<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Title</th>
<th>Last Reviewed</th>
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</thead>
<tbody>
<tr>
<td>101</td>
<td>Accidents/Incidents</td>
<td>5/2017</td>
</tr>
<tr>
<td>103</td>
<td>Falls</td>
<td>3/2016</td>
</tr>
<tr>
<td>104</td>
<td>Falls Related Death</td>
<td>12/2014</td>
</tr>
<tr>
<td>111</td>
<td>Admissions</td>
<td>1/2015</td>
</tr>
<tr>
<td>114</td>
<td>Residents Funds &amp; Petty Cash</td>
<td>1/2015</td>
</tr>
<tr>
<td>118</td>
<td>Behaviour Management</td>
<td>1/2015</td>
</tr>
<tr>
<td>124</td>
<td>Missing Resident</td>
<td>2/2016</td>
</tr>
<tr>
<td>125</td>
<td>Care Planning</td>
<td>1/2015</td>
</tr>
<tr>
<td>126</td>
<td>Allied Health</td>
<td>4/2014</td>
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<td>127</td>
<td>Catheter care</td>
<td>1/2015</td>
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<tr>
<td>128</td>
<td>Gastrostomy Tube (PEG)</td>
<td>6/2015</td>
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<td>129</td>
<td>Continence Management</td>
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<td>130</td>
<td>Diabetes</td>
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<td>131</td>
<td>Complex Care, Observations and Therapy</td>
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</tr>
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<td>132</td>
<td>Medical Care</td>
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<td>Medication</td>
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<td>134</td>
<td>Nutrition and Hydration</td>
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<td>135</td>
<td>Oxygen Therapy</td>
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<td>136</td>
<td>Pain Management</td>
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<td>137</td>
<td>Ambulance Policy</td>
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<td>138</td>
<td>Syringe Driver</td>
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<td>140</td>
<td>Urinalysis</td>
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<td>141</td>
<td>Use of Laser treatment for wounds and pain</td>
<td>1/2015</td>
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<td>142</td>
<td>UTI</td>
<td>1/2015</td>
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<td>145</td>
<td>Wound Management</td>
<td>1/2016</td>
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<tr>
<td>146</td>
<td>Audits and Internal Assessment</td>
<td>1/2015</td>
</tr>
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<td>147</td>
<td>Call System</td>
<td>1/2015</td>
</tr>
<tr>
<td>148</td>
<td>Children and Eden</td>
<td>1/2015</td>
</tr>
<tr>
<td>149</td>
<td>Clothing</td>
<td>1/2015</td>
</tr>
<tr>
<td>150</td>
<td>Committees - Residents and Friends</td>
<td>1/2015</td>
</tr>
<tr>
<td>151</td>
<td>Consent</td>
<td>1/2015</td>
</tr>
<tr>
<td>152</td>
<td>Resident Documentation and Funding</td>
<td>1/2015</td>
</tr>
<tr>
<td>157</td>
<td>Quality Improvement and Comments and Complaints</td>
<td>2/2016</td>
</tr>
<tr>
<td>158</td>
<td>Mandatory Reporting of Suspected Abuse</td>
<td>2/2016</td>
</tr>
<tr>
<td>161</td>
<td>Homelike Environment</td>
<td>1/2012</td>
</tr>
<tr>
<td>162</td>
<td>Multicultural Policy</td>
<td>1/2015</td>
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<tr>
<td>164</td>
<td>Physiotherapy Services for Residents</td>
<td>11/2011</td>
</tr>
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<td>165</td>
<td>Privacy and Dignity</td>
<td>11/2011</td>
</tr>
<tr>
<td>167</td>
<td>Resident Alcohol Consumption</td>
<td>1/2015</td>
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<td>168</td>
<td>Risk Taking</td>
<td>11/2011</td>
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<td>169</td>
<td>Sleep</td>
<td>1/2012</td>
</tr>
<tr>
<td>170</td>
<td>Lifestyle and Recreational Programs</td>
<td>1/2015</td>
</tr>
<tr>
<td>171</td>
<td>Palliative Care</td>
<td>1/2015</td>
</tr>
<tr>
<td>172</td>
<td>Restraint</td>
<td>1/2015</td>
</tr>
</tbody>
</table>
Residential Care Policies and Procedures

Policy No. 101

Subject: Accidents / Incidents

Effective Date: May 2017

Developed by Director of Nursing

PURPOSE

To ensure that detailed investigation and documentation is carried out following accidents/incidents so as to enable appropriate action to be taken to avoid a recurrence.

POLICY

All accidents/incidents are to be reported immediately to the staff member in charge. An accident/incident form is to be completed in full.

Where injury to an individual has occurred or may result, medical assessments may be necessary.

a) The resident: Notify RN or Village Nurse.
b) Visitors: Doctor of choice
c) Staff: Doctor of Choice, HR Manager MUST be notified immediately.

PROCEDURE

There are three types of Accident/Incident Report forms:

1. For the Resident => Leecare General Incident Report
2. For the Resident => Leecare Medication Incident Report
3. For Staff and Visitors => Accident/Incident/Near Miss Report (paper based).

(Further information refer to Occupational Health & Safety Policy and Procedures 751).

These forms are to be completed in full as soon as possible after the event and before leaving the premises on the day the incident/accident occurred.

Resident General and Medication Incident Form management is the responsibility of the Director of Nursing. Staff and visitor Accident/Incident/Near Miss Report management is the responsibility of the Human Resources Manager.

Both the person becoming aware of the accident/incident and the Registered Nurse who investigates the cause and assesses the resident's/staff's condition are expected to complete the details (refer to flow chart attached). The resident's next-of-kin or POA are to be notified of the Resident General and Medication Incidents.

If a person/staff/visitor/ is hospitalised following an accident/incident, the HR Manager must be informed as soon as this information is known, who will forward the appropriate documentation to the Division of Workplace Health and Safety if appropriate.
INCIDENT OCCURS

Staff Member / RN 1

Manager

Quality

Incident Report Form is completed by the person becoming aware of incident. (Either General Incident or Medication Incident)

RN1 reviews the Incident Report to ensure all relevant fields completed and actions / interventions documented.

RN1 reads the Leecare message and updates the relevant Incident Form with the additional information

RN1 sends Leecare message to Manager advising that additional information / actions are completed.

Manager is responsible for ensuring that all actions are appropriate and the Incident Form is completed appropriately.

Where additional information / actions are required then a Leecare message is sent to the RN1 requesting additional information (Incident Form details included).

Where no further information / actions are required then the evaluation date is set by the Manager.

Evaluation is completed by the Manager and the Incident Form marked as resolved (where applicable).

Incident Report information is used to develop the clinical indicator reports and identify trends with individual resident’s incidents.
103 – Falls
152 – Documentation
158 – Mandatory Reporting of Suspected Abuse
528 – Medication related incidents
751 – Hazard and Incident Reporting and Investigation.
Residential Care Policies and Procedures

Policy No. 103
Subject: Falls
Effective Date: March 2016
Developed by Director of Nursing

PURPOSE

To ensure that falls are minimized and clear processes are in place to manage them

POLICY

To reduce the number of falls and fall-related complications and optimize the elderly person’s confidence in their ability to move about as safely and as independently as possible:

PROCEDURE

Assessment and Prevention

On admission all residents who enter any facility are to be assessed for their potential to fall.

AIM:

To accurately assess the trauma sustained after a fall and provide the necessary medical, nursing and allied health professional services required

To identify any environmental or medical causes that contributed to the fall

To minimize the risk of further falls and associated trauma

To minimize the risk of undiagnosed head injuries causing further functional decline, increased morbidity or death.

To ensure the resident has been appropriately assessed for changes to function that may have lead to a fall and ensure additional equipment can be provided if required.

NOTE: Residents who roll out of bed and who meet the 3 below requirements, do not need an incident report competed or observations as per the Falls Policy. If all 3 requirements are not meet then an incident form is to be completed and treated as an unwitnessed fall.

1. Low / low / high bed in the lowest position
2. Fallout mat in situ.
3. Resident rolls out of bed onto the fallout mat and remains on the mat.

1. In the Event of A Fall

a) Assess for serious and obvious injury
b) Notify RN or In Charge
c) Assess for signs and symptoms of a fracture e.g. pain at or near the site of the injury; loss of power; difficult or impossible normal movement of the limb; tenderness when gentle pressure is applied; swelling over/around the fracture; bruising; deformity; abnormal twist or shortening.
   If a fracture is suspected, immobilise the limb, leaving the resident where they are, make them comfortable and call 000 for ambulance and transport to hospital.

d) Assess the residents behaviour e.g. anxiety, ‘flat’, ‘shocked’, ‘confused’, state of consciousness etc.
e) Carry out a full physical examination -
i. **Head** - assess for skin tears; lacerations; haematomas; state of consciousness or change in usual level of confusion. Palpate the skull for swelling or "bumps".

ii. **Eyes; Ears; Nose; Mouth; Neck** - (for any unusual signs eg bleeding or discharge or pain and pupil reaction)

iii. **Limbs** - check for skin tears; bruising; pain; range of motion - do this gently.

iv. **Vital Signs** — pulse, blood pressure, temperature, respiration, BSL if diabetic.

  1. If a fracture is suspected, immobilise the limb, leaving the resident where they are, make them comfortable and call 000 for ambulance and transport to hospital.
  2. If an unwitnessed fall or witnessed and hit head, commence neuro obs as per protocol below.
  3. If neuro obs are abnormal, transfer resident to hospital via emergency ambulance advising of suspected head injury.
  4. If resident is on anticoagulant therapy, monitor closely for signs and symptoms of hemorrhage and call 000 for ambulance and transfer to hospital if suspected
  5. Dress wounds
  6. Monitor BGL if diabetic
  7. Complete incident report
  8. Notify GP by phone or fax copy of incident report
  9. Notify resident's NOK/POA
  10. Document incident in progress notes
  11. Monitor resident over next 48 hours and report on residents wellbeing
     i. Pain level
     ii. Signs of bruising – commence wound chart to monitor
     iii. Mobility and weight bearing changes
     iv. Behavioural changes
     v. Conscious state
     vi. General function
  12. Refer to physiotherapist
  13. Review Falls Risk Assessment within 24 hours of fall, unless already classified HIGH. This can be done by either the Physio or the Physio Aide (who has appropriate training) or RN.
  14. Contact the Falls Prevention Service or the ROSS team for further assistance if required.

**Falls Prevention Service Peninsula Health**  Ph: 9788 1260  Fax: 9788 1212

**ROSS Team, Peninsula Health**  Ph: 9788 1547  Mobile: 0439 117 955

**NEURO OBS PROTOCOL**

Neurological Observations (Neuro Obs) are to be commenced for all residents involved in a fall where:

a) The resident hit their head
b) The fall was unwitnessed
c) You suspect a head injury

Neuro obs are to be conducted:

- half hourly for 2 hours;
- hourly for 2 hours;
- 4 hourly for 24 hours.

A copy of the neuro obs chart is to be attached to the incident form.

If obs are abnormal, call 000 for an ambulance advising them of suspected head injury.

**RELATED POLICIES AND DOCUMENTS**

- 144 - Vital signs / Reportable
- 101 – Incidents
- 102 – Ambulances
- 151 – Consent
- 152 – Documentation
- 156 – Medical & personal care records
- Falls Flow Chart
Residential Care Policies and Procedures

Policy No. 104
Subject: Falls Related Deaths
Effective Date: December 2014
Developed by Business Manager / RN

PURPOSE

If a resident dies soon after a fall or as a result of injuries sustained in a fall, the treating hospital are likely to report the death to the State Coroner for investigation, it is possible that we will not know that this referral has occurred. The following policy outlines the documentation that the coroner will require and that shall be prepared for all residents whose death could be related to a recent fall. It is possible that a request for information from the Coroner could be made some years after the resident has died, so it is necessary to prepare all of the required documentation and file it the archive with the resident’s history.

POLICY

The documentation should be prepared by the Supervisors in conjunction with the Care Manager. The Care Manager / DON must be notified immediately if any resident died after a fall or is suspected will pass away soon after a fall has occurred.

The Care Manager / DON must notify the Operations Manager and provide a written report with 24 hours. The details of the report will be conveyed to the Board at the next meeting.

PROCEDURE

The following written information to be gathered to prepare a submission for the coroner. Original documents should be held securely by the Care Manager in their locked office until the case has been investigated and closed out by the coroner’s office. Only copies of documents should be supplied.

1. Details of the following including exact copies of any documents:
   - Initially assessment or review of the resident for falls risk
   - The actual fall incident(s) and the events leading to the fall
   - Who has knowledge of the incident,
   - A statement from each staff member on duty at the time of the fall detailing specifically what they did, what they saw, what position the resident and any associated equipment or furniture was in (drawings are ok) what they heard, who they may have telephoned and what they observed others doing

2. The Incident report

3. Falls Risk screening policy and assessment documents

4. Falls prevention policy and related documents and/or procedure manuals

5. Falls management policy and protocol documents and/or procedure manuals

6. Additional material will be required setting out:
   - When the policy or procedure documents were last reviewed and by whom
   - If as a result of the incident under investigation by the Coroner, there have been changes to policies or procedures, please forward the details of the changes and how they occurred. (i.e. how was the new policy or procedure developed and what additional information was sought from other agencies as to the preferable countermeasures to be adopted to address the perceived problem).
Specific questions to be answered in a report style format:

1. Patient history
a) What is the patient’s past medical history? (Please include co-morbidities, current medications and reasons for hospital admission).

2. The event and events leading up to the fall
a) What happened immediately before and after the fall?
b) How many falls or near falls did the deceased have in the past twelve months?
c) Had the deceased previously suffered any major injury from a fall?
d) Had the deceased undergone a risk screening assessment about the risk of falling in this facility? If so what action resulted from the assessment?
e) How often was the patient re-assessed or the falls management plan reviewed and checked?
f) What were the circumstances surrounding the fall immediately prior to death?
g) What external factors were present? For example: Wheelie walker, State of floor surface (slippery, uneven?), Lighting, Staff/carer supervision, Other…
h) Was there a detailed incident report form or similar completed? Is there any information regarding the fall that is recorded other than in the incident form or resident history?

3. The facility’s system for falls management
a) What were the facility’s policy, protocol and practice regarding risk screening for falls at the time of the incident?
b) What are the facility’s policy, protocol and practice regarding falls prevention strategies?
c) What are the facility’s policies, protocols and practices regarding falls management after a fall has occurred.
d) What previous initiatives, if any, has the facility undertaken in the last 2 years regarding risk screening for falls and falls prevention and management of clients following a fall?

4. Relevant equipment or work practice
If equipment or a particular work practice was involved in the fall (i.e. wheel chair, low-line beds, walking frame):
a) Has the operation of that equipment / work practice been reviewed to see whether any improvement can be made? If so, has the product manufacturer or some other expert been required to assist with the review?
b) If a particular product was involved, were the manufacturer's instructions available and followed? (If not, why not?).
c) If a particular work practice was involved, how often has that practice (or part thereof) been reviewed? Is this practice commonly used across the sector?

RELATED POLICIES AND DOCUMENTS

- 101 – Accidents / Incidents
- 171 – Death – Dying with dignity
- 152 – Documentation
- 103 – Falls
- 156 – Medical & Personal Care records
- 131 – Change in Health Status
Purpose
To ensure that all residents are offered a variety of lifestyle programs for their therapeutic, emotional, social and spiritual well-being.

Policy
To ensure consistency of the information given to residents and/or their representatives, and to ensure staff access and document important information on the day of entry and to be eligible for entry, a person must:

- Have significant care needs which can be appropriately meet through the provision of residential care.
- An Aged Care Assessment Team (ACAT) approves a care recipient for entry to residential care and will also determine if the care level required is high care or low care.

Procedure
1. On admission
   - Complete:
     - Resident Orientation Form
     - Commence Admission Assessment Guide
     - Advise relevant department of new admission (movement sheet)
     - Notify Pharmacy and Doctor of new admission.
## Resident Orientation

**Entry/Orientation date:** .............................................

<table>
<thead>
<tr>
<th>Orientated to:</th>
<th>Comments (if appropriate)</th>
<th>Initial and date when completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientate resident and relatives/representative to room and facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Information Booklet (state date received)</td>
<td></td>
<td></td>
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<tr>
<td>Bathrooms and toilets</td>
<td></td>
<td></td>
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<tr>
<td>Call bell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal times and menu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available services (e.g. hairdressing, allied health, lifestyle program)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduced to personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident rights and responsibilities explained</td>
<td></td>
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<tr>
<td>Care planning explained</td>
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<td>OHS explained</td>
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<tr>
<td>Falls prevention program explained</td>
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<tr>
<td>Introduced to other residents.</td>
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<tr>
<td>Resident/Relative meeting explained</td>
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<tr>
<td>Comments and complaints procedure explained (QIF)</td>
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<tr>
<td>Specified care and services explained</td>
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<tr>
<td>Pharmacy services explained and admission form faxed</td>
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<tr>
<td>All clothing and personal objects labelled</td>
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<tr>
<td>‐  Glasses</td>
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<td>‐  hearing aids</td>
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<td>‐  mobility aids</td>
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<tr>
<td>‐  dentures</td>
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<tr>
<td>‐  clothing labels ordered (Nationwide)</td>
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<tr>
<td><strong>Photo for Medication Chart &amp; Care Plan taken</strong></td>
<td></td>
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<tr>
<td>Allergy stickers: front of history and medication chart (if applicable)</td>
<td></td>
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<tr>
<td>Water jug and cup (if resident not on thickened drinks)</td>
<td></td>
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<tr>
<td>Door of room labelled (with permission)</td>
<td></td>
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<tr>
<td>Terminal care wishes explained</td>
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<tr>
<td>Medical practitioner notified</td>
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<td>Physio notified</td>
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<tr>
<td>Food Services notified</td>
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<tr>
<td>Lifestyle personnel/department notified</td>
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<tr>
<td>Hotel services notified (Nationwide)</td>
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<tr>
<td><strong>Evacuation List updated</strong></td>
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<tr>
<td><strong>Handover form updated</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Resident Register completed</strong></td>
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<tr>
<td><strong>Other:</strong></td>
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</tr>
</tbody>
</table>

**To be completed within 24 hours of entry (or as soon as practicable)  
File in Residents File**

Erigo M.A.C. Pty Ltd
**Admission Assessment Guide**

1. Assessments to be completed on the day specified.
2. Progress notes to completed every shift for first seven days and then daily for the first month.
3. Appropriate care plan to be completed once assessment is complete by RN. *(Low care = RN, EN or PCA)*.

<table>
<thead>
<tr>
<th>DAY</th>
<th>ASSESSMENTS</th>
<th>STAFF RESPONSIBLE</th>
<th>STAFF DATE AND INITIAL</th>
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<tbody>
<tr>
<td>1-2</td>
<td>Initial Assessment and Care Plan</td>
<td>Admitting RN/EN</td>
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<tr>
<td></td>
<td>Resident Orientation</td>
<td>PCA</td>
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<tr>
<td></td>
<td>Consent form</td>
<td>Admitting RN/EN</td>
<td></td>
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<tr>
<td></td>
<td>End of Life Choices (if not completed pre-admission)</td>
<td>Manager/GP</td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>Commence Urinary Flow Chart Stage 1 Observations (3 days)</td>
<td>RN/EN/PCA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mobility and Falls Risk Assessment (Refer to physio once complete)</td>
<td>RN/EN</td>
<td></td>
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<tr>
<td></td>
<td>Nutrition and Hydration Assessment (forward copy to catering department)</td>
<td>RN/EN/PCA</td>
<td></td>
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<tr>
<td></td>
<td>Medication Management Assessment</td>
<td>RN/EN</td>
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<tr>
<td></td>
<td>Commence Bowel Chart</td>
<td>RN/EN/PCA</td>
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<td>GP BGL Reportable Levels (residents with diabetes only)</td>
<td>RN/EN</td>
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<tr>
<td>5</td>
<td>Complete Urinary Flow Chart Stage 2 (3 days)</td>
<td>PCA</td>
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<tr>
<td>1-7</td>
<td>Progress notes (Entry required on each shift)</td>
<td>PCA</td>
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<tr>
<td>8-31</td>
<td>Progress notes (Entry required at least daily)</td>
<td>PCA</td>
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<tr>
<td>8</td>
<td>Continence Assessment</td>
<td>RN/EN</td>
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<td></td>
<td>PAS (if appropriate)</td>
<td>RN</td>
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<tr>
<td></td>
<td>Cornell Scale for Depression (if appropriate)</td>
<td>RN</td>
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<tr>
<td></td>
<td>Behaviour Assessment</td>
<td>RN/EN/PCA</td>
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<td>Commence Behaviour Charting (for 7 days)</td>
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<td>9</td>
<td>Communication and Comprehension Assessment</td>
<td>RN/EN</td>
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<td>Hearing and Vision Assessment</td>
<td>RN</td>
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<td>Dexterity Assessment</td>
<td>EN</td>
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<td>10</td>
<td>Personal Hygiene Assessment</td>
<td>PCA</td>
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<td>Oral and Dental Assessment</td>
<td>PCA</td>
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<td>11</td>
<td>Health Summary</td>
<td>RN/EN</td>
<td></td>
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<tr>
<td>16</td>
<td>Review Behaviour Charts and Complete Behaviour Assessment</td>
<td>RN/EN</td>
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<tr>
<td></td>
<td>Implement Behaviour Alert system (for residents displaying violent or aggressive behaviours)</td>
<td>RN</td>
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<td></td>
<td>Complete Risk assessment (if required e.g. aggressive, displays at risk behaviour etc.)</td>
<td>RN/EN/PCA</td>
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<tr>
<td></td>
<td>Skin Assessment</td>
<td>RN/EN/PCA</td>
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<tr>
<td>17</td>
<td>Sleep charting (7 days)</td>
<td>PCA</td>
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<tr>
<td></td>
<td>Pain Assessment (Part 1)</td>
<td>RN/EN</td>
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<td></td>
<td>Pain Charting (7 days)</td>
<td>RN/EN/PCA</td>
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<td>Complete Key to Me</td>
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<tr>
<td>21</td>
<td>Complete Lifestyle Assessment</td>
<td>DT</td>
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<td>24</td>
<td>Sleep Assessment</td>
<td>ND RN/EN</td>
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<td></td>
<td>Pain Assessment (Part 2)</td>
<td>RN/EN/PCA</td>
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<tr>
<td></td>
<td>Refer to Physio for Pain Management Program (if required)</td>
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<tr>
<td>28</td>
<td>Bowel Assessment and Management Plan</td>
<td>RN/EN</td>
<td></td>
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<tr>
<td></td>
<td>Complete Care Plan Consultation with resident and/or representative</td>
<td>RN/Manager</td>
<td></td>
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<tr>
<td>28-31</td>
<td>Develop Care Plan (RN ONLY for High Care residents)</td>
<td>RN/EN</td>
<td></td>
</tr>
</tbody>
</table>
Initial Assessment and Care Plan

- **Vital signs on admission/entry:**
  - BP
  - P
  - T
  - R
  - Weight
  - Height (cm)

- **Urinalysis:**

- **Allergies** (specify allergen and reaction):

- **Medical History:**

- **Medication:**
  - Complete the Medication Management Assessment and if appropriate, the Medication Self Administration Assessment

- **Communication/Comprehension**:
  - Is there a cognitive impairment that affects communication?  □ No  □ Yes (specify):
  - Does the resident have difficulties associated with speech?  □ No  □ Yes, specify:
  - Languages: English  □ No  □ Yes  □ Other Languages:
  - Interpreter required?  □ No  □ Yes

- **Sensory Perception**:
  - Vision impairment:  □ No  □ Yes (visual aids)
  - Hearing impairment:  □ No  □ Yes (hearing aids)  □ left  □ right  □ Doesn’t use aids
  - Altered taste:  □ No  □ Yes (specify what and cause if known)
  - Altered smell:  □ No  □ Yes (specify what and cause if known)
  - Altered sense of touch:  □ No  □ Yes (specify what and cause if known)

- **Continence**:
  - Continent of urine?  □ Yes  □ No  □ Continent of faeces?  □ Yes  □ No, specify management strategies:

- **Activities of Daily Living**
  - Mobility:  □ Ambulant  □ Non-ambulant  □ History of falls?  □ No  □ Yes, falls risk rating:
  - Specify falls history:
    - Transfer Assistance:  □ No  □ Yes, tick appropriate:  □ bed to chair  □ sitting to standing  □ other:
  - Number of staff required for transfer:  □ One (1)  □ Two (2)
  - Any transfer aids required?  □ No  □ Yes, if yes, specify:
  - Mobility aids required/used  □ No  □ Yes, if yes, tick appropriate:  □ walking frame  □ stick  □ wheelchair  □ motorised wheelchair  □ scooter  □ other:
  - Hygiene:  □ Assistance with hygiene needed?  □ No  □ Yes, if yes, specify:
  - Preferred hygiene:  □ Shower  □ Sponge  □ Bath  □ Preferred time:  □ Frequency:
Initial Assessment and Care Plan

Aids used for hygiene (eg: shower chair, non-slip mat):

Known problems associated with hygiene?  ☐ NO  ☐ YES, if yes, specify:

Natural teeth:  ☐ YES  ☐ NO  ☐ YES, specify:

Loose teeth:  ☐ NO  ☐ YES, specify:

Dentures:  ☐ NO  ☐ YES  ☐ Partial  ☐ Full  ☐ Top  ☐ Partial  ☐ Full  ☐ Bottom  ☐ Partial  ☐ Full

Assistance required/further information:

Skin  Does the resident have any skin problems or conditions (e.g. rash, redness, dry, flaky skin, bruises)  ☐ NO  ☐ YES

If yes, specify, including usual management strategies, including aids such as air mattress:

Does the resident have a wound  ☐ NO  ☐ YES, commence a Wound Management Assessment and Plan

Nutrition and Hydration:  Complete Nutrition and Hydration Assessment

Pain Management:  Does the resident experience pain?  ☐ NO  ☐ YES

Details (location, type, cause, etc):

Current pain management strategies:

(Refer to ACFI Co-ordinator for PMP assessment)

Sleep and Rest:  Any problems associated with sleep?  ☐ NO  ☐ YES, specify:

Preferred time for going to bed:  Preferred time for getting up:  Periods of rest during the day:

Behaviour:  NB ACAT, medical assessments, family/representative and resident discussions

Are there any known problems associated with behaviour?  ☐ NO  ☐ YES, if yes, specify:

☐ Pacing  ☐ Agitation  ☐ Loosing items  ☐ Unsafe smoking habit

☐ Physical aggression  ☐ Verbal aggression  ☐ Wandering  ☐ Resistive assistance

☐ Repetitive  ☐ Anxiety  ☐ Walking without aids  ☐ Depression

☐ Restless  ☐ Hiding items  ☐ Withdrawal  ☐ Alcohol related issues

☐ Smoker  ☐ ETOH  ☐ Social drinker  ☐ Interfering

Any known triggers for the behaviour?  ☐ NO  ☐ YES, if yes, specify:

Behaviour management strategies:

Social and Recreational (refer Resident Vital Data)  Complete Lifestyle Assessment

Allied Health:  Has the resident been receiving any of the following? (tick appropriate boxes)

☐ Podiatry  ☐ Exercises  ☐ Centre based day centre

☐ Dietician  ☐ Physiotherapy  ☐ OT

☐ Ophthalmology tests  ☐ Audiology tests  ☐ Dialysis

☐ Chemo/radiotherapy  ☐ Other, specify:

Current plan for therapies/treatments that will continue:

Date: ............................................  Name: ............................................................

Designation: ....................................  Signature: ....................................................

Ergo M.A.C Pty Ltd
RELATED POLICIES AND DOCUMENTS

- 110 – Accommodation
- 149 – Clothing
- 151 – Consent
- 152 – Documentation
- 161 – Furnishings
- 162 – Homelike Environment
- 154 – External Complaints
- 341 – Suggestions Comments Complaints and Feedback
- 153 – Power of Attorney
- 147 – Call system
- 341 – Suggestions, Complaints, Comments, Feedback
- 332 – Resident movement into Hostel
- 0906 – Accommodation Bond liquidity
Residents are encouraged to maintain control over their financial affairs and may use the office’s petty cash system to bank money.

**POLICY**

Resident Petty Cash accounts are to be managed by Office Staff. Payment of accounts and charges that the Village has not expressly been given written consent to pay could be considered theft by the Resident or Family and will result in disciplinary action.

**PROCEDURE**

To encourage and assist residents to maintain control over their financial affairs:

- Village Baxter does not require residents to have their finances, pension, etc administered by the facility. Management is not allowed to take over control of residents’ money/pension refunds, or financial activities generally.

- Residents are encouraged to maintain control of their own finances.

- If a resident does not wish to manage his/her own finances, we strongly suggest the resident creates an Enduring Power of Attorney in favour of an appropriate person of their choosing. This will allow continued administration of finances even if the resident is unable to do so through incapacity. Further information on how to do this can be obtained from: http://www.publicadvocate.vic.gov.au

- If a Resident wishes to keep cash or valuables in their suite, then a bedside cabinet with a lockable top drawer is provided.

- Management recognises and supports resident’s independence and their desire to hold money in their room but discourages residents from keeping large amounts. Whilst all care is taken to ensure safety and security, and a thorough investigation will be undertaken should a theft occur or money be mislaid, no responsibility can be taken for money that has not been stored in the safe within the office of the facility in which they reside.

- The resident petty cash system is managed by Office Staff of each facility utilising the balancing documents.

- Money kept for petty cash purposes is held in a locked safe.

**RELATED POLICIES AND DOCUMENTS**
Residential Care Policies and Procedures

Policy No. 118
Subject: Behaviour Management
Effective Date: January 2015
Developed by Director of Nursing

PURPOSE
To ensure that staff have guidance in regards to the managing of challenging behaviours.

POLICY
The needs of residents with challenging behaviours will be managed effectively utilizing strategies identified in the care planning process. Restraint is only implemented once all other strategies have been exhausted.

PROCEDURE
Behaviour Management strategies are identified by the following methods:

- On admission, information relating to behaviours of concerns are identified from the discharge summary (previous institution ie: hospital, nursing home etc), the ACCR, discussions with NOK and treating doctor. The behaviours identified with their triggers and management strategies are written on the Initial Assessment and Care Plan.

- Behaviour charting is competed for 7 days with new admissions or when behaviours not previously known are identified. Staff are required to complete behaviour charting identifying the undesirable behaviour, possible triggers, and the interventions which were attempted to address the behavior. The effect of the intervention is also required to be documented.

- Information from the behaviour charting is to be transcribed to the behaviour assessment and care plan by the Registered Nurse. Residents’ behaviour strategies and intervention are to be developed with the least invasive intervention trialed in the first instance.

- Where restraint is required to manage resident behavior then Residential Care Policies and Procedures Restraint 172 must be followed. Restraint as a management strategy for behaviors of concern must only be implemented after all other appropriate interventions have been attempted.

RELATED POLICIES AND DOCUMENTS

- 124 – Absconding/Wandering Residents
- 125 – Care Planning
- 152 – Resident Documentation and Funding
- 172 – Restraint

Behaviour Assessment
Behaviour Chart
Residential Care Policies and Procedures

Policy No. 124
Subject: Missing Residents
Effective Date: February 2016
Developed by Director of Nursing

PURPOSE

1. To ensure staff notify the necessary people and/or agencies in the event of a resident identified as missing.
2. To ensure all residents at risk of absconding are identified and protected.

POLICY

Where a resident is identified as absent from the care facilities and the absence cannot be explained then a thorough search / investigation is to take place to locate the resident. If the residents whereabouts cannot be established within 1hr then the police are to be notified of a missing resident and the department notified.

PROCEDURE

Notify & search:
1. Check diary and sign-out board/book
2. Inform Registered Nurse / Manager
3. RN/Manager instigates and coordinates a search of the building and grounds
4. RN/Manager contacts other departments/areas with the Village seeking location of resident
5. RN/Manager notifies NOK/POA and checks whether any knowledge of whereabouts or of places resident is likely to go.
6. Village Nurses to be contacted to search local area. RN/Manager to provide details of clothing resident was wearing (if known).

Resident is located within the facility / or whereabouts established:
1. No further action required

Resident is located outside of facility within one 1 hour (if appropriate complete the following)
1. Complete "Absconding Risk – Resident Identification form"
2. Commence 3-day Visual Safety Check chart
3. Complete Incident Report

Resident is not located with one (1) hour
1. RN/Manager notifies the Director of Nursing and obtains approval to notify police
2. RN/Manager contacts police and provides a recent photograph, description of clothing (if known) and potential places the resident may have gone.
3. The Director of Nursing notifies the General Manager, Executive Manager and reports absconded resident to the to the Department of Health on 1800 081 549 or via electronic submission as per the Department Website.
4. RN/Manager completes the report of missing resident on the “Absconding Risk – Resident Identification form” and commences the resident Incident form. Note – all actions taken must be recorded on the Resident Incident form

Resident is located
1. RN/Manager notifies NOK/POA, external agencies and other areas of the Village involved in the search, once the resident is located
2. Progress note entry is made regarding where resident found, health condition and treatment required if applicable
3. The Director of Nursing completes the Mandatory Reporting Register as soon as practicable

Note: The department must also be notified if the police return a residents and the facility was unaware that the residents was missing. The Mandatory Reporting Register is to be completed.

RELATED POLICIES AND DOCUMENTS

Absconding Resident Procedure Flow-chart located in Nurses Stations of facilities.
Residential Care Policies and Procedures

Policy No. 125

Subject: Care Planning

Effective Date: January 2015

Reviewed by Director of Nursing

PURPOSE

To ensure all residents have their care needs thoroughly assessed upon entry and at regular intervals according to best practice.

POLICY

All residents will have a care plan developed in consultation with the resident and/or their representative.

PROCEDURE

The Care Planning process occurs as per the following procedure:

- Upon admission, the Admission Assessment Guide is commenced to guide staff regarding the assessments to be completed. The RN ensures the assessments are completed by the “staff responsible” (RN/EN/PCA etc).

- The Initial Assessment and Care Plan must be completed within 24 hours of admission. The Initial Assessment and Care Plan guides the delivery of care until the long term care plan is completed.

- The long term Care Plan is completed within 4–8 weeks of admission using the information gathered from the assessments, Charts and consultation with residents/representatives.

- When changes in residents care requirements occur, then the relevant assessment is reviewed and updated as required - the corresponding care plan is also updated. Notifications of changes to care requirements are to be updated on the handover sheet and communicated to staff.

- Care plans are to be reviewed monthly using the ROD Care Plan Review form. Residents classified as High Care must have their care plans reviewed by the Registered Nurse.

- A ROD schedule is displayed in the nurses’ station that identifies which residents care plan is due for review.

RELATED POLICIES AND DOCUMENTS

Admission Assessment Guide
Initial Assessment and Care Plan
ROD Care Plan Review form
ROD schedule
Residential Care Policies and Procedures

Policy No. 126

Subject: Allied Health Policy

Effective Date: March 2014

Developed by Director of Nursing

PURPOSE

To ensure Village Baxter complies with The Aged Care Act 1997 in regard to residents’ access to health practitioners and specialised therapy services.

POLICY

Village Baxter will liaise with health practitioners and specialised services to visit the RACFs on a regular basis or as required. Where health practitioners and specialised services are unable to visit the RACFs, assistance will be provided to organise external appointments, including transport

PROCEDURE

Internal Visit:

General Practitioners:

Each RACF has a referral book for GP visits. Attending GP’s review this book each visit and attend to the issues raised. RN Staff advise GP’s of urgent medical issues via telephone or fax as appropriate. When the resident’s GP is not available, the preferred Locum service will be contacted to review the concern.

Physiotherapy:

A Physiotherapist attends the RACF each week. A Physiotherapy review book is utilised for staff to advise the Physiotherapist of resident/s requiring review.

Podiatry:

A Podiatrist attends the RACF on regular basis. Residents have their podiatry requirements attended on a 6 weekly cycle. Emergency reviews are available upon request from the Area Manager.

Dentist:

The Village has an arrangement with a local dentist to visit annually and review the dental health of residents with natural teeth. Referral may also be made to Dental Health Services Victoria, Domiciliary Dentistry Programme.

Optometrist:

The Optometrist reviews each resident annually or more frequently as required. Attendance at the RACF is weekly or by arrangement.

Audiologist:

The Audiologist attends The Village on a regular basis and reviews occur as per request or as indicated by the Audiologist.

Dietitian:

A dietitian is available to attend the RACF on a sessional basis. The visit cycle is usually 4-6 weeks however, this changes with demand. Urgent matters can be attended to if required. The Registered Nurses in each facility monitor the review requirements.

Denture Technician:
A Denture Technician is available to attend the RACF as required. Repairs and denture fit issues are generally rectified within 2-3 days. Requests for Denture Technician services should be made through the Area Manager.

**External Visit:**

Residents have the choice to select their own health practitioners and specialised services that do not attend the RACF. In such cases, staff at the RACF will assist residents in organising transport to external appointments – this includes arranging a relative, representative, volunteer to accompany residents to appointments.

*Note: Homecare services need to be booked in advance and attract a small charge payable by the residents.*
Residential Care Policies and Procedures

Policy No. 127

Subject: Catheter Care

Effective Date: January 2015

Developed by Director of Nursing

PURPOSE

To ensure staff have clear guidelines regarding the changing of catheters and the ongoing care requirements for residents.

Definition

IDC: Indwelling Urethral Catheter. An IDC is part of a disposable system consisting of catheter, tubing and drainage bag. A thin tube (as specified by resident’s medical doctor) is passed via the urethra into the bladder to drain urine.

SPC: Suprapubic Catheter. SPC’s are surgically inserted through the abdominal wall into the bladder thereby diverting urine from the urethra and drainage urine into the drainage bag attached to the catheter.

POLICY

The use of a catheter is to be at the discretion of residents LMO or Medical Specialist.

PROCEDURE

Procedure for Female Catheterisation

Equipment

The following equipment is required [4]:

- Disposable catheter pack;
- 1 sachet normal saline;
- 2 sterile catheters;
- 1 sterile urinary drainage bag;
- 10ml syringe;
- 10ml sterile water;
- Incontinence sheet;
- Disposable gloves;
- Catheter support;
- Sterile scissors;
- Adhesive tape

Ensure that the expiration date and condition of all equipment is checked.

Procedure Inserting an Indwelling Catheter for a Female Resident

1. Explain the procedure, obtain consent, answer questions and prepare the resident.

2. Resident or nurse should shower the resident or wash the resident’s pubic area with soap and water.
3. Ensure the resident’s bed or examination table is at the correct height to prevent strain on your back whilst performing the procedure. Place the resident in a recumbent position, knees flexed and wide apart with incontinence sheet under resident.

4. Ensure adequate amount of light available for procedure.

5. Open disposable catheter pack.

6. Wash hands.

7. Open and add extra equipment to the catheter pack using aseptic technique. Place catheter in the receiver.

8. Saturate cotton wool balls with normal saline.


10. Using forceps and cotton wool balls cleanse the resident’s labia majora using a downward stroke. Hold labia part with gloved hand and cleanse the resident’s labia minora and urethral opening.

11. Place a small amount of lubricant into the receiver.

12. Discard one glove and syringe.

13. Position the sterile towel to establish a sterile field between the resident’s legs.

14. Using forceps, place receiver and drainage bag on the sterile field.

15. With fingers, remove the cap from the drainage bag and place the sterile end into the receiver.

16. With fingers, pick up catheter, remove distal sheath and connect catheter to the drainage bag.

17. Fill the syringe with the required amount of sterile water. Inflate the catheter balloon and check for leaks. Deflate the balloon and leave syringe attached.

18. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.

19. Using gloved hand, lubricate the catheter tip. Separate the resident’s labia and gently insert the catheter directly into the resident’s urethra without contaminating the catheter. Check for flow of urine to confirm correct positioning.

20. Inflate the catheter balloon and gently withdraw the catheter until resistance is felt.

21. Remove the remaining plastic sheath from the catheter.
22. Dry the resident. Secure the catheter on the resident’s thigh in a position that will minimise dragging or kinking of the catheter. Hang the catheter bag below the level of the resident’s bladder.

23. Ensure the resident is comfortable and clear the area.

24. Wash hands.

25. Document the date of the catheter insertion in the resident’s notes and care plan.

**Procedure for Male Catheterisation**

In most instances a medical practitioner performs male catheterisation, however the procedure may be delegated to a Registered Nurse with adequate training/experience in performing the procedure.

**Equipment**

The following equipment is required:
- Disposable catheter pack;
- 1 sachet normal saline;
- 2 sterile catheters;
- 1 sterile urinary drainage bag;
- 10ml syringe;
- 10ml sterile water;
- Incontinence sheet;
- 10ml syringe lignocaine anaesthetic jelly and chlorhexidine;
- Adhesive tape; and
- Disposable gloves.

Ensure that the expiration date and condition of all equipment is checked.

**Procedure Inserting an Indwelling Catheter for a Male Resident**

1. Explain the procedure, obtain consent, answer questions and prepare the resident.

2. Ensure the resident’s bed or examination table is at the correct height to prevent strain on your back whilst performing the procedure. Place the resident in a supine position with incontinence sheet under resident.

3. Open disposable catheter pack.

4. Wash hands.

5. Open and add extra equipment to the catheter pack using aseptic technique. Place catheter and 1 pair of forceps into the receiver. Attach syringe to centre of nozzle and open lignocaine anaesthetic jelly.


7. With a paper towel, pick up the resident’s penis and retract the resident’s foreskin if necessary.

8. Clean the resident’s meatus and glans using the forceps and saturated cotton wool balls.
9. Position a second paper towel under the resident’s penis and lower the penis onto the towel. Discard the first paper towel.

10. Position the sterile towel leaving only the cleaned part of the resident’s penis exposed.

11. Using the drape, hold the resident’s penis in a vertical position. Place a small amount of lubricant into the receiver and slowly insert the anaesthetic lignocaine jelly into the resident’s urethra. Hold the jelly insitu for 3 minutes. Discard syringe.

12. Using forceps, place receiver and drainage bag on the sterile field.

13. With fingers, pick up catheter, removal distal sheath and connect the catheter to the drainage bag.

14. Fill the syringe with the required amount of sterile water. Inflate the catheter balloon and check for leaks. Deflate the balloon and leave syringe attached.

15. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.

16. Lubricate the catheter tip. Using the drape, hold the resident’s penis vertically and use the forceps to gently insert the catheter into the resident’s urethra. Check for urine flow to ensure correct positioning.

17. Inflate the catheter balloon and gently withdraw the catheter until resistance is felt.

18. Dry the resident’s penis to remove all anaesthetic lignocaine jelly. Replace foreskin if necessary. Secure the catheter on the resident’s lower abdomen or thigh in a position that will minimise dragging or kinking of the catheter. Hang the catheter bag below the level of the resident’s bladder.

19. Ensure the resident is comfortable and clear the area.

20. Wash hands.

21. Document the date of the catheter insertion in the resident’s notes and care plan.

**Procedure for Suprapubic Catheterisation**

**Equipment**

The following equipment is required:

- Disposable catheter pack;
- 1 sachet normal saline;
- 2 sterile catheters;
- 1 sterile urinary drainage bag;
- 10ml syringe;
- 10ml sterile water;
- Incontinence sheet;
- 10ml syringe lignocaine anaesthetic jelly and chlorhexidine (if required)
- Adhesive tape; and
- Disposable gloves.

Ensure that the expiration date and condition of all equipment is checked.
## Procedure Inserting an Suprapubic Catheter

1. Explain the procedure, obtain consent, answer questions and prepare the resident.

2. Ensure the resident's bed or examination table is at the correct height to prevent strain on your back whilst performing the procedure. Place the resident in a supine position with incontinence sheet under resident.

3. Open disposable catheter pack.

4. Wash hands.

5. Open and add extra equipment to the catheter pack using aseptic technique. Place catheter and 1 pair of forceps into the receiver. Attach syringe to centre of nozzle and open lignocaine anaesthetic jelly.


7. Using forceps, place receiver and drainage bag on the sterile field.

8. With fingers, pick up catheter, removal distal sheath and connect the catheter to the drainage bag.

9. Fill the syringe with the required amount of sterile water. Inflate the catheter balloon and check for leaks. Deflate the balloon and leave syringe attached.

10. Clean the resident's catheter insertion site with forceps and saturated cotton wool balls.

11. Remove previous catheter by deflating the balloon and with a swift movement remove catheter from site.

12. Insert catheter site with Lignocaise jelly (if using – refer to residents care plan if required), discard syringe.

13. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.

14. Lubricate the catheter tip. Use the forceps to gently insert the catheter into the resident’s catheter site. Check for urine flow to ensure correct positioning.

15. Inflate the catheter balloon and gently withdraw the catheter until resistance is felt.

16. Dry the resident's catheter site to remove all anaesthetic lignocaine jelly. Secure the catheter on the resident’s lower abdomen or thigh in a position that will minimise dragging or kinking of the catheter. Hang the catheter bag below the level of the resident's bladder.

17. Ensure the resident is comfortable and clear the area.
Removing a Catheter

Equipment

The following equipment is required:

- 1 disposable receiver
- Paper towel
- Syringe
- Non sterile gloves

Ensure that the expiration date and condition of all equipment is checked.

Procedure for removing a catheter

<table>
<thead>
<tr>
<th>Procedure for removing a Catheter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure, obtain consent, answer questions and prepare the resident.</td>
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<tr>
<td>2. Place the receiver between the resident’s thighs.</td>
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<tr>
<td>3. Wash hands and put on the non-sterile gloves.</td>
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<tr>
<td>4. Attach the syringe to the balloon valve and withdraw the entire contents of the balloon.</td>
</tr>
<tr>
<td>5. Remove the catheter and place it in the receiver.</td>
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<tr>
<td>6. Ensure the resident is comfortable and clear the area.</td>
</tr>
<tr>
<td>7. Measure any remaining urine in the urine collection bag; disconnect the catheter from the drainage bag and dispose of catheter equipment in an appropriate infectious waste bin.</td>
</tr>
<tr>
<td>8. Wash hands.</td>
</tr>
<tr>
<td>9. Document in the resident’s notes, care plan and fluid balance chart (if applicable).</td>
</tr>
</tbody>
</table>

Common concerns

1. Urinary Tract Infections (UTI) are common side effect of long-term catheter use so staff are to be aware of the signs and symptoms of a UTI. Refer: Residential Care Policies and Procedures UTI 142

2. The urinary drainage system should be kept closed at all times to reduce the risk of UTI.

3. Kinking of catheter tubing can cause back flow and increase risk of infection, drainage bags are to be kept lower than the resident without resting on floor (use of leg begs that fix to resident's leg are encouraged)

4. The urinary catheter bag should be emptied regularly and a separate collection jug should be used for each resident to minimise the risk of cross infection. The drainage bag is to be changed regularly in accordance with each resident’s individual care plan.

5. Contamination should be prevented when emptying the catheter bag including wearing disposable gloves.

6. Urine output should be recorded for residents as required.

7. The resident’s catheter is to be changed regularly as per resident’s individualized care plan.
8. Catheter leakage can occur due to IDC blockage, UTI or bladder spasms, which may occur in residents with long term IDCs. Spasming of the bladder creates a force that overwhelms the drainage capacity of the catheter, resulting in leakage.

9. Where leakage is regularly occurring and thought to be due to bladder spasm, the resident’s GP should be informed and the need for an IDC reviewed.

10. Where the likely cause of catheter leakage is considered to be a catheter blockage, e.g. no urine has flowed into the collection bag over 4 hours; a catheter change may be indicated upon consultation with resident’s LMO or medical specialist.

11. Catheter leakage should not be corrected by using a larger diameter catheter.

12. Routine catheter irrigation is not to be done, unless instructed and documented by Medical Practioners or treating medical specialists.

13. The development of biofilm material (encrustation) is caused by buildup of microorganisms and cellular material and may lead to obstruction of the IDC. Encrustation is more likely to occur when the urine is more alkaline. If this is occurring regularly it should be discussed with a resident’s LMO or medical specialist.

14. Staff are to ensure accurate documentation in relation to a resident’s catheter care

References


**RELATED POLICIES AND DOCUMENTS**

125 – Assessment of Resident Care Needs
131 – Health Status – Change in
132 – Medical Care
142 – UTI
152 – Documentation
156 – Medical and Personal Care Records
Residential Care Policies and Procedures

Policy No.  128
Subject:  Gastrostomy Tube (PEG)
Effective Date:  June 2015
Developed by  Director of Nursing

PURPOSE
To ensure staff have a clear understanding of the management requirements of residents with Gastrostomy Tubes (PEG) which is based on best practise guidelines.

POLICY
The management of PEG tubes is undertaken by the Registered Nurses and may be delegated to the Endorsed Nurse with the appropriate knowledge and competence.

PROCEDURE
Stoma Site Management:
1. All staff are required to monitor the stoma site and surrounding skin for irritation, discolouration and infection. Where concerns are identified this is to be reported the Registered Nurse who will contact the stoma therapists for assistance.
2. The PEG site is to be washed with warm soapy water, rinsed well and kept dry.
3. The tube is to be rotated daily 360° and pushing it in and out gently.
4. If the resident pulls the PEG tube out then the Registered Nurse is to immediately stick the tube back in the hole to keep the stoma open (it can close over in 30 minutes). Alternately a sterile catheter tube can be used to fill the hole. Refer to the PEG OUT FLOWCHART located in the nurses station.

Pre Feed Procedure:
1. Explain procedure and purpose to the resident and ensure privacy.
2. Verify Medical Practitioner’s/Dietitian orders.
3. Check allergies.
4. Wash hands.
5. Warm feed to room temperature by removing from refrigerator 15 prior to the due feed.
6. Position the resident with upper body raised at 30-45 degrees.

Requirements:
- 2 x 50 cc syringes (for aspiration and flushing tube)
- 20 cc syringe (for administration of medications)
- Ordered feed
- Jug of water at room temperature
- Feeding administration set (if ordered by dietitian)
- IV pole at bedside (if ordered by dietitian)
- Stethoscope

Note:
- Where pumps are used to administer feeds, then the giving sets are to be replaced daily or as per manufacturers’ recommendations.
- Continuous feeding is to be administered by an enteral pump only.
- Ready Hang Formulations have the Giving Set screwed directly onto formula bottle without removing foil seal.
Feed Procedure
(Registered Nurse and Endorsed Nurse with the appropriate knowledge and competence).

1. Assess the stoma and surrounding skin for irritation, discolouration and infection.
2. Check that the external flange marking at skin level (ie: 4 cms). If it has moved then follow steps below 3 – 6.
3. Check for bowel sounds using stethoscope and to listen over epigastrium for air, by injecting 10mL air into tube.
4. Check placement of tube by aspirating tube to assess to assess gastric contents and pH level for acidity (urinalysis sticks).
5. Once correct positioning of tubing is established then the Registered Nurse can commence the procedure.
6. Flush the tube with 50mL of water before starting feed.

Bolus Feeds (with 50cc syringe)
1. Attached a 50cc syringe to the PEG tube and pour the feed into the syringe. Gravity will make the fluid to flow. ONLY USE THE PLUNGER GENTLY TO ASSIST.

Bolus / Intermittent Feeds (using a giving set)
2. Prepare bag and tubing to administer feed. Close the clamp on the administration set and pour the feed into the set container.
3. If some of the feed is left over, cover feed with lid to avoid contamination, label it with the date and time of opening and return it to the refrigerator as soon as possible. Feeds are to be used within manufacturer’s recommendations.
4. Ensure all air is expelled from the administration set before connecting it to the gastrostomy tube.
5. Hang the container and regulate the rate of flow of the feed as ordered.
6. Provide water bolus every 2 hours or as per Medical Practitioner’s/Dietitian orders to maintain water intake.
7. Avoid excessive hanging time of tube feed. During the day hanging times should not exceed 4 hours or as per the manufactures recommendations, unless utilising equipment specifically designed to hang longer.
8. When the feed has finished, remove the administration set and flush the tube with 50mL of water.
9. If medications are administered via gastrostomy tube, ensure they are well crushed and flushed through with 50mL of water or as per Medical Practitioner’s/Dietitian recommendations.
10. Blockages may be cleared by pushing through 50mL water, sodium bicarbonate or soda water. Avoid using Coca Cola as this can cause the inside of the tube to perish.

Post Feed Procedure:
1. Reposition resident so they are comfortable for at least 1/2hr post feed.
2. Clean feeding flask/bag, administration set or syringe by rinsing after each bolus feed with cold water. After the last feed of the day, wash equipment thoroughly with warm to hot soapy water using a bottle brush if necessary. Rinse in hot water and dry with non-linting cloth, shake or hang items to dry to remove excess water.
3. DO NOT SOAK.
4. Observe for and report nausea, vomiting, distension, cramping or diarrhea to the Medical Practitioner/Dietitian.
5. Store dry equipment in a clean sealed container. Place in refrigerator until next use.
6. If continuous feeding regime, replace and clean equipment daily.
7. Check items for damage, leaking, organic matter and fungal growth.
8. Gastrostomy feeding sets should be discarded weekly unless otherwise recommended by the manufacturer. Syringes can be reused until the plunger sticks. If the syringe is used to administer/measure medications, it is to be discarded once the numbers are difficult to read.
9. Monitor laboratory results for indicators of nutritional status.
10. If there is concern about the health and well-being of the resident, this is to be reported to the Registered Nurse.
11. All findings care given and outcome is to be documented by exception on the resident/client’s care plan and relevant notes.
Newly inserted Gastrostomy Tube

- Maintain fluid Balance Chart
- Do not rotate tube or push tube in and out,
- Wash with soap and water at least once per day.
- Flange to be kept tight.

Medications

- Use liquid forms where possible.
- Pharmacist to advise on suitability of medications for crushing, where liquid form is not available.
- Each medication is to be administered separately.
- Flush with water before and after administering each medication.

Pathology Tests

- The residents doctor is to be encouraged to monitor U&E, Calcium, Phosphate, Magnesium and Albumin while the feeding regime is being established.

Reference material:


RELATED POLICIES AND DOCUMENTS

134 – Nutrition and Hydration
Residential Care Policies and Procedures

Policy No. 129
Subject: Continence Management
Effective Date: January 2015
Developed by Director of Nursing

PURPOSE
To identify the processes in place for assessing, planning, reviewing and evaluating the continence care needs of Residents.

POLICY
Residents’ continence will be managed effectively, utilising contemporary practice and in accordance with resident needs and preferences.

PROCEDURE
Continence Management occurs as per the following procedure:

- Upon admission, The Initial Assessment and Care Plan is completed within 24 hours of admission to guide staff regarding the delivery of care until the comprehensive care plan is completed. The residents initial continence requirements are identified and listed on this document from hospital discharges, ACCR, medical records, doctors and allied health, and in consultation with residents/representative.

- During the admission period, a Urinary Flow Chart is commenced along with daily bowel charting. Information from both charting is reviewed and a Continence and Bowel Assessment is completed. This assessment provides guidance for the specific continence requirements for the resident. For example toileting schedules (where applicable) or a bowel management program.

- Continence requirements are listed on the resident comprehensive care plan. This document is reviewed at least monthly to ensure it remains reflective of residents requirements.

- Each resident’s continence management plan is individualized and where incontinence is identified a re-assessment is undertaken. The Urinary Flow Chart is completed on a needs basis and is useful for identifying patterns in incontinence to establish a toileting schedule. The Urinary Flow Chart is also useful to confirm that resident on toileting schedules remains effective.

- Where required, doctors may prescribe medications to assistance with continence management or refer residents to specialist to review the concern. Staff are to assist with booking of external appoints (as required).

RELATED POLICIES AND DOCUMENTS

- Resident Admission Guide
- Initial Assessment and Care Plan
- Bowel chart
- Urinary Flow Chart
- Continence Assessment
- Bowel Assessment
Residential Care Policies and Procedures

Policy No. 130
Subject: Diabetes
Effective Date: January 2015
Reviewed by Director of Nursing

PURPOSE
To provide staff with information to manage residents with diabetes and limit any adverse effects and complications from this disease.

POLICY
All residents with a diagnosis of diabetes will receive the appropriate monitoring of their BGL’s and receive the correct and timely administration of medications prescribed to treat this disease.

PROCEDURE
Diabetes Management occurs as per the following procedure:

- Upon admission, The Initial Assessment and Care Plan is commenced within 24 hours of admission to guide staff regarding the delivery of care until the comprehensive care plan is completed. The residents diabetes requirements are identified and listed on the GP BGL Reportable levels chart.

- After the admission period a comprehensive care plan is developed – Diabetes Management Care Plan. This care plan is reviewed monthly or as required and provides guidance to have blood glucose levels remaining within the acceptable range.

- The GP Reportable levels chart provides clinical guidelines for the management of residents with diabetes. This includes Frequency of BSL Monitoring and what blood sugars levels are to be reported to the doctor – includes below and above reportable ranges.

- The BGL Monitoring chart lists the times and frequency of monitoring, the reportable levels (below and above), and provides instructions for staff to notify the RN for BGL outside of reportable ranges. This form also requires staff to enter action taken (if required), the date and time reported to the RN and GP along with whether a progress note was completed. Staff are to write a progress note if a BGL is reportable.

- When LOW blood sugars are identified, staff are required to flow the Hypoglycemia Flow Chart to manage this clinical incident. A Hypoglycemia Management Kit is available in the treatment room of the Lodge and in the nurses station of the Manor (flow chart is located in the kit)

- To ensure staff are able to accurately measure residents BGL levels Blood Glucose Monitoring Competency Assessment are required to be undertaken by PCA staff and re-tested every 2 years (only applies to the Lodge)

RELATED POLICIES AND DOCUMENTS
- 133 – Medication
- 134 – Nutritional Care
- GP BGL Reportable levels chart
- Diabetes Management Care Plan
- BGL Monitoring chart
- Hypoglycemia Flow Chart
Residential Care Policies and Procedures

Policy No. 132
Subject: Medical Care
Effective Date: January 2015
Reviewed by Director of Nursing

PURPOSE

To ensure that the directives of the resident’s chosen health care professional are carried out by Staff.

POLICY

Residents are encouraged to select their own Medical Practitioner. Some Medical Practitioners do not provide visiting services and arrangements should be made for residents to access their preferred Practitioner in these circumstances at their cost.

PROCEDURE

- Residents are to receive appropriate medical care by a Doctor of their choice when needed.
- A medical assessment of the resident is to be undertaken as soon as practicable following admission.
- Residents are also able to visit their Doctor of choice outside the Facility. Relatives/Representatives may be required to accompany the resident. Home Care Services may be purchased if there is no relative able to assist with transportation. Staff can assist residents with making such arrangements.
- A record of assessment, diagnosis and treatments is to be readily available to enable other medical practitioners are able to treat the resident appropriately in emergency situations. It is recommended that doctors and allied healthcare providers write their progress notes and directives on the day of review and avoid providing notes at later date.
- Medical care is to be reviewed as required for ongoing assessment / adjustment of the treatment program and / or referral to appropriate specialists in accordance with any change in the resident’s care needs.
- The treatment and medication prescribed by the medical practitioner is to be correctly administered.
- After hours medical service is to be called if necessary if the resident's own doctor is unavailable.
- Ambulance transfer to hospital for assessment may also be appropriate at times. If this occurs the next of kin / POA should be notified.
- Residents are enabled and encouraged to make informed choices about their care.

RELATED POLICIES AND DOCUMENTS

- 101 – Accidents / Incidents
- 111 – Admissions
- 125 – Assessment of Care Needs
- 152 – Documentation
- 133 – Medication
- 156 – Medical & Personal Care Records
- 131 – Health Status – Change in
Residential Care Policies and Procedures

Policy No. 133

Subject: Medication

Effective Date: January 2015

Developed by Director of Nursing

PURPOSE

To protect the safety of residents by appropriate prescription, administration, storage and disposal of drugs and to ensure that staff are given clear directions on the procedure to be followed in accordance with State regulations and good care practice:

POLICY

Refer to medication policy and procedure manual for comprehensive policies and procedures.

PROCEDURE

Refer to medication policy and procedure manual for comprehensive policies and procedures.

Helpful Resources

EMIMS on-line

RELATED POLICIES AND DOCUMENTS

Refer to medication policy and procedure manual numbers 500 – 590 and Appendix A-F for comprehensive policies and procedures.
Residential Care Policies and Procedures

Policy No. 134

Subject: Nutrition and Hydration

Effective Date: August 2015

Reviewed by Director of Nursing

PURPOSE

To ensure that residents have a variety of nutritious foods and fluids in keeping with their dietary needs and individual preferences.

POLICY

Residents will receive adequate nourishment and hydration in accordance with their needs and preferences, with independence promoted.

PROCEDURE

Residents Nutritional and Hydration needs are met as per the following procedure:

- On admission, the Admission: Dietary/Nutrition Assessment is completed on Leecare within 24 hours. The residents nutritional and hydration needs are identified and listed on this document from the hospital discharge document, ACCR, medical records, doctors and allied health directives etc. and in consultation with resident or representative.

- A copy of the Admission: Dietary/Nutrition Assessment is to be printed and forwarded to the Head Chef – Catering Department within 24 hours.

- The Catering Manager prints list as per their schedule

- Within 30 days of admission, a Detailed Care Plan is developed, which identifies all of the nutritional and hydration needs of the resident. This care plan is reviewed two-monthly with the care evaluation, or earlier if required and provides guidance to staff for the resident's identified needs and choices.

- When subsequent changes throughout the resident's stay are required, the Dietary Details Assessment in Leecare is updated and the Nutrition and Hydration Changes Form completed and forwarded to the Head Chef – Catering Department.

- All residents requiring food and/or fluids of a modified texture due to swallowing/functional concerns are to have an assessment by the appropriate health care practitioner (i.e. Speech Therapist).

- Staff who identify a resident coughing or having difficulty eating or drinking are to notify the RN for a review. In such circumstances the resident should be encouraged to stop eating or drinking until a review by the RN has occurred.

- Residents are weighed (at least monthly) and where required have their intake monitored on the appropriate chart (Food Chart, Fluid Balance Chart, Observation Record).

- The Nutrition Risk Screening Tool is completed during the admission process and as assessed thereafter:

- Note: Increased monitoring of the Residents nutrition and hydration is required during the warmer months. Additional fluid to be offered as required (unless on 1 Lt. fluid restriction).

RELATED POLICIES AND DOCUMENTS
Residential Care Policies and Procedures

Policy No.  135

Subject: Oxygen Therapy

Effective Date: January 2015

Reviewed by Director of Nursing

PURPOSE

Oxygen is to be used with caution in accordance with this policy

POLICY

Oxygen therapy should be administered by and/or under the direction of a RN and understand the body’s response to oxygen. Oxygen Cylinders are available in all areas for emergency use.

PROCEDURE

Oxygen is required by the body to facilitate the breakdown of glucose into a useable energy form. It is an odourless, tasteless, colourless gas and necessary for life. It passes into the body through the respiratory system and is transported to the body’s cells by haemoglobin, attached to red blood cells. Supplemental oxygen increases the amount of oxygen in the blood, increasing the amount of oxygen delivered to the tissues.

1. DEFINITION:

Oxygen therapy is a procedure in which oxygen is administered at a concentration that is greater than that found in the environmental atmosphere. The aim of oxygen therapy is to provide adequate oxygen transport in the blood, decreasing the work of breathing and reducing stress on the myocardium of the heart.

2. ASSESSMENT:

Hypoxaemia

Is a decrease in arterial oxygen tension in the blood. Manifestation of hypoxaemia may present with changes in mental status, dyspnea, increased blood pressure, changes in heart rate, dysrhythmias, diaphoresis and cool extremities. Hypoxaemia usually leads onto hypoxia.

Hypoxia

Is a decrease in oxygen supply to the tissues. If severe enough hypoxia can be life threatening. Rapidly developing hypoxia causes changes in the central nervous system due to the higher neurological centres being more sensitive to oxygen deprivation. This may be presented resembling alcohol intoxication with incoordination and impaired judgement. Long term hypoxia as caused chronic obstructive pulmonary disease and chronic congestive heart failure, may present with fatigue, drowsiness, apathy, inattentiveness and delayed reaction time.

Hypoxaemic

Results from decreased oxygen levels in the blood, which leads to hypoxia decreased oxygen diffusion into the tissues. Causes can be pulmonary embolism.

Circulatory hypoxia.

Results from inadequate blood circulation. It can be caused by decreased cardiac output, local vascular obstruction, shock, and cardiac arrest. This is treated by identifying and treating the underlying cause.

Oxygen is indicated for use in patients who have suspected hypoxaemia or respiratory distress from any cause, cute chest pain if myocardial infarction is suspected, and shock from any cause or major trauma.
3. METHODS OF ADMINISTRATION:
Oxygen is usually dispensed from a piped system or an oxygen cylinder. A reduction gauge is used to reduce the pressure to a working level and a flow meter regulates the flow of oxygen in litres per minute.

<table>
<thead>
<tr>
<th>Device</th>
<th>Suggested Rate (l/min)</th>
<th>O2 Percentage</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Cannula (prongs)</td>
<td>1-2, 3-5</td>
<td>23-30, 30-40</td>
<td>Lightweight, comfortable, inexpensive, easy to use while eating and doing activity.</td>
<td>Dries nasal mucosa, not precisely accurate</td>
</tr>
<tr>
<td>Mask, Simple (low to medium concentration)</td>
<td>6-8</td>
<td>40-60</td>
<td>Simple to use, inexpensive</td>
<td>Can be poor fitting, not precisely accurate, must be removed to eat</td>
</tr>
<tr>
<td>Mask, Venturi (moderate concentration)</td>
<td>4-6, 6-8</td>
<td>24, 26, 28, 30, 35, 40</td>
<td>Provides low levels of supplementary O2, accurate delivery, additional humidity available</td>
<td>Must be removed to eat</td>
</tr>
<tr>
<td>Oxygen Concentrators (usually used in the home setting/on going use)</td>
<td>1-4</td>
<td>Approx 36</td>
<td>Relatively portable, easy to operate, cost effective.</td>
<td>More maintenance than other systems, cannot deliver flows in excess of 4 litres.</td>
</tr>
</tbody>
</table>

PREPARING A CYLINDER FOR USE:
A full cylinder should have a plastic stopper inserted in the valve outlet, or if a smaller cylinder, plastic tape wound around the outlet.

When preparing a cylinder for use:
- Check the external condition and colour of the cylinder and make sure that it is an oxygen cylinder.
- Check the valve and outlet port, and wipe them clean.
- Remove the plastic stopper or tape and check for moisture in the outlet port.
- Point the cylinder away from you and 'crack' the valve for one second.
- Ensure the valve is turned off tightly.

CONNECTION OF OXYGEN EQUIPMENT:
When the selected cylinder has been prepared, connect the equipment as follows.
- Attach the appropriate yolk device, ensuring that the valve fittings correspond to those on the valve stem.
- Tighten the locking screw gently with a cylinder spanner (larger cylinders), or 'finger tight' (smaller cylinders).
- Attach appropriate oxygen therapy devices.

STORAGE OF CYLINDERS:
Oxygen cylinders should be stored carefully and in accordance with relevant Government regulations. Prior to storing cylinders, you should contact BVB OH&S representative for direction and advice.

Some important points to remember are:
- Cylinders should be kept cool, dry and undercover.
- All cylinders should be kept in a secure but accessible area near the oxygen equipment.
- Cylinders should be contained or secured to prevent movement and precautions should be taken to prevent them falling over.
- The storage area should be out of direct sunlight and away from heat.
- Do not store near grease or oil.
- Full and empty cylinders should be clearly marked and kept stored separately.
- The storage area should have the regulation signage.
- There should be no naked flames or smoking allowed within 25 metres of stored oxygen cylinders.
Empty cylinders should be returned for filling without delay.

PROCEDURES FOR ADMINISTERING OXYGEN:

BY FACE MASK:

- Reassure the person
- Explain the need for oxygen therapy
- Explain that the oxygen mask will assist with breathing
- Select mask
- Connect oxygen tubing to mask
- Connect oxygen tubing to flow meter
- Turn on the oxygen
- Turn on flow meter to appropriate rate ( lts/min )
- Place mask comfortably over persons face, covering the mouth and nose
- Adjust straps
- Adjust metal strip over nose
- Continue to reassure the person
- Continue to observe the person
- Document procedure

BY NASAL PRONGS:

- Reassure the person
- Explain the need for oxygen therapy
- Explain that the oxygen mask will assist with breathing
- Select appropriate size nasal prongs
- Connect oxygen tubing to flow meter
- Turn on the oxygen
- Turn on flow meter to appropriate rate ( lts/min )
- Place tips into persons nostrils
- Place tubing over and then under persons ears ( as in Diagram A )
- Adjust for comfort
- Secure tubing to resident’s clothing
- Continue to reassure the person
- Continue to observe the person
- Document procedure

Diagram A:

4. ADVERSE EFFECTS:

Excessive oxygen may produce toxic effects of the lungs and central nervous system or it may depress ventilation eg COPD patients. Signs of inadequate oxygenation should be observed for when oxygen is administered, and the resident should be assessed frequently for: confusion, restlessness progressing to lethargy, diaphoresis, pallor, tachycardia, tachypnea, and hypertension. As a medication, oxygen can have serious side effects such as oxygen induced hypoventilation and atelectasis (collapsed lung). Another potential side effect and perhaps the most serious is oxygen toxicity. This may occur when oxygen is administered at too high a concentration for an extended period. Signs and symptoms of oxygen toxicity include substernal distress, paresthesias, dyspnea, restlessness, fatigue, malaise, progressive respiratory difficulty and an alveolar pattern on chest x-ray.

Any signs of adverse effects should be documented and reported to LMO immediately for further treatment. Ambulance transfer to hospital may be required.

5. CARE IN THE USE OF OXYGEN:

*Oxygen for medical use:*

Medical oxygen is stored under pressure (up to 13,400 kPa ) in steel or aluminium cylinders. These cylinders can be identified by the following features.

- Australian standard pin index valve for oxygen equipment.
- Black bottle with white collar.
- The cylinders should be labelled 'Medical Oxygen'.

Common cylinder sizes are:
6. SAFETY WITH OXYGEN:

- DON'T drop or roll cylinders
- DON'T completely empty a cylinder – leave pressure in the cylinder to prevent moisture entering
- DON'T expose cylinders to extreme heat or flame
- DON'T smoke near oxygen equipment
- DON'T use petroleum based oil or grease products near oxygen equipment

7. The minimum contents of a portable resuscitation unit should be:

- oxygen cylinder not less than half full
- regulator and flow meter (regulator may incorporate the flow meter)
- oxygen therapy mask
- oxygen therapy tubing
- oxygen cylinder key-wheel
- spare bodock seal

Additional supplies may include

- suction unit (manual or oxygen powered)
- guedel airways sizes 1, 2, 3 and 4

RELATED POLICIES AND DOCUMENTS

- 101 – Accidents / Incidents
- 111 – Admissions
- 102 – Ambulances
- 125 – Assessment Resident Care Needs
- 151 – Consent
- 152 – Documentation
- 132 – Medical Care
- 156 – Medical & Personal Care Records
PURPOSE

To ensure all residents are as free from pain as possible:

POLICY

All residents will be monitored for signs and symptoms of pain and the appropriate intervention undertaken to ensure the residents remains as pain free as possible.

PROCEDURE

Pre-amble

DEFINITION:

Pain is a very individual experience and therefore difficult to measure. Hence, only those with pain can communicate their perception of its presence and intensity. This communication may be verbal, or non-verbal eg. a change in usual behaviour.

If pain is present, a detailed assessment is to be undertaken including:

- location;
- pattern and character;
- residents response to the pain;
- factors that may bring on the pain;
- factors that may relieve the pain, etc.

Residents’ pain management needs are met as per the following procedure:

- Upon admission, the Initial Assessment and Care Plan is completed within 24 hours of admission to guide staff regarding the delivery of care until the comprehensive care plan is completed. The residents pain management needs are identified and listed on this document from hospital discharges, ACCR, medical records, doctors and allied health, and in consultation with residents/representative.

- During the admission period, a new Pain Assessment is completed and Pain Charting undertaken for 3-5 days.

- Pain charting is to be completed on the authorized form. This form has both the Pain Score (scale 1-5) and Abbey Pain Score (faces). This chart will capture resident who are able to communicate their pain and residents who have difficulties expressing pain (palliative care or cognitive deficits).

- After the admission period a comprehensive care plan is developed from the Pain Assessment and Pain Charting. The Pain Management Care Plan provides staff with the interventions to keep residents as pain free as possible.

- For resident with chronic pain, the physiotherapy pain management program (Pmp) may be implemented. The RN is to notify the ACFI Coordinator to obtain approval for the program.

- Where residents pain strategies are reviewed by the Doctor or RN and changes made (ie: medications), a pain chart should be commenced to monitor the effects of the new treatment in controlling resident pain.
Related Policies

- 170 – Lifestyle and recreational programs
- 111 – Admissions
- 125 – Assessment of Resident Care Needs
- 152 – Documentation
- 132 – Medical Care
- 131 – Health Status – Change in
Residential Care Policies and Procedures

**Policy No.** 137

**Subject:** Ambulance Policy

**Effective Date:** January 2015

**Reviewed by** Director of Nursing

**PURPOSE**

To ensure staff have a clear understanding of the process when requesting an Emergency or Non-Emergency Patient Transport (NEPT).

**POLICY**

Village Baxter staff will request ambulance services in accordance with the Ambulance Victoria and the Department of Health guidelines.

**PROCEDURE**

**Emergency Ambulance booking process:**
Where a resident, staff member or visitor is assessed as requiring urgent medical assistance, which cannot be managed onsite, then an ambulance is to be called.

The RN1 on duty (or delegate) calls “0”000.

The Operator will -

- Request the exact location of the emergency – e.g.: 8 Robinsons Rd Frankston South...
- Request the phone number you are calling from.
- Ask what is the problem, what exactly happened? Are you with the patient, is the person breathing?
- Ask the age of the person – if unsure provide an estimate
- Ask is the person awake/conscious?
- Ask do they have chest pain.
- Advise the estimated time of arrival.

**Non-Emergency Patient Transport (NEPT) booking process:**

- The Medical Practitioner (includes RN1) identifies that a resident requires transport for medical intervention/investigation which is not considered urgent.
- The resident is considered stable and meets the guidelines for transport by NEPT.
- The Ambulance Victoria (AV) Non-Emergency Transport Request Form is to be completed and faxed to either stretcher or walker/wheelchair department.
- A confirmation fax will be returned to the booking origin.

**Note:** The patient acuity is a requirement when making a booking and information relating to patient acuity can be located on the reverse side of the Non-Emergency Transport Request Booking Form or near the phone in the main nurses’ station of either Facility. [http://www.ambulance.vic.gov.au/media/docs/NEPTRequestMayv2-d610b37b-d8a5-48a2-abca-f638b0c13747-0.pdf](http://www.ambulance.vic.gov.au/media/docs/NEPTRequestMayv2-d610b37b-d8a5-48a2-abca-f638b0c13747-0.pdf)
Residential Care Policies and Procedures

Policy No. 138

Subject: Syringe Driver

Effective Date: January 2015

Reviewed by Director of Nursing

**PURPOSE**

To give staff a clear understanding of how to use a syringe driver

**POLICY**

Staff are required to successfully complete the syringe driver competency, follow the manufacturers guidelines and instructions, and administer medication as per doctors' orders.

**PROCEDURE**

Syringe Driver NIKI T34.
Register Nurse to manage NikiT34.

**PPE Required**
- Gloves
- Protective Eyewear
- Handwash

**Tools/Equipment**
- Medications
- Niki T34 Syringe Driver with a lock box, key and 9 volt alkaline battery in situ.
- BD plastipak leur lock syringe for loading (largest syringe fitting is 50ml) – determined by the volume of drugs.
- 1ml/2ml syringes (for accurate drawing up)
- Needles for drawing up medications
- Saf-T-Intima
- Extension tubing: Tuta, 75cm leur lock tubing.
- Sodium Chloride 0.9% ampoule, 10ml ampoule/s as diluent, unless H20 ordered
- Swabs
- Opsite transparent dressing
- Medication chart with written orders from the Medical Practitioner
- Sharps container
- Additive label: to be completed with the relevant details

**KEY POINTS**
- Delivery rate is set in millilitres (ml) per hour (ml/hr)
- Any medication can be administered which does not cause interaction in the syringe, or irritation to the tissue.

The Syringe Driver will give an audible alarm and visual display on the screen when:
- Occlusion occurs (between pump & patient)
- On completion of the program
- Program near completed
- Near end syringe, empty syringe
- Battery is lower than 7volts
- Battery depleted
Wrong setting (protocol requested is outside of same limits set by senior personal under level 3 access code)

The LED backlit display screen also indicate:

- Infusion time remaining
- Rate
- Syringe brand and size
- Remaining volume (VTBI=volume to be infused)
- Volume Infused (VI)
- Battery level

The Syringe Driver, battery, tubing & SC site require to be checked regularly.

**STEPS TO CARRY OUT THE JOB**

**Step 1 – Preparing the Syringe**
- Use the prescribed luer lock syringe BD-Plastipak

**STEP 2 – Connect Infusion Set to the Syringe**
- Select the appropriate infusion set
- Connect the infusion set securely to the syringe and prime the tubing (if new infusion)

**STEP 3 – Prepare the NIKI T34 Syringe Pump**

Preloading and Syringe Placement
- Ensure that the barrel clamp arm of the NIKI T34 is down.
- Turn on the NIKI T34; press and hold the “ON / OFF” button. The pump will beep once and the software version of the NIKI T34 will appear on the screen.
- The LCD display will show “PRE-LOADING” and the actuator will start to move, wait until it stops moving. The pump is calibrating itself during this process. The NIKI T34 will prompt you to load the syringe.

Checking the Battery by pressing “INFO” key repeatedly until the battery level appears on the screen and then press “YES” key to confirm.

*Note*: Discard the battery if less than 20 % life is remaining. The average battery life, starting at 100 %, is approximately 3-4 days depending on use.

**STEP 4 – Fitting the Syringe to the NIKI T34**
- Lift the barrel arm up
- Seat the filled syringe collar / ear and plunger so the back of the collar / ear sits against the back of the central slot (ensure correct placement). The syringe collar / ears should be vertical.
- Lower the barrel clamp arm.

**STEP 5 – Confirm the Syringe Size and Brand.**
The NIKI T34 will detect the syringe size and brand once loaded. You must ensure the correct brand of syringe is selected as the NIKI T34 reads the volume digitally and the incorrect choice of syringe brand could result in an incorrect volume being detected.

If the NIKI T34 has selected the correct brand and size of the syringe press the “YES” key to confirm

OR

Use the ▲▼ arrows to scroll up or down to view other syringe brand choices, select your correct syringe brand and then press “YES” key to confirm.

**STEP 6 – Setting the Infusion Parameters (New Patient)**
After the syringe has been confirmed the next screen that appears will show the volume of the content of the syringe, default duration and rate. The NIKI T34 calculates and displays the deliverable volume, duration of an infusion eg. 24 hours and the rate of this infusion will be displayed in mls/hr eg. 0.36ml/hr.

Press “YES” Key if these details are correct.
The pump screen will then prompt “START INFUSION”

**STEP 7 – Review the Infusion Parameters (Same Patient)**
After the syringe confirmation, the first screen that appears below.
- Press “YES” Key to resume the same programme / infusion
OR

- If this is a new infusion – press “NO” key for a new programme

STEP 8- Start the Niki T34
Now that that the infusion has been confirmed the Niki T34 will prompt you to commence the infusion.
- Check the line connection to the pump and press the “YES” key to start the infusion.

Place the loaded syringe driver in the lock box and lock same


RELATED POLICIES AND DOCUMENTS

133 – Medication
131 – Health Status – Change in
125 – Assessment of Resident Care Needs
132 – Medical Care
152 – Documentation
Residential Care Policies and Procedures

Policy No. 140

Subject: Urinalysis

Effective Date: January 2015

Reviewed by Director of Nursing

PURPOSE

To provide guidelines for staff to perform urinalysis.

POLICY

Urinalysis should be performed as part of a Resident admission, continence care review or at other appropriate times as clinically indicated.

PROCEDURE

Preamble:

Urinalysis is a term used to describe a process used to examine urine using chemical and/or physical means. Urinalysis consists of whole host of chemical and microscopic tests, and it is a useful screening tool for diseases such as urinary tract infections, renal disease, and other diseases of the body which result in the formation of compounds that can be detected in the urine at abnormal levels. The urinalysis has proven itself as a procedure that can be performed relatively quickly and easily while providing the doctor with lots of useful information.


Process:

1. Collect fresh urine in a yellow lid specimen container.
2. Check regent strips – within used by date.
3. Dip one reagent stick completely into urine as per manufactures instructions.
4. When pulling stick out of urine, run one edge along the rim of the jar to remove excess urine
5. Hold stick flat to prevent colours mixing.
6. 30 seconds after dipping reagent stick into urine, compare coloured areas to chart on the bottle.
7. Begin with glucose moving upwards toward top. Note that leucocytes time is 2 full minutes.
8. Record results as you go – see below for details
9. Be sure to wash your hands. Wearing gloves is recommended.

<table>
<thead>
<tr>
<th>Analyte</th>
<th>What is it?</th>
<th>Normal results</th>
<th>Abnormal results could indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td>Sugar</td>
<td>Negative to Trace</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Bilirubin</td>
<td>Comes from the normal breakdown of blood cells</td>
<td>Negative</td>
<td>Liver disease</td>
</tr>
<tr>
<td>Ketones</td>
<td>Comes from body using stored body fat for energy</td>
<td>Negative</td>
<td>Diabetes, weight loss</td>
</tr>
<tr>
<td>Specific Gravity</td>
<td>Proportion of dissolved solids to fluids</td>
<td>1.005 to 1.030</td>
<td>Low: diabetes, High: dehydration, liver</td>
</tr>
</tbody>
</table>
**Blood**
- Blood cells or parts of dead blood cells
- Negative
- Urinary tract infection or kidney disease

| pH | Acidity or alkalinity | 5.0 to 6.0 | Low (acid) – high protein diet, diabetes
High (alkaline) – Infection, some medications can cause this

| Protein | Normal albumins and globulins in body | Negative to Trace | Kidney disease, urinary tract infection

| Urobilinogen | Comes from bilirubin | 0.2 to 1.0 mg/dL | Liver disease

| Nitrite | Comes from bacteria | Negative | Urinary Tract infection

| Leukocytes | White blood cells | Negative | Urinary tract infection

---

**STICKY LABEL**

- **NAME:**
- **SUITE:**

**Colour**
- Appearance
**Glucose**
**Bilirubin**
**Ketone**
**S G**
**Blood**
**pH**
**Protein**
**Urobilinogen**
**Nitrites**
**Leucocytes**

Report the results on a label using the following as a guide. Be sure to time and date the entry when the label is stuck into the resident’s file:

1. Urine colour as: colourless, straw, yellow, amber, red, brown, blue, or green.
2. Urine appearance as: clear, slightly cloudy, moderately cloudy, or turbid.
3. Glucose as: negative, 100, 250, 500, 1000, or ≥2000 g/dL.
4. Bilirubin as: negative, small, moderate, or large.
5. Ketone as: negative, trace, small, moderate, or large.
6. Specific gravity as: 1.000, 1.005, 1.010, 1.015, 1.020, 1.025, or 1.030.
7. Blood as: negative, trace, small, moderate, or large.
8. pH as: 5.0, 6.0, 6.5, 7.0, 7.5, 8.0, or 8.5.
9. Protein: negative, trace, 30, 100, 300, 2000
10. Urobilinogen as: normal, 2, 4 or 8
11. Nitrites as: negative or positive.
12. Leucocytes as: negative, trace, +, ++, or +++

Sticky Labels are available in all treatment rooms / nurses stations for recording results.

**RELATED POLICIES AND DOCUMENTS**

- 142 - Urinary Tract Infections
- 111 – Admissions
- 125 – Assessment of Resident Care Needs
- 152 – Documentation
- 156 – Medical and Personal Care Records
- 131 – Health Status – Change in
- 224 – Hand washing
- 228 – Protective clothing
- 232 – Waste Management
PURPOSE

The TerraQuant MQ2000 is a non-invasive laser device used in wound healing and pain management. This policy will outline the procedures to be followed when it is believed that a resident may benefit from the use of the device.

POLICY

A variety of pain management techniques should be considered in the overall care of residents. The Hostel and Manor have invested in a Laser for wound care and pain management. This is a medical device and should be used strictly according to this policy.

PROCEDURE

1. Resident use:
   a. A complete Nursing Assessment undertaken and documented in relation to the problem for which the laser will be used to treat.
   b. Discussions are to be held and documented with the Resident’s GP to confirm that they approve the treatment.
   c. Discussions are to be held and documented with the Resident and/or family members to obtain consent for the proposed treatment.
   d. A treatment plan is to be documented on an acute care plan.
   e. Evaluation of the progress and outcome of the treatment is to occur as per the usual cycles.

2. Health and Safety requirements.
   a. The machine is to be operated according to the precise directions outlined in the Terraquant operator manual. The guidelines for laser pulse frequency and program duration should be followed exactly and not altered without written orders from the Residents GP or Treating specialist.
   b. Protective eyewear should be worn whilst operating the machine near the face. A sign “Treatment session underway” or similar, should be displayed on the door of the room where the laser machine is being operated.
   c. The machine should never be used on or in the vicinity of, a person with a pacemaker.
   d. The machine is only to be operated by a staff member who is appropriately trained to do so. The staff member should have read and understood the TerraQuant operator manual and obtained approval from their supervisor to use the machine.
   e. The machine is to be stored safely in the locked medication rooms in the Manor when not in use.
   f. Damage or malfunction of the machine is to be reported immediately to the Care Manager and the machine not to be used if damage or malfunction is suspected.
   g. The machine will be tagged and tested in accordance with electrical safety requirements and will not be used if the safety tag has been removed.
   h. Staff members wishing to use the machine for their own purposes must seek and obtain permission to do so first.

RELATED POLICIES AND DOCUMENTS
• 125 – Assessment of Resident Care Needs
• 151 – Consent
• 152 – Documentation
• 156 – Medical & Personal Care Records
• 136 – Pain Management
• 145 – Wound Management
• 228 – Protective Clothing
• 752 – Maintenance of equipment
• 435 – Staff Competencies
PURPOSE

Urinary tract infections (UTI) represent one of the most commonly seen bacterial infections within the community. These occur frequently in the elderly and require thorough assessment and prompt treatment.

POLICY

Residents with a UTI should be assessed every shift by nursing staff for signs and symptoms suggesting progression of infection and/or worsening of overall condition:

PROCEDURE

Urinary tract infection is the presence of pathogenic micro-organisms in the urine, urethra, bladder, kidney, or prostate.

Pyelonephritis is an infection of the upper urinary tract including the kidneys that usually develops as a complication of lower UTI when bacteria travels up the urine tract, pyelonephritis can develop rapidly into septicaemia if not managed correctly and promptly.

Assessment

Initial assessment

The most common presenting signs and symptoms of UTI are:

- Dysuria (difficulty voiding)
- Frequency
- Suprapubic discomfort and tenderness (above the pubic bone)
- Urgency
- Hematuria (blood in urine)
- Nocturia (goes to toilet many times at night)
- Cloudy and/or foul smelling urine.

Residents with pyelonephritis (kidney infection) present with the following signs and symptoms:

- May or may not have symptoms of lower UTI
- Pain (side of abdomen over kidney site)
- Fever
- Nausea and vomiting
- Diarrhoea
- General malaise.(feeling tired & generally low)

Older adults frequently present with atypically signs and symptoms such as falls, immobility, increased confusion, shock, anorexia or poor general health.
Investigations
Diagnosis of lower UTI or pyelonephritis (kidney infection) is dependent on presence of bacteriuria and pyuria. The following investigations should be conducted to confirm diagnosis and severity of illness and to direct antimicrobial therapy choices.

**Urinalysis**
For residents suspected of having a UTI, a clean catch mid-stream urine (MSU) specimen should be collected for urine dipstick analysis. This test checks for the presence of white blood cells (pyuria) and nitrates in the urine.

- **Pyuria test**: looks for white blood cells
- **Nitrate Test**: Detection of nitrates indicates the presence of nitrate-producing bacteria in the urine.

**Urine Microscopy and Culture**
Urine culture traditionally used to confirm a diagnosis of UTI diagnosis. An MSU should be collected prior to commencement of antimicrobial therapy. Success in bacteria isolation depends on specimen collection technique. Fifty percent of MSUs fail to detect specific pathogens in symptomatic Residents due to incorrect specimen collection technique.

Urine culture is indicated in the following circumstances:
- Doubt about the diagnosis
- History of recent urinary infection (within the last 3 weeks) suggesting relapse of the previous infection and a degree of antibiotic resistance
- History of recent urinary tract instrumentation (eg catheterisation)
- Presence of diabetes
- Populations with high risk of infection with resistant organisms (e.g RACF residents)
- Elderly Residents presenting with atypically signs and symptoms.

Urine for microscopy and culture should be refrigerated at 4oC whilst awaiting processing, which should be performed as soon as possible after MSU collection. Urine that has been stored at 4oC for up to 48 hours is suitable for culture, but not for microscopy.

**Ongoing Assessment**
Residents should be assessed every shift by nursing staff for signs and symptoms suggesting progression of infection and/or worsening of overall condition:
- Rigors (indicate ongoing bacterial sepsis)
- Pain
- Ongoing dysuria, frequency or hematuria
- Fever
- Dehydration (eg dry tongue, tissue turgor, urine colour).
- Residents should be referred for review at an acute hospital facility if there is persistent high fever and/or rigors, vomiting, or significant pain for longer than 48 hours.
- The resident should be reviewed by his or her GP within 48hrs to determine progress and check urine culture results.

**Oral antibiotics**
As prescribed by the GP, strictly according to schedule.

**Fluids**
Dehydration should be corrected and Residents with severe vomiting may require either intravenous or subcutaneous re-hydration. Increasing fluid intake is common advice for women suffering from lower UTI, however the effectiveness of increasing fluids to ‘wash out’ the bladder has not been clearly established and may cause distress to Residents with dysuria.

**RELATED POLICIES AND DOCUMENTS**

- 140 – Urinalysis
- 262 – Infection reporting criteria
- 263 – Monitoring of Infections
- 226 – Laboratory Specimens
- 156 – Medical and Personal Care Records
Residential Care Policies and Procedures

Policy No. 145
Subject: Wound Management
Effective Date: January 2016
Reviewed by Director of Nursing

PURPOSE

To ensure that there is a record of diagnosis, treatment plan and ongoing review where skin conditions have been identified:

POLICY

Wound management must be appropriate to the type of wound and follow contemporary practice.

Note: From time to time the Manager or Supervisor may identify a Personal Carer with the appropriate skills required for additional education in skin and wound management. Once appropriate education has been attended and theoretical and practical competency assessed, the Personal Carer may perform simple dressings when directed to by a Registered Nurse.

Competency skills must be assessed by the Manager or Registered Nurse.

PROCEDURE

1. All residents identified with a wound must have a Wound & Skin (acute) Management Plan & Evaluation commenced in the Wound / Skin Management Plan And Evaluation section of Leecare.

2. RN's and EN's are encouraged to take a photo and upload to the Wound & Skin (acute) Management Plan - this will assist with monitoring the progress of the wound.

3. Residents with complex wounds, multiple co-morbidities and risk factors for severe adverse effects are to be reviewed by the Clinical Care Coordinator or RN or appropriate wound care specialist regularly.

4. RN's and EN's are responsible for documenting when wounds have been redressed and updating the next review date in the Wound Healing Status/Evaluation section of Leecare.

5. Scheduled reviews (see "unresolved wounds" under quality tab in reports in Leecare Reports) must be performed by an RN or EN. High care residents are to be managed by the RN.

6. All wounds are to be viewed daily by staff delivering care to ensure dressings are intact and clean with no signs of deterioration. Where wounds are identified as not intact or have deteriorated then the RN is to be notified.

7. Soiled dressings and bandages are to be disposed of in appropriate waste bins and infectious dressings to the yellow bin.

8. RN's are to mark the Wound / Skin Management Plan and Evaluation as “resolved” when the wound has healed.

NOTE: Staff are select "yes" for a progress notes when changes are made to the Wound & Skin (acute) Management Plan & Evaluation.

RELATED POLICIES AND DOCUMENTS

- 125 – Care Planning
- 152 – Resident Documentation and Funding
- 131 – Complex Care, Observations and Therapy
- 220 – Aseptic Technique
- 224 – Hand Washing
- 228 – Protective Clothing
- 232 – Waste Management
Residential Care Policies and Procedures

Policy No. 146 (Under Review – January 2015)

Subject: Audits and Internal Assessment

Effective Date: November, 2011

Developed by Care Manager

PURPOSE

To ensure all processes, policies and procedures are audited and reviewed against practice and regularly assessed to ensure policy represents practice and actual and potential gaps in process are identified.

POLICY

All documents, policies and procedures will reflect actual practice in association with current legislation and clinical best practice.

PROCEDURE

References:
- Standards and Guidelines for Residential Aged Care Services 1998: 1.1; 1.2; 1.5; 1.6; 1.8; 2.1; 3.1; 4.1
- Aged Care Act 1997
- AS/NZS 4269:1995 Complaints Handling
- AS/NZS 3806:1998 Compliance Programs
- AS/NZS AS3911.1:1992 Guidelines for Auditing Quality Systems

<table>
<thead>
<tr>
<th>ITEM / WHO</th>
<th>KEY STEPS</th>
<th>CLARIFICATION</th>
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</table>
| 1 Manager  | Training  | 1. Training programs are in place to ensure staff have the appropriate skills (Refer: Education and Staff Development)  
2. Additional training is conducted by the DON or an external training provider when necessary |
| 2 Quality Manager and Director of Nursing & Care Manager | Audit, Internal Assessment and Review Schedule | 1. Schedule audits and internal assessments on a 12 month schedule annually (Audit Schedule).  
2. Each policy and procedure is audited against practice at least annually.  
3. Practices and documented procedures are internally assessed against the Aged Care Standards on creation and when required due to legislative changes.  
4. Audits are developed and scheduled according to importance and risk of activity being conducted and assessed/reviewed. Additional audits are scheduled if required and using statistics and results from Incident Reports, Quality Improvement Forms, Complaints, and Surveys and other data and statistics that may be gathered from time to time.  
5. Amended on an ongoing basis according to the data and statistics gathered.  
6. The document is reviewed following the internal assessment |
| 3 Internal auditor or assigned staff members | Conducting the Internal Assessment | 1. Staff are assigned the date and time for conducting the audit by the Manager as requested by the Quality Manager and/or Director of Nursing as per the Audit Schedule on the notice board and in the Audit Folder  
2. Procedure audits are conducted using the relevant procedure and all associated relevant forms as described in the procedure. |
<table>
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<tr>
<td>3. The auditor checks for conformity throughout the documents and with the stated actions within “clarification” headings to ensure what we are saying we do is what we are doing.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 4. Internal auditor or assigned staff member | Audit Assessment, Reporting and Actions | 1. Results are documented on the specific audit or on an Audit Report for policy and procedural audits.  
2. The Audit Schedule is updated by the Quality Manager once audit has been completed and returned.  
3. If a gap (variance) has been identified, a Quality Improvement Form (QIF) is completed.  
4. QIF’s are collected and logged as per the Quality Improvement Procedure.  
5. Gaps identified by the audit are to be fixed at the time if possible and this documented on the audit and the QIF.  
6. Audit results are tabled at Supervisors Meetings and in Reports displayed on staff notice boards in Staff Room.  
7. All assessment results are tabled at the Management Meeting.  
8. Copies of completed audit and results are filed in the Audit Folder located in the Quality Manager’s office. |
| 5. Director of Nursing and Care Manager | External Audits and Reviews | 1. Management, staff, residents and other stakeholders are informed of dates and times via notice boards and meetings and email if appropriate.  
2. Results are tabled at Supervisors Meeting, Senior Staff Meeting and Resident and Relative Meeting.  
3. Results are filed in the Audit Folder.  
4. Gaps identified by the external auditors are reported on a QIF and action taken as per Quality Improvement Procedure. |
| 7. Director of Nursing and Care Manager | Monitoring | 1. Audits are conducted as per Audit Schedule and issued by CMA.  
2. Facility Manager conducts or assigns staff member to complete audit and gaps identified are transferred to the Quality Improvement System (refer Quality Improvement)  
3. Data and statistics obtained from Incident Reports, Quality Improvement Forms, Management Reports and internal assessment/audit results are analysed and plans developed to improve outcomes for the resident/client, organisation and personnel.  
4. This procedure is audited and reviewed at least annually. |

**RELATED POLICIES AND DOCUMENTS**
Residential Care Policies and Procedures

Policy No. 147
Subject: Call System
Effective Date: January 2015
Reviewed by Director of Nursing

PURPOSE
To ensure staff have knowledge regarding the nurse call system so all residents have access and information related to the nurse call system.

POLICY
To ensure all residents have a reliable and accessible means of requesting assistance from staff.

PROCEDURE
Staff are to answer call bells promptly. Failure to answer a call bell in a reasonable period without reasonable explanation may result in disciplinary action.

1. Call buttons
   A nurse call system is operating throughout the Lodge and Manor.
   One is provided at each bedside and in the toilets, showers and throughout communal areas.
   The personal carers in the Lodge and Manor are to carry pagers on their person at all times when on duty. When a resident presses their call bell, the number of the room appears on the pager and enunciator in the corridors and nurses station.
   Regular preventative maintenance program ensures the batteries in the pagers are changed on a regular basis.
   Failure or breakdowns of the nurse call system is an emergency maintenance request and urgent attention should be sought 24 hours a day. Failure to report a problem with the nurse call system will result in disciplinary action.

RELATED POLICIES AND DOCUMENTS
Residential Care Policies and Procedures

Policy No. 148

Subject: Children and Eden

Effective Date: January 2015

Reviewed by Director of Nursing

PURPOSE

The purpose of this policy is to implement Eden principle No 2: Life in a truly human community revolves around close and continuing contact with children, plants and animals. These ancient relationships provide young and old alike with a pathway to a life worth living.

POLICY

The children of Staff and Resident’s families are welcome in our Village. We believe that their presence can bring joy and a variety of experiences to the lives of our Residents.

PROCEDURE

Our expectations for the Children’s behaviour:
- Children are visitors in our Resident’s home and will behave accordingly
- Children will not enter Resident’s rooms unless invited to do so.
- Children will be signed into the visitor’s book and signed out when they leave where possible.
- Children of Staff will wear badges that identify their Parent’s name.
- Children will not frighten or mistreat the animals that live in the Village.
- Children will treat residents and staff with respect.

Our expectations for the parents of Children who come to the Village:
- Parents will take full responsibility for their children when they are here.
- Parents are expected to arrange for suitable activities and entertainment for the children while they are in the Village.
- Parents who have been asked not to bring their children into the Village will not do so.
- Parents will ensure children are aware of the location and appropriate use of facilities, (eg toilets, games, TV etc)

Our expectations for our staff’s behaviour toward the children:
- Staff will understand that children may sometimes misbehave.
- Staff will not confront children with concerns about their behaviour, they will raise the matters with their parent.
- Staff will report serious issues of concern about the behaviour of children to the Unit Supervisor.
- Staff will welcome children and treat them with the same courtesy and consideration as afforded to adult visitors.
- Staff will appreciate the role that children have in bringing enjoyment to residents

The following behaviours have been identified as unacceptable and if children do behave in this manner they will be asked not to come back again.

- Behaving in a threatening manner towards Residents, staff, animals or other children
- Behaving in an offensive and socially unacceptable manner.

RELATED POLICIES AND DOCUMENTS

- 170 – Lifestyle & Recreational Programs
- 162 – Homelike Environment
- 165 – Privacy & Dignity
Residential Care Policies and Procedures

Policy No. 149

Subject: Clothing

Effective Date: January 2015

Reviewed by Director of Nursing

PURPOSE

To ensure that residents are appropriately dressed and well groomed in their own clothing:

POLICY

Residents should have an adequate supply of clothing for all seasons and weather conditions. Clothing that is laundered by the Village MUST be correctly labeled.

PROCEDURE

- All Residents should be informed of the requirement to have all clothing permanently labelled prior to entry. Assistance with purchasing permanent labels can be obtained from the Lodge or Manor reception.
- Staff are to notify residents next of kin if additional clothing is required. Consent should be obtained from the resident prior to making such requests.
- The labelling of new clothing is to be labelled by Nationwide. A communication book exists in each RACF to log clothing items for labelling.
- Residents are encouraged to choose the clothes they wear.
- Residents should not wear clothing belonging to other residents.
- Residents are to be well groomed and appropriately dressed for the time of day.
- Residents must have access to their own clothing with sufficient supplies in their wardrobe.
- Residents’ next of kin are responsible for mending and replacing clothing. Arrangements can be made for residents who do not have family.
- Residents and families should be made aware that all clothing laundered on site is washed according to the Australian Laundry standard which requires very high wash and drying temperatures. This will ‘wear’ clothing at a much faster rate than domestic machines which do not meet laundry standards for temperature and duration of wash and dry cycle. Delicate items such as underwear and singlets will wear quickly and will need to be regularly replaced throughout the year.
- Lost laundry is laundry that residents or family members have not labelled and placed in the wash. This clothing cannot be returned as the owner is unknown. This is kept in a single area in each facility for claiming.

RELATED POLICIES AND DOCUMENTS

- Welcome Kit
- Family Welcome Letter
- 111 – Admissions
- 328 – Lost personal property
- 160 – Freedom of Choice
- 165 – Privacy and Dignity
- 114 – Residents funds and petty cash
Residential Care Policies and Procedures

Policy No. 150

Subject: Committees – Residents and Friends

Effective Date: January 2015

Reviewed by Director of Nursing

PURPOSE

The purpose of this policy is to encourage Residents and their relatives or representatives to be involved in the decision making processes affecting the operation of our facility.

POLICY

To provide an avenue through which residents, and their relatives or representatives, can be involved in the decision making processes affecting the operation of our facility, they are to be encouraged to make contributions to their lifestyle either informally (at any time) or formally, by way of meetings or discussion groups.

This contribution also includes being involved in the decision making processes of the facility, which will facilitate the development of a consensus in relation to any proposed changes or dealing with shared concerns.

This participation is important for the residents’ self-esteem and self-worth.

PROCEDURE

Residents and Relatives or Representatives

A gathering of residents and their representatives is held regularly.

Matters of interest are discussed.

Concerns and suggestions may also be shared at this meeting.

If problems or special requests are identified, appropriate action is taken and the evaluation or outcome assessed prior, to or at, the next meeting.

Residents and/or representatives (depending upon the situation) will personally be informed of the proposed action and outcome. This provides an avenue for further discussion.

The meeting will be chaired by a nominated member of staff and minutes of the meetings will be kept and subsequently circulated. Senior members of staff may attend by invitation.

Other staff are not present unless the residents’ request.

RELATED POLICIES AND DOCUMENTS

- 170 – Lifestyle and Recreational programs
- 154 – External Complaints Services
- 341 – Suggestions Comments Complaints
Residential Care Policies and Procedures

Policy No. 151

Subject: Consent

Effective Date: January 2015

Developed by Director of Nursing

PURPOSE

Consent should be obtained to ensure residents have freedom of choice in the care and services that they receive.

POLICY

To ensure that residents are given options, have freedom of choice, and participate in decision making regarding services.

PROCEDURE

Consent may be
- implied
- given verbally
- given in writing

Consent is valid only if
- given voluntarily
- informed
- the person giving the consent has the legal capacity to do so.

Evidence of consent is always to be documented in the Residents’ progress notes

Consent is to be sought
- Prior to any procedure being carried out
- Prior to any care being performed
- Prior to displaying residents name or photographs

Informed consent
- explanation of proposed treatment including inherent risks, benefits and alternatives,
- adequate time given for questioning by resident,
- the option to withdraw at any time.

- If a resident has an intellectual impairment, and is not able to comprehend the nature and consequences of the proposed treatment, the Legal Guardian may be called for consultation and consent.
- All Residents should be offered the standard Village Baxter Consent form upon admission and it should be updated from time to time as necessary.

RELATED POLICIES AND DOCUMENTS

- 114 – Resident’s funds and petty cash
- 111 - Admissions
- 160 – Freedom of Choice
- 165 – Privacy & Dignity
- Consent Form
Residential Care Policies and Procedures


Subject: Resident Documentation and Funding

Effective Date: October, 2011

Developed by Director of Nursing and Care Manager

PURPOSE

To ensure documentation is legible, informative, objective and factual.
To ensure care staff, nursing staff, medical professionals and allied health professionals are provided with the necessary information to provide health and personal care for the resident.
To ensure available funding is received for the care provided.
To ensure documentation is consistent and validates claims for funding under audit.
Documentation meets the relevant legal requirements for Aged Care Residential Facilities.

POLICY

Documentation for resident care, administration and funding will be completed in accordance with legislation, and will be adequate, accurate and consistent to enable proficient resident care, drive improved resident outcomes, and ensure the care provided is funded by Medicare in accordance with the ACFI rules and guidelines.

PROCEDURE

Scope: All residents within the Village Baxter Manor and the Village Baxter Hostel/Lodge.

References:
- Standards and Guidelines for Residential Aged Care Services, 1998: 1.2, 1.8, 2.0;
- Aged Care Act, 1997;
- The Residential Care Manual, 2009, Commonwealth Department of Health and Ageing;
- Privacy Act 1988; and Privacy Amendment (Private Sector) Act, 2000

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<thead>
<tr>
<th>ITEM / WHO</th>
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| 1a Clerical Officer, Admin Support | Resident Files | 1. Sets up resident files prior to resident entry  
   a. Resident Administration File accessed only by Management and financial staff, and agents of the Commonwealth or State Governments and The Aged Care Standards and Accreditation Agency, except with the express permission of the General Manager  
   b. Resident History, Care plans, Resident History archive accessed only by Health and Personal Care and Lifestyle staff, Health Practitioners, Management and agents of the Commonwealth or State Governments and The Aged Care Standards and Accreditation Agency, except with the express permission of the General Manager or Director of Nursing/Care Manager |
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<tr>
<td><strong>1b</strong> <strong>Health and Personal Care, Medical, and Allied Health Staff</strong>&lt;br&gt;Documentation Principles</td>
<td>1. Identification label on each page ([e.g. surname, given name/s, record no, Medicare no, doctor, DOB])&lt;br&gt;2. Use black or blue indelible ink&lt;br&gt;3. Record the date and actual time for each entry (times are not included in care plans)&lt;br&gt;4. Sign and print name and designation&lt;br&gt;5. Legible, brief but clear, comprehensive, factual, objective and accurate; resident's words are quoted if this describes the situation more clearly&lt;br&gt;6. Avoid phrases which provide vague, non-specific information, e.g. 'usual day', 'appetite poor'&lt;br&gt;7. Use accepted abbreviations only as approved by Australian Safety Council and displayed in Nurses Station and available at: <a href="http://www.countryhealthsa.sa.gov.au/LinkClick.aspx?fileticket=MrTKXCI7fEY=">http://www.countryhealthsa.sa.gov.au/LinkClick.aspx?fileticket=MrTKXCI7fEY=</a>&lt;br&gt;8. Cross errors with one straight line, sign and date</td>
<td></td>
</tr>
<tr>
<td><strong>1c</strong> <strong>Facility Manager</strong>&lt;br&gt;Signature Register</td>
<td>1. Maintains a signature and initials register for all staff and kept in Medication Folder&lt;br&gt;2. Old or out of date Signature Register's archived and retained for 7 years</td>
<td></td>
</tr>
<tr>
<td><strong>1d</strong> <strong>Health and Personal Care, Medical, and Allied Health Staff</strong>&lt;br&gt;Progress Notes</td>
<td>1. Assessment; treatment; evaluation; exceptional reports; records of health practitioner visits and discussions/communication regarding resident care&lt;br&gt;2. Incident Reports involving residents&lt;br&gt;3. Documentation includes the following: Date &amp; time, printed name, signature and designation Notes are objective and factual Issues are stated, strategies and interventions documented, evaluation is recorded or planned.&lt;br&gt;4. Changes to status are recorded on handover and care plan following same documentation principles.</td>
<td></td>
</tr>
<tr>
<td><strong>2b</strong> <strong>ACFI and Admission Co-ordinator</strong>&lt;br&gt;Resident Entry and ACFI Classification</td>
<td>Refer: Resident Entry, Orientation, Discharge and Transfer&lt;br&gt;1. Ensures the resident has a valid Aged Care Client Record (ACCR)&lt;br&gt;2. Completes Resident Register and Resident Details form&lt;br&gt;3. Completes Resident Entry Record online within five business days of resident entry&lt;br&gt;4. Issues assessments for completion by Care Staff (refer clause 4) and submits ACFI Application for Classification following ACFI rules and guidelines in order to accurately assess the level of care required and ensure funding is provided for the care delivered.&lt;br&gt;5. All evidence of care delivered that may be required as stated in the ACFI User Guide are copied from source documents with originals returned to appropriate files and copies filed with the application and stored in the ACFI and Admission Coordinator's office.&lt;br&gt;6. All evidence that is required to maintain the claimed funding level is available in the pack.&lt;br&gt;7. Monitors Medicare Claim Summary and Provider Transcript Records for expiring ACFI classifications</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> <strong>ACFI and Admission Co-ordinator</strong>&lt;br&gt;Respite Residents</td>
<td>1. Ensures the resident has a valid Aged Care Client Record (ACCR)&lt;br&gt;2. Completes Resident Register and Resident Details form&lt;br&gt;3. Completes Resident Entry Record online within five business day of resident entry&lt;br&gt;4. Ensures resident has adequate respite days remaining prior to admission, and discharge date is within required timeframe.</td>
<td></td>
</tr>
<tr>
<td>ITEM / WHO</td>
<td>KEY STEPS</td>
<td>CLARIFICATION</td>
</tr>
<tr>
<td>------------</td>
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<td>---------------</td>
</tr>
</tbody>
</table>
| **4 Health Personal Care and Lifestyle Staff** | Resident Assessment and Re-appraisal | Refer: Care Planning  
1. Complete initial assessments on admission as per Admission Assessment Guide  
2. Completes the ACFI appraisal assessments and other documents as directed by the ACFI and Admission Coordinator and/or RN.  
3. Documents care required and delivered in progress notes on all new residents each shift for one week.  
4. Documents care required and delivered in progress notes daily for resident during ACFI assessment period as directed by ACFI and Admission Coordinator |
| **5 ACFI and Admission Coordinator, DON/CM & Reception** | Monitoring and Tracking Funding | 1. Ensures Monthly Resident Movement, and forms are completed and correct  
2. Reception forwards copy of Medicare Claim Summary and Medicare Payment Statement to DON/CM.  
3. DON/CM reviews and forwards to ACFI/Admission Coordinator.  
4. Payment Statement is checked against Claim Form, raising concerns with Medicare Australia immediately  
5. Document explanations of any discrepancies and the action taken and file with the appropriate Claim Summary  
6. Completes Medicare Claim online by 3rd business day of the following month.  
7. Payment Statement and Claim Form are retained in Medicare Claim and Payment Statements Folder  
8. Monthly Resident Movement form is returned to DON/CM and filed in Monthly Reports |
| **6 Director of Nursing and Care Manager** | Monitoring | 1. Audits are conducted as per Audit Schedule and issued by CMA.  
2. Facility Manager conducts or assigns staff member to complete audit and gaps identified are transferred to the Quality Improvement System (refer Quality Improvement)  
3. Data and statistics obtained from Incident Reports, Quality Improvement Forms, Management Reports and internal assessment/audit results are analysed and plans developed to improve outcomes for the resident/client, organisation and personnel.  
4. This procedure is audited and reviewed at least annually. |
Residential Care Policies and Procedures

Policy No. 157

Subject: Quality Policy including Comments, Complaints and Suggestions (CCIF)

Effective Date: February 2016

Developed by Director of Nursing

PURPOSE

1. To ensure that systems and processes are monitored for compliance and areas of improvement.
2. To promote a culture of continuous improvement in the RACF and to ensure that industry best practice is implemented.
3. To ensure that a Comments and Complaints system exists with all stakeholders having access.

POLICY

All staff, residents, relatives, visitors, and other stakeholders are able to contribute to our quality program which includes having access to a compliment, complaint or improvement system (CCIF).

PROCEDURE

Quality System:
A number of feedback systems exist throughout the aged care facilities to ensure quality of service is monitored and to identify areas for improvement. Feedback systems include but not limited to:

1. Scheduled auditing program
2. Incident reporting recommendations / actions
3. Clinical indicator result
4. Minutes of meetings
5. CCIF – Comments, Complaints & Improvement Form.
7. Direct feedback received from staff, residents and representatives
8. External reviews – such as a government department
9. Data collected from Education Evaluations
10. Media formats – Journals etc.

Where areas for improvement are identified, they are listed on a central register known as the PCI (planned continuous improvement). The PCI outlines activity, actions, progress and evaluation. Constant monitoring and updating of the PCI is the responsibility of the Director of Nursing who ensures that all areas of care and service are monitored for their contribution to the continuous improvement process.
Organisational developments and improvements are captured and monitored through the Board of Management and Senior Staff meetings and documented in the minutes of these meetings. These larger issues are not managed through the PCI as they involve wider strategic issues rather than the smaller operational ones the PCI sets out to manage.

Results from the feedback system are provided (where applicable) back to the originator/s and/or displayed/communicated in central areas such as noticeboards, meeting minutes or newsletters.

**Comments, Complaints and Improvement (CCIF)**

The CCIF system enables stakeholders to raise concerns and/or suggestions at the Village Baxter RACF. All details are managed in a confidential way and originators of CCIFs can choose to remain anonymous – however this option will limit Village Baxter management to provide a feedback response.

CCIF’s can be completed by residents, relatives, clients, staff, volunteers, visitors or contractors and/or staff on behalf of residents (with their permission).

Completed forms can be placed in the suggestion box located near Reception or given directly to the Area Manager, or can be forwarded to the Director of Nursing.

A written response will be provided within 30 days of receipt (note: the outcome of the concern/suggestion may not be finalised in some circumstances).

If you are dissatisfied with the outcome, you may raise this directly with the Area Manager.

You may also refer to the Director of Nursing on BH: 5971 6317, Mob: 0417 695 162 or email simonarmstrong@villagebaxter.com

Alternatively you can contact the General Manager – Stuart Shaw.

You may also choose to contact the following organisations.

**AGED CARE**

Aged Care Complaints
Commissioner
Phone 1800 550 552
If you are deaf or have a hearing or speech impairment, we can help through the National Relay Service.
Call 1800 555 677 and ask for 1800 550 552

**Write to us**
Aged Care Complaints Commissioner
GPO Box 9848
Melbourne 3001

**COMMUNITY CARE**

Department of Health
Southern Metro Region
Home & Community Care
Government Services Building
165-169 Thomas Street
Dandenong 3195
P.O. Box 692
Dandenong 3195

**AGED & COMMUNITY CARE**

Elder Rights Advocacy
Level 4, 140 Queen Street
Melbourne VIC 3000
PH: (03) 9602 3066
1800 700 600 - free call in Victoria except from mobile phones
Fax: (03) 9602 3102
Email: era@era.asn.au
**Policy No.** 158  
**Subject:** Mandatory Reporting of Suspected Abuse  
**Effective Date:** February 2016  
**Developed by** Director of Nursing

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**PURPOSE**

**Background:**

Compulsory reporting of assaults (relating to residents) is the responsibility of an approved provider under the *Aged Care Act 1997* (the Act). Approved providers must:

- Report to the police and the department incidents of alleged or suspected reportable assaults on residents within 24 hours of the allegation, or when the approved provider starts to suspect a reportable assault
- Take reasonable measures to ensure staff members report any suspicions or allegations of reportable assaults to the approved provider (or other authorised person), to the police and the department
- Take reasonable measures to protect the identity of any staff member who makes a report and protect them from victimisation.

**Five key elements to Mandatory Reporting**

- The Act requires that, except in very specific and sensitive circumstances, all approved providers of residential aged care must report all allegations or suspicions of reportable assaults.
- Reports must be made to both the police and the department within 24 hours of the allegation being made or the approved provider starting to suspect on reasonable grounds, that a reportable assault may have occurred.
- If a staff member makes a disclosure that qualifies for protection under the Act, the approved provider must protect the identity of the staff member and ensure that the staff member is not victimised.
- If an approved provider fails to meet compulsory reporting requirements the department may take compliance action.
- Compliance with compulsory reporting requirements is monitored by the Australian Aged Care Quality Agency (the Quality Agency).

**What is a reportable assault?**

A reportable assault as defined in the Act (section 63-1AA) means:

- unlawful sexual contact with a resident of an aged care home, or
- unreasonable use of force on a resident of an aged care home.

This definition captures assaults ranging from deliberate and violent physical attacks to the use of physical force on a resident.

**POLICY**

Mandatory Reporting requirements will reported as per Aged Care Act 1997 with the appropriate evidence surrounding each suspected or actual case maintained in central register onsite at Village Baxter.

**PROCEDURE**

1. Volunteers, contractors and Village staff
If a volunteer or any staff suspects or identifies that abuse is occurring they are responsible for:

- Providing for the immediate safety of the Resident / Client;
- Informing the Resident / Client of the need to talk to their supervisor;
- Informing their supervisor immediately;
- Maintaining the confidentiality of the investigation and not discussing the allegations with other colleagues;
- Completing an incident report form.

2. Supervisors / Managers / Team Leaders

When a Supervisor/Manager/Contractor Site Manager receives reports from staff/volunteers they are responsible for:

- Immediate investigation of the circumstances of the alleged abuse;
- Completion of documentation and collection of other evidence to ensure that an accurate written record of the circumstances exists;
- Liaising with the Resident / Client to support their long term safety from abuse;
- Immediately informing the Director of Nursing or another senior staff member.

3. DON / Senior staff member

- Ensuring that the reporting responsibilities are met;
- Liaison with Resident / Client / reporting staff member / volunteer / contractor;
- Within 24 hours of becoming aware that abuse or suspected abuse has occurred, reporting the incident to the police on 9784 5555 or 000 and to the Department of Health on 1800 081 549 or via electronic submission as per the Department Website. Note: Discretionary reporting maybe applicable if the perpetrator is a co-resident with Cognitive or mental impairment or the circumstances are similar or previously reported incidents. Refer to Appendix 1
- In the absence of the Director of Nursing these responsibilities are delegated to another Senior Staff Member.
- All abuse or suspected abuse claims are to be documented on the central register held in the Administration Building.

What if staff are involved in the abuse or suspected abuse?

Any circumstance where a staff member or volunteer is alleged to have committed an abusive act shall be investigated.

Staff suspected of abuse will be contacted and advised of the following:

- They will not have contact with residents/clients until a thorough investigation has occurred;
- They must not discuss the allegation with other Staff, Residents, Clients and maintain strict confidentiality;
- The allegation has been reported to police on 9784 5555 or 000 and the Department of Health and Ageing;
- They may be suspended from all duty during the investigation period;
- They will be informed of the details of the allegation made against them without disclosing the identity of the person making the complaint;
- They have the right of reply to the allegation; and
- They have the right to representation

The above actions are reflective of the Village Baxter’s compliance with Commonwealth Laws in relation to Mandatory Reporting of abuse, a decision as to the allegation and whether abuse occurred will be made by the Village following the completion of the above process. The Village Baxter investigation and subsequent actions (if any) are independent of any police action that may occur as a result of the report. Further action may be taken by the Village Baxter at a later date if the Police investigation reveals additional details of the incident.

Managing staff reporting abuse

Any Staff Member / Volunteer or Contractor who suspects on reasonable grounds that a reportable assault has occurred must report the suspicion as soon as reasonably practicable prior to leaving the Village, to one or more of the following people, as chosen by the staff member:

- Department Head / Manager / Supervisor;
The General Manager, Executive Manager
Human Resources Manager;

The Village will discourage vexatious or false reports;

The reporting of actual and suspected abuse by staff / volunteers and contractors is a very serious matter that may result in the Police taking action against person or persons involved and the termination of the alleged abusers employment.
Reports that are found to be Vexatious (made just to cause trouble for someone) or false (deliberately untrue) will be investigated by the Village and may result in disciplinary action and termination of employment. The person who made the vexatious or false report may also be investigated by the Police.

False and vexatious reports are not made in good faith and the reporter in these instances is not protected under the Commonwealth Laws

The Village will protect staff who report allegations.

In summary, the staff member who makes a protected disclosure is:
- protected from any civil or criminal liability for making the disclosure (unless the staff member is reporting themselves).
- protected from breaching confidentiality and privacy obligations if the report is made to one of the persons or organisations outlined above.
- protected from victimisation. Staff who cause detriment (by act or omission) to another Staff member because the other staff member reports (or may report) abuse or suspected abuse shall be investigated and disciplinary action or termination of employment may result.

Types of disclosures that are protected are, in summary:
- the reporter is an approved provider of residential care, or a staff member / volunteer or contractor of the approved provider.
- the disclosure is made to:
  - a Police Officer;
  - The Department of Health and Ageing
  - Persons identified in the Village Baxter policy above; and
- the reporter informs the person to whom the disclosure is made of the discloser’s name before making the disclosure; and
- the reporter has reasonable grounds to suspect that the information indicates that a reportable assault has occurred; and
- the reporter makes the disclosure in good faith.

**RELATED POLICIES AND DOCUMENTS**

**Note**: Mandatory Reporting Flow Charts are located in the toilets of the Residential Care Facilities.
Appendix 1:

When is an approved provider not required to report alleged or suspected assaults

In limited circumstances approved providers are not required to report alleged or suspected assaults. Approved providers so not need to report when:

- alleged assault is perpetrated by a resident with an assessed cognitive or mental impairment, and
- subsequent reports of the same or similar incident have been made.

These limited circumstances do not prevent an approved provider from reporting an assault to the police or the department.

- Cognitive impairment refers to declining ability in judgement, memory, learning, comprehension, reasoning and/or problem solving and can result from a number of conditions, including dementia, delirium and/or depression.
- Mental impairment includes senility, intellectual disability, mental illness, brain damage, and severe personality disorder.

Assaults perpetrated by a resident with cognitive or mental impairment

For the requirement to report alleged or suspected assaults to not apply, the approved provider is required to meet the following conditions that are detailed in the Accountability Principles 2014:

- within 24 hours of receiving an allegation or the start of the suspicion, the approved provider forms an opinion that the assault was committed by a resident, and
- prior to the receipt of the allegation, the resident has been assessed by an appropriate health professional as suffering from a cognitive or mental impairment, and
- the approved provider puts in place, within 24 hours of receiving the allegation of an assault, or of suspecting an assault has occurred, arrangements for management of the resident’s behaviour, and
- the approved provider has:
  - a copy of the assessment (or other documents) regarding the resident's cognitive or mental impairment, and
  - a record of the behaviour management strategies that have been put in place under paragraph (c) above.

The Accreditation Standards require providers to effectively manage the needs of care recipients with challenging behaviours.

Appropriate assessment of cognitive and mental impairment

- To meet the requirements of the Act, an assessment of a resident's cognitive or mental impairment could be undertaken by one of more of the following:
  - a resident’s medical practitioner
  - geriatrician
  - a registered nurse (RN)
  - another medical practitioner with the appropriate clinical expertise.

It is important to note also that an assessment may have been undertaken in a community or hospital setting.
Residential Care Policies and Procedures

Policy No. 162 (Under Review – January 2015)

Subject: Homelike Environment

Effective Date: January 2012

Developed by Care Manager

PURPOSE

The Village is the home of the Residents that reside within it. Staff are invited guests and must respect the residents right to live in warm, homely environment.

POLICY

To provide for continuity of care for residents and to ensure maximum health for residents and staff. Residents are encouraged to furnish their units with their own belongings but are encouraged not to overcrowd their unit for safety reasons.

PROCEDURE

- All clothing items should be labelled to guard against loss.
- Accommodation is offered to Residents on a permanent basis (see Accommodation).
- Animals are welcome to visit. Animals must be on a leash when in communal areas and are not permitted in the Kitchen and dining room.
- Staff are to be mindful of noise levels in the residents’ common rooms (e.g. from sound systems / TV) and to keep these at an acceptable level.
- Seating arrangements which reflect each resident’s preferences are to be provided wherever possible to enable residents to undertake individual and social activities.
- No responsibility is taken by the Company for routine maintenance of resident’s property.
- Residents and their visitors are welcome to use indoor and outdoor areas freely. A barbecue is available for ‘family’ gatherings.
- ‘Family’ meals may also be arranged. To assist with catering, advance notice is required and payment required.
- Visitors are free to help themselves to tea and coffee making facilities / request staff’s assistance.

RELATED POLICIES AND DOCUMENTS

- 110 – Accommodation
- 170 – Lifestyle & Recreational Programs
- 111 – Admissions
- 125 – Assessment of Resident Care Needs
- 149 – Clothing
- 152 – Documentation
- 160 – Freedom of Choice
- 161 – Furnishings
- 148 – Children and Eden
- 757 – Visitors & Volunteers
- 772 – Attachment 6 OHS Responsibilities of Residents and their families
• 7612 - Smoking
Residential Care Policies and Procedures

Policy No. 163

Subject: Multicultural Policy

Effective Date: January 2015

Developed by Director of Nursing

PURPOSE

To ensure that provision is made for residents with differing cultural customs:

POLICY

The Village recognises and respects the cultural preferences and needs of all of our residents.

PROCEDURE

- Following admission, the cultural and linguistic needs of our residents are identified and documented on the in the Lifestyle Assessment and Care Plans. Care is directed towards meeting these needs and preferences.

- Our resident’s personal customs in relation to health care are always respected. This includes respect for their values and differing beliefs (including superstitions).

- Support and assistance to practice their Religious, personal and cultural customs, is always given to our residents. Special food is provided during religious celebrations as requested.

- Ministers of religion visit regularly and are contacted as requested.

- Care of the dying is also provided according to tradition and custom. Residents are encouraged to bring familiar objects with them to the Facility, and are encouraged to decorate their surroundings according to their traditional style.

- Encouragement is given and provision made for residents to socialise with members of their community both in and outside the Facility.

- National days, feast days and name days are celebrated (following the Residents consent).

- Food preferences are also discussed with our residents and their family. An item of the traditional diet can be provided daily and a typical meal is served at least weekly.

- Care is also designed to meet the linguistic needs of our non-English speaking residents. Access to an interpreter and bilingual doctor is provided when needed and on request. Communication boards and dictionaries are also used.

- In-service education is provided (as required) to staff to create an increased awareness of the cultural and linguistic needs of our residents. A Cultural Care Kit is also available in the nurses station to assist staff with recognizing of the various cultural traditions of resident.
RELATED POLICIES AND DOCUMENTS

- Cultural Care Kit is available in all departments.
- The services of the Migrant Resource Centre are always available for use. They can be contacted at
  - Moorleigh Branch Office – 92 Bignell Road Bentleigh  Phone: 9576 4038
  - Oakleigh Head Office – 18 Chester Street Oakleigh  Phone: 9563 4130
  - Prahran Branch Office – 40 Grattan Street Prahran  Phone: 9510 5887
- 170 – Lifestyle & Recreational Programs
- 111 – Admissions
- 125 – Assessment of Resident Care Needs
- 151 – Consent
- 171 – Death, Dying with Dignity
- 152 – Documentation
- 160 – Freedom of Choice
- 162 - Homelike Environment
- 156 – Medical & Personal Care Records
- 742 – Communication, Language and Cultural Issues
- 0904 – Relationship between the Company and the Village Church and Chaplains
Residential Care Policies and Procedures

Policy No. 164 (Under Review – January 2015)

Subject: Physiotherapy Services for Residents

Effective Date: January 2012

Developed by Care Manager

PURPOSE

A Physiotherapy Program is provided to Residents to support mobility and functional abilities.

POLICY

For physiotherapists to work with residents referred for assessment of their physical status, identify deficits and plan individual programs to meet their needs. Provide appropriate services whilst completing review and documentation procedures in accordance with accreditation standards and assessment of resident care needs.

A pain management program is provided via referral from the Director of Nursing or Activities Co-ordinator.

All residents should be re-assessed by a physiotherapist following a fall.

PROCEDURE

Overview:

Assessment, development of program, implementation and review of residents’ physiotherapy needs and evaluation of programs.

Assessment:

Aim of assessment is to identify:
- Resident’s capabilities
- Resident’s physical deficits
- History of physical activity/lifestyle
- Safety/Environment issues.
- Desired outcome.
- Ways in which physiotherapy would help the resident.

<table>
<thead>
<tr>
<th>Process/Documentation</th>
<th>By Whom</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy Assessment</td>
<td>Physiotherapist</td>
<td>Within 1 week of referral</td>
</tr>
<tr>
<td>Physiotherapy Program Plan</td>
<td>Physiotherapist</td>
<td>Within 1 week of assessment</td>
</tr>
<tr>
<td>Generic Physiotherapy Program</td>
<td>Physiotherapist Assistant</td>
<td>Within 1 week of assessment</td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Physiotherapy</td>
<td>Physiotherapist</td>
<td>As needed</td>
</tr>
</tbody>
</table>

Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>By Whom</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>File notes</td>
<td>Physiotherapist and Physiotherapist Assistants according to involvement</td>
<td>On day of interaction</td>
</tr>
<tr>
<td>Physiotherapy Review</td>
<td>Physiotherapist</td>
<td>ACFI Frequency or as needed according to individual</td>
</tr>
</tbody>
</table>
Implementation:

Physiotherapy Assistants to initiate resident’s involvement in exercise program as per physiotherapy assessment and plan.

<table>
<thead>
<tr>
<th>Process/Documentation</th>
<th>By Whom</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete attendance records and note any variations</td>
<td>Physiotherapy Assistants</td>
<td>Each attendance</td>
</tr>
<tr>
<td>Inform physiotherapist at next consultation any matters relevant to program</td>
<td>Physiotherapy Assistants</td>
<td>Twice Weekly</td>
</tr>
</tbody>
</table>

Evaluation:

A. Individual Resident Review

Review each referred resident’s physiotherapy program according to RCS/ACFI reviews or more frequently as needed by individual circumstances.

<table>
<thead>
<tr>
<th>Process/Documentation</th>
<th>By Whom</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Reassessment and completion of assessment form</td>
<td>Physiotherapist</td>
<td>ACFI Requirements</td>
</tr>
<tr>
<td>Therapeutic interventions file notes and instructions to care Staff</td>
<td>Physiotherapist</td>
<td>According to individual need</td>
</tr>
</tbody>
</table>

B. Program Review

Review entire physiotherapy service.

<table>
<thead>
<tr>
<th>Process/Documentation</th>
<th>By Whom</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce Review Report for Administration</td>
<td>Physiotherapist</td>
<td>Annually</td>
</tr>
<tr>
<td>Meet with Care Manager Notes of Meeting</td>
<td>Physiotherapist and Physiotherapy Assistants</td>
<td>Annually</td>
</tr>
<tr>
<td>Formalise following year’s structure</td>
<td>Physiotherapist</td>
<td>Annually</td>
</tr>
</tbody>
</table>

RELATED POLICIES AND DOCUMENTS

- 111 – Admissions
- 125 – Assessment of Resident Care Needs
- 151 – Consent
- 152 – Documentation
- 156 – Medical and Personal Care Records
- 131 – Health Status – Change in
- 168 – Risk taking
- Physiotherapy Referral \server\users\Public\Master Copies\physio referral.doc
Residential Care Policies and Procedures

Policy No. 165 (Under Review – January 2015)
Subject: Privacy and Dignity
Effective Date: November, 2011
Developed by Care Manager

PURPOSE

To ensure that privacy, a fundamental right of our society, is not denied any of our residents and that they have a sense of control over their environment:

POLICY

The Village is home for the Residents who live within the Village Community, Staff are guests. At all times staff must show respect for Residents and never treat a Resident’s home as a clinical institution.

PROCEDURE

- The residents personal property is their own and staff and other residents are not free to use it unless invited to do so.
- Privacy must be given to each resident when undertaking personal activities eg. bathing, toileting and dressing.
- Residents are to be allowed privacy when speaking with visitors and during phone conversations. Mail is not to be opened or read by staff unless the resident requests or requires assistance.
- All information relating to residents is to be treated confidentially.
- The environment within the Facility is to be free from undue noise. Residents may be asked to use earphones if their sound equipment is too loud.
- Residents are to be well groomed and dressed appropriately for the time of day and privacy and dignity maintained.
- Where a resident has chosen to return to their unit and close their door, this choice must be respected.
- Residents have the right to choose not to be cared for by a particular staff member. Where this decision creates a risk to the safety and wellbeing of the resident, a family meeting will be called and a solution found.
- Assessment and medical procedures should always be undertaken in private and never in an area in view of other residents and visitors.
- Staff and contract staff must always knock and wait to be invited into a resident’s room (unless an emergency situation exists). Staff are not to use a resident’s suite or unit while the resident is out for rest or relaxation during meal breaks.
- Staff and contract staff are not to discuss the health and wellbeing of residents in front of other residents or where they may be overheard.
Staff and contract staff should be respectful of personal and company property and buildings. E.g.: it is not polite to leave underwear in baskets outside of resident rooms visible to other residents and visitors, personal information on public view etc.

Staff and contract staff must always address a resident by their preferred name and never use terms such as ‘darling’, ‘love’, ‘sweetie’, ‘buddy’ etc. Speaking to residents in this manner is considered disrespectful and is in conflict with our Accreditation obligations outlined under outcome 3.6 Privacy and Dignity.

Staff should ensure that items such as medical equipment, health information posters, trolleys, linen skips etc are all placed or kept discreetly and not as features in main living and dining areas.

Resident’s medical history, progress notes and other documents identifying residents and/or medical concerns are to be stored in the Nurses Station and area locked if not supervised.

**RELATED POLICIES AND DOCUMENTS**

- 111 – Admissions
- 125 – Assessment of Resident Care Needs
- 151 – Consent
- 152 – Documentation
- 160 – Freedom of Choice
- 162 – Homelike Environment
- 156 – Medical & Personal Care Records
# Residential Care Policies and Procedures

**Policy No.** 167 (Under Review – January 2015)

**Subject:** Resident Alcohol Consumption

**Effective Date:** November, 2011

**Developed by** Care Manager

## PURPOSE

To ensure residents living in the Aged Care facilities have freedom of choice to consume alcohol in their own unit / suite or common areas of the facility and to protect the safety of other residents, staff and volunteers.

## POLICY

Residents have the right to consume alcohol, however, they are asked to discuss possible interaction with medications with their doctor.

Residents are able to keep alcohol in their own refrigerator or cupboard.

It is expected that alcohol consumption will not compromise the consumer’s safety or the safety of others. Excessive consumption that presents a danger to others or to property may be in breach of the lease agreement. In these circumstances steps will be taken to liaise with the Resident and family to reduce the risks to others.

Residents are expected to conduct themselves in a manner in keeping with the values and standards of the Village community.

## PROCEDURE

Residents who consume socially disruptive amounts of alcohol will be counseled by the Supervisor / Manager / LMO / Chaplain.

Residents who book a common area of the Hostel, Manor or Lodge for a function may consume alcohol within these areas. It is NOT permitted to consume alcohol in other common Village areas (including the Grapevine) as this is against the Village by-laws.

Staff are not to supply alcohol to residents.

Staff may as part of their duties purchase grocery items (including alcohol) on behalf of residents using resident funding as requested at the time by the resident unless an issue has occurred (refer above and to Charter of Resident’s Rights and Responsibilities).

## RELATED POLICIES AND DOCUMENTS

- Charter of Resident’s Rights and Responsibilities
- 125 – Assessment of Resident Care Needs
- 151 – Consent
- 152 – Documentation
- 160 – Freedom of Choice
- 133 – Medication
- 132 – Medical Care
- 168 – Risk Taking
- 118 – Behaviour Management
Residential Care Policies and Procedures

Policy No. 168

Subject: Risk Taking

Effective Date: January 2015

Developed by Director of Nursing

PURPOSE

To remind staff that risk taking is a normal part of everyday life and residents are not necessarily deprived of this right as long as they do not threaten their own, or others’, safety or rights.

POLICY

The residents’ right to participate in activities which may involve a degree of risk is respected.

PROCEDURE

- If staff consider that a resident's action may involve significant risks of injury to the resident, they have a responsibility to advise the resident or representative of their concerns, and the RN in charge.

- If the resident decides to act against such advice, the resident's decisions as well as staff recommendations are documented in Progress Notes. A Treatment Against Advice form or Risk Agreement (depending on issue and application) is completed and the residents representative, GP and other health team members consulted as appropriate (e.g. physiotherapy for mobility aid refusal).

- Staff safety and OH&S policies and procedures are to be adhered to at all times.

- The actions of the resident must not impact adversely upon another resident or staff member.

- If it is foreseeable that the resident's choices or actions will endanger another resident or staff member, then the matter is to be referred to the Manager. The safety of other residents, staff and stakeholders is not to be compromised.

RELATED POLICIES AND DOCUMENTS

- Risk Agreement
- Treatment Against Advice
PURPOSE

To ensure a quiet, restful environment that is conducive to sleep is provided.
To ensure residents receive the appropriate level of rest required to maintain quality of life and enjoyment of activities.
To promote a healthy sleep patterns that enhances the resident’s overall health and wellbeing and reduces stress.

POLICY

Residents will be assisted to achieve natural sleep patterns.
Sleep management programmes will be designed to enhance the residents’ quality of life.

PROCEDURE

References:
Standards and Guidelines for Residential Aged Care Services, 1998: 2.6, 2.17;
Occupational Health and Safety Act, 2004 VIC, 2000 NSW; and
Aged Care Act, 1997.

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<thead>
<tr>
<th>ITEM / WHO</th>
<th>KEY STEPS</th>
<th>CLARIFICATION</th>
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<tbody>
<tr>
<td>1.0 Refer: Resident Documentation and Funding, and Care Planning</td>
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<tr>
<td>2 Manager</td>
<td>Training</td>
<td>3. Training programs are in place to ensure health, personal care and lifestyle staff have the appropriate skills to assist residents to sleep (Refer: Education and Staff Development)</td>
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<td>4. Resource information is available in Nurses Station</td>
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<tr>
<td>3 Health &amp; Personal Care Staff</td>
<td>Assessment</td>
<td>1. Refer Admission Assessment Guide</td>
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<td>2. Assess residents on admission and on an ongoing basis in response to the resident’s changing health status and preferences</td>
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<td>3. Document information on the Initial Assessment and Care Plan on the day of admission</td>
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<td>4. Complete the Sleep Assessment and Charting using available information in the resident’s records, and by interviewing the staff, the resident, and the resident’s family/representative.</td>
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<td>4.0 Interventions / Strategies / Treatment</td>
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<tr>
<td>4a RN Health &amp; Personal Care Staff</td>
<td>Development and Documentation</td>
<td>1. Refer residents to specialist practitioners, as required, and in accordance with their preferences (refer: Health Practitioners and Emergency Treatment)</td>
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<td>2. Inform residents of available treatments (both pharmacological and other contemporary research based alternatives), strategies, interventions and specialists</td>
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<td>3. If complementary therapies are required they are accessed and included to the extent they are safe (in consultation with the health care team)</td>
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<td>4. Should the resident wish to receive therapies/treatment against the advice of the health care team, a Treatment Against Advice form is completed in consultation with the resident’s medical practitioner</td>
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<td>5. Interventions/strategies reflect contemporary practice and are preventive as well as reactive</td>
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<td>6. Complete Care Plan</td>
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<td>7. Consult the resident/ representative regarding the resident’s Care Plan (face to face or via telephone) for initial development.</td>
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<tr>
<td>ITEM / WHO</td>
<td>KEY STEPS</td>
<td>CLARIFICATION</td>
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</table>
| 4b RN Health & Personal Care Staff | Evaluation and Review | 1. A measurement of the effectiveness of interventions / strategies / treatment in achieving the goals is driven by the resident’s clinical prognosis (predicted health status changes), exception reporting in Progress Notes and assessments.  
2. Frequency varies according to the care need/problem (at least monthly) and as indicated by exception reporting in the Progress Notes.  
3. Document full Care Plan evaluations/reviews on the ROD Care Plan Review and in Progress Notes at other times.  
4. Care Plans are amended to reflect changes and reassessment initiated as per Clause 3: Assessment.  
5. Manager schedules evaluation and review dates (Evaluation and Review Schedule) and posts schedule on the notice board in the Nurses Station. |
| 5 Director of Nursing and Care Manager | Monitoring | 1. Audits are conducted as per Audit Schedule and issued by CMA.  
2. Facility Manager conducts or assigns staff member to complete audit and gaps identified are transferred to the Quality Improvement System (refer Quality Improvement).  
3. Data and statistics obtained from Incident Reports, Quality Improvement Forms, Management Reports and internal assessment/audit results are analysed and plans developed to improve outcomes for the resident/client, organisation and personnel.  
4. This procedure is audited and reviewed at least annually. |
Residential Care Policies and Procedures


Subject: Lifestyle & Recreational Programs

Effective Date: January 2012

Developed by Care Manager

PURPOSE

To ensure that all residents are offered a variety of lifestyle programs for their therapeutic, emotional, social and spiritual well-being.

POLICY

Policy

There will be a program for the introduction of the resident, their families and/or others of significance into the residential community.

Resources will be provided to ensure that the environment is conducive to meeting the rights of the resident including privacy, dignity and confidentiality.

Each resident will be respected as an individual, with programs tailored to their needs and expectations, including interests, beliefs and culture, with assistance provided for the achievement of maximum independence, friendship maintenance and participation in the life of the community within and outside the residential care service.

Resident and/or their representatives will be encouraged to participate in decisions about the services provided, and will be able to exercise lifestyle choice and control while not infringing on the rights of others

Scope

All Residents

References

- Standards and Guidelines for Residential Aged Care Services, 1998: 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 4.4; Privacy Act, 1988
- Aged Care Act, 1997
- Complaints Handling AS/NZS 4269:1995

<table>
<thead>
<tr>
<th>Who</th>
<th>Key Steps</th>
<th>Clarification</th>
</tr>
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<tbody>
<tr>
<td>Lifestyle Co-ord All personnel</td>
<td>Independence</td>
<td>1. Resident interests, preferences and opportunities to participate in community life both within and outside the residential care service are assessed on admission, documented and reviewed (Refer: Leisure Interests and Activities)</td>
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<td>2. Residents and their families/representatives are regularly consulted to ensure resident interests and preferences are included in care planning (documented in Progress Notes)</td>
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<td>3. Programs are implemented to support community involvement both within and external to the service</td>
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<td>4. Residents:</td>
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<td>- Can express their ideas, suggestions, comments and complaints freely (refer: Comments and Complaints)</td>
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<td>- Are encouraged to express their rights in ways that do not impinge on the rights of others</td>
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<td>- Are encouraged to extend their expectations of independence with the appropriate support</td>
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<td>- (representative) are assisted to identify preferences in managing the resident's financial affairs, with the resident's interests protected when they are unable to manage their financial affairs themselves (Care Plan)</td>
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<td>5. Resident-directed social activity, autonomy and participation are encouraged and supported</td>
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<tr>
<td>Health Care Team; All personnel</td>
<td>Privacy and dignity</td>
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<tr>
<td>1. Support residents to maintain personal relationships and carry out personal activities in private</td>
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<tr>
<td>2. Support residents to die with dignity, with the cultural, religious and other aspects of their terminal care respected and implemented and support families/representatives</td>
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<td>3. Resident records and personal information is securely stored (refer Privacy: Information Systems)</td>
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<tr>
<td>4. Maintain resident confidentiality</td>
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<td>5. Address residents according to their wishes</td>
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<tr>
<td>6. Foster professional relationships between residents and their families/representatives (Resident / Representative Meetings and through mentoring of staff)</td>
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<thead>
<tr>
<th>All personnel</th>
<th>Emotional Support</th>
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<tbody>
<tr>
<td>1. Residents and/or their representatives are given information and a guided tour prior to entry when possible, including:</td>
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<tr>
<td>- geography of the environment;</td>
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<td>- available services and personnel;</td>
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<td>- fees and charges, resident rights and responsibilities;</td>
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<td>2. On entry all residents and/or their representatives receive an orientation (Resident Orientation)</td>
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<tr>
<td>3. Resident expectations, interests and needs including cultural, spiritual and linguistic are assessed, documented and reviewed (refer Care Planning)</td>
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<thead>
<tr>
<th>All personnel</th>
<th>Choice and Decision-Making</th>
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<tbody>
<tr>
<td>1. Encourage residents and their representatives to express their views about the facility’s policies and practices that affect the services offered (Comments and Complaints and Resident / Representative Meetings)</td>
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<tr>
<td>2. Information about advocacy services is available (Rights and Responsibilities Brochure)</td>
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<tr>
<td>3. Residents and/or their representatives are informed of the implications of refusing treatment and any decision to do so is clearly documented (Refer: Palliative Care)</td>
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<table>
<thead>
<tr>
<th>All personnel</th>
<th>Cultural and Spiritual Life</th>
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<tbody>
<tr>
<td>1. Value, foster and encourage the expression of resident’s individual interests, customs, beliefs and cultural identity including language</td>
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<td>2. Areas are available for the observance of cultural, spiritual and religious ceremonies</td>
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<td>3. Admission assessments include cultural, spiritual and linguistic issues, including special dietary requirements, likes and dislikes in relation to health and personal needs, which are incorporated into the resident’s individual Care Plan</td>
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<td>4. Contact with ethnic, religious and cultural groups and their participation in leisure interests and activities plans of the resident’s choice is encouraged and facilitated (Refer: Leisure Interests and Activities)</td>
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<td>5. Interpreters are involved in the care planning process and other situations as required ensuring residents remain informed (Refer: Cultural Care Kit)</td>
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<thead>
<tr>
<th>Activities Personnel</th>
<th>Lifestyle Interests</th>
</tr>
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<tbody>
<tr>
<td>1. Leisure and recreational activities are designed and provided to enhance the psychological, spiritual, social and physical well being of residents, providing stimulation mentally, physically, and socially, and assisting them to attain the maximum quality of life possible for them, while encouraging and supporting independence (Refer: Leisure Interests and Activities)</td>
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<tr>
<td>2. Each resident’s social, cultural and spiritual requirements and needs, interests and therapeutic requirements are identified, documented and incorporated into their care plan, with support and encouragement provided for participation</td>
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<tr>
<td>3. Residents are encouraged to initiate and direct their own activities</td>
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<td>4. Contributions from family, friends and representatives are valued in the development and evaluation of individual resident’s lifestyle program</td>
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<td>5. Community involvement and friendships are encouraged and facilitated to meet the needs and interests of residents</td>
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<tr>
<td>6. Resident choices are recognised, and their right to participate in activities of personal risk is supported with decisions to do so documented (Care Plan)</td>
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<tr>
<td>All Personnel</td>
<td>Living Environment</td>
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<tr>
<td>1. Resident’s property is respected with systems in place for security</td>
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<td>2. The environment is assessed to ensure it supports the comfort of residents and safe work practices with clean surroundings</td>
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<td>3. There are documented programs for planned, preventive and corrective maintenance for all equipment, fittings and buildings (Refer: Inventory and Equipment and Maintenance)</td>
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<td>4. Safe work practices are supported through a comprehensive occupational health and safety program that meets legal requirements</td>
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<td>5. A system is available for the identification, reporting, documentation and resolution of hazards and risks (Refer: Comments and Complaints, Incident Reporting, and Hazard Management)</td>
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<td>6. Residents are encouraged to personalise their individual living area and have access to amenities such as telephones and televisions</td>
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<td>7. Refer: Resident Information Booklet</td>
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<tr>
<th>DON/Care Manager</th>
<th>Monitoring</th>
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<tr>
<td>1. This procedure is audited and reviewed at least second yearly (according to organisational risk) as per Audit, Internal Assessment and Review Schedule</td>
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<tr>
<td>2. Data and statistics: Incident Reports, Comments and Complaints System, Clinical Report and internal assessment results</td>
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<tr>
<td>3. Data and statistics are analysed and plans developed to improve outcomes for the resident/client, service and personnel</td>
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**RELATED POLICIES AND DOCUMENTS**

- 125 – Assessment of Resident Care Needs
- 152 – Documentation
- 160 – Freedom of Choice
- 162 – Homelike Environment
- 156 – Medical & Personal Care Records
- 163 – Multicultural Policy
- 165 – Privacy & Dignity
- 168 – Risk Taking
- 118 – Behaviours of Concern
- 148 – Children & Eden
Residential Care Policies and Procedures

Policy No. 171 (Under Review – January 2015)

Subject: Palliative Care

Effective Date: November, 2011

Developed by Care Manager

PURPOSE

To ensure all resident’s end of life care wishes are supported and they are able to die with dignity.

POLICY

The comfort and dignity of terminally ill residents will be maintained. Palliative care programmes will be designed to enable family involvement, accommodate religious, spiritual and cultural beliefs and recognise an individual’s right to die with dignity.

PROCEDURE

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<tr>
<th>ITEM / WHO</th>
<th>KEY STEPS</th>
<th>CLARIFICATION</th>
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</table>
| 2 Manager  | Training  | 1. Training programs are in place to ensure health, personal care and lifestyle staff have the appropriate skills to effectively manage residents receiving palliative care (Refer: Education and Staff Development)  
2. Resource information is available in Nurses Station and staff rooms. |
| 3 RN and/or Manager | Assessment | 1. Refer Admission Assessment Guide  
2. Identify palliative and terminal care wishes and needs on admission on Palliative and Terminal Care Wishes and on an ongoing basis in response to the resident’s changing health status and preferences  
3. Respect and where possible act upon wishes and needs  
4. Should a resident/their representative choose to refuse medical treatment, a Refusal of Treatment Certificate (Schedule 1 Medical Treatment Act, 1988) is completed in consultation with the residents GP  
6. If existing Advanced Healthcare Directive unavailable, assist resident and/or representative to complete Respecting Patient’s Choices in accordance with resident wishes. |
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<th>ITEM / WHO</th>
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<tr>
<td>4.0 Interventions / Strategies / Treatment</td>
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</table>
| 4a RN | Development and Documentation | 1. Refers residents to specialist practitioners, as required, and in accordance with their preferences (refer: Health Practitioners and Emergency Treatment)  
2. Informs residents of available treatments (both pharmacological and other contemporary research based alternatives), strategies, interventions and specialists  
3. If complementary therapies are required they are accessed and included to the extent they are safe (in consultation with the health care team)  
4. Should the resident wish to receive complementary therapies against the advice of the health care team, a Treatment Against Advice form is completed  
5. Interventions reflect contemporary practice  
6. Documents on Care Plan and Palliative and Terminal Care Wishes  
7. All information regarding palliative care including consultation and discussions with the resident and/or representative and the health care team are documented in the Progress Notes  
8. For ACFI validation, directives are signed by practitioners as per ACFI 12 Complex health care |
| 4b RN, Health & Personal Care Staff | Evaluation and Review | 1. A measurement of the effectiveness of interventions / strategies / treatment in achieving the goals  
2. Is driven by the resident's clinical prognosis (predicted health status changes), exception reporting in Progress Notes and assessments  
3. Frequency varies according to the care issue/need/problem (at least 2-monthly) and as indicated by exception reporting in the Progress Notes  
4. Document scheduled Care Plan evaluations/reviews on the Holistic Evaluation and in Progress Notes at other times  
5. Care Plans are amended to reflect changes and reassessment initiated as per Clause 3: Assessment  
6. Manager schedules evaluation and review dates (Evaluation and Review Schedule) and posts schedule on the noticeboard in the nurses’ station  
7. Once resident has reached terminal or end of life phase, the Care Plan is discontinued and the Palliative Care Pathway is implemented. |
| 4c RN and/or Health & Personal Care Staff | Care of the Deceased | 1. Once deceased, the resident is washed and dressed in clean nightwear  
2. Open wounds are covered.  
3. DO NOT shave male residents.  
4. Should the family wish the resident may be dressed in special clothing, however, the RN must discuss and suggest that this may not be practicable and it is suggested that this be given to the Funeral Director for later dressing so that clothing remains as clean as possible. |
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<th>ITEM / WHO</th>
<th>KEY STEPS</th>
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| 5 RN       | Notification, Documentation and Removal | 1. Document time of death and verification on Verification of Death form.  
2. Notify GP  
3. Ask GP if Death Certificate will be issued  
4. If GP will not issue death certificate or cannot be contacted, advise Funeral Director and DON/CM immediately.  
5. Notify NOK/POA  
6. Funeral Director  
7. Manager  
8. DON/CM  
9. Chaplains  
10. Complete progress notes detailing who was notified and when, details of all jewellery on the resident and whether left on – if removed this is to be documented and jewellery locked in safe.  
11. Document when resident is taken into the care of funeral director and ensure a property list is signed by Funeral Director for any jewellery resident is wearing.  
12. Update Emergency Evacuation Lists and Handover  
13. Manager or other nominated person to notify administration reception.  
14. All Care Plans, Charts, History, Physiotherapy/PMP Plans, and other resident documentation is to be gathered and forwarded to Manager for archiving. |
| 6 Director of Nursing and Care Manager | Monitoring | 1. Audits are conducted as per Audit Schedule and issued by CMA.  
2. Facility Manager conducts or assigns staff member to complete audit and gaps identified are transferred to the Quality Improvement System (refer Quality Improvement)  
3. Data and statistics obtained from Incident Reports, Quality Improvement Forms, Management Reports and internal assessment/audit results are analysed and plans developed to improve outcomes for the resident/client, organisation and personnel.  
4. This procedure is audited and reviewed at least annually. |

**RELATED POLICIES AND DOCUMENTS**

- Palliative Care Pathway
- Terminal Care Wishes
Residential Care Policies and Procedures

Policy No.  172

Subject:  Restraint

Effective Date:  January 2015

Developed by  Director of Nursing

PURPOSE

To ensure that all appropriate interventions have been trialed prior to restraint being investigated and implemented. To ensure that residents have the ability to move as desired as much as possible without causing harm to others. To reduce the incidence of restraint use and ensure residents have the right to take risks.

POLICY

Residents will live in a safe and comfortable environment with their rights assured. Extreme restraints (refer ‘Definitions’) will not be used under any circumstances, and High Risk Restraint (refer ‘Definitions’) will only be used as a last resort following trialing of alternatives. Legal requirements of common law and duty of care will be maintained, and ethical considerations incorporated into restraint practices. In an emergency situation restraint will be authorized by an RN and medical practitioner and will not be used for a period longer than 12 hours without proper assessment. Restraint will only be used in the resident's best interests, with precautions rigorously implemented.

PROCEDURE

Preamble:

Legal requirements for consent to use restraint:

- A family member must have a relevant guardianship order or enduring power of attorney to have the legal capacity to consent to the use of restraint.
- Consent might need to be obtained from the Guardianship Board or its equivalent, particularly if the ongoing use of restraint is contemplated.
- Service providers should obtain legal advice in cases where there is any doubt about the use of restraint.

Definitions:

Restraint is any aversive practice, device or action that interferes with a resident's ability to make a decision or which restricts their free movement.

1. Physical Restraint: The intentional restriction of a resident's voluntary movement or behaviour by using a device, or removal of mobility aids, or physical force. Physical restraint includes but is not limited to lap belts, tabletops, poseys or similar products, bed rails, and chairs that are difficult to get out of such as beanbags, waterchairs and deep chairs.

2. Chemical Restraint: The intentional use of medication to control a resident’s behaviour when no medically identified condition is being treated, where the treatment is not necessary for the condition or amounts to overtreatment of the condition.

3. Aversive treatment practices/ punishment: One that uses unpleasant physical, sensory or verbal stimuli e.g. any voice tone, command or threats that are used to limit a resident's mobility or actions in an attempt to reduce undesired behaviour. Aversive treatment also refers to any withholding of basic human rights or needs (e.g. food, warmth, clothing, or positive social interaction); or a resident’s goods/belongings; or a favoured activity, for the purpose of behaviour management or control.

NB: threats to do harm or punish are an assault under Australian law and perpetrators may be charged.

4. Environmental Restraint: Limiting a resident to a particular environment (e.g. their bedroom) or excluding a resident from an area to which they want to go (e.g. restricting access to an outside courtyard or sitting room, or preventing a resident from leaving the building).
The Village manages restraint by the following procedure:

- Resource information is available in the **Restraint Folder** located in the Nurses Station. This includes *The Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care.*

- If any form of restraint is considered as a management strategy, it will remain the option of last resort.

- A **Risk Assessment** to establish alternative strategies and controls is to be completed by RN in consultation with resident / representative.

- A **Restraint Assessment** is completed by RN in consultation with GP and the residents representative (note: a family member must have a relevant guardianship order or enduring power of attorney to have the legal capacity to consent to the use of restraint) and clearly specifies the type of restraint, circumstances and duration of restraint.

- The **Restraint Assessment** is fully completed and evidence of consultation with Medical Practitioner is to be documented on **Restraint Assessment** and in **Progress Notes**.

- Resident/representative are consulted on commencement of restraint and at least six monthly during **restraint authorization review**.

- Monitor restrained residents frequently and observations are documented (the effectiveness of strategies and potential risks to residents) on **Restraint Checking Chart** and/or **Visual Observation Chart**

- **Restraint Checking Chart** findings are regularly evaluated throughout the period of use, with strategies and/or a review scheduled immediately if resident’s condition changes or new risks identified.

- If restraint is utilised as a falls prevention strategy, the physiotherapist is consulted and participates in the assessment and documents assessment findings on **Physiotherapy Assessment, Care Plan** and **Progress Notes** as required

- Additional assistance can be sourced from the RIR - ROSS team for falls prevention strategies. Contact details can be found in the **Nurses Station**.

- If physiotherapist recommends restraint for falls management, this must be done in consultation with **Area Manager** and **Director of Nursing** prior to implementation of restraint.

- Restraint must be ceased immediately should any health and safety concerns be identified and **Area Manager** or **Director of Nursing** be notified immediately.

- Completed **Restraint Assessments** are filed in the **Restraint Folder**.

- Restraint review and re-authorisation is conducted during re-assessment 3 monthly by **RN** and 6 monthly with RN, GP and resident/representative.

- Where chemical restraint is approved, the **Chemical Restraint Reduction Assessment** must be completed at the 6 monthly review or prior as required.

**RELATED POLICIES AND DOCUMENTS**

- Restraint Folder
- Risk Assessment
- Restraint Assessment
- Chemical Restraint Reduction Assessment
- Restraint Checking Chart
- Visual Observation Chart