Disability support provider quality of care and risk management (11HDC00384, 24 June 2013)

Disability support provider ~ Systems issues ~ Staff training ~ Hazard identification ~ Incident reporting ~ Risk management ~ Culture of compliance ~ Rights 4(1), 4(4)

A man with Attention Deficit Hyperactivity Disorder, an intellectual impairment, and behavioural issues, was attending a work skills programme run by a disability support provider when he was involved in an accident in which he was injured.

On the day of the accident the man, who was known to staff for his distractibility and poor attention to instructions, was assigned an activity that involved working with tools and machinery, including power saws. It was the disability support provider's policy that there needed to be a minimum of two staff to attend and supervise that activity when clients were involved, and that only staff and clients who had completed training and passed certain safety assessments could participate in the activity and use power tools. The two supervising staff and the man had not been adequately trained to use tools and machinery, including power saws.

At mid-morning, the man had an accident when the power saw he was using became entangled in his overalls. It was decided that it was not safe for the man to continue using the power saw, and he was asked to perform a different activity. A short time later, one of the two staff assigned to supervise the man and two other clients, was called away. The man started the power saw again but the remaining staff member did not intervene. The man sustained an injury when he was cutting through a wooden plank.

It was held that the disability support provider did not have rigorous assessment and review processes in place to assess the man's suitability to take part in the assigned activity. The risks attached to the activity had not been appropriately identified and responded to, and staff were not adequately trained and supported. It was also held that there was a culture of non-compliance with the disability support provider's policies, particularly its policies relating to supervision requirements, training, hazard identification and incident reporting. The disability support provider's documentation also fell below expected standards. The disability support provider did not provide services with reasonable care and skill and that minimised potential harm to the man, and therefore breached Rights 4(1) and 4(4). The disability support provider was referred to the Director of Proceedings.

The man's care manager breached Right 4(4) of the Code because she failed to assess the man's suitability for the activity and failed to adequately reassess his suitability for the activity when potential risks were identified.

The activity co-ordinator also breached Right 4(4) of the Code because he did not fulfil the obligations set out in his job description or the disability support provider's policies, and made a number of errors of judgement. In particular, the activity coordinator allocated the two supervising staff members to work on the activity using power saws with the man when neither the man nor the two supervising staff members had met all the required competencies for that activity.

The supervising staff member who was present when the accident occurred also made a number of errors of judgement in that he did not take appropriate action to mitigate the risk to the man following the first accident and did not respond appropriately to the risk posed when the man started up and began using the circular saw for a second time after having been instructed not to use it. For those errors, the supervising staff member failed to take steps to minimise harm to the man and breached Right 4(4).