited areas, e.g. kitchen or dining areas
    - use different utensils to prepare non-allergenic and allergenic dishes
    - wash foods or place in sink/dishwasher immediately after use
    - clean grills; use foil to protect the surface when cooking
    - clean all surfaces after preparing food
    - clean countertops before preparing food.

General food preparation

- Minimise the cumulative time that potentially hazardous food is kept within the temperature danger zone (maximum two hours).

- Clean, sanitise and dry all food contact surfaces, utensils, chopping boards and equipment after preparing food.
- Store raw and cooked food separately.
- Wash all fruits and vegetables to remove contamination.
- Use single-use or disposable cloths where possible.
- If multi-use cloths are used, they will be cleaned and sanitised after each task.

Cleaning and sanitation

- Clean all food preparation areas with an anti-bacterial solution and paper towel.
- Thoroughly wash glasses, cutlery, crockery and utensils with hot water and detergent.

Utensils

- Saucepans, bowls, plates, etc., must be clean and sanitised.
- Utensils should be durable, washable, unchipped and uncracked.
- Use microwave-safe containers in microwaves.

Cutting boards

- Allocate and label separate plastic boards for preparing cooked or raw foods.
- After use, scrape boards and wash in hot, soapy water; use a sanitiser.
- If using a wooden board, wash in hot soapy water, smear with salt and then wash again before using.

Food handling

- Tongs, spoons and forks should be used for handling food, in preference to gloved hands
- Separate tongs should be used for serving raw foods and cooked foods.
- Use gloves to handle food if no tongs are available.
- Wash and dry hands thoroughly.
- Hair must be tied back, and a hairnet used.

- Stop clothes, jewellery or a phone from touching food or surfaces (e.g. tie hair back, remove loose jewellery and rings, cover open sores).
- Wear clean clothing and aprons.
- Do not eat, spit, smoke, sneeze, blow or cough over food or surfaces that touch food
- Inform supervisor if sick or unwell, or food has been contaminated in any way.

Washing hands properly

- Use the sink provided just for handwashing.
- Wet hands under warm, running water.
- Lather hands with soap.
- Thoroughly scrub fingers, palms, wrists, back of hands, and under nails for approximately 20 seconds.
- Rinse hands under warm, running water.
- Turn off taps using a paper towel or elbow.
- Thoroughly dry hands with a single-use towel.

When to wash hands

- Before handling food, or if returning to handle food after completing other tasks.
- Before working with ready-to-eat food.
- After handling raw food.
- After using the toilet.
- After smoking, coughing, sneezing, using a handkerchief or tissue.
- After eating or drinking.
- After touching the face, hair, scalp, nose, etc.
- After doing anything else that could dirty their hands, e.g. handling garbage, touching animals or children or completing cleaning duties.

When to wear gloves

- Wear neatly fitting disposable gloves at all times.

- Wear fresh gloves when alternating between handling raw foods and cooked foods.
- Discard gloves after each use.
- Wear gloves during cleaning up to protect hands from food contamination.

Freezing, defrosting and reheating food

Frozen foods must be maintained below -17ºC. To maintain the integrity of frozen food, the freezer requires:

- regular defrosting
- never to be overloaded
- cabinet doors to be shut when not in use
- regular checking of temperature.

Our workers observe the following rules:

- store delivered frozen foods immediately in the freezer
- rotate older goods to the top/front of the freezer
- expel air and reseal bulk frozen foods, review the use-by date and return promptly to the freezer if still within the use-by date
- store frozen solid any potentially hazardous foods, and never partially thaw.
- inspect potentially hazardous food daily to ensure it remains frozen
- wrap or cover food, store in food-grade containers which allow for proper air circulation
- keep the storage area in a clean condition
- check daily to ensure food is protected from contamination, stored in food-grade containers, and has free air circulation.

Defrosting

- Defrost all foods in a refrigerator at or below 5°, or rapidly defrost them in a microwave oven using the defrost setting.
- When using microwaves, thaw food at medium/low defrost.

- Use correct microwave procedures, such as:
    - alter the position of food pieces during thawing
    - ensure potentially hazardous food is properly thawed
    - only use microwave approved materials
    - cook all meat immediately after thawing.
- **Never refreeze** food after thawing or keep and reheat hot foods left from the day before.

Reheating

- Reheat food immediately before use, where possible.
- Heat food from a refrigerator to above 60oC as quickly as possible.
- Use a meat probe thermometer, if available, to check internal temperatures
- Slow cooking, as in a crockpot, can be dangerous and is not recommended
- Never reheat a precooked product more than once.
- Boil eggs for 10 minutes and then place in cold water for five minutes.

Food storage

General storage requirements

- Check packaging and labels are in good condition and "use by" dates are current.
- Check labels for special storage instructions.
- Unpack frozen or cool-type foods and place them in the fridge immediately.
- Store food in a cool, dry area in food-grade containers with tight-fitting lids and date-mark.
- Store chemicals in a separate area so as not to contaminate food.
- Store food off the floor (e.g. at a minimum height of 15 centimetres) to allow easy cleaning.

Dry goods storage

Dry good storage areas must:

- be fly proof and vermin proof
- be adequately ventilated
- have properly fitting doors which seal completely
- have the lowest shelf at least 30 centimetres from the floor
- have containers made from food-grade materials with tight-fitting lids that are emptied and washed before refilling.

Refrigerated storage

All foods that require refrigeration must be stored below 5°C. Cooked and uncooked foods must be kept separate to prevent cross-contamination:

- Store raw meats below cooked, where they cannot drip onto cooked foods.
- Store dairy products in their original packaging.
- Reseal opened cheeses or store them in airtight containers.
- Recap and refrigerate after opening products sold in jars (e.g. mayonnaise, pickles, etc.)
- Store food according to the manufacturer's instructions.
- Use food within its date marking and on a stock rotation basis.
- Cover food products with plastic or store them in food-grade containers.
- Keep the storage area clean.
- Use insulated thermal bags when grocery shopping with participants, and there is likely to be a delay in returning foods to a refrigerator.
- Clean and sanitise refrigerators weekly.

Transporting food and delivery of meals

- no animals or chemicals are to be carried in the vehicle while food is being transported
- keep food transport containers/eskies in a clean and sanitary condition
- keep food transport vehicles in clean condition
- keep all meals under appropriate temperature control to prevent the growth of food poisoning bacteria and the production of toxins

- delivered food or meals within a minimal period
- do not deliver food or meals damaged during transportation
- store any meals or food damaged during transportation separately from undamaged food or meals in the transport vehicle
- deliver food or meals directly to the client and do not leave unattended
- return or discard all left-over meals and never leave in eskies at the participant's home.

Pest control

Report to supervisor any evidence of the need for:

- pest control
- fly screens
- airtight garbage bins.

Smoking

Smoking is not permitted in any food handling area or the participant's home while workers are present.

Practice Guidelines -Choking

Definition

Choking occurs when something gets stuck in the back of the throat and blocks the airway. When the airway has been partially blocked, the participant can usually cough and still make noises. When it is blocked, the participant cannot make any sound.

Causes

As participants age, their swallowing function can deteriorate, and their teeth can be weak or absent. There is a loss of muscle strength in the mouth and throat; this slows the swallowing process and makes it difficult for some aged persons to swallow hard or dry solid foods. The surfaces in the mouth and throat are also less moist.

The following factors may increase the risk of choking:

- eating or drinking too quickly
- swallowing food before it is properly chewed
- swallowing small bones or small objects
- inhaling small objects.

Common food choking hazards

Foods that present a choking hazard include:

- lollies
- raw peas
- meat, including chicken and fish (especially with bones)
- nuts
- raw carrot
- raw apple
- fruit pips and stones

- water and thin fluids - thickening agents can be added to make water more viscous.
- bread
- dairy foods.

Prevention strategies

- Follow any dietary plan as outlined in the Meal Support Plan.
- Please do not rush the participant to eat their meal.
- Keep noise and activities in the environment to a minimum.
- Do not encourage the participant to drink fluids while eating.
- Do not encourage talking while the participant is eating, as the epiglottis (the hinge-like flap at the base of the tongue that keeps food from entering your windpipe) does not know whether to open or close as it cannot register whether food or air is entering.
- Do not let the participant eat lying down.
- Always peel fruit (e.g. apples, pears) before serving to a participant.

If a participant is choking

- Firstly, check if they can cough. Encourage the participant to do so, as people can often clear blockages themselves.
- If they cannot cough, bend them forward, supporting their chest with one hand, and use the flat of your other hand to give a firm back blow between the shoulder blades.
- Check to see if the blockage has cleared before giving another blow.

Observe, record, and report

It is essential that staff:

- are alert to any changes in the participant's condition and signs of issues in swallowing

- act quickly in passing on this information to a supervisor or clinical manager, and in the handover documentation
- call 000 in emergency
- in the event of a serious incident, follow the *Reportable Incident, Accident and Emergency Policy and Procedure*

4.5 Management of Waste

Management of Waste Policy and Procedure

1.0 Purpose

Strength In Care provides clear guidelines around the management of waste in a manner that meets both the *Work Health and Safety Act (2011)* and environmental requirements.

2.0 Scope

Front-line workers must understand how to manage waste products correctly and procedurally, ensuring all participants accessing, or using our services, are in safe environments.

Strength In Care will ensure that all staff are trained to respond to emergencies and incidents appropriately.

3.0 Policy

Strength In Care have a responsibility to protect our participants and any other person in the home of a participant from harm by avoiding exposure to waste; infectious and hazardous substances generated during the delivery of supports.

Strength In Care's policies, procedures and practices are in place for the safe and appropriate storage and disposal of waste. Infectious or hazardous substances must comply with current legislation and local health district requirements (see the Work Health Safety and Environmental Management Policy and Procedure). Staff are trained in the use of PPE and any other clothing required when handling waste or other substances.

Any incidents of exposure to the waste, infectious or hazardous substances are to be referred to the Director to implement relevant processes applying to staff and participants.

Hazardous waste includes infectious waste such as:

- Waste contaminated by bodily fluids
- Waste from clients who have infections (e.g. bandages, swabs)
- Pathological waste
- Human tissue, organs or fluids (not including hair, teeth and nails)
- Sharps (needles, syringes, disposable scalpels and blades)
- Chemical waste (e.g. disinfectants, batteries, heavy metals in medical devices)
- Pharmaceutical waste (expired, unused or contaminated medicines and vaccines)
- Cytotoxic waste that contains genotoxic agents (e.g. cancer medications)
- Radioactive waste.

Note: **Urine, faeces, vomit, sputum and meconium are not considered bodily fluids.** According to legislation, these can be flushed or disposed of in landfills without treatment. The only exceptions are if they visibly contain blood or if the client has a known or suspected communicable disease.

Adverse Effect

Our policy is the eliminate any adverse effects that may result from exposure to hazardous waste or accidental release into the environment, including:

- Infections
- Antimicrobial resistance
- Injuries from sharps
- Air pollution
- Thermal injuries
- Radiation burns
- Environmental contamination

- Environmental damage

4.0 Procedure

4.1 Waste storage and disposal

All waste should be stored in secure areas until collected. Waste disposal companies licensed with the Environmental Protection Authority (EPA) will collect all clinical and pharmaceutical waste for disposal in specialised waste disposal facilities, which the EPA also licenses.

Waste should be removed from clinical areas at least three times each day and more frequently as needed, such as from specialised areas. Waste bags should be tied before removing them from the area.

4.1.1 Safe Collection of Hazardous Waste

Hazardous waste should be bagged, packaged, or placed into the designated container at the time and place of generation. After this initial collection, there should be no more direct contact with the waste.
When collecting waste in a plastic bag, ensure the bag is strong enough to contain the waste and is appropriately labelled depending on the type of waste.

Do not fill the bag beyond two-thirds of its capacity.

The following are essential considerations for waste collection:

- If the container is to be incinerated, use non-PVC plastic liners
- Do not secure bags with closure devices (e.g. metal staples) that could puncture them
- Waste must be transported in containers. Do not use bags to transport waste

- Containers used to store cytotoxic waste must be strong enough to resist spillage, leakage or breakage. They must not be reusable
- Containers used to store pharmaceutical waste must be non-reactive, tamper-proof, resist impact rupture and contain spills. Once the waste is ready to be disposed of, you should not be able to remove it from the container
- Double-bagging may be used to increase strength when transporting heavy loads. However, this will need to be performed carefully to avoid spillage or accidental exposure to waste.

4.1.2 Waste Segregation

- Segregation is an integral component of safe waste, allowing different types of waste to be easily identified. It must be maintained during storage and transportation.
- Waste is segregated using a standardised colour-coding system. Each type of waste should be disposed of in a designated colour bin, and staff should separate waste **at the time and place it is generated**.

Type of Waste	Colour	Symbol
Clinical (infectious, pathological and sharps waste)	Yellow	
Cytotoxic	Purple	
Radioactive	Red	

(Adapted from QLD Government 2019)

4.1.3 General waste disposal

- Place in the general waste bin for removal.

4.1.4 Clinical waste disposal

- Staff are required to use the biohazard bags provided by our organisation.
- Staff workers will place clinical waste in biohazard bags as soon as possible.
- Biohazard bags have a biohazard symbol and are currently coloured yellow
- Single-use sharps are to be placed (by the user) into a sharps container that meets the Australian and New Zealand Standards AS 4031:1992 and AS/NZS 4261:1994.

4.1.5 Pharmaceutical waste disposal

- When uncertain about how to dispose of leftover pharmaceuticals, staff workers should return to the pharmacy for correct disposal.
- Most disinfectants can be disposed of through the sewer system by running cold water into the sink before pouring the disinfectant into the sink. Leaving the cold water running for a few moments after the disinfectant has been disposed of dilutes the disinfectant.

4.1.6 Sharps disposal

Collecting Sharps

Sharps containers must have rigid walls (hard, unbendable sides resistant to breakage). Single-use sharps containers must never be reused.

When collecting sharps:

1. Ensure a sharps container is closed when handling sharps for immediately sharps disposal.
2. Always wear PPE when handling sharps.
3. Ensure the sharps container has adequate space to accommodate the sharp.
4. Place the needle and syringe (still connected) into the sharps container).
5. **Do not** try to recap the needle or separate the needle and syringe.

Sharps Containers

Sharps containers must only be used for objects that can puncture the skin, including:

- Hypodermic needles
- Syringes
- Scalpels
- Lancets
- Wires.

Do not put other objects or non-sharp components of sharps (e.g. IV bags) into sharps containers.

4.1.7 Safe Storage of Hazardous Waste

Hazardous waste has designated storage areas away from food and clean storage areas. Storage areas are enclosed spaces such as sheds, garages or fenced areas. They must be cleared routinely and provide access to the necessary cleaning materials.

Storage areas must be inaccessible by the public or other unauthorised persons, labelled with appropriate signage and ideally segregated by a lockable door. The flooring of the storage area should be a rigid, impervious surface (e.g. concrete). Specific waste may require refrigeration to prevent decomposition and odour.

Hazardous waste is stored in bags and containers according to the colour-coding system.

4.1.8 Safe Disposal of Hazardous Waste

There are a variety of treatment methods for hazardous waste. The most appropriate method will depend on the type of waste, with the goal being to:

- Make the waste as safe as possible
- Minimise harm to the environment
- Reduce the volume of the waste
- Render the waste non-recognisable by altering its physical nature.

Furthermore, the treatment and disposal process should:

- Limit the creation of hazardous or toxic by-products
- Have automatic controls and fail-safe mechanisms
- Ensure no waste can bypass the process.

Once treated, the waste is generally sent to a landfill. Compaction can decrease the volume of some types of waste before treatment and disposal, but it is not an appropriate standalone method (QLD Government 2019).

The following table outlines the appropriate treatment and disposal options for each type of hazardous waste:

	Incineration	Autoclaving and shredding	Chemical disinfection (hypochlorite) and shreddi	Chemical disinfection (peroxide and lime) and	Microwave and shredding	Compaction	Landfill
Chemical	YES (if licensed)	NO	NO	NO	NO	NO	NO
Cytotoxic	YES	NO	NO	NO	NO	NO	NO
Pharmaceutical	YES	NO	NO	NO	NO	NO	NO
Radioacti	NO	NO	NO	NO	NO	NO	NO
Treated clinical	-	-	-	-	-	YES	YES
Untreated clinical	YES	YES	YES	YES	YES	YES (other than animal carcasses and	NO (other than in a scheduled area)

(Adapted from QLD Government 2019)

4.2 Cytotoxic Waste Management

Cytotoxic medications are agents that are toxic to cells and are mainly used to treat cancer. However, they may also treat some autoimmune diseases such as multiple

sclerosis, psoriasis, rheumatoid arthritis and lupus. Their function is to destroy rapidly growing cells.

They are known to be mutagenic, carcinogenic and/or teratogenic and have proven to be highly toxic to non-target cells, mainly through their action on cell reproduction. Some have been shown to cause secondary cancers in cancer patients.

A participant taking cytotoxic medication excretes body fluids contaminated with the unchanged medication or its metabolites.

4.2.1 Cytotoxic Waste

Damaged medication packages must be discarded in the cytotoxic waste bin (provided by the selected waste management company and organised by Strength In Care), and the pharmacy notified.

A purple waste disposal receptacle is provided for cytotoxic waste, e.g. a dropped pill or continence pads. Cytotoxic waste must be removed by an environmental protection authority for appropriate destruction.

Unused cytotoxic medications must be appropriately sealed and returned to the pharmacy. Staff should place medications in a sealed plastic bag, ensuring that the purple container is visible, or apply a purple cytotoxic sticker to the outside of the bag.

4.2.2 Caring for a participant taking cytotoxic medication:

- If the participant is incontinent of urine or faeces, always wear two pairs of purple cytotoxic gloves when attending to toileting or personal care.
- Place soiled incontinence pads in a purple plastic waste bag and outer gloves, and seal purple plastic waste bags.
- Assist in changing consumer clothing and bed linen.

- Discard grossly contaminated linen in the purple cytotoxic waste bag.
- Linen that is only moderately to lightly soiled can be laundered using the following process:
  - wear PPE, including gloves and apron, throughout the washing and drying process
  - launder separately to all other linen
  - place the linen into the consumer's washing machine
  - do not stir up linen to avoid the generation of dust/particles
  - use domestic washing powder
  - wash linen at a maximum cycle in either hot or cold water
  - dry laundry on a line or in a dryer
- Once laundered, previously contaminated linen and clothing can be reused.
- Remove gloves and discard them into the cytotoxic waste bin.
- Wash hands.

4.2.3 Managing a cytotoxic spill:

- Alert all those in the immediate vicinity that a cytotoxic spill has occurred and tell them to stay clear.
- Locate the spill kit and read instructions inside the spill kit.
- Bring a spill kit to the area of the spill, restrict access and call the Director for assistance, if required.
- Don an N95 face mask, two pairs of cytotoxic gloves (inner and outer), and appropriate personal protective equipment (e.g. gown, goggles).
- For liquid spills, wait a few seconds for aerosols to settle, then cover the spill using available absorbent material, taking care not to generate any splashes. For large spills, use a spill pillow to absorb the liquid.
- If the spill involves a powder, place an absorbent mat over the powder and ensure minimal dust production. Carefully wet the mat so that the powder dissolves and is absorbed by the mat. Discard collected waste into a cytotoxic plastic waste bag.

- Wash the area several times with detergent and water, work from the least-contaminated area, and rinse the area thoroughly with water.
- Dry the affected area with absorbent towels or other suitable materials.
- Discard the contaminated cleaning waste into the purple cytotoxic plastic waste bag.
- Discard outer gloves into the cytotoxic plastic waste bag, seal the bag, and place it inside a second cytotoxic plastic waste bag.
- Discard contaminated PPE and inner gloves in the outer bag and seal it.
- Place the cytotoxic plastic waste bag into the large purple cytotoxic waste bin.
- Wash hands with soap and water
- Complete Incident Investigation Form and inform the Director immediately.
- Ensure that the cytotoxic spill kit is replenished/replaced.

4.3 Donning and doffing of personal protective equipment

Staff must wear personal protective equipment when handling hazardous or infectious materials, including urine, faeces, vomitus, and body fluids. Below are the donning and doffing of PPE.

4.3.1 Donning

1. **Perform hand hygiene.**
2. **Put on the gown.**
    - Fully cover the torso from your neck to knees and your arms to the end of your wrists, then tie at the back.
    - The gown should be large enough to allow unrestricted movement without gaping.
    - Fasten at the back of the neck and waist.
3. **Put on a surgical mask or P2/N5 respirator.**
    - Secure the ties or elastic bands at the middle of the head and neck.
    - Fit flexible band to the nose bridge.

- Fit mask snug to face and below the chin.
- A fit-check respirator according to manufacturer instructions.

4. **Put on protective eyewear or face shield.**
    - Place over eyes/face and adjust to fit.
5. **Put on gloves.**
    - Extend the gloves to cover the wrist of the gown.

4.3.2 Doffing

Following a correct doffing procedure is especially crucial in controlling and preventing infection, and it is the essential step in preventing infection transmission. The doffing of PPE should protect the clothing, skin and mucous membranes from contamination. Remember that all PPE is contaminated after use.

Perform hand hygiene immediately after each step of doffing**.** Gloves and gowns should be removed *before* exiting the participant's room (CDC 2014).

1. **Remove gloves.**
    - Using one hand, grasp the palm of the other hand and peel off the first glove.
    - Hold the removed glove in the gloved hand.
    - Slide fingers of the ungloved hand under the remaining glove at the wrist and peel it off over the first glove.
    - Discard gloves in a waste container.
2. **Perform hand hygiene.**
3. **Remove gown.**
    - Unfasten the ties, ensuring the sleeves don't contact your body.
    - Pull the gown away from the neck and shoulders, touching the inside only.
    - Turn the gown inside out.
    - Fold or roll the gown into a bundle and discard it in the waste container.
4. **Perform hand hygiene.**
5. **Exit the patient's room and close the door.**
6. **Remove goggles/face shield.**

- Remove from the back of the head by lifting headbands or earpieces.
- If reusable, place it in the designated reprocessing receptacle. If not, discard it in the waste container.

7. **Perform hand hygiene.**
8. **Remove mask/respirator.**
   - Grasp the bottom ties/elastics, then the top ones, and remove them without touching the front of the mask.
   - Discard in the waste container.
9. **Immediately perform hand hygiene.**

4.4 Incidents

All incidents involving infectious material, body substances or hazardous substances are:

- reported to the Director
- recorded on a Hazard Report Form
- investigated by the Director
- reviewed and added to the Continuous Improvement Register.

4.5 Emergency plan

An individual emergency plan is developed for participants whose supports may have hazardous waste requirements. This emergency plan will identify:

- type of waste
- waste management
- risk assessment
- actions in case of emergency

This information is recorded in their support plan and staff trained in this process.

During an emergency, such as a chemical spill or biohazard, staff will:

- identify the spilt hazardous material or biohazard

- contact the Director
- follow the cytotoxic spill procedure (see 4.2.4)
- alert people at the workplace to an emergency, e.g. in a home environment, inform the participant or other people onsite
- evacuate participants, ensuring that correct processes are implemented to assist hearing, vision or mobility-impaired people as required
- follow the emergency evacuation map in the workplace, which illustrates the location of fire protection equipment, emergency exits and assembly points
- if in a home environment, take the participant and others to a safe location away from the house.

After the emergency, the Director will:

- record the incident
- notify the regulator, if applicable
- organise trauma counselling or medical treatment.

4.6 Reviewing and evaluating

- The Director will train staff in the necessary process and procedures.
- The Director will analyse the emergency and inform of any updates required to the Continuous Improvement Policy and Procedure.

4.7 Staff training

Strength In Care will undertake the training of all staff workers who are involved in handling waste or hazardous substances. This training will include:

- safe handling of hazardous materials and substances, including:
    - body waste
    - infectious materials (e.g. used dressings)

  - Hazardous substances (e.g. chemicals, toxic or corrosive substances, bloodborne pathogens, biological hazards, chemical exposures, respiratory hazards, sharps injuries)
- use of personal protective equipment
- clothing requirements (e.g. leather shoes, face masks or similar)
- removal or mitigation of the hazard and reporting procedure to the Director of any problems/issues
- correct use of the off-site work kit, including emergency contact details, gloves and aprons.

5.0 Related documents

- Continuous Improvement Policy and Procedure
- Continuous Improvement Register
- Continuous Improvement Plan
- Emergency Plan - Waste
- Hazard Report Form
- Incident Report
- Incident Investigation Form
- Incident Investigation Form Final Report
- Incident Register
- Staff Orientation Checklist
- Training Attendance Register – In-house
- Training Register
- Staff Training Record
- Staff Training Plan
- Work Health Safety and Environmental Management Policy and Procedure

6.0 References

- Disability Services Act 1986 (Commonwealth)

- Disability Discrimination Act 1992 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021
- Monash University 2011, Syringes and Needles: Use, Disposal and Incident Follow-up, Monash University, viewed 17 July 2020, https://www.monash.edu/ohs/info-docs/safety-topics/biosafety/syringes-and-needles-use,-disposal-and-incident-follow-up
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