Contents

Policy Number:	101		
Title:	Accidents / Incidents		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

- **PURPOSE**
- To ensure that detailed investigation and documentation is carried out following onsite 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.
        - **Resident:** Notify Nurse in Charge or Village Nurse
        - **Visitors**: Doctor of choice
        - **Staff**: HR Manager
- **PROCEDURE**
    - There are two types of Accident/Incident Report forms:
        - Resident: Leecare General Incident Report
        - Staff and Visitors: Accident/Incident/Near Miss Report (paper based). For 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 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.
    - 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.

Policy Number:	103		
Title:	Falls		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

3.1. Assessment and Prevention

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

The aim assessment is to:

3.1.1. To assess the potential for a fall and provide necessary medical, nursing and allied health professional services

3.1.2. To identify any environmental or medical causes that may contribute to a fall

3.1.3. To minimise the risk of falls and any associated resultant trauma

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

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

3.2. 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 and incident form is to be completed and treated as an unwitnessed fall.

3.2.1. Lo-Lo or high-low bed in the lowest position

3.2.2. Fallout mat in situ.

3.2.3. Resident rolls out of bed onto the fallout mat and remains on the mat.

3.3. In the Event of A Fall

3.3.1. Notify Nurse In Charge

3.3.2. Nurse in Charge will assess for injury and monitor accordingly

3.3.3. If an unwitnessed or witnessed head strike, commence neuro obs. as per protocol

3.4. Neurological Observations Protocol

Neurological Observations are to be conducted:

3.4.1. half hourly for 2 hours;

3.4.2. hourly for 2 hours;

3.4.3. 4 hourly for 24 hours.

3.4.4. If clinically indicated increase the frequency of observations.

3.5. Hospitalisation is based on Nurse In Charge or General Practitioner assessment

3.6. Refer to allied health

3.7. Review/update care plan and relevant assessments.

4. RELATED POLICIES AND DOCUMENTS

- 101 Accidents/Incidents
- 104 Falls Related Deaths

Policy Number:	104		
Title:	Falls Related Deaths		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

1.1. 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. 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.

1.2. 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 archive it with the resident history.

2. POLICY

2.1. The documentation should be prepared by the RN In-Charge.

2.2. The RN On-Call must be notified immediately if any resident died after a fall or is suspected will pass away soon after a fall has occurred.

2.3. The RN On-Call must notify the Executive Manager.

3. PROCEDURE

The following information is to be gathered to prepare a submission for the coroner.

3.1. A list of all the staff involved in:

3.1.1. Initial assessment and review of resident in regard to falls risk

3.1.2. The actual incident(s) and the events leading to the fall

3.1.3. Those staff who have knowledge of the incident

3.1.4. A statement from each staff member on duty at the time of the fall detailing:

- 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
- What they observed others doing

3.2. The incident report (this will be sourced from Lee Care digital records). Any other information regarding the fall that is recorded other than in the incident form or medical record.

3.3. A copy of the Falls Policy (Policy 103), along with the review history and changes made.

3.4. Where policy changes have been made as a result of the incident under investigation, information must be provided as to what changes were made, and how best practice information was sourced to address risk.

3.5. 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?

3.6. Resident's medical history; including co-morbidities and current medications.

3.7. Copies of falls risk assessments for the previous 12 months and actions undertaken to address identified risks.

3.8. Environmental factors, including:

- 3.8.1. Use of cot-sides
- 3.8.2. Fixed legs or wheels or equipment. Were they locked / unlocked at the time?
- 3.8.3. State of the floor surface. Slippery? Uneven?
- 3.8.4. Lighting
- 3.8.5. Staff / Carer supervision
- 3.8.6. Any other environmental/external factors.

3.9. The events leading up to the fall, including:

- 3.9.1. What happened immediately before and after the fall?
- 3.9.2. How many falls or near falls did the deceased have in the previous 12 months?
- 3.9.3. Had the deceased previously suffered any major injury from a fall?
- 3.9.4. What were the circumstances surrounding the fall immediately prior to death?

3.10. Relevant equipment or work practice

- 3.10.1. If equipment or a particular work practice was involved in the fall (i.e. wheel chair, low-line beds, walking frame)
- 3.10.2. 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?
- 3.10.3. If a particular product was involved, were the manufacturer's instructions available and followed? (If not, why not?).
- 3.10.4. 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?

4. RELATED POLICIES AND DOCUMENTS

- 101 Accidents/Incidents
- 103 Falls
- Victorian State Coroner's Office Clinical Liaison Service Webpage – Standards for Investigation. http://www.health.vic.gov.au/cls/standards.htm
- Victorian State Coroner's Office Clinical Liaison Service – Fall-Related Deaths in Hospital http://www.health.vic.gov.au/cls/standard1.pdf

Policy Number:	114		
Title:	Resident Funds and Petty Cash		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

Residents are encouraged to maintain control over their financial affairs and may use the office's petty cash system to deposit and withdraw money.

2. 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.

3. PROCEDURE

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

3.1. 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.

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

3.3. 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

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

3.5. 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 is 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.

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

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

Policy Number:	118		
Title:	Behaviour Management		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

The needs of residents with behaviours will be managed effectively utilising strategies identified in the care planning process.

3. PROCEDURE

Behaviour Management strategies are identified by the following methods:

3.1. On admission, information relating to behaviours of concerns are identified. The behaviours identified, their triggers and management strategies are written on the Admission Assessment and Care Plan.

3.2. Behaviour charting is commenced for new admissions, or when behaviours not previously known are identified. Staff are required to complete behaviour charting identifying the behaviour, possible triggers, and the interventions which were attempted to address the behaviour. The effect of the intervention is required to be documented.

4. RELATED POLICIES AND DOCUMENTS

- 124 – Unexplained Absence
- 125 – Care Planning
- 172 – Restraint

Policy Number:	124		
Title:	Unexplained Absence		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

1.1. To ensure staff notify the necessary people and/or agencies in the event of a resident identified as missing.

1.2. To ensure all residents at risk of absconding are identified and protected.

2. 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 resident's whereabouts cannot be established within one hour, then the police are to be notified of a missing resident and the Department of Health is to be notified.

3. PROCEDURE

3.1. Notify and Search

- 3.1.1. Check diary and sign-out board/book
- 3.1.2. Inform Nurse in Charge
- 3.1.3. Nurse in Charge instigates and coordinates a search of the building
- 3.1.4. Nurse in Charge notifies NOK/POA and checks whether any knowledge of whereabouts or of places resident is likely to go.
- 3.1.5. Village Nurses to be contacted to search local area

3.2. Resident is located within the facility or their whereabouts are established.

- 3.2.1. Refer to Behaviour Management policy-118

3.3. Resident is not located.

- 3.3.1. Nurse in Charge to notify police
- 3.3.2. Follow Police instructions
- 3.3.3. Notify Director of Nursing On Call
- 3.3.4. Notify the Department of Health on 1800 081 549
- 3.3.5. Add to the Continuous Improvement Plan for operational and strategic review to avoid future reoccurrences
- 3.3.6. The department must also be notified if the police return a resident and the facility was unaware that the resident was missing.
- 3.3.7. The Mandatory Reporting Register is to be completed.

4. RELATED POLICIES AND DOCUMENTS

https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/compulsory-reporting-for-approved-providers/unexplained-absences-report

Policy Number:	125		
Title:	Care Planning		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

3.1. The ***Admission Assessment*** must be completed within 24 hours of admission. The ***Admission Assessment*** guides the delivery of care until the long term care plan is completed.

3.2. The ***Detailed Care Plan*** is completed within 8 weeks of admission using the information gathered from the assessments, charts and consultation with residents/representatives.

3.3. When changes in residents care requirements occur, then the relevant assessment is reviewed and updated as required.

Policy Number:	130		
Title:	Diabetes		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. 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.

3. PROCEDURE

The GP provides Reportable levels to guide management of residents with diabetes. This includes frequency of BGL, reportable ranges and appropriate actions.

4. RELATED POLICIES AND DOCUMENTS

- Medication Chart
- GP Reportable limits

RESIDENTIAL CARE

Policy Number:	132		
Title:	Medical Care		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. 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.

3. PROCEDURE

3.1. Residents are to receive appropriate medical care by a Doctor of their choice when needed.

3.2. A medical assessment of the resident is to be undertaken as soon as practicable following admission.

3.3. 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.

3.4. 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.

3.5. 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.

3.6. The treatment and medication prescribed by the medical practitioner is to be correctly administered.

3.7. After hours medical service is to be called if necessary if the residents own doctor is unavailable.

3.8. Ambulance transfer to hospital for assessment may also be appropriate at times. If this occurs the next of kin / POA should be notified.

3.9. Residents are enabled and encouraged to make informed choices about their care.

4. RELATED POLICIES AND DOCUMENTS

- 101 – Accidents / Incidents
- 125 – Assessment of Care Needs

Policy Number:	133		
Title:	Voluntary Assisted Dying		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. POLICY

1.1. Voluntary assisted dying means the administration of medications to cause death in accordance with the processes set out in the Voluntary Assisted Dying Act 2017.

1.2. The Voluntary Assisted Dying Act 2017 prohibits all health practitioners, including nurses, from raising or suggesting voluntary assisted dying with or to patients.

2. PROCEDURE

2.1. If a Resident requests information about Voluntary Assisted Dying, Staff should reassure the Resident and advise that they must make their request to a specialist medical practitioner (including general practitioner). The Director of Nursing must be immediately informed of the Resident's request to ensure that the Resident feels safe and pain free while waiting to see their Medical Practitioner of choice.

2.2. Only specialist medical practitioners can receive formal requests to access voluntary assisted dying from patients.

2.3. Additional information for Aged Care Providers is also available at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-guidance-aged-care-providers

2.4. Village Baxter has chosen "Pathway C: Information and support service" The Village will be able to provide information and/or referrals for people who request voluntary assisted dying and, where appropriate, continue to provide support to these people.

2.5. Nurses are not permitted to administer medications under the Voluntary Assisted Dying Act, any staff member who feels they need additional support in relation to working with a Resident who has requested access to Voluntary Assisted Dying should see their Manager to access support under the Employee Assistance Program.

3. RELATED POLICIES AND DOCUMENTS – see links listed above.

Policy Number:	147		
Title:	Call System		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

3.1. 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.

3.2. Call Buttons

3.2.1. A nurse call system is operating throughout the Lodge and Manor.

3.2.2. One is provided at each bedside and in the toilets, showers and throughout communal areas.

3.2.3. 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.

3.2.4. Regular preventative maintenance program ensures the batteries in the pagers are changed on a regular basis.

3.2.5. 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.

4. RELATED POLICIES AND DOCUMENTS

- Nil.

Policy Number:	150
Title:	Committees – Residents and Friends
Owner:	Director of Nursing
Review Date:	February 2021 **Policy Risk Rating:** Low

1. 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.

2. 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.

3. PROCEDURE

3.1. A gathering of residents and their representatives is held regularly.

3.2. Matters of interest are discussed.

3.3. Concerns and suggestions may also be shared at this meeting.

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

3.5. 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.

4. RELATED POLICIES AND DOCUMENTS

- Nil.

Policy Number:	151		
Title:	Consent		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

3.1. There are three types of consent:

- 3.1.1. Implied
- 3.1.2. Verbal
- 3.1.3. Written

3.2. Consent is only valid if:

- 3.2.1. It is given voluntarily
- 3.2.2. It is informed
- 3.2.3. The person giving consent has the legal capacity to do so

3.3. Where consent has been gained it is to be documented in the Residents' progress notes

3.4. Consent is to be sought:

- 3.4.1. Prior to any procedure being carried out
- 3.4.2. Prior to any care being performed
- 3.4.3. Prior to displaying residents name or photographs

3.5. Informed Consent

- 3.5.1. Explanation of proposed treatment including inherent risks, benefits and alternatives,
- 3.5.2. Adequate time given for questioning by resident,
- 3.5.3. The option to withdraw at any time.
- 3.5.4. 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.

4. RELATED POLICIES AND DOCUMENTS

- 114 – Resident funds and petty cash
- 165 – Privacy and Dignity

Policy Number:	157
Title:	Continuous Improvement / Quality
Owner:	Director of Nursing
Review Date:	February 2021 **Policy Risk Rating:** Low

1. PURPOSE

1.1. To ensure systems and processes are monitored for compliance and areas of improvement.

1.2. To promote a culture of continuous improvement in the RACF and to ensure that industry best practice is implemented.

1.3. To ensure a Comments and Complaints system exists, with all stakeholders having access.

2. 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 and improvement system.

3. PROCEDURE

3.1. Quality System:

3.1.1. 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:

i. CQIF – Continuous/Quality Improvement Form.
ii. A scheduled auditing program
iii. Incident reporting – review / recommendations / actions
iv. Clinical indicators
v. Minutes of meetings
vi. Surveys – Residents & Staff
vii. Direct feedback received from staff, residents and representatives
viii. External reviews – e.g. Government departments
ix. Data collected from Education Evaluations
x. Media formats – Journals etc.

3.1.2. Where areas for improvement are identified, they are listed on a central register known as the CQIP (Continuous Quality Improvement Plan). The CQIP outlines activity, actions, progress and evaluation. Constant monitoring and updating of the CQIP is the responsibility of the organisation and ensures all areas of care and service are monitored for their contribution to the continuous improvement process.

3.1.3. Organisational developments and improvements are captured and monitored on the Continuous/Quality Improvement plan.

3.1.4. Results from the feedback system are provided (where applicable) back to the originator and are discussed at Resident, Staff and Clinical Governance meetings

3.2. Continuous/Quality Improvement Form (CQIF)

3.2.1. The CQIF system enables stakeholders to raise concerns and/or suggestions for the Village Baxter Residential Aged Care Facility.

3.2.2. All details are managed in a confidential way and originators of the CQIF can choose to remain anonymous – however this option will limit Village Baxter management to provide a feedback response.

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

3.2.4. A response will be provided via email, in person or electronic documentation system (note: the outcome of the concern/suggestion may not be finalised in some circumstances).

3.2.5. If the originator is not satisfied with the outcome; the following external organisations are available to raise concerns.

Aged Care	Aged & Community Care	Community Care
Aged Care Quality and Safety Commission Telephone: 1800 951 822 Web: http://www.agedcarequality.gov.au	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	Department of Health Southern Metro Region Home & Community Care Level 5 165-169 Thomas Street Dandenong 3175 Telephone: 8765 5444 Email: enquiries@dhhs.vic.gov.au

4. RELATED POLICIES AND DOCUMENTS

- Nil

Policy Number:	158		
Title:	Serious Incident Response Scheme		
Owner:	Director of Nursing		
Review Date:	March 2021	**Policy Risk Rating:**	High

1. PURPOSE

The **Serious Incident Reporting Scheme** (SIRS) for residential aged care, overseen by the Commission, operates within the context of the aged care legislative framework and is administered under the following:

- Charter of Aged Care Rights (the Charter) 'consumers have the right to live without abuse and neglect'
- Aged Care Quality Standards which require aged care providers to have effective risk management systems and practices for identifying and responding to abuse and neglect of consumers and an Open Disclosure process when things go wrong, Standard 8 Organisational governance, Standard 6 Feedback and Complaints
- Aged Care Quality and Safety Commission (the Commission) which accredits and monitor providers performance against the Standards and helps consumers resolve complaints about a provider's responsibilities or actions

The focus of the SIRS is the organisation's response to an incident which includes supports for the impacted consumer; expectations of open disclosure when harm has occurred; actions taken by the provider to continuously improve and reduce the likelihood of incidents recurring; the way information about incidents informs the management of these risks; feedback and education to staff and ways to improve the service's capability to prevent, manage and resolve incidents.

Reporting of serious incidents is intended to focus on incidents that pose the highest risks to consumers. This will support providers to engage in risk management and continuous improvement activities to deliver safe, quality care to consumers.

2. POLICY

A 'serious incident' for mandatory reporting:

> 'A serious incident is an alleged, suspected or actual occurrence of the following categories of incident, where the person affected by the incident is a consumer in residential aged care. These incidents must be reported to the Commission'. SIRS
>
> 'Incidents where an aged care consumer is the person who commits an incident and the person affected by an incident is a staff member or visitor are not included in the serious incident definition for mandatory reporting. These incidents will be addressed (identified, recorded, managed and resolved) in line with a provider's incident management arrangements.' SIRS

The Village Baxter is to:

- record incidents; report alleged, suspected or actual serious incidents to the Commission; and matters of a criminal nature to the police (e.g. assault).
- Staff members are responsible for alerting management of alleged, suspected or actual serious incidents.
- have in place systems and processes to ensure staff members alert management of alleged, suspected or actual serious incidents.

The Commission will:

- Assess and respond to the provider's compliance with incident management obligations. Assess and monitor the providers performance under the aged care law and the Standards such as risk management, open disclosure, clinical governance and the providers' systems and practices in place to prevent and respond to reportable incidents.
- Assess the adequacy of the providers response to an incident
- Assess any complaints made by a consumer that may be a serious incident

If the organisation fails to meet the requirements of the SIRS, the Commission can undertake enforcement actions eg imposing sanctions and may also be given powers to enforce any civil penalty provisions under the SIRS.

3. PROCEDURE

3.1 CATEGORIES OF INCIDENTS:

3.1.1 Unreasonable use of force:

Unreasonable use of force on a consumer, ranging from deliberate and violent physical attacks on consumers, to the use of unwarranted physical force.

This does not include touching an aged care consumer to attract their attention, to guide or to comfort them if they are distressed.

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Staff member	Consumer	Hitting, pushing, shoving, rough handling
Family member / visitor	Consumer	Hitting, pushing, shoving
Consumer	Consumer	Hitting, punching, pushing, shoving, throwing objects, kicking, biting

3.1.2 Unlawful or in appropriate sexual contact:

Unlawful sexual contact, or sexual misconduct committed against, with, to, or in the presence of a consumer.

Consumers have the right to sexual freedom and to receive affection. In the Charter, consumers have the right to: "have control over and make choice about my care and personal and social life, including where the choices involve personal risk"

This category does not include consenting sexual relations between aged care consumers or between an aged care consumer and a partner that is not a resident at the home (that may visit or volunteer at the home).

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Staff member	Consumer	Showing own genitals to a consumer. Masturbating in front of a consumer. Masturbating a consumer.

		Sexual innuendos. Sexually explicit language. Showing pornography to a consumer. Grooming. Stalking or making sexual threats. Touching consumer's genitals (or other private areas) without a care need. Sexually penetrating a consumer with another part of their body or an object
Family member / visitor	Consumer	Sexual threats or stalking. Activities without sexual consent: Showing own genitals to a consumer. Masturbating in front of a consumer. Masturbating a consumer. Sexual innuendos. Sexually explicit language. Exposing a consumer to pornography or using a consumer in pornography. Sexually penetrating a consumer with another part of their body or an object. Touching consumer's genitals (or other private areas) without a care need.
Consumer	Consumer	Sexual threats or stalking. Activities without sexual consent: Showing own genitals to a consumer. Masturbating in front of a consumer. Sexual innuendos. Sexually explicit language. Exposing a consumer to pornography. Sexually penetrating a consumer with another part of their body or an object

3.1.3 Psychological or emotional abuse:

Verbal or non-verbal acts that cause significant emotional or psychological anguish, pain or distress including verbal taunts, threats of maltreatment, harassment, humiliation or intimidation, or a failure to interact with a person or acknowledge the person's presence.

In addition to single event incidents, such as a staff member yelling at an aged care consumer, this category includes incidents that form a part of a pattern of abuse. While the behaviour may not cause significant harm or suffering to the individual in each instance, the repetitive nature of the behaviour (over time) has a cumulative effect which intensifies the level of harm to the individual or in some circumstances individuals.

Approved providers' incident management systems must be able to record incidents in a way that allows for repeated minor instances of these types of behaviour to be identified easily so that any pattern of abuse can be identified and reported as a single reportable incident.

Person who commits an incident	**Person affected by an incident**	**Examples include (but are not limited to)**
Staff member	Consumer	Yelling. Name calling. Ignoring a consumer. Feigning violence. Threats to withhold care or services. Threatening gestures. Punishing a consumer by refusing access to care or services Making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity or religious identity Repeatedly flicking, tapping, bumping etc a resident, which of itself does not constitute physical assault, but the repetitive nature causes psychological or emotional anguish, pain or distress
Family member / visitor	Consumer	Yelling. Feigning violence. Name calling. Threatening gestures

		Making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity or religious identity Repeatedly flicking, tapping, bumping etc a resident, which of itself does not constitute physical assault, but the repetitive nature causes psychological or emotional abuse
Consumer	Consumer	Yelling. Feigning violence. Name calling. Threatening gestures Making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity or religious identity Repeatedly flicking, tapping, bumping etc a resident, which of itself does not constitute physical assault, but the repetitive nature causes psychological or emotional anguish, pain or distress.

3.1.4 Unexpected death:

Death that is unexpected, where steps may not have been taken to prevent the death, or the death results from an intervention.

Person who commits an incident	**Person affected by an incident**	**Examples include (but are not limited to)**
Staff member	Consumer	A consumer falls while being moved or shifted, with the injuries sustained resulting in the consumer's death.
Provider	Consumer	Untreated pressure injury left untreated that becomes infected, and appropriate medical assessment/treatment was delayed or not given resulting in the consumer's death. A fall results in an unexpected death.
Consumer	Consumer	Where the actions of a consumer result in the death of another consumer, such as from an assault.

3.1.5 Stealing or financial coercion by a staff member

Stealing from an aged care consumer or behaviour that is coercive, deceptive, or unreasonably controls the finances of an aged care consumer by a staff member.

Person who commits an incident	**Person affected by an incident**	**Examples include (but are not limited to)**
Staff member	Consumer	A staff member coerces a consumer to change their will in favour of the staff member. A staff member steals money or valuables from a resident.

3.1.6 Neglect

Intentional or reckless failure in the duty of care for an aged care consumer that may also be a gross breach of professional standards resulting in significant harm or the potential to result in death or significant harm.

Neglect may be as a result of systemic issues eg lack of oversight of care, lack of appropriate policies and practices that result in poor quality of care. It may be deliberate, the conduct of one individual as a one-off incident or repeated incidents.
Note that consumers have a right to have control over and make choices about their care. This category does not include situations where a consumer refuses to shower, or a diabetic who refuses to eat a diabetic diet with the result they have a wound with poor healing prognosis.

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Staff member	Consumer	Withholding personal care such as showering or oral care Untreated wounds. Maggots on/in the consumer Leaving a resident outside unprotected in the sun resulting in significant burns
Provider	Consumer	Serious injury sustained by a consumer that requires hospitalisation. Where a consumer's meals are not appropriately modified to account for their difficulty of swallowing (dysphagia) as recorded in their care plan, or insufficient assistance is given to the consumer to eat their food, resulting in the consumer either not being able to eat meals or the consumer choking.

3.1.7 Inappropriate physical or chemical restraint

The use of physical or chemical restraint that does not meet the requirements of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019.

Providers are required to minimize the use of physical and chemical restraint. Only after alternatives to restraint have been explored and a number of conditions satisfied, can either form of restraint be used.

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Provider	Consumer	Where physical restraint is used on a consumer, when it is not an emergency and the provider does not seek prior informed consent. Where a provider uses physical restraint without consent and does not inform the consumer's representative as soon as practicable after the restraint starts to be used. A provider administers a drug to a consumer for the purpose of influencing their behaviour as a chemical restraint. The consumer's representative was not informed before the drug was administered, or shortly afterwards.

3.1.8 Unexplained absence from care

Reporting will occur where the:

- care recipient is absent from the service; and
- the absence is unexplained; and
- the absence has been reported to the police.

The missing consumer is to be reported to the police within a reasonable timeframe so an appropriate response and action can be taken to locate the consumer.

Management must report to the Commission as soon as reasonably practicable, but not later than 24 hours after the care recipient's absence was reported to the police.
If the consumer is returned before their absence was reported to police, no report to the Commission is required.
If the police are aware of the consumer's absence or the consumer is returned by police, the approved provider must report to the Commission.

Report a missing consumer to the Commission using the Commission's **unexplained absence webform** and a receipt number will be automatically issued**.**
Any amendments or additions to a submitted notification is via email compulsoryreports@agedcarequality.gov.au and quote the receipt number.

3.2 DISTINGUISHING CRITICAL INCIDENTS AND OTHER SERIOUS INCIDENTS

Management will categorise incidents based on the impact to the person affected by an incident as either: critical incidents (higher impact) or all other serious incidents (low or no impact). The following table sets out the impact categories for providers to assess impact.
Information at each stage will be set out in a form provided by the Aged Care Quality and Safety Commission.

Impact category	Degree of harm	Incident type	Incident notification to the Commission
No impact	Low level of harm	**Serious** incident	To the **Commission within 30 days** of either suspecting or becoming aware of the alleged or actual incident.
Minor physical or psychological injury or discomfort which were resolved without medical or psychological interventions	Low level of harm	**Serious** incident	To the **Commission within 30 days** of either suspecting or becoming aware of the alleged or actual incident.

Impact category	Degree of harm	Incident type	Incident notification to the Commission (Part A) and report to police where necessary	Incident status report to the Commission (Part B)	Final report to the Commission (if required)
Physical or psychological injury or illness requiring onsite medical or psychological treatment	Higher level of harm	**Critical** incident	**To the Commission within 24hours** of becoming aware of the incident. If a criminal nature report to **police within 24hours** of becoming aware of the incident.	Within **5 business days** or by a date specified by the Commission of the date of the incident notification	Within **60 business days** of submitting the incident report or as specified by the Commission.
Physical or psychological injury or illness requiring a hospital admission (but not permanent)	Higher level of harm	**Critical** incident	**To the Commission within 24hours** of becoming aware of the incident. If a criminal nature report to **police within 24hours** of becoming aware of the incident.	Within **5 business days** or by a date specified by the Commission of the date of the incident notification	Within **60 business days** of submitting the incident report or as specified by the Commission.
Permanent physical or psychological impairment	Higher level of harm	**Critical** incident	**To the Commission within 24hours** of becoming aware of the incident.	Within **5 business days** or by a date specified by the Commission of the	Within **60 business days** of submitting the incident report or

Impact category	Degree of harm	Incident type	Incident notification to the Commission (Part A) and report to police where necessary	Incident status report to the Commission (Part B)	Final report to the Commission (if required)
			If a criminal nature report to **police within 24hours** of becoming aware of the incident.	date of the incident notification	as specified by the Commission.
Fatality or severe permanent physical or psychological impairment	Higher level of harm	**Critical** incident	**To the Commission within 24hours** of becoming aware of the incident. If a criminal nature report to **police within 24hours** of becoming aware of the incident.	Within **5 business days** or by a date specified by the Commission of the date of the incident notification	Within **60 business days** of submitting the incident report or as specified by the Commission.

3.3 PROCESSES TO BE FOLLOWED

Process steps	Processes to be followed	By whom	How we monitor
	Management will ensure following processes reflect the vision, mission and philosophy of care of the organisation and the Commonwealth Standards.	Management	Policy statement
	The organization will continue to maintain its internal incident management system to Identify, assess, record, manage and resolve all incidents.	Management	Incident management system
	'Serious incidents' for mandatory reporting are: • Unreasonable use of force • Unlawful or in appropriate sexual contact • Psychological or emotional abuse • Unexpected death • Stealing or financial coercion by a staff member • Neglect • Inappropriate physical or chemical restraint • Unexplained absence from care	Management All staff	Observation Incident report Critical incident report
	Management will categorise incidents based on the impact to the person affected by an incident as either: **critical incidents (higher impact) or all other serious incidents (low or no impact).** **This includes information on incident notification to the Commission: Incident notification (Part A) and incident status report (Part B) and reporting to police where necessary.**	Management	Incident report Critical incident report Serious incident report
To report a serious incident or a missing consumer, management will complete the following:			
	To report a serious incident use the Commissions **reportable assault webform**. • The organization will receive a receipt number	Management	Regulatory compliance Reportable assault webform

Process steps	Processes to be followed	By whom	How we monitor
	• A Compulsory Reporting Officer will be in contact to provide a notification case number and request any further information that may be required • Additions or amendments to the submission notification are made using the compulsoryreports@agedcarequality.gov.au and quote the receipt number.		
	To report a missing consumer use the Commission's **unexplained absence webform** • Whether police have been contacted • The organisation will receive a receipt number • A Compulsory Reporting Officer will be in contact to provide a notification case number and request any further information that may be required • Any amendments or additions to a submitted notification is via email compulsoryreports@agedcarequality.gov.au and quote the receipt number.	Management	Regulatory compliance Unexplained absence webform
	Report to the police: Any allegation or suspicion of a serious incident of a criminal nature are to be reported to the police within 24 hours of becoming aware of suspecting a serious incident has occurred. • An allegation is usually a claim or accusation made to management. • A suspicion is where there is no actual allegation or where an assault may not have been witnessed, and where staff observe signs that an assault may have occurred. **Police** decide whether the incident is criminal in nature and what further police action is required.	Management	Police report Incident report
	Management will consider all allegations of incidents and if it is not required to be reported as a serious incident, will manage it through the internal incident management system for documentation and management	Management	Incident report
	Through the organisations internal incident system, management are to be aware of incidents that appear to occur as a single episode, but when incident forms are analysed the incidents are repetitive and accumulate into a pattern of abuse which harms the individual; this will be put into the SIRS as an incident.	Management	Incident report
	Management are not required to report an allegation or suspicion of a serious incident (later allegation or suspicion) if: • The later allegation or suspicion relates to the same, or substantially the same, factual situation or event as an earlier allegation or suspicion and • An earlier allegation or suspicion was reported to the police or Commission Eg two staff members observed the same serious incident and make separate reports of the same situation or event do not need to be reported twice under the SIRS	Management	Incident report
	A consumer's particular repetitive behaviour, which has been proven as related to cognitive impairment and not related to fact, is not reported eg a consumer that has a delusion and reports every morning they were assaulted during the previous night.	Management	Behaviour assessment

Process steps	Processes to be followed	By whom	How we monitor
	Staff members are required to report: • if they suspect on reasonable grounds that a serious incident has occurred, to report the suspicion immediately to their immediate supervisor.	All staff	Staff training program
	Protecting individuals who report an assault (Section 96-8) of the Aged Care Act establishes protections for staff and approved providers who report alleged or suspected assaults. • It states disclosure of information by a person qualifies for protection if the person is an approved provider of residential aged care or a staff member of an approved provider **Disclosure is made** to any or all of the following: • Police office • The Commission • The approved providers • One of the approved providers key personnel • Another person approved by the approved provider to receive such reports The person making the disclosure: • Informs the person to whom the disclosure is made of their name before making the disclosure • Has reasonable grounds to suspect that the information indicates that a reportable assault has occurred • Does so in good faith.	Police officer The Commission Approved providers Approved Key personnel	Incident form Compulsory report
	Approved providers or staff members reporting an assault are protected from: (refer to the Act) • Any civil or criminal liability for making the disclosure • A contract that the person making the disclosure is a party cannot be terminated on the basis that the disclosure breaches the contract. • Victimization, detriment and threats because of a disclosure that qualifies for protection Consumers of aged care homes, their families and advocates, visiting medical practitioners, other allied health professionals, volunteers and visitors are not required under the Aged Care Act to report an assault and are not afforded statutory protection under the legislation.	Management All staff	The Act
	Staff will have received training to include: • Staff know who to report to • How to recognise an incident • How to respond to the person involved • The legal requirement to report alleged or suspected serious incidents • Option to report to the Commission if they are concerned about their anonymity or where they may be concerned about reporting incidents that may directly involve staff or the organisation • Protections are in place and the circumstances in which they would qualify for protection • Consequences of providing false or misleading information	Management All staff	Staff training program
	Record keeping: Records of all incidents must be kept in a consolidated record. Each record is to include:	Management	Compulsory reporting records Incident reports

Process steps	Processes to be followed	By whom	How we monitor
	• The date the organization received the allegation, or started to suspect on reasonable grounds a reportable incident occurred • A brief description of the allegation or circumstance that gave rise to the suspicion • Information whether a report was made to the Commission and police • All records will be retained and stored as set out in the Record Principles 2014		Record keeping legislation
	The organization will comply with privacy relating to: • Compliance with the protection of personal information • Compliance with State, Territory or Commonwealth legislation, such as the Privacy Act 1988	Management	Privacy and Confidentiality policy
	UNEXPLAINED ABSENCE OF A CONSUMER		
	A consumer is considered missing when they are absent and the service is unaware of any reasons for the absence	Management	Incident form
	The missing consumer is to be reported to the police within a reasonable timeframe so an appropriate response and action can be taken to locate the consumer.	Management	Police report
	Management is required to notify the Commission using the **unexplained absence webform** if the consumer is: • Absent from the facility • The absence is unexplained • The absence has been reported to the police		Compulsory report Incident form Police report
	If the consumer is returned before their absence was reported to police, no report to the Commission is required. If the police are aware of the consumer's absence or the consumer is returned by police, the approved provider must report to the Commission.	Management Police The Commission	Compulsory report Incident form Police report
	Management responsibilities for SIRS • complete the Commission **reportable assault webform** for a serious incident • complete the Commission **unexplained absence webform** for an unexplained absence • complete and submit **part A Incident notification** form and part **B incident status** report to the Commission within required timeframes • complete the organisations incident form detailing the event and actions taken • notify the police and complete actions as required by police • notify the consumers general practitioner, attend to medical issues / contact ambulance as required • provide emotional support to consumer • notify / involve family / advocacy • include the consumer in the investigation, notify consumer of outcome of investigations • undertake actions and investigation as directed by the Commission and report as directed • review consumer behaviour assessments, strategies as required • include the report into the organization incident management system	Management	Regulatory compliance Incident form Consumer records Incident management system Continuous improvement plan Staff training records Feedback and complaints Open disclosure

Process steps	Processes to be followed	By whom	How we monitor
	• Identify actions to be taken to improve systems / reduce risks • Review or undertake staff training for SIRS • Open disclosure where appropriate		

1. ASSOCIATED DOCUMENTS / LINKS:

Link to Commission Website : https://www.agedcarequality.gov.au/sirs

Policy Number:	159
Title:	Visitors' Code of Conduct
Owner:	Director of Nursing
Review Date:	February 2021
Policy Risk Rating:	Medium

1. PURPOSE

1.1. To provide protection to all employees, contractors, volunteers and other visitors from potentially inappropriate and offensive conduct and treatment by visitors who enter any Village Baxter facility or workplace.

1.2. To ensure that all staff, contractors, volunteers and other individuals who work and visit The Village Baxter do so in a safe harassment free environment which promotes their wellbeing and fosters respect and co-operation between employees, volunteers and all visitors to The Village Baxter.

2. VALUES

2.1. The Village Baxter, through the practice of a Person Centred Care Approach, values every client their family, friends, staff and all other partners in their care.

2.2. The Village Baxter works with stakeholders and partners on a range of initiatives to support social, physical, emotional, psychological and spiritual wellness.

2.3. As an organisation, The Village Baxter also recognises the need for protection of fundamental human values in the context of the common good of all who deliver and receive residential care.

2.4. ALL Village Baxter employees which is inclusive of volunteers and contractors have a right to be treated with dignity and respect and for their human values to be respected and met by all individuals that they come into contact with whilst employed at The Village Baxter.

2.5. The Village Baxter as an organisation commit ourselves to protecting the rights of our employees, contractors and volunteers and will uphold the following rights of these individuals:

- ✓ Their right to be treated with respect;
- ✓ Their rights to work in an environment free of harassment and any anti-social behaviour;
- ✓ Their right to practice any religion of their choice and to have their cultural identity respected;
- ✓ Their right to professional and personal privacy and confidentiality;
- ✓ As direct or indirect employees of The Village Baxter, these individuals have a right to work in a professional and supportive environment;

2.6. The Village Baxter has specific legal and ethical responsibilities to protect staff rights as stated above. If as an organisation we fail to protect these rights we are at a significant risk of losing our valued staff, contractors and volunteers which invoke a loss of knowledge, expertise, commitment and compassion which our staff actively and willingly imparts on our residents and community clients.

3. EXPECTATION

3.1. The Village Baxter therefore has an expectation of all visitors who enter a Village Baxter facility or worksite to treat all staff, contractors and volunteers with dignity and respect.

3.2. Staff, contractors and volunteers are in turn expected to treat families of residents and clients with the same degree of respect, dignity and courtesy.

3.3. The following behaviour directed to staff, contractors and volunteers ***WILL NOT*** under any circumstances be tolerated:

× Shouting;

× Abusing;

× Threatening;

× Swearing (in English or any other language);

3.4. If the Village Baxter is to receive from a staff member, contractor or a volunteer a complaint about any of the above behaviour(s) exhibited by a visitor, the visitor shall be advised in writing and will be given an opportunity to respond in a meeting with a member of Senior Executive of The Village Baxter.

3.5. If the abusive or inappropriate behaviour persists legal avenues of redress may be actioned by the Executive Team after consultation with the General Manager.

3.6. In extreme circumstances where the behaviour is continuing and is jeopardising the Occupational Health and Safety of our staff, contractors and volunteers serious measures to limit the individual access to any Village Baxter facility and site will be consider.

4. RELATED POLICIES AND DOCUMENTS

- Acknowledgement to Proactive Complaints Management (steve@proactivecm.com.au) for the provision of the original policy.

Policy Number:	162		
Title:	Homelike Environment		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. 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.

3. PROCEDURE

3.1. All clothing items should be labelled to guard against loss.

3.2. Accommodation is offered to Residents on a permanent basis (see Accommodation).

3.3. 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.

3.4. 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.

3.5. Seating arrangements which reflect each resident's preferences are to be provided wherever possible to enable residents to undertake individual and social activities.

3.6. No responsibility is taken by the Company for routine maintenance of resident's property.

3.7. Residents and their visitors are welcome to use indoor and outdoor areas freely. A barbecue is available for "family' gatherings.

3.8. 'Family' meals may also be arranged. To assist with catering, advance notice is required and payment required.

3.9. Visitors are free to help themselves to tea and coffee making facilities / request staff's assistance.

RESIDENTIAL CARE

Policy Number:	163		
Title:	Diversity		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

3.2. Our resident's personal customs in relation to health care are always respected. This includes respect for their values and differing beliefs.

3.3. Support and assistance to practice their life choices and customs, is always given to our residents.

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

3.5. Care of the dying is also provided according to life choices and customs. Residents are encouraged to bring familiar objects with them to the Facility, and are encouraged to decorate their surroundings according to their traditional style.

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

3.7. Care is also designed to meet the life choices and customs of all residents.

3.8. In-service education is provided (as required) to staff to create an increased awareness of resident diversity.

4. RELATED POLICIES AND DOCUMENTS

- https://agedcare.health.gov.au/support-services/my-aged-care/lgbti-ageing-and-aged-care-resources
- http://www.culturaldiversity.com.au/service-providers/multilingual-resources/communication-cards
- https://agedcare.health.gov.au/older-people-their-families-and-carers/people-from-diverse-backgrounds

Policy Number:	165		
Title:	Privacy and Dignity		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Low

1. PURPOSE

To ensure privacy and dignity for all residents is maintained and they have control over their environment.

2. 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.

3. PROCEDURE

3.1. The resident's personal property is their own and staff and other residents are not free to use it unless invited to do so.

3.2. Privacy must be given to each resident when undertaking personal activities e.g. bathing, toileting and dressing.

3.3. 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.

3.4. All information relating to residents is to be treated confidentially.

3.5. 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.

3.6. Residents are to be well groomed and dressed appropriately for the time of day and privacy and dignity maintained.

3.7. Where a resident has chosen to return to their unit and close their door, this choice must be respected.

3.8. Residents have the right to request not to be cared for by a particular staff member.

3.9. Assessment and medical procedures should always be undertaken in private and never in an area in view of other residents and visitors.

3.10. Staff and contract staff must always knock and wait to be invited into a resident's room (unless an emergency situation exists).

3.11. Staff and contract staff are not to discuss the health and wellbeing of residents in front of other residents or in communal areas.

3.12. Staff and contract staff must always address a resident by their preferred name and never use terms such as ‘darling’, “love”, ‘sweetie’, ‘buddy’’ etc..

3.13. 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.

3.14. 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.

4. RELATED POLICIES AND DOCUMENTS

- Nil.

Policy Number:	167		
Title:	Resident Alcohol Consumption		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. 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.

2. POLICY

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

2.2. 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.

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

3. PROCEDURE

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

3.2. Residents who book a common area for a function may consume alcohol within these areas.

3.3. Staff are not to supply alcohol to residents.

4. RELATED POLICIES AND DOCUMENTS

- 125 – Care Planning
- 151 – Consent
- 132 – Medical Care
- 118 – Behaviour Management

Policy Number:	172		
Title:	Restraint		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

To ensure all care is person centred and the facility has a restraint free approach.

2. POLICY

To ensure that restraint is used in exceptional circumstances only, once all other interventions and strategies have been reviewed.

3. PROCEDURE

When a restraint free approach is unable to be achieved, refer to the following link:

Decision-Making Tool: Handbook - Supporting a Restraint Free Environment in Residential Aged Care

Policy Number:	180		
Title:	Medication Advisory Committee		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide leadership and direction in the safe use and administration of medicines to residents in accordance with best practice, legislative and statutory requirements.

2. POLICY

The Medication Advisory Committee (MAC) will monitor, review and evaluate the safe and quality use of medicines at Village Baxter.

3. PROCEDURE

3.1. MAC meetings are held at Village Baxter at least three times per calendar year

3.2. The MAC assists with the development of policy, reviews performance indicators relating to medication administration and advises on the implementation of standards, guidelines, and relevant legislation.

3.3. The MAC will advise on the Village Baxter medication monitoring and reporting system, reviews medication incidents such as adverse drug reactions or other medication related events with the objective of reducing medication issues.

3.4. The MAC will advise on the current information surrounding education and training resources to be maintained for residents, carers, staff and other health professionals.

3.5. Agenda items for the MAC Meeting should be submitted to the Director of Nursing prior to each scheduled meeting.

4. RELATED POLICIES AND DOCUMENTS

https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit

Policy Number:	181
Title:	Medication Administration for Enrolled Nurses and trained Personal Care Assistants
Owner:	Director of Nursing
Review Date:	January 2021 **Policy Risk Rating:** High

1. PURPOSE

To Ensure Registered Nurses are guided in how they delegate to Enrolled Nurses and trained Personal Care Assistants.

2. POLICY

The Registered Nurse managing medication may delegate the administration of medication to an Enrolled Nurse or trained Personal Care Assistant in accordance with professional guidelines and the relevant legislation.

3. PROCEDURE

3.1. Enrolled Nurses and trained Personal Care Assistants who have completed the Village Baxter Medication Competency are authorised to administer medication under the supervision and direction of a Registered Nurse.

3.2. Enrolled Nurses and trained Personal Care Assistants designated as being able to administer medication must work within Village Baxter policies, procedures and protocols at all times.

3.3. Enrolled Nurses and trained Personal Care Assistants designated as being able to administer medication have the skills and knowledge to administer and monitor medications and evaluate their effectiveness.

3.4. Enrolled Nurses and trained Personal Care Assistants are accountable for making decisions about their own practice and about what is within their own capacity and scope of practice.

3.5. Medication trained Personal Care Assistants may not complete suppositories or injectables.

3.6. It is Village Baxter policy that:

3.6.1. An Enrolled Nurse or trained Personal Care Assistants cannot administer PRN Medication without prior consultation with a Registered Nurse.

3.6.2. An Enrolled Nurse or trained Personal Care Assistants may not accept a verbal or telephone order but may be witness to an RN accepting the verbal or telephone order.

3.6.3. An Enrolled Nurse or trained Personal Care Assistants cannot administer Nurse Initiated Medication without prior consultation with a Registered Nurse.

4. RELATED POLICIES AND DOCUMENTS

- 182 – Staff Medication Competency
- Health Practitioner Regulation National Law Act 2009
- https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit
- https://www2.health.vic.gov.au/ageing-and-aged-care

Policy Number:	182		
Title:	Staff Medication Competency		
Owner:	Director of Nursing		
Review Date:	January 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To ensure Registered Nurses, Enrolled Nurses and trained Personal Care Assistants are competent in their medication administration role.

2. POLICY

Registered Nurses and Enrolled Nurses are competent in the administration of medication as per their scope of practice.

Trained Personal Care Assistants - Medication Competency is granted on successful completion of the Medication Module training conducted by an external provider of the Village Baxter's choosing.

3. PROCEDURE

3.1. RN's / ENs - in the event of medication issues or incidents, an additional competency may be required and is at the discretion of the Unit Manager and / or Director of Nursing.

3.2. Personal Care Assistants competency will be re-assessed at the discretion of the Unit Manager / or Director of Nursing.

4. RELATED POLICIES AND DOCUMENTS

https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit

Policy Number:	183		
Title:	Medication Charts and Orders		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide clear understanding of the requirements regarding medication orders and charts.

2. POLICY

Medications are dispensed individually for each resident and are only to be administered in accordance with relevant State & Federal legislation and guidelines.

3. PROCEDURE

3.1. Medication orders are to be legible and written by the Doctor (or other lawfully authorised person) on the Long Term Medication Management Chart. Prescribers must ensure that medication orders are clear and not open to misinterpretation.

3.2. Each Medication Order must include:

i. Medication name (brand or generic),

ii. Medication Strength, Dose, Route and Frequency of Administration,

iii. Commencement date and completion date (if limited term),

iv. Date and signature of the Doctor or lawfully authorised person ordering the medication.

3.3. All details on the front of the Medication Chart are to be completed. The Administration Instructions label should reflect the information on the residents Medication Assessment and Care Plan.

3.4. All internal pages are to be labelled with the resident's name, D.O.B. and an ID label attached to the Approved Nurse Initiated Medication List on the inside back cover.

3.5. If an Allergy/Sensitivity is identified then an Allergy/Sensitivity sticker including details of the reaction (if known) is applied to the front page and Drug Alert Stickers applied to the other pages of the chart in the spaces provided.

3.6. The non- packed Medication Box is marked and highlighted on the left hand side of the regular and PRN orders.

3.7. When a new chart is written by a GP, the new chart becomes the current Medication Chart and all previous charts (completed or otherwise) are obsolete and are not to be used. The previous drug charts are to be marked “ceased” on allocated area of front cover.

3.8. When a Medication Chart is altered or updated, the entire Medication Chart, including the front page is to be faxed to the Pharmacy

3.9. In the absence of a Medication Chart, or where the hospital medication list is not signed by a Doctor or Pharmacist, the clear directions contained on the resident’s dose administration aid are acceptable orders. Medications given to residents when a Medication Chart is not available, or there is no space in the Medication Chart to sign, are to be recorded in the Progress Notes in Lee Care until the Doctor has reviewed and updated the Medication Chart.

3.10. Standing Orders are not generally appropriate in Aged Care as medicines are dispensed for individual residents and stocks of medication (other than NIMS) not kept.

4. RELATED POLICIES AND DOCUMENTS

- 186 - PRN Medication Administration
- https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit

Policy Number:	184		
Title:	Dose Administration Aid		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To implement best practice as per Guiding Principles for Medication Management in Residential Aged Care Facilities.

2. POLICY

Village Baxter uses Dose Administration Aids for all solid oral medications.

3. PROCEDURE

3.1. The Pharmacy packs each resident's tablets into a Dose Administration Aid. The Dose Administration Aid includes prescribed medications.

3.2. Separate Dose Administration Aids are packaged for antibiotics, PRN orders, Warfarin and short term orders.

3.3. The contents of a Dose Administration Aid is not to be transferred to any other container and stored prior to administration.

3.4. Advisory labels for special medication alerts are applied by the pharmacist to the Dose Administration Aid e.g. "before food", "do not crush" etc.

3.5. Each week a new supply of Dose Administration Aids will be provided with the used frames collected and returned to the pharmacy for repackaging.

3.6. Non-packed and PRN items are not included in the automatic weekly cycle for packed medication. These medications are replaced as required.

3.7. When a medication is ceased by an authorised prescriber, a ceased sticker is placed over the Dose Administration Aid containing the ceased medication until it can be returned for repackaging.

3.8. All Dose Administration Aids are labelled with the resident's name, date of birth, RACF, suite number, Doctor and allergy sticker.

4. RELATED POLICIES AND DOCUMENTS

- Nil

Policy Number:	185		
Title:	Injectable Medications		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide guidelines for Registered and authorised Enrolled Nurses to manage medication administered by injection.

2. POLICY

All medication for injection will be stored as per pharmacy recommendations, administered in accordance with the medication order and as per the manufacturer's recommendations.

2.1. Administration of Medication via Injection

2.1.1. Only a Division 1 nurse or a Division 2 (endorsed) nurse who has completed the appropriate training may administer injectables.

2.2. Insulin Administration

2.2.1. Only Registered and authorised Enrolled Nurses can administer insulin

2.2.2. Insulin is only administered after a Blood Glucose Level has been taken and recorded or as directed by a General Practitioner.

2.2.3. Two staff are required to check Insulin order and dose preparation.

3. RELATED POLICIES AND DOCUMENTS

- 130 – Diabetes
- 183 - Medication Orders and Medication Charts
- 188 - Self-Administration of Medications

Policy Number:	186
Title:	PRN Medication Administration
Owner:	Director of Nursing
Review Date:	February 2021 **Policy Risk Rating:** Medium

1. PURPOSE

To provide clear understanding of the process for managing PRN Medication Administration.

2. POLICY

PRN medication may be administered on an "as needed" basis for the relief of specific signs & symptoms. All PRN medications must have a valid medication order and be authorised by a Registered Nurse.

3. PROCEDURE

3.1. PRN orders must be written in the PRN section of the Medication Chart.

3.2. PRN orders must specify the reason for which the medication is to be administered, e.g. Stematil “for dizziness” or “for nausea”. The authorised prescriber or pharmacist is permitted to complete the section next to the order, on the Medication Chart labelled “prescriber to complete reason”.

3.3. PRN orders must specify the administration time range if applicable e.g. Nocte and the maximum daily dosage e.g. Temaze 1-2 Nocte PRN (Max. 2).

3.4. An EN/PCA med comp must consult with the Registered Nurse if she/he believes a PRN medication is indicated. The subsequent administration of a PRN medication is based on the clinical judgement of the RN, and may be delegated to an EN/PCA med comp.

3.5. Non-pharmacological strategies should be considered prior to PRN medication administration.

3.6. Prior to administering any PRN Medication RN/EN/PCA staff must cross reference the Regular and PRN Medication Orders to ensure the maximum daily dose is not exceeded, and appropriate time frames between administrations are maintained.

3.7. The administration of all PRN medication is to be recorded on the Medication Chart, Handover sheet and documented in the resident’s Progress Notes in Lee Care. A follow up Progress Note must be written advising of effectiveness in Lee Care and where a PRN medication is not effective then a progress note will be required to advise what action has been taken.

3.8. The evaluation of the medication should be completed by the staff member administering the medication; however where evaluation is required after a change of shift, the oncoming RN/EN is responsible for the evaluation.

3.9. If the PRN medication administered is not effective or is required on a regular basis (e.g. 4-7 consecutive days) the R.N. must be notified, and the GP requested to review the order.

4. RELATED POLICIES AND DOCUMENTS

- 183 - Medication Orders / Medication Charts
- https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit

Policy Number:	187
Title:	Nurse Initiated Medicines (NIM)
Owner:	Director of Nursing
Review Date:	February 2021 **Policy Risk Rating:** Medium

1. PURPOSE

To provide a clear understanding for the management for Nurse Initiated Medication (NIM).

2. POLICY

The Village Baxter Medication Advisory Committee (MAC) has developed a list of approved non-prescription (S2 & S3 & non-scheduled products) medications which with the prior agreement of the residents GP may be given to a resident for the relief of indicated symptoms on NIM list.

3. PROCEDURE

3.1. The list of approved NIMS for each resident is recorded by the general practitioner for each resident. Residents who do not have the approved list signed by their GP in their Medication Chart cannot receive NIMs. Note: It is the GPs responsibility to indicate on the list which medications are not suitable for a particular resident.

3.2. NIMs are only to be authorised by an RN after a clinical assessment of the resident has occurred. The RN may delegate administration of the NIM to an authorised Enrolled Nurse.

3.3. The RN records the NIM on the Nurse Initiated Medication page of the Medication Chart and in a progress note.

3.4. The RN will evaluate and document the effects of the medication administered and record a Progress Note.

3.5. The resident's GP is notified of the administration of the NIM at their next visit or contacted for a telephone order/further advice if the NIM is not effective.

3.6. NIMs are only intended for one-off or occasional use. If the use of a NIM becomes regular, the resident should be reviewed by their GP and if considered appropriate a regular or PRN order written on the Medication Chart.

3.7. Village Baxter will purchase a small impress stock of NIM from the approved NIM list which may be reordered from Pharmacy as required.

3.8. The list of NIM is reviewed annually by the Medication Advisory Committee at their first meeting of each calendar year.

4. RELATED POLICIES AND DOCUMENTS

- 183 – Medication Orders / Medication Charts
- https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit
- Appendix A – Approved nurse initiated medication.

Policy Number:	188		
Title:	Self-Administration of Medication		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide guidelines for staff to support residents who are assessed as being able to self-administer their medications.

2. POLICY

Village Baxter supports residents who wish to administer their own medication provided it has been assessed that medication administration can safely be carried out by that individual.

3. PROCEDURE

3.1. Residents who self- administer some or all of their medications must have an accurate and up to date record of all medications being taken including any items they purchase "over the counter" recorded on their Medication Chart.

3.2. The residents' ability to self-administer all or some of their medications is assessed by the Registered Nurse in consultation with the resident and their GP using the Medication Administration Assessment.

3.3. If the resident becomes unsafe to self-administer medications, the Registered Nurse should intervene, remove medications from the resident and advise the general practitioner. RACF staff should continue to manage the resident's medication management until further assessment of the resident can be completed and they are deemed competent.

3.4. All medications are to be stored in the lockable drawer in the resident's room and the key appropriately and securely stored.

3.5. Reassessment of the resident's ability to self-medicate shall occur as clinically indicated.

4. RELATED POLICIES AND DOCUMENTS

- 168 – Risk Taking
- Dept. Health & Ageing Guiding principles for medication management in residential aged care facilities 2012 https://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm

Policy Number:	189
Title:	Management of Controlled Substances
Owner:	Director of Nursing
Review Date:	February 2021 **Policy Risk Rating:** High

1. PURPOSE

To assist Registered and Enrolled nursing staff to manage controlled drugs safely and correctly.

2. POLICY

Controlled substances at Village Baxter will be managed in accordance with relevant Regulatory Guidelines.

3. PROCEDURE

3.1. All controlled substances are to be delivered by an authorised pharmacy staff member in individually labelled tamper evident packaging and handed directly to the RN/EN on duty.

3.2. The authorised persons delivering and receiving the controlled drug enter the details of PRN DD in the DD Book and sign the entry.

3.3. The DD safe must be kept locked at all times except when actually in use. The keys for the DD storage safe/s in the RACFs are to be held on the authorised personnel.

3.4. The administration of a controlled PRN drug must be witnessed by two authorised staff. The witness must remain present throughout the entire procedure of accessing, checking, preparation, administration and recording the administration of a controlled drug. Drugs are to be taken to the bedside in an individual receptacle (dish).

3.5. The stock balance of every controlled drug stored in the DD safe must be checked and verified in the DD register daily by authorised personnel.

3.6. Any discrepancy in the DD register is to be noted in the DD Register and documented on a Medication Incident Report form. The DON/RN on call must be notified regarding any discrepancies of controlled substances.

3.7. The DD register is not to be altered with correction fluid or an eraser. If an alteration is required then a single line is to be drawn through the change and countersigned. The change should be documented on a new line using a black pen.

3.8. If a medication is prepared and not used or only partly used, then the balance must be discarded in the presence of an authorised staff member and an entry made in the DD Register. Discarded medication should be placed in the sharps container.

3.9. Any controlled substance that is not required is to be returned to the Pharmacy and signed out of the DD register.

3.10. Large quantities of DDs should not be kept on-site unless required for administration or clinically indicated to reflect this action.

3.11. DD Books must be retained/archived for three years from the date of the last entry.

3.12. DD that are prescribed regularly are to be packed in a tamper proof DAA and can be stored and managed with the regular medication DAA. These medications do not require to be recorded in the DD register. Any discrepancies are to be managed through the incident management procedure.

4. RELATED POLICIES AND DOCUMENTS

- 191 – Medication Storage and Disposal
- http://www.health.vic.gov.au/dpcs/agedcare
- F:\Anstat
- https://www2.health.vic.gov.au/about/publications/policiesandguidelines/apac-medication-management-residential-aged-care-facilities-resource-kit

Policy Number:	190		
Title:	Warfarin Management		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide guidelines for the management of Warfarin therapy.

2. POLICY

The Village Baxter prefers ALL residents who are prescribed Warfarin to have their dosing managed by the Warfarin Department at the Pathology Laboratory.

3. PROCEDURE

3.1. Warfarin is dispensed directly from the original packaging.

3.2. All Warfarin medication should be administered as per medication chart.

3.3. The daily dosing is made in line with the INR results, and residents medication chart. RN/EEN must both check the amount to be given as per INR result.

3.4. The G.P.'s preferred pathology laboratory will monitor INR blood testing requirements.

3.5. INR testing is used to keep Warfarin within safe and therapeutic levels. INR results and dose are faxed to the relevant RACF, GP and the Pharmacy within 24 hours of test date.

3.6. The Pathology Department will telephone if a dose is to be withheld and also advise of the next test date. If the Warfarin dose has already been administered then the Pathology Department will provide guidance on the appropriate action required. This process needs to be documented in a Progress Note.

3.7. The change of dose is managed by the RN in charge and will commence from the day after the test.

3.8. The Pharmacy or the Pathology INR Department can be consulted during business hours regarding Warfarin dosing. E.N. staff are required to consult with the R.N. on duty regarding any Warfarin dosing or administration issues prior to contacting Pharmacy or Pathology.

3.9. If a new resident is receiving Warfarin Therapy on admission, then the appropriate Pathology Department is to be advised on the day of admission. Notification should also be made if dental or surgical procedures are scheduled or if serious illness/hospitalisation occurs.

3.10. If a GP chooses to manage a residents Warfarin dosing (doctor dosing) then Warfarin can only be administered with a VALID doctor's order. If no order is available then the doctor MUST be contacted.

4. RELATED POLICIES AND DOCUMENTS

- 183 - Medication Orders / Medication Charts
- 184 – Dose Administration Aid

Policy Number:	191
Title:	Medication Storage and Disposal
Owner:	Director of Nursing
Review Date:	June 2018 **Policy Risk Rating:** Medium

1. PURPOSE

To ensure medications are stored in accordance with legislative requirements and the manufacturers recommended storage conditions for the drug (e.g. refrigerator or room temperature).

2. POLICY

All medications must be stored securely, in a way that protects the safety of all residents, staff and visitors and prevents unauthorised access.

3. PROCEDURE

3.1. Access to the locked medication storage areas is restricted to authorised personnel.

3.2. Ensure medications are locked, except when performing a specific action directly related to the medication, such as to administer the medicine or to do an inventory check.

3.3. The key/s to medication storage areas are kept by the person/s responsible for medication administration at all times whilst on duty. Any spare keys are to be secured in a separate location.

3.4. Medications not packaged in a dose administration aid are stored in their original packaging and only transferred from these containers when being administered.

3.5. Eye-drops are to be stored in individual containers and clearly identify the date opened.

3.6. The temperature (maximum and minimum) of the Medication storage refrigerator is checked daily and recorded on the Refrigerator Temperature Form in the Medication Room. Corrective action is taken if the temperature is outside the acceptable range of 2 - 8°C.

3.7. The Pharmacy will collect and dispose of any unwanted medication.

3.8. Insulin Storage – opened insulin must be labelled with the date of opening and stored in the fridge. Unopened insulin can be left unrefrigerated for 28 days.

3.9. Schedule 8 medication must always be stored in a dedicated safe- separate from other medication. For those Schedule 8 medications that require refrigeration will be stored

3.10. All resident medication is locked into the medication cupboard in individual residents' rooms. Including PRN medication. Additional supplies and PRN are kept in the locked medication room.

4. RELATED POLICIES AND DOCUMENTS

- 189 - Management of Controlled Substances
- http://www.health.vic.gov.au/dpu/reqhealth.htm
- Guiding principles for medication management in residential aged care facilities 2012 - https://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm

Policy Number:	192		
Title:	Medication Incidents		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	High

1. PURPOSE

To provide staff with clear guidelines for the management of medication errors and incidents.

2. POLICY

Village Baxter has a medication incident reporting system to capture and appropriately manage Medication Incidents.

3. PROCEDURE

3.1. All medication administration staff are required to report a medication incident (not limited to), error, or suspected adverse drug reaction, missed signatures, pharmacy packaging error, to the Registered Nurse in charge of the shift immediately. Medication incidents may be related to any of the steps in medication management, including prescribing, dispensing, administration and documentation.

3.2. The Registered Nurse in charge is responsible for the initial action and management of all medication incidents.

3.3. If the wrong medication is administered and the resident is allergic to the medication, or clinical signs of an adverse effect are evident, telephone advice from the GP, Pharmacy, or on-call Registered Nurse should be sought. If the reaction is potentially serious then hospital transfer is recommended.

3.4. The incident form is completed by the person identifying the incident. The Registered Nurse in charge is responsible for ensuring the appropriate corrective action, notifications and documentation.

3.5. The DON will ensure review of the incident form and appropriate follow up action has occurred. Staff based medication errors must be followed up with a debrief with RN/DON. Where required additional education will be provided. External provider to complete a medical competency.

3.6. The Medication Advisory Committee (MAC) oversees the medication monitoring and reporting system all Medication errors, incidents and other concerns are referred to the MAC for review.

3.7. Staff may be asked to step down from medication management (depending on the severity of the error).

4. RELATED POLICIES AND DOCUMENTS

- 180 – Medication Advisory Committee
- Guiding principles for medication management in residential aged care facilities 2012

Policy Number:	193		
Title:	Imprest Medication Management		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

To ensure a safe Imprest system and safe administration of medication from the Imprest to residents.

2. POLICY

The Village Baxter will hold the licence to have an imprest system, with the Director of Nursing as the nominated responsible person for this licence

3. PROCEDURE

3.1. The imprest medications will be kept in a separate cupboard, labelled and locked in a location accessible by the designated person to provide medications for any resident in the facility should the need arise. Pharmacy will be notified of the location of the imprest medication cupboard to facilitate delivery of replacement stock.

3.2. All required documentation and ordering forms will reside within the locked cupboard (balance book, reorder form, emergency medication list).

3.3. The designated person will dispense from an order from the GP/Locum/Nurse Practitioner prescribed on the resident's medication chart or from a fax order from the GP.

3.4. If the order is prescribed outside of pharmacy's trading hours, then the designated person can access the imprest system to supply the prescribed medication to the resident.

3.5. Staff are to remove the entire box of medication from the imprest cupboard and assign to the resident and should be recorded in the imprest register as per order form.

3.6. If the medication is a DD (S8) medication, staff should adhere to facility's protocol for handling and management of the DD (S8).

3.7. The designated person will assign the removed box of medication to the individual resident and place a Bradma sticker onto the box.

3.8. The Emergency Imprest Medications Reorder Form is to be completed, indicating the medication removed from the cupboard for the particular resident. The form will then be faxed to the pharmacy, accompanied with relevant order that was previously given by the GP/Locum/Nurse Practitioner. This ensures that the medication that was used is replaced and the medication continues to be dispensed.

3.9. If the prescription is available at the time of prescribing, this will be placed in the pharmacy returns box.

3.10. If a resident is not a user of the Terry White Pharmacy, they will not be disadvantaged. Staff must seek authorisation by the family that they will make payment for the medications used prior to being dispensed and recorded in the progress notes.

3.11. For medications that do not require packing into a Webster pack, the pharmacy will provide a dosing label which will come to the facility on the next business day. This label will be placed over the Bradma by the designated person.

3.12. For medications that require packing into a Webster pack, pharmacy will come to the facility to collect the medication the morning of the next business day during the week, and will endeavour to deliver the medication, packed in a Webster pack, in the afternoon.

3.13. The imprest system will be audited by the aged care facility monthly to ensure compliance by all the staff. Any errors or discrepancies are to be reported and investigated as per facility's protocol.

3.14. If there are any medications that have been unused and have expired, pharmacy will dispense the medication to replace the expired stock and charge these medications to the facility. This medication can be reviewed at the next Medication Advisory Committee if it should still be kept in the imprest system.

3.15. The list of nominated medications to be kept in the imprest system will be ratified by the Medication Advisory Committee periodically, from the date of licence provision. Should additional drugs be required or added prior to this review, it will be advised at the MAC meeting and ratified at the meeting. The Emergency Medications list will be updated to reflect the change.

AFFIX BRADMA

APPROVED NURSE INITIATED MEDICATION LIST

Drug and Strength	Indication	Dosage	Maximum Dose Allowed to be Administered
Paracetamol 500mg	Pain, headache, fever	1–2 every 4 hours	2 doses
Mylanta	Indigestion	20mls	2 doses
Bisolvon	Cough	10mls	4 doses
Oxygen	.... (state indication)	2litre/minute	Continuous via nasal prongs. Contact LMO.
Nulax	Constipation	1 teaspoon nocte	PRN
Coloxyl and Senna	Constipation	2-3 twice daily	2 doses
Movical 13.125 macrogol	Constipation	I daily	1 satchel
Glycerine suppository	Constipation	1–2 if bowels not opened after 3 days	1 dose
Microlax Enema	Constipation	1	1 dose
Imodium	Diarrhoea	2 stat and report to GP	1 dose and refer to GP

- These are the nurse-initiated medications that the Medication Advisory Committee (MAC) has agreed upon.
- This list will be kept with the Medication Chart belonging to this resident.
- GP is notified of administration of NIM on their next visit.
- GP is contacted for telephone order (or other medical plan/advice) if NIM is not effective.
- RN records NIM on the Medication Chart, signs and dates for administration, recorded in progress notes in Lee Care, written on handover sheet and verbal hand over to next shift.
- Medication is ordered from pharmacy on an as needs basis.
- Oxygen is kept in the treatment room or other appropriately identified area.
- The list of NIM's is reviewed annually by the MAC.

I, Dr.....

Have read the nurse initiated medication list and give my consent that the above medications can be given in accordance with the parameters set out for my patient (refer to Bradma label above or enter name below).

RESIDENT NAME.....

DATE.....

GP SIGNATURE: .....

Authorised by: Medication Advisory Committee Issue: 4/10.3.17