OPERATIONAL PROCEDURE HANDBOOK

ARC DISABILITY SERVICES INC.

59 187 522 904

92 Little Street, Manunda, QLD 4870
P.O. Box 942, North Cairns, QLD 4870
T: +61 (07) 4046 3600
E: info@arcinc.org.au
W: www.arcinc.org.au

Table of Contents

PROCEDURE TITLE:	002 – RECOGNITION AND REPORTING OF ABUSE PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	20/05/2020

RECOGNITION OF ABUSE

Children and adults with a disability may be abused both within a person's home or in community settings. The organisation acknowledges that some individuals seek to use voluntary and community organisations to gain access to children and adults with disabilities and that it is necessary to have an open mind when the possibility arises that a person is suspected of abuse or inappropriate activity. Violence, neglect, exploitation and discrimination are all considered as abuse.

The following may indicate that an individual is being or has been abused:

- Unexplained or suspicious injuries, particularly if such an injury is unlikely to have occurred accidentally.
- An injury for which the child's or adult's explanation appears inconsistent.
- The child or adult with disability describes an abusive act or situation.
- Unexplained changes in behaviour.
- Inappropriate sexual awareness or sexually explicit behaviour.
- The child or adult with disability is distrustful of adults or a particular person.
- The child or adult with disability is not allowed to be involved in usual social activities.

The recognition of abuse is not always easy and the organisation acknowledges that its staff are not experienced in this area and will not easily know whether or not abuse is taking place. Indeed, it is not the place to the staff to make a judgement, however it is their responsibility to act on concerns in order to safeguard the welfare of the individual.

REASONABLE GROUNDS TO SUSPECT ABUSE

- When a child or adult with disability speaks about being abused or being in danger of abuse – about what has happened, about how they feel.
- When someone else (perhaps a relative, friend, acquaintance or sibling of the child) informs a member of staff that they suspect abuse and gives some indication as to what concerns them.
- When a child or adult with disability tells a member of staff that they know a child or person with disability who has been abused (often the child is referring to him/herself).
- When a member of staff observes a particular child's behaviour, physical appearance, condition or behaviour or their knowledge of children or adults with disability generally leads to suspicion of abuse.

INCIDENTS THAT MUST BE REPORTED/RECORDED

If any of the following occur, you should report this immediately to your manager or coordinator.

- If you accidentally hurt a child or adult with disability.
- If a person you are working with appears unusually distressed in any manner.
- If you are concerned that a relationship is developing that could represent an abuse of trust.
- If you are concerned that the child/adult is becoming attracted to you.
- If you are concerned that a colleague is becoming attracted to someone in his/her care.
- If a child/adult misunderstands or misinterprets something you have done.
- If you have had to use reasonable physical restraint to prevent a child/adult harming themselves, or another, or from causing significant damage to property.
- If a child/adult reports an allegation of abuse.

IF A CHILD OR ADULT WITH DISABILITY SAYS SOMETHING OR ACTS IN SUCH A WAY THAT ABUSE IS SUSPECTED, THE PERSON RECEIVING THE INFORMATION SHOULD:

- React in a calm but concerned way.
- Tell the child/adult that s/he is right to share what has happened and that s/he is not responsible for what has happened.
- Take what the individual says seriously, believe what they say.
- Keep questions to an absolute minimum only to clarify what the individual is saying and not to interrogate.
- Do not interrupt the child/adult when they are recalling significant events.
- Reassure the child/adult that the problem can be dealt with.
- Reassure the child/adult that the information will only be passed on to those people who need to be informed.
- Make a full record of what is said and done, though this should not result in a delay in reporting the issue.
- Tell the person what you plan to do now, keep them informed about what is happening. Ensure ongoing support if this is required

- The record should include:
  - A record of the participant's disclosure, as accurately as possible and should not include assumptions or opinions.
  - A detailed account of the nature of the disclosure or concern.
  - A description of any visible physical injury (clothing should not be removed to inspect the participant.
  - The participants account of what has occurred.
  - Any dates, times or places any other potentially useful information.

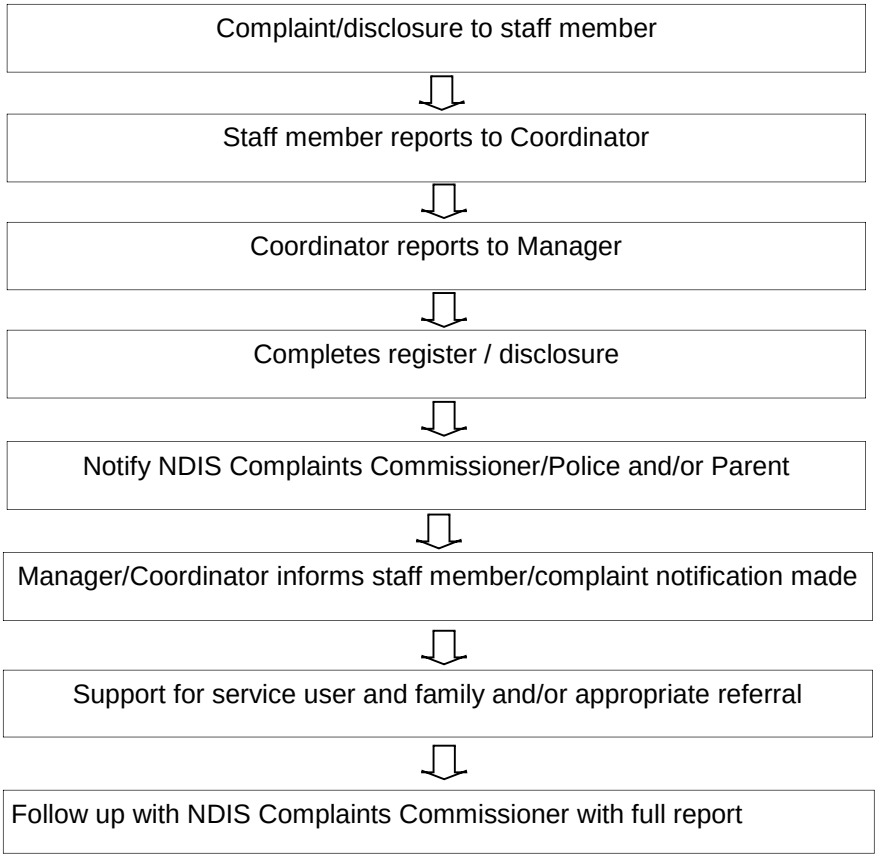
- The problem should be reported **immediately** to the manager or a coordinator who will take appropriate action. If this is out of hours, then the Service Coordinator's Emergency after Hours Phone should be notified. If the Service Coordinator is not contactable, ARC's Chief Services Officer of CEO should be contacted.
- It is recognized that staff may need support after receiving a disclosure from an individual and will be offered appropriate support and counselling. During this time, they will have access to ARC's Employee Assistance Program.

IF ABUSE IS REPORTED OR SUSPECTED PROCEDURE

- Everyone involved with the organisation is encouraged to discuss any concerns or reports with a manager or coordinator of the organisation as soon as possible.
- Confidentiality should be maintained at all times as appropriate.
- Suspicions must not be discussed with others not involved in the process.
- The Manager or Coordinator has the responsibility to act on behalf of the organisation in dealing with disclosures or suspicions of abuse or neglect. This will include collating details of the disclosure or suspicion, completing appropriate documentation and then referring the matter to the appropriate authorities.
- Under no circumstances should members of the organisation carry out their own investigation into suspicions or disclosures or abuse, neither should they question individuals closely as to do so may distort any investigation that may be carried out by Child Safety or the Police.
- If a parent discloses to you that they have harmed or think they are likely to harm, or are unable to protect a child, they may feel ashamed and suffer low esteem. It is important to convey that they have done the right thing in seeking help and that assistance is available.
- The ARC Investigation Policy & Procedure may be followed should a concern be raised in relation to the conduct of an employee or volunteer whilst carrying out their duties with Service Users of ARC.
- ARC is required to report any abuse or suspected abuse to the NDIS Complaints Commissioner within a 24-hour period – please refer to Incident Policy for further information.

Responding to Participant Concerns/Disclosures

Procedures to follow are according to ARC Disability Services Incident Policy and address all forms of abuse i.e. physical, emotional, sexual, neglect, financial and other vulnerable person's policy.



GOVERNING POLICIES

Duty of Care, Dignity of Risk and the Least Restrictive Alternative Policy
Children and Other Vulnerable Persons Policy
Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	003 – RECRUITMENT AND SELECTION PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	25/10/2017
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	20/05/2020

RECRUITMENT

ARC Disability Services Inc. (ARC) recruitment and selection procedures are based on merit and equity principles.

Merit relates to the assessment of applicants' abilities, skills, knowledge, experience, qualifications and potential relative to a selection criterion which is relevant to the effective performance of the position.

Equity relates to equity in employment to ensure fairness, consistency, access and non-discrimination principles and demotes impartiality in the selection process.

INTRODUCTION

This procedure involves a range of activities designed to ensure open competition, so that:

- People qualified for a position have the opportunity to apply for that position;
- Applicants are assessed against the selection criteria;
- The opportunity exists for applicants to demonstrate to the selection panel their merit in relation to the selection criteria;
- The process is conducted systematically and fairly;
- Applicants can obtain feedback about their performance against the selection criteria (natural justice principles).

ARC is an Equal Employment Opportunity (EEO) employer and the focus of this procedure is the applying of procedures that will attract and place the right person in the job.

The recruitment and selection procedure is to be applied in all instances there is an ongoing vacant position is to be filled, excepting those casual and/or temporary positions which will be at the discretion of the HR Manager or CEO.

The CEO shall ensure compliance with the principles of this procedure – within this framework, managers and supervisors may use their discretion and judgment in applying the procedure, but must be able to demonstrate that the principles of Merit and Equity have been upheld.

POSITIONS OF LEVEL 5 AND ABOVE

1. THE VACANCY

- A vacancy may be in three (3) categories: -
  1. Establishment of new position:
  2. Restructure of an existing position; and
  3. A vacant position due to an employee leaving that position.
- In all the above cases the vacant position shall be in accordance with funding guidelines and operational requirements.

2. ANALYSIS OF THE VACANT POSITION

When an employee leaves a position and the position is declared vacant the CEO in collaboration with the relevant Manger(s) shall conduct a Job Analysis, to ensure: -

- That the position functions and duties are relevant and required;
- That the classification level is correct;
- That the position description is reviewed;
- That the selection criteria are reviewed.

3. FORMATION (CONVENING) OF A SELECTION PANEL

A selection panel shall be convened under the direction of the HR Manager. A selection panel shall consist of no less than two (2) persons and no more than four (4) persons.
The members of the selection panel shall be chosen so as to ensure that the panel's recommendations are based on adequate knowledge of the requirements and outcomes of the position and of this procedure. Recommendations shall be free from bias in relation to any applicant.

4. SELECTION STRATEGY

The Selection Panel shall use the following selection techniques: -

- Assessment of the application including a curriculum vitae (resume);
- Structured interview;
- Assessment of referee reports and references;
- Security checks and criminal conviction checks.

Steps are to be taken by the selection panel to accommodate a particular need of an applicant, as appropriate during the selection process. It is appropriate to inquire of applicants if a disability or health condition might prevent them from performing the duties of the position and if so, how the duties or work environment might be adjusted.

5. ADVERTISING THE VACANT POSITION

The HR Manager shall authorize advertising of the vacant position, as delegated by the CEO.

6. RECIEPT OF APPLICATIONS

The HR Officer shall receive all applications on behalf of ARC Disability Services Inc. and shall ensure:

- That there is a register of applications received;
- That the applications received are held in a secure place with full confidentiality.
- That on the day after the closing date for applications all the applications received is handed to the Selection Panel, together with a copy of the register of application.

7. SHORT LISTINGS

Short listing is the process of determining which applicants have the strongest claim to the vacant position and which shall undergo further assessment. Short listing shall be undertaken in a systematic, fair and consistent manner by making an assessment against the selection criteria.

8. INFORMATION GATHERING

All aspects of information gathering, including structured interview and other selection techniques shall be undertaken in a systematic, fair and consistent manner by making an assessment against the selection criteria.
Information gathering may include: -

- Structured interview;
- Security checks and criminal conviction checks.
- Curriculum vitae/resume

9. WEIGHTING SELECTION CRITERIA

The selection criteria must be weighted in importance either prior to advertisement of the vacancy or prior to short listing. Quantitative or qualitative weightings may be used and the Selection Panel must have a common understanding of the meaning of the weighting assigned to each criterion. Some criteria may be assessed as being of equal weight.
The assigned weightings must reflect the relative importance of each selection criterion as a performance indicator of the applicants' ability to achieve the outcomes of the position.
Each time the position is advertised, the weightings may change according to the requirements of the role. I.e. varying the weightings may assist in obtaining an appropriate blend of skills and abilities in the team.
A suggested scale is:

5. **Outstanding - Excellent:** Very high standard, proven performance, excellent examples, and definite strengths that are measurable.
4. **Above Requirements:** Very Good, high standard, some definite strengths, good examples, confirmed performance.
3. **Meets Requirements:** Adequate satisfies minimum standards, some identified weaknesses.
2. **Average:** Less than adequate lacks strengths in significant areas.
1. **Not Acceptable:** Very low standard, clearly inadequate.

10. INFORMATION VERIFICATION

Information verification, using a range of selection techniques, should validate or supplement information gathered from the applicants and/or provide new information about them in relation to the selection criteria. Information verification may include: -

- Assessment of referee reports and references;
- Discussions with previous employers;
- Security checks and criminal conviction checks.

Reference checks are a valuable source to verify information gathered. Attention should be given to the relationship of the referee and the applicant, ideally the previous supervisor of the applicant would be an important source of information against the selection criteria. The Selection Panel shall make every effort to verify the claims of the applicant in relation to achievements, qualifications, employment history and other significant matters.
The Selection Panel in assessing applicants against the selection criteria shall use the form, “Referee Check list”.

11. SELECTION DECISION

The decision of the application shall be as per the delegation’s policy.

12. POST SELECTION ACTION

The HR delegate shall take action to notify the successful applicant and the unsuccessful applicants.
The successful applicant shall be advised of the conditions of employment of ARC which shall include written notice of a probationary period.

13. GRIEVANCES

Any current Employee who is unhappy with the selection outcome shall have access and receive support to use the Grievance Procedure.

POSITIONS OF LEVEL 4 AND BELOW

1. THE VACANCY

A vacancy may be in four (4) categories: -

1. Establishment of new position:
2. Restructure of an existing position; and
3. A vacant position due to an Employee leaving that position.
4. A short term/contracted position for a specific project

In all instances the vacant position shall be in accordance with funding guidelines and organisational operational budgets.

2. ANALYSIS OF THE VACANT POSITION

When an Employee leaves a position and the position is declared vacant the HR Manager shall conduct a Job Analysis, to ensure:

- That the position functions and duties are relevant and required;
- That the classification level is correct;
- That the Position Description is reviewed;
- That the Selection Criteria is reviewed.
- If an existing team member has been acting in the role successfully for an extended period of time.

3. SELECTION STRATEGY

The HR Manager shall use the following selection techniques: -

1. Assessment of the application including a curriculum vitae (resume);
2. Structured interview;
3. Assessment of referee reports and references;
4. Security checks and criminal conviction checks.
5. The success of an individual currently acting in the role.

Steps are to be taken by the HR Manager to accommodate a particular need of an applicant, as appropriate during the selection process. It is appropriate to inquire of applicants if a disability or health condition might prevent them from performing the duties of the position and if so, how the duties or work environment might be adjusted

I. If an individual has been acting in a permanent role for an excess of three months, the HR Manager may appoint the team member to the position in a permanent basis without the need to advertise, ensuring merit and equity is demonstrated in the decision.
II. In instances of a short term/contracted position, the HR Manager or CEO may appoint an individual to the position without the need to advertise, ensuring merit and equity is demonstrated in the decision.

4. ADVERTISING THE VACANT POSITION

The HR Manager shall identify if a position is required to be advertised internally/externally, based on existing staffing levels, and team members acting in such positions. It is the preference of the organisation to look within the current team to promote career development and opportunities for existing team members.

5. RECIEPT OF APPLICATIONS

The HR delegate shall receive all applications on behalf of ARC Disability Services Inc. and shall ensure:

- That there is a register of applications received;
- That the applications received are held in a secure place with full confidentiality.

6. SHORT LISTINGS

Short listing is the process of determining which applicants have the strongest claim to the vacant position and which shall undergo further assessment. Short listing shall be undertaken in a systematic, fair and consistent manner by making an assessment against the selection criteria.

7. INFORMATION GATHERIG

All aspects of information gathering, including structured interview and other selection techniques shall be undertaken in a systematic, fair and consistent manner by making an assessment against the selection criteria. In formation gathering may include: -

1. Structured interview;
2. Security checks and criminal conviction checks.
3. Curriculum vitae/resume
4. Evidence from experience of the applicant acting in the existing role

8. WEIGHTING SELECTION CRITERIA

The selection criteria must be weighted in importance either prior to advertisement of the vacancy or prior to short listing. Quantitative or qualitative weightings may be used and a common understanding of the meaning of the weighting assigned to each criterion. Some criteria may be assessed as being of equal weight.
The assigned weightings must reflect the relative importance of each selection criterion as a performance indicator of the applicants' ability to achieve the outcomes of the position.

A suggested scale is listed above.

9. INFORMATION VERIFICATION

Information verification is as listed above in point 10.

10. SELECTION DECISION

The decision of the application shall be as per the delegation's policy.

11. POST SELECTION ACTION

The HR delegate shall take action to notify the successful applicant and the unsuccessful applicants.
The successful applicant shall be advised of the Conditions of Employment of ARC which shall include written notice of a probationary period.

12. GRIEVANCES

Any current Employee who is unhappy with the selection outcome shall have access and receive support to use the Grievance Procedure.

GOVERNING POLICIES

Recruitment and Selection Policy
General Grievance Resolution Policy
Police Check Policy
Workplace Bullying Policy
Anti-Discrimination and Harassment Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	004 – ABANDONMENT PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/04/2009
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	20/05/2020

PURPOSE

This procedure informs staff of the structured way in which to respond to the risk of abandonment or the actual abandonment of a participant at an ARC location.

PROCEDURE

All Employees have a responsibility to notify their Coordinator, Manager or CEO, if informed by a participant's family or carer that they will not be collecting their family member from an ARC location or support, or if the family or carer fails to take the person home at the scheduled time.

If the participant is a child:

The Coordinator, Manager or CEO will:

- Assume responsibility to ensure that all requirements of the ARC Incident Reporting policy and procedures are met and all actions are followed as per the ARC policy and procedures.
- Contact the family or carer to confirm their intent to abandon the child.
- If the intent to abandon the child is confirmed, ensure that Dept. Child Safety are notified of the situation as well as any key coordination staff i.e. Coordinator of Supports or in the place of Coordinator of Supports the NDIS LAC.
- If the family are unable to be contacted, ensure that the Dept. Child Safety are notified of the situation and suspicion of possible abandonment.
- Liaise with relevant coordinators and Child safety to discuss possible extensions of the support or alternate arrangements where this is appropriate and required.

If the participant is an adult:

The Coordinator, Manager or CEO will:

- Assume responsibility to ensure that all requirements of the ARC Incident Reporting policy and procedures are met and all actions are followed as per the ARC policy and procedures.
- Contact the family or carer to confirm their intent to abandon the person.
- If the intent to abandon the person is confirmed, ensure that the Office of the Adult Guardian are notified of the situation as well as any key coordination staff i.e. Coordinator of Supports or in the place of Coordinator of Supports the NDIS LAC.
- If the family are unable to be contacted, ensure that the Office of the Adult Guardian and Coordinator of Supports are notified of the situation and suspicion of possible abandonment.
- Liaise with relevant coordinators to discuss possible extensions of the support or alternate arrangements where this is appropriate and required.

GOVERNING POLICIES

Incident Reporting Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

005 – WORKPLACE HEALTH & SAFETY INCIDENT REPORTING PROCEDURE OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**005 - WORKPLACE HEALTH & SAFETY INCIDENT REPORTING PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

This procedure refers to instances where an injury, incident, workplace illness or dangerous event has occurred, or been contracted, within the workplace. This procedure extends to “near miss” instances, or any other circumstances, in which an injury or potential injury has been avoided yet exposure to significant risk has been identified. Incidents can be classed into two types, Critical or General.

CRITICAL INCIDENTS

A critical incident is an incident that includes any incident that results in the overnight hospitalisation or death, severe injury or trauma.

1. Any critical incident must be bought to the immediate attention of one of the Managers or the CEO.
2. In the case of serious injury or work-related illness no person shall move or otherwise interfere with any materials or other thing connected with the injury, illness or event without the permission of a Workplace Health & Safety Inspector from the Division of Workplace Health & Safety, or if an inspector is unavailable a police officer.
3. No person will be seen as being in breach of section 2 of this policy if the movement or interference is necessary to save life, relieve suffering or to prevent injury to a person or item of property.
4. Any worker involved in a critical incident must have counselling made available as soon as possible after the incident. Further counselling will be available through the ARC Employee Assistance Program.
5. The CEO, Manager or Quality Coordinator must report all critical incidents to the NDIS Quality and Safeguards Commission within 24 hours.
6. All processes involved in the general incident procedure are required to be undertaken.

GENERAL INCIDENTS

1. All incidents need to be reported to worker’s immediate supervisor as soon as possible. If the incident is urgent and the immediate supervisor is not able to be contacted, the worker is to contact another member of the coordination or management team
2. Employees of ARC are required to complete an *Incident Report* within 24 hours of any event from which an injury, or potential injury may arise.
3. The report must be submitted online using ProSIMS
4. Upon completion the form is automatically forwarded to the relevant service Coordinator or Manager within 24 hours of the incident.
5. The relevant service Coordinator/Manager will review the report, action the report and forward to appropriate Manager within 48 hours of the incident occurring.
6. The Manager shall review the report and consult with the reporting party, the relevant Safety Representative and any other relevant parties within 72 hours of receiving the report. This consultation is to be directed at identifying the potential causes of the injury, illness or dangerous event and should encompass a thorough risk assessment and identify means of eliminating or minimising any further risk to the Workplace Health & Safety of individuals in the workplace.
7. All incident Reports received will be tabled for review at the Managers meeting the appropriateness of risk management processes evaluated.
8. All Incident Report forms received will be kept in the Incident Report Register for a minimum of 1 year following the event, injury or illness. A copy of the report or reference to location of the report is to be kept in the consumer/employee’s file, where relevant. Copies of reports are kept to support register.

GOVERNING POLICIES

Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	**006 – CRITICAL INCIENT PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

This guideline informs practice in relation to complying with the requirements for reporting critical incidents.

INTRODUCTION

The purpose of the critical incident guidelines is to ensure all critical incidents are reported to the CEO to ensure efficient and effective operational and media management as well correct notification to the NIDS Quality and Safeguards Commission. These critical incidents relate to:

- All service users who are in receipt of a service
- All staff, Board members, volunteers or contractors
- Matters where media attention has occurred or is possible

Critical incident reporting applies to all staff to ensure the reporting of critical incidents results in:

- Immediate crisis management of a critical incident
- Informed, accurate and timely response to media enquires
- Management of subsequent information requests and briefings
- Information relevant to a subsequent review that may be required

WHAT IS A CRITICAL INCIDENT?

Occurrences considered to be critical incidents are those situations that might present a risk of significant bodily harm, property damage, legal involvement, media activity or other unusual activity that falls outside the scope of activity undertaken by ARC such as:

- Death: Death of a service user who is actively receiving services from ARC.
- Injury: The infliction of bodily harm.
- Damaged Property: The intentional or wilful damage to property.
- Significant occurrences: Whether by a service user, volunteer or staff member on duty or other person. Any threats or physical assaults, or behaviour so bizarre or disruptive that it places others in a reasonable risk of harm, or causes harm.
- Sexual contact or attempted contact by a staff member on or off duty, volunteer or Board member directed at a service user.
- Situations potentially generating publicity in the media.
- Situations requiring reporting under state or federal statute including issues relating to children and vulnerable persons.
- Situations which result in the use of restrictive practices as a last resort, and/or to ensure the safety of other service users or staff, as an immediate response based on obligations of duty of care.

PROCEDURE

The responsibilities of staff in relation to critical incident reporting are outlined below.

- Any staff member who is involved in, witnesses or has a critical incident brought to their attention must promptly report the critical incident to their manager. In such circumstances staff must complete an Incident Report form identifying the detail of the critical incident.
- The incident Action form will identify the incident is considered critical and the appropriate section will be completed.
- All critical incidents must be reported to the NDIS Quality and Safeguards Commission
- Should a critical Incident also raise an opportunity for service improvement then a Service Improvement Form should also be completed
- If a critical incident also raises concern regarding workplace health and safety, then a Workplace Health and Safety Hazard Form should also be completed.

- Where extenuating circumstances apply, such as a staff member being injured, the CEO may waive or approve a delay in a staff member completing relevant documentation. In these circumstances, the CEO must attempt to gather all available information from other sources to enable submission as soon as possible.
- The CEO is responsible for determining if a need is identified to report any criminal acts to the police and/or alternative agencies as per requirements.
- If unauthorized restrictive practices have been used The CEO is responsible for ensuring the reporting of this to the NDIS Quality and Safeguards Commission
- All media enquires in relation to any aspect of a critical incident are to be directed through the CEO. ARC will adequately document the nature and circumstances related to the critical incident and include at least:

1) The circumstances of the incident and any support services or other treatment provided.
2) Recommendations for any quality improvement activities that ARC should consider as a result of the critical incident.
3) Follow up of activity to be undertaken.

CONFIDENTIALITY

Reporting of critical incidents shall be in conformance with all state and federal privacy laws and regulations.

QUALITY MANAGEMENT

ARC shall review critical incidents on an ongoing basis.

TRAINING

ARC shall ensure that all service users, Board members, staff, volunteers are aware of their obligations related to this critical incident policy.

GOVERNING POLICIES

Incident Report Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	007 – MANUAL HANDLING PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	10/03/2020

PURPOSE

To give guidelines to employees of ARC Disability Services Inc. (ARC) to ensure safe manual handling procedures.

PRINCIPLES OF MANUAL HANDLING

All employees need to be aware of caring for themselves whilst supporting Participants. Caring for your body especially your back is very important during any manual handling.

1. Stop – Do not just rush in
2. Think and Assess – Think about what you are going to do
3. Plan – look at the plan if appropriate, get any equipment and prepare
4. Perform – Follow the plan appropriate and trained manual handling techniques
5. Review – report any concerns or potential hazards.

- When one or two employees are assisting a participant to be transferred this will be carefully planned and coordinated.
- The surrounding environment will be checked for anything that may hinder or obstruct the transfer. The distance across which a participant need to be transferred or transported should be as short as possible.
- If two employees are involved in the transfer one employee will be appointed to coordinate the transfer. Both employees will be clear about what is going to happen before the transfer takes place.
- The participant who is being transferred will be included in the planning and will be informed exactly what is going to happen and when.
- A correct Manual Handling Plan must be followed whenever using assistive mechanical devices

Mechanical Lifting and Using Assistive Devices

- All employees will be trained in the correct use of relevant mechanical equipment and assistive devices.
- Mechanical lifting devices will be regularly serviced and maintained.
- Whenever possible two employees will be present when assistive mechanical devices are being used.

Procedure for using Mechanical Lifting Devices (Hoists)

1. The surrounding environment will be checked for anything that may hinder or obstruct the transfer. The distance over which a participant need to be transferred or transported should be as short as possible.
2. Ensure the sling is properly positioned around the person.
3. Tell the participant you are transferring that the hoist is about to lift them up.
4. As the sling tightens, stop to ensure it is not cutting or pinching the person.
5. As the hoist is moved from one position to another, one employee should be pushing the hoist while a second employee stabilises the person who is being moved.
6. Always be aware of privacy issues when a participant is being moved, i.e. if a participant is undressed ensure that their dignity is preserved by using a towel to cover them.
7. The brakes of the hoist must be off and the area to which the participant is being moved must be ready, before the person is lowered.
8. As the participant is lowered, a second employee should stand behind the person and guide them into the chair/onto the bed.
9. Once the participant is stable, the sling should be removed and seating adjustments be made as required and the hoist moved away as soon as possible.

QUALITY MANAGEMENT

The Manual Handling Procedure will be reviewed and updated as required as well as biennially as part of the internal audit schedule. Consultation and review shall take place with families, participants, staff and coordinators to ensure relevance of the procedure at this stage.

GOVERNING POLICIES

Manual Handling Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	008 – NEEDLE STICK PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	20/05/2020

PURPOSE

To ensure that needle stick injuries are managed appropriately and safely.

NEEDLE STICK INJURY:

1. If skin is penetrated, wash the area well with soap and water.
2. If blood gets on the skin, irrespective of whether there are cuts or abrasions, wash well with soap and water.
3. Ensure the safe disposal of the needle or sharp.
4. Then report **immediately** to the coordinator/manager and complete an Incident Report Form which must include:
    - Date and time of injury/exposure
    - How the incident occurred
    - Name of participants supporting

Regardless of whom the participant is the affected person should immediately be evaluated and the risk assessed preferably by a physician or trained healthcare worker and immediate action taken as directed.

ARC'S RESPONSIBILITIES

1. Ensure that immediate steps are taken to reduce the risk to the employee of contracting a serious illness.
2. Ensure the employee has thoroughly washed the exposed area and needle or sharp has been disposed of safely.
3. Arrange for the employee to be assessed and have blood taken if necessary.
4. Ensure incident reporting is completed within 24 hours or as soon as practicable as per OH&S procedures.
5. Provide support and counselling if required to the employee or individual
6. Investigate the circumstances of the incident and take measures to prevent recurrence. This may include changes to work practices, changes to equipment, and/or training.

Locations of Sharps Containers

1. Idalia Street – Kept in locked filing cabinet in staff sleepover room
2. Carmel Close – Kept in filing cabinet in staff sleepover room
3. Holiday House - Medication Cabinet in Kitchen
4. ARC Office – Kept upstairs in ARC Coordinators office
5. ARC Office – Downstairs – Programs office

DISPOSAL OF NEEDLE STICK/SHARPS

All sharps/needles have the potential to cause injury through cuts or puncture wounds. In addition, many sharps are contaminated with blood or body fluids, microbiological material posing a risk of infection or illness if they penetrate the skin. It is therefore essential to follow safe procedures when using and disposing of sharps/needles in order to protect employees and participants from sharps/needle stick injuries.

1. All areas which use sharps/needles must have a designated container suitable for the safe storage of used sharps/needles. These containers are rigid and impervious, with a tightly fitting lid and are clearly labelled as sharps containers. They must be discarded when full.
2. All sharps/needles are to be placed in a sharps container immediately after use. If the container is full then do not try to force further sharps inside as this may lead to an injury.
3. To avoid needle, stick injuries, needles must not be recapped or manipulated in anyway.
4. When the sharps container is full the lid must be securely closed and the container disposed of properly. Sharps containers must not be placed into the general rubbish but taken to the Portsmith/Smithfield Transfer Station or to an accepting pharmacy – ensuring that a replacement is purchased at the same time.

GOVERNING POLICIES

Needle Stick Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	009 – PARTICIPANT BUILDING SECURITY PROCEDURE		
VERSION:	001	DATE EFFECTIVE:	09/06/2020
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	09/06/2020

PURPOSE

ARC Disability Services Inc. is committed to supporting participants to achieve their goals, ARC has a duty of care to ensure the participant's personal safety, whilst actively considering their rights and needs. In some cases, it shall be deemed necessary for the locking of external doors, gates or windows in line with community standards for safety. ARC is committed to ensure the greatest choice and control of participants and that these community standards limit their freedoms to the least extent possible.

PARTICIPANT BUILDING SECURITY PROCEDURE

Upon a participant commencing services with ARC they will be supported to fill in a Participant Individual Risk Assessment form, this form may call for the use of a building security and access form to assist in supporting the participant's individual needs. This documentation requires the participant's guardian/another stakeholder when possible to co-sign this information. This document will outline the participant's level of support required around building security and access. This form shall also outline any strategies or requirements needed to support the participant with Building Security. This information will be reviewed every two years, or as needed due to an individual's change of circumstance.

The process for Building Security is as follows:

1. Participant engages with ARC services
2. Participant is assisted to complete a participant individual risk assessment form, if a risk is identified with building security they will also complete a building security information form.
3. If on the Participants Building Security and Access form it stipulates that the participant requires use of a key/access code, then this will be organised with the service coordinator prior to service commencing. This only applies to SIL arrangements and Short Term Accommodation, due to the communal nature of Programs participants will not have access to keys for these locations however will not be hindered by locked doors during their program.
4. The key will be added to the individual services key register, or in the case of Short Term Accommodation it will be recorded in the service diary.
5. Every 2 years or as needed due to a change of circumstances, the participants individual risk assessment will be updated/reviewed.
6. Copies of the information outlined in the participants building security and access form will be available to support workers and the information outlined within will be communicated to support staff upon confirmation of a support with that participant.
7. The coordinator is responsible for ensuring that if any changes occur to this information that this is communicated to all support staff. This will be through either a team meeting or direct verbal/digital communication with the worker.
8. This form is filed into the participant's consumer folder in the ARC system.
9. The participants primary service coordinator or a delegated administration officer is responsible for ensuring that a digital alert is set for a reviewal after 2 years.

ACCESS

In the event that a participant is assessed to require a key or alternate method for access using the Building Security and Access form for when they are in a SIL accommodation or in short term accommodation then this will be supplied. This key/ other means of access will be recorded on a key register or Short Term Accommodation service diary which the service Coordinator will be responsible for.

SUPPORTED INDEPENDENT LIVING

If a participant who lives in a SIL arrangement has the capacity to manage and utilise a key, they will be supported with this. The participant will be supported and encouraged to use this key as much as possible to assist in skill growth and independence. The Coordinator will be responsible for ensuring this key is on the key register.

SHORT TERM ACCOMODATION

- Participants accessing short term accommodation services who are assessed on their building security and access form to have access to a key will be supported with this.
- The Coordinator and support staff are responsible for ensuring that the key is signed out and recorded in the diary upon them arriving at the accommodation.
- The key number must be recorded to enable tracing of keys in the event that any go missing.
- It is important to note that this key must be signed back in again at the end of their stay.

STRATEGIES

Not all participants will have the capacity to use or access a key or a key lock, these participants will instead have a strategy for communicating that they want a door opened.

1. This strategy is outlined in the participants Building Security and Access form. It is important that the participant, their stakeholders and the coordinator are in agreeance over this strategy.
2. The support staff who will be supporting the individual have the strategy explained to them, the coordinator will ensure that all staff have a good knowledge around the strategy and how to implement it.
3. The coordinator is responsible for ongoing reviewal of the strategy to ensure effectiveness and participant choice and control. This is supported by Support Staff ensuring they are writing effective and reflective case notes around any events that occur around building security and access.

GOVERNING POLICIES

Building Security Policy
Restrictive Practice Policy
Duty of Care, Least Restrictive Alternative Policy

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	010 – EMPLOYEE DISCIPLINE PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	HR Manager	DATE REVIEWED:	26/05/2020

THIS POLICY IS BASED ON NATURAL JUSTICE PRINCIPLES

PURPOSE

The aim of employee discipline is to enhance performance and the work environment by modifying unacceptable behaviour and improving skill deficits. Disciplinary action should be directed towards correcting an employee's behaviour and not for punishment.

Instances that could result in disciplinary action being taken include, but are not restricted to, the following: falsifying of records, revealing confidential information, theft, fraud, harassment, working under the influence of drugs or alcohol, excessive absenteeism, non or poor performance, failure to comply with the policies and procedures and code of conduct of the organisation.

Employees who exhibit unsatisfactory performance or behaviour shall be counselled to ensure that they understand the standards expected of them and will be offered assistance, training and guidance as deemed necessary in achieving those standards. The Employee shall be given notice either verbally or in writing of any disciplinary issue with an appropriate opportunity to respond to any allegations before any action is taken. In circumstances of serious misconduct these steps may be skipped over.

INFORMAL COUNSELLING

The employee shall be told as soon as possible of any allegations of unsatisfactory performance or behaviour. The relevant supervisor will be designated to discuss the issue with the employee and if necessary will outline how the employee may meet the standard required. The aim is to communicate clearly and effectively the nature of the issue and the way in which the employee can address this to achieve the required standard. Notes will be recorded in the employee's electronic file stating details of the informal counseling. A copy of these details will be given to the employee if requested.

If after offering counselling and support, or depending on the severity of the issue, it is determined that the appropriate course of action is to start formal disciplinary proceedings the following steps will be adhered to:

(At all stages of the disciplinary process the employee shall have the right to have a person of his/her choice, present as a support person. Should employees wish further assistance/advice, the employee may request the presence of a person to act on his/her behalf, such a person may be a Union representative should the employee be a member of that Union.)

VERIFICATION

The Supervisor or Manager shall ensure that the details relating to the issue are verified and investigated prior to proceeding. In some instances, it may be necessary to stand the employee down on full pay during the investigation.

FORMAL COUNSELLING (VERBAL)

The Supervisor will meet with the employee at a predetermined time. The issue will be discussed in detail with the employee. The employee will be given the opportunity to respond to any allegations. Any assistance required by the employee to meet the standard will be identified and provided where possible by the employer. A written record of the meeting will be made, with details of the required improvements in performance noted, a copy of which will be given to the employee. A review date may be set. Depending on the severity of the concern, a decision may be made to move straight to the formal written warning.

FORMAL WARNING (WRITTEN)

Should the behaviours continue or occur again after the verbal reprimand, the issue/s will then be discussed at a formal meeting with the supervisor and/or Manager. The employee will be given notice to attend the formal meeting and will have the right to respond to the allegations. Within this notice the employee will be notified of what the meeting will be about and has the right to bring a support person. The employee will be given a formal warning in writing detailing the allegation of unsatisfactory performance or behaviour and the action necessary to meet the required standard.
The aim of the meeting will be to resolve the issue/s and if required, to identify the steps that need to be taken to improve performance to meet the standard. A review date will be set.

REVIEW

On the review date a counseling session should be scheduled with the employee to determine if the required improvements in performance have been achieved. If they have, this should be noted in the employees' file, and no further action taken.
If the required improvements have not been made, a decision must be made, depending on performance and conduct, to extend the review period or proceed with a final written warning or begin dismissal proceedings.

FINAL WARNING (WRITTEN)

A final warning will be issued if the employee has not taken action to meet the standard of performance and behaviour required or if the action taken is insufficient to meet the required standard of performance, as per outcome of review. Management shall fully investigate the issue/s and in respect of any hearing the employee will be given the opportunity to put his/her case forward in defence. The employee is to be informed that the final warning has been issued for unacceptable conduct/behaviour following previous counseling and warning; continuation of such conduct/behaviour may lead to dismissal. A review date will be set.

FINAL REVIEW

On the final review date, a counseling session should be scheduled with the employee to determine if the required improvements in performance have been achieved. If they have, this should be noted in the employees' file, and no further action taken.
If after review an employee has still not demonstrated an ability to correct the unsatisfactory performance or behaviour, or does not demonstrate a willingness to improve, the employee shall be requested to "show cause", as to why the employee should not be disciplined, and/or why the employee's employment should not be terminated. Management shall make a decision based on the evidence and shall either formally discipline the employee or terminate the employment of the employee in line with industrial legislation requirements.
Should a decision be made to terminate the employment of an employee it will be made on the basis that the employees' conduct has been of a serious and willful nature and amounted to either a refusal by the employee to fulfill his/her obligations or an intention by the employee not to fulfill his/her obligations in the future.
The requirements of the Fair Work Act (2009) with respect to termination of employment are: valid reason for termination, the employee must be consulted; and, dismissal must not be harsh, unjust or unreasonable.

DISMISSAL

Should management decide that termination of employment is the only course of action which can be followed due to an employee being unable to show cause as to why their employment should be continued, then expert advice shall be sought as to the correct process to follow in line with current industrial legislation.

IMMEDIATE DISMISSAL (SERIOUS MISCONDUCT)

Nothing in this procedure shall limit the right of ARC Disability Services Inc. to summarily dismiss an employee for proven serious misconduct. Serious misconduct may include, but is not limited to: -

- Theft, assault, fraud;
- The employee being intoxicated at work;
- Any conduct by an employee that causes imminent and serious risk to a person's health or safety;
- Any conduct by an employee that causes imminent and serious risk to the reputation or viability of ARC Disability Services Inc.;
- Any willful or deliberate behaviour that is inconsistent with the employment contract;
- The employee refusing to carry out a lawful and reasonable instruction;
- Any breach of confidentiality;

- An inability by the employee to recognise the rights or dignity or show respect to ARC's Participants, in accordance with the Disability Services Act 2006, NIDS Quality and Safeguards Framework and the Human Services Quality Framework.
- Serious breach of policy and/or procedure
- Unsafe data breach or unsolicited release of organisation information

The requirements of the Fair Work Act (2009) with respect to termination of employment are: valid reason for termination, the employee must be consulted; and, dismissal must not be harsh, unjust or unreasonable. These requirements still apply to summary dismissal.

GOVERNING POLICIES

Sexual Harassment Policy
Non Smoking Policy
Alcohol and Other Drugs Policy
Employee Supervision Policy
Privacy and Confidentiality Policy

AUTHORISATION

This Procedure is approved and issued by:

Sarah Dart

HR Manager

PROCEDURE TITLE:	011 – MEDICATION PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Health Facilitator	DATE REVIEWED:	27/05/2020

PURPOSE

To ensure that all medication is managed safely and effectively, providing continuity of process across the organisation as per Medication Policy.

MEDICATION PROCEDURE

GENERAL MEDICATION ASSISTANCE PRINCIPLES

- Medication Authorisation Forms must be completed for any participant requiring any assistance with medication both prescribed and non-prescribed and including any complementary or alternative therapies. Authorisation is required from a Registered Health Professional, Parent/Guardian/Participant and signed off by an ARC representative.
- Employees may only assist with medication which is correctly labelled for the named participant by a pharmacist.
- Supported Independent Living participants will have medication dispensed from a Webster Pack as appropriate, prepared and labelled by the pharmacist. Employees to assist as per Webster pack instructions and document as per organisational requirements. Webster packs to be checked on collection from pharmacy and documented on Webster Pack Check sheet.
- Medications will be assisted with as per directions from the pharmacy and as labelled and not crushed or mixed unless specified by a health professional, pharmacist or approved by authorisation.
- A medication sheet must be completed and signed by employees for all medications assisted with.
- Training is provided in medication assistance and ongoing education and updates are available.
- All employees assisting with medication need to understand the effects and side effects of any medication they are assisting with.

ASSISTING WITH MEDICATION

- Employees to follow the seven 'rights' for safe medication administration. Right Person, Right Medication, Right Dose, Right Time, Right Route, right to Refuse and Right Documentation.
- Employee will provide assistance with medication where needed and must observe participant taking medication before signing documentation.
- If a second employee is available at the time of medication assistance, then second employee to check medication and cosign they have checked it.
- Employee to seek advice from a health professional/pharmacist or manager/coordinator if there is any discrepancy with medication.

MEDICATION ERRORS AND INCIDENTS

In the event of a medication error or medication incident the employee must immediately report, seeking advice from a health professional/pharmacist or manager/coordinator and document. If the situation appears to be an emergency call an ambulance immediately and complete an incident form as soon as possible and no later than 24 hours. If a critical incident, then critical incident procedure to be followed including advising CEO.

If the situation is not an emergency, then the following guidelines apply:

- Know the detail of medication incident or error for reporting and documenting
- Speak to appropriate health professional/manager/coordinator/pharmacist
- Document advice and instructions given and name of person giving instructions. If necessary, follow emergency instructions given immediately.
- If this is not a coordinator/manager, then report to a coordinator or manager.
- Document all information, whom contacted and advice given by whom.
- Complete incident form as soon as possible detailing the medication incident or error.

STORAGE OF MEDICATION

- All participants needing medication assistance will have a completed Medication Access Information Form completed.
- All medications must be stored out the reach of children, in a cool, dry location or refrigerated if required.
- All medications must be stored in original packaging or pharmacist dispensed container.
- All medications should be kept in secure lockable storage that is not accessible to other participants or unauthorised people within all sites utilised or managed by ARC

GOVERNING POLICIES

Medication Policy
Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

SHERIDAN LAWTON
Health Facilitator RN

PROCEDURE TITLE:	012 – ASTHMA MANAGEMENT PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Health Facilitator	DATE REVIEWED:	10/03/2020

PURPOSE

To ensure the safety and wellbeing of participants who have asthma and may present asthma symptoms or have an asthma attack or flare-up. To ensure that employees to have a structured procedure to manage a participant having an asthma attack, flare-up or presenting symptoms should they not have an Asthma Information Action Plan available.

ASTHMA MANAGEMENT

It is preferable that all ARC participants who have asthma or may display symptoms should have a documented Asthma Information Action Plan. In situations where a participant may not have a documented plan or the plan is unavailable, the following procedure should be followed.

ASTHMA FIRST AID

1. Asthma first aid is required when someone is having an asthma flare-up or asthma attack. An asthma flare-up is a worsening of asthma symptoms and lung function compared to what would usually be experienced day to day.
2. An asthma flare-up can come on slowly, over hours, days or even weeks, or very quickly over minutes. A sudden or severe asthma flare-up can be called an asthma attack.
3. Remain calm and reassure the participant.
4. Determine the severity of symptoms presenting. Some or all of the symptoms may show for each category.

MILD-MODERATE	SEVERE	LIFE THREATENING
Coughing	Cannot Speak Full Sentences	Unable to Speak one or two Words
Wheezing	Coughing	Collapsed and/or Exhausted
Minor Difficulty Breathing	Wheezing	Gasping for Breath
		May not cough and/or wheeze
		Drowsy/Confused/Unconscious
		Blue Lips

5. If Life Threatening or Severe call an ambulance immediately ringing 000 and begin asthma first aid.
6. Sit the participant upright to maximise airway, continue to reassure and do not leave them alone.
7. Give 4 separate puffs of blue/grey reliever puffer by: shaking puffer, put 1 puff into spacer, participant to take 4 breaths, repeat 4 times total. (if a child Bricanyl or Symbicort inhaler only 2 puffs)
8. Wait 4 minutes, if no improvement repeats 4 puffs (or child 1 puff)
9. If still no improvement calls an ambulance, if symptoms are relieved continue to monitor and report to coordinator/manager
10. If no medication available seek advice and follow instructions immediately.
11. If an ambulance is called stay with the person, reassure them
12. Contact a Manager / Coordinator who will contact the family/carer.
13. If possible the participant should be accompanied to hospital. If this is not possible then the Manager / Coordinator will arrange for a staff member or family/carer representative to get there as soon as possible.
14. An incident report must be completed as soon as possible, within 24 hours.
15. If hospitalisation is not required then the situation should be monitored and documented fully both on an incident report and in participants notes to ensure that all staff, families/carers are fully informed of the situation.

Call emergency assistance immediately dialling 000 if:

- The participant is not breathing
- The participant's asthma suddenly gets worse or is not improving

- The participant is having an asthma attack and a reliever is not available
- You are not sure if it is asthma

If the incident becomes a critical incident, then the incident reporting procedure for critical incidents must be followed.

GOVERNING POLICIES

Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

Sheridan Lawton

Health Facilitator RN

.

PROCEDURE TITLE:	013 – SEIZURE MANAGEMENT PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Health Facilitator	DATE REVIEWED:	25/05/2020

PURPOSE

To ensure the safety and well-being of participants who may have seizures. Ensures that employees to have a structured procedure to assist a participant who may be having a seizure/seizures should they not have a specified Seizure Information Form or Health Care Plan available.

SEIZURE MANAGEMENT

All ARC participants who have epileptic or non-epileptic seizures should have a documented Epilepsy Information Action Plan or Health Care Plan.

If an Epilepsy Information Action Plan or Health Care Plan is available this should be followed.

In situations where a participant may not have a documented plan or the plan is unavailable, the following procedure should be followed.

Most seizures generally stop within a few minutes.

SEIZURE FIRST AID

1. Stay calm, reassure the person and stay with the person.
2. What you do will also depend on the type of seizure the participant is having.
3. Note the time immediately as this is important and time the seizure.
4. Protect the participant from injury – remove any harmful objects from the area if possible
5. Do not try to restrain the participant, put anything in their mouth.
6. Protect the head- place something soft under their head, or support head if in a wheelchair and loosen any tight clothing.
7. Gently roll the participant onto their side when and if safe to do so and push jaw forward to open airway.
8. Stay with and reassure the participant until they have fully recovered.
9. Record the seizure details on an Incident Form.
10. Call an ambulance immediately if:
    - The active or jerking movements of the seizure lasts more than five minutes or as per Health Care Plan or Seizure Information Management Plan
    - Another seizure quickly follows or as per Health Care Plan or Seizure Information Management Plan
    - The participant has been injured or is in water
    - The participant is non responsive for more than 5 mins after seizure stops
    - Or you are in any doubt as prolonged or repetitive seizures require medical attention.

11. If an ambulance is required a Manager or Coordinator must be contacted as soon as possible.
12. If possible the participant should be accompanied to hospital. If this is not possible then the Manager / Coordinator will arrange for a staff member or family/carer representative to get there as soon as possible.
13. An incident report must be completed as soon as possible or within 24 hours.
14. Do not give a participant anything to drink or eat or any medication unless authorised for epilepsy management as per plan

GOVERNING POLICIES

Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

SHERIDAN LAWTON

Health Facilitator RN

014 – SERIOUS INJURY MANAGEMENT PROCEDURE OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**014 –SERIOUS INJURY MANAGEMENT PROCEDURE**		
VERSION:	003	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	07/10/2021

PURPOSE

To ensure the provision of appropriate and immediate first aid to persons suffering serious injury in the workplace of ARC Disability Services.

SERIOUS INJURY MANAGEMENT

1. For the purposes of this procedure *serious injury* shall be defined as an injury or group of injuries for which a medical referral is required (i.e. the provision of simple first aid is not sufficient to treat the injury). This may include, but is not limited to, injuries such as:

   - Cuts requiring stitches
   - Significant grazes and abrasions
   - Potential broken bones
   - Potential sprains
   - Head trauma
   - Loss of consciousness
   - Signs of internal bleeding, i.e. extreme pain, loss of colour.
   - Ingestion of toxic substances
   - Injury to the eye or ear
   - Electrocution
   - A combination of more minor injuries

2. In the instance of a serious injury occurring the employee in charge should make an immediate judgement as to whether an ambulance is required. This judgement should not interfere with the immediate provision of assistance.

3. Should an ambulance be required the Queensland Ambulance Service should be contacted on their **Emergency Number: 000** and their directions followed. After contacting the ambulance contact one of the Coordinators or Managers immediately.

4. Should it be decided that the presence of an ambulance is not required a Manager / Coordinator should be contacted immediately and assistance should continue to be applied. It is important to continue monitoring the individual's comfort and health status until medical assistance has been sought.

5. The Coordinator or Manager should ensure that the number of support staff available to manage the situation is adequate, particularly in the instance of an employee being the individual that has been injured or where there have been a number of parties involved in the incident.

6. The Coordinator or Manager should contact the emergency contacts of the individuals concerned and inform them of the incident.

7. Incident reports should be completed as soon as possible and submitted to the office for documentation and recording and follow up by Manager / Coordinator.

8. In the event that a serious injury is sustained by a participant this is required to be reported to the NDIS Quality and Safeguards Commissioner.

GOVERNING POLICIES

Incident Report Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	015 – HYGIENE AND PERSONAL CARE NEEDS PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Health Facilitator	DATE REVIEWED:	25/05/2020

PURPOSE

To ensure the highest possible standards of hygiene practices and to provide guidelines for assisting a participant with personal care needs.

HYGIENE AND PERSONAL CARE NEEDS

1. Employees will have access to written information regarding personal hygiene, food handling and infectious disease.
2. Where applicable, appropriate training will be made available.
3. Employees who are required to attend to the personal care needs of the participants they work with, will be supplied with appropriate personal protective equipment and resources they need to meet the person's needs.
4. All employees are required to maintain high standards of their own personal hygiene in regards to hand washing and clean attire.

HYGIENE IN PERSONAL CARE TASKS

1. Employees will wear disposable gloves when assisting participants with any personal care or toileting needs or any other task, which may involve contact with bodily fluids.
2. Employees who may have open cuts or sores on their hands must have these covered with any appropriate band aid or dressing, and will wear disposable gloves at any time they are attending to the needs of any participant. The band aid must be changed at regular intervals as needed not to compromise any cross infection.
3. Personal care accidents will be immediately attended to and cleaned as appropriate with employee wearing appropriate personal protective equipment.
4. Soiled/wet linen and clothing shall be replaced and soaked or washed immediately if possible, or placed in a plastic bag for attention at an appropriate time.
5. Soiled/wet nappies/incontinence/sanitary aids will be disposed of in appropriate sanitary bin if available or tied in a plastic bag and disposed of as to the appropriate place dependent upon the situation or location and what is available.
6. Open cuts/wounds/sores on a participant will be treated immediately as recommended by the doctor pharmacist or parent as per written instructions. First Aid procedures will be followed if no written instructions are available.
7. A participant who has a highly contagious/infectious condition will not be proceeded with a service during the period in which they are contagious due to the risk of infection to other staff and participants. If support is already being provided or the participant is living independently/supported accommodation, then appropriate control of infection procedures will be put into place immediately to minimise risks to employees and other people. Refer to Infectious Disease and Health Management Policy.

ORAL HYGIENE TASKS

Employees may need to assist participants to maintain oral hygiene.

- Employees should always wash their hands and wear gloves when assisting individuals with oral hygiene and ensure that any deterioration of the mouth and teeth is reported.
- Teeth should be gently brushed twice a day or as appropriate for the participant.
- The brush should be held at 45-degree angle and all surfaces. Brush with short strokes, back and forth. The gums and tongue should also be brushed to remove debris. The toothbrush should be changed every 12-16 weeks.
- Participants living independently/supported accommodation to be assisted by employees to maintain a good oral hygiene program to include, dental check-ups, daily teeth cleaning and good dietary guidelines.
- Side effects of medication can affect the condition of the mouth, employees to be aware of any medications the individual may be taking in relation to this.

BATHING/SHOWERING/SPONGING TASKS

Employees may be required to assist participants with bathing/showering and sponge baths.

- Before assisting a person with their bath/shower, prepare the bathroom and any equipment required, removing any potential hazards.
- Employees must ensure the participants and their own safety within a wet area including the employee wearing flat, non-slip shoes in the bathroom and appropriate clothing.
- Employees should never leave a participant unattended in a bathroom if their safety may be at risk. Risk assessment may be required to determine risk.
- Employees must ensure safety with the use of any electrical equipment within the bathroom and that there is adequate lighting, risk assessment required for any electrical equipment in a bathroom.
- Employees to encourage the participant to assist with dressing, undressing, transferring and attending to their own personal care if they are able to do so.
- Employees to follow the bathing/showering/sponging procedures as per ARC's guidelines and competencies.

HAIR WASHING TASKS

Employees may need to provide assistance to participants to wash their hair. This is usually undertaken during the bathing or showering process.

- If necessary, place a dry face washer over the participants face to protect their eyes.
- Check the water temperature to ensure it is not too hot or cold before applying to the participant's head.
- Wet the individual's hair thoroughly and apply shampoo/conditioner and gently rub into a lather.
- Rinse the hair with water and gently dry with a towel and hair dryer if required. Ensure hair dryer is not on too hot or held to the head too long causing burning to scalp or head.
- Employees should never leave the participant unattended unless a risk assessment determines safe to do so.
- Employees to be aware of control of infection procedures and workplace health and safety issues.
- Employees must not assist a participant to wash their hair over a sink or basin due to workplace health and safety.

NAIL CARE

1. Employees **must not** cut a participant's nails, unless authorised to do so by a Coordinator/ Manager or health professional. Should authorisation be given nail scissors must be used, NOT nail clippers.
2. Only routine nail care is able to be provided this includes:
   - Cutting of finger nails if coordinator/manager/health professional approval given
   - Filing of nails
   - Application of nail polish
   - Removal of nail polish with non-acetone nail polish remover.
3. It is essential that a podiatrist supervises the delivery of toe nail care.
4. Nail clippers are not to be used by employees.
5. Any additional nail equipment, specialised polish/creams needs to be risk assessed.

DRESSING AND UNDRESSING

Employees may need to assist a participant with dressing and undressing.

- Employees must maintain a participant's privacy and dignity.
- Employees to ensure that participants have the opportunity to choose their own clothes where possible.
- Employees prior to commencing task to prepare clothing or footwear required.
- Participant's to be encouraged to assist where they are able.
- Participants to wear footwear as appropriate.
- Clothes are fastened, straightened and fitted correctly.
- Employees to avoid repetitive bending, minimise risks as far a possible when assisting participants.

GROOMING

Employees may be required to assist a participant with grooming tasks.

- Assisting participants to brush and comb their hair.
- Provide assistance with jewellery and choices regarding grooming as requested by participant.
- Employees to assist participants with shaving as required to face, under arms and legs if required. Risk assessment may be required.

- Employees to assist with the application of individual skin lotions, cosmetics, perfume and aftershave as required. Some skin lotions may need authorisation, check any documentation.

EAR CARE

Only the external part of the ear is to be dried, employees must not use anything to stick into a participant's ear to clean or dry it. Any other ear care to be authorised by appropriate person and documentation provided.

COMPETENCIES

Where necessary competency assessments will be undertaken with employees.

GOVERNING POLICIES

Customer Service Policy
Workplace Health and Safety Clothing and Manner of Dress Policy

AUTHORISATION

This Procedure is approved and issued by:

SHERIDAN LAWTON

Health Facilitator RN

016 – EVENT OF A DEATH PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**016 – EVENT OF A DEATH PROCEDURE**		
VERSION:	003	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	10/07/2021

PURPOSE

To clarify the obligations of staff in the event of discovering a Participant in our care whom an employee believes may be dead. To provide staff with a structured way in which to assist families who experience the death of a child or close relative whilst in the care of their family. To ensure the organisation is meeting the requirements under the Coroners Act (2003) and the NDIS Quality and Safeguards Framework

IN THE EVENT OF A DEATH

ARC Disability Services Inc. (ARC) aims to ensure that the death of a participant is responded to with dignity and promptness, and that all services have a coordinated response to minimise the distress that may impact upon family members, employees and other participants.

IMMEDIATE PROCEDURES

1. In the event of a staff member suspecting the death of a Participant within the care of ARC, the employee will immediately call emergency services on 000, request the services of both the Police and Ambulance, and follow any advice or instructions given.

2. The employee should check for potential risks to themselves and others around them before undertaking any additional actions.

3. Immediately after Emergency Services has been contacted, the employee will contact the service coordinator who will contact the CEO or General Manager immediately. If they are uncontactable continue to call other ARC coordinators.

4. The CEO, Manager, or Coordinator will arrive at the scene as soon as possible and notify the Participant's parents, guardian, carer or family as soon as possible. **Careful consideration must be given when talking with parent, guardian, carer, or family. Do not inform them over the telephone of the suspected death.** The parents/carer should be informed that an accident has occurred and that they should come to the scene as soon as possible. In the event of the person being transferred to the hospital, the parent/carer should be given the hospital name and advised to go to the hospital as soon as possible. The CEO, Manager or Coordinator should organise to meet the parent/carer at the hospital.

5. Upon arrival at the scene, staff members are to follow the instructions of the Emergency Services Officers.

6. When a death has been confirmed and the police have arrived, staff should be aware that a Coroners inquiry may be required and they should not interfere with the body or the scene of death.

7. The needs of other Participants must not be neglected and arrangements must be made to call in other workers if required.

8. The most senior employee on duty will be present when police arrive to assist them with their inquiries. If the police wish to interview other Participants, the person must be supported by a carer/parent /guardian, and if desired or necessary, legal representation.

9. As required, the General Manager or Coordinator is responsible for contacting the Guardianship Tribunal and relevant funding bodies notifying of the Participants death. This must include the NDIS Quality and Safeguards Commission.

10. As soon as possible, the employee who discovered the deceased will follow Incident and Reporting guidelines and fill out an incident report. This report is to remain confidential between the CEO, Manager, Service Coordinator, staff members on duty, carer/parents and the appropriate authorities.

11. The CEO will notify the Department of Communities, Child Safety & Disability Services as per the department's incident reporting procedure if required. They will also be required to notify the NDIS Quality and Safeguards Commissioner if not already contacted, this must occur within 24 hours.

FOLLOW UP PROCEDURE

1. The CEO or General Manager is to ensure that support and assistance is provided to the family/parents of the Participant. Be aware that people can respond in unique ways, that there may be cultural influences and personal past experiences which impact upon the ways in which people receive devastating news. The appropriate professional support may need to be offered to other Participants.

2. It is important to ascertain who should be notified to help support the family, ask family members if they would like a religious elder notified or a social worker from the hospital. Staff may also consult with or refer family members to the following: Community Health Intake Officer who may make a referral to a more appropriate service, such as Lifeline, Centacare or the Social worker at either the Hospital or Centre link.

3. In some cases, the carer/parent may experience difficulty in making funeral arrangements, support and assistance is to be offered with these arrangements. In cases where the family cannot meet the costs of a funeral, they are to be assisted in a referral to the local courthouse (Magistrates Court) where a clerk of the court will ask them to complete an application form, which is means tested, to receive assistance. This form is forwarded to the Attorney General's office who contacts a local contractor that provides assistance with burials and cremations. This contractor will contact the family.

4. Employees who wish to attend the Funeral Service should make arrangements for this with the General Manager or Coordinator. General Managers are responsible for arranging relief where necessary to accommodate staff attending the Funeral Service.

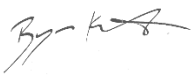
5. The General Managers are to offer and facilitate the debriefing of staff and other Participants. Further assistance is available from the Employee Assistance Program.

GOVERNING POLICIES

Incident Policy
Stress Management Policy

AUTHORISATION

This Procedure is approved and issued by:



BENJAMIN KEAST

Chief Executive Officer

017 – GENERAL EMERGENCY MANAGEMENT PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**017 – GENERAL EMERGENCY MANAGEMENT PROCEDURE**		
VERSION:	003	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	06/09/2021

PURPOSE

Provide direction to all ARC employees of what to do in an emergency.

Emergency Management

1. In the event of any emergency, it is of the utmost importance that the health and safety of all participants and employees be seen as the first priority. The preservation of property, whilst important, should always be seen as secondary to this.

2. Employees should ensure that all participants are removed from any immediate or impending danger as quickly as is practical.

3. Actions should be taken to minimise the impact of any injury, accident or event. (e.g.: contain spills, remove other participants from the vicinity of aggressive behaviour etc.).

4. Once all participants and employees are removed from any immediate danger the need to contact the appropriate emergency service should be assessed.

5. If an injury has occurred and a delegated First Aid Officer is available, they should assess the injury. If the injury is within their level of training and competence, they should apply first aid. If the First Aid Officer is not available, or the injury is beyond their level of training and competence, then a medical professional should be contacted.

6. Should the presence of an emergency service be deemed appropriate, action should be taken to contact them on **000 (this number applies to POLICE, AMBULANCE and the FIRE BRIGADE).**

7. The office should be contacted as soon as is practical. The situation should be clearly explained and all relevant details supplied, including but not limited to:
   - How the situation occurred
   - The people involved
   - Injuries sustained
   - The potential for further injury or recurrence of the original incident
   - Any impending issues such as medication due to be taken, lack of staff due to incapacitation of staff or changes in participant's behaviour
   - Action you have taken to this point and actions you may intend to undertake.

If the emergency takes place out of hours, please contact a Manager/Coordinator as soon as possible via the After Hours Emergency contact list provided to each staff member. If you cannot get onto the coordinator continue to call other Coordinators.

8. Upon resolution of the situation incident reports should be completed and provided to the office for documentation recording and any follow up as reasonably possible. This will be required within 24 hours.

9. Any employee or Participant that requires a debrief post emergency will be able to talk to a member of the coordination/management team. The Employee Assistance Program will also be available.

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	018 – TEMPERATURE CONTROL PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Health Facilitator	DATE REVIEWED:	25/05/2020

PURPOSE

To ensure the safety and wellbeing of participants and provide a structured way for employees to deal with a high or low temperature.

TEMPERATURE CONTROL

It should be noted that "normal" body temperature varies from person to person. The effects of a "high temperature" or "low temperature" can have a serious impact on the wellbeing of a person and therefore intervention should be made as per the below procedure in all situations where a high or low temperature is suspected or apparent, unless otherwise detailed in the participant's information.

If you are concerned that someone may have a high or low temperature then access to a thermometer needs to be sought immediately. If it is an ARC location then contactless thermometers should be available on site. If not an ARC location then alternative option will need to be sourced. Options could include:

- Returning participant home to parent/carer/guardian immediately
- Accessing an ARC location where a thermometer is available

HIGH TEMPERATURE

Record the time and the participant's temperature, if the participant's temperature is elevated (usually 37.6 degrees Celsius or higher) then steps must be taken to assist the lowering of the participant's temperature, as per the following procedure:

1. Reduce the amount of clothing the participant is wearing, assist the person to take paracetamol as per the participants Personal Details Form and Medication Authorisation Form. Follow the dosage and instructions on the Authorisation and Packaging. Ensure that the participant is comfortable, maybe use a damp washer to wipe their face & neck.

2. Retake the participant's temperature 20-30 minutes after administering the paracetamol. Record the time and the participant's temperature for the second time.

3. If the participant's temperature has not begun to drop, then a tepid bath/sponge (pat dry do not rub with towel) may also assist. Should the person start to shiver stop the tepid bath/sponge immediately. Take the participants temperature 20-30 minutes after the tepid bath/sponge. Record the time and participant's temperature again.

4. If the participant's temperature has not begun to reduce after taking the above steps, then you must contact a Coordinator/Manager or health professional.

5. Follow the instructions from the Coordinator/Manager or health professional.

6. If you cannot contact a coordinator/manager or if the participant's temperature remains elevated for an extended period of time seek medical advice immediately.

LOW TEMPERATURE

If the participant's temperature is below 35 degrees Celsius then steps must be taken to raise the participant's temperature, as per the following procedure:

1. Increase the amount of clothing the participant is wearing, ensuring that they are not wearing any wet clothing.
2. Move them to a warmer space i.e. inside out of the wind or into direct sun. Warm blankets could also be used at this stage.
3. Offer the participant a warm drink, avoiding alcohol or caffeine as this speeds up heat loss.
4. Take the participants temperature 20-30 minutes after trying options. Record the time and the participant's temperature for the second time.
5. If the participant's temperature has not begun to rise, then a warm bath/sponge (pat dry do not rub with towel) may also assist. Should the person start to shiver or be burnt stop the warm bath/sponge immediately. Take the participants temperature 20-30 minutes after the warm bath/sponge. Record the time and participant's temperature again.
6. If the participant's temperature has not begun to rise after taking the above steps, then you must contact a Coordinator or Manger or seek advice from a health professional and let a coordinator/manager know.
7. Follow the instructions from the Coordinator/Manager or health professional.
8. If you cannot contact a coordinator/manager or if the participant's temperature remains low for an extended period of time, medical advice must be sought immediately.

GOVERNING POLICIES

Duty of Care, Dignity of Risk and The Least Restrictive Alternative Policy

AUTHORISATION

This Procedure is approved and issued by:

SHERIDAN LAWTON

Health Facilitator RN

PROCEDURE TITLE:	**019 – HAZARD IDENTIFICATION PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

The reporting of hazards, existing and potential is an obligation of all employees of ARC Disability Services Inc. (ARC). The accurate and timely reporting of hazards within the workplace will aid in the preservation of a safe and healthy workplace for all.

HAZARD IDENTIFICATION

Hazards may present themselves as an unsafe work practice, dangerous or faulty equipment, unhealthy or unsafe working conditions or any other work related issue.

Whilst the provision of a totally safe and healthy working environment is the objective of ARC, it is acknowledged that it may not always be possible to completely eliminate a potential risk from the workplace and that a risk management plan may need to implemented.

1. All hazards should be reported in a timely manner. This time frame should not exceed 24 hours and in cases where a serious hazard has been identified the relevant Service Coordinator/Manager should be contacted immediately and a risk assessment undertaken.

2. If it is safe to do so and in conjunction with the relevant Service Coordinator/Manager, the reporting party should take what immediate steps are available to remedy the hazard or reduce the risk of an incident occurring due to the hazard.

3. All identified risks shall be reported using the relevant online employee portal to complete a hazard report.

4. Once received the report should be reviewed by the Work Health & Safety Administrator/Officer and if relevant to a participant or service, should be forwarded to the relevant Service Coordinator/Manager for follow up.

5. The relevant Service Coordinator/Manger or Work Health & Safety Administrator/Officer shall review the report and consult with the reporting party and any other relevant parties within a maximum of five working days of receiving the report.

6. A thorough hazard evaluation and risk assessment will be undertaken by the Service Coordinator/Manager or Work Health & Safety Administrator/Officer and recorded on the Incident Management Register for a minimum period of one year following initial lodgement of the report.

7. Following the risk assessment hazards will be prioritised for intervention with the most significant risks being assigned the highest priority. The actions undertaken are to be recording within an action plan and reviewed by the relevant manager.

8. All Hazard Reports received will be tabled for follow up review by the Leadership team and the appropriateness of risk management processes evaluated.

GOVERNING POLICIES

Incident Policy
Workplace Health & Safety Audit Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	020 – IMPULSIVE/VIOLENT EPISODIC BEHAVIOUR PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	25/10/2017
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	27/05/2020

PURPOSE

To protect participants and employees from harm during an **impulsive / violent** episode in a structured way and to meet legislative requirements.

IMPULSIVE/VIOLENT EPISODIC BEHAVIOUR

1. Try to contain the situation using the strategies provided by the family/carer/primary service provider or guardian, as detailed in the personal detail form or relevant behaviour support plan if in place.

2. In the event of a violent episode other participants are to be moved to a safe place and supervised until the situation is resolved. Do not be concerned about the house furnishings etc. as the safety of participants and staff is of paramount importance.

3. If it is not possible to remove other participants from the vicinity, protective action should be taken. Protective action is action by one individual, which uses reasonable force to avoid injury or harm from another person. i.e. physically directing the person away from other participants if safe to do so.

4. Unless specified otherwise in the participant's personal details form the following approach should be followed:

a) Approach the person with a calm, confident and firm manner. Use non-confrontational strategies, especially interrupt and redirection, as this will change the focus for the person and help to diffuse the situation. This attitude should assist to calm the person, and help them to compose themselves. Be aware that this type of behaviour is usually episodic and is a means of expressing feelings of frustration, anger, fear or helplessness about a situation.

b) If the person continues to be aggressive then give the person space, do not make sudden movements. Remain silent for two minutes and then try a) again. Continue this cycle to try to contain the situation

c) If the person is carrying a weapon first, ask them to place it in a neutral area. If that is unsuccessful offer an exchange of items. Try interrupt and redirect again. If still unsuccessful quietly wait out the period till the person loses interest in the weapon.

d) Encourage the participant to sit quietly, then supervise from a distance or try to involve the participant in an activity, which they enjoy, i.e. watching a video etc.

5. Emergency use of containment, seclusion or restraint of the person should only be used as a last resort, and/or to ensure the safety of other participants or staff, as an immediate response based on obligations of duty of care. In the event that this occurs this must be reported to the NDIS Quality and Safeguards Commission.

6. Physical removal / restraint (i.e. using the minimal physical contact possible to assist the person to move to another location) of the person should only be used when all other reasonable solutions have been exhausted and /or to ensure the safety of the participant themselves, other participants and employees. In the event that this occurs this must be reported to the NDIS Quality and Safeguards Commission.

7. If none of the above strategies are working and it is believed that the situation is escalating to a point where there is concern for the safety of all persons present, then the police are to be contacted and all persons are to evacuate to a safe area.

8. Once the situation is contained i.e. all parties are safe; the relevant Manager, coordinator or CEO must be contacted.

9. A written incident report must be completed as soon as possible.

10. If the incident involved impulsive or violent behaviour by an adult a risk assessment will be undertaken by the Manager, Coordinator or CEO, and should it be deemed likely that use of restrictive practices may be required again, an interim behaviour support plan must be developed with an authorised practitioner in the period prior to a full plan being developed.

11. In situations where there are multiple impulsive/violent episodes involving participants please refer to the "Persistent Aggressive Behaviour Procedure"

GOVERNING POLICIES

Restrictive Practice Policy
Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

021 – PERSISTENT AGGRESSIVE BEHAVIOR PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**021 – PERSISTENT AGGRESSIVE BEHAVIOR PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Services Officer	**DATE REVIEWED:**	27/05/2020

PURPOSE

To provide employees with a process to follow in situations where a participant displays continuous or aggressive behaviour, ensuring the safety of all participants and staff and to meet legislative requirements.

PERSISTENT AGGRESSIVE BEHAVIOUR

1. Try to redirect the person using the strategies provided by the family/carer primary service provider or guardian, as detailed in the personal detail form or relevant behaviour support plan if in place.

2. Employees should assess the ramifications of the continued behaviour on the household, participants and employees. The CEO, relevant Manager, or Coordinator should be contacted if one or more of the following are deemed true by the employee on duty:
   - **a.** If other people and /or employees are continually at risk due to the persons' behaviour
   - **b.** If management of the person's behaviour requires so much attention by employees that the needs of the other participants cannot be met properly.
   - **c.** If attempts to redirect the person using the strategies provided by the family/carer**/**primary service provider or guardian, are consistently failing.
   - **d.** If the behaviour is escalating to a degree where the employees are unsure how to handle it effectively.

3. Emergency use of containment, seclusion or restraint of the person should only be used as a last resort, and/or to ensure the safety of other participants, employees or members of the public as an immediate response based on obligations of duty of care. In the event that a Restrictive Practice is used this must be reported to the NDIS Quality and Safeguards Commission.

4. The development of the behaviour and strategies used to manage the situation must be documented in detail in the participants file notes, as well as incident reports as necessary.

5. If it is apparent that support cannot be provided safely then arrangements will be made for the participant to return home if possible.

6. If the incident involved impulsive or violent behaviour, a risk assessment will be undertaken by the CEO, Manager or Coordinator, and should it be deemed likely that use of restrictive practices may be required again an interim behaviour support plan will need to be developed prior to a full positive behaviour support plan being developed.

7. Prior to further support being provided expert assistance will be sought from a Positive Behaviour Support Practitioner, to put in place an appropriate positive behaviour support plan.

8. The CEO and/or relevant Manager will ensure that future situations are monitored closely to ensure the effectiveness of the behaviour support plan and will seek further expert assistance as required.

GOVERNING POLICIES

Restrictive Practice Policy
Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	022 – EXIT PROCEDURE		
VERSION:	003	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	04/08/2020

PURPOSE

This procedure acknowledges and documents those circumstances when a Participant or Employee exit from or no longer have access to the service. It applies to all of the organisations service delivery programs.

EXIT PROCEDURE

In certain circumstances a person receiving a service from the organisation will stop receiving a service because it is no longer viable, appropriate or the individual no longer wishes to engage with ARC, this decision may be made individually by the Participant or in conjunction with the organisation. Typically, should either Party wish to terminate the Service Agreement without cause before the cease date, they must give 14 days' notice.

If either Party seriously breaches this Service Agreement, the Agreement can be terminated immediately for cause.

BREACH OF SERVICE AGREEMENT

A service Agreement may be terminated if:

- ARC or the Participant fails to do what is required of them under the Service Agreement,
- Communication has broken down between the Parties,
- Workplace health and safety considerations are ignored,
- The Participant or stakeholders fail to comply with ARC's policies and procedures,
- The Participant or Stakeholders fail to communicate and provide information pertaining to health and medication or changes to support needs.

"DISCHARGED" OR "INACTIVE" REGISTER

The organisation documents using ProSIMS all Participants and Employees who exit the service and reason for exiting. If required a report can be produced detailing people who have exited the organisation and reason for doing so.

RISK ASSOCIATED

ARC ensures that upon the exit of a Participant or Employee that any risks associated with the transition are identified, documented and responded to.

EXIT INTERVIEW

Where necessary, an exit interview with the relevant Manager or Coordinator will be offered to discuss the reasons for exiting the service. Employees at this time will be requested to return any items as appropriate to the organisation.

Information collected at individual exit interviews will be used to document the reasons for exiting and to identify any areas of service where improvements need to be made. The organisation will provide an opportunity for support, assistance or advocacy to the Participant or Employee in the exit process if required.

ADVICE/ALTERNATIVE SERVICES OPTIONS

Where appropriate, information and advice regarding any suitable, alternative, services will be offered to the Participant or Employee.

CONFIDENTIALITY OF EXIT INFORMATION

Information will only be disclosed on a "need to know" basis for service improvement, management of personnel practices and the work environment. Information collected will not be used in any way to reflect upon the exiting Participant or Employee.

RECORDS

All relevant records and information about the Participant or Employee will be archived as appropriate in accordance with the Information Management Policy.

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	**023 – EMERGENCY/ FIRE EVACUATION PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

To ensure the safety of employees, volunteers, community members and Participants in the event of a fire or other emergency.

EMERGENCY/FIRE EVACUATION

1. All employees are to familiarise themselves with this fire evacuation procedure and the fire evacuation plans displayed in each ARC building; or familiarise themselves within the location in which they are working.
2. Ensure the immediate safety of anyone within the vicinity of the fire.
3. Close the door to the area where the fire is, if possible.
4. Call the fire service by dialling Tel**: 000**.
   Give clear directions to the location.
5. Attack the fire if safe to do so. Firefighting equipment can be located as per the fire exit plan with in the buildings.
6. Evacuate the building as per the fire evacuation plan displayed in each ARC building.
   To evacuate the building get people out by any means possible. Assess the group of people and where possible utilise the abilities of any person to assist with the evacuation of those people who may require assistance. For those people who use a wheelchair but circumstances dictate that that may not be a feasible possibility quickly use any means possible, i.e. use a quilt on the floor to drag the person to safety etc.
7. All persons should congregate as per the fire evacuation plan for each particular location.
8. Remain at the assembly area until the emergency services arrive. Ensure everyone is accounted for.
9. The CEO, or member of the Management Team should be informed as soon as possible.
10. The CEO, Manager or Coordinators will arrange for the families of all necessary persons to be contacted (i.e. family members of all guests and contact persons of employees).
11. Incident reports should be completed as soon as possible by each individual employee who was on duty.

Practice evacuations will be undertaken periodically throughout the organisation. Team members are to respond to the practice evacuations as if there were real.

GOVERNING POLICIES

Fire Policy
Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	024 – IDENTIFYING RESTRICTIVE PRACTICE PROCEDURE		
VERSION:	001	DATE EFFECTIVE:	09/06/2020
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	09/06/2020

PURPOSE

To outline the process around how to identify and respond to unauthorised restrictive practices.

IDENTIFICATION

WHAT IS A RESTRICTIVE PRACTICE?

A restrictive practice is a practice that is classified as any intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person from harm.
Regulated restrictive practices are:

- Seclusion
- Chemical Restraint
- Mechanical Restraint
- Physical Restraint
- Environmental Restraint

METHODS OF IDENTIFICATION

In the event that a potential restrictive practice is identified it is important that It is actioned and followed up on with immediacy.
A restrictive practice may be identified in many different ways:

- Through an Incident Occurring/Emergency Use
- A new participant commencing services
- A complex behaviour emerging
- Positive Behaviour Support Plan (PBSP)
- Employee/ Stakeholder Identifying restrictive practice

When a potential restrictive practice is brought to the attention of a service Coordinator it is important that this is notified to the Chief Services Officer (CSO) immediately for evaluation.

IDENTIFICATION THROUGH EMERGENCY USE

In the event that a participant requires the emergency, unauthorised use of a regulated restrictive practice this must be reported to the NDIS Quality and Safeguards Commission. As part of this report ARC is required to ascertain whether it was a one-off emergency that is unlikely to recur. If it is deemed that it is likely to recur, then ARC will support the participant to engage with a positive behaviour support practitioner to assist in supporting the complex behaviours. This process will involve contacting stakeholders, Support Coordinators and other members of their support network. ARC will then support the Positive Behaviour Support Practitioner to gather the data needed to put together the participants PBSP.

IDENTIFICATION THROUGH A PARTICIPANT COMMENCING SERVICES

Upon a participant commencing services with ARC the Coordinator will be responsible for completing personal detail forms, as part of this, they will complete a Participant Individual Risk Assessment which will highlight any potential restrictive practices which could be part of their current routine and care plan. Once completing this form with the participant and their stakeholders, if it is deemed that any potential restrictive practices are present the Coordinator will seek clarification from the CSO. In the event that the CSO deems it restrictive then the participant will be encouraged to engage with a Positive Behaviour Support Practitioner to assist in creating strategies to assist with the complex behaviour.

COMPLEX BEHAVIOUR OBSERVED

If a participant who currently receives support from ARC begins to exhibit complex behaviours, a review of that participant's individual risk assessment may be required. In the event that the participant requires support around a behaviour of concern, then a positive behaviour support practitioner may be engaged.

AUTHORISATION PROCESS

After a potential restrictive practice is identified it is important that it is treated with immediacy. If the practice is currently being used, then this must be reported to the NDIS Quality and Safeguards Commission within 5 days as per ARC's Incident Policy. The participants key stakeholders will be notified of the incident and a risk assessment will be completed by the CSO as to whether a PBSP should be engaged. Further Information can be found in ARC's restrictive practice policy.

GOVERNING POLICIES

Restrictive Practice Policy
Incident Policy

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

025 – BUILDING SECURITY & BUILDING MAINTENANCE PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**025 – BUILDING SECURITY & BUILDING MAINTENANCE PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

All buildings under the control of ARC Disability Services Inc. shall have doors and windows that are able to be secured by easy to use locking systems. Where there is risk of entry by unauthorised persons, security screens shall be fitted to windows and doors specifications of which shall also conform to fire evacuation specifications.

BUILDING SECURITY & MAINTENANCE

UNOCCUPIED BUILDINGS

Where a building is to be left unoccupied the building shall be made secure by the last person leaving the building. At the end of a work day Employees shall check the security of all windows and doors prior to leaving the work area. The last Employee leaving is responsible for securing the building. Where a building cannot be secured the person responsible for securing the building shall contact the CEO and seek assistance or direction on how to secure the building. The building shall not be left unsecured.

NOTE: The ARC Office at 92 little street and 90/5 Aumuller Street are alarmed and monitored by FNSS Security. They have a key to the buildings and will call the CEO if there is a disturbance during the night. Any employees accessing the building outside of regular office hours are to contact FNSS security and let them know they are in the building and how long they will be in for. FNSS afterhours number is 4041 0375.

OCCUPIED BUILDINGS

Where a building is occupied and participants are in residence all external doors which lead to unsecured areas are to be locked or latched to impede the entry of undesired persons.

BOUNDARIES

All external areas to buildings for access to participants shall have secure boundaries so as to allow the free use of the area by the participants.

(a) **Fences**
Fences to contain external areas shall be specified so as to impede undesirable persons entering the area.

(b) **Gates**
Gates for entry and exit to external areas shall be secured by locks or child proof latches so as to allow easy exit in times of emergency.

MAINTENANCE

All Buildings shall be maintained to a standard where safety is not compromised and the value of the asset is protected. The CEO shall ensure an annual maintenance program is functioning and an annual maintenance budget will be prepared by the CFO for submission to the Board of Management. The CFO shall ensure day to day maintenance is attended to, so as to protect the buildings and to ensure that Employee amenities are maintained to specification.

GOVERNING POLICIES

Duty of Care, Dignity of Risk and the Least Restrictive Alternative Policy
Building Security and Access Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

026 – OPERATION OF WHEELCHAIR LIFT (VAN) PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	026 – OPERATION OF WHEELCHAIR LIFT (VAN) PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	27/05/2020

PURPOSE

To ensure that the wheelchair lift in the bus is always used correctly and safely, and only by approved staff who are following this procedure.

OPERATIONS OF A WHEELCHAIR LIFT

PROCEDURE FOR LOADING PASSENGERS

1. Open rear door.
2. Stand well clear of area surrounding the ramp, and ensure that the person in the wheelchair and all other persons are also well clear but in a safe waiting position.
3. Using the hand control, located to the left of the ramp, fold out the ramp. (may have a release button)
4. Using the hand control lower the ramp fully.
5. Assist the person in the wheelchair onto the ramp, facing towards the front of the vehicle. Ensure that the wheelchair is positioned centrally, but well back towards the yellow plate.
6. Ensure that electric wheelchairs are turned off and that brakes are on (all chairs). Ensure that the person's feet are on their footplates and that their toes will not hit the overhanging plate.
7. Using the hand control whilst also holding one handle of the person's wheelchair, raise up the ramp fully.
8. Assist the person into the van. Ensure that the wheelchair is centrally located between the anchorage points and straps located on the floor.
9. Put on the brakes, ensuring that the wheelchair does not move.
10. Find a secure place on the frame of the wheelchair and attach hooks securely. Some wheelchairs have specific hooks for this purpose. Tighten straps by appropriate method.
11. Attach lap belt, over shoulder belt and tighten, also ensure that the person's own lap belt is secure. The loops should be on the frame for wheelchair anchorage
12. Ask the person if they feel safe and secure. If they do not, then try to ascertain the reason for the person not feeling secure and recheck all straps. Ensure that the person is comfortable.
13. Using the hand control, fold the ramp and ensure that the rear door has been closed securely before driving off.
14. Whilst driving the bus and carrying a passenger who is in their wheelchair, always drive slowly and with care, attention and caution.

PROCEDURE FOR UNLOADING PASSENGERS

1. Open rear door.
2. Stand well clear of area surrounding the ramp and ensure all other persons are also well clear.
3. Using the hand control, located to the left of the ramp, fold out the ramp. (may have release button)
4. Assist the person in the wheelchair onto the ramp, facing towards the front of the vehicle. Ensure that the wheelchair is positioned centrally, but well back towards the yellow plate.
5. Ensure that the electric wheelchairs are turned off and that the brakes are on, (all chairs). Ensure that the person's toes are on their footplates and that their toes will not hit the overhanging plate. Using the hand control whilst also holding one handle of the person's wheelchair, lower the ramp fully.
6. Assist the person off the ramp into a safe position if waiting.
7. Standing well clear of the area surrounding the ramp, use the hand control to raise up the ramp fully. Fold in the ramp and close the door securely.

PROCEDURE FOR MANUAL OPERATION OF THE WHEELCHAIR LIFT

1. Locate the manual crank bar and the emergency release button on the hoist. The crank is positioned on the side of the lift where the hand control is and is clipped to the upright bar of the lift.
2. Dependent upon the needs of the situation, the lift can be operated manually in the following ways:
   To raise & lower the lift
   Insert the crank bar into the round hole at the back of the control box.
   Crank the handle up and down until the lift is level with the floor of the bus.
   Remove the crank bar before assisting a passenger onto the ramp.
   To fold in the lift
   Reinsert the crank bar into the lever and pump until the ramp has been fully folded in.

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	028 – WORKPLACE REHABILITATION PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	10/03/2020

PURPOSE

The aim of ARC Disability Services Inc. procedure is to ensure: -

- That a culture of acceptance for workplace rehabilitation exists;
- We have a process to support an early safe return of any employee who has an injury/illness;
- The position of the rehabilitation and return to work coordinator is adequately resourced; and
- Adequate storage is provided for rehabilitation files to maintain confidentiality of this information.

DEFINITIONS

Rehabilitation

Rehabilitation of an employee is a process designed to ensure the employee's earliest possible return to work or to maximize the employee's independent functioning. Rehabilitation involves the provision of approved services, services provided by a registered person, suitable duties programs or necessary and reasonable aids or equipment to an injured employee. All Queensland employers must take all reasonable steps to assist or provide their injured employees with rehabilitation for the period for which the employee is entitled to compensation.

Standard for Rehabilitation

The rehabilitation provided to our employees will meet the standard outlined in the Workers' Compensation and Rehabilitation Regulation 2003.

Rehabilitation and Return to Work Coordinator (RRTWC)

The RRTWC is a person who has satisfactorily completed an accredited workplace rehabilitation course. The RRTWC is the link between the injured employee, treating doctor, management, supervisors, WorkCover Queensland, rehabilitation providers and any other relevant parties.

Suitable Duties Programs

These specially selected duties at the workplace are a means of providing a monitored and graduated return to normal duties. They are:

- Matched to the capabilities of the employee;
- Time limited and regularly upgraded according to his/her level of recovery and treating medical doctor advice.

The following issues must be considered when choosing suitable duties:

- The employee's pre-injury duties, age, education, skills and work experience and nature of the incapacity;
- And restrictions and limitations specified by the treating doctor, who must also document approval for all plans and amendments; and
- The duties must be meaningful and have regard for the objectives of the employee's rehabilitation
- The duties will be reviewed on a regular basis and the program progressively upgraded, consistent with the employee's recovery.

A copy of each employee's suitable duties program will be provided to the insurer.

Suitable Duties Programs may be:

⇨ **Fully funded** by WorkCover Queensland. WorkCover Queensland continues to pay ongoing compensation to the employee at the rate they would receive if totally incapacitated; OR

⇨ **Partially funded** by both the employer and WorkCover Queensland. Employer pays the employee at the normal rate for work performed and WorkCover Queensland pays a top up amount.

ROLES

The Role of the Injured Employee
Responsibilities:

- To apply for employees' compensation
- To advise their doctor of the availability of workplace rehabilitation
- To ask their doctor to complete the Work Capabilities Checklist (if required)
- To actively participate in workplace rehabilitation
- To maintain communication with the employer/rehabilitation and return to work coordinator about relevant issues related to their compensation claim.

Rights:

- To employees' compensation for work-related injuries accepted by the insurer
- To choose their own doctor
- To authorise out rehabilitation and return to work coordinator to contact their doctor for advice on suitable duties
- To confidential, safe keeping of this personal information
- To be provided with suitable duties, if practicable
- To be consulted in the development of a suitable duties plan
- To union representation if so desired
- To ask for a Q-COMP review of certain insurer's decisions with which they do not agree (Act s540)
- To have access to an impartial grievance mechanism, which is accessed in the first instance by raising the grievance with the rehabilitation and return to work coordinator for resolution or escalation.

The Role of the Rehabilitation and Return to Work Coordinator (RRTWC)

To ensure an efficient system exists for immediate reporting of injuries to enable early employee contact regarding rehabilitation, to comply with employer's duty to report injury to the insurer and to ensure confidentiality of information received.

To develop, coordinate and monitor workplace rehabilitation strategies for injured employees, including developing suitable duties plans in consultation with injured employees undertaking rehabilitation.

- To educate all employees about the workplace rehabilitation policy and procedures and what to expect when an injury occurs. To educate Managers, Coordinators and employees regarding their role and responsibilities for rehabilitation. To ensure education is part of the new staff induction process.

- Where possible and on behalf of the employer, to ensure rehabilitation for a employee is coordinated with an understood by Managers, Coordinators and co-employees.

- To promote ARC's workplace rehabilitation program internally to maintain staff's commitment, and externally, to local doctors so as to build a good working relationship and gain their trust and assistance.

- To keep a file for each employee undertaking rehabilitation and to ensure confidentiality of both verbal and written information.

- To keep accurate and objective file notes of all communications, actions and decisions, and reasons for actions and decisions and to sign and date each notation.

- To ensure currency of the workplace rehabilitation policy and procedures and their own rehabilitation and return to work coordinator accreditation.

- To provide injured employees with the opportunity to give feedback on the rehabilitation system and to document this feedback.

The Role of Managers and Coordinators

- To actively assist the rehabilitation and return to work coordinator in identifying and coordinating suitable duties.
- To adjust workplace procedures and rosters to enable successful implementation of the suitable duties plan.
- To monitor the injured employee's progression in relation to suitable duties.
- To generally offer support and encouragement to any injured employee.

The Role of Co-Employees

- to generally offer support and encouragement to injured employees

PAYMENT OF WAGES

WorkCover Queensland will determine the liability of a claim, i.e. accept or reject application

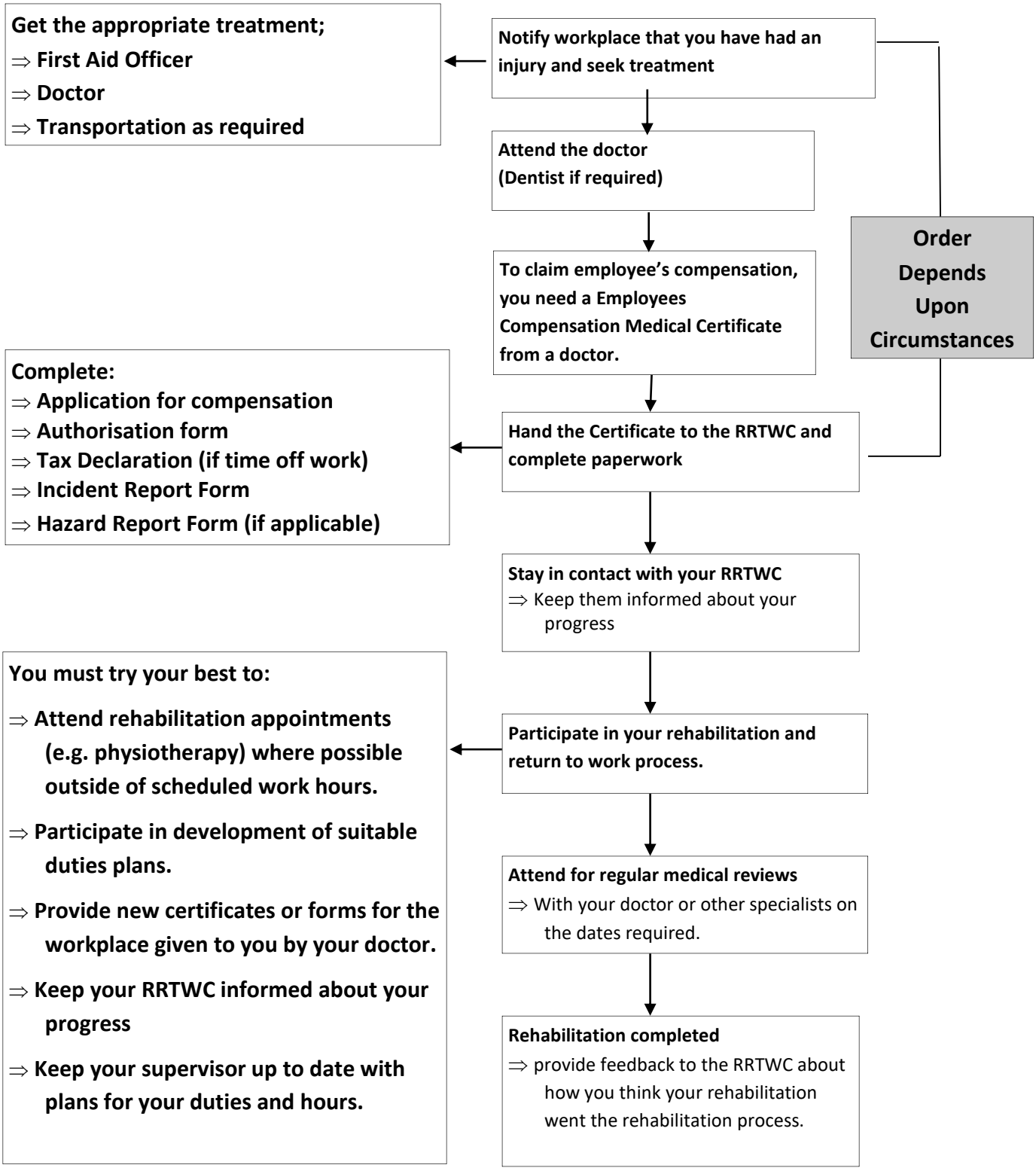
ARC Disability Services Inc. may pay sick or other accrued leave to an employee while the claim is being determined. Upon acceptance of a claim, leave will be reimbursed. If the claim is accepted, WorkCover Queensland will pay weekly benefits to employees directly or ARC may choose to pay employee directly and seek reimbursement form WorkCover Queensland.

For employees participating in a **partially funded** suitable duties program, ARC will pay the employee at the normal rate for work performed and WorkCover Queensland pays a top up amount. ARC will obtain a partial incapacity form from the WorkCover Queensland case manager and advise of the gross amount paid to the employee at the end of each pay period. WorkCover Queensland will then process a top up payment directly to the employee.

GRIEVANCE PROCEDURE

If an injured employee is unhappy with a decision made at the workplace regarding their rehabilitation, they can raise the matter with the RRTWC. If the matter is unresolved they can request the manager review the decision. If they remain unhappy with the decision following internal review they may request that the WorkCover Queensland case manager becomes involved to resolve the dispute.

If either an injured employee or the employer is unhappy with a decision made by WorkCover Queensland, the decision may be reviewable with Safe Work Australia. Strict time frames apply.


Notify workplace that you have had an injury and seek treatment
Get the appropriate treatment;
⇒ First Aid Officer
⇒ Doctor
⇒ Transportation as required
Attend the doctor
(Dentist if required)
To claim employee's compensation, you need a Employees Compensation Medical Certificate from a doctor.
Order Depends Upon Circumstances
Hand the Certificate to the RRTWC and complete paperwork
Complete:
⇒ Application for compensation
⇒ Authorisation form
⇒ Tax Declaration (if time off work)
⇒ Incident Report Form
⇒ Hazard Report Form (if applicable)
Stay in contact with your RRTWC
⇒ Keep them informed about your progress
You must try your best to:
⇒ Attend rehabilitation appointments (e.g. physiotherapy) where possible outside of scheduled work hours.
⇒ Participate in development of suitable duties plans.
⇒ Provide new certificates or forms for the workplace given to you by your doctor.
⇒ Keep your RRTWC informed about your progress
⇒ Keep your supervisor up to date with plans for your duties and hours.
Participate in your rehabilitation and return to work process.
Attend for regular medical reviews
⇒ With your doctor or other specialists on the dates required.
Rehabilitation completed
⇒ provide feedback to the RRTWC about how you think your rehabilitation went the rehabilitation process.

GOVERNING POLICIES

Workplace Rehabilitation Policy

AUTHORISATION

This Procedure is approved and issued by:

Sarah Dart

HR Manager

PROCEDURE TITLE:	**030 – CYCLONE PROCEDURE**		
VERSION:	003	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	08/09/2021

PURPOSE

To ensure that in the event of a cyclone directly threatening the Cairns area, that all employees and Participants are aware of the action required and the plans which the organisation has in place.

PROCEDURE

CYCLONE WATCH – ALL SERVICES

When a cyclone watch is issued for the Cairns Region, Management and Coordination staff will ensure that:

- The cyclone kits have been checked and restocked with sufficient batteries, candles, tape and plastic bags.
- Staff lists (after hours' numbers) are up to date and printed off
- Participant/carer lists are up to date and printed off with any contact details
- All motor vehicles are filled with fuel
- All phones are charged
- Outside areas are free from rubbish
- Outside furniture is stowed away if possible, or if not, tied down appropriately.
- Families identified as needing extra assistance to prepare for a cyclone are contacted to ascertain what additional assistance will be required and provide advice and direction to the family accordingly.
- Employees are contacted to ascertain availability to continue working in essential services should the cyclone threat increase.

CYCLONE WARNING – ALL SERVICES

When a cyclone warning is declared for the Cairns Region, Management and Coordination staff will contact all ARC locations to ensure that preparation is being progressed in line with this procedure. The CEO and Managers will ensure to keep updated as to the latest developments by accessing the Bureau of Meteorology and Disaster Coordination Centre websites. Recommendations made by emergency services and local council personnel will be followed in making any on the spot decisions required.

If a warning with sirens is activated or if it becomes apparent that the cyclone is likely to hit in a short timeframe all non-essential personnel will be advised to return home and continue their personal preparations.

The Management and Coordination Team will:

- Contact all employees to let them know that all non-essential services will be suspended until further notice.
- Ensure ARC locations which are being closed or evacuated secured and locked.
- All motor vehicles are located high enough to avoid flood damage if possible or undercover to avoid tree damage if possible.

HOLIDAY HOUSE

Cyclone Warning

1. When a cyclone warning is issued the Parents/Carers of those guests in our care and impending guests will be contacted.

2. The Parents/Carers will be informed that in the event of a cyclone warning with sirens being issued, or if it becomes apparent that the Cairns area is at risk within a short period of time, that they will need to make arrangements for the Participant to return home.

3. Unless it is deemed necessary to immediately evacuate the house due to safety concerns for both employees and guests, carers will be given the option to collect the guest straightaway or to wait and see if the cyclone develops further.

Cyclone Warning / Siren Stage or advice that the cyclone is likely to hit in a short timeframe

1. Parents / Carers will be contacted and asked to make arrangements for the Participant to return home.

2. Belongings will be packed as per usual procedure.

3. Guests will be sent home as soon as practicably possible. Every attempt will be made by the Manager or Coordinator to place guests who are unable to return home with an alternate family member or appropriate person.

4. Those guests unable to leave the holiday house will remain at the house with an employee of ARC

5. The house will be secured as per procedures recommended by the Bureau of Meteorology.

6. Particular attention may need to be paid to documents / files which may need to be placed in boxes and plastic bags and then stored in a safe place.

7. Non-essential employees will return home, once the house is secured.

8. Any employees remaining on duty will shelter in the hall area between the house and the flat, with any guests who have not returned home, unless it is recommended otherwise.

9. Usual Cyclone Procedures will be followed in accordance with information provided by the bureau of meteorology and state emergency services as per warnings issued regularly on television and via radio.

INDIVIUDAL AND GROUP SUPPORTS

Cyclone Warning

1. The Management and Coordination team will confer regarding current and impending supports. An assessment will be made as to the impending threat and intensity posed by the current cyclone and based on this assessment a decision will be made regarding the timeframe to implement the following steps. Advice provided by Emergency Services and the Bureau of Meteorology will be followed at all times.

2. When a cyclone warning is issued the Parents/Carers of the Participants in our care and Participants due to be provided with support will be contacted.

3. The Parents/Carers will be informed that in the event of a cyclone warning with sirens being issued, or if it becomes apparent that the Cairns area is at risk within a short period of time, that support will be cancelled. The Parents/Carers of Participants will be required to meet them at their support, or the Participant will be assisted to return home. Parents/Carers will have the option of ending support immediately if they so wish. In this instance ARC's Cancellation Policy will be void.

4. Employees will be contacted and informed that supports are being cancelled as a precautionary measure.

Cyclone Warning / Siren Stage or on advise that the cyclone is likely to hit in a short timeframe

5. Parents/Carers and employees will be contacted and informed that supports are cancelled and arrangements will need to be made for returning Participants home.

6. Usual Cyclone Procedures will be followed in accordance with information provided by the bureau of meteorology and state emergency services as per warnings issued regularly on television and via radio.

7. ARC facilities which are being closed or evacuated will be secured.

8. Parents/carers will be informed that service will be suspended until further notice as a precaution.

SUPPORTED INDEPENDENT LIVING

ARC Supported Independent Living arrangements have “cyclone kits”. These kits are reviewed annually in September/October to ensure they remain current for the impending cyclone season.

Cyclone Warning

1. The Management and Coordination team will confer regarding the situation. An assessment will be made as to the impending threat and intensity posed by the current cyclone, and based on this assessment a decision will be made regarding the timeframe to implement the following steps. Advice provided by Emergency Services and the Bureau of Meteorology will be followed at all times.

2. When a cyclone warning is issued the Participants and employees at each of the Supported Independent Living houses will be contacted and informed that a cyclone warning is current.

3. Each house will follow its own pre-planned procedure in the event of a cyclone. Each Participant’s family/guardian or advocate will be contacted to check that they still wish to follow the pre organized plan and the employees on shift will prepare accordingly. Part of this will be ensuring the iPad is charged

Cyclone Warning / Siren Stage or on advise that the cyclone is likely to hit in a short timeframe

4. Each house will be secured as per procedures recommended by the Bureau of Meteorology.

5. Particular attention may need to be paid to documents / files which may need to be placed in boxes and plastic bags and then stored in a safe place.

6. Non-essential employees will return home, once the house is secured.

7. Any employees remaining on duty will shelter in a safe place with Participants as per direction for each particular house.

8. Usual Cyclone Procedures will be followed in accordance with information provided by the bureau of meteorology and state emergency services as per warnings issued regularly on television and via radio.

POST CYCLONE – ALL SERVICES

When the cyclone threat has passed the CEO and Managers will make contact with each other and assess the next steps required.

Safety will be of the utmost importance and the advice of Emergency Services and the Disaster Coordination Centre will be taken into account in all decision making

Employees will be contacted with information about recommencing supports and services.

Any damage to ARC facilities will be assessed and if necessary the insurance company will be contacted to assess the damage.

PROCEDURE REVIEW

At the end of each cyclone season in May this procedure will be reviewed along with the individual plans for each of the Supported Independent Living houses in order to identify improvements which may be required. Each houses SIL Coordinator will be responsible for the individual review for that service. An allocated member of the corporate team will be responsible for reviewing this procedure.

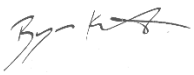
Any necessary alterations will be made and communicated to all relevant employees.

GOVERNING POLICIES

Crisis Management Policy

AUTHORISATION

This Procedure is approved and issued by:



BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	031 – INDUCTION PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	HR Manager	DATE REVIEWED:	26/05/2020

PURPOSE

ARC is committed to the importance of an induction program, providing all employees with a positive welcome to their employment with the organisation. It will ensure that all new employees undertake a structured and comprehensive induction that will enable them to provide a safe and quality service to ARC's Participants.

INDIVIDUALS RESPONSIBILITIES

- The individual employee is responsible for attending the organisations induction program.
- The individual employee is responsible for carrying out tasks and duties in the manner described at the induction program, acting safely and competently at all times.
- Where an individual does not feel that they are yet competent to carry out their role safely and competently they should inform their supervisor as soon as possible.

ARC'S RESPONSIBILITIES

1. To familiarise employees with the organisation and assist them settling into their position.
2. To minimize turnover amongst new employees.
3. To build upon the positive aspects of the recruitment process.
4. To undertake basic training and information on aspects of the organisation and participant information to assist in being able to commence work.
5. To reduce anxiety experienced by a new employee in order that they:
   - Understand the standards, vision, policies and procedures of the organisation.
   - Establish effective working relationships with the organisation.
   - Begin to perform their new role.

The induction process takes place prior to the person starting work except in exceptional circumstances. This includes information and appointment letter.

The induction process takes place over one full day prior to the person starting their employment with ARC.

Having been given an offer of employment potential employees will be notified of the next available induction date which includes:

- Completion and copying of all relevant paperwork.
- Relevant training and information required to commence work.
- Required training to meet legislated standards.

Initial Induction checklist to be completed and signed by both employee and Manager / Coordinator.

Completed induction checklists to be kept on employees' individual personal file. The checklists give structure to the induction and also ensures that both the new employee and organisation know what has or has not been covered at any given time.

Where an employee does not feel that they are yet competent to carry out their role safely and competently they should inform the HR Manager, other Manager or Coordinator as soon as possible.

New employees will be given an Employee Handbook at induction. It acts as a reference document containing information on what employees need to know, should know or may wish to know about the organisation and their employment.

GOVERNING POLICIES

Recruitment and Selection Policy

AUTHORISATION

This Procedure is approved and issued by:

Sarah Dart

HR Manager

PROCEDURE TITLE:	032 – LEAVE PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	10/03/2020

PURPOSE

This Leave procedure is created to ensure a clear understanding of the entitlements for all employees, and to provide a structured process to apply for leave with the aim of forward planning and convenience for both the employee and the organisation.

LEAVE

The Leave Procedure covers the following types of leave:

- annual;
- personal/carers;
- community services;
- maternity/paternity;
- leave without pay;
- long service leaves; and special leave.

The procedure applies to all full-time, part-time and casual employees of the organisation.

It is the procedure of ARC Disability Services Inc. to ensure that staff are encouraged and supported to take regular approved absences/holiday breaks. Annual leave is important in regard to management of stress in the workplace, as well as in ensuring a flexible, family friendly environment.

Leave entitlements for staff members will be accrued as prescribed within the National Employment Standards, and the Social, Community Services, Home Care and Disability Services Industry Award.

It is preferable that at least two weeks of annual leave should be consecutive in each year, with no minimum requirement for periods of leave for the remaining time.

Accrual of annual leave is restricted to:

- No more than eight weeks' paid annual leave, or
- For a shift worker if they have accrued more than 10 weeks' paid annual leave.

Accrual of annual leave beyond this requires the permission of the CEO or HR Manager; who may consider issues such as planned extended holidays, family reasons etc. in making the decision. The CEO or HR Manager may direct a staff member with annual leave in excess of 30 days to take annual leave with one months' notice.

Some sections of the organisation close, or operate with minimal staffing levels during the Christmas Period. Employees may be required to take annual or unpaid leave during this time. Employees will be given a minimum of one months' notice. Should a public holiday fall on a day an Employee would have ordinarily worked the team member will be remunerated the base rate for the ordinary hours.

In the interest of planning for requirements of the organisation, all permanent full-time and part-time employees are requested to provide the organisation with requests for leave as soon as practicable. Annual leave requires a minimum of two weeks' notice to be approved. Approval of requests will be based upon the operating requirements of the organisation, and services within the organisation. Where possible, only one team member per team will have leave approved at a time, unless otherwise negotiated and planned.

PROCEDURES

Procedure is for all planned absences to be requested via online software system, Unplanned or emergency absences are required to notify coordinator/manager as soon as possible making direct verbal contact. This exception and the reason will be documented within the staff members HR Notes. For Time off in Lieu (TOIL) please refer to the organisations TOIL and Overtime Policy.

Note: When team members have an accrual of TOIL, the TOIL will be paid prior to the team member accessing their annual leave entitlement. This will be monitored by the Payroll Officer at the time of pay.

ANNUAL LEAVE

Full time employees are entitled to 20 days' annual leave per annum (Pro rata leave will apply to part time staff; Staff members who are deemed "Shift Workers" under the award are entitled to an additional week's leave). Staff will be paid a leave loading of 17.5% (unless otherwise specified within the employment contract) on top of their regular pay for periods of annual leave. Casual team members have no entitlement to Annual Leave.

The Manager/Coordinator will accept/reject the leave requested based on the needs of the service/organisation and Award requirements.
If the leave request is rejected, the staff member will be notified that the leave has been rejected. Staff members have the right to contact the HR Manager and negotiate at this time.
If the leave is accepted (or after negotiation leave is accepted) the HR Manager will notify the team members, the request has been accepted.

If the request is for leave to be paid in advanced, the HR Officer will notify the Payroll Officer for processing as required.

Staff members will ensure a timesheet is submitted for the duration of their annual leave. (For extended leave, the Payroll Officer will make appropriate arrangements during the payroll process)

1. For leave of two work days or less, request may be given to the employee's direct supervisor in writing, or in extra ordinary cases, verbally. Any verbal request will be confirmed via e-mail with the team member.
   - The staff members' direct supervisor will accept/reject the request and notify the team member.
   - The direct supervisor will notify the HR Officer to ensure the leave is recorded within ProSIMS and is communicated to all relevant coordination staff.
   - Team members will indicate on their fortnightly timesheet when the leave was taken to ensure accuracy with the payroll system.
2. Should team members wish to vary their approved leave, they will put the request in writing to their Direct Supervisor who will notify the team member if this has been accepted or rejected. In extenuating circumstances, this request may be verbally, and the direct supervisor will ensure the request is noted within the HR management system. The Direct Supervisor will notify the HR Officer of the alteration to the original leave to ensure that ProSIMS reflects the changes.
3. Cashing out of Annual Leave - leave payout will be within the confines of the Award Where an employee has an excess of Annual Leave accrued, they may request for up to two weeks' annual leave to be paid out, as long as the balance of their annual leave accrual remains above four weeks. Requests need to be put in writing to the HR Manager and each case will be considered on a case by case basis. Leave payed out will be taxed at the rate of 31.5%. All documentation regarding the payout of leave will be maintained in the employee HR file. Request for leave payout may only occur once per financial year.

PERSONAL/CARERS LEAVE

ARC Disability Services Inc. provides Personal/Carers leave in accordance with the National Employment Standards and the Social, Community Services, Home Care and Disability Services Industry Award.

Personal/Carers leave encompasses sick leave and carer's leave.

ARC Disability Services Inc. encourages all employees who are not fit for work, to remain home to rest and recuperate before returning. This assists in both the employees' health and wellbeing, and protecting all other employees and participants from the possibility of infection. Employees who display symptoms of illness whilst at work will be directed by their Direct Supervisor to return home until better.

Employees who have more than two consecutive days away from work for Personal/Carers Leave, or the Personal/Carers leave occurs the day before or after a public holiday or approved leave, are required to provide the organisation with evidence of sickness. Often this is the form of a Doctors Certificate, but may also be a letter from a specialist or health practitioner. A statutory declaration may be required if you are unable to provide a medical certificate, or appropriate evidence from a specialist/health practitioner. ARC is bound by all Doctors Recommendations, should an employee wish to return to work prior to what is detailed within their existing medical certificate, the staff member will be required to obtain a new certificate detailing they are fit for work.

Full time employees are entitled to 10 days Personal/Carers Leave per annum (Pro rata leave will apply to part time staff). Personal/Carers leave will accrue progressively for each year of service.

Casual team members have no entitlement to paid Persona/Carers Leave, however are able to access unpaid Personal/Carers Leave.

To access time off for Personal/Carers leave, the process is the same for both paid and unpaid. The difference is employees who have an accrual of Personal/Carers leave are required to record the time absent from work on their fortnightly timesheet for payroll processing. Evidence of Personal/Carers leave is required prior to employees being remunerated for the time away from their employment. This is managed by the Payroll Officer at the time of payment.

1. Employee identifies they are unable to attend their employment.
2. Employee contacts the ARC office during office hours or one of emergency contacts outside of office hours and notifies the organisation they are unable to attend. (it is the expectation that the employee will physically speak to a representative of the organisation)
3. The Coordinator/Manager will notify any additional Coordinators who may require the information, and ensure the families and participants are notified if there are any changes or cancellations to support.
4. Employees will remain in regular contact with ARC updating of health, and detailing when they will return to full duties.

There is no allowance within this policy, the National Employment Standards or the Industry Award for the cashing out of Personal/Carers Leave.

Team members unable to fulfil their role due to illness or injury for a period greater than three months, will be required to notify the HR Manager of situation. The HR Manager will assess the role the employee undertakes within the organisation and identify the ongoing impact, as to whether the organisation can continue to hold the position for the employee.

COMMUNITY SERVICES LEAVE

ARC Disability Service Inc. provides community services leave in accordance with the Industrial Relations Act.

Employees are entitled to be absent from work in order to perform jury service. Employees (other than casuals) who are absent from work in order to perform jury service are entitled to receive payment at their base rate of pay for ordinary hours of work for which they are absent for the first 10 days. This will not include payment for any allowances, loadings, penalties or the like. The payment will be processed at the usual pay time provided the employee has complied with the notice and documentation required. The amount paid to the employee for the first 10 days of the absence for jury service will be reduced by the jury service pay which the employee is entitled to receive from the court. Staff members are required to provide ARC with evidence of any jury service pay they have received or may be entitled to receive.

Employees are entitled to be absent from work (without pay) to undertake voluntary emergency management activities if:

1. The employee engages in an activity that involves dealing with an emergency or natural disaster; and
2. The employee engages in the activity on a voluntary basis (whether or not the employee is paid a gratuity); and

3. The employee is a member of, or has a member-like association with a recognised emergency body such as a fire-fighting, civil defence or rescue body, and either:
   a. Is requested by or on behalf of the body to engage in the activity; or
   b. It is reasonable to expect that such a request would have been made if circumstances permitted; and
4. The employee's absence is reasonable in all the circumstances.

COMPASSIONATE/ BEREAVEMENT LEAVE

ARC Disability Services Inc. provides compassionate leave in accordance with the Industrial Relations Act.

Compassionate leave for employees other than casuals will be made at the employee's base rate of pay for the employee's ordinary hours of work in the period. This will not include payment for any allowances, loadings, penalties or the like. The payment will be processed at the usual pay time providing the employee has complied with the notice and documentation requirements.

Employees (other than casuals) are entitled to up to two days' paid compassionate leave for each occasion when a member of the employee's immediate family, or a member of their household has a personal illness or injury that poses a serious threat to their life, or has passed away.

Casual employees are entitled to up to two days' unpaid compassionate leave for each occasion when a member of the employee's immediate family, or a member of their household has a personal illness or injury that poses a serious threat to their life, or has passed away.

Employees must notify the HR Manager as soon as practicable, to inform the organisation that they need to leave to:

1. Grieve following the death of a member of the employee's immediate family or a member of the employee's household; or
2. Attend the funeral of that immediate family member of a member of the employee's household; or
3. Spend time with an immediate family member of a member of the employee's household because that member has a personal illness or injury that poses a serious threat to their life.

Employees must also provide the organisation with any evidence request to substantiate the face that the leave is to provide care and supported for an immediate family member suffering a personal illness or personal injury (such as a medical certificate or statutory declaration), or is for one of the reasons for compassionate leave listed above.

Compassionate leave is event based leave; it does not accrue and accordingly is not an entitlement and will not be paid out on termination of employment.

MATERNITY/PATERNITY LEAVE

ARC Disability Services Inc. provides Maternity/Paternity Leave in accordance with the Industrial Relations Action and National Employment Standards.

Employees are entitled to apply for up to one year leave without pay when:

1. The employee gives birth
2. The employee's spouse or de facto partner gives birth
3. The employee adopts a child under the age of 16.

Employees are able to request an additional 12 months of leave. This request will be assessed by the organisation and discussed with the employee.

ARC Disability Services Inc. is registered to support the Paid Parental Scheme through the Department of Human Services: Centrelink.

Employees wishing to take Maternity/Paternity Leave are required to notify the HR Manager in writing as soon as practicable, but a minimum of one month prior to the commencement of leave. Employees are required to detail projected dates, and maintain contact with the organisation during this time.

Employees wishing to return from Maternity/Paternity Leave are required to notify the HR Manager in writing with one months' notice of the date they wish to return.

LEAVE WITHOUT PAY

Employees are welcome to apply for up to one year leave without pay. Approval of such leave only occurs in unusual circumstances. Requests need to be in writing to the HR Manager and provide at least one months' notice from the commencement of the leave. The HR Manager will notify the relevant coordinators, along with any other effected areas from the leave without pay, should it be accepted. It is a requirement that staff members exhaust all leave entitlements before leave without pay is granted.

LONG SERVICE LEAVE

Long Service Leave is provided in accordance with the Industrial Relations Act. Employees wishing to access their Long Service Leave, once it has become an entitlement, are able to follow the same process as Annual Leave, but will be required to identify on the leave application the leave is to come from their Long Service Leave entitlement.

Long Service Leave can be accrued per decade, but shall become an entitlement after the staff members initial ten years.

ARC Disability Service Inc. will commence accruing staff members long service leave as a provision from the staff members fifth year.

FORCED CLOSURE

On occasions outside the control of the organisation (i.e. Natural Disasters) the organisation may be forced to close part or all of the operations until such time as it is safe to re-commence. At these times, staff members are able to access any time off in lieu, or annual leave to supplement their income. Staff members need to indicate this on their timesheet for that pay fortnight for the Payroll Officer to include and remunerate.

VARIATIONS

ARC Disability Services Inc. reserves the right to vary, replace or terminate this policy from time to time.

GOVERNING POLICIES

Overtime and Time Off in Lieu Policy
Leave Policy

AUTHORISATION

This Procedure is approved and issued by:

Sarah Dart

HR Manager

PROCEDURE TITLE:	033 – ALCOHOL AND OTHER DRUG PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	HR Manager	DATE REVIEWED:	26/05/2020

PURPOSE

To ensure a structured way in which to deal with situations where it is believed that an employee may be under the influence of alcohol or other drugs which may affect their ability to perform their duties safely.

ALCOHOL AND OTHER DRUGS

The following procedure will apply if an employee is suspected of being under the influence of alcohol or other drugs which may impair their performance of duties in any way. Random and/or targeted breath testing may be conducted by an employee in an accredited/certified position. This will follow the Australian Standards for testing. Alternatively, they will be referred to a medical professional externally for initial or secondary testing.

1. Any employee who suspects that a colleague, or themselves may be under the influence of alcohol or other drugs which may adversely affect or impair their performance must immediately notify the relevant Coordinator, Manager or the CEO.
2. The Coordinator, Manager or the CEO will attend as soon as possible to speak with the employee.
3. If there is any doubt about the employee's ability to continue with their duties the employee will be asked to attend their GP or another convenient Medical Practitioner to ascertain the appropriateness of continuing to perform their duties.
4. Should the employee refuse to attend their GP or another convenient Medical Practitioner they will be suspended from duty without pay for the remainder of the day and disciplinary action may be initiated.
5. If the Medical practitioner determines that the employee is unfit to continue working due to being under the influence of alcohol or other drugs, then the employee shall be asked to return home. No payment will be made from the time that the employee was asked to attend the medical practitioner.
6. If the Medical Practitioner determines that the employee is fit to continue with their duties, then they shall return to the workplace. Payment will be made for the period of time lost in attending the Medical Practitioner.
7. In all instances where an employee is suspected of being under the influence of alcohol or other drugs in the workplace resulting in implementation of this procedure the utmost confidentiality will surround all proceedings.
8. For any employee who is asked to return home from the workplace due to being under the influence of alcohol or other drugs will be counselled by the appropriate Manager or CEO on their return to work. If appropriate the employee will be offered information regarding support available to deal with misuse of alcohol or other drugs.
9. A detailed incident report must be completed by all persons involved with the situation. Incident reports pertaining to the employee will be kept on the employee's personnel file.
10. As part of this process ARC maintains the right to request a drug test from its employee's where there is reasonable suspicion, this will be done at cost to the organisation.

GOVERNING POLICIES

Incident Report Policy
Alcohol and Other Drugs Policy

AUTHORISATION

This Procedure is approved and issued by:

Sarah Dart

HR Manager

034 – INFORMATION MANAGEMENT AND CONTROL OF DOCUMENTS PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**034 – INFORMATION MANAGEMENT AND CONTROL OF DOCUMENTS PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	11/03/2016
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

The organisation has established, implemented and maintained effective systems for ensuring only updated and current versions of organisational documents are accessible to employees through the electronic database. Generally, all information owned by ARC is to only be accessed by employee employed by ARC. However, access to certain documentation can be granted as per the privacy procedures, or by authorisation of the CEO.

DEFINITIONS

ARC uses the following terminology to differentiate between documents and forms: -

- ***Documents:*** policies, procedures, manuals, registers and files.
- ***Forms:*** single or multi-part paper work that has an approved layout. When data is recorded on forms these in turn become records. Forms may be computer generated or pre-printed.

INFORMATION MANAGEMENT AND CONTROL OF DOCUMENTS

DOCUMENT AND FORM IDENTIFICATION AND AMENDMENTS

- A unique title shall identify documents and forms created by the organisation.
- When an internal document or form is amended the date and revision number shall be recorded on the Document Register.

AUTHORISATION OF POLICIES

Organisational Policies provide the governance and management framework for the organisation. Policies are developed by the CEO and the Board of Management in consultation with employee and participants.

- The CEO has the delegated authority to approve Service Delivery and Operational related policies.
- The Board of Management shall approve Strategic and Governance related Policies.
- All Policy changes are reported to the Board of Management by the CEO.
- The endorsement of all policies shall be recorded in the minutes of Board of Management.
- The endorsement of all policies shall be recorded in the minutes of Employee and Management Team Meetings.
- Service Delivery related policies shall be reviewed biennially by the Management Team and reported to the Board of Management.
- The Board of Management shall ensure that Strategic and Governance related policies are reviewed at least biennially.
- The Quality Coordinator will maintain a timetable for the review of policies, however policies may be reviewed at any time to ensure best practice is maintained.
- A record of policy amendments, including the date and number of revisions is maintained in the Policy Register.

AUTHORISATION OF PROCEDURES

Procedures are formulated to support organisational policies. They provide the operational framework to ensure:

- policies are followed
- organisational expectations are maintained
- Standard, legislative and contractual requirements are met.
- The Quality Coordinator shall register each procedure on the Procedure Register
- A record of procedure amendments, including the date and number of revisions is maintained through Procedure Register
- All employee are notified of any changes to procedures via email
- The implementation and / or amendment of all procedures shall be recorded in the minutes of Employee and Management Team Meetings

- Service Delivery related procedures shall be reviewed biennially by the Management Team
- The Quality Coordinator will maintain a timetable for the review of policies, however policies may be reviewed at any time to ensure best practice is maintained.

APPROVAL & CONTROL OF OTHER DOCUMENTS

- The CEO shall approve all documents that are written for use within the organisation prior to distribution to employee
- The nominated Corporate Services Officer will record each document on Document Register once it is approved for use
- The nominated Corporate Services Officer shall ensure that copies of forms carry a unique title, and issue/revision date and the original form is held on the electronic database
- Requests for new or revision of forms are submitted to the Management Team for authorisation

AMENDING EXTERNAL DOCUMENTS

- The nominated Corporate Services Officer shall ensure that external documents used as regulatory or compliance documents for operations are available to employee
- All required external documents are recorded in the Document Register

RETENTION OF OBSOLETE DOCUMENTS, RECORDS AND FORMS

- All obsolete electronic documents, records and forms are electronically archived in folders in the computer system until such time that it is no longer a legal requirement to hold such records / documents
- Any hard copies of obsolete documents which need to be retained for legal or knowledge purposes will be stamped "superseded" and securely archived
- Obsolete documents and forms shall not be used for operational purposes
- All Participant records will be destroyed seven years after the person exits the service. Destruction of hard copy records and documents will be by shredding
- Any significant data which is destroyed will be recorded within the participant's electronic file.

DOCUMENT SECURITY

- All personal and sensitive information is secured in locked cabinets
- All documentation and records which are critical to business operations are secured in locked cabinets
- Access to electronic files and documentation is secured by access passwords
- Any attempted unauthorised access is reported to the CEO
- ARC employee are advised of organisational procedures and expectations regarding document security as part of the induction process. Employee will not:
    - **a.** Photocopy/scan any confidential documents, forms or records
    - **b.** Convey any confidential data to any unauthorised person

- Breaches of document security are subject to disciplinary action and recorded as per the organisations *Notifiable Data Breach* Policy.

PARTICIPANT RECORDS/FILE NOTES

A Participants contact/file note is:

- **a.** A chronological record of Participant programme activities
- **b.** A factual record of Participant programme activities
- **c.** A legal document/evidence of fulfilling contractual obligation

Contact information will be:

- **a.** Date of contact
- **b.** Method of contact
- **c.** Location of contact
- **d.** Who was involved in the contact
- **e.** Subject matter

- Participant contact records are to be completed within 12 working hours or as soon as practical after contact
- Participant contact notes will be recorded according to ARC's privacy and confidentiality policy and protocols
- All Participants notes will be:
    - **a.** Written in plain English
    - **b.** Non –discriminatory and non- judgemental
    - **c.** Freed of personal opinion
    - **d.** Objective

EMPLOYEE RECORDS

- All employee records, including copies of employment contracts, Position Descriptions, resume, induction program, Employee appraisals and any other policy matters will be securely held by the HR Manager
- To maintain confidentiality, Supervision / Performance Management related records are securely held by the responsible Manager / CEO
- To maintain confidentiality, WorkCover related records are separately maintained and secured by the HR Manager
- Access to employee records is restricted to the CEO, HR employee, and executive members of the Board of Management
- Access to employee records for any other purpose, including external audits will require signed consent of the individual employee member in accordance with the ARC Privacy and Confidentiality Policy and Procedures
- Employee Records will be retained in accordance with statutory requirements
- Employee wishing to access their personnel file are required to provide written notification to the HR Manager who shall make the appropriate arrangements.

INFORMATION TECHNOLOGY

- ARC Disability Services' computers are intended for the recording and access to information required by employee to perform duties as outlined in employee Position Descriptions
- All work undertaken in the organisational computers is the intellectual property of ARC. Management must not be prevented, by password or any other means from accessing any information in any of the organisational computers
- The nominated ARC System Administrators (CEO / Manager, delegated corporate services team member and the contracted external IT service provider) are authorised to access or change passwords as required
- No hard or electronically recorded copy of ARC documentation will be taken from the organisational premises without the express permission of the CEO
- Accessing pornographic sites or transmission of inappropriate messages is strictly prohibited
- All data including internet data will automatically be scanned using antivirus software. The contracted external IT service provider / ARC Management will ensure that the antivirus software is updated as required
- Only the contracted external IT service provider or person approved by the CEO shall load authorised software onto company computers. Employees may not load any software onto company computers without approval from the CEO.
- The Management of ARC reserves the right to log into any "@arcinc.org.au" emails/documents and review activity at any time.

BACK UP ELECTRONIC DATA

- Daily backups of computer data are completed by a contracted external IT service provider

TELEPHONES/MOBILE PHONES

- Limited personal phone calls are permitted during working hours but should be kept to a minimum
- Employees making non-business related STD or international calls are liable for the cost.

- Employee that are provided with mobile telephones and should be contactable on them during their working day. Voicemail should be activated at any time the employee member is unable to be contacted.
- Phones provided by the organisation have an allowance of reasonable personal use as an organisational contribution acknowledging any potential out of hours contact that may be required.

GOVERNING POLICIES

Privacy and Confidentiality Policy
Information Management and Control of Documents (Privacy) Policy
Information Management Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	**037 – SIBLING SUPPORT PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Services Officer	**DATE REVIEWED:**	27/05/2020

PURPOSE

The ARC Disability Services Inc. Sibling Policy has been developed to assist in providing clear guidelines around the supporting of siblings by employees of ARC. It acknowledges that the person with a disability is a member of a household and may have siblings living with him/her. The policy is intended to ensure that no participant or employee is put at any risk in the course of support being provided

SIBLINGS SUPPORT

1. Should a family require support for any siblings by an employee of ARC, it must be discussed and negotiated with the Direct Services Coordinator prior to support commencing.
2. The Direct Services Coordinator will take into consideration the needs of the person with a disability.
3. Siblings shall not be included in a support if this inclusion is deemed to mean that the person with a disability is at risk of not having their needs fully met.
4. Siblings may be included in the support if it is to be in-home support.
5. Siblings will not be included in the support if it is to be community access support. (Unless agreed with the Direct Services Coordinator for a specific reason and assessed and documented accordingly).
6. Alternative options for sibling support to be explored before it is agreed that they may be included in the planned support.
7. If siblings are to be included in the support, then an information sheet on each sibling to be supported must be completed.
8. The Direct Services Coordinator will organise support workers accordingly to ensure that the needs of the number of children, their ages and any disabilities are met.

GOVERNING POLICIES

Freedom of Choice Policy

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	038 – SCABIES PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Health Facilitator	DATE REVIEWED:	25/05/2020

PURPOSE

To provide employees with a process to follow in situations where it is suspected that a participant may have scabies.

SCABIES

Scabies is a very itchy skin condition caused by a tiny mite and is very contagious and can spread very quickly. Common areas are wrists, between fingers, folds of the armpit and elbow, the groin and creases of the bottom. This procedure is for employees who suspect a participant may have scabies.

1. Employees are made aware or observe any of the following symptoms:
- Intense itching, particularly at night.
- Red, raised bumps in body areas outline above.
- Clearly visible burrows on the skin

2. If any of the above symptoms are present we may suspect that the person has scabies.

3. If we suspect a participant has scabies, the participant must go to the doctor for diagnosis and if necessary will then be prescribed medication. Employees to be aware of any prolonged skin to skin contact with the participant and any shared items such as towels or places of long skin contact until diagnosis is confirmed.

4. A decision is to be made whether we are supporting the participant to the doctor or if the parent/carer will take them.

5. The doctor may make one of 3 comments, based on visual examination only:
- **a. Participant does not have scabies**,
  - In this case, the participant may resume the ARC service they were accessing, following whatever orders the doctor gives.
- **b. Participant definitely does have scabies**.
  - In this case, the Participant is to go home for treatment and may resume services after 24 hours.
  - If it is not possible for the participant to go home or they are in a SIL arrangement, they will be treated with their parents/carers/guardian knowledge.
- **c. Doctor is unsure whether or not participant has scabies.**
  - In this case the participant must have a skin scraping to confirm diagnosis.
  - In the meantime, the participant is to be considered infectious and should return home until the results of the skin scraping are back and treatment has taken place if necessary.
  - If it is not possible for the participant to go home or they are in a SIL arrangement, they will be treated with their parents/carers/guardian's knowledge.

In situations where it is not possible to contact the person's parents/carer/guardian then the participant's regular doctor is to be contacted to ensure that there is no reason that the participant should not be treated. For further clarification please contact a Coordinator or Manager.

6. If a participant has gone home or is being treated at the holiday house, for scabies that participant's bed linen is to be washed in hot soapy water, and the entire house (including lounges) vacuumed. This will also occur if the participant is accessing other short term respite services.

7. The parents/carers/guardians of all other participants (that they have had contact with) are to be informed that their family members may have come into contact with scabies. If the family or the participant requests, we

will treat the participant as a precautionary measure. The cost of the treatment will be met by ARC Disability Services Inc.

7. Employees who have been working with the participant may treat themselves as a precautionary measure if they so choose. Discussion will be had around the cost of this treatment being met by ARC Disability Services Inc.

GOVERNING POLICIES

Infectious Disease and Health Management Policy
Duty of Care, Dignity of Risk and the Least Restrictive Alternative Policy

AUTHORISATION

This Procedure is approved and issued by:

SHERIDAN LAWTON

Health Facilitator

PROCEDURE TITLE:	039 – MONEY HANDLING PROCEDURE		
VERSION:	003	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	26/06/2020

PURPOSE

To ensure that all monies relating to participants are kept safely and balanced at all times.

ALL SERVICES

SHIFT HANDOVER

All money in individual's personal money must be counted and signed for at the commencement of each shift. Where there is a handover, this is to be completed by both employees. Discrepancies of balance must be reported to Coordinators with Statutory Declarations required if monies cannot be traced. A Statutory Declaration must be filled out and then signed by a Justice of the Peace and handed in to the relevant Coordinator within 48 business hours.

The Coordinator must be contacted if the expenditure is under or over the expected amount;

- Over/under by $10 or less: contact Coordinator through business hours.
- Over/under by more than $10: contact Coordinator via phone call immediately.

SUPPORTED INDEPENDENT LIVING

It is integral that if a participant requires assistance with managing their expenditure, that ARC keeps a full record of all expenditure. This is done by ensuring that all incoming and outgoing money is recorded and all receipts are retained following all purchases.

If when filling out the participants Individual Risk Assessment and accompanying money handling form, it is decided that the participant requires support with money whilst in Supported Independent Living, the following applies:

1. Staff will assist participants to access their bank on a weekly basis to withdraw approved budgeted amount for personal spending and housekeeping. Participants use either a key card or passbook account. Automated teller or over the counter transactions will be accessed. A receipt is to be kept and processed.
2. Participants who do not access the bank, will have their budget bought to the house by a stakeholder.
3. All money is to be recorded into either the housekeeping ledger or the Participant's individual funds. This can be found on the house IPad. These documents outline all expenditure and transactions in and out of the bank.
4. Staff to record in the ledger money allocated to activities/spending sheets. This amount will be predetermined between participants, the Coordinator and any stakeholders involved. The breakdown of this can be found at the top of the spreadsheet.
5. Housekeeping money will remain in the safe at the house.
6. After money is used it is important that the receipt of any expenditure is recorded and uploaded.

To streamline archiving processes for participants in SIL services, receipts for purchases will be uploaded to OneDrive directly by the support worker who supported the participant in making the purchase. Once back at the house, these will be numbered in a chronological order (1-100) restarting at 1 at the commencement of each month. Each fortnight, the Admin Key Worker will check if the spreadsheet is reflective of the receipt given. All receipts will remain at the house until the end of the month before being brought into the main office with the monthly archiving documents when the SIL Coordinator will also check for accuracy.

Expenditure recording occurs as follows:

1. Open OneDrive app on the IPad.
2. Locate the Banking Folder.
3. Depending on the purchase made, navigate to the relevant folder. (Housekeeping, Household Misc., Participant Personal Banking etc.) and open the relevant folder e.g. (Name) Household Misc. Banking Receipts.
4. Open Current Year, then open the Current Month.
5. Open the relevant banking spreadsheet using Excel and check the banking spreadsheet and the physical receipt envelope to check what the current receipt number is.
6. Write the number on the new receipt, ensuring that the number is also recorded on the Banking spreadsheet.
7. Initial and sign the receipt next to the receipt number.
8. Tap the "+" option in the top right hand corner of OneDrive to open a sub menu.
9. Tap "scan" and hold the IPad above the receipt. Align the blue lines along the edges of the receipt, take a photo of the receipt, ensuring it is clear and easily read.
10. Tap "Done" on the bottom right hand corner and wait for the scan to upload to the OneDrive folder.
11. Once uploaded, tap the "3 dots" on the right hand side of the file, which will open settings and give you the option to tap "Rename this file".
12. "Backspace" to remove the current file name, and then rename the file "(number in chronological order for current month) (Name) (banking type) Receipt ()" e.g. "01 Jane Personal Receipt", "01 Fake St Housekeeping Receipt" , "01,Fake St Household Misc. Receipt".
13. Place Receipt into the corresponding envelope.

SUPPORTED INDEPENDENT LIVING MONEY

- Individual's personal spending ledgers are saved on One Drive in the Banking folder.
- All money for each individual that enters the house, either from them going to the bank or a parent/stakeholder bringing money to the house must be recorded directly into each individual's personal spending ledger.
- When the individual's personal money enters the house, the whole amount is to be recorded in the individual's personal spending ledger. It is important that you:
  - Record the date;
  - Record where the money is from;
  - You must initial to indicate that you have entered the money and what the new balance is.
- When you are assisting individual's with their banking, please see the budget break down that is found on the excel spreadsheet for each participant's personal banking on OneDrive. This will indicate the following:
  - How much money is received?
  - How to enter the amounts into their personal spending sheets?
- A handwritten receipt from a place/person of purchase is acceptable; please include – Date, item description, name of seller, and signature of seller.
- Do not combine totals - Each receipt and purchase is to have a separate line.

END OF MONTH

- Receipts to be sent to the ARC office for reconciliation at the end of each month.
- Coordinators or relevant administration officer will ensure all receipts have been saved and are in the correct folder on the server.
- Once approved by Coordinator, paper copies will be destroyed.

GIFT CARDS

If a gift card is received for an individual please phone the relevant Coordinator to start a new spending tab in the individual's ledger. This is to be checked and initialled at each money count.

SHORT TERM ACCOMODATION

PETTY CASH

1. The petty cash money will be kept in the purse in the cash box and placed in locked cupboard/cabinet, and locked at all times.
2. Budgeting of the petty cash money and collection of the sales dockets is the responsibility of each staff member as the purchases are made. Any money spent must have a receipt. All receipts are to be recorded on the petty cash ledger, the total balanced and checked by the staff person who spent the money. Receipts are to be kept in the plastic envelope corresponding to the petty cash ledger page.
3. The petty cash money is balanced at the beginning of each new shift and signed for on the handover form record sheet.
4. Any discrepancy will be noted on the handover form and the Coordinator informed as soon as possible.
5. The petty cash money will be reconciled by the Coordinator.

SPENDING MONEY

If when filling out the Participants Individual Risk Assessment and accompanying money handling form, it is decided that the participant requires support with money whilst in short term accommodation, the following applies.

1. On arrival each guest's spending money will be put into a separate plastic wallet in the spending money folder.
2. A spending money record form will be completed showing the balance of the money.
3. Each time a guest spends some of their spending money it will be recorded on the spending money record sheet. As money is taken out it should be recorded as a debit, and when any change is put back in it should be recorded as a credit, with details of what was spent.
4. Receipts will be obtained as and where possible and returned to the parents/carer, along with the spending money record sheet and any change when the guest departs.
5. Guest's spending money is to be checked and balanced at the beginning of each new shift and documented on the handover form.

GOVERNING POLICIES

Management of Participant Money and Property Policy

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	040 – FINANCIAL TRANSACTION CARDS PROCEDURE		
VERSION:	002	DATE EFFECTIVE:	01/06/2006
AUTHORISED BY:	Chief Executive Officer	DATE REVIEWED:	20/05/2020

PURPOSE

To outline the use and distribution of organisational financial transaction cards.

FINANCIAL TRANSACTION CARDS

It is the responsibility of the CFO to ensure that:

- Employees and volunteers are aware of this procedure;
- Any breaches of this procedure coming to the attention of management are dealt with appropriately.

It is the responsibility of all employees and volunteers to ensure that their usage of credit cards conforms within this procedure.

PROCESSES

1. CARD ISSUE

Any organisational financial transaction cards may only be issued to an employee where their functions and duties would be enhanced by their use of the card. Cards will thus be issued only to people on the approved Organisational Financial Transaction Card List. The list shall be held by the CFO.

Other persons may be added to the list by the Board. The Board may delegate the power to add persons to the list to any or all of:

- The Finance Committee;
- CEO

Cards may be issued on a temporary basis and recovered afterwards.

Each financial transaction card will be issued to a specific person, who will remain personally accountable for the use of the card. Cardholders will sign a declaration to this effect.

Only the authorised signatory may use the card. No more than one card shall be issued per cardholder. Credit limits as appropriate shall be set for each card by the issuing authority.

Monthly MYOB reconciliations and substantiating documentation will be made available at Finance Committee meetings, and audited as part of ARC's annual financial audit.

2. CARDHOLDERS RESPONSIBILITY

The Cardholder shall:

- In all cases obtain and retain sufficient supporting documentation to validate the expense (e.g. tax invoice) or shall in lieu provide a statutory declaration.
- Complete and sign credit card authorization form and attach to documentation.
- Attach supporting documentation to the monthly statement from the bank.
- CFO to review the monthly statement for inaccuracies.
- Verify that that goods and services listed were received.
- Monthly statement is to be reconciled and verified at Finance Meeting.
- Notify the bank and the CFO (or in the case of the CFO, CEO) immediately if
  - **a.** The card is lost or stolen; and/or
  - **b.** Any unauthorised transaction is detected or suspected.
- Notify the CFO and the bank of any change in name or contact details.
- Take adequate measures to ensure the security of the card.
- Return the card to the CFO if:

   a. The cardholder resigns;
   b. the CFO determines that there is no longer a need for the cardholder to retain his or her card; or
   c. The card has been cancelled by the bank.
- Be personally liable for any unauthorised transaction unless the card is lost, stolen or subject to fraud on some part of a third party.

The Cardholder shall not:
- Exceed any maximum limits set for the card from time to time.
- Obtain cash advances through the card.
- Use the card for any unauthorised purchases.
- Authorise their own expenditure.
- Claim double allowances (i.e. request reimbursement for an expense already paid by the card).

3. CARD EXPENDITURE

The card will only be used for those activities that are a direct consequence of the cardholders' function within the organisation.

Where coincident and/or private expenditure occurs on the same transaction (where, for example, a person incurs a debt for personal telephone calls during a hotel stay) the cardholder must settle the private expense prior to charging the balance on the organisational card.

Where doubt exists as to whether or not an item is function-related, prior authorisation should be obtained from the CFO (or, in the case of the CFO's own card, the CEO).

The use of the corporate card for "services of a dubious nature" is expressly prohibited. "Services of a dubious nature" are defined as any goods or services that might bring the name of the organisation into disrepute.

4. CARD MISCONDUCT

Wherever a breach in this policy occurs, the CFO must assess the nature of the breach and, address appropriately. Should the breach raise concerns that inappropriate use of the card has taken place the investigation policy should be followed to ascertain the circumstances. If any concern as to criminal or fraudulent use of the card is raised a report of the breach is to be made to the police for criminal investigation.

At the next Finance Committee meeting the CFO shall report:
- the investigation of the circumstances of the breach
- police report and action (if any)
- disciplinary action taken (if any)

GOVERNING POLICIES

Finance and Accounting Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	041 – INTAKE PROCEDURE		
VERSION:	003	DATE EFFECTIVE:	01/03/2013
AUTHORISED BY:	Chief Services Officer	DATE REVIEWED:	04/08/2020

PURPOSE

To make sure enough information and the right information is:

- Given to the Participant when they say they are interested in receiving a service;
- Taken from the Participant about their care needs;
- Taken from the family/carer about their needs.

And to make sure the Participant has access to the Service based on the resources that ARC has available and the priority of need as identified by the Participant and ARC's Intake Officer.

INTAKE

1. Referral to the Organisation can be made through an individual, any other organisation or member of the community and referrals can be by phone, email or online through the ARC website.
   - The Participant or their family can contact ARC directly at our main office on 4046 3600 and request to speak to the Intake Officer. The Intake Officer will discuss with them the different services that ARC offers and what may suit their need in particular.
   - ARC's Intake Officer actively works with the Participant and their family to identify which service they might require. The Participants enquiry is then forwarded either internally to check organisational capacity to the Chief Services Officer, or externally to another organisation. External referral may be required due to ARC not providing the services they require and/or not having the capacity to fulfil those services. If external referral is required, ARC may assist the Participant to make this connection. ARC's Intake Officer logs and tracks all enquiries that are moved to internal referral through the enquiry tab in ProSIMS. Once capacity is confirmed, the ARC Intake Officer meets with the Participant to discuss capacity, and establish the intake process.
   - At this stage the CSO is responsible for assessing any risks associated with the participant's transition to the provider and ensure that this is identified, documented and responded to.
2. In determining access to services, Participant will not be discriminated against on the basis of ethnicity, cultural background or religion. All decisions will be based solely on the organisation is seen as appropriate to meet their needs.
3. The ARC Intake Officer will meet with the Participant, provide them with a welcome package that gives them information about ARC and assist them to complete a Service Agreement and gather some relevant information to be passed onto the relevant service Coordinator. In some instances, Participant's may have several Coordinators. The Coordinator of the service/s will contact the Participant or their family to ask for more detailed information, and will liaise with the Participant or their family to provide the most appropriate support to meet their needs.

COMMENCEMENT OF SERVICES

1. Once a Participant has chosen ARC for supports and services, a Service agreement will be provided for each service engaged. The service agreement will ensure that both the Participant and the organisation have a clear understanding of the supports and services chosen and how they will be provided. ARC ensures that the service agreement is communicated using the language, mode of communication and terms that the Participant is most likely to understand. The Intake Officer will provide and work through the documents with the Participant and/or stakeholders using appropriate resources for the Participant to ensure that:
   - The service agreement reflects the wishes and expectations of the Participant and the organisation;
   - That each party receives a signed copy of the service agreement, supports schedule and relevant policy and procedure -
     - Service Agreement/s

- Document Confirmation
- Cancellation Policy
- Privacy & Confidentiality Form
- Business Practice for the NDIS Policy
- General Grievance Resolution Policy
- Freedom of Choice Policy.
- Information Release Consent
- Media Consent Form

- Each policy/document provided will be discussed with the Participant and their Support person to ensure their understanding and ability to seek any additional clarification if required.
- Schedules will be updated to reflect any changes within plans or at request of Participant/stakeholder.

2. In Conjunction with the CSO, the Intake Officer will allocate the appropriate Coordinator to ensure the Participants supports are implemented. The Coordinator will establish the support requirements and preferred skills, gender, age group of the staff members. The Coordinator will work with the Participant to complete a suite of internal documents that will provide information to ARC about the individual and their needs, requirements, preferences, strengths and goals.

   These documents include but are not limited to:
   - ARC Personal Details Form;
   - ARC Individual Risk Assessment ;
   - ARC In - Home Safety check in (should supports chosen be within the home);
   - ARC Medication Forms;
   - ARC Health Care Plan;
   - ARC Activity Sheets;

   These documents are updated biennially, if a change triggers this earlier or at the request of the Participant or stakeholder.

   ARC respects Participants right to Choice and Control, Dignity of Risk and works to support individuals in a least restrictive manner. Supports and services can be cancelled as one off supports, a block of supports or ongoing in line with
   - The ARC Cancellation policy and
   - The ARC Service agreement.

AUTHORISATION

This Procedure is approved and issued by:

Natasha Rivett

Chief Services Officer

PROCEDURE TITLE:	**045 – INTERNET AND WIFI PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/06/2006
AUTHORISED BY:	Chief Executive Officer	**DATE REVIEWED:**	20/05/2020

PURPOSE

Internet and Wi-Fi is part of the organisational electronic network. It provides Internet access across the organisation, including the ARC Holiday House, ARC Hall, ARC Hub, ARC 90-5 ARC 51 and Supported Independent Living Services. The features of this service are a privilege and not a right. All employees, participants, volunteers and community members are expected to practice responsible computing and to adhere to these requirements for acceptable use when accessing the internet or Wi-Fi.

INTERNET AND WIFI USAGE

1. Devices to be connected to ARC's internet or Wi-Fi will be identified by a member within the Management Team.
2. The Device will be connected to the network under the direction of the HR Manager.
3. Connected devices will be monitored regularly.
4. Unauthorised devices will be disconnected from the network, and passwords will be changed.
5. Any concerns with devices connecting to the network will be forward to a member of the HR team who will trouble shoot, or contact appropriate professional support.
6. No unauthorised "apps" will be downloaded without consent from a member of the Management Team.

GOVERNING POLICIES

Internet and Wi-Fi Policy

AUTHORISATION

This Procedure is approved and issued by:

BENJAMIN KEAST

Chief Executive Officer

PROCEDURE TITLE:	**046 – WORKING FROM HOME PROCEDURE**		
VERSION:	002	**DATE EFFECTIVE:**	01/03/2015
AUTHORISED BY:	HR Manager	**DATE REVIEWED:**	26/05/2020

PURPOSE

ARC Disability Services Inc. recognises the importance of flexible working arrangements in helping to retain its workforce, while at the same time ensuring a strong team-based culture. The Working from Home Procedure outlines the range of flexible working arrangements available to the team within ARC. The opportunity to work from home is not an entitlement or a right. Home-based work is a voluntary and cooperative arrangement agreed to between an employee and the organisation. Home-based work will be considered on a case by case basis.

PROCEDURE

When an employee or Supervisor is considering whether working from home is appropriate, consideration must be given to the nature of the work to be performed at home, the employees attributes, the home-based worksite and facilities, the effects on co-workers and participants, and whether service delivery is impacted.

WORK REQUIREMENTS

An initial view must be formed about whether the work to be performed at home can be performed productively in a home-based environment. Positions that:

- are predominantly participant facing;
- need on-site information, equipment, systems or facilities;
- require a high degree of supervision to perform the role effectively; may not be suited in their current form for home-based work.

An employee's managerial responsibilities may render a position unsuitable for regular home-based work. Where home-based work arrangements are feasible for an employee with managerial responsibility, the approved arrangements should ensure that the employee concerned is accessible to other employees and that a reasonable proportion of the employees work time is spent on site.

WORK RELATIONSHIPS AND TEAM BUILDING

In the interest of promoting co-operative and collaborative working relationships, it is essential that a reasonable amount of the staff member's work time is spent on site.

PERSONAL SKILLS, ATTRIBUTES AND WORK PERFORMANCE

Consideration should be given to the employee's suitability to work at home. The employee must be able to work as efficiently and effectively as if the employee was on site. Relevant factors in assessing this will include:

- demonstration of self-motivation, time-management and organisational skills;
- capacity to work independently; and
- a proven record of satisfactory work performance

Any requests for extension or continuation in a Working from Home Arrangement (WFHA) will be based on the employee's satisfactory demonstration of these factors.

REASON FOR HOME BASED WORK

Employees must outline the specific reason why they would like to undertake home-based work. ARC will take reasons into account when assessing an application.

CONTACT AVAILABILITY

Contact arrangements must be agreed upon between the employee and Supervisor, and are to be clearly detailed in the WFHA. These arrangements may range from diverting the employees phone number to their home phone or mobile, limiting contact to e-mailed, and the screening of calls by another work colleague if appropriate and/or practicable. The suitability of these arrangements will be determined on the basis that service delivery will not be adversely affected. The employees home contact details will remain confidential and will not be provided to other people unless the employee has agreed in advance.

RECORD OF HOURS WORKED

The WFHA should have clear and detailed understanding of the hours to be worked, including any flexible working hours' arrangement.

All Award implications remain current and employees working five hours or over are required to take an identified un-paid break.

All personal; sick; carers; un-paid; and annual leave are required to be adhered to within the same application/notification processes as an employee working on site.

SUITABILITY OF THE HOME-BASED WORKSITE AND FACILITIES

WHS requirements and responsibilities apply equally in home-based workplaces as for on-site workplaces.

Prior to an employee being granted approval to commence regular home-based work, the following processes must be complied with:

- Working from Home Agreement Completed
- Home Work Health and Safety Check List Completed
- Assessment on the equipment to be used for home based work
  - **Note***: it is the responsibility of the employee to establish a suitable home-based worksite. If the task requires equipment not available at the home-based worksite, it is the responsibility of the employee to acquire the identified equipment. ARC will not financially support the purchasing of additional equipment and resources to support an employee working from home, unless under extenuating circumstances approved by the CEO.*
- Any changes within a home-based worksite is instantly communicated with the supervisor.

During a WFHA, at any time during the identified work times, ARC may access the employee's house to review the safety of the home-based workplace. Consent will be requested prior to arrival; such consent must not be unreasonably withheld.

FOLLOWING THE COMMENCEMENT OF A WFHA

Employees are to:

- Take reasonable precautions to protect ARC's privacy, confidentiality, information and assets;
- Comply with the WFHA;
- Deliver on agreed work outcomes on a consistent basis;
- Participate in team meetings and relevant learning and development activities on site;
- Report any accidents or injuries within 24 hours.
- By agreement, provide access for the organisation to periodically undertake WHS audits and reports.
- Monitor and review the WFHA

Supervisors are to:

- Monitor the home-based work arrangement to ensure the agreed work outcomes are consistently being delivered;
- Review and sign off on records of hours worked (timesheets) fortnightly

All parties of the WFHA may terminate the agreement but providing the other party with at least two weeks' written notice.

GOVERNING POLICIES

Workplace Health and Safety Policy
Information Management and Control of Documents Policy
Risk Management Policy
Workplace Health and Safety Incident Reporting
Stress Management Policy
Privacy and Confidentiality Policy
Information Management Policy

AUTHORISATION

This Procedure is approved and issued by:

Sarah Dart

HR Manager

047 – EMERGENCY USE OF RESTRICTIVE PRACTICE PROCEDURE
OPERATIONAL PROCEDURE

PROCEDURE TITLE:	**047 – EMERGENCY USE OF RESTRICTIVE PRACTICE PROCEDURE**		
VERSION:	001	**DATE EFFECTIVE:**	04/08/2020
AUTHORISED BY:	Chief Services Officer	**DATE REVIEWED:**	04/08/2020

PURPOSE

To outline the process that occurs when Emergency Unauthorised Restrictive Practice use occurs.

EMERGENCY USE OF RESTRICTIVE PRACTICE

In the event that a regulated restrictive practice is used without an authorising positive behaviour support plan this is considered as an unauthorised restrictive practice and is therefore considered a reportable incident to the NDIS Quality and Safeguards Commission. The unauthorised use must be reported through ARC's internal incident reporting system; this will then be flagged with the Management Team. The Management Team is then responsible for ensuring the reporting to the Quality and Safeguards Commission. Refer to the 'Identifying Restrictive Practice Procedure' for more information on what is considered an unauthorised Restrictive Practice. The Management Team is also responsible for ensuring that any other providers / services are notified promptly these include but are not limited to:

- Police
- Other Emergency Services
- Mental Health Services
- Treating Medical Practitioners
- Allied Health Clinicians

The Participants stakeholders and support network will also be notified with consent from the Participant.
After all cases of unauthorised restrictive practice's any employees involved will be offered an opportunity to debrief – this will allow for identification of areas of improvement and to inform further action.

ARC will then take every step possible to limit any repeat occurrences of the unauthorised restrictive practice, if it is deemed that the restrictive practice is likely to occur again, then ARC will offer to support the Participant to engage with a positive behaviour support practitioner. ARC will undertake work with the positive behaviour support practitioner to support the development of the behaviour support plan.

ARC will ensure that once the positive behaviour support plan is developed all relevant employees are knowledgeable in its contents and training will be provided if necessary in order to correctly support the Participant.

GOVERNING POLICIES

Restrictive Practice Policy

AUTHORISATION

This Procedure is approved and issued by:

NATASHA RIVETT

Chief Services Officer