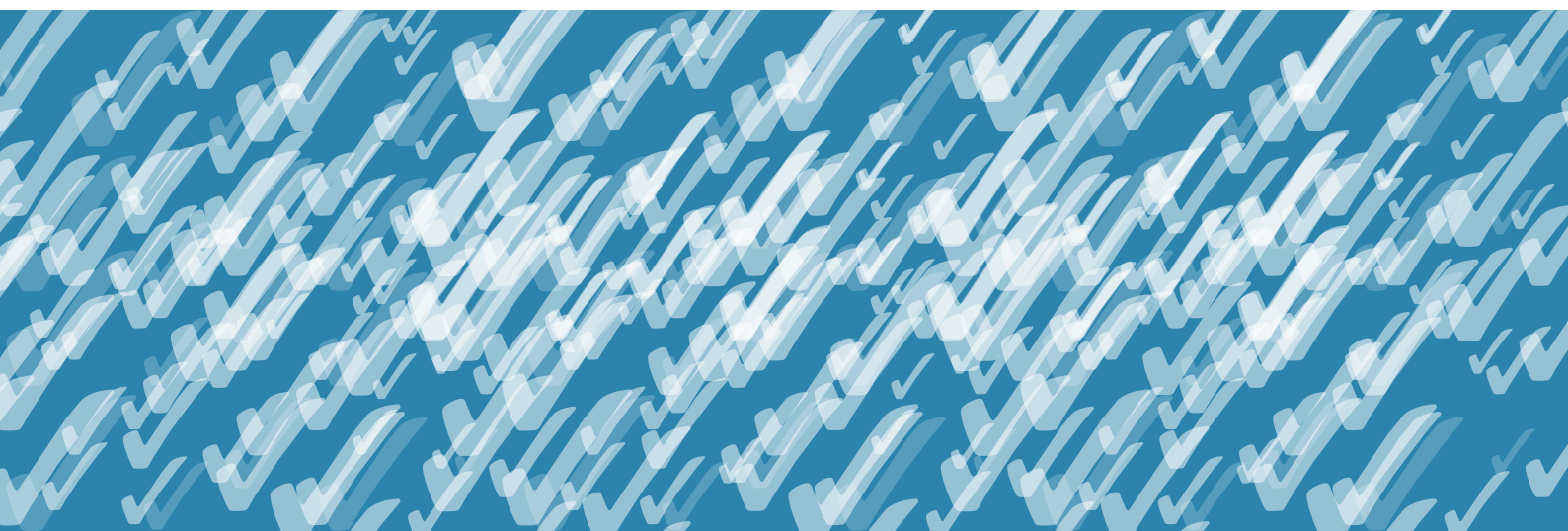


Code of practice

for the prevention and management of
occupational violence in disability services



**Code of practice for the prevention and
management of occupational violence in
disability services**

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Contents

| | |
|---|-----------|
| 1. Introduction | 1 |
| 1.1 What is the purpose of the code? | 1 |
| 1.2 What is occupational violence? | 1 |
| 1.3 What is the code based on? | 1 |
| 1.4 How has the code been developed? | 1 |
| 1.5 How can the code be used? | 1 |
| 2. OHS legal requirements and occupational violence | 3 |
| 2.1 Understanding the OHS law | 3 |
| 2.2 Employer duties | 3 |
| 2.3 Employee duties | 3 |
| 2.4 Contractors | 4 |
| 2.5 Temp agencies | 4 |
| 2.6 Designers of disability services facilities | 4 |
| 2.7 Family and visitors | 4 |
| 2.8 Balancing OHS with other legal duties | 5 |
| 3. Planning to prevent occupational violence | 6 |
| 3.1 General | 6 |
| 3.2 Assign OHS responsibilities | 6 |
| 3.3 Consultation | 9 |
| 3.4 Assessment and placement | 10 |
| 3.5 Communication and information sharing | 10 |
| 3.6 Training | 11 |
| 3.7 Recruitment | 13 |
| 3.8 Staffing and rostering | 14 |
| 4. Risk management for occupational violence in accommodation services | 15 |
| 4.1 Risk management approach | 15 |
| 4.2 Understanding occupational violence hazards | 16 |
| 4.3 Risk Assessment | 16 |
| 4.4 Risk Control | 18 |
| 4.5 How to evaluate risk controls? | 18 |
| 4.6 What are reasonably practicable risk controls? | 19 |
| 4.7 Case studies in managing occupational violence | 21 |
| 4.8 Risk control: Restrictive Interventions | 24 |
| 5. Risk Management in other Disability Services settings | 25 |
| 5.1 Client services and outreach | 25 |
| 5.2 Forensic mental health | 25 |

| | |
|---|-----------|
| 6. Review and response | 26 |
| 6.1 Managing change | 26 |
| 6.2 Emergency Response: | 26 |
| 6.3 Post incident Response | 27 |
| 6.4 Incident reporting | 27 |
| 6.5 Investigating incidents | 28 |
| 6.6 Review | 29 |
| 7. Appendix 1: Recent case | 30 |
| 8. Appendix 2: Case study format | 31 |
| 9. References | 32 |

1. Introduction

1.1 What is the purpose of the code?

The purpose of the code is to provide practical guidance on how to prevent and manage occupational violence in disability services.

The code provides overall guidance on management of occupational violence but does not replace specific policies and procedures on occupational violence. Where relevant these are referenced in the code.

The code primarily addresses occupational violence issues within disability accommodation, as this is the highest exposure area (see **Part 4**). However much of the guidance is also relevant to areas such as outreach and client services (see **Part 5**).

The code covers services managed by the Department of Human Services using directly employed staff of the department.

The code covers the matters agreed to in the Health Services Union of Australia (HSUA) *Department of Human Services Disability Services Certified Agreement 2004*, section 29.9: *Occupational Assault*.

1.2 What is occupational violence?

Occupational violence is defined, for the purpose of this Code, as any event initiated by a person receiving services from the department or member of the public, in which staff are abused, threatened or assaulted in circumstances arising out of or in the course of their employment.

1.3 What is the code based on?

This code reflects the underlying Occupational Health and Safety (OHS) legislative duties of the respective parties in the industry (for example employers, employees, contractors) and the 'state of knowledge' about managing occupational violence in disability services.

1.4 How has the code been developed?

The code has been produced in conjunction with the disability services sector and their representative bodies to provide guidance on the management of occupational violence issues in the sector.

This guidance material has been prepared using information drawn from the current practices of Victorian Department of Human Services disability service providers, and there has been extensive consultation and testing of the code to ensure it meets the needs of the sector.

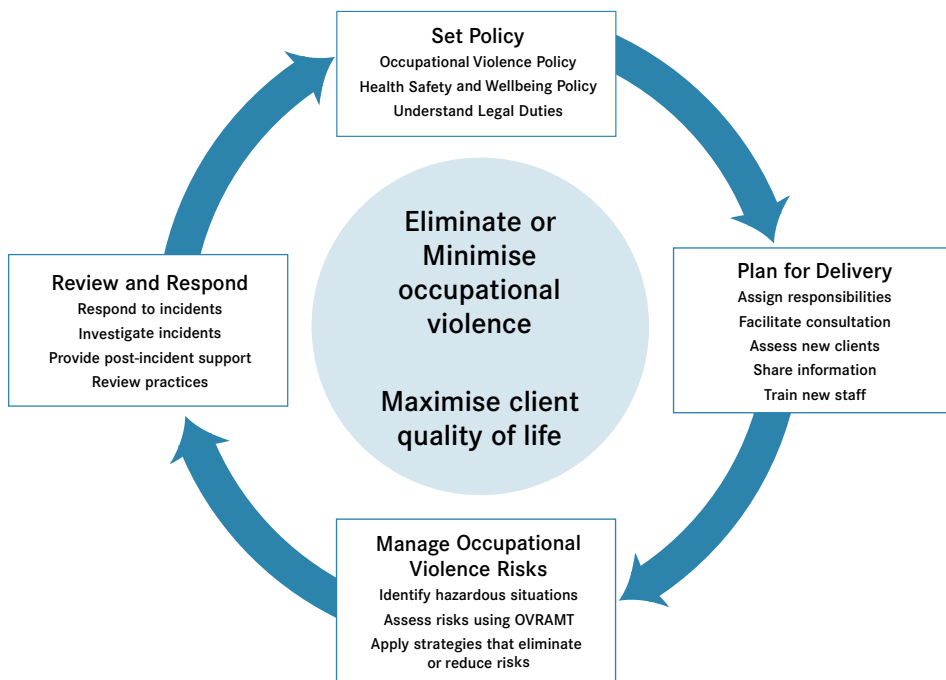
1.5 How can the code be used?

Disability service providers managed by the department can use the guidance material to check occupational violence prevention practices and, if necessary, bring practices up to standard.

The code also provides a basis for consulting with elected Health and Safety Representatives (HSR) and employees on occupational health and safety issues.

The OHS legislation and modern health and safety practice are based on identifying hazards, assessing risks and then controlling any risks. Figure 1 illustrates the general approach.

Figure 1: Approach to managing occupational violence



2. OHS legal requirements and occupational violence

2.1 Understanding the OHS law

The Occupational Health and Safety Act (2004) sets out a number of principles of health and safety. These principles can be summarised as follows:

- People at work including employees and other persons should be given the highest level of protection against risks to their health and safety that is reasonably practicable in the circumstances.
- Those who control or manage matters that create risks are responsible for eliminating or reducing them.
- Employers should be proactive in managing OHS.
- There should be an exchange of OHS information and ideas to eliminate or reduce risks.
- Employee participation in OHS should be encouraged.

In this context the Act defines what responsibilities or duties different persons have. These duties are described below. In **Part 3** these duties are discussed in the context of the management of occupational violence in disability services.

2.2 Employer duties

Under section 21 of the Act an employer has a broad duty or responsibility to provide and maintain, so far as is reasonably practicable, a safe and healthy working environment for its employees.

The employer duty also extends to other persons including people receiving services from the employer, visitors, members of the public and contractors who may be engaged to undertake maintenance works in houses.

Duties of the employer in the disability services setting include consulting employees, assessing occupational violence risks, introducing risk reduction strategies and keeping records of incidents and assessments.

2.3 Employee duties

Employees have a duty to employers and to others to take reasonable care and not put themselves or others at risk by their actions or omissions.

Under the Act employees have a duty to cooperate with the measures that an employer has developed to eliminate or reduce risks. Consequently employees must be made aware of all of their employer's policies and procedures in respect of occupational violence.

Duties of employees in the disability services setting include following behaviour management strategies, reporting incidents and applying methods for defusing hazardous situations. Employees are expected to use the training and information provided to work with people receiving services in a way that reduces risks.

It is critical that support staff are aware of the impact of their actions when working with people receiving services where there is potential for occupational violence.

2.4 Contractors

Contractors may be required to undertake maintenance work at disability accommodation facilities. To meet their duties contractors should meet requirements of Contractors Checklists, follow the directions of a house supervisor or unit manager (or other senior person) and undertake work at a time and in a manner that is least disruptive to people receiving services.

2.5 Temp agencies

Agencies providing direct care staff for disability services have duties to ensure the health and safety of their employees. These duties overlap with those of the host employer (Department of Human Services) but include assessing occupational violence risks and matching placements with suitably qualified staff.

2.6 Designers of disability services facilities

The duty for designers of buildings and structures is to ensure that it is designed, so far as is reasonably practicable, to be safe and without risk to people using it as a workplace for a purpose for which it was designed.

The relevant reference for disability accommodation is the Disability Services Accommodation Standards and Design Guidelines for the Provision of: 1.1 Shared Supported Accommodation (General). The design guidelines are applicable to new properties and specifically address the need to reduce risk associated with matters such as occupational violence.

2.7 Family and visitors

Families are expected to provide any relevant information about their family member who is a resident that may reduce the risk of occupational violence. This would typically involve providing any relevant information about their family member who is a resident that may improve quality of life and reduce the risk of occupational violence.

In cases where family members and visitors by their conduct create risks the service provider may require certain standards to be met. This may include following defined protocols to reduce occupational violence risks when visiting disability accommodation facilities.

Section 32 of the Act states that all persons have a duty not to recklessly endanger any person at a workplace by their conduct.

2.8 Balancing OHS with other legal duties

The services provided by disability accommodation and related activities are determined by the principles set out in disability legislation.

These principles include the role of these services to provide opportunities for individual aspirations to be achieved and for quality of life and independence to be maximised. In addition these principles cover respect for privacy and dignity and the right to participate in activities with some degree of risk.

The Act does not require disability service providers to sacrifice the interests of one party for the other. On the contrary providers must, so far as is reasonably practicable, ensure the safety of both support staff and people with a disability. Where possible, conflicts need to be resolved by strategies that do not disadvantage either party.

In the case of occupational violence the ability to understand and respect the person with a disability is the common pathway to both quality of life and minimised risk.

Where courts have had to consider the relationships between staff and people with a disability there remains a strong emphasis on meeting OHS obligations.

In Appendix 1 an example of a recent OHS prosecution is summarised to illustrate the matters a court takes into account.

3. Planning to prevent occupational violence

3.1 General

Planning to prevent occupational violence is based on the systems and procedures used to provide a high quality service to people with a disability. These systems and procedures include specific OHS components that are aimed at reducing risks and protecting staff.

In this section the building blocks of a process to eliminate or minimise occupational violence risk is outlined. In the following sections specific risk management measures and responses to occupational violence are covered.

The general planning steps to reduce occupational violence risks are:

- incorporate OHS responsibilities in each management and service delivery role
- maintain and review consultative arrangements
- incorporate occupational violence assessments in all assessment and review stages
- share and communicate information pertinent to occupational violence risks
- recruit staff with suitable skills and experience
- allocate and place staff to minimise risks
- provide relevant training to meet the needs of people with a disability and reduce occupational violence.

3.2 Assign OHS responsibilities

The responsibilities for OHS are set out in the *Department of Human Services Occupational Health and Safety Accountability Framework* and reinforced in the *Occupational Violence Prevention Policy*.

Lack of clarity about responsibilities can be a source of risk if matters are not acted upon quickly and appropriately.

The specific issues that have to be managed by people in their various roles are illustrated in **Table 1**.

Table 1: Responsibilities for occupational violence

| Responsible party | Typical OHS responsibilities | Examples |
|--|--|--|
| Regional Disability Services Manager | <p>Ensure occupational violence prevention and management systems are in place</p> <p>Advise on high risk issues</p> <p>Identify systemic problems in preventing occupational violence</p> <p>Facilitate resolution of region level occupational violence issues</p> | <p>Ensure assessments include risk of occupational violence at all entry and review points</p> <p>Endorse or recommend actions in response to serious incidents (for example Category 1 incidents involving occupational violence)</p> <p>Review region level data on occupational violence</p> <p>Ensure regional consultation arrangements are in place</p> |
| Disability Accommodation Services Manager | <p>Address high risk occupational violence issues</p> <p>Monitor risk controls for occupational violence</p> <p>Respond to risk assessments and incident reports</p> <p>Resolve high risk situations unable to be managed at house or cluster level</p> | <p>Manage resident and staff mix for overall reduction of risk</p> <p>Apply protocols on restrictive interventions</p> <p>Make decisions on serious incidents issues (for example critical occupational violence assessments)</p> <p>Actively follow up effectiveness of strategies introduced to reduce risks</p> |
| Client Services Manager | <p>Manage assessment processes</p> <p>Coordinate specialist input to the needs of people receiving services</p> <p>Case manage individuals</p> <p>Manage emergency placements of people with a disability</p> | <p>Incorporate an assessment of occupational violence risk in assessments</p> <p>Oversee preparation of behaviour management strategies</p> <p>Ensure risk information is understood across providers</p> <p>Liaise with cluster managers on placements to reduce risk</p> |
| Cluster or area manager | <p>Apply assessment and risk reduction methods at cluster level</p> <p>Supervise and assist house supervisors</p> <p>Resolve occupational violence issue unable to be managed at house level</p> <p>Respond to incident reports</p> | <p>Work with specialist support services, house supervisor and staff on behaviour management strategies</p> <p>Provide professional development and training opportunities for house supervisors</p> <p>Manage resident and staff mix at cluster level to minimise risk</p> <p>Follow up action taken to address issues raised in Disease <i>Injury Near Miss Accident</i> forms (DINMAs) and incident reports</p> |

| Responsible party | Typical OHS responsibilities | Examples |
|---|---|--|
| House supervisor or unit manager | <p>Apply assessment and risk reduction methods at local level</p> <p>Supervise support staff</p> <p>Manage occupational violence issues with individuals receiving services</p> <p>Coordinate specialist input at house and unit level</p> | <p>Ensure behavioural management strategies minimise risks</p> <p>Advise and assist support staff on occupational violence strategies</p> <p>Work with people with a disability to minimise risks</p> <p>Work with specialist support services on high risk and emergency placement cases</p> |
| Disability accommodation support staff | <p>Participate in, and contribute to, team discussions of strategies to reduce risks</p> <p>Follow procedures for to minimise risks of occupational violence</p> <p>Avoid situations that put themselves, co-workers or people with a disability at risk</p> <p>Report incidents and injuries</p> | <p>Advise on effective strategies for dealing with particular individuals</p> <p>Apply behaviour management strategy</p> <p>Apply principles of good communication, behaviour and positive intervention from training</p> <p>Report incidents using the departmental incident reporting system or, if necessary the WorkSafe Victoria Incident Notification form, and injuries using supplied forms (DINMAs)</p> |
| Client services or outreach staff | <p>Participate in, and contribute to, team discussions of strategies to reduce risks</p> <p>Follow procedures to minimise risks of occupational violence</p> <p>Avoid situations that put themselves, co-workers or people with a disability at risk</p> <p>Report incidents/injuries</p> | <p>Advise on effective strategies for dealing with particular individuals</p> <p>Follow visit protocols (for example, arrival and return times)</p> <p>Assess environment on home visit and contact supervisor if not considered safe to enter</p> <p>Advise of incidents and injuries using supplied forms (DINMAs)</p> |

3.3 Consultation

The Department of Human Services *Occupational Violence Prevention Policy* sets out a commitment to consult with employees, reflecting the requirement under the OHS Act.

Part 4 of the Act states that there is a duty for employers to consult with employees (and with the employees of any contractor engaged) on OHS matters. The Act states that employers must consult (so far as is reasonably practicable) on matters including:

- identifying hazards and assessing risks (for example use of Occupation Violence Risk Assessment Management Tool- OVRAMT)
- decisions on risk controls (for example changes to house environment)
- decisions on workplace amenities (for example first aid)
- decisions on consultation and issue resolution arrangements (for example coverage of designated work groups)
- decisions on information and training (for example changes to mandatory training for occupational violence)
- decisions on proposed changes that may affect OHS (for example changes to placement and screening procedures.)

Consequently the key stages of the occupational violence risk management process should involve health and safety representatives and employees. The means of involving employees will vary but includes OHS Committees, *Health and Safety Representatives* (HSRs) and less formal means such as house meetings. Having OHS on the agenda of all staff meetings is one way of ensuring occupational violence issues can be raised on a regular basis.

Where employees have elected an HSR the OHS Regulations (2007) state that the HSR must be consulted on issues and information before they are conveyed to all employees. The employer must give an HSR reasonable time to consider any information before it is provided to employees and take into account the views of the HSR.

Employees should be encouraged to:

- assist in development and implementation of occupational violence policies, procedures and tools
- raise any occupational violence concerns
- give regular feedback on how well strategies to reduce occupational violence are working.

Resolution of occupational violence issues should follow the DHS issue resolution procedures.

3.4 Assessment and placement

Potential occupational violence issues need to be addressed at the earliest possible stage and an appreciation of occupational violence risks needs to be incorporated into the overall process of assessing and placing individuals. The Entry, exit and relocation checklist incorporating the OVRAMT tool should be used for this task. The key stages include:

- assessment of the needs of people entering services
- development of behavioural management strategies
- placement of individuals
- transfer of individuals
- review of individuals' needs and strategies.

In circumstances such as emergency placements defined protocols should be followed (for example Respite and emergency accommodation entry form) and precautions such as additional staff should be taken where there is limited or incomplete information available on which to assess risks.

3.5 Communication and information sharing

Effective case management to maximise the development opportunities for individuals includes an understanding of occupational violence risks.

The various parties in the process of assessing, referring, placing and reviewing individual profiles and plans need to coordinate their activity if the shared objective of improved quality of life and reduced occupational violence risk is to be achieved.

Case managers, specialist support services and other agencies involved in providing services to people with a disability need to share information for the best outcomes to be achieved.

Similarly at unit or house level support staff should share information about successful strategies in managing relationships with people with a disability. The checklist below highlights some key issues.

COMMUNICATION AND INFORMATION CHECKLIST

- ✓ Are the results of assessments of people with a disability using the OVRAMT, or equivalents, communicated to all relevant parties?
- ✓ Do planning and interventions by specialist support staff incorporate strategies to minimise risk to staff and other people with a disability?
- ✓ Is there regular communication and information sharing with other service providers on changes in the needs, health or behaviour of people with a disability?
- ✓ Are changes to behaviour strategies for individuals explained to support staff before they are introduced?
- ✓ Is there a suitable handover process for new or casual staff?

3.6 Training

Relevant training required for the position, along with other specific disability training modules comprise the platform on which the ability to manage occupational violence is based.

Because the majority of occupational violence in disability services occurs in accommodation services the potential for occupational violence usually centres on the relationship between people with a disability, staff and the house environment. Core training along with the learned experience of staff is the key to minimising occupational violence.

Other core training includes first aid, medication administration and cardiopulmonary resuscitation.

Induction training and workplace orientation

Induction and orientation for all staff whether full time or casual should cover:

- occupational violence policy
- consultation arrangements
- procedures for managing occupational violence
- incident reporting procedures
- emergency response procedures
- available support services such as the employee assistance program.

These topics may be covered in a general induction program or at a house or unit orientation session.

Specialist training on occupational violence

Specific training such as the *Inclusive Communication and Behaviour Program* focuses on communication, behaviour and positive intervention from the perspective both of improving quality of life and managing and reducing risks.

Inclusive communication and behaviour training or other specialist response training constitute risk controls (see para 4.1 Risk Management Approach) and should be provided to staff where risks have been identified and analysed: and specialist response training has been identified as a necessary response or control.

Update training

Update training should not only cover the mandatory items such as first aid, cardiopulmonary and fire safety but also tools, policies and procedures relevant to reducing occupational violence. This training may be in the form of on site briefings or shorter off site training. Topics could include:

- the OVRAMT and how it is used
- major legislative changes
- policy and protocols on restrictive interventions
- updated practice manuals.

On the job training

For new staff and casual and agency staff it is important that any formal training is reinforced with on the job training.

In disability accommodation the house supervisor or unit manager is the key person in introducing new staff to working with people with a disability in a way that minimises occupational violence risks. When they are not present other senior staff in the house or unit should supervise new staff. In other area of disability services the line manager plays a similar role.

The checklist below identifies issues that house supervisors or unit managers (or other senior staff) should cover with new staff.

HOUSE SUPERVISOR AND UNIT MANAGER NEW WORKER CHECKLIST

- ✓ Has the new staff member undertaken a house orientation covering emergency procedures and reporting procedures?
- ✓ Has the new staff member read and understood individuals' communication strategies, routines and behaviour support plans?
- ✓ Has the new staff member been closely supervised and assisted in their initial interactions with people with a disability?
- ✓ Has the new staff member been given specific feedback on their performance in the first day and first week of duty?
- ✓ Has the new staff member been encouraged to raise issues relevant to reducing occupational violence?

3.7 Recruitment

Selection of suitable staff is an important part of planning disability accommodation support services to minimise risks.

Disability service providers require people with both the right qualifications and experience and an understanding of how to work safely in an accommodation facility.

Selection of staff should take into account the nature of the work, the needs and preferences of people with a disability and staff training and qualifications.

Recruitment of staff is an opportunity to make clear the nature of the work and the physical and mental demands of working in this setting.

An effective recruitment policy will ensure that there will be sufficient personnel with the knowledge, skills and experience necessary to perform their roles safely and effectively, to meet both the needs of people with a disability and organisational requirements.

Position descriptions that include OHS responsibilities for all levels of management and support staff should be communicated to staff and potential applicants.

3.8 Staffing and rostering

Good staffing and rostering practices are essential for efficient service delivery but can also assist in reducing occupational violence risks.

Appropriate levels of staffing and the ability to change levels to address higher risk situations are part of the strategy to reduce occupational violence.

Staffing should also consider ways of managing the cumulative impact of continual exposure to behaviours of concern.

The potential for psychological injury as a result of exposure to occupational violence is best addressed through an organisational process such as *well@work*. This strategy includes action at a number of levels within the organisation.

Examples in disability accommodation include staff rotation across houses and facilities and active monitoring by supervisors to identify early warning signs of stress.

Reference should be made to *well@work: A strategy to promote psychological wellbeing and prevent and manage psychological injury*.

The checklist below highlights matters to ensuring appropriate staffing arrangements are made to minimise risks.

STAFFING CHECKLIST

- ✓ Does the number and experience of staff match the potential risk and the recommendations in behaviour management strategies?
- ✓ Do supervisors ensure that new staff working their first shift are always supported by another staff member and never work their first shift alone?
- ✓ Do staff have the opportunity to improve skills by working in a number of settings?
- ✓ Is there capacity to reduce cumulative exposure to occupational violence risk by staff rotation and placements?
- ✓ Do supervisors actively monitor the potential impacts of continual exposure to occupational violence and provide supportive responses to assist staff?

4. Risk management for occupational violence in accommodation services

4.1 Risk management approach

The conventional approach to managing health and safety risks is through a risk management approach. This is the basis of departmental policies, procedures and tools and is applied in this section to accommodation services.

The OHS risk management approach has three basic steps.

At each step, consultation with employees is essential for risk management to be effective. Communication with specialist support services, other agencies and the families of people with a disability is also necessary.

1. Identify hazardous situations: Occupational violence hazards in the disability setting are best described as situations in which there is potential for harm.

2. Assess risks: The risk assessment process is a way of estimating the level of risk and the nature of the risks before taking action. Understanding the nature of the risk means working out what could happen and why.

The Occupational Violence Risk Assessment and Management Tool (OVRAMT) is the current means of undertaking occupational violence assessments.

3. Control risks: Risk controls that will achieve the highest level of protection so far as is reasonably practicable need to be considered.

Options from elimination of the risk, through to substitution of safer alternatives, designing out risks, down to administrative procedures and personal protective equipment have to be assessed.

In practice, a combination of risk controls may be required to reduce risks.

Effective risk management also requires action to monitor if controls are operating effectively and that circumstances have not changed. In the disability setting this is very dynamic and requires attention to behaviour management strategies, residential settings and interaction between people with a disability and staff.

Finally, the risk management process involves a review of strategies and the introduction of new measures where required.

4.2 Understanding occupational violence hazards

The nature of disability accommodation settings and the services provided does not result in a simple list of tangible and easily described hazards.

The hazards of occupational violence in the disability accommodation setting are found in situations in which people with a disability, families, direct support staff, specialist support staff and other community agencies interact.

Generally described these hazards include:

- situations where individuals are bored, frustrated and disinterested
- situations where the physical environment (for example house, implements) creates a potential for harm
- situations where placement of incompatible individuals creates potential for conflict
- situations where information about individuals' needs and behaviour is not known or available to staff
- situations where the contributing factors to individual behaviours are not well understood
- situations where the staff and the person with a disability have difficulty communicating
- situations where staff are assigned without adequate support
- situations where staff work with people with a disability outside a house or facility setting.

4.3 Risk Assessment

The hazardous situations identified above represent common situations in which the potential for harm arises. The situations described in the hazards section can be further assessed to establish whether they are likely to result in harm to staff (and to other people with a disability).

The process of risk assessment is necessarily integrated into the overall assessment of individual needs and the appropriate strategies to achieve the individual's personal objectives.

In this section the focus is on assessing risks that could result in occupational violence. The risk assessment is required when the *Initial Screening Tool* in the OVRAMT identifies a risk of occupational violence. The generic risk factors covered in OVRAMT include:

- an incompatible mix of people with a disability, which regularly triggers behaviours of concern
- inadequate control and regular management of the physical setting
- lack of a consistent approach in supporting people with a disability
- inadequate staffing levels or experience for high risk settings
- lack of focus on the goals and development of people with a disability
- lack of access to and sharing of strategies between providers, specialist support and staff
- lack of staff awareness and skill in assessing violence triggers
- lack of emergency and contingency planning.

Each of the hazardous situations is assessed below in **Table 2** with the emphasis on identifying some of the typical risk factors that increase or accelerate risks. Only by understanding these risk factors can meaningful ways of reducing risk be identified.

Table 2: Risk Assessment Examples

| Hazardous situation | Risk factors |
|--|--|
| 1) Situations where individuals are bored, frustrated and disinterested. | <ul style="list-style-type: none"> • Lack of meaningful activities that reflect individual's preferences • Individual preferences not known • Individual's whole life not considered. |
| 2) Situations where the physical environment (for example house, implements) creates a potential for harm. | <ul style="list-style-type: none"> • No physical hazards check undertaken • Space not adequate to allow individuals and staff to live and work comfortably • Poorly lit spaces. |
| 3) Situations where the placement of incompatible individuals creates potential for conflict. | <ul style="list-style-type: none"> • Excessive noise • No consideration of impact on other people with a disability when mix of individuals changed • Staff unaware of triggers. |
| 4) Situations where information about individual needs and behaviour is not known or available to staff. | <ul style="list-style-type: none"> • Inadequate information available on new individuals • Inconsistent strategies used by different providers • Information about changes in individual's needs or behaviour not shared by different service providers. |
| 5) Situations where the contributing factors to individuals' behaviours are not well understood. | <ul style="list-style-type: none"> • Lack of documented and current client medical information • Use of medication in a reactive rather than preventative way • Escalation because of desire to control individual's behaviour rather than use judgement to defuse the situation. |
| 6) Situations where staff are assigned without adequate support. | <ul style="list-style-type: none"> • Staff on first shift without appropriate briefing on strategies to use with individuals • No structured process for providing handover information • Lack of training in managing behaviours of concern. |
| 7) Situations where the staff and people with a disability have difficulty communicating. | <ul style="list-style-type: none"> • Lack of understanding of behaviour management strategy • Lack of documented information on communication strategies readily available to all staff • Staff have low self awareness of the impact of their actions or inactions on a person with a disability or the group of people living in the house or unit. |
| 8) Situations where staff work with people with a disability outside a house or facility setting. | <ul style="list-style-type: none"> • Lack of support in case of emergency • Lack of visit planning and contact protocols • Different or unfamiliar routines trigger behaviours of concern. |

4.4 Risk Control

In the disability accommodation setting risk controls are best described as interrelated strategies for reducing risks that are as compatible as possible with the individual's quality of life.

In general terms the common risk control strategies for occupational violence in disability accommodation are:

- design houses and facilities to minimise occupational violence risks to staff
- eliminate or restrict access to objects or areas that could be used to harm staff
- develop and apply individualised plans for people with a disability that minimise boredom and frustration
- develop and apply behaviour management strategies consistently
- update and regularly review plans of people with a disability to manage risks of occupational violence
- assign staff and place people with a disability for best mix to reduce risks
- allocate suitable staffing levels and staffing capability for working in the highest risk environments
- maintain procedures and systems to manage and reduce the severity of any occupational violence incidents (including long term exposure) that have an impact on staff health and safety
- use personal protective equipment and personal security measures (duress alarms, suitable clothing).

These general risk control solutions are the kind of measures that would be included in a *Workplace Action Plan* which is referenced in OVRAMT.

4.5 How to evaluate risk controls?

There may be a number of options for controlling occupational risks. What is meant by 'the highest level of protection' is best described by the concept of the hierarchy of control.

The principle behind the hierarchy of control is that risk controls that are dependent on individual behaviour are less reliable than risk controls that engineer or design out risks.

This hierarchy does not easily apply where hazards and risks are related primarily to interaction in particular situations.

Elimination can only be thought about as elimination of triggers to behaviours of concern and, to a more limited extent, of the underlying causes of such behaviours.

Consequently most risk control strategies are risk reduction measures such as designing new disability accommodation to minimise occupational violence risks and using administrative measures such as behaviour management plans to manage risks.

As most of the risk reduction strategies are at the lower levels of the hierarchy they rely heavily on the training, supervision and support of staff and the interchange of information and advice.

4.6 What are reasonably practicable risk controls?

The duty to eliminate or otherwise reduce risks to health and safety, although absolute, is qualified by what is ‘reasonably practicable’. ‘Reasonably practicable’ takes into account the level or magnitude of risk. The greater the risk, the greater the effort that may be needed to eliminate or reduce it.

‘Reasonably practicable’ also takes into account the state of knowledge about the risk and the availability and suitability of ways of eliminating or reducing it.

This aspect is critical in disability services as interactions between the person with a disability and the staff member are highly dependent on knowledge of what triggers behaviours of concern and how they are best managed. In some cases an understanding of individual behaviours and needs may be incomplete.

Finally, ‘reasonably practicable’ takes into account the cost of eliminating hazards or risks.

Consequently, providing the highest level of protection from risks to health and safety as far as ‘reasonably practicable’ means using measures that are known to be effective and eliminate or reduce risk proportionate to the cost of doing so.

An emergency placement in a respite facility may mean that normal processes of managing the risk of incompatible individuals are difficult to achieve.

However, to refuse the placement on the grounds that it is not ‘reasonably practicable’ to ensure health and safety would be difficult to justify. Various interim measures could be (and are) applied to manage this potentially higher risk situation.

‘Reasonably practicable’ also means that the measures to control risks are not such that the business or undertaking is unable to continue.

In the case of disability accommodation the community expectation, as embodied in disability legislation, is that people with a disability have the opportunity to live as full lives as possible.

The traffic lights table shown in **Table 3** below illustrates risk control strategies and shows that interim measures may need to be used until a more suitable resource or time is available to apply more effective measures.

Table 3: Common risk control solutions

| HIGH RISK | REDUCED RISK SOLUTION | PREFERRED SOLUTION |
|--|--|--|
| No use of screening tool such as OVRAMT | Documented assessment by support professional in behaviour management plan | All new residents assessed for risk of occupational violence using OVRAMT |
| New individual rated by OVRAMT with extreme risk score unable to be immediately placed in suitable house | Additional resources at high risk times to protect staff and other people with a disability | Placement based on assessment and availability of suitable supports to minimise behaviours and impact on others |
| Inconsistent use of behaviour management plan by individual staff | Feedback to staff on interaction that could give rise to behaviours of concern | House supervisor briefs and monitors consistent application of behaviour management plan |
| No access to a safe area and emergency communication | No interim solution | Designated safe area and issue of emergency communication devices |
| No consideration of mix of individuals in new placements | Allocation of experienced staff to initial shifts | Resident mix that maximises individuals' quality of life and minimises risk to staff and people with a disability |
| Placement of new or inexperienced staff member in house with high potential for exposure to occupational violence | Close supervision of new staff member and active feedback to worker over a defined period | Rotation of new staff members through different houses to build up skills in managing more complex situations |
| Visit by family members or other visitors triggers behaviours of concern in person with a disability | Separation of other people with a disability while visit occurs | Strategies for family members to minimise triggers and arrangement of visiting time when other people with a disability are absent |
| Inaccurate and variable descriptions of behaviours to treating doctors by different staff who accompany person with a disability | Objective description (that is not in terms of emotions) of behaviours that result in assault of staff or other people with a disability | One point of contact with doctor to increase consistency in information and better feedback on impact of medication |
| Emergency placement in respite without opportunity for any risk assessment | Allocation of experienced staff to initial shifts | Booking suspended until preparation and risk assessment undertaken |
| No assessment of house for potential sources of harm to people with a disability and support staff | No interim solution | Regular check of house against physical hazards checklist |
| Exposure to continual verbal abuse over a long period | Rotation of staff to reduce continual exposure and use of employee counselling services | Review of behaviour management plan to identify measures to reduce incidence of such abusive behaviour |
| Behaviour management strategy not able to be read by new staff member before shift | Close supervision of new staff member by house supervisor until strategy read by staff member | Behaviour management strategy accessible and understood by all support staff before commencing |
| Unplanned transport of people with behaviours of concern | Loading arrangements and seating plan to minimise triggers for disruptive or assaultive behaviour to occur | Vehicle with added physical safety inclusions such as screening around the driver or bus with space to minimise contact with others in the vehicle |

4.7 Case studies in managing occupational violence

To illustrate the risk management process several cases are described below.

In each case the need to provide a quality of life for the person with a disability is balanced with the need to protect support staff from risks to their health and safety.

In Appendix 2 a case study format is provided for working through other cases. This format could be used in house meetings or in staff development.

Risk Management Case Study 1

Jim is in his thirties and needs physical support and assistance to attend to all his personal care needs. He does not have speech but can use gestures to indicate his wants.

Jim's mobility is limited and he uses a wheelchair, although he can shuffle himself along the floor if he is supported to get out of his chair. He also has severe epilepsy. Jim can, at times, be highly aggressive and kick, punch and scratch at people who are supporting him. He has broken noses and caused other injuries that have required medical treatment.

Support staff have continued to assist Jim at these times despite his causing significant injury to others. People supporting Jim reported feeling obliged to continue to assist him due to his high level of physical dependence on others for care.

The key risk factors identified using OVRAMT were:

- An individual's preferences, needs, personal goals are not known.
- Changes occur in the individual's life and environment without the individual having been informed beforehand.
- Staff are unclear how to respond to an individual.
- An individual becomes frustrated because they cannot communicate effectively.

The main risk factor was activities being changed or interrupted with little or no warning. The second was related to pre- and post- seizure activity. There were some incidents that did not appear to be a result of either of these triggers, but on close examination it was found that Jim had given a clear gesture of holding up a clenched fist.

Support staff used the results of the monitoring to develop strategies that were implemented to reduce the incidence of assault. The strategies included:

- Staff were shown the signs that Jim used to indicate that he wanted to be left alone (such as a clenched fist) and reminded that Jim has the right to refuse support; which he was clearly doing with this gesture.
- Staff were to ensure that Jim was informed of any activities at least 10 minutes in advance, remind him again before staff entered his space and respect his choice if he refused.
- Staff were not to attend to Jim if he had clenched or raised his fist, as he was thus clearly indicating that he did not want assistance.
- Staff were to be especially cautious at times that Jim was displaying signs that seizure activity might be commencing; and also immediately post seizure. (Jim had certain, easily identifiable, tics that occurred pre- seizure.)

When staff followed the strategies there were no reported injuries or assaults. Staff were given further support and instruction to understand their role, their responsibility for health and safety and Jim's right to refuse support.

Risk Management Case Study 2

Jane is in her late forties, has a high level of independence and a history of occasional minor physical assault towards staff. This usually took the form of kicking or punching and had not caused serious injury or significant lost time for staff.

Her behaviour began to alter and increase and she was expressing delusional thoughts. This caused her to believe that others were a threat to her and she had to protect herself, which increased her assault behaviours significantly. Her behaviour included verbal abuse, punching, wrestling people to get them on the ground and kicking. Jane began to make allegations against staff and secrete items that she could use as weapons, which she had not been known to do previously. Jane also began to attack other people with a disability.

The key risk factors identified using OVRAMT were:

- referral to specialised services not made
- behaviour management plan and environment not assessed
- lack of immediate staff support
- lack of time to provide individualised support.

Medical assessments were carried out and as there were no physical problems found, a referral to a psychiatrist was made. Specialist support involvement was also requested.

Interim safety strategies were implemented at the house to reduce access to items that Jane might use as weapons. This included locking all cutlery, utensils, gardening equipment, mops, brooms and other items Jane had tried to access as weapons and restricting Jane's access to these items. Jane was only able to access and use the items under strict supervision.

Other strategies developed in consultation with staff included:

- Extra staffing was put in place to provide Jane with one-to-one support. These strategies were also implemented at Jane's day activity.
- The psychiatrist diagnosed Jane with a mood disorder that was known to cause delusions and paranoia, and admitted Jane to hospital to introduce medication. While she was in hospital the staff and specialist support practitioner worked with mental health professionals to develop appropriate support and intervention strategies.
- Information provided indicated that Jane would continue to pose a significant risk to the other people she currently lived with and that the physical layout of her current home did not provide sufficient safe space for staff. Alternative accommodation was located for Jane where staff had the training, skills and knowledge to support her safely.
- Jane was supported to see familiar people at her new home and was able to continue her day activity with increased support.

Case Study 3: Responding to Mary's family

Mary is in her late thirties and has high support needs. Her family have been supporting her at home, but are no longer able to provide the level of care she needs. Three months ago they (reluctantly) decided to move Mary into supported accommodation.

Mary's family have a high level of involvement in every aspect of her life and believe that staff are not providing Mary with appropriate care. As a result, they have made a number of complaints to the House Supervisor. Recently they have approached and verbally abused individual staff and written unpleasant letters to them alleging serious allegations regarding Mary's care.

The Area Manager has investigated and found no grounds for any of the complaints. The house has lost staff due to the issues with Mary's family and the remaining staff have informed the House Supervisor and Area Manager they feel distressed.

The manager attempted to address the issues with the family but the level of abuse toward staff has increased. The family refuses to meet with the manager to further discuss the issues.

Key risk factors identified:

- Stress caused by complaints.
- Intimidation / aggression.

Risk management strategies/actions:

- Inform the family what the service provides, how it generally functions and what the family can reasonably expect of the service.
- Write to the family and inform them that:
 - They are to direct all future complaints and issues to the area manager.
 - The department has OHS obligations towards staff.
 - Their behaviour is having a negative impact on staff and the quality of care.
- Write to the family clearly outlining the complaints they have made and the actions that have been taken to address them.
- Organise team and individual debriefing for staff.
- Organise appropriate training for staff, including conflict resolution.
- Conduct information sessions for staff to assist in their understanding of grief and loss issues that may affect the family's behaviour.
- Provide staff with strategies to end a phone call or ask the family to leave the house if they became abusive.
- Involve case management and the regional Work Health Unit to review the supports available to residents and staff.
- Provide the family with contact details for organisations that provide counselling and support to families of people with a disability.

If the situation had not resolved additional strategies and actions could include:

- Suggest to the family that they discuss their concerns with a Disability Advocacy Agency.
- The Disability Accommodation Manager can inform the family that aggressive behaviour towards staff is inappropriate and cannot continue.
- Inform the family that they were at risk of having limits placed on their visits because of the impact of their abusive behaviour on staff and residents.
- Inform the family in writing of the expected behaviour towards staff when they visit Mary.
- Develop a formal visiting plan with the family. This may specify times and lengths of visits or just standards of behaviour.

4.8 Risk control: Restrictive Interventions

A restrictive intervention means any intervention used to restrict the rights or freedom of a person with a disability, such as restraint and seclusion which includes:

- chemical restraint
- mechanical restraint
- seclusion.

An individual's behaviour management plan may include the use of restrictive interventions. These interventions are part of a planned approach endorsed by specialist support staff and authorised by nominated officers.

The only other circumstance in which restrictive interventions may be used is an emergency if the approved disability service provider believes:

- There is imminent risk of the person with a disability causing serious physical harm to themselves or any other person.
- It is necessary to use restraint or seclusion to prevent that risk.

In these cases the least restrictive measure must be used and authorised through defined procedures.

Use of restrictive interventions to manage an occupational violence incident would also need to be documented and reported through incident reporting and DINMA systems.

5. Risk Management in other Disability Services settings

5.1 Client services and outreach

The risk management process set out in this code primarily applies to supported shared accommodation. However, there are other settings that have specific characteristics, such as outreach and client services.

Much of the advice in this code applies to all settings but the distinctive risk controls for specific settings are noted below.

Likewise accommodation services staff can also apply the guidance referenced below to community visits and transporting people with a disability.

Services delivered to people with a disability in their own home involve a number of specific factors in the risk assessment and risk control stages.

In addition to building a relationship with people with a disability these services must also respect the way each person organises and wants to live in their home.

A risk management approach is relevant and specific issues such as hazard checks of premises, protocols for working in the community and protocols for working alone are particularly important to reducing risks.

The risks to staff in this setting have been covered in the *Staff Safety in the Workplace Guidelines* published by the department in 2007.

These risks are also addressed in the *Victorian Home Care OHS Guide* published in 2005.

Transport of people with a disability to participate in community activities should be undertaken in the context of the person's individual plan and, where appropriate, behaviour management plan.

Risk reduction measures include reliable communication and an itinerary that enables supervisors to monitor the visit.

Further guidance on these matters can be found in the *Staff Safety in the Workplace Guidelines* and the *Victorian Home Care OHS Guide* noted above.

5.2 Forensic mental health

People with a disability who are assessed as posing a threat to others may be treated in a forensic mental health facility with medication, counselling and rehabilitation.

The risks to staff in this setting have been covered in the *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* published in 2004.

These guidelines adopt a similar risk management approach to this code and specific risk controls for the circumstances covered.

6. Review and response

6.1 Managing change

This section addresses changes in disability services that require a response.

The need for response is required where there is:

- an occupational violence incident that creates an immediate risk to staff or other people with a disability
- staff or other people with a disability are injured as a result of an incident
- there is evidence that cumulative exposure to occupational violence is a risk to health and safety.

(Note that other emergency situations such as fire or health of people with a disability are covered in relevant policies and practice manuals.)

The need for review is required where there are:

- changes to the health status and needs of people with a disability
- changes in behaviours of people with a disability
- changes to an accommodation setting
- changes in support and supervision arrangements
- evidence of ineffective strategies.

6.2 Emergency Response:

The general requirements for responding to emergencies in disability accommodation are set out in the *Residential Services Practice Manual*.

The requirements for emergencies involving occupational violence should be risk based and may include:

- a clear process to call on extra staff
- access to a safe area (for example a sleepover room)
- communication with nearby houses or units to provide back-up support, if required
- duress alarms where appropriate
- emergency contact numbers displayed, easily visible and programmed into cordless phones
- mobile phones where appropriate.

These emergency procedures should be included in induction for permanent or casual staff and reinforced through specific house orientations.

Emergency information should be included in house folders.

For client services and outreach programs emergency contact numbers and protocols along with suitable communication equipment are essential.

6.3 Post incident Response

Following an occupational violence incident a number of responses may be required:

- immediate first aid for staff member (and person with a disability)
- medical assistance for staff member (and person with a disability)
- formal debriefing through the *Critical Incident Stress Management Service*
- informal debriefing by peers
- use of the *Employee Assistance Program*.

These services may all be required depending on the seriousness of the incident.

As well as providing services to support staff following an incident, it is important to rebuild relationships, as incidents have an impact on the dynamics of the accommodation setting.

Consequently the further investigation of the incident and introduction of new measures must take into account the overall house or facility situation and particularly the impact on other staff and people with a disability.

6.4 Incident reporting

Incidents resulting in injury must be reported to WorkSafe Victoria if they are within the scope of Part 5 of the OHS Act. Where incidents are required to be reported there is also a requirement to preserve the scene of an incident until investigations are complete.

The two internal reporting systems relevant to disability accommodation are the departmental incident reporting system and the *Disease Injury Near Miss Accident* (DINMA) reporting system.

Departmental Incident reporting: Category One and Two assault incidents are relevant to this code and the protocols are set out in *Incident reporting: Departmental instruction*.

Disease Injury Near Miss Accident form: this form meets the requirement for a register of injuries under compensation law but also plays a broader role in identifying occupational violence incidents requiring action.

Comprehensive reporting provides an accountability trail for the protection of staff and a record of the pattern of events requiring action.

Variation in reporting practices in the health and community services sector is well known, with under reporting a major issue.

The following reporting effectiveness checklist can be used throughout the management chain to ensure reporting is both efficient and effective.

REPORTING EFFECTIVENESS CHECKLIST

- ✓ Are there widely different understandings of what should be reported?
- ✓ Are the recommendations for action a continual restatement of previous strategies?
- ✓ Does it take months rather than days or weeks to get feedback on report recommendations?
- ✓ Are incident reports used primarily to get attention for staffing or individual issues?
- ✓ Are high volume cases treated the same as one off cases?
- ✓ Is it widely thought that reports just disappear and nothing ever happens to address them?

6.5 Investigating incidents

Incident reports require a brief explanation of why the incident occurred. Within the OVRAMT the Post Incident Tool also seeks to identify reasons for the incident and the need to make changes to current practices.

From a risk management point of view the reasons for investigating incidents are to:

- prevent similar incidents recurring in the future
- identify any new hazards
- identify and choose suitable controls or strategies.

The following principles should be applied in undertaking any investigation of occupational violence:

- The purpose of the investigation is to examine the causes and results of any incident objectively. No assumptions should be made and any judgement should be based on information that is known to be full and accurate.
- The purpose of an investigation is establish the reasons for the incident to prevent a recurrence - not to assign blame.
- Incidents typically have multiple causes and the focus should be on conditions that may create the potential for occupational violence.

If the results of any investigation show that changes need to be made, corrective action must be taken. The risk management process outlined in the code should be the basis of identifying the best solutions.

CORRECTIVE ACTIONS CHECKLIST

- ✓ Are staff trained in new strategies or briefed on the new approach?
- ✓ Are changes followed up to make sure they are working?
- ✓ Have HSRs, employees, or OHS Committees been consulted on significant changes?
- ✓ Have affected people with a disability and families been briefed on proposed changes

6.6 Review

The provision of service to people with a disability includes regular reviews of their individual plans, and, where relevant, behaviour management plans. These also present the opportunity to check that any risks identified in OVRAMT are reviewed.

Apart from regular reviews the following situations may require a reassessment of occupational violence risks:

- **Change to health status and needs of people with a disability:** Changes to mobility, age related health changes and changes to an individual's personal goals may all have an impact on the potential for occupational violence (increased or decreased). Strategies should be amended to adjust to these changes.
- **Changes in behaviours of people with a disability:** An increase in behaviours of concern, although they may not have resulted in any injury to staff or other people with a disability, is reason enough for reviewing the situation.
- **Changes to accommodation setting:** Transfer of people with a disability to other accommodation, or the placement of new people with a disability into a house, may disrupt routines and needs to be handled sensitively.
- **Changes in support and supervision arrangements:** Changes to staff such as new house supervisors and different support staff may change house dynamics. Similarly changes to the number or experience of staff in particular settings may also require a review of the risk profile.
- **Evidence of ineffective strategies:** Feedback from care staff that current strategies are not working needs to be followed up with review and specialist input to identify ways of improving quality of life and reducing any attendant risks.

These situations may not require a detailed reassessment of risk (that is, through OVRAMT) but rather a fine-tuning of existing strategies and risk profiles.

The involvement of HSRs and support staff in these review stages is important to allow the views of those most affected to be considered, and to ensure that new measures are well understood by everyone who has to apply them.

7. Appendix 1: Recent case

In the case of *Inspector Keniry v The Crown in Right of the State of New South Wales (Department of Community Services) [2002]* it was alleged that the employer had failed to meet general duties under the OHS Act in regard to a community house.

The court found in a number of cases the Department had failed to:

- (a) provide adequate emergency procedures and equipment to ensure the safety of its employees when the employees were confronted by clients who demonstrated aggressive or violent behaviour;
- (b) ensure that incidents resulting from client behaviour that represented a risk of injury to employees were adequately reported, investigated and monitored;
- (c) ensure that employees were adequately supervised in managing the behaviour of clients;
- (d) ensure that employees were provided with adequate information to be able to properly and safely manage the behaviour of clients;
- (e) ensure that clients who had a predisposition to violent or aggressive behaviour were properly and safely managed;
- (f) ensure that employees received adequate counselling following incidents with clients involving violent or aggressive behaviour;
- (g) ensure that clients who had a predisposition to violent or aggressive behaviour did not have access to substances which increased the potential for violent or aggressive behaviour;
- (h) ensure that adequate communication facilities were made available to employees at the premises.

The Department was fined \$285,000 on a number of charges.

8. Appendix 2: Case study format

This format could be used to stimulate discussion of good practices and provide an opportunity for staff to share experiences of managing particular relationships.

| | |
|---|--|
| Description of case | |
| Typical risk factors (triggers) | |
| Behaviours observed in relation to risk (triggers) | |
| Current strategies to reduce risks and outcomes | |
| Further strategies that might be required | |
| Discussion of other factors | |

9. References

All references listed below are Department of Human Services documents.

Accommodation standards and design guidelines: 1.1 shared supported accommodation (general)

Entry, exit and relocation checklist

Incident reporting: departmental instruction

Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services

Issue resolution procedures

Occupational health and safety accountability and consultation in the Department of Human Services

Occupational violence prevention policy

Occupational violence risk assessment and management tool (OVRAMT)

Respite and emergency accommodation entry

Victorian home care industry occupational health and safety guide

well@work: A strategy to promote psychological wellbeing and prevent and manage psychological injury

Workplace safety

