Incident management by disability support service
17HDC00439, 25 October 2019

Disability support service ~ Community support worker ~ Policies ~ Induction ~ Communication ~ Right 4(1)

This case discusses the care provided to a woman in a secure unit by a community support worker and a disability support service.

The woman became heightened in mood, entered the office at the secure unit, and was removed from the office area by the support worker. The way in which the woman was removed from the office area is disputed; however, the following facts are not disputed:

- When the woman's behaviour and mood became heightened, she entered the office, threw herself on the floor twice, and grabbed, pulled, and threw objects in the office. The support worker did not exit from the situation.
- When the woman refused to leave, the support worker removed the woman from the office. She did this by coming into physical contact with the woman in order to get her out of the office.

The woman's support plans contain several references to how staff should respond to the woman when she is in a heightened state. The plan sets out specific de-escalation strategies such as giving her space, leaving the situation, and redirecting the woman if she exhibits self-injurious behaviour.

The woman's personal plan states that "staff are to remove themselves and others if she becomes violent". Her safety plan documents that one of the woman's known triggers is being touched, and that staff should avoid physical touching where possible, especially when the woman is unsettled, and ensure that she has enough personal space and remain at a safe distance if she becomes elevated.

The disability service and the support worker dispute the level of orientation she received when she first began her role at the secure unit. However, it was found that even if it is accepted that the support worker received the training reported by the disability service, this was insufficient.

Following the incident, the support worker did not complete an incident report. Furthermore, the disability service did not inform the woman's welfare guardian of the incident until 25 days later, despite the woman's welfare guardian having asked to be notified of serious incidents on the day they occurred. The disability service accepts that it did not inform the welfare guardian in a timely manner.

There was evidence of a lack of clarity from staff about when to report incidents. In particular, staff reported having been advised that in some instances, incident reporting was not required, or that there was a "threshold" for reporting incidents.

Findings

Adverse comment was made about the support worker for not exiting the room, and for coming into physical contact with the woman when she was heightened in mood. However, it was accepted that the support worker could have been better supported in her role by a

higher level of induction at the start of her employment. The support worker was criticised for not completing an incident report.

The disability service was found to have departed from accepted standards on the issues of incident reporting and the support worker's orientation. The disability service has an organisational duty to ensure that staff are supported appropriately in their role, and that incident reporting policies are well understood and implemented by all personnel. Accordingly, it was found that the disability service did not provide services with reasonable skill and care, and breached Right 4(1).

Recommendations

It was recommended that the support worker and the disability service each provide an apology to the woman, copied to her welfare guardian.

The disability service advised that it had implemented refresher training for staff and improved its incident reporting and management policy, and had provided additional training for staff on incident reporting and following up incidents.