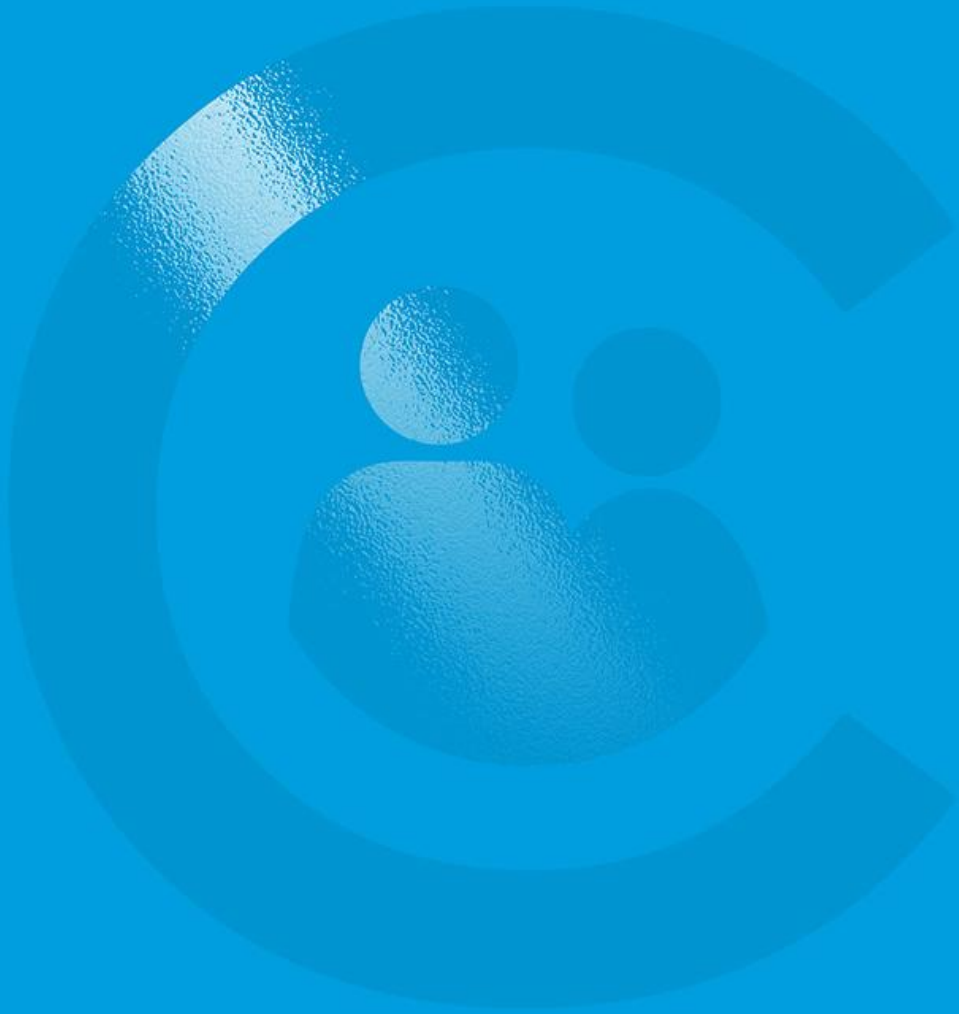
ACare WA
Smart Choice Local Care



ACARE WA COMMUNITY NURSING SERVICES FOR VETERAN CARD HOLDERS

Policy and Procedure Manual

08/2025

Version 2.80

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Overview

About This Manual

This Policy and Procedure Manual (“Manual”) outlines the policies and procedures that govern the operations of **ACare WA**, ensuring the provision of support to clients in a safe, legal, efficient, and systematic manner.

All policies and procedures in this Manual comply with applicable Commonwealth and State Government Legislation, Regulations, and Standards relevant to the company's services. This Manual is designed to complement, not override, State and Commonwealth legislation, Acts of Parliament, or other legal requirements, serving as a compliance guide.

This policy applies to all staff involved in patient care within the company. Non-compliance with these policies and procedures will be treated with utmost seriousness and may result in disciplinary action, which could include consequences from clients, service providers, government bodies, and other relevant parties.

Management is expected to refer to the Manual regularly and remain updated on any changes.

Management is also responsible for ensuring that the Manual is easily accessible to all staff, whether in print or electronic format, including online platforms or intranet systems, to facilitate easy reference and searchability.

For the purposes of this document, "staff" is defined as any individual who works for the company, including but not limited to: permanent, temporary, full-time, part-time, or casual employees; volunteers; students; contractors; consultants; or anyone engaged in any other capacity.

Regular Review

These policies and procedures are subject to regular review within established timeframes to maintain their relevance and effectiveness (at a minimum of every three years or in line with relevant legislation).

Accessing Policies, Templates & Forms via ACare WA Clinical Portal on www.acarewa.com.au

All documents in this manual are available digitally on the ACare WA Clinical Portal to ensure you are always using the most current version.

How to Access and Download:

1. **Log in to the ACare WA Clinical Portal:**
    - Use your staff login credentials provided during induction.
    - If you do not have access, contact the ACare WA admin team.
2. **Navigate to the "Clinical Resources" Section:**
    - Click on Policies & Templates.
    - Choose the relevant category (Procedures, Templates, DVA Forms, Onboarding, etc.).
3. **Download or Print:**
    - Select the document you need.
    - You can download as a PDF for completion or print directly from the portal.
    - Always check the date/version number on the portal to ensure it's the latest copy.
4. **Complete and Upload (if required):**
    - If the template requires submission (e.g., Care Plan, Incident Report), complete it and upload back to the portal under the client record or email to admin@acarewa.com.au as per procedure.
5. **For Help:**
    - If you experience issues accessing or printing documents, contact the ACare WA it@acarewa.com.au or SMS **0474 357 003** for assistance

Section 1

Primary Care Partnerships & Referral Pathways

Collaboration with Primary Care and Referral Process

ACare WA and Denmark Medical Practices

Purpose

To ensure a consistent and collaborative approach to supporting older clients through streamlined referrals, communication, and service delivery between ACare WA and general practices in Denmark, including Denmark Medical Centre and Denmark Family Practice.

Referral Process & Health Summaries

- When referrals come to ACare WA from Denmark Medical Centre or Denmark Family Practice, we aim to onboard clients efficiently and safely.
- An up-to-date Health Summary is essential and requested within two business days.
- For self-referred clients, ACare WA obtains written consent to share information with their GP and any relevant providers.
- Medical practices are welcome to contact ACare WA to confirm if a client has provided consent; we maintain signed consent forms on file.

Allied Health Referrals – Format Request

- To ensure correct claiming and reduce client confusion, referrals should be issued as separate documents for each provider.
- A single referral letter listing multiple providers is often not accepted.
- With Medicare changes effective 1 July 2025, care plan formats may vary. ACare WA is flexible during this transition.
- If the practice has referred a client or signed a consent form, ACare WA can request a copy of the Care Plan as needed.

Clarifying TCA vs HCP

TEAM CARE ARRANGEMENT (TCA)	HOME CARE PACKAGE (HCP)
Created by GP under Medicare (Items 721/723)	Requires ACAT assessment via My Aged Care
Enables up to 5 subsidised allied health visits/year	Provides ongoing, flexible support via a care budget
Providers may bulk bill or charge a gap	Services are paid from the package
Short-term or condition-specific care	Long-term, coordinated at-home care
No aged care supports included	Designed to keep people at home longer

- A TCA does not trigger HCP eligibility.
- A separate referral to My Aged Care is required for an ACAT assessment.

When a Home Care Package May Be Appropriate: Consider referring to My Aged Care when a patient:

- Receives regular support with meals, hygiene, or mobility
- Shows signs of frailty, memory loss, or isolation
- Has a carer experiencing strain
- Needs support beyond Medicare (e.g., equipment, transport)
- Could benefit from ongoing, coordinated in-home care

My Aged Care Referral Options:

- Online: www.myagedcare.gov.au/referral
- Phone: 1800 200 422
- Via Best Practice or Medical Director software

Tip: Include “likely suitable for a Home Care Package” in the referral notes to assist ACAT prioritisation.

GP Home Visits – Collaborative Support

- ACare WA recognises that GP home visits are limited due to logistics.
- If a client is particularly frail or housebound, ACare WA can flag this via a formal request to the medical practice.
- Acknowledging that this is a case-by-case decision, we remain available to support any internal GP discussions on this matter.
- Funding via HCP is not the barrier – logistics and safety are key considerations.

ACare WA Support to Denmark Medical Centre and Denmark Family Practice With consent, we are happy to:

- Share patient lists supported under HCP
- Provide care plans and service updates
- Assist families in making My Aged Care referrals
- Coordinate services including nursing, equipment, and allied health

Palliative Care Collaboration

- ACare WA supports regional palliative care under a 12-month agreement with WACHS Great Southern.
- We work closely with Jane Davenport (Denmark Palliative Care Clinical Nurse) and align with her direction for all clients referred.
- Since January, we have supported four clients through this collaborative care model.
- Communication Channels
- We will continue to communicate via: admin@denmarkmedicalcentre.com.au and admin@denmarkfamilypractice.com.au
- We are happy to adapt to internal systems or preferences at both practices to support patient outcomes.

Conclusion We value our partnership with both Denmark Medical Centre and Denmark Family Practice and remain committed to delivering high-quality, coordinated care to our shared clients. Please contact us at any time for clarification or collaboration.

This section will be reviewed and updated following major Medicare changes or system update-information correct as of July 2025.

About ACare WA

ACare WA is a locally operated, Western Australian home care coordination service, supporting older people to remain independent, safe, and connected in their homes and communities. Founded with a personal commitment to care and a deep understanding of the challenges families face, ACare WA partners with clients, families, GPs, and service providers to deliver tailored care solutions that reflect local needs and values.

Our Mission

To provide responsive, respectful, and person-centred care that empowers older Australians to live well at home with dignity and choice.

Our Vision

Communities where ageing in place is supported by compassionate coordination, trusted relationships, and professional clinical care.

Our Core Values

- Respect: We honour the lived experience, culture, and preferences of every individual.
- Partnership: We work alongside clients, families, and healthcare teams to ensure care is truly collaborative.
- Trust: We maintain transparency, integrity, and reliability in all our actions.
- Flexibility: We respond to the unique needs and changes in each client's journey.
- Excellence: We uphold the highest standards in clinical care, governance, and communication.

Our Community Focus

Based in Denmark, WA, ACare WA was founded by locals for locals. We understand the importance of social connection, rural access, and culturally safe services. We pride ourselves on:

- Offering real-time, place-based support from staff who know the community
- Coordinating services that balance clinical safety with personal goals
- Ensuring clients feel seen, heard, and respected every step of the way

ACare WA operates under the principles of the Aged Care Quality Standards and is committed to continual improvement, ethical service delivery, and community wellbeing.

Key Strengths and Enhancements Identified

1. **Branding and Organization**

   - Content has been tailored specifically for ACare WA.
   - Custom branding and contact details are present.
   - Inclusion of ACare WA's mission, vision, values, and a strong community-focused narrative.
   - Strengthened introductory sections such as "About ACare WA" with local context for Denmark, WA.

2. **Structure and Content Depth**

   - New and relevant sections such as Telehealth, CALD (Culturally and Linguistically Diverse) Support, Continence Management, Clinical Handover, and Emergency Preparedness.
   - Appendices now include templates, practice guides, and reference materials.

3. **Compliance and Regulatory Alignment**

   - Extensive references to DVA, ACAT, My Aged Care, and WACHS.
   - Distinction between care models (e.g. TCA vs HCP).
   - Alignment with Aged Care Quality Standards and state-specific health services in WA

4. **Policy Depth and Practical Examples**

   - Includes workflows, checklists, and client journey maps.
   - Clear documentation of risk management strategies and clinical governance frameworks with visual aids.

5. **Language and Audience Appropriateness**

   - Client-centred and professional tone.
   - Clear role distinctions for RNs, ENs, and PCWs.
   - Strong emphasis on person-centred care and family inclusion in care planning and governance

6. **Staff and Subcontractor Management**

   - Detailed policies for subcontractor selection, oversight, and DVA notification requirements.
   - Structured approach to staff screening, competency validation, onboarding, and delegation.

7. **Contemporary Care Models**

   - Integration of telehealth services and remote monitoring practices.
   - Culturally responsive care models for CALD communities.
   - Protocols introduced for falls prevention, continence care, and emergency preparedness.

8. **Document Presentation**

   - Effective use of tables and structured definitions.
   - Visual frameworks including clinical governance models.
   - Well-organised formatting with clear use of headings, subheadings, and flowcharts.

About This Manual

This manual outlines the clinical policies and procedures that guide ACare WA's provision of safe, person-centred, and culturally responsive community nursing services. ACare WA is a locally Denmark WA based care coordination service committed to supporting older Australians in their own homes through collaboration, compassion, and clinical excellence.

Glossary of Key Terms

TERM	DEFINITION
ACare WA	A Western Australian Denmark-based care coordination service delivering in-home nursing and support through the Home Care Package program.
Care Coordinator	An ACare WA team member who manages client care plans, liaises with families, and ensures services meet individual needs and care goals.
Subcontractor	An independently contracted provider (e.g., support worker, nurse, OT) who delivers care under the direction and standards of ACare WA.
Client	An individual receiving nursing or care coordination support through ACare WA and funded via the Home Care Package program.
Home Care Package (HCP)	A Commonwealth-funded aged care program that provides coordinated support and services for older Australians to remain at home.
My Aged Care (MAC)	The national entry point to Australian government-funded aged care services, including referrals for ACAT assessments.
ACAT	Aged Care Assessment Team – a health professional team that assesses eligibility for HCPs and other services.
GP	General Practitioner. Refers to the client's primary care physician, who is involved in care coordination and referrals.
TCA	Team Care Arrangement. A Medicare-based care planning tool used by GPs to coordinate short-term allied health services.
Clinical Lead	A senior registered nurse responsible for clinical oversight, governance, and escalation of client care concerns at ACare WA.
CALD	Culturally and Linguistically Diverse – clients whose cultural or language background differs from the dominant English-speaking population.
WACHS	WA Country Health Service – the public health service that ACare WA collaborates with for some services, including palliative care

Section 2

Clinical Governance

Policy Statement

ACare WA is committed to a robust clinical governance framework that ensures a consistent, systematic approach to quality improvement, safety, and accountability in all clinical practices. Clinical governance encompasses leadership, accountability, risk management, clinical effectiveness, and staff engagement.

Purpose and Scope

This policy provides guidance for the company and all staff in implementing clinical governance processes across its operations, ensuring that:

- The company's goals and targeted outcomes are effectively met.
- Clients receive safe, high-quality care aligned with the company's standards and priorities.

The purpose is to implement a clinical governance framework that ensures clients receive safe, high-quality care and services.

This policy applies to all employees and contractors (both clinical and non-clinical) providing services to our clients, as well as to management. All employees are expected to actively contribute to effective and robust clinical governance by fulfilling their individual roles and responsibilities, as outlined in this policy.

Definitions

TERM	DEFINITION
Clinical Governance	A component of the corporate governance of health service companies that ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to clients and the community for ensuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving" (ACQSHC, 2017).

Our Clinical Governance Framework

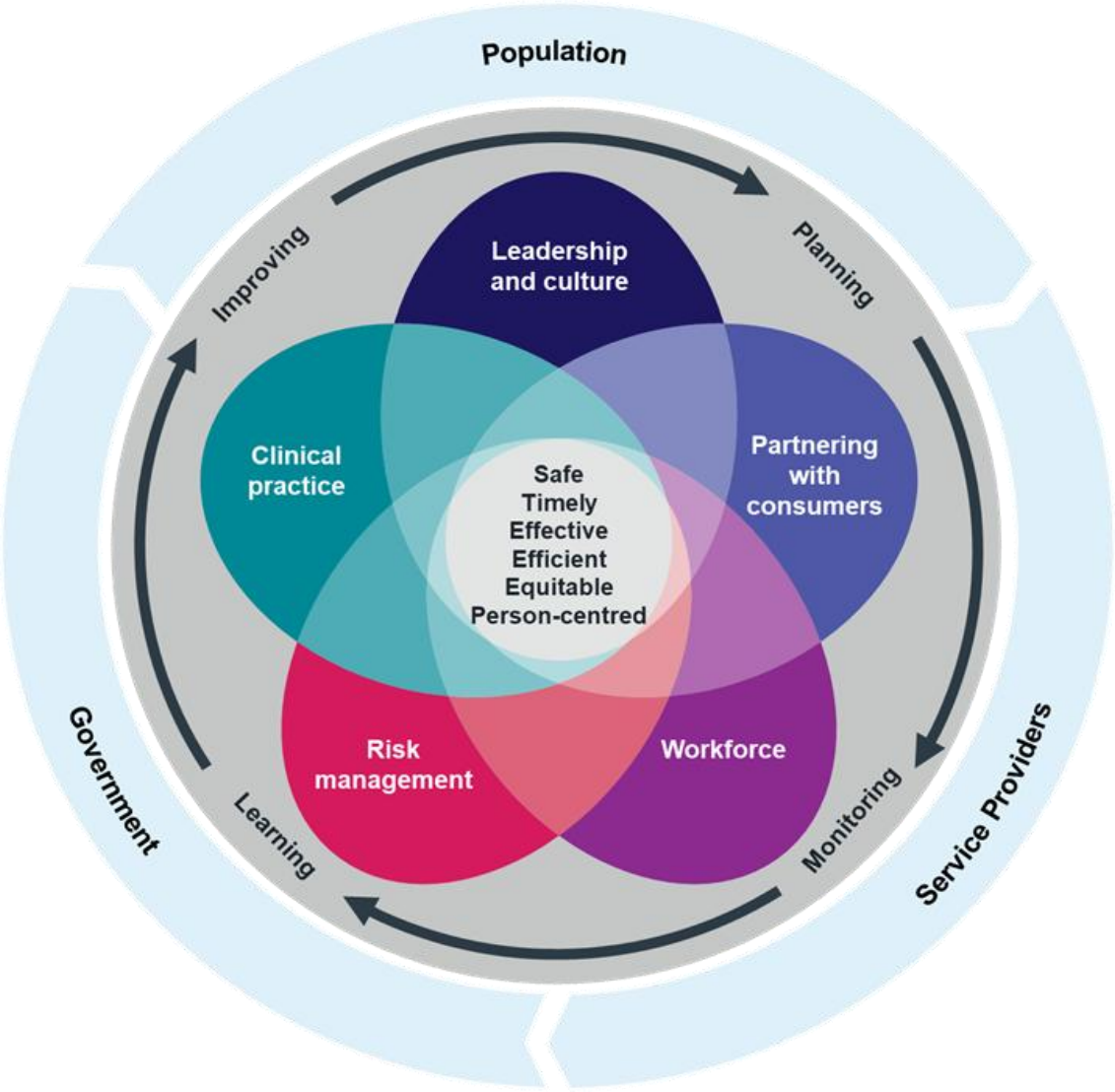


***Figure 1**: Clinical Governance Framework*

The components of our Clinical Governance Framework are as follows:

1. **Governance, Leadership, and Culture**
    - **Comprehensive Governance Systems**

      Corporate and clinical governance systems are integrated to continuously improve patient safety, care quality, and outcomes. These systems uphold clear standards and regulations, ensuring compliance and consistency in all aspects of clinical and operational practice.

- **Strong Leadership**

  Leaders cultivate a safe, supportive, and positive environment where staff are empowered to engage in decision-making, contribute their expertise, and take ownership of patient care quality. This supportive environment promotes transparency, ethical practices, and accountability across all levels.

- **Organisational Culture**

  A culture dedicated to high-quality care is encouraged, with policies and structures focused on patient-centred services informed by consumer and workforce insights. This commitment to quality care is reflected in the encouragement of innovation and continuous feedback mechanisms.

2. Patient Safety and Quality Improvement Systems

- **Proactive Safety Systems**

  Safety and quality processes are systematically embedded within governance structures to manage and improve patient care effectively, prioritising patient safety at all times.

- **Performance Data and Benchmarking**

  Staff receive relevant data on performance metrics to support individual learning, growth, and team-driven improvement. This data includes patient feedback, clinical outcomes, and incident reporting, which are used to foster a culture of continuous improvement.

- **Data-Driven Decision Making**

  A variety of data is collected and shared with management, guiding strategic decisions that reduce unnecessary variation and enhance quality. By monitoring data across all areas, we identify trends and risks, thus enabling proactive adjustments to policies and practices.

- **Clinical Outcomes Analysis**

  Regular review of clinical outcomes helps identify best practices and areas needing improvement, with insights informing targeted quality improvement strategies.

- **Risk Management**
  - Identify, document, and proactively mitigate or minimise risks.
  - Continuously monitor and evaluate the effectiveness of our risk mitigation strategies to ensure optimal protection.
  - Empower our workforce, partners, and the communities we serve to recognize, report, and address incidents or concerns promptly and effectively.

3. Clinical Performance and Effectiveness

- **Qualified and Competent Workforce**

  Our workforce is equipped with the necessary qualifications, experience, and oversight to deliver high-quality, safe care. Ongoing professional development and training ensure that all employees maintain and enhance their competencies in line with current standards and advancements in healthcare.

- **Educational Resources and Training**

  Employees have consistent access to training and educational resources to support the continued development of the skills needed to meet patient care standards and adapt to evolving healthcare practices.

4. Clear Accountability and Ownership

- **Individual and Organisational Accountability**

  All employees are responsible for upholding the standards of clinical governance, taking ownership of their professional roles, and contributing to the company's objectives. This includes adhering to policies, participating in training, and actively engaging in continuous quality improvement initiatives.

5. Partnering with Consumers

- **Collaborative Care Models**

  Systems are in place to promote meaningful partnerships with patients, carers, families, and consumers in all aspects of healthcare planning, design, measurement, and evaluation. This ensures that healthcare services are tailored to the needs and preferences of the individuals we serve.

- **Engagement in Personalised Care**

  Patients are engaged as active participants in their own care, ensuring that decisions align with their values and preferences. This patient-centred approach builds trust and encourages adherence to treatment plans.

- **Health Literacy**
  Efforts are made to improve health literacy among consumers, providing clear, accessible information to empower informed decision-making and encourage proactive health management.

- **Consumer Involvement in Organisational Design**
  Patients and families contribute to organisational design and governance, helping shape policies, programs, and service delivery models that reflect the broader community's needs and priorities.

Roles and Responsibilities

Every stakeholder associated with a health service has specific responsibilities to contribute to achieving and maintaining high quality and safe care.

ROLE	RESPONSIBILITIES
Clients / Patients	Clients are integral to clinical governance, playing a central role by: • Engaging in their healthcare and treatment, as well as that of their families and carers, to the extent they choose. • Collaborating with health services in designing, delivering, and enhancing service quality. • Contributing to system-wide improvements in quality and safety. • Partnering with healthcare companies in governance, planning, and policy-making to co-design and enhance performance monitoring, measurement, and evaluation. • Advocating for patient safety to support optimal treatment and outcomes for themselves and others. • Sharing feedback, insights, and personal experiences to inspire and drive meaningful change.
Personnel	• Maintain personal professional skills, competence and performance. • Comply with professional regulatory requirements and codes of conduct. • Monitor personal clinical performance.

ROLE	RESPONSIBILITIES
Personnel	• Contribute proactively to fostering an organisational culture that prioritises patient safety and quality. • Clearly communicate their profession's dedication to delivering safe, high-quality healthcare. • Demonstrate professional conduct that consistently reflects a commitment to safety and quality. • Seize opportunities to deepen understanding of safety and quality theories and systems. • Actively participate in the management of clinical services. • Support, mentor, and guide colleagues in providing safe, high-quality care. • Engage in every phase of developing, implementing, evaluating, and monitoring governance processes.
Management	• Maintain personal professional skills, competence and performance. • Set up an operational policy and procedure framework. • Clearly communicate the company's commitment to delivering safe, high-quality care. • Provide opportunities for workforce education in safety and quality principles and systems. • Exemplify the company's safety and quality values throughout all management practices. • Drive the creation of business plans, strategic initiatives, and organisational policies that prioritise safety and quality. • Embed safety and quality principles into organisational plans, policies, and procedures. • Establish strong partnerships with relevant health services to promote positive clinical outcomes. • Periodically, systematically review the design of systems for safety

ROLE	RESPONSIBILITIES

	and quality.
	• Set up an operational policy and procedure framework, with the active engagement of all staff.
	• Implement and resource effective systems for management of
	  ◦ clinical education and training
	  ◦ performance monitoring and management
	  ◦ quality improvement and measurement
	  ◦ risk management
	  ◦ incident management
	  ◦ open disclosure
	  ◦ feedback and complaints
	• Systematically monitor performance across all safety and quality systems.

Subcontracting

Purpose and Scope

This policy sets out requirements for the use of subcontracted companies in the delivery of community nursing services. It ensures that any subcontracting arrangements comply with regulatory requirements, maintain service quality and safety, and protect the rights of clients.

This policy applies to all subcontracted companies and personnel engaged in delivering community nursing services.

Policy Statement

All subcontracting arrangements must:

- Comply with DVA's requirements.
- Ensure continuity, safety, and quality of care.
- Maintain our full accountability for services delivered.

Procedure

Approval and Notification to DVA

- The management must notify DVA in writing within 30 days of entering into any subcontracting arrangement.
- Notification must include:
    - The subcontracted company's legal name, ABN, ACN.
    - Registered or principal place of business.
    - Completed DVA subcontracting template available on DVA website.
- DVA may request to view and authorise the terms of any subcontract.
- A signed copy of the subcontract must be supplied to DVA on request.

Selection of Subcontracted Companies

- Only appropriate service providers may be engaged - sole traders or individuals cannot be selected as subcontractors.
- Subcontracted companies must:
    - Employ suitably qualified and competent personnel in accordance with the requirements outlined in Section 4 – Human Resources of the DVA Notes for Community Nursing Providers.
    - Comply with all relevant laws, including anti-discrimination laws.
    - Have an employee code of conduct that personnel adhere to.
    - Have access to, and demonstrate understanding of, the current DVA Notes and any relevant DVA material.
    - Be made aware of the obligations, conditions, and accountability requirements contained in the company's agreement with DVA.
    - Comply with the DVA Service Charter.
    - Allow DVA to request and review documentation related to services provided under the subcontract, including during audits.

Contractual Requirements

- All subcontracts must contain clauses that:
    - Impose obligations on the subcontracted company equivalent to those imposed on the company under the DVA Agreement and Notes.

    - Grant rights to DVA (either directly or through the company) equivalent to those in the DVA Agreement.
- Ensure appropriate payment and remuneration of subcontracted companies, including all tax-related obligations.

Ongoing Management and Oversight

- The company must ensure the continuing suitability of subcontracted companies.
- The company remains fully responsible for the quality and safety of all services delivered by subcontractors.
- The company must provide orientation, training, and access to all relevant policies and procedures to subcontracted personnel.
- Performance of subcontracted companies must be regularly monitored to ensure compliance with this policy, the DVA Notes, and all legal obligations.

Accountability

- The company is fully accountable to DVA for all services delivered under subcontracting arrangements.
- Engaging subcontractors does not reduce our responsibility to meet all applicable regulatory requirements, and we remain fully accountable for the quality of services delivered by our subcontractors.
- Any breaches by subcontracted organisations will be treated as breaches by the company itself.

Client Journey

This section outlines our approach to service delivery. The journey depicted in Figure 2 applies universally to all programs and services we provide.

Figure 2: *Client Journey*

Information and Referral: The journey begins by providing clients with relevant information, helping them navigate available services and connect with the right resources.

Intake and Assessment: Clients undergo an intake and assessment process to identify their specific needs and determine the appropriate level of support.

Care Planning: Following the assessment, a personalised care plan is developed in collaboration with the client, outlining tailored goals and interventions.

Service Delivery: Services are then delivered according to the established care plan, ensuring clients receive the support they need.

Evaluating Services Received: After service delivery, feedback is gathered to assess the quality and effectiveness of the services, identifying any areas for improvement.

Continuing Journey: The client's journey doesn't end with service delivery. There is a focus on ongoing support, reassessment, or transition to new services as needed, ensuring continuous engagement and adapting to evolving needs.

Application of the Clinical Governance Framework

Figure 3: *Application of the Clinical Governance Framework*

The effective implementation of the Clinical Governance Framework will be ensured through well-developed, standardised policies and procedures. Where possible, policies, procedures, tools, and templates are harmonised across the company to promote consistency, facilitate effective oversight, and support comprehensive monitoring and assurance. This standardisation ensures that all team members operate under a unified set of guidelines, enhancing accountability, quality of care, and adherence to best practices across all programs and services.

References

- National Safety and Quality Health Service Standards
- National Model Clinical Governance Framework
- Victorian Clinical Governance Framework
- DVA, Notes for Community Nursing Providers

Section 3

Our Community Nursing Services

Scope of Services

The aim of our community nursing (CN) services provided to veteran card holders is to enhance the independence and health outcomes of a client and avoid early admission to hospital and/or residential care through the provision of community nursing services that meet the client's assessed nursing needs. We provide a primary care service that aims to support the general health of a patient with low risk, simple clinical interventions.

Nursing services include both clinical and personal care services required to meet a defined health outcome.

Nursing services are provided by nursing staff and can include:

- caring for wounds
- helping with medication
- helping to manage symptoms of medical conditions
- helping with end of life and palliative care
- checking overall health
- helping after an operation or a stay in hospital
- helping with day-to-day activities, like showering, going to the toilet and dressing
- helping with other tasks if there is a clinical need

Out of Scope Services

Within the scope of our community nursing services for veteran card holders, we do not deliver a high level of nursing interventions.

We do not deliver community nursing services to a client in any of the following locations:

- an acute care facility (including hospital in the home programs)
- a residential aged care facility
- a multi-purpose centre
- a community centre
- a clinic in any location

Under our community nursing services, we do not provide in-home respite care or supervision, or provide services to meet needs associated with Instrumental Activities of Daily Living (IADLs), including:

- companionship and emotional support, transportation, meal preparation, shopping, communicating with others, managing finances, cleaning/dishwashing, routine laundry
- childcare in some short-term and crisis care circumstances
- lawn mowing, gardening, cleaning gutters
- arranging for medications and filling prescriptions

Care Environment

The care environment for community nursing services provided to veteran card holders is the client's own home.

- The community nursing services shall be delivered to a client face-to-face in their place of residence.
- Where face-to-face services cannot be delivered and it is clinically appropriate to do so, these services may be delivered remotely, such as by telephone or online.
- The community nursing services shall be delivered in a safe, effective and responsive manner to facilitate positive outcomes for the client, and in a manner that promotes privacy, dignity and respect for the client, including taking into account the client's culture and diversity.
- The community nursing services shall be delivered in accordance with the nursing care plan.
- All clients shall be provided a contact for emergency purposes 24 hours a day, 7 days a week.

Eligibility

To be eligible for our community nursing services, clients must meet one of the following criteria:

- **Hold a Veteran Gold Card**

  A Veteran Gold Card enables a client to receive health care and related services to meet all of their assessed clinical nursing and/or personal care needs.

- **Hold a Veteran White Card,** with eligibility for medical treatment related to accepted service-connected injuries or conditions.

  To determine eligibility to receive community nursing services for an assessed clinical nursing and/or personal care need, contact the DVA:

  DVA Provider Enquiry Line: 1800 550 457

Note: The Veteran Orange Card is for use only for pharmaceuticals and wound dressings through the Repatriation Pharmaceutical Benefits Scheme (RPBS) for eligible Commonwealth and Allied veterans and mariners. It cannot be used to access any CN services.

Referrals

To provide services to Veteran Card Holders, a valid written referral is required from one of the following authorised referral sources:

- General practitioner (GP)
- Treating medical practitioner in a hospital
- Hospital discharge planner
- Nurse practitioner (NP) specialising in a CN field

The referral should be on either the referral source's official letterhead or the DVA Community Nursing referral form.

Referrals should outline necessary services to meet an assessed nursing care need for a medical condition. The clinically required nursing and personal care interventions should be included in the referral.

The referral must include the following information:

- authorised referral source details, including provider number (for a referral from a discharge planner or treating medical practitioner in a hospital, the hospital's provider number must be used)
- the medical condition/s the client requires community nursing services for, and clinical details of the condition/s including recent illnesses and injuries
- if medication administration or assistance is required, a medication authority or signed current medication chart/list that includes medication information
- a measure of the person's level of independence. If the level of independence has not been included in the referral, the Registered Nurse should assess this as part of the initial comprehensive assessment. If assistance with eating to meet a clinical need is determined, a nutritional assessment must also be conducted to determine the nutritional risk
- other health / support services the client is receiving
- whether an aged care assessment has been conducted by an Aged Care Assessment Team (ACAT) assessor, and the outcome of any assessment.

Referral period

- Referrals from GPs and NP are **valid for 12 months**. A new referral from the client's GP or NP specialising in community nursing will be required if a client is transferred to another community nursing provider, discharged and later readmitted, and at the end of every 12-month period where ongoing services continue to be required.
- Referrals from hospitals are valid for six weeks post discharge. An updated referral is required from the client's GP to cover care needs beyond the six-week period.

Informed Consent

Before commencing our community nursing services, written informed consent must be obtained from the client. If the client is unable to provide consent, a designated representative (such as a guardian, Power of Attorney, legal representative, or person with a guardianship or administration order) may give consent on their behalf.

To ensure the client can make an informed decision about the proposed services, the following information should be clearly communicated and discussed with the client:

- A verbal explanation of the proposed community nursing services, presented in a way that the client can easily understand, along with a written version if needed.
- An overview of their rights and responsibilities as a client.
- An outline of the role of the care personnel involved in their services.
- Information regarding the potential need to disclose personal information to other health providers as clinically appropriate, and, in some cases, without prior consent.
- Notification of the right of the Department of Veterans' Affairs (DVA) or any authorised person or company to access their records, including care documentation.
- Details on how to provide feedback or make a complaint about the services received.

This process ensures that clients or their representatives have all necessary information to make informed choices about their care and understand their rights, responsibilities, and avenues for support.

Rights and Responsibilities

Our Responsibilities

As part of our commitment to delivering high-quality services to clients, all personnel are required to uphold the following standards:

1. **Treat Clients with Dignity and Respect**
    - Show respect for each client's rights, preferences, and individuality. Avoid any behaviour or language that could be perceived as dismissive or disrespectful.
2. **Prioritise Client Choice and Autonomy**
    - Actively involve clients in decision-making regarding their care. Encourage them to express their preferences and ensure they feel their input is valued.
3. **Ensure Care is Safe, Appropriate, and Tailored to Client Needs**
    - Deliver services that are clinically safe and personalised to each client's unique health requirements and circumstances. Assess and adjust care as needed to meet these individual needs effectively.
4. **Promote a Safe and Comfortable Environment During Visits**
    - Ensure clients feel secure and at ease when you visit. Establish a warm, professional atmosphere and be mindful of their comfort and privacy.
5. **Listen to Client Concerns and Support Feedback or Complaints**
    - Pay close attention to any concerns clients may raise about their care. If they express dissatisfaction, guide them through the feedback or complaint process in a supportive and professional manner.
6. **Demonstrate Competence and Compassion in All Interactions**
    - Exhibit both technical skills and empathy when providing care. Show clients that they are in capable, caring hands by consistently performing your duties to a high standard.
7. **Instil Confidence Through Professionalism and Expertise**
    - Build trust by being reliable, knowledgeable, and by following best practices. Demonstrate your commitment to high-quality care in every interaction, ensuring clients feel confident in our services.

Our Clients' Responsibilities

Clients are expected to uphold the following responsibilities. Staff should familiarise themselves with these guidelines to help communicate them clearly and professionally to clients when needed:

1. **Maintain a Safe Environment for Nursing Staff**
    - Clients should ensure their home environment is safe and free from hazards that may impact the nursing staff's ability to provide care effectively.
2. **Treat Nursing Staff with Respect**
    - Clients are expected to treat all nursing staff with courtesy and respect, fostering a positive and professional care environment.
3. **Inform Nursing Staff of Any Changes in Health**
    - Clients should communicate any changes in their health to the nursing team promptly, allowing staff to adjust care plans as necessary to meet evolving needs.
4. **Take Responsibility for Actions and Choices**
    - Clients are encouraged to be mindful of how their actions and choices affect their health and to actively participate in decisions related to their care.
5. **Provide Accurate and Complete Information**
    - Clients are responsible for providing relevant health and personal information to ensure nursing staff can deliver appropriate and personalised care.
6. **Notify Staff in Advance of Visit Cancellations**
    - Clients should give ample notice if they need to cancel a scheduled visit. This allows the team to reallocate resources effectively and maintain efficient scheduling.
7. **Report Any Concerns Promptly**
    - Clients should be encouraged to voice any concerns or issues with their care as soon as possible so the provider can address these promptly and improve their care experience.
8. **Inform the Provider of Changes in Service Needs**
    - If a client plans to change providers, they are responsible for informing the current provider in advance and specifying the date when services will no longer be required.

Staff should review these responsibilities with clients at the beginning of service and as needed throughout the care relationship. Reinforcing these expectations helps establish a mutual understanding, contributing to a positive and safe care experience for both clients and nursing staff.

Client Not Responding

The purpose of this policy and procedure is to establish a standardised, compliant approach for managing situations when a client does not respond during a scheduled in-home visit.

The company is committed to ensuring client safety by implementing individual or generic client non-response plans, developed with each client's input where possible. If a client does not respond during a scheduled visit, staff will follow the established non-response procedure to confirm the client's wellbeing while respecting their autonomy and privacy.

Definitions

- Non-Response: The absence of response from the client after reasonable attempts to contact them at the scheduled time of service.
- Individual Client Non-Response Plan: A plan developed with the client that outlines specific steps and contact persons to be engaged if the client does not respond during a scheduled visit.
- Generic Non-Response Plan: A standardised plan implemented when a client has not developed an individual non-response plan, ensuring client safety during non-response events.

1. Development of Non-Response Plans

1.1. Individual Client Non-Response Plans

- Upon initiation of services, the RN should discuss and develop a customised non-response plan with each client, if they agree.
- The plan should include:
  - The name and phone number of a designated contact person for welfare checks.
  - Specific instructions based on the client's preferences and needs.
- Document the individual plan in the client's care file, including any emergency contacts, and ensure it is accessible to all staff.

1.2. Generic Non-Response Plan

- For clients who decline an individual plan, a generic non-response plan must be implemented.
- This plan includes a standardised approach to contact attempts and welfare checks if the client does not respond.

1.3. Client Reminder System

- Implement a reminder system to notify clients of upcoming visits. This may include phone calls, text messages, or reminders agreed upon with the client.
- Document reminder notifications in the client's record to support consistent and effective communication.

2. Initial Contact Attempt During Scheduled Visit

2.1. Scheduled Visit Non-Response

- If the client does not respond when the nurse arrives at their home:
  - Knock on the door and wait a reasonable period.
  - Attempt to contact the client by phone, if available.
  - If no response, attempt another phone call and wait an additional few minutes.

2.2. Observation and Assessment

- Conduct a visual check of the home exterior (if safe) for signs of activity or potential safety concerns.
- Avoid entering the home without consent unless there are clear signs of an emergency.

3. Escalating to the Client's Emergency Contact or Care Coordinator

3.1. Notifying the Emergency Contact

- If the client remains unresponsive:
  - Contact the emergency contact listed in the client's individual or generic plan, inform them of the situation, and ask if they can confirm the client's wellbeing.
  - Request that the emergency contact reach out to the client or check on them if possible.

3.2. Escalation to Care Coordinator

- If the emergency contact cannot confirm the client's wellbeing or is unavailable, contact the Care Coordinator to escalate the situation.
- The Care Coordinator may attempt further contact or initiate a welfare check through local authorities if necessary.

4. Involving Emergency Services

- If the Care Coordinator assesses that a welfare check is needed, they may contact emergency services to request a welfare check at the client's address.
- Provide emergency services with relevant client details, including recent contact attempts, emergency contact information, and any health concerns.

5. Documentation and Reporting

5.1. Documenting Non-Response Incidents

- Nursing staff must document all attempts to contact the client, including:
  - Date and time of each contact attempt.
  - Details of the conversation with the emergency contact, if applicable.
  - Actions taken, including escalation steps or involvement of emergency services.

5.2. Summary of Events

- Document a summary of events in the client's care file as required by the DVA, particularly if the non-response plan was activated.
- Ensure the record includes the outcome of the incident and any follow-up actions needed.

5.3. Incident Report

- Complete an incident report for each non-response event to support quality assurance.
- Review the incident with the Care Coordinator and assess if further action or adjustment to the plan is necessary.

5.4. Claiming Guidelines

- If a client non-response plan was not activated or followed, a claim for the visit should not be submitted as per DVA guidelines.

6. Follow-Up Actions

6.1. Client Communication

- If the client is located and safe, follow up to inform them of the actions taken and review their non-response plan preferences.
- Ensure that the client's emergency contact details and any other information in their plan are updated if necessary.

6.2. Review and Quality Assurance

- Review all non-response incidents periodically to identify trends and improve non-response protocols.
- Adjust training or procedures as necessary based on review findings to ensure efficiency and enhance client safety.

7. Staff Training and Compliance

- All staff must complete training on these Client Non-Response procedures, including the development and implementation of individual and generic non-response plans, contact attempt protocols, and emergency escalation steps.
- Staff must complete refresher training annually, or as required if updates to the policy or procedure occur.

Refusal of Services

1. Identify and Confirm Refusal

If a client or their nominated representative (such as an authorised guardian, Power of Attorney, or legal representative) indicates a refusal of community nursing services, clarify the scope of the refusal (whether it pertains to some or all services) to ensure accurate understanding and documentation.

2. Inform the Client of Consequences

Clearly and respectfully inform the client (and/or their representative) of the potential consequences of refusing the proposed community nursing services. Explain how this decision may impact their health and any risks associated with their refusal.

Offer alternative support options if appropriate, and address any concerns or misunderstandings the client or their representative may have regarding the services.

3. **Notify Relevant Parties**

   General Practitioner (GP): Notify the client's GP in writing of the refusal, including details of the refused services and any expected impact on the client's health and well-being.

   Nominated Representative: If a representative is involved, they should also receive written communication regarding the refusal and its potential consequences.

4. **Document the Refusal and Actions Taken**
   - Record the refusal and all subsequent actions taken in the client's care documentation. This should include:
   - Date and time of refusal
   - Details of services refused
   - Summary of the discussion with the client or representative about the expected consequences
   - Notification details sent to the GP and representative
   - Ensure this documentation is thorough and factual, preserving all relevant information for future reference.

5. **Maintain Eligibility for Future Services**

   Clearly indicate in the client's care documentation that this refusal does not exclude the client from accessing community nursing services in the future. Ensure that the client and their representative are aware that they may request community nursing services again as needed.

Client Care Handover/Transfer Between Personnel

Handover or transfer of client care between personnel shall be managed with a structured process to ensure that critical information is communicated effectively, reducing the risk of errors and maintaining high standards of care.

Procedure for Client Care Handover/Transfer:

1. **Handover Initiation:**

   Handover is required when there is a change in personnel responsible for the client's care, including shift changes, leave cover, or transfer to another team member.

2. **Information to be Transferred:**
   - Client's personal details and medical history.
   - Current care plan, including medication schedules, treatment plans, and special needs.

- Any recent changes in the client's condition.
- Upcoming appointments or scheduled treatments.
- Key contact information, including client's GP and emergency contacts.

3. **Handover Methods:**
   - Verbal Handover: Conducted face-to-face or via a secure communication platform, ensuring both parties have an opportunity to ask questions and clarify information.
   - Written Handover: Documented in the client's care records, ensuring all relevant details are accurately recorded and accessible.

4. **Responsibilities of Personnel:**
   - Outgoing personnel must provide a complete and accurate handover to the incoming personnel.
   - Incoming personnel must review the handover information and seek clarification if required.

5. **Handover Documentation:**
   - Maintain detailed records of all handovers, including date, time, and personnel involved.
   - Update the client's care plan and records to reflect any changes communicated during the handover.

6. **Client Involvement:**
   - Inform the client of any changes in their care team.
   - Provide reassurance to the client to ensure they feel supported during the transition.

7. **Monitoring and Review:**
   - Regular audits of handover processes to ensure adherence to this policy.
   - Continuous improvement initiatives based on feedback from personnel and clients.

Client Care Transfer to Another Provider

All client transfers shall be managed in full compliance with DVA requirements. Transfers due to capacity or other contractual reasons are not permitted once services have commenced, unless prior approval is obtained from DVA.

Contacting DVA

- DVA Provider Enquiry Line: 1800 550 457
- Email Enquiries:
    - General CN program information: nursing@dva.gov.au
    - Exceptional Cases: exceptional.cases@dva.gov.au
    - Contractual Matters: NMBCN@dva.gov.au

Procedure for Client Transfer:

9. **Initiating a Transfer:**
    - Transfers initiated due to client choice or relocation do not require prior DVA approval.
    - For transfers due to capacity or contractual reasons, prior approval from DVA is mandatory.

10. **Developing a Transfer Plan:**
    - An agreed transfer plan must be established before any transfer takes place.
    - The plan must include agreed wording and an approach for notifying the client.

11. **Notification and Coordination:**
    - Inform the client of the transfer details using the agreed approach.
    - Coordinate with the receiving CN provider to ensure continuity of care.
    - Ensure the client's GP is involved in the transfer process.

12. **New Referral Requirement:**
    - A new referral from the GP is required when a client is transferred to another CN provider.

13. **Supporting a Smooth Transfer:**
    - Provide all necessary support to ensure there is no disruption in CN services during the transfer.
    - Ensure all client records and care plans are shared with the receiving CN provider.

13.1. Documentation:

- Maintain accurate records of the transfer, including communication with the client, GP, receiving CN provider, and DVA where applicable.

13.2. Monitoring and Review:

- Regularly review transfer processes to ensure compliance with DVA policies and continuous improvement in client care.

Referral to Other Health Professionals or Legal Authorities

We are committed to ensuring that clients receive the most appropriate care and support. Where required, staff will refer clients to external health professionals or legal authorities to ensure their safety, well-being, and access to specialised care. The referral process will be managed with confidentiality, respect, and in accordance with regulatory requirements.

1. Triggers for Referral

A referral to a health professional or legal authority is required in the following circumstances:

1.1. Health Professional Referral

- Changes in the client's health status requiring specialised care (e.g., sudden onset of illness, injury, or decline in mobility).
- Mental health issues or psychological distress requiring support from a psychologist or counsellor.
- The need for ongoing care or intervention from an allied health professional (e.g., physiotherapy, podiatry, occupational therapy).
- Clinical signs of malnutrition, dehydration, or other health risks that require additional support.

1.2. Legal Authority Referral

- Client Abuse or Neglect: If there is suspicion, allegation, or evidence of physical, emotional, financial, or sexual abuse of a client.
- Mandatory Reporting: Where a legal obligation exists to report certain matters (e.g., child protection, elder abuse, or domestic violence) to the relevant authorities.
- Aggressive or Violent Behaviour: If a client, family member, or visitor exhibits threatening or violent behavior towards staff or other clients, referral to the police may be required.
- Breach of Legal Obligations: Where a breach of the law or non-compliance with DVA or other regulatory requirements is identified.

2. Referral Process

2.1. Identification of Need

- The staff member identifies the need for a referral during service delivery, routine assessments, or as a result of a client or family request.
- If the referral is urgent (e.g., in the case of serious injury, aggression, or an imminent threat), the staff member must act immediately and contact emergency services (e.g., 000) before proceeding with the formal referral process.

2.2. Consultation and Consent

- Where appropriate, consult with the client (or their legal guardian) regarding the need for referral.
- Obtain consent from the client before making the referral, unless urgent action is required to prevent immediate harm.

2.3. Referral to Health Professionals

- Contact the appropriate health professional directly to make the referral (e.g., GP, allied health professional).
- Provide the health professional with relevant client information to support the referral, ensuring confidentiality and privacy.
- Document the referral in the client's file, including the reason for the referral, the health professional's name, and any follow-up actions required.

2.4. Referral to Legal Authorities

- For urgent matters (e.g., violence, abuse, or immediate danger), contact police or emergency services immediately.
- Complete the required documentation (incident report) and submit it to the relevant legal authority.

2.5. Follow-Up and Review

- Track the outcome of the referral to ensure the client's needs have been met.
- Maintain a record of all communications related to the referral, including dates, times, names, and actions taken.

Supporting Documents

- Incident report form
- Nursing care plan
- Risk assessment form
- Waste disposal log

Section 4

Human Resources Management

Recruitment Policies and Procedures

Purpose and Scope

The purpose of this policy is to outline the procedures for recruiting, selecting, onboarding, and managing employees, ensuring compliance with Australian labour laws and healthcare regulations while fostering an inclusive and productive work environment.

This policy applies to all employees, contractors, and prospective candidates involved in the recruitment and human resources management processes.

Personnel

Our community nursing services may be delivered by the following qualified personnel:

- Registered Nurses (RN)
- Enrolled Nurses (EN)
- Personal Care Workers (PCW)

All personnel involved in the delivery of our community nursing services must meet the following criteria:

- Be Fit and Proper Persons: All staff must demonstrate high ethical standards and professional integrity.
- Possess Required Qualifications, Experience, and Competencies: Personnel must hold the appropriate qualifications, relevant experience, and competencies necessary for their roles.
- Hold Current Registration: All relevant personnel must maintain current professional registration, where applicable.
- Complete Screening Checks: Staff must successfully pass all required screening checks.

Records of qualifications, background checks, current registration, and documentation of continuing education must be meticulously maintained and updated. These records ensure that all personnel meet the necessary standards for providing safe, quality care.

Screening and Clearance Requirements

All personnel and subcontractors with client access must have:

- A national police check conducted within the last three years, or
- A NDIS worker screening check completed within the last three years.

Additionally, staff must hold a "Working with Vulnerable People" registration or clearance (or State/Territory equivalent) if required by the laws of the State or Territory in which services are delivered to adults.

Compliance with Standards and Statutory Requirements

All personnel must adhere to the relevant national standards and meet all applicable State, Territory, and Commonwealth statutory requirements. This includes working within established frameworks to ensure high-quality, compliant service delivery across all locations.

These criteria ensure that our personnel are qualified, compliant, and committed to maintaining the highest standards in client care.

Registered Nurses (RN)

- RNs providing community nursing care and services must have:
- current registration with the Australian Health Practitioner Regulation Agency (Ahpra), with no restrictions to practice
- while a minimum of two years' post graduate experience including wound management is recommended, a minimum of one year supervised post-registration practice will be accepted
- completed infection prevention and control training
- medication management competency
- current manual handling competency
- current Basic Life Support (BLS) certification

Qualifications and competencies must be maintained and recorded in personnel files.

- RNs are responsible for:
- comprehensively assessing client nursing care requirements, face-to-face in the client's home including the client's level of independence, memory, mood, mobility and skin integrity
- reporting the outcomes of the assessment to the client's GP
- development of a tailored nursing care plan informed by the comprehensive assessment
- delegating aspects of client care to ENs and PCWs according to their respective role, scope of practice, competencies and capabilities
- monitoring, supervising and providing assistance as and when required to ENs and PCWs
- ensuring clinical nursing notes and assessment documentation are legible, current, based on industry best practice standards and including delegation of care, are documented in the

client's clinical records

- providing CN care and services in accordance with the position description and the Registered Nurse standards for practice developed by the Nursing and Midwifery Board of Australia (NMBA).

Enrolled Nurses (EN)

ENs providing community nursing care and services must have:

- current registration with the Australian Health Practitioner Regulation Agency (Ahpra), with no restrictions to practice
- while a minimum of two years' post graduate experience including wound management is recommended, a minimum of one year supervised post-registration practice will be accepted
- completed infection prevention and control training
- current manual handling competency
- current Basic Life Support (BLS) certification
- medication management competencies (where applicable) and provide CN care and services as delegated by an RN and in accordance with the position description
- care and services should also be provided in line with the Enrolled Nurse standards for practice developed by the Nursing and Midwifery Board of Australia (NMBA), which can be found at NMBA - Enrolled nurse standards for practice.

Personal Care Workers (PCW)

The minimum required qualifications for PCWs delivering CN services to a client are:

- one of the following qualifications:
    - a Certificate III in Home and Community Care, Aged Care or Disability (pre December 2015); or
    - a Certificate III in Individual Support (post December 2015). This includes a medication module for PCWs to provide assistance with medication that is recognised by the Community Services Health Industry Skills Council; or

    - a Certificate III in Health Services Assistance; or
    - a student in the second or third year of Bachelor of Nursing degree at an Australian university or accredited higher education provider;
- completion of infection prevention and control training
- medication assistance competency (where applicable)
- current manual handling competency
- current Basic Life Support (BLS) certification
- current Applied First Aid certificate

All CN services provided by PCWs must be in accordance with the relevant standards and qualifications included in the Community Services Training Package, or equivalent training.

Recruitment Process

- **Job Postings and Advertisements**
    - All job postings must accurately reflect the qualifications, skills, and experience required for the position.
    - Job postings will be made publicly available through relevant channels, including the clinic's website and external job boards, to ensure equal opportunity.
    - Job descriptions will be reviewed regularly to ensure alignment with company needs.

- **Candidate Selection**
    - Candidates will be shortlisted based on merit, qualifications, and alignment with the clinic's values and goals.
    - Initial interviews will be conducted via video conferencing to accommodate the telehealth environment.
    - Final candidates will undergo a thorough background check, including verification of qualifications, references, and relevant medical or legal clearances.

- **Anti-Discrimination**
    - We are committed to equal employment opportunities and prohibits discrimination based on age, gender, race, disability, or any other characteristic protected by law.
    - All recruitment and selection activities will comply with Australian anti-discrimination laws, including:
- Age Discrimination Act 2004
- Disability Discrimination Act 1992
- Racial Discrimination Act 1975
- Sex Discrimination Act 1984
- Fair Work Act 2009

Onboarding Process

- **Employment Contracts**
    - All employees will be provided with a written employment contract outlining the terms of employment, including duties, compensation, benefits, and conditions.
    - Employment contracts will comply with the Fair Work Act 2009 and healthcare-specific regulations
- **Orientation and Training**
    - New employees will receive an orientation that covers our mission, values, and policies, including patient care, and privacy practices.

Performance Management

- **Performance Reviews**
    - Employees will receive regular performance reviews to assess their job performance, provide feedback, and identify development opportunities.
    - Performance reviews will be conducted annually and based on predefined performance criteria.
- **Professional Development**
    - We will offer continuous professional development opportunities, including training on all relevant areas.

- Staff members are encouraged to pursue external certifications relevant to their roles.

Employee Benefits & Leave Entitlements

Employees are entitled to leave in accordance with the National Employment Standards (NES), including:

- **Annual Leave:** Full-time employees accrue 4 weeks of paid annual leave per year. Requests must be submitted via the HR portal at least 2 weeks in advance.
- **Personal/Carer's Leave:** Employees are entitled to 10 days of paid personal/carer's leave annually for illness or caring responsibilities. A medical certificate is required for absences longer than 2 days.
- **Compassionate Leave:** 2 days of paid compassionate leave are provided for the death or serious illness of a close family member.
- **Parental Leave:** Up to 12 months of unpaid parental leave is available for eligible employees. Requests must be submitted in writing at least 10 weeks before the expected start date.
- **Community Service Leave:** Employees can take unpaid leave for voluntary emergency management activities or jury duty.
- **Long Service Leave:** Available after 7 years of continuous service as per state-specific legislation.
- **Superannuation:** Contributions made in line with the Superannuation Guarantee.

Termination and Resignation

- **Voluntary Termination**
  - Employees must provide the required notice as per their employment contract or applicable industrial awards.
  - An exit interview will be conducted to gather feedback and insights for improving the work environment.
- **Involuntary Termination**
  - Termination may be initiated by us due to performance issues, misconduct, or redundancy, in accordance with the Fair Work Act 2009.
  - Employees will receive written notice and, where applicable, severance pay based on tenure and the terms of their contract.

Employee Grievances

- Employees may raise grievances related to their employment, including concerns about workplace conditions or conflicts with colleagues.
- Grievances will be handled in a confidential, fair, and timely manner in accordance with the Fair Work Act 2009.

Record-Keeping

- We will maintain accurate records of all recruitment activities, performance reviews, training, immunisation status and employment contract.
- Employee records will be stored securely and will only be accessible by authorised personnel.

References

- Fair Work Act 2009
- Privacy Act 1988
- Equal Opportunity Act 2010 (Victoria)
- National Employment Standards (NES)
- Australian Health Practitioner Regulation Agency (AHPRA) Guidelines
- Australian Immunisation Handbook

Delegation of Care

Purpose and Scope

This policy outlines the principles and procedures for the delegation of care within the company.

All community nursing services delivered by an EN and/or PCW shall be planned, delegated, supervised and documented by an RN.

This policy applies to all RNs, ENs, and PCWs employed by the company providing community nursing services.

Delegation of Care

All delegated care must be appropriately documented in clinical records and kept on the client's file.

An RN must delegate aspects of care to others according to their competence and scope of practice. This includes:

- delegation of aspects of care according to role, functions, capabilities and learning needs
- monitoring aspects of care delegated to others and providing clarification/assistance as required
- recognising own accountabilities and responsibilities when delegating aspects of care to others
- delegation to and supervision of others consistent with legislation and organisational policy.

The RN must recognise the differences in accountability and responsibility between RNs, ENs and unlicensed care workers (i.e. PCWs).

- Accountability
- Accountability means that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public.
- Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation.
- Accountability cannot be delegated.
- The RN who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.

Delegation

- Delegation is the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse or a person who is not a nurse.
- Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service.
- The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment.
- For further details see the NMBA's National framework for the development of decision-making tools for nursing and midwifery practice (2013).

Key Considerations for Delegation

- Assessing the risk associated with the task.
- Ensuring the task is within the scope of practice of the EN or PCW.
- Providing necessary training and competency assessments prior to delegation.
- Maintaining clear and open communication channels.
- Regularly reviewing and updating delegation practices.

Documentation

- All delegated tasks must be documented in the client's clinical records.
- Documentation must include:
    - Task delegated.
    - Person responsible for the task.
    - Date and time of the task.
    - Observations, outcomes, and follow-up actions.

References

- Notes For Community Nursing Providers (Delegation of care)
- AHPRA – Registered Nurse Standards for Practice

Staff Competencies and Training Policy and Procedure

Purpose and Scope

This policy outlines the requirements for staff competency assessment and training to ensure all personnel providing community nursing services are qualified, competent, and continually trained.

This policy applies to all personnel providing community nursing services.

Competency Requirements

First Aid and BLS competency requirements

- Personnel must hold current First Aid and BLS certificates.
- Certification must be renewed annually.
- Training must be completed through a registered training company (RTO)

Medication management competency

Where applicable, personnel administering and/or assisting with medications must maintain medication management competency.

Infection prevention and control training

All personnel shall be trained in infection prevention and control.

Further information and recommended courses on COVID-19 and infection prevention and control can be found at:

- Department of Health and Aged Care – COVID-19 resources and training
- Australian Commission on Safety and Quality in Health Care:
    - Infection prevention and control for aged care eLearning modules
    - Infection prevention and control – advanced education eLearning modules

Continuing education and performance management for personnel

All personnel are required to engage in ongoing continuing education and professional development, with a particular focus on enhancing skills and knowledge related to community nursing services. This commitment to regular, ongoing training ensures that staff remain up-to-date with best practices and maintain a high standard of care.

Assessment of Competency

- Competency assessments will be conducted upon commencement of employment, annually, and as required when introducing new procedures, equipment, or regulatory updates.
- Assessments will include:
    - Practical skills assessments
    - Written knowledge assessments covering core competencies, clinical procedures, medication management, infection control, and DVA-specific requirements.
    - Peer reviews and feedback from supervisors, colleagues, and patients.
    - Self-assessment to encourage reflection on practice and identification of training needs.
- Non-compliance or failure to meet competency standards will result in immediate additional training, a tailored development plan, supervised practice, and a re-assessment within a specified timeframe to ensure competency is achieved.
- Responsibilities:
    - Management: Ensure all training programs meet regulatory requirements, maintain accurate records, develop, implement and schedule regular training programs.
    - Personnel: Complete all required training, maintain certifications, and adhere to policies.

Training Records Management

- Comprehensive records of all completed training and competency assessments must be maintained for each staff member.
- Training records will be kept up-to-date and securely stored.
- Records must be readily accessible for audit purposes and meet the requirements of the Australian Health Practitioner Regulation Agency (Ahpra) Standards for Nursing.

More information can be found at the following link: www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.

Personnel should be kept informed and maintain awareness of all current applicable organisational policies and procedures.

Section 5

Nursing Care

Purpose and Scope

The purpose of this policy and procedure is to ensure the delivery of high-quality, safe, and patient-centred nursing care to Veteran Card Holders, in compliance with the Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers, Aged Care Quality and Safety standards, and all other relevant laws and regulations governing community nursing in Australia.

This policy applies to all clinical and non-clinical staff involved in the planning, coordination, and delivery of nursing care to Veteran Card Holders.

Admission

Eligibility Verification

- Confirm Veteran Card Holder Status

  Client is eligible to receive community nursing services if they have an assessed clinical need for nursing and/or personal care at home and are a:

  - Veteran Gold Card holder; or
  - Veteran White Card holder and need this service for an accepted service-related condition.

  If a client has a Veteran White Card, contact DVA to determine if the client can receive DVA funded community nursing services before providing care to the client: **1800 550 457**

- Check the Validity of the Referral

  1. **All clients need a written referral if they are either:**
     - new to receiving community nursing services
     - have been out of care from a CN provider for over 28 days
     - at the end of each continuous 12 month period of care
  2. **A written referral must come from an authorised referral source:**
     - General Practitioner (GP)
     - Treating medical practitioner in a hospital
     - Hospital discharge planner
     - Nurse practitioner specialising in a community nursing field

3. **The referral period shall be valid:**
    - Referrals from a GP or nurse practitioner are valid for 12 months.
    - Referrals from hospitals are valid for six weeks.
    - A new referral is required if the patient has been out of care from the community nursing provider for over 28 days or wishes to change providers.
4. The referral shall outline the necessary services required to meet the assessed nursing needs for relevant medical conditions.

Assessment

An assessment by a Registered Nurse (RN) is essential to determine a client's nursing care needs accurately and ensure services align with their current health status and personal care requirements. This comprehensive assessment ensures that care is appropriate, evidence-based, and responsive to each client's unique situation.

Assessment Process

1. **Face-to-Face Comprehensive Assessment**

    An RN must conduct a face-to-face assessment in the client's home to accurately gauge nursing care needs and ensure comfort in the home environment. Assessments are required:

    - Upon receiving a referral from an authorised source, confirming the need for community nursing services.
    - Following a transfer from another Community Nursing (CN) provider, to ensure continuity and appropriate transition of care.
    - Annually, on the 12-month anniversary from the start of care, if there have been 13 consecutive 28-day claim periods, indicating a continuous need for service.

2. **Environmental Risk Assessment**

    As part of the initial comprehensive assessment conducted at the client's first face-to-face visit, the Registered Nurse (RN) must perform an environmental risk assessment of the client's home or place of residence.

    The purpose of this assessment is to identify any risks to the safety of both the client and staff delivering services.

Procedure:

- The RN must inspect the client's environment to identify hazards such as:
    - Poor lighting or visibility
    - Clutter or trip hazards
    - Unsafe flooring or steps
    - Pets that may pose risks
    - Access and egress challenges for staff or emergency services
    - Any other factors that may affect the safe delivery of care
- Discuss any identified risks with the client and/or their carer, seeking their input on mitigation strategies.
- Document identified risks and agreed mitigation measures in the client's care plan and records.
- Where risks cannot be adequately mitigated, escalate the matter to the Care Coordinator or Manager for further review and planning.
- Review environmental risks regularly (e.g. during scheduled reviews or if circumstances change) and update documentation accordingly.

This environmental risk assessment ensures that the services are delivered in a safe, effective, and responsive manner, in line with best practice and DVA requirements.

3. Use of Validated Assessment Tools

The RN must employ validated assessment tools that align with current community nursing industry best practices to ensure accuracy and consistency. These tools should cover all aspects of health, including physical, mental, and functional capacity.

4. Independence and Functional Assessment

Where a client's level of independence is not documented in the referral, the RN should conduct an initial assessment of Activities of Daily Living (ADL) using an industry-recognized measure. This assessment identifies areas where the client requires support to maintain independence safely.

5. **Clinical Need Verification**

For community nursing services to be provided, the client must demonstrate an assessed clinical need. If the assessment concludes that there is no ongoing need for nursing services, only the initial assessment is claimable (using the item code NA99), and no ongoing services should be billed.

6. **Coordination of Allied Health Services**

The RN should identify any additional support services that may benefit the client, such as occupational therapy, delivered meals, or other community services. Where appropriate, the RN should request the GP to arrange these referrals.

7. **Assessment of Personal Care Needs**

If a client is assessed as requiring low-level personal care services without a clinical need for additional community nursing services, they should be referred to the Veterans' Home Care (VHC) Program.

The client shall be referred to a **VHC Assessment Agency** on **1300 550 450.**

If a client is assessed as requiring above 1.5 hours of personal care services per week this may not be considered low level personal care, and services may need to be provided through the community nursing program.

When a client is assessed as requiring personal care services as well as having a clinical need for community nursing services, all of the personal care services required should be provided through the community nursing program.

Reporting and Communication of Assessment Outcomes

- **Reporting to GP:** The RN must report the outcomes of the comprehensive assessment to the client's GP. If the original referral did not come from the GP but ongoing services are needed, an updated referral from the GP must be obtained.
- **Communication with Client and Carer:** The RN must clearly communicate assessment outcomes to the client, and if applicable, their carer. This ensures they understand the care plan, expected services, and any additional support available.

Nursing Care Plan Development

A nursing care plan must be developed and completed by an RN following the comprehensive assessment. The nursing care plan serves as a comprehensive guide for delivering personalised, consistent, and safe care to the client. Developed collaboratively with the client, and when appropriate, the carer and family, the care plan ensures that all care needs are documented and regularly updated to reflect the client's evolving condition and preferences. The care plan must be developed in alignment with industry-recognised, evidence-based best practices within the community nursing industry.

All services must be delivered in accordance with the nursing care plan.

Development and Documentation:

1. **Collaborative Development**
    - The RN must involve the client in developing their care plan to ensure it aligns with their needs, preferences, and goals. If applicable, the client's carer and family should also participate in this process to support a holistic approach.
    - The client, and if applicable the carer / family, must sign the nursing care plan.
2. **Timely Access to Care Documentation**
    - The client must be provided with, or be able to access in a timely manner, an up-to-date copy of their care plan. This ensures they are informed and empowered regarding their own care.
3. **Regular Updates and Revisions**
    - The care plan must be updated consistently:
    - At each assessment and review: Following comprehensive reassessments, the care plan should reflect any new findings.
    - As changes occur: Revisions should be made when the client's needs, goals, or preferences evolve, when there is a shift in their physical or mental health, or when any new risks are identified.
    - When additional information becomes available: If any new factors that could impact the client's care arise, these should be integrated promptly into the care plan.
4. **Ongoing Accessibility and Reference**

The care plan must be accessible to the client and relevant staff. Personnel are required to reference the most current care plan during each service visit to ensure all care aligns with the documented plan.

Components of the Nursing Care Plan:

A nursing care plan must include the following essential elements:

1. **Clinical and Personal Care Needs**
    - Document all clinical and personal care needs identified from the comprehensive assessment, specifying activities required to meet these needs.
2. **Level of Independence**
    - Assess and record the client's level of and capacity for independence, noting any support needed for Activities of Daily Living (ADLs).
3. **Client Goals and Agreed Actions**
    - Establish the client's short- and long-term care goals, incorporating their personal values, preferences, and cultural needs, with clear actions to achieve these goals.
4. **Clinical Interventions**
    - Include specific clinical and nursing interventions aligned with best practice standards to ensure safe and effective care.
    - Any aids, appliances, or nursing equipment required to successfully complete interventions.
    - A summary of other health services and/or supports the client is receiving that support their health and wellbeing, to provide a holistic overview of the client's care needs.
    - All medication interventions including if medication is being administered by an RN/EN or assisted by a PCW.
5. **Desired Outcomes**
    - Define outcomes for each care goal to assess care effectiveness.
6. **Delegation of Care**
    - Delegate care activities appropriately within the RN's Scope of Practice.
7. **Review Dates and Schedule of Services**
    - Specify scheduled review dates and the agreed days and approximate timeframes for service delivery.

8. **Wellbeing and Quality of Life Supports**

   - Identify supports to promote the client's wellbeing, independence, and quality of life, with a focus on reablement strategies.

9. **Risk Management**

   - Identify care risks and outline mitigation strategies.

Aged Care Assessment Team (ACAT) Assessment

Where an ACAT assessment has not been conducted, the RN should facilitate one within the first 28-day claim period for eligible clients.

Clinical Progress Notes

Purpose and Scope

This policy outlines requirements for maintaining clinical progress notes as part of client care documentation. This ensures safe, high-quality, and consistent care, and supports team communication.

This policy applies to all staff providing clinical and personal care services to clients.

Policy Statement

All visits and contacts where care is delivered must be documented through detailed clinical progress notes. Notes must be objective, factual, and completed in a timely manner to ensure they reflect the care provided and support continuity of services.

Requirements

- Clinical progress notes must be written for every visit or contact where care is delivered.
- Notes must be contemporaneous- that is, completed as soon as practicable after the visit or contact.
- All entries must be objective, factual, clear and legible.
- Abbreviations should be standardised and approved within the company.
- Corrections must maintain the integrity of the original record (no erasing or deleting).
- Clinical progress notes must be securely stored in the client's record in accordance with privacy, confidentiality, and information management requirements.

- Notes must include:
    - Date and time of the visit or contact
    - Name and role of the staff member providing care
    - Services or interventions provided (including clinical and personal care)
    - Client's response to care or interventions
    - Any changes in the client's condition or circumstances
    - Communication with the client, carers, family members or other health professionals, as relevant
    - Any issues identified and actions taken (including referrals or escalation)

Review and Use

- Clinical progress notes must be regularly reviewed by the care team to inform ongoing assessment, care planning, and review processes.
- Accurate and complete clinical progress notes help deliver safe, high-quality, and person-centred care. Staff are encouraged to seek clarification or support if unsure about documentation requirements.
- Records must be readily accessible to authorised personnel involved in the client's care.

Review of Care

Purpose and Scope

This policy establishes mandatory processes for reviewing client care at structured intervals, ensuring services remain safe, effective, appropriate, and responsive to changing needs.

This policy applies to all personnel involved in the assessment, planning, delivery, and coordination of community nursing services.

Policy Statement

Clients receiving community nursing services must have their care needs reviewed at the following minimum intervals:

- **Seven (7) days** after admission
- Every twenty-eight (28) days during ongoing care
- E**very three (3) months** for clients with continuing services

Procedure

1. Seven-Day Review

- Conducted by a Registered Nurse (RN).
- A client classified under the Personal Care schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid must be reviewed every seven days.
- All clients with Exceptional Case status must be reviewed at least once per week.
- Includes review of:
- Initial assessment findings.
- Current nursing care plan.
- Client’s early response to care.
- Must be documented in the client’s care record.

2. Twenty-Eight-Day Review

- Conducted at the end of each 28-day claim period.
- Required for all clients receiving ongoing care.
- Conducted by a RN for Clinical Care, or by an EN when only Personal Care is provided without any clinical add-ons.

Includes review of the nursing care plan and clinical documentation to verify that the classifications and care delivered reflect the item number/s claimed, including the:

- core schedule visit type classification
- opposing schedule visit type add-on (if required)
- other care and service/s provided from the schedule (if required)
- changes in the client's health status and care needs
- must be documented in the client's care record

3. Three-Monthly Review

- The three monthly reviews must be conducted prior to the end of every third 28 day claim period regardless of the type of community nursing services being delivered.
- Conducted by an RN.
- Includes comprehensive reassessment of:
  - Client's clinical condition.
  - Functional status and independence.
  - Medication management needs.
  - Environmental risks.
  - Goals of care and service appropriateness.
- All delegated care details must be appropriately documented in clinical records and kept in the client's file.
- Must result in an updated nursing care plan reflecting any required changes.
- The changes must be implemented in consultation with the client or their nominated representative.

If the review identifies a change to services is required, the RN must:

- Notify the client's GP as relevant.

- Reclassify the client within the Schedule of Fees if there is a change to the majority of care (e.g. from clinical to personal care).
- Identify if the client may require assessment through the Exceptional Case process.
- Consider discharging the client from community nursing services if there is no ongoing clinical need.
- For clients classified as Palliative Stable in the community, determine whether claiming this item continues to be appropriate.
- Where there is no clinical need for community nursing services and only non-clinically necessary personal care is required, discharge the client and refer them to Veterans' Home Care (VHC) for an assessment for personal care services.

4. Ad-Hoc Reviews

- Conducted whenever there is a change in the client's assessed care needs.
- Includes review and update of assessment documentation and the nursing care plan.
- Conducted by an RN.
- Must be documented in the client's care record.

Medication Management

Medication management is a critical aspect of providing safe and quality care to clients.
The following are some of the key requirements and procedures involved:

1. Medication Assessment

Upon admission or receipt of a referral, an RN must conduct a comprehensive medication assessment. The assessment must include:

- Review of the Client's Medication Regimen: Obtain and review a complete list of the client's current medications, including prescription, over-the-counter (OTC) medications, complementary medicines, and supplements. Verify the accuracy of the medication list against available medical records, referral documents, or medication charts.
- Verification of each medication's purpose, dosage, frequency, route, and timing.
- Identification of allergies, contraindications, or drug interactions.
- Discussion with the client (and carer if applicable) to confirm understanding of each medication's purpose and potential side effects.

2. Documentation

- Document all medications in the client's care plan in the medication management section, including details from the initial assessment and any updates.
- A medication authority or signed medication chart must be provided by the prescribing/referring medical practitioner. All prescribed medications must be documented on a medication chart approved and signed by the client's GP. Any changes to medication orders must also be confirmed in writing and signed by the GP.
- Maintain accurate and up-to-date records of all medication administration events, including time, dosage, route, and any observations or adverse reactions.

3. Medication Administration

3.1. The client must be classified under the Clinical Care Schedule.

3.2. Medications should be administered by trained and authorised staff according to the prescriber's instructions. The care must be provided by an RN or EN with an approved qualification in administration of medications if the client requires the administration of:

- prescribed medications (Schedule 4 and above)
- Schedule 8 drugs if dispensed from a bottle/packet, including Schedule 8 transdermal patches

- prescribed medicated eye drops (Schedule 4 and above)
- prescribed creams

A client can be assisted with self-administered medication by PCWs when the following criteria are met:

- the client's medical condition/s is/are stable
- there is a medication authority or medication chart signed by the prescribing medical practitioner
- there is a nursing care plan in place which includes medication contraindications (interactions and side-effects) and emergency contacts; and
    - there is a blister pack filled by a registered Pharmacist which meets the DVA Dose Administration Aid service requirements; or
    - it is over-the-counter medication, or prescribed/non-prescribed cortisone or topical cream;
    - if assisting with a sub-cutaneous injection this must be pre-filled
- the PCW:
    - has completed the required assistance with medication administration competencies recognised by the Health Industry Skills Council
    - adheres to the relevant Commonwealth and State/Territory Drug Acts
    - adheres to the CN provider's Medication Administration/assistance Policy/ies
    - the PCW is working under the delegation of an RN, and any change in health status is reported immediately to the RN
- the RN (or an EN with an approved qualification in administration of medication) conducts a face-to-face visit and reviews the client on a weekly basis if assistance with the self-administration of Schedule 8 drugs is involved
- the provider conducts annual medication competencies for the relevant PCWs and keeps individual PCW records for auditing and safety requirements.

If the above criteria cannot be met by a PCW, the care must be provided by an RN or EN and classified under the Clinical Care schedule.

3.3. Verification Prior to Administration

- Verify the client's identity and confirm medication details against the medication chart.
- Check that the medication aligns with the prescription or doctor's orders, ensuring no discrepancies in dosage or timing.
- Obtain informed consent before administering each dose, explaining the medication and its purpose.

3.4. Administer medications following the "five rights" of medication administration:

- Right client
- Right medication
- Right dose
- Right route
- Right time

3.5. Observe the client for immediate reactions and provide support as needed.

4. Documentation of Administration

Where a client requires medication administration or assistance with medication, the care interventions are to be documented in the medication management section of the nursing care plan for each prescribed dose and time of administration. A medication authority or signed medication chart must be provided by the prescribing/referring medical practitioner.

- Record the administration event in the client's medication chart, noting the date, time, and any pertinent observations.
- If a client refuses medication, document the refusal, reason (if provided), and any immediate action taken.
- Report any adverse reactions or side effects to the prescribing physician and document the incident in the client's care record.

5. Monitoring and Review

A client classified in the Personal Care schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid must be reviewed by an RN (or an EN with an approved qualification in administration of medication) every seven days.

All clients with Exceptional Case status must be reviewed by an RN at least once per week.

- Observe the client for changes in health status that may affect medication efficacy or tolerance.
- Monitor for any side effects or adverse reactions, documenting findings and reporting them to the prescribing GP as necessary.
- Conduct regular checks on medication storage to ensure compliance with safety and handling guidelines.
- Collaborate with the client's GP or authorised prescriber to conduct a medication review:
    - Every six months, or sooner if there is a change in the client's condition.
    - Following hospital discharge or any major change in medication.
    - To discontinue or adjust medications if deemed unnecessary or inappropriate.
- Update the client's care plan and medication chart based on the outcomes of the medication review.

6. Storage and Handling of Medications

6.1. Safe Storage

- Store medications securely in the client's home, following manufacturer instructions for temperature and light sensitivity.
- Ensure that medications are inaccessible to unauthorised individuals, especially in households with children or pets.
- Staff members are required to regularly inspect medication storage areas for expired or unused medications. This task must be completed during every medication administration shift change or, at a minimum, on a weekly basis.
- Expired or unused medications identified during these checks are to be separated immediately to prevent their use.

6.2. Controlled Substances

- For prescribed controlled substances, adhere to the regulatory guidelines for documentation, storage, and disposal.
- Maintain a record of controlled substances in the client's file, tracking inventory, administration, and disposal details.

7. Medication Disposal

7.1. Medications must be identified for disposal if they are:

- Expired or beyond their safe use date.
- No longer required by the client due to a change in prescription.
- Damaged, contaminated, or deemed unsafe for use.

7.2. Approved Disposal Methods

- **Return to Pharmacy:** Medications should be returned to an authorised pharmacy.
- **Incineration or Destruction by Licensed Facility:** For certain controlled substances and hazardous drugs, arrange for incineration or destruction through a licensed waste disposal company that complies with state and federal environmental laws.
- **Home Disposal (Exception):** In cases where medications must be disposed of immediately and cannot be returned to a pharmacy, small quantities of non-hazardous medication may be disposed of following local waste guidelines. However, this should be an exception and documented with clear rationale.

7.3. Controlled Substances and Hazardous Waste Disposal

Controlled substances and hazardous waste require specific handling and disposal methods to ensure compliance with Australian laws and protect public health and safety.

These substances **cannot be disposed of at home** and must be managed through approved, secure processes.

- Return to Authorised Facility
  - All controlled substances and hazardous medications must be returned to an authorised pharmacy or licensed disposal facility. Pharmacies participating in the Return Unwanted Medicines (RUM) program are equipped to manage the safe disposal of these medications.
  - Controlled substances and hazardous medications must be separated and placed in specialised containers designated for pharmaceutical waste. These containers are designed to prevent leaks, spills, and accidental exposure, ensuring the safety of handlers and the environment.
  - High-risk medications should be stored in purple-lidded containers or other containers specifically approved for hazardous waste, as outlined in Safe Work Australia guidelines.

7.4. Documentation

Detailed records must be maintained for compliance and accountability, including:

- **Medication Details:** Include the name, strength, and quantity of the medication being disposed of.
- **Reason for Disposal:** Document the reason for disposal, such as expiration, change in prescription, or damage.

Date, Time, and Method: Record the date and time of disposal, as well as the method used (e.g., returned to pharmacy or incineration at licensed facility).

Disposal Authorisation: Record the authorisation for disposal, including the names and signatures of the healthcare professional who authorised and implemented the disposal.

7.5. Secure Transport and Destruction

- Once medications are prepared for disposal, they must be transported securely to the authorised facility.
- All transport and destruction steps must adhere to relevant state and territory regulations, ensuring safe handling of potentially dangerous goods.

7.6. Record Retention and Compliance Audits

- All documentation related to medication disposal, including logs for controlled substances, should be retained for a minimum of seven years or as required by local regulatory authorities.
- Regular compliance audits should be conducted to ensure proper handling, documentation, and disposal procedures are in place, identifying any areas for process improvement.

8. Adverse Event Management and Reporting

If an adverse reaction occurs:

- Follow immediate first-aid and emergency protocols as appropriate.
- Document the event in detail, noting the reaction, time, intervention, and follow-up action.
- Inform the client's GP and coordinate follow-up care as needed.

9. Incident Management and Reporting

In the event of a suspected medication error, immediate and thorough action is required to ensure client safety and compliance with reporting standards. The following steps must be taken:

9.1. Immediate Response

- Stop Administration: Staff must immediately halt the administration process as soon as a potential medication error is identified.
- Notify the Care Manager: Staff must promptly notify the Care Manager about the suspected error for further assessment.
- Inform the Client: The care recipient must be informed of the potential error clearly and compassionately, ensuring they understand the steps being taken to ensure their safety.

9.2. Assessment by the Care Manager

- The Care Manager will assess the situation to determine the nature and severity of the error, reviewing factors such as the medication involved, dosage, and potential impact on the client's health.
- If necessary, the Care Manager will provide immediate care to the affected client to stabilise their condition and address any immediate health concerns.

9.3. Communication with Healthcare Providers

The Care Manager must contact the client's GP or relevant medical practitioner to discuss the error and determine the appropriate course of action. This may include adjusting medication, monitoring for adverse effects, or seeking emergency medical intervention.

9.4. Documentation

The Care Manager is responsible for documenting the medication error in the incident report system, providing a detailed account of the event, including:

- Description of the error
- Date and time of the incident
- Steps taken to address the error and provide care
- Communication with healthcare providers
- Follow-up actions and monitoring requirements

This documentation is essential for tracking and analysing medication errors, helping to prevent recurrence and improve medication management practices.

10. Continuous Professional Development

To ensure safe, effective, and compliant medication management, all staff involved in medication handling and administration must participate in ongoing training and education. Continuous Professional Development (CPD) is essential for maintaining competency, staying current with best practices, and adapting to changes in medication management protocols, regulations, and emerging treatments.

10.1. Mandatory Training Requirements

All nursing and support staff involved in medication management must complete mandatory training, covering topics such as:

- Safe handling, storage, and disposal of medications, including controlled substances and hazardous drugs.
- The "five rights" of medication administration (right client, right medication, right dose, right route, right time).
- Recognizing and managing adverse drug reactions and medication errors.
- Training must be updated annually or as required.

10.2. Updates on Best Practices and New Medications

- Staff should receive training on the latest best practices in medication management, including new developments in pharmacology and updated clinical guidelines.
- Regular updates on new medications, including potential interactions, side effects, and specific administration guidelines, should be provided to ensure all staff are knowledgeable and prepared.

10.3. Regulatory and Policy Compliance

- Staff must stay informed on changes in legislation, including state and federal regulations related to controlled substances and medication disposal, and any new guidelines from regulatory authorities.
- Training should also cover the company’s internal policies and procedures, ensuring that staff understand and adhere to all documentation, reporting, and safety protocols.

10.4. Competency Assessments

- Competency assessments should be conducted regularly to verify that staff are proficient in all aspects of medication management. Assessments may include practical evaluations, knowledge quizzes, and supervised administration to ensure compliance with best practices.
- Staff who do not meet competency standards should receive additional training and mentorship until they demonstrate the required level of skill.

10.5. Documentation of CPD Activities

- All training and development activities should be documented in each staff member's professional development record. This includes the date, type of training, topics covered, and outcomes of any competency assessments.
- Regular audits of CPD records should be conducted to ensure compliance with professional development requirements and regulatory standards.

Medication Management and Webster Pack Compliance in Community Nursing

Purpose and Scope This policy outlines ACare WA's procedures and responsibilities for safe, compliant medication management, including the use of Webster packs. It ensures safe handling, administration, documentation, and review of medications in accordance with national safety guidelines and clinical best practices.

This policy applies to all Registered Nurses (RNs), Enrolled Nurses (ENs), Personal Care Workers (PCWs), and care coordinators delivering medication-related services within ACare WA.

Definitions

- Webster Pack: A pharmacist-prepared medication dose administration aid that organizes prescribed medicines into time-specific slots.
- Medication Incident: Any preventable event that may cause or lead to inappropriate medication use or harm to a client.
- Scope of Practice: The boundaries within which a health professional is competent and authorized to perform tasks.

Policy Statement ACare WA is committed to ensuring safe medication practices, reducing medication-related risks, and supporting clients with effective administration systems like Webster packs. Medication management must be client-specific, evidence-based, and consistent with relevant clinical legislation.

Roles and Responsibilities

- RNs: Perform medication assessments, administer medications, verify Webster packs, report incidents
- ENs: Administer medications under RN delegation
- PCWs: May assist with medications only if competent and delegated by an RN, within ACare WA's scope-of-practice framework
- Care Coordinators: Monitor compliance and liaise with pharmacies and prescribers

Medication Assessment and Review

- All clients must undergo a full medication assessment on admission, including:
- Medication history and reconciliation
- Allergies and adverse drug reactions

- Use of complementary or over-the-counter medicines
- Medication reviews must be:
- Conducted at least annually
- Triggered by a hospital discharge, medication change, or adverse event

Webster Pack Protocols

- All medications administered by staff must be in a pharmacy-prepared Webster pack unless otherwise documented by the RN
- Webster packs must:
- Be labelled with client name, photo (if applicable), medication name, dosage, and time
- Be sealed and intact before use
- Be stored in a safe, temperature-controlled location
- If a medication dose is missed, refused, or altered, it must be documented and reported immediately

Medication Administration

- Follow the “Five Rights” of medication administration:
    1. Right person
    2. Right drug
    3. Right dose
    4. Right route
    5. Right time
- RNs and ENs must verify each medication against the client’s chart and Webster pack
- PCWs may assist with topical creams, eye drops, or prompting only if trained and documented in care plan

Client Education and Consent

- Clients must be informed about:
- Their medications and potential side effects
- The purpose of Webster packs and their contents
- Their right to refuse medication (with documentation)
- Consent must be documented at the commencement of care

Medication Incidents and Errors

- Must be reported immediately to the RN and Care Coordinator
- Incident form must be completed, including:
- Nature of the incident
- Action taken
- Client response and follow-up required
- Serious incidents must be escalated to the Clinical Governance Team within 24 hours

Disposal of Medications

- Expired or ceased medications must be returned to the pharmacy by the client/family or documented disposal by the RN
- No staff may take or redistribute medications

Documentation Requirements

- Clinical progress notes must include:
- Time and dose of administered medications
- Any changes, refusals, or side effects observed
- Maintain updated medication charts and review records

Training and Competency

- RNs and ENs must maintain current medication competency
- PCWs must undergo annual medication assistance training and be assessed as competent
- All staff must understand Webster pack protocols and documentation standards

Related Policies

- Infection Control Policy
- Incident and Risk Management Policy
- Clinical Delegation and Scope of Practice Policy
- Client Rights and Responsibilities Policy

References

- Aged Care Quality Standards (Standard 3 – Personal and Clinical Care)

- Australian Commission on Safety and Quality in Health Care – Medication Safety Guidelines
- Department of Health Medication Management Guidelines
- ACare WA Clinical Governance Framework

Anaphylaxis Management Policy and Procedures

Purpose and Scope

Anaphylaxis is a severe, potentially life-threatening allergic reaction that occurs rapidly and requires immediate medical intervention, even if emergency medication has been administered on site.

This policy outlines the management of anaphylaxis, ensuring all staff are equipped to recognise, respond to, and prevent anaphylactic reactions.

All staff members must uphold the highest standards of care and strictly adhere to this policy, as timely and appropriate action is critical to safeguarding the individual's life.

We are committed to ensuring the safety of clients by:

- Promptly recognising and responding to anaphylaxis
- Ensuring all staff are trained in anaphylaxis management
- Maintaining appropriate equipment and medications

Definitions

- Anaphylaxis: A severe, potentially life-threatening allergic reaction.
- Anaphylaxis Response Kit: A kit equipped with the appropriate materials and procedures to assist in anaphylaxis management.
- Adrenaline (Epinephrine): The first-line treatment for anaphylaxis.

Procedure

1. Overview of Anaphylaxis

Anaphylaxis is a severe, potentially life-threatening allergic reaction that typically involves respiratory and/or cardiovascular symptoms. While mild or moderate allergic reactions may precede anaphylaxis, they may not always occur before a severe reaction.

2. Prevention and Preparation

- Obtain and document allergy history from all clients.
- Review and maintain action plans for clients with known allergies.
- Ensure adrenaline auto-injectors are within expiry dates.

3. Signs and Symptoms

Anaphylaxis should be suspected if any one of the following signs is present:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in the throat
- Difficulty talking or hoarse voice
- Wheeze or persistent cough (unlike the cough in asthma, the onset of coughing during anaphylaxis is usually sudden)
- Persistent dizziness or collapse
- Abdominal pain, vomiting

4. Staff Responsibilities in the Event of Anaphylaxis

If an anaphylactic response occurs, follow these steps:

- Administer adrenaline immediately via an auto-injector.
- Call emergency services (000) for an ambulance.
- Place the client in a lying position with legs elevated, unless breathing difficulties require them to sit.
- Administer additional adrenaline if no improvement after 5 minutes.
- Commence CPR at any time if the person is unresponsive and not breathing normally.
- Do not allow the patient to stand or walk until they are haemodynamically stable, which is usually a minimum of 1 hour after 1 dose of adrenaline and 4 hours if more than 1 dose of adrenaline.

5. Post-Emergency Care

- Stay with the patient until emergency services arrive.
- Notify next of kin and primary healthcare provider.
- Document the incident and treatment provided.

6. Equipment Required for Acute Management of Anaphylaxis

- Adrenaline auto-injectors (e.g., EpiPen) with current expiry dates
- Airway management devices (e.g., oropharyngeal airways)
- Bag-valve mask for assisted ventilation
- Blood pressure monitor
- Stethoscope
- Pulse oximeter
- Emergency contact list and action plans

7. Training and Education

All nursing staff must complete annual training in:

- Recognition of anaphylaxis
- Administration of adrenaline
- Emergency response protocols

8. Documentation and Record-Keeping

- Maintain records of clients' allergies and action plans.
- Document all anaphylaxis incidents and management.

9. References

- Australasian Society of Clinical Immunology and Allergy (ASCIA) Resources: https://www.allergy.org.au/anaphylaxis
- ASCIA Guidelines - HP Acute Management of Anaphylaxis 2024: https://www.allergy.org.au/hp/papers/acute-management-of-anaphylaxis-guidelines

Waste Management

Purpose

This policy ensures the safe, compliant, and environmentally responsible management of all types of waste generated by community nursing services in accordance with Safe Work Australia guidelines, state and territory environmental and health regulations, and industry best practices.

All waste shall be managed efficiently and effectively to minimise environmental impact. Staff shall actively work to reduce waste generation, prioritise the reuse of multi-use items, and recycle suitable materials wherever possible. This approach supports environmental sustainability while maintaining safe and compliant waste management practices.

All staff must adhere to waste segregation, handling, storage, transportation, and disposal procedures to protect staff, clients, and the environment while ensuring compliance with relevant Australian legislation.

Waste Management Principles

1. **Minimisation** – Reduce waste generation where possible.
2. **Segregation** – Correctly separate waste into appropriate categories.
3. **S**afe **Handling & Storage** – Ensure all waste is contained and stored safely before disposal.
4. **Compliance –** Follow all legislative and regulatory requirements.
5. **Environmental Responsibility –** Encourage recycling and responsible disposal practices.
6. **Documentation & Audit –** Maintain records of waste disposal and conduct regular compliance audits.

Waste Segregation and Collection

All waste must be correctly identified, segregated, and disposed of in designated waste bins or containers.

- **General Waste (Non-Hazardous):**
  - General waste is waste which can be disposed of in the general waste bins. It does not contain hazardous material, will not cause infection and does not contain private or confidential information.
  - General waste can be bagged at point of generation and disposed of in the general waste bins. Items such as incontinence pads may be disposed of in the general waste bin if they are securely bagged in a strong plastic bag to contain any odours or leakage.

  Disposal:

  - Place in black or dark green general waste bins.
  - Ensure secure bagging before disposal.

- **Clinical Waste (Biohazardous):**
  - Clinical waste is any waste that poses a potential risk of harm or infection, including items contaminated with blood or bodily fluids, such as dressings, gauze, and saturated bandages, as well as full sharps containers.
  - All clinical waste must be double-bagged and disposed of in designated clinical waste bins.
  - Pharmaceutical waste, including expired or unused medications, drug containers, IVs, tubes, bottles, syringes, and needles, should also be treated as clinical waste and handled according to regulatory requirements for safe disposal.

  Disposal:

  - Double-bag all clinical waste before placing it in yellow-lidded clinical waste bins.
  - Sharps must be placed in approved sharps containers (rigid, puncture-resistant, and yellow in colour).
  - Arrange collection through a licensed clinical waste disposal service.

- **Pharmaceutical Waste (Including Controlled Substances):**
  - Expired or unused medications, including controlled substances, that require proper disposal. Pharmaceutical waste shall be disposed of in accordance with the procedures outlined in the Medication Management section.
  - Place pharmaceutical waste in containers labelled “Pharmaceutical Waste” and keep them in a secure area until collection.

  Disposal:

  - Store in purple-lidded pharmaceutical waste bins (or other Safe Work Australia-approved hazardous waste containers).
  - Controlled substances:
  - Must be recorded in a disposal log and destroyed under supervised conditions.
  - Must be disposed of via a licensed pharmaceutical waste disposal service.
  - **DO NOT** dispose of controlled substances in general or clinical waste.

- **Cytotoxic Waste (Chemotherapy & Hazardous Medications)**

  Includes chemotherapy drugs, cytotoxic-contaminated materials, and waste from clients receiving cytotoxic treatments, such as:

  - Cytotoxic medication containers and administration materials (IV bags, tubing, syringes)
  - PPE and contaminated dressings
  - Urine, faeces, and bodily fluids of patients receiving cytotoxic therapy (handled within 7 days of treatment)

  Disposal:

  - Use purple-lidded cytotoxic waste bins or purple hazard bags.
  - All cytotoxic waste must be sealed, labelled, and securely stored before collection by a licensed cytotoxic waste disposal provider.

  ⚠ Precaution:

  - Staff handling cytotoxic waste must use special PPE.
  - Avoid direct contact with contaminated materials.

- **Confidential Waste:**
  - Confidential waste includes any documents or materials that contain private, personal, or commercially sensitive information.
  - To protect privacy, all confidential waste should either be shredded or have personally identifiable information redacted before disposal. This ensures compliance with privacy laws and prevents unauthorised access to sensitive information.

  Recycling: Recyclable waste, such as paper, plastic, glass, and metal that can be safely recycled, should be disposed of in recycling bins. Staff should make every effort to correctly separate and dispose of recyclable materials to support environmental sustainability efforts.

- **Bulky Waste (Incontinence Aids, Large Disposable Items):**

  Includes bulky disposable items used in community care, such as:
  - Incontinence pads, adult nappies, sanitary products
  - Disposable bed protectors
  - Other bulk medical disposables

  Disposal:
  - Double-bagged and placed in general waste bins.
  - Ensure bags are strong and leak-proof to contain odours.

  ⚠ Alternative Disposal:

  If disposal volumes are high, a clinical waste collection service should be used.

Waste Handling & Disposal Procedures

1. All waste must be placed in appropriate containers and segregated at the point of generation.
2. Label all waste containers clearly with the correct waste category.
3. Securely seal waste bags or containers before disposal or collection.
4. Clinical, pharmaceutical, and hazardous waste must be disposed of via licensed waste disposal services in accordance with Australian state and territory regulations.
5. Maintain compliance with environmental and health regulations for waste transportation and disposal.

Waste Disposal

- Coordinate with approved waste disposal services for regular collection of clinical, pharmaceutical, and hazardous waste.
- Ensure that all waste is transported and disposed of in compliance with environmental regulations and state/territory guidelines.
- General waste can be disposed of through standard waste removal services as per local council guidelines. Ensure bins are securely closed to prevent pests and accidental spillage.
- All sharps must be disposed of in designated, puncture-resistant sharps containers. Once containers are full, they should be sealed and disposed of via a licensed disposal service.

Documentation and Record-Keeping

Maintain a waste disposal log for **clinical**, **hazardous**, and **pharmaceutical waste** documenting the following:

- Date and time of waste disposal
- Type and quantity of waste
- Method of disposal (e.g., returned to pharmacy)
- Name of the waste disposal service

Incident Reporting

- Document any waste management incidents in the incident report system.
- Record corrective actions taken and review the incident for any needed changes to waste management practices.

Staff Training and Compliance

- All staff must complete training on waste handling, segregation, disposal procedures, and spill management.
- Training should be conducted annually and whenever regulatory changes or updates to this policy occur.

Regular Audits

- Regular audits shall be conducted of waste management practices to ensure compliance with this policy and identify areas for improvement.
- Audit findings shall be used to adjust procedures and provide targeted training to address any compliance gaps.

Infection Control

Purpose

The company is committed to providing safe, high-quality care by implementing effective infection control practices to prevent the spread of infections. All staff must adhere to the infection control procedures outlined in this document to ensure the safety of clients, their families, and staff members.

Definitions

- Infection Control: Measures implemented to prevent and control the spread of infectious diseases by minimising or eliminating sources of infection and interrupting the transmission pathways, in alignment with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.
- Standard Precautions: The minimum infection prevention and control practices that must be applied to all client care, regardless of the client's infectious status, as per nationally agreed definitions. These precautions include hand hygiene, use of personal protective equipment (PPE), respiratory hygiene, environmental cleaning, safe handling and disposal of sharps, and cleaning and disinfecting of shared client care equipment.
- Transmission-Based Precautions: Additional infection prevention and control measures required when caring for clients with known or suspected infections that are transmissible by contact, droplet, or airborne routes. These precautions are used in addition to standard precautions to prevent the spread of infection and are consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.
- Antimicrobial Stewardship (AMS): A coordinated approach to promoting the appropriate use of antimicrobials to improve client outcomes, reduce resistance to antibiotics, and decrease the spread of multi-drug-resistant organisms.

1. Responsibilities for Infection Prevention and Control

- Executive Management: Responsible for ensuring adequate resources, support, and training are provided for infection prevention and control.
- Infection Control Officer (ICO): Responsible for monitoring compliance, leading audits, and overseeing infection control strategies.
- Care Manager: Coordinates infection control efforts, including communication with clients, GPs, and health services, and ensures adherence to infection control policies.
- Staff Members: Responsible for following infection control procedures, attending training sessions, and reporting non-compliance or risks.

2. Processes for Assessing Compliance

- Compliance Monitoring: Regular audits of hand hygiene, PPE usage, sharps management, environmental cleaning, and disinfection activities.
- Quality Improvement Plan: Address areas for improvement identified during audits and non-compliance investigations.
- Reporting: Audit outcomes and compliance rates are reported to management and included in organisational reporting structures.

3. Standard Precautions

Standard precautions are applied during all client interactions to reduce the risk of infection transmission. In a home care setting, standard precautions include:

3.1. Hand Hygiene

- Perform hand hygiene using soap and water or an alcohol-based hand rub:
  - Before entering and after leaving the client's home.
  - Before and after direct client contact.
  - After contact with blood, bodily fluids, or contaminated items.
  - After removing gloves or other PPE.
- Encourage clients and family members to practice regular hand hygiene.

3.2. Personal Protective Equipment (PPE)

- Use PPE based on the task and level of exposure risk in the home setting:
  - Gloves: Wear gloves when in contact with blood, bodily fluids, or contaminated surfaces.
  - Masks and Eye Protection: Use face masks and eye protection when there is a risk of splashing or aerosol generation.
  - Gowns: Wear gowns to protect skin and clothing when providing care that may involve direct contact with bodily fluids.
- Ensure PPE is disposed of appropriately within the client's home after use.

3.3. Respiratory Hygiene and Cough Etiquette

- Educate clients and family members on covering their mouth and nose with a tissue or elbow when coughing or sneezing.
- Dispose of tissues immediately in a sealed bag and encourage hand hygiene afterward.

3.4. Environmental Cleaning and Disinfection

- Clean and disinfect high-touch surfaces within the client's immediate care area regularly, especially after performing procedures.
- Use disinfectants appropriate for home care settings and compliant with Australian standards.
- Regularly monitor and audit the cleaning practices to ensure adherence to the Australian Guidelines for Prevention and Control of Infection in Healthcare and identify areas for improvement.

3.5. Equipment Sterilisation

- Sterilise reusable equipment (e.g., stethoscopes, thermometers) between each client visit.
- Use single-use equipment when possible to minimise cross-contamination risks.

4. Aseptic Technique

Aseptic technique is a set of practices that protect patients from healthcare-associated infections and protects healthcare workers (HCW) from contact with blood, body fluid and body tissue. Aseptic technique is required for procedures where contamination could introduce infection.

Aseptic technique, when performed correctly will:

- Minimise contamination of key sites
- Protect patients from their own pathogenic microorganisms that may cause infection
- Reduce the transmission of microorganisms
- Maintain the sterility of equipment and key parts used for aseptic procedures

For optimal aseptic technique to occur, all the elements of standard precautions must be used by the healthcare worker.

4.1. Principles of Aseptic Technique

Aseptic technique involves:

- Key-Part Protection: Ensuring sterile equipment (e.g., needles, syringes, catheters) remains sterile until use.
- Key-Site Protection: Avoiding contamination of vulnerable patient sites (e.g., open wounds, IV insertion points, urinary catheters).
- Hand Hygiene & PPE: Performing hand hygiene before and after procedures and using appropriate sterile gloves, masks, and gowns.
- Non-Touch Technique: Avoiding direct hand contact with sterile areas and maintaining a sterile field.
- Sterile Equipment and Environment: Using single-use sterile supplies where applicable and ensuring a clean clinical area.

4.2. Procedures Requiring Aseptic Technique

Procedures requiring aseptic technique include, but are not limited to:

- Wound Care and Dressing Changes
- Catheterisation and Urinary Care
- Injection and Medication Administration – Intravenous (IV), intramuscular (IM), subcutaneous (SC), and intradermal (ID) injections
- Enteral and Parenteral Nutrition – Gastrostomy tube management and IV feeding

4.3. Principles of Aseptic Technique

There are essential principles that should be applied when performing a procedure that requires aseptic techniques. These principles are:

4.3.1. **Sequencing:** a series of actions that ensure each procedure is performed in a safe and appropriate order. Sequencing includes assessing risks to patient safety and the HCW and identifying strategies to mitigate these risks prior to starting the procedure. When considering the steps for sequencing, the HCW should consider the following points:

- Performing a risk assessment:
  - Are there environmental or patient factors that increase the risk for the procedure?
  - Is the procedure technically difficult or an emergency situation?

- Is there a risk of infection transmission or contamination risk with this procedure?
- Do you know how to perform this procedure?
- What PPE do you need for this procedure?
- What action is required to mitigate these risks?

- Pre-procedure preparation
  - Prepare the environment
  - Select the correct equipment; check the condition, integrity and expiry date of each item required for the procedure
  - Plan each step of the procedure to avoid a breach in asepsis
  - Inform the patient and prepare them for the procedure
- Performing the procedure
  - Set up the equipment immediately prior to performing the procedure
  - Maintain standard precautions
  - Perform the procedure in a safe, logical order
- Post procedure practices, handover and documentation
  - Remove gloves and perform hand hygiene
  - Settle the patient
  - Pack away equipment and dispose of waste
  - Document the outcome from the procedure including any breaches in asepsis, any corrective actions taken at the time of the procedure to minimise any infection risks or if multiple attempts were required to complete the procedure.

4.3.2. Environmental control

There are many factors which can increase the risk of infection and patient harm during a procedure. These factors include:

- Other activities that are occurring in the nearby environment that may increase the risk of contamination during the procedure (e.g. for example bed making, dusting, or cleaning)
- Fans and open windows can cause air turbulence and contamination of the aseptic field.

Prior to aseptic procedures, ensure there are no avoidable nearby environmental risk factors.

4.3.3. Hand hygiene: Perform hand hygiene before a procedure and after a procedure or body fluid exposure.

Hand and wrist jewellery must be removed prior to the procedure and performing hand hygiene. If gloves become grossly contaminated or torn during a procedure, the gloves need to be removed, hand hygiene must be performed, and new gloves applied.

4.3.4. Maintenance of aseptic fields

Ensure that the aseptic field, the key parts, and key sites are always protected.

- Cleaning and/or disinfection of equipment and patient prior to procedure(s)
- Establishing an aseptic field
- Use of sterile equipment
- Maintenance of the aseptic field, including protecting the key sites and key parts
- Use of a non-touch technique

4.3.5. PPE: Correct selection and use of sterile and non-sterile PPE

Consider the following points:

- What PPE is required to protect the patient, the aseptic field and yourself during the procedure?
- What is the correct sequence for putting on and removing PPE?

5. Transmission-Based Precautions

For clients with known or suspected infections that are highly transmissible, apply transmission-based precautions in the home as follows:

5.1. Contact Precautions

- Use gloves and gowns for all interactions with the client and their environment.
- Minimise contact with surfaces within the client's home and bring only essential equipment.

5.2. Droplet Precautions

- Wear a surgical mask when within close proximity of the client if respiratory symptoms are present.
- Encourage the client to wear a mask when interacting closely with staff.

5.3. Airborne Precautions

- Use a fit-tested N95 respirator if the client is known or suspected to have an airborne infection.
- Conduct care in a well-ventilated area of the home, if possible, and limit exposure time.

6. Incident Management and Reporting

6.1. Exposure Incidents

- In the event of an exposure incident (e.g., needlestick injury, contact with infectious material), immediately perform appropriate first aid and report to the Care Manager.
- The Care Manager will assess the exposure and initiate any required follow-up, including medical evaluation and incident documentation.

6.2. Infection Outbreaks

If an outbreak occurs within a client's home or affects multiple clients, implement enhanced infection control measures, including increased PPE use, additional environmental cleaning, and notification of relevant health authorities as per regulatory requirements.

6.3. Documentation

- Document any infection control incidents in the incident report system.
- Record corrective actions taken and review the incident for any needed changes to infection control practices.

7. Tools for Assessment, Reporting, and Review of Infection Control Risks

- **Risk Assessment Tools:** Infection control risk assessments will be conducted at the commencement of services and regularly during ongoing care. The risk assessment process will identify potential hazards, determine risk levels, and document risk mitigation strategies. Tools include risk matrix and infection control checklist.
- **Reporting Tools:** Staff must report any infection control incidents, potential exposures, and near misses using the Incident Report Form. These reports are reviewed and logged into the Incident Management System for follow-up actions.
- **Review Tools:** Infection control practices and incident reports will be reviewed during regular audits and post-incident reviews. The review process will identify areas for

improvement, update training content, and support the continuous improvement of infection control protocols.

- **Quality Improvement Plan:** Audit outcomes are used to inform a continuous quality improvement plan. Corrective actions and training are implemented as needed.
- **Client Involvement:**
  - Information on infection prevention shall be available in culturally and linguistically appropriate formats.
  - Clients shall be encouraged to engage in decisions about their care and infection control measures.
- **Infection Risk Communication:** Infection risk must be communicated when care is transferred between clinicians or health services.
  - Pre-Transfer Communication: Prior to transferring a client's care to another clinician or health service, the responsible staff member must communicate all relevant infection-related information.
    - This includes the client's current infection status, any recent exposure to infectious agents, the use of transmission-based precautions, and ongoing antimicrobial therapy.
    - All infection-related details must be documented in the client's transfer summary or discharge summary.
  - Communication Tools: Phone or electronic handovers are used to ensure infection control information is effectively transferred.

8. Processes and Responsibilities Relating to Antimicrobial Stewardship (AMS)

- **Lines of Communication with Client's GP:** Communication with the client's GP is essential for ensuring the appropriate use of antimicrobials. Staff must communicate any signs of infection to the GP promptly.
- **Prescribing and Therapy Duration:** Where applicable, staff must obtain information on the antimicrobial prescribed, dosage, and the expected duration of therapy. This information must be documented in the client's care record.
- **Monitoring and Review:** Staff must monitor the client's response to antimicrobial therapy, noting any adverse effects or signs of resistance. Any concerns must be promptly escalated to the GP.
- Roles and Responsibilities:

- RN: Responsible for coordinating communication with the GP and ensuring that information on the prescribed antimicrobial and its duration is accurately recorded.
- Staff: Responsible for monitoring the client's response to antimicrobial therapy and reporting concerns or changes in the client's condition.
    - GP: Responsible for prescribing antimicrobials, advising on appropriate duration, and providing guidance on any necessary adjustments to treatment.

9. Mandatory Infection Control Training

9.1. Training Schedule

- Induction Training: All new staff must complete infection prevention training as part of their induction program before commencing duties.
- Annual Training: All staff must complete annual refresher training to reinforce infection prevention knowledge and ensure continued compliance.
- Ad-Hoc Training: Additional training must be provided whenever infection control guidelines are updated, new risks are identified, or new equipment, procedures, or PPE are introduced.

9.2. Training Content

Training content must include but is not limited to the following key topics:

- COVID-19 Specific Protocols: Updates on COVID-19 infection prevention measures and relevant jurisdictional requirements.
- Hand Hygiene: Techniques for proper handwashing and the correct use of hand sanitiser, in line with the National Hand Hygiene Initiative.
- Personal Protective Equipment (PPE): Correct selection, donning, doffing, and disposal of PPE, including gloves, masks, gowns, and eye protection.
- Standard and Transmission-Based Precautions: Guidance on how to apply standard precautions and implement contact, droplet, and airborne precautions where necessary.
- Cleaning, Disinfection, and Waste Disposal: Procedures for cleaning high-touch surfaces, disinfecting reusable equipment, and disposing of clinical and general waste.
- Incident Reporting: Reporting exposure incidents, handling infection outbreaks, and following escalation protocols.

9.3. Record Keeping

- Training records must be maintained for all staff, detailing participant names, training dates, topics covered, and assessment outcomes.

- Documentation must be retained as part of the company's compliance records and made available for audits and inspections.
- Evidence of training completion must be available upon request by regulatory authorities or during internal audits.

10. Audits and Compliance Monitoring

- Regular audits shall be conducted to assess adherence to infection control practices in clients' homes, identify areas for improvement, and ensure alignment with community nursing standards.

  The scope of the audits shall include, but is not limited to:

  - Hand hygiene practices, including education and competency assessments.
  - Use of personal protective equipment (PPE).
  - Safe handling and disposal of clinical waste.
  - Cleaning and disinfection of reusable equipment.
  - Adherence to standard and transmission-based precautions.
- Audit results shall be thoroughly reviewed by management to identify non-compliance, potential risks, and areas for improvement. Corrective actions, including staff re-education, policy revisions, and additional training, will be implemented promptly.
- All audit findings, including identified non-conformities, corrective actions taken, and follow-up reviews, must be documented and securely maintained as part of the company's compliance records. Documentation will also include a schedule for ongoing audits to ensure continuous compliance and quality improvement.
- Audit reports shall be submitted to relevant regulatory bodies as required and made available during inspections or upon request.

Reference

- National Hand Hygiene Initiative
- Australian Guidelines for the Prevention and Control of Infection in Healthcare
- Australian Immunisation Handbook
- Antimicrobial Stewardship Clinical Care Standard
- Australian Therapeutic Guidelines
- Department of Health and Aged Care - COVID-19 Resources and Training

Workforce Immunisation Policy

Purpose

The purpose of this Workforce Immunisation Program is to protect the health and safety of employees, clients, and the broader community by ensuring the workforce is appropriately immunised against vaccine-preventable diseases (VPDs).

This program aligns with the Australian Immunisation Handbook, jurisdictional requirements, and all relevant Australian legislative and regulatory standards.

Scope

This Workforce Immunisation Program applies to all employees, contractors, volunteers, and other personnel working within the company who provide direct or indirect services to clients in their homes. It includes administrative, clinical, and support staff who may be exposed to infectious agents or pose a risk of transmission to clients.

Objectives

- To prevent the transmission of vaccine-preventable diseases to employees, clients, and the community.
- To comply with the Australian Immunisation Handbook and all relevant jurisdictional and legislative requirements.
- To ensure employees are aware of their responsibilities and obligations regarding immunisation.
- To maintain accurate immunisation records for all employees.
- To establish a process for managing non-compliance and exemptions.

Vaccination Requirements

The company requires the following vaccinations in accordance with the Australian Immunisation Handbook and jurisdictional requirements:

- **Influenza (annual vaccination):** Annual influenza vaccination is strongly recommended for all healthcare workers, especially those caring for individuals at higher risk of influenza-related complications.
- **Measles, Mumps, Rubella (MMR):** Healthcare workers born during or since 1966 are recommended to have received 2 doses of measles- and rubella-containing vaccines, unless they have documented evidence of immunity.

- **Varicella (Chickenpox):** Employees must provide evidence of immunity or receive the varicella vaccine, especially those who have not previously had chickenpox.
- **Pertussis (Whooping Cough):** A booster dose of dTpa (diphtheria, tetanus, pertussis) is required for employees, particularly those providing care to vulnerable clients.
- **Hepatitis B:** Staff must be vaccinated against Hepatitis B if there is a reasonable expectation of exposure to blood or body fluids.
- **Other Vaccinations:** Additional vaccinations may be required for certain employees based on the nature of their role, exposure risk, or jurisdictional health directives.

Immunisation Process

1. Pre-Employment Requirements:

- New employees must provide documented evidence of their vaccination history prior to commencing employment.
- Candidates who cannot provide immunisation records may be required to undergo serological testing to confirm immunity.
- If evidence of vaccination is not available, the employee must complete the required vaccinations before starting work.

2. Ongoing Immunisation and Booster Requirements:

- Employees must comply with all vaccination requirements.
- Employees will be notified of any required booster doses for vaccination in line with current health recommendations.

3. Exemptions:

- Employees may apply for a medical exemption where a vaccine is contraindicated. Exemptions must be supported by a medical certificate or documentation from a medical practitioner.
- Temporary deferrals may be granted for employees who are pregnant or have a temporary medical condition that contraindicates vaccination.
- Non-medical exemptions (e.g., conscientious objections) are not accepted under this program.

4. **Refusal to Comply:**

- Employees who refuse to comply with the immunisation requirements without an approved exemption may face restrictions on their duties or be excluded from client-facing roles.

Documentation and Record-Keeping

- The company shall maintain a secure immunisation register for all employees.
- The register records the employee's vaccination status, dates of vaccination, and evidence of immunity.
- Records are retained for the duration of employment and comply with confidentiality and privacy laws, including the Privacy Act 1988 (Cth).
- Employees must provide updated vaccination records if they receive additional vaccines or booster doses.

Compliance and Monitoring

- Audit and Review: Regular audits are conducted to ensure compliance with the vaccination program.
- Non-Compliance Management: If non-compliance is identified, employees will be notified and given an opportunity to address the issue. Continued non-compliance may result in disciplinary action.
- Data Reporting: Immunisation data is included in infection control compliance reports provided to senior management and may be submitted to regulatory authorities if required.

Information, Education, and Support

- The company provides information to employees on vaccine-preventable diseases, vaccination schedules, and the importance of immunisation.
- Resources from the Australian Immunisation Handbook are made available to employees.

Review and Continuous Improvement

- This Workforce Immunisation Program will be reviewed annually or in response to changes in the Australian Immunisation Handbook, jurisdictional requirements, or public health advisories.
- Feedback from employees and health authorities will be incorporated to ensure continuous improvement.

Relevant Legislation, Standards, and Guidelines

- Australian Immunisation Handbook
- Privacy Act 1988 (Cth)
- Fair Work Act 2009 (Cth)
- Work Health and Safety (WHS) laws and state-based health directives
- RACGP - Infection prevention and control guidelines

This Workforce Immunisation Program ensures the safety and wellbeing of employees and clients while supporting regulatory compliance with Australian laws and public health directives.

Palliative and End-of-Life Care

Purpose and Scope

This policy outlines the procedures and responsibilities related to the provision of palliative and end-of-life care under the ACare WA community nursing service. The aim is to ensure high-quality, person-centred care that supports comfort, dignity, and quality of life for clients with life-limiting illnesses in the home setting.

This policy applies to all Registered Nurses (RNs), Enrolled Nurses (ENs), Personal Care Workers (PCWs), and subcontractors involved in delivering palliative or terminal care services through ACare WA.

Definitions

- Palliative Care: An approach that improves the quality of life of clients and their families facing life-threatening illness, through the prevention and relief of suffering by early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial, and spiritual.
- End-of-Life Care: Support and care provided during the final stages of life, typically defined as the last days to weeks of life.
- Terminal Phase: When death is imminent and likely within days.
- Advance Care Plan (ACP): A document that outlines a client's preferences and directions for future care, usually completed prior to loss of capacity.
- Anticipatory Medications: Medications prescribed for expected symptoms during the terminal phase.

1. Policy Statement

ACare WA is committed to delivering safe, compassionate, evidence-based palliative and end-of-life care that honours the client's values, wishes, and cultural needs. Care will be coordinated with the client's GP, specialists, family/carers, and palliative care services, in alignment with the National Palliative Care Standards (2020).

2. Admission Criteria

- Must hold a valid referral from a GP, hospital specialist, or palliative care service.
- Must have a documented clinical need for palliative care in the home.
- Veteran card holders (Gold or White) must meet DVA eligibility.

3. Assessment and Care Planning

- An RN must complete a face-to-face comprehensive palliative care assessment.
- The assessment must include:
  - Stage of illness
  - o Current symptom burden
  - o Communication capacity
  - o ACP documentation or Advance Health Directive (if applicable)
  - o Carer availability and capacity
  - o Psychosocial and spiritual needs
  - A nursing care plan must be developed or updated to reflect palliative goals. It must:
  - o Document anticipated needs and interventions (e.g. pain relief, pressure care)
  - o Include medication chart for anticipatory medications
  - o Include cultural or spiritual considerations
  - o Be shared with the client, carers, and healthcare team

4. Symptom Management

- Symptom control will follow evidence-based guidelines such as the Therapeutic Guidelines: Palliative Care.
- RNs are responsible for administering subcutaneous or oral medications prescribed by the GP or palliative care specialist.
- Anticipatory medication kits (if prescribed) must be safely stored and documented.
- Pain, breathlessness, agitation, nausea, and secretions must be regularly assessed and managed.

5. Coordination of Care

- The RN is responsible for:
  - Liaising with the client's GP, palliative care team, and pharmacy
  - Ensuring after-hours escalation options are in place
  - Monitoring carer fatigue and recommending supports (e.g. respite, Carer Gateway)
- The RN must maintain communication with the family and ensure clarity around expectations during the terminal phase.

6. End-of-Life Phase (Terminal Care)

- In the terminal phase:
  - Nursing visits may increase in frequency as clinically indicated
  - The care plan will focus on comfort and dignity
  - The RN may guide family in basic care tasks (e.g. repositioning, oral care)
  - Medication administration should be simplified and aimed at symptom relief
- Personal Care Workers may support care under RN delegation but are not to administer injectable medications.

7. After-Death Protocol

- Upon death:
  - The attending RN (if present) or family must notify the GP and relevant authorities
  - The RN will confirm death only if within scope and trained (if not, the GP or paramedic will confirm)
  - RN to provide comfort and guidance to family
  - Death must be documented in clinical records and progress notes
  - Notify ACare WA Care Coordinator and close client's file
  - Complete internal incident/debriefing form where applicable

8. Cultural, Religious, and Legal Considerations

- Care must be delivered in a culturally safe manner.
- Client preferences for religious/spiritual practices at end-of-life must be documented and supported.
- Respect any formal Advance Health Directive or decision made by legal substitute decision-maker.
- In the case of a reportable death, follow legal and coronial procedures.

9. Documentation Requirements

- All care provided must be recorded in the client's progress notes.
- Medications administered must be documented in the medication chart.
- Palliative care plans, symptom charts, and carer instructions must be kept in the client record.
- Death confirmation (if completed) and time of death must be recorded with full clinical detail.

10. Training and Competency

- All nurses providing palliative care must:
  - Complete palliative care competency annually
  - Hold current BLS and infection control training
  - Be familiar with the use of subcutaneous administration devices and symptom management guidelines
- PCWs providing palliative personal care must be supervised and receive orientation on end-of-life protocols.

References

- National Palliative Care Standards (PCA, 2020)
- DVA Notes for Community Nursing Providers
- Australian Guidelines for the Terminal Phase
- AHPRA Registered Nurse Standards of Practice
- ACare WA Medication Management Policy
- Advance Care Planning Australia – Clinical Guidelines

[NEW STANDALONE POLICY]

Home Care Package (HCP) Integration in Community Nursing

Purpose and Scope This policy outlines how community nursing services delivered by ACare WA align with, support, and integrate into the broader Home Care Package (HCP) Program. The aim is to ensure consistency with aged care legislation, enhance coordination of care, and ensure eligible clients receive clinically appropriate, efficient, and compliant support under their HCP.

This policy applies to all staff, including Registered Nurses (RNs), Enrolled Nurses (ENs), Personal Care Workers (PCWs), and care coordinators involved in the care of HCP-funded clients.

Definitions

- Home Care Package (HCP): A government-subsidised program that provides coordinated care and services to older Australians with complex needs who wish to remain at home.
- Support at Home Program (SAHP): The upcoming program that will unify HCP and CHSP under a single framework (expected 2025–2027).
- Level 1–4 Package: Refers to increasing levels of care needs under the HCP framework (Level 1 = basic care, Level 4 = high care needs).

Policy Statement ACare WA is committed to delivering community nursing services that are compliant with the Aged Care Act 1997, Aged Care Quality Standards, and Department of Health guidance on the use of HCP funds. Nursing services must be evidence-based, clinically justified, and clearly aligned to a care plan that supports the goals of the HCP recipient.

1. Eligibility and Referral Alignment

- Clients must have an assigned HCP (Level 1–4) and be actively managed by an Approved Provider (e.g., Trilogy Care).
- Community nursing services must be:
  - identified as a need in the client's Care Plan
  - linked to a clinical condition, diagnosis, or symptom that justifies nursing intervention
  - referred by a GP, hospital discharge planner, or specialist (if relevant)

Examples of Eligible Nursing Services Under HCP

- Clinical wound care
- Medication management and review (e.g. blister pack assistance, S8 medications)
- Continence care

- Chronic disease management (e.g. diabetes, hypertension)
- Clinical assessments and care planning
- Palliative and end-of-life care (see dedicated policy)
- Allied health referrals coordination (e.g. OT for falls risk)

Exclusions (Not Covered Under HCP Nursing)

- Services already subsidised under Medicare (e.g. GP Management Plans, EPC referrals)
- Duplicate services covered under state-based programs
- Social support, companionship, and non-clinical supervision
- Services intended primarily for respite or lifestyle

2. Funding and Budget Considerations

- Services must be pre-approved by the client's Care Coordinator or Provider
- RN must ensure:
  - Clear documentation of need in progress notes and care plans
  - Accurate service item coding (e.g. based on CMP or provider software)
  - Quotes provided for ongoing nursing interventions (if required)
  - Coordination with support workers to avoid service duplication

3. Communication and Documentation

- Nursing assessments must be shared with the Approved Provider via secure systems
- Significant clinical events (e.g. deterioration, hospitalisation, change in function) must be escalated to the provider
- Nursing goals and services must be aligned to the client’s overarching HCP goals

4. Coordination with the HCP Team

- Regular case conferencing is encouraged (e.g. RN, support worker, care coordinator)
- RN should provide monthly summaries if requested by Provider
- Nursing must complement, not override, the Provider's overall care plan

5. Compliance and Review

- All services must comply with:
  - Aged Care Quality Standards (particularly Standard 3 – Personal and Clinical Care)
  - Department of Health's Home Care Packages Program Operational Manual
  - Any transitional requirements under Support at Home reform

6. Training and Oversight

- RNs providing services to HCP clients must complete annual training in aged care funding compliance
- Supervisors must review documentation quarterly to ensure all services are clinically appropriate and billed correctly
- References
- Aged Care Quality Standards
- Aged Care Act 1997
- Home Care Packages Program Operational Manual (Department of Health)
- ACare WA Clinical Governance Framework
- ACare WA Nursing Care Plan and Documentation Policy

Telehealth and Remote Monitoring in Community Nursing

Purpose and Scope This policy outlines the use of telehealth and remote monitoring technologies to deliver safe, timely, and effective community nursing services to clients of ACare WA. It supports flexible care delivery in regional, remote, and rural environments and ensures compliance with clinical and privacy standards.

This policy applies to all nursing personnel (RNs, ENs), care coordinators, and administrative staff involved in scheduling, delivering, or managing telehealth or remote health monitoring.

Definitions

- Telehealth: The use of telecommunications (video, phone, secure messaging) to deliver health services remotely.
- Remote Monitoring: The use of devices (e.g., blood pressure monitors, fall alarms) to capture and transmit health data for clinical review without in-person contact.
- Hybrid Care: A model combining in-person and remote health interventions.

Policy Statement ACare WA supports the use of telehealth and remote monitoring to enhance accessibility, maintain care continuity, and support clinical decision-making. These services must be clinically appropriate, consent-based, and compliant with AHPRA and Commonwealth privacy standards.

Eligibility and Suitability Criteria Telehealth may be used:

- When a client resides in a remote/rural area or has mobility issues
- For follow-up assessments, care plan reviews, education, or check-ins
- If clinically appropriate, and in accordance with RN judgment
- With client consent and a stable cognitive and communication baseline

Remote monitoring may be applied:

- For chronic disease management (e.g., hypertension, diabetes)
- Where clinical deterioration is suspected and daily observations are needed
- For post-hospital discharge follow-up
- For falls prevention or safety monitoring (e.g., personal alarms)

Permitted Telehealth Activities

- RN consultations, progress checks, medication reviews (verbal confirmation only)

- Review of non-urgent wound photos securely submitted
- Care coordination or case conferencing with clients and/or family
- Allied health triage or coordination

Exclusions

- Initial assessments must be conducted in person
- Personal care or wound dressing cannot be delivered via telehealth
- Medication administration or verification of S8 medications must be done in person

Remote Monitoring Devices Approved uses include:

- Blood pressure monitors, pulse oximeters, glucometers
- Fall detectors or movement sensors
- Weight scales (for fluid management)
- Safety alarms (e.g., Live Life Alarms, Guardian, Rosie)

Nursing responsibilities:

- Ensure clients and carers are trained in device use
- Review data daily or as clinically indicated
- Document all clinical decisions based on remote readings
- Report anomalies and escalate to GP if warranted

Consent and Privacy

- Written consent must be obtained for all telehealth sessions and monitoring use
- Clients must be informed of the nature, limitations, and risks of telehealth
- All communications must occur via secure, encrypted platforms
- Client data from remote devices must be securely stored and protected under the Privacy Act 1988

Documentation Requirements

- Document all telehealth encounters in the progress notes
- Note client condition, concerns, and advice provided
- For remote monitoring, log data received and any clinical actions taken

Technology Standards

- Devices must meet Australian medical device compliance standards (TGA-registered where applicable)
- Video platforms must comply with healthcare-grade encryption (e.g., Coviu, HealthDirect)

Emergency Protocols If deterioration is identified remotely:

- Attempt phone or video follow-up immediately
- Escalate to emergency services or GP as needed
- Contact family or carer if unable to reach the client
- Document the incident and actions taken

Training and Supervision

- All nurses using telehealth must complete training on:
  - Conducting remote assessments
  - Interpreting remote data
  - Privacy and documentation requirements
- Supervisors must ensure competencies are reviewed annually

Quality and Review

- Audit telehealth records quarterly for clinical adequacy and policy compliance
- Evaluate client outcomes linked to remote monitoring to determine effectiveness

References

- AHPRA Guidelines on Telehealth
- Australian Digital Health Agency – Telehealth Standards
- Privacy Act 1988 (Cth)
- Therapeutic Goods Administration (TGA) – Medical Devices
- ACare WA Clinical Governance and Information Management Policies.

[NEW STANDALONE POLICY]

Behavioural and Cognitive Impairment Management in Community Nursing

Purpose and Scope This policy outlines how ACare WA manages community nursing care for clients experiencing behavioural and/or cognitive impairment, including those with dementia, delirium, acquired brain injury, or other neurodegenerative conditions.

It provides guidance to staff on recognising, assessing, and managing behavioural symptoms while upholding dignity, safety, and individualised care. This policy applies to all ACare WA nursing personnel, care coordinators, support workers, and subcontractors.

Definitions

- Cognitive Impairment: A decline in memory and/or other thinking skills that interferes with daily function (e.g., dementia, delirium).
- Behavioural and Psychological Symptoms of Dementia (BPSD): Symptoms such as agitation, aggression, anxiety, wandering, hallucinations, or depression associated with dementia.
- Behaviour Support Plan (BSP): A documented strategy for responding to behaviours of concern in a way that minimises harm and supports wellbeing.

Policy Statement ACare WA is committed to delivering compassionate, person-centred care to clients with cognitive or behavioural impairment. We aim to minimise distress and risk through early identification, tailored strategies, and multidisciplinary collaboration.

Identification and Assessment

- All clients must undergo an initial cognitive screen at intake or first assessment, using validated tools (e.g., MMSE, GPCOG, or clinical indicators).
- Where cognitive concerns arise, the RN must:
  - Document observed behaviours or changes
  - Notify the GP or treating team
  - Request a specialist review if needed (e.g., geriatrician, neurologist)

Common Risk Indicators

- Confusion, memory loss, or disorientation
- Repetitive questioning or wandering

- Resistance to care or aggression
- Emotional distress or paranoia
- Non-adherence to medication or medical devices

Care Planning

- Develop an individualised care plan that includes:
  - Communication preferences (e.g., tone, pace, language)
  - Known triggers and calming strategies
  - Medication supports (e.g., antipsychotics, if prescribed)
  - Supervision needs and fall risk mitigation
  - Approved behavioural strategies from clinicians
- A Behaviour Support Plan (BSP) must be developed for moderate-to-severe behavioural symptoms, in collaboration with the client's GP, family, and clinical specialists.

Environmental and Communication Strategies

- Maintain consistent staff wherever possible
- Use clear, simple, reassuring communication
- Avoid confrontational language or rushing
- Maintain calm, low-stimulus environments
- Involve family members or known persons in difficult tasks

Behavioural Escalation and Incident Response

- If a client displays escalating behaviour:
  - Use verbal de-escalation first
  - Cease non-essential care tasks
  - Contact Care Coordinator or family representative
  - Document incident and notify GP if required
- For acute deterioration or aggression:
  - Leave environment if unsafe
  - Contact emergency services (000)

- Notify Care Coordinator immediately
- Complete incident report within 24 hours

Staff Safety and Supervision

- Never provide care in unsafe conditions
- Use buddy systems or scheduled welfare checks if risk is known
- Care Coordinators may assign high-risk clients to staff with specific dementia training

Referral and Support Services

- RNs may refer clients to:
  - Dementia Australia services
  - Older Adult Mental Health Teams
  - Geriatricians or neurologists
  - ACAT for residential respite if risk is high

Family and Carer Engagement

- Encourage families to:
  - Share insight into behavioural patterns and preferences
  - Assist with reorientation and calm during visits
  - Participate in regular reviews or case conferences
- Provide carers with contact details for emergency advice

Documentation Requirements

- All behavioural events must be logged in clinical notes
- BSPs must be reviewed every 3 months or after major incidents
- Clinical decisions must be recorded in the client care plan

Training and Competency

- All nursing and care staff must complete:
  - Annual dementia and cognitive impairment training
  - Behavioural de-escalation training (online or in-person)
- Supervisors must assess staff confidence and adjust rostering accordingly

Legal and Ethical Considerations

- Use least restrictive approaches at all times
- Do not physically restrain unless client safety or staff safety is at immediate risk
- Report all incidents to the Care Coordinator
- Respect privacy and dignity throughout all interactions

References

- Dementia Australia Clinical Guidelines
- Aged Care Quality Standard 3 – Personal and Clinical Care
- National Safety and Quality Health Service (NSQHS) Cognitive Impairment Standard
- ACare WA Clinical Governance Framework
- ACare WA Incident and Risk Management Policies

Cultural and Linguistic Diversity (CALD) Support in Community Nursing

Purpose and Scope This policy establishes ACare WA's commitment to providing culturally safe and inclusive community nursing care to clients from culturally and linguistically diverse (CALD) backgrounds. It outlines practical steps to respect, support, and respond to the cultural, spiritual, and communication needs of all clients.

This policy applies to all nursing personnel, care coordinators, support workers, and subcontractors delivering or coordinating services through ACare WA.

Definitions

- CALD (Culturally and Linguistically Diverse): Refers to individuals who identify as having a cultural or ethnic background different from the dominant culture, including those who speak a language other than English at home.
- Cultural Safety: An environment that is spiritually, socially, and emotionally safe for people, where there is no challenge to their identity, and where cultural needs are respected.
- Interpreter: A certified professional who facilitates spoken or signed language communication between people who do not share a common language.

Policy Statement ACare WA ensures that every client receives respectful, inclusive care that acknowledges their cultural identity, language, religious beliefs, and traditions. Services must be adapted to accommodate cultural needs and communication preferences in line with the Aged Care Quality Standards and national clinical best practice.

Cultural Needs Identification and Documentation

- During intake and nursing assessment, clients must be asked:
  - What language they speak at home
  - If they require an interpreter
  - Their cultural or ethnic background
  - Religious, dietary, or spiritual practices relevant to care
- This information must be recorded in the client's care plan and communicated to all staff involved in service delivery.

Use of Interpreters

- A professional interpreter must be used if:
  - The client has limited English proficiency

- Complex or sensitive information is being conveyed (e.g., medication changes, consent, end-of-life discussions)

- Family members must not be used as interpreters for clinical matters unless in an emergency.
- Only interpreters certified by NAATI (National Accreditation Authority for Translators and Interpreters) may be used for formal translation services.

Religious and Cultural Practices

- Staff must accommodate requests related to:
  - Dietary restrictions (e.g., halal, kosher, vegetarian)
  - Prayer times and space requirements
  - Gender-specific care (e.g., preference for female nurse)
  - Traditional healing or complementary therapies (if safe and appropriate)
  - Observance of religious holidays (e.g., Ramadan, Easter, Yom Kippur)
- Clients and families should be invited to share any practices that are meaningful to them and impact how care is delivered.

Language and Communication

- Speak clearly, avoid jargon, and check for understanding using techniques like teach-back.
- Use translated written materials whenever possible for common procedures, rights, or complaints processes.
- Offer interpreter-facilitated case conferences or reviews where appropriate.

Family and Community Engagement

- Encourage family involvement in care planning if culturally appropriate.
- Where relevant, support connections with multicultural community groups or spiritual advisors.

Staff Cultural Competency

- All staff must complete cultural awareness training annually.
- Supervisors will assess staff ability to manage CALD-related concerns and provide coaching or mentorship as required.
- Staff are encouraged to self-report any uncertainties or seek support from Care Coordinators.

Inclusion in Care Planning

- Each client's cultural needs must be integrated into the nursing care plan.
- Review and update cultural information during major reviews or after client or family feedback.
- Adjust routines or personal care practices in alignment with cultural expectations where feasible.

Responding to Discrimination or Cultural Concerns

- Any concerns raised by clients or families related to cultural insensitivity must be taken seriously and escalated to management.
- All staff are required to uphold a zero-tolerance approach to racism or cultural stereotyping.
- The complaints process must be accessible in multiple languages and supported by interpreters if needed.

Documentation Requirements

- Cultural and language preferences must be documented clearly in:
  - Initial nursing assessment
  - Care plan
  - Clinical progress notes (as relevant to interactions)
- Interpreter usage must be documented including name, language, and summary of interaction.

References

- Aged Care Quality Standards (Standard 1 and 6)
- Australian Commission on Safety and Quality in Health Care: Partnering with Consumers Standard
- Diversity Framework for Aged Care (Department of Health)
- NAATI Code of Ethics
- ACare WA Rights and Responsibilities Policy
- ACare WA Clinical Governance Framework

Falls Prevention Strategy in Community Nursing

Purpose and Scope This policy outlines ACare WA's approach to preventing and managing falls among community nursing clients. Falls can have serious health consequences for older adults and individuals with disability, particularly those living independently at home. This strategy promotes early identification of falls risk, timely intervention, and safe response protocols.

This policy applies to all Registered Nurses (RNs), Enrolled Nurses (ENs), Personal Care Workers (PCWs), and care coordinators delivering services through ACare WA.

Definitions

- Fall: An unexpected event in which a person comes to rest on the ground, floor, or lower level.
- Falls Risk: The likelihood of an individual experiencing a fall based on intrinsic and extrinsic factors.
- Reablement: A person-centred, goal-oriented approach that helps individuals regain functional abilities after illness, injury, or decline.

Policy Statement ACare WA is committed to reducing fall-related harm through early identification of risk, person-centred care planning, home environment modifications, and staff training. Falls prevention is integrated into every stage of care delivery.

Initial Assessment and Screening

- At admission, all clients must undergo a falls risk screening using a validated tool (e.g., Falls Risk for Older People in the Community - FROP-Com)
- Risk indicators include:
  - History of recent falls
  - Impaired mobility or balance
  - Polypharmacy or psychoactive medications
  - Poor vision, cognitive impairment, continence issues
- Screening outcomes must be documented in the care plan

Comprehensive Falls Risk Assessment

- For clients at moderate or high risk, a full falls risk assessment must be completed by the RN within 7 days of admission
- Areas assessed must include:
  - Mobility, gait, and use of assistive devices
  - Medication review (with GP or pharmacist)
  - Environment (lighting, flooring, obstacles)
  - Functional status and ADLs
  - Footwear, podiatry needs, and continence status
- Document mitigation strategies in the care plan

Care Planning and Interventions

- Develop a Falls Prevention Plan tailored to the client's needs
- Interventions may include:
  - Strength and balance exercises (via physiotherapy referral)
  - Home modifications (e.g., grab rails, ramps, lighting)
  - Medication review with GP
  - Continence management
  - Education on safe footwear and walking aids
  - Support worker monitoring and engagement
- Family or carers should be involved in falls prevention planning when appropriate

Response to a Fall (Post-Fall Protocol)

- If a fall occurs:
  - Ensure the client is safe; assess for injury
  - Provide immediate first aid and call emergency services if required
  - Notify the Care Coordinator
  - Document the incident in detail (see Documentation)
  - Reassess and update the care plan
- Conduct a post-fall review to identify contributing factors

Staff Responsibilities

- RNs: Conduct risk assessments, coordinate care, and oversee intervention strategies
- PCWs: Monitor client environment and report changes or hazards
- Coordinators: Arrange allied health referrals and ensure care plan updates

Training and Competency

- All staff must complete annual falls prevention training, including:
  - Safe mobility assistance techniques
  - Use of mobility aids and manual handling equipment
  - Environmental risk identification

Environmental Modifications

- Encourage clients and families to:
  - Remove trip hazards (e.g., rugs, cords)
  - Improve lighting and install night lights
  - Install grab bars in bathrooms and stair rails
- RNs and OTs should work collaboratively to recommend and implement changes

Monitoring and Review

- Falls risk must be reviewed:
  - At minimum every 3 months
  - After any reported fall
  - When there is a change in condition, medication, or environment
- Care plan to be adjusted accordingly

Documentation Requirements

- Record falls risk score and screening outcomes in the clinical record
- Maintain detailed notes on interventions, referrals, and client education
- Post-fall documentation must include:
  - Time, location, circumstances, injuries (if any)
  - Actions taken and follow-up arrangements

References

- Australian Commission on Safety and Quality in Health Care – Falls Guidelines
- Aged Care Quality Standards (Standard 3 – Personal and Clinical Care)
- Department of Health – Staying on Your Feet Program
- ACare WA Clinical Governance and Risk Management Framework
- ACare WA Incident Management Policy

Client Emergency Preparedness Plan in Community Nursing

Purpose and Scope This policy outlines ACare WA's approach to ensuring all community nursing clients have an individualised emergency preparedness plan. The aim is to protect clients and support continuity of care during local emergencies such as bushfires, power outages, floods, pandemics, or other unforeseen disruptions.

This policy applies to all care staff, including Registered Nurses (RNs), Enrolled Nurses (ENs), Personal Care Workers (PCWs), care coordinators, and administrative personnel responsible for planning and communication.

Definitions

- Emergency Preparedness: The planning and actions taken to respond to and recover from emergencies or natural disasters.
- Client Emergency Plan: A written plan that outlines actions, contacts, and contingencies tailored to a client's needs during an emergency.
- Essential Services: Services that are critical to the client's health and wellbeing (e.g., medication, wound care, oxygen support).

Policy Statement ACare WA is committed to proactively supporting clients in preparing for and managing emergency events. Each client must have a documented plan that prioritises safety, medical continuity, and timely communication.

Emergency Risk Identification

- Upon admission and at each quarterly review, RNs must identify risks based on:
  - Geographic location (e.g., bushfire or flood-prone area)
  - Client's medical dependency (e.g., oxygen, refrigeration needs)
  - Communication vulnerabilities (e.g., no mobile reception, hearing impairment)
- Risk level must be documented and flagged for priority contact during emergencies

Components of a Client Emergency Preparedness Plan

- Confirmed next of kin or emergency contact details
- List of essential services and who provides them
- Action plan if nursing or support services are delayed or suspended
- Alternative arrangements (e.g., generator, relative who can assist)
- Transport and evacuation preferences or restrictions

- Current medications, allergies, and medical alerts
- Preferred GP and pharmacy contact details
- Communication method in emergencies (e.g., SMS, landline, in-person)

Plan Development and Client Engagement

- RNs must develop the emergency plan in collaboration with the client and/or their carer within the first 28 days of service
- Emergency plans must:
  - Be written in clear, plain English
  - Be stored in the client file and hard copy provided to the client/carer
  - Be updated at least every 12 months, or after a significant change in health or location

Client Education

- Provide clients with:
  - Information on local emergency numbers and community resources
  - Practical tips on preparing an emergency kit
  - How to access medications and health support if services are interrupted
- Where applicable, offer translated materials for CALD clients

Continuity of Care Planning

- Identify clients who are most vulnerable during a service disruption (e.g., palliative clients, insulin-dependent diabetes)
- Care Coordinators must have a rapid contact tree in place
- Arrange back-up services or escalation plans with local health providers where needed

Communication During Emergencies

- In an active emergency:
  - Contact high-priority clients first to confirm safety
  - Use pre-determined communication channels (e.g., group SMS)
  - Notify staff of service changes and reallocation
- Keep detailed logs of contact attempts and client outcomes

Staff Responsibilities

- RNs: Develop, review, and update emergency plans
- PCWs: Assist clients in understanding and following emergency plans
- Coordinators: Maintain client emergency register and update logistics as needed

Documentation Requirements

- All emergency preparedness plans must be documented in the clinical file
- Contact attempts and updates must be logged during emergencies
- Plan reviews should be dated and signed by the RN and client/carer

Training and Competency

- All care staff must complete annual emergency response training
- Training will include:
  - Recognising vulnerable clients
  - Coordinating evacuation and welfare checks
  - Managing care continuity during local events

References

- Australian Government Emergency Preparedness Guidelines for Aged Care
- Aged Care Quality Standards – Standard 3 and 8
- ACare WA Risk Management and Incident Response Policies
- State Emergency Services and Local Emergency Management Plans
- Australian Red Cross: Emergency Ready Checklists

Continence Management in Community Nursing

Purpose and Scope This policy outlines ACare WA's approach to supporting clients with bladder and bowel care needs as part of comprehensive community nursing. It ensures that continence issues are identified early, managed effectively, and supported through appropriate assessment, interventions, referrals, and product access.

This policy applies to Registered Nurses (RNs), Enrolled Nurses (ENs), care coordinators, personal care workers (PCWs), and allied health professionals working in partnership with ACare WA.

Definitions

- Continence: The ability to control bladder and bowel function.
- Incontinence: Involuntary loss of urine or faeces.
- Continence Assessment: A comprehensive evaluation of the client's urinary and bowel habits, patterns, and contributing factors.

Policy Statement ACare WA aims to enhance client dignity, independence, and quality of life through effective continence care and management. We prioritise individualised care planning, clinical education, and support access to appropriate continence aids and health professionals.

Initial Assessment and Screening

- All clients must be screened for continence issues during admission and nursing assessments.
- Screening should include:
  - Bladder and bowel patterns
  - Fluid intake
  - Frequency of incontinence episodes
  - Product use
  - Skin condition
  - Current medications
- Document findings in clinical notes and care plans

Continence Assessment and Review

- Clients with identified issues must undergo a full continence assessment by an RN or referred to a Continence Nurse Advisor or GP.
- The assessment includes:

- Voiding diary (3-day minimum)
- Fluid balance and fluid intake pattern
- Relevant medical history (e.g., UTI, cognitive impairment)
- Functional mobility, toileting access
- Skin assessment and hygiene practices

- Assessments should be reviewed:
  - Every 6 months, or
  - After hospital discharge, or
  - Following a significant health change

Care Planning and Interventions

- Individualised continence care plans must include:
  - Toileting schedule or prompted toileting
  - Use of pads/pull-ups or continence aids
  - Dietary adjustments (e.g., fibre, hydration)
  - Skin care and hygiene routines
  - Environmental considerations (e.g., commode, night lighting)
  - Behavioural or cognitive factors impacting continence
- PCWs must follow the plan and report changes promptly

Product and Funding Access

- Assist clients to:
  - Access funding for continence aids via CAPS (Continence Aids Payment Scheme)
  - Order and manage supply of appropriate continence products
  - Liaise with product suppliers if client has sensitivity or fitting issues

Referral Pathways

- Refer to GP, Continence Nurse Advisor, Urologist, or Physiotherapist as needed
- Include occupational therapist input for toileting access, equipment, or environmental modification

Infection Control and Skin Integrity

- Staff must:
  - Use appropriate PPE during care
  - Ensure proper perineal hygiene and drying after toileting
  - Monitor and report any skin breakdown or signs of infection
  - Apply barrier creams as clinically indicated

Client Education and Empowerment

- Educate clients and carers on:
  - Normal bladder and bowel health
  - Diet and hydration
  - Effective use of continence aids
  - Signs of infection or complications
- Provide printed resources or interpreter-supported sessions where needed

Documentation Requirements

- Document all continence assessments and reviews
- Record continence status in nursing notes and care plans
- Log skin integrity concerns in clinical progress notes
- Track product usage and funding details if applicable

Training and Competency

- All care staff must complete annual training on:
  - Continence care techniques
  - Infection prevention in personal care
  - Early signs of complications

Related Policies

- Wound Care and Pressure Injury Prevention
- Infection Control Policy
- CALD Support Policy
- Personal and Clinical Care Standards Policy

References

- Continence Foundation of Australia Guidelines
- Aged Care Quality Standards (Standard 3)
- Department of Health Continence Aids Payment Scheme (CAPS)
- ACare WA Clinical Governance and Risk Framework

Clinical Handover and Communication Protocols in Community Nursing

Purpose and Scope This policy outlines the protocols for clinical handover and communication across ACare WA's community nursing services. Its purpose is to ensure continuity of care, reduce clinical risks, and maintain clear and timely communication between nurses, care workers, allied health professionals, and external providers.

This policy applies to all clinical staff (RNs, ENs), support workers, care coordinators, and subcontracted health professionals operating under the ACare WA framework.

Definitions

- Clinical Handover: The transfer of professional responsibility and accountability for some or all aspects of care for a client.
- ISBAR: A structured communication tool used for clinical handover: Identify, Situation, Background, Assessment, Recommendation.
- Handover Note: A written summary used during shift changes or service handovers.

Policy Statement: ACare WA is committed to high-quality, structured clinical handovers to support safe, consistent, and person-centred care. All handovers must be timely, accurate, and aligned with client goals and clinical needs.

Handover Scenarios Structured handovers must occur:

- At shift changes between RNs or ENs
- When transferring care responsibility (e.g., weekend agency, after-hours services)
- After hospital discharge or significant health changes
- When involving external clinicians (e.g., GP, OT, palliative nurse)
- At entry or exit from the service

ISBAR Framework for Verbal and Written Handover. All handovers must follow the ISBAR model:

- **I** – Identify: Client name, DOB, RN/EN name and role
- **S** – Situation: Reason for handover or clinical issue
- **B** – Background: Relevant health history, diagnoses, services in place
- **A** – Assessment: Current clinical status, medications, risks, or concerns
- **R** – Recommendation: Required actions, follow-ups, referrals, next review

Documentation Requirements

- Handover notes must be documented in the clinical record
- Emails or SMS handovers must be copied or attached to the client file (where appropriate and privacy-compliant)
- All external correspondence (e.g., GP reports, discharge summaries) must be uploaded to the system and noted in progress notes

Client and Family Communication

- Clients and carers must be informed when care shifts or new team members are introduced
- Any client preference for communication (e.g., landline, face-to-face) must be respected
- Interpreter use is required if English proficiency is limited

Escalation and Risk Communication

Urgent clinical concerns must be:

  - Reported verbally to the most senior clinician on duty
  - Documented clearly and flagged in the client's notes
  - Escalated to a GP or emergency services if required
- Any care refusal, change in condition, or safeguarding concern must be communicated same day

Allied Health and External Provider Handover

- Use structured clinical referral templates where possible
- Include all relevant attachments (e.g., assessments, photos, care plans)
- Confirm receipt of information by the external provider
- Training and Competency

- All clinical staff must be trained in the use of **ISBAR** and clinical communication protocols
- Annual competency reviews will assess:
- Use of handover documentation
- Ability to convey information clearly under pressure
- Responsiveness to follow-up communication

Related Policies

- Risk and Incident Management Policy
- Cultural and Linguistic Diversity (CALD) Support Policy
- Clinical Assessment and Care Planning Policy
- Emergency Preparedness Plan

References

- Australian Commission on Safety and Quality in Health Care – Clinical Handover Protocols
- Aged Care Quality Standards (Standard 3 and 6)
- ACare WA Privacy and Documentation Policy
- ISBAR Clinical Communication Toolkit – SA Health

Uridome (Condom Catheter) Application and Management Procedure

Purpose

This instruction provides step-by-step guidance to clinical and care staff on the correct application, management, and removal of a uridome (also known as a condom catheter) in a community setting. It ensures comfort, dignity, infection prevention, and effective urinary drainage.

Scope

Applies to Registered Nurses (RNs), Enrolled Nurses (ENs), and trained Personal Care Workers (PCWs) under clinical supervision, providing continence care to male clients.

Equipment Required

- Appropriate size uridome (as per client fitting guide)
- Measuring tape or size guide
- Non-powdered gloves
- Mild soap and warm water or cleansing wipes
- Towel or cloth for drying
- Skin prep wipe or barrier wipe (if required)
- Leg or night drainage bag and tubing
- Securement strap or Velcro tape (if not built-in)

Step-by-Step Instructions

1. Preparation

- Explain the procedure to the client and ensure privacy and consent.
- Wash hands and apply gloves.
- Assess the penis for any irritation, wounds, or infections. Do not proceed if skin is compromised—refer to RN or GP.

2. **Hygiene and Sizing**

- Gently wash and dry the penis. Ensure the skin is clean and dry before application.
- Measure the penile shaft at the base to determine the correct uridome size. Use manufacturer's guide.
- If using skin barrier wipes, allow to dry completely before proceeding.

3. **Application**

- Open the uridome package and unroll the sheath halfway.
- Gently place the sheath over the glans (tip) and unroll evenly down the shaft. Ensure no wrinkles or tightness.
- Leave a 1–2 cm space between the tip of the penis and the end of the uridome to allow free flow of urine.
- Secure the uridome in place using the integrated adhesive or provided securing strip (avoid tight compression).

4. **Connection to Drainage**

- Attach the end of the uridome to the tubing of the leg or night bag.
- Ensure the tubing is not kinked and the bag is positioned below bladder level to allow gravity drainage.

5. **Monitoring and Maintenance**

- Check hourly (initially) for flow, leaks, and skin condition.
- Replace uridome every 24 hours or as per manufacturer's guidelines.
- Clean the area during daily personal care.
- Monitor for:
  - Swelling or redness
  - Leakage or detachment
  - Pressure injury or skin maceration

6. Removal

- Gently roll off the uridome from the base upward.
- If adhesive is strong, use warm water or adhesive remover wipe to ease removal.
- Wash and dry the penis.

Clinical Considerations

- Do not use on uncircumcised men without retracting and cleaning under the foreskin first, then returning it to its natural position.
- Avoid use in clients with:
  - Latex allergy (use silicone versions)
  - Severe penile retraction or deformity
  - Open wounds on genital area
- Always document application, condition of skin, size used, and any adverse signs.

References

- Continence Foundation of Australia
- Manufacturer Instructions for Use
- ACare WA Continence Management Policy

Appendices

Appendix A - Procedures

- ACWA CSP2240 - Uridome Application and Care – Procedure

Review Period: Annually or as new products/protocols are introduced.

Continence Care Policy and Procedure – ACare WA Community Nursing Services

Purpose and Scope

To provide guidance on the safe, respectful, and effective management of continence care within ACare WA's community nursing services. This policy applies to nurses, care coordinators, and support staff involved in assessment, care planning, and implementation of continence strategies.

Key Components of the Policy

1. Assessment and Care Planning

- Complete a continence assessment as part of the nursing intake.
- Identify causes of incontinence (e.g., mobility, cognitive decline, medication).
- Use bladder/bowel diaries where appropriate.
- Collaborate with GPs or continence specialists as needed.

2. Interventions

- Prompted toileting and bladder retraining
- Use of appropriate products (pads, uridomes, commodes, night bags)
- Perineal hygiene and regular toileting routines

3. Skin Integrity and Infection Prevention

- Conduct daily skin checks
- Apply barrier creams as needed
- Follow standard precautions per Infection Control Policy

4. Product Use and Storage

- Products must be stored in a dry, clean area away from contaminants
- Single-use products (pads, gloves, wipes) must be disposed of in clinical waste
- Refer to Appendix A for fitting uridome guidance

5. Support Worker Delegation

- Personal Care Workers (PCWs) may assist with pad changes and hygiene if trained and delegated

- Tasks requiring clinical judgement (e.g., uridome fitting, catheter care) must be conducted or supervised by a nurse

6. Red Flags for Referral or Escalation

- Sudden change in continence status
- Burning, odour, or blood in urine
- Repeated UTIs
- Pain or discomfort
- Concerns about product fit or skin breakdown

7. Financial Assistance and Product Access

- Refer eligible clients to:
  - Commonwealth Continence Aids Payment Scheme (CAPS)
  - WA Continence Aids Assistance Scheme (CAAS)
- Clients may also be referred to continence clinics or nurse specialists

8. Privacy and Dignity

- Always maintain privacy during toileting or pad changes
- Use language that is sensitive and respectful
- Seek consent before all continence care procedures

9. Documentation Requirements

- Document:
  - Continence status and product used
  - Care provided and client tolerance
  - Skin condition and hygiene
  - Any escalation or referral

10. Staff Training

- PCWs must complete continence care training
- RNs and ENs must maintain clinical competencies
- Refer to Staff Competencies and Training Policy

Appendices

Appendix A - Procedures

- ACWA CSP2205 - Health and Wellbeing - Procedure
- ACWA CSP2240 - Uridome Application and Care – Procedure

Appendix B - Guides

- ACWA CSP2250 - Continence Product Reference Guide

Appendix C - Templates

- Continence Assessment Template
- Bowel/Bladder Diary Template

References

- Aged Care Quality Standards (Standards 3 and 7)
- Continence Foundation of Australia
- WA Continence Aids Assistance Scheme (CAAS)
- Commonwealth Continence Aids Payment Scheme (CAPS)
- ACare WA Infection Control Policy
- ACare WA Safeguarding and Abuse Prevention Policy
- ACare WA Clinical Governance Framework

Next Review: August 2026

Section 6

Risk Management

Risk Management Policy and Procedure

Purpose and Scope

The purpose of this policy and procedure is to establish a structured framework for identifying, assessing, managing, and mitigating risks to ensure the safety, well-being, and quality of care for clients and staff. This policy aims to support compliance with the Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers and the Aged Care Quality Standards.

This policy applies to all staff, clients, contractors, and stakeholders involved in the delivery of community nursing services and extends to all activities and environments where care is provided.

Policy Statement

We are committed to fostering a proactive risk management culture that ensures compliance with legal, regulatory, and contractual obligations. Risk management processes will align with the principles outlined in AS ISO 31000:2018 Risk Management – Guidelines, promoting systematic, transparent, and evidence-based practices.

We are dedicated to:

- Ensuring the health, safety, and well-being of clients, staff, and stakeholders.
- Identifying and mitigating risks that could adversely impact service delivery, quality of care, or company operations.
- Maintaining a robust clinical governance framework to oversee and manage risk effectively.
- Continuously improving risk management practices through regular reviews and staff engagement.

Procedures

1. Risk Identification

Risk identification involves proactively detecting and recording risks that may arise in clinical, operational, financial, or environmental contexts.

- Regularly identify risks through client assessments, staff feedback, audits, and environmental scans.

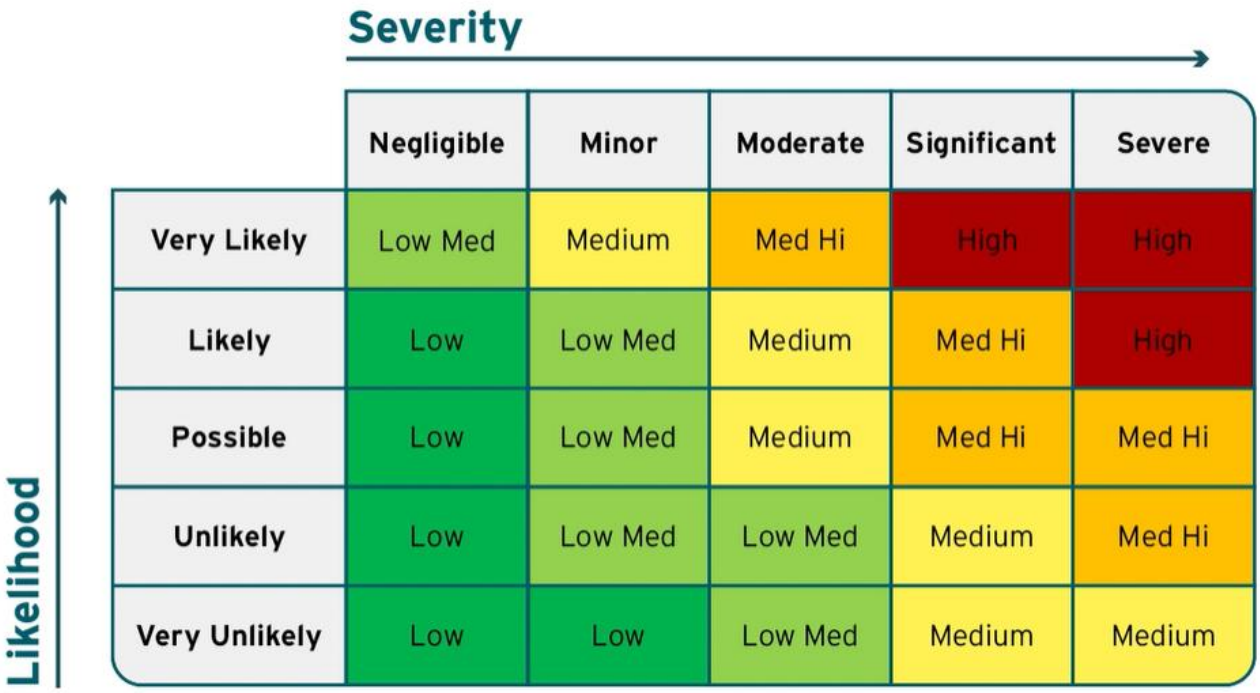
- Classify risks into categories, including but not limited to:
  - Clinical risks (e.g., medication errors, infection control breaches)
  - Operational risks (e.g., staff shortages, technology failures)
  - Financial risks (e.g., funding disruptions, cost overruns)
  - Environmental risks (e.g., physical hazards, extreme weather events)

2. Risk Assessment

Assess risks based on their potential likelihood and impact to prioritise management efforts.

- Utilise a risk matrix to rate risks on a scale of low, medium, high, or extreme.
- Document all identified risks in the Risk Register, including:
  - Risk description and category
  - Assessment of likelihood and impact
  - Assigned risk level
  - Responsible person(s) for managing the risk
  - Timeframes for action and review

Risk Assessment Matrix



3. Risk Control and Mitigation

Implement control measures to eliminate or minimise the likelihood and/or impact of identified risks.

- Develop tailored mitigation strategies, such as:
  - **Staff training** to address gaps in skills or knowledge
  - **Policy updates** to strengthen organisational procedures
  - **Process improvements** to streamline service delivery and reduce errors
- Assign clinical governance oversight for high-risk areas to ensure appropriate monitoring and intervention.
- Establish a system for escalating extreme risks to executive management and relevant authorities as needed.

4. Monitoring and Review

Risk management is an ongoing process requiring regular monitoring and review to ensure effectiveness.

- Conduct monthly risk review meetings to:
  - Evaluate the status of existing risks
  - Identify new or emerging risks
  - Review and update the Risk Register
- Perform periodic audits and surveys to assess the effectiveness of risk controls and identify areas for improvement.
- Incorporate risk management into routine **continuous improvement activities** to foster a culture of safety and compliance.

5. Reporting and Communication

Maintain open and transparent communication regarding risk management across the company.

- Share relevant risk information with staff during team meetings and training sessions to promote awareness and accountability.
- Report significant risks, including those assessed as high or extreme, to the executive team and, where applicable, external authorities (e.g., the DVA, ACQSC).
- Maintain a record of all communication and actions taken regarding risk management to ensure traceability and accountability.

6. Responsibilities

- **Executive Team:** Ensure organisational alignment with risk management objectives and approve risk management policies and mitigation plans.
- **Clinical Governance Committee:** Provide oversight for clinical risks and high-risk areas, ensuring appropriate management and escalation procedures are in place.
- **Risk Manager:** Maintain the Risk Register, coordinate risk reviews, and lead risk mitigation efforts across the company.
- **Staff Members:** Identify and report risks in their areas of responsibility, participate in training, and comply with risk management procedures.

7. Compliance and References

This policy and procedure align with the following regulatory and industry standards:

- DVA Notes for Community Nursing Providers
- Aged Care Quality Standards
- AS ISO 31000:2018 Risk Management – Guidelines
- Work Health and Safety Act 2011 (Cth)

Incident Management Policy and Procedure

Purpose and Scope

This policy ensures a structured, consistent approach to the management of incidents, accidents, and dangerous occurrences that may occur during the delivery of services in clients' homes. The objective is to maintain the safety of clients, staff, and any others present while meeting legal and regulatory obligations.

- This policy applies to all incidents, including but not limited to:
- Clinical incidents (e.g., medication errors, treatment-related harm) occurring during service delivery.
- Workplace accidents (e.g., slips, trips, and falls) at the client's home.
- Dangerous occurrences (e.g., environmental hazards, equipment malfunctions) encountered in the client's home.
- Any events involving clients, staff, or visitors at the service location.

Policy Statement

The company is committed to:

- Prompt and effective management of incidents to ensure safety and mitigate risks during in-home service delivery.
- Maintaining transparency and accountability throughout the incident management process.
- Using incident data to drive continuous improvement and minimise the likelihood of recurrence.
- Meeting all obligations under the Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers and the Aged Care Quality Standards.

Procedures

1. Incident Reporting

1.1. Immediate Reporting

- All incidents that occur in a client's home must be reported to a supervisor or manager immediately.
- Complete an Incident Report Form within 24 hours of the incident, capturing relevant details such as the time, location (client's home address), and nature of the incident, as well as those involved.

1.2. Notification to Authorities

- Reportable incidents must be promptly communicated to the DVA and any other regulatory bodies as required. Reportable incidents include:
  - Any serious harm, injury, or threat to the health, safety, or well-being of a veteran. This encompasses incidents such as abuse, neglect, assault, or significant medical events.
  - It also includes cases where a death occurs during the provision of care or is linked to the care provided.
  - Release of hazardous chemicals into the environment
  - Dangerous incident that exposes a person to serious risk, even if no injury occurs.
- For serious incidents, notify relevant authorities without delay.
  - **WorkSafe ACT**:

    Phone (Notifiable Incidents): **13 22 81** (24/7 emergency line)
  - **SafeWork NSW**

    Phone (Notifiable Incidents): 13 10 50 (24/7 emergency line)
  - **NT WorkSafe**

    Phone (Notifiable Incidents): 1800 019 115 (24/7 emergency line)
  - **Workplace Health and Safety Queensland (WHSQ)**

    Phone (Notifiable Incidents): 1300 362 128 (24/7 emergency line)
  - **SafeWork SA**

    Phone (Notifiable Incidents): 1800 777 209 (24/7 emergency line)
  - **WorkSafe Tasmania**

    Phone (Notifiable Incidents): 1300 366 322 (24/7 emergency line)
  - **WorkSafe Victoria**

    Phone (Notifiable Incidents): 13 23 60 (24/7 emergency line)
  - **WorkSafe WA**

    Phone (Notifiable Incidents): 1800 678 198 (24/7 emergency line)

Written Notification Requirements

- A written notification of the incident must be submitted to the DVA and other relevant authorities as soon as practicable and within the required timeframe.
- The notification should include a detailed description of the incident, persons involved, immediate actions taken, and any known contributing factors. Copies of incident reports, investigation reports, and any photographic evidence should be attached to the written notification.
- Written notifications must be stored securely as part of the incident records and retained for a minimum of 7 years.

1.3. Stakeholder Communication

Inform family members, guardians, or other stakeholders about the incident where appropriate, ensuring sensitivity and professionalism in all communications.

2. Incident Investigation

2.1. Assign an Investigation Team

An Incident Investigation Team will be appointed for all significant incidents. This team may include management, safety officers, and staff involved in delivering the in-home service.

2.2. Root Cause Analysis (RCA)

Conduct a thorough RCA, considering factors unique to the client's home environment:

- Physical hazards (e.g., uneven flooring, poor lighting)
- Accessibility issues (e.g., limited mobility support)
- Equipment and tools used during service delivery

2.3. Corrective Actions

Based on the investigation findings, recommend and implement corrective actions specific to in-home service settings, such as providing additional training, modifying service protocols, or addressing identified environmental risks.

2.4. Report Submission

Submit detailed investigation reports to the DVA and other required bodies within the stipulated timeframe.

3. Follow-Up Action

3.1. Support for Affected Individuals

Provide immediate support, including first aid, medical assistance, or counselling, to affected individuals in the client's home.

3.2. Monitoring and Evaluation

- Track the effectiveness of corrective actions implemented. Conduct follow-up checks to ensure safety measures remain effective.
- Assess the effectiveness of the incident management process and make corrections if necessary.

4. Preservation of Incident Site

- Following an incident, the site where the incident occurred must be preserved to allow for an effective investigation.
- No changes should be made to the incident site unless it is necessary to prevent further harm or danger.
- Where it is safe to do so, restrict access to the site by using barriers, signage, or supervision.
- Document the state of the incident site through photographs, diagrams, and written descriptions before any alterations are made.

5. Documentation and Record Keeping

5.1. Detailed Record Maintenance

- Maintain comprehensive records of all incidents, including those occurring in clients' homes, investigation findings, actions taken, and communications.
- Store records securely for a minimum of 7 years, ensuring confidentiality and compliance with privacy legislation.

5.2. Trend Analysis and Preventive Action

- Regularly review incident data to identify patterns or trends, particularly those specific to in-home service environments.
- Use insights to implement proactive measures to prevent similar incidents.

6. Compliance and Notification

6.1. Regulatory Compliance

Follow all applicable regulatory requirements, including those outlined in the ***Aged Care Quality Standards*** and workplace health and safety legislation.

6.2. Stakeholder Notification

Notify relevant parties, including clients, families, and authorities, promptly and appropriately.

7. Responsibilities

- **Staff Members:**
  - Report all incidents promptly and accurately.
  - Adhere to specific safety protocols for in-home service delivery.
  - Participate in investigations and corrective actions as required.
- **Supervisors and Managers**:
  - Ensure incidents are managed effectively and in accordance with this policy.
  - Facilitate communication with affected parties and regulatory bodies.
- **Incident Investigation Team:**
  - Conduct thorough investigations and recommend preventive measures.
  - Ensure compliance with all reporting and documentation requirements.
- **Executive Leadership:**
  - Oversee the implementation of this policy and ensure organisational adherence.
  - Use incident reports to guide continuous improvement efforts.

Emergency Management Policy and Procedure

Purpose and Scope

To ensure the staff is fully prepared and capable of providing a coordinated, effective, and timely response to emergencies while safeguarding the health, safety, and wellbeing of clients, staff, and visitors in home-based care settings. This policy also ensures continuity of care during emergencies in clients' homes.

This policy applies to all staff delivering services in clients' homes and encompasses all potential emergencies, including but not limited to medical emergencies, natural disasters, fire incidents, pandemics, and other critical situations that may arise during the provision of care.

Policy Statement

We are committed to maintaining a robust emergency management procedure that adheres to all legal and regulatory requirements. The procedure will ensure a proactive approach to emergency preparedness, response, and recovery for home-based care services while prioritising the continuity of care and minimising risks to clients and staff.

An emergency is a situation of grave risk to health, life or environment. A disaster is any phenomenon, natural or man-made, that has the potential to cause extensive destruction of life and property.

Disasters and emergencies include:

- flood
- fire
- heatwave
- snowstorm
- storms or cyclones
- pandemic

Procedures

1. Emergency Preparedness

- **Risk Assessment:**
  - Conduct regular risk assessments to identify potential emergency scenarios relevant to home-based care, including medical emergencies and home-specific hazards (e.g., fire risks, accessibility issues).
  - Evaluate each client's home environment for potential risks during the initial assessment and review this information periodically.
  - Keep a register of clients at risk including client contacts and next of kin.
- **Emergency Equipment and Resources:**
  - Provide staff with portable emergency kits that include:
    - First aid supplies.
    - Contact lists for emergency services and organisational support.
    - Relevant client information, such as emergency contacts and medical alerts.
- **Emergency Contact List:**
  - Maintain an updated contact list of:
    - Emergency services (fire, police, ambulance).
    - Register of clients, client emergency contacts and next-of-kin.
- **Communication Channels:**
  - Ensure staff have access to reliable communication devices (e.g., mobile phones) during home visits.
  - Use multiple communication channels (e.g., SMS alerts, direct calls) to notify staff and clients of emergencies.

2. Staff Training:

- Conduct mandatory training for all staff annually on:
  - Recognising and responding to emergencies in clients' homes.
  - Administering first aid, managing fire risks, and evacuation procedures tailored to home environments.
- Include scenario-based training for emergencies that may arise during home visits
- Train staff on safe evacuation techniques for clients in various home environments, including those with mobility challenges.
- Provide staff with guidance on managing shelter-in-place situations in clients' homes, such as during severe weather events or external threats.
- Ensure clients and staff understand how to identify safe areas in the home and access necessary supplies.

3. Responding to Emergencies in Clients' Homes

3.1. How to Safely Evacuate Clients If Necessary

Step 1: Assess the Situation

- Determine the nature and severity of the emergency.
- Evaluate the immediate risks to the client and staff (e.g., fire, structural damage, gas leak).

Step 2: Initiate Evacuation

Follow these steps to ensure a safe and efficient evacuation:

a. **Inform the Client:** Calmly explain the situation and the need to evacuate. Provide clear, simple instructions tailored to their needs (e.g., visual aids or step-by-step guidance for clients with cognitive impairments).

b. **Assist the Client:** If the client has mobility challenges, use appropriate techniques to assist them. For example:
   - Use mobility aids (e.g., walkers, wheelchairs) if available.
   - Employ safe lifting techniques if the client requires physical assistance.

c. **Gather Essentials:** Quickly grab necessary items, such as medications, identification, and a phone, if it is safe to do so.

d. **Follow Pre-Identified Routes:** Use the safest and most direct evacuation route identified during the initial home risk assessment. Avoid elevators if the home has them.

Step 3: Move to Safety

- Take the client to a safe location outside the home, such as a designated assembly point or a safe neighbour's house.
- Ensure both staff and the client are clear of potential hazards (e.g., debris, smoke).

Step 4: Contact Emergency Services (if not already done)

- Provide the address and a description of the emergency.
- Inform emergency personnel of the client's condition, mobility status, and any special requirements.

3.2. When to Call Emergency Services

- **Immediate Situations Requiring Emergency Services:**
  - Fire, gas leak, flood, or other structural hazards.
  - Life-threatening medical emergencies, such as chest pain, difficulty breathing, unconsciousness, severe bleeding, or suspected stroke.
  - External threats, such as intruders or violent behaviour.
- **Steps for Calling Emergency Services:**
  - **Dial 000** and request the appropriate service (fire, ambulance, police).
  - Follow the operator's instructions and remain on the line until told to hang up.
- **Non-Emergency Situations:**
  - For less critical issues (e.g., minor injuries, property damage), contact the appropriate local non-emergency number for advice.

3.3. How to Communicate with the Client and Their Family or Emergency Contact

Step 1: During the Emergency

- **With the Client:**
  - Use calm, clear, and reassuring language to explain what is happening.
  - Tailor communication to the client's needs, considering language, sensory impairments, or cognitive abilities.
  - Provide simple, step-by-step instructions.
- **With Emergency Contacts:**
  - If safe to do so, contact the client's family or emergency contact immediately after ensuring the client is safe.
  - Provide the following information:
    - The nature of the emergency.
    - The actions taken (e.g., evacuation, medical assistance).
    - The client's current location and condition.

Step 2: After the Emergency

- **With the Client:**
  - Provide updates about the situation and actions being taken to resolve it.
  - Address any questions or concerns they may have.
  - Offer emotional support or referrals for counselling services if needed.
- **With the Family or Emergency Contact:**
  - Update them on the client's status and the resolution of the emergency.
  - Provide information about next steps, such as arranging alternative care or temporary accommodation if necessary.

Step 3: Document the Incident

- **Complete an incident report detailing:**
  - The nature of the emergency.
  - Actions taken by staff, including communication efforts.
  - Outcomes and follow-up steps.

Step 4: Follow-Up Communication

- **Check in with the client and their family/emergency contact within 24-48 hours to:**
  - Address any ongoing concerns.
  - Provide updates on additional steps being taken (e.g., repairs, additional assessments).

4. **Post-Emergency Emergency Contact List:**

- **Debriefing and Review:**
  - Conduct post-emergency debriefings with staff involved in home-based emergencies to identify lessons learned and areas for improvement.
  - Document findings and update the emergency management procedures as needed.
- **Support for Clients and Staff:**
  - Provide access to counselling and support services for clients and staff impacted by the emergency.
  - Communicate with clients and families to address concerns and provide updates on service continuity.
- **Continuous Improvement:**
  - Review and update the emergency management procedures annually or after any significant event.
  - Incorporate feedback from staff and clients into future training and plan development.

Emergency Contact List

How and when to call the emergency services in Australia:

Triple Zero (000)

Triple Zero (000) is Australia's main emergency service number. You should call 000 if you need urgent help from police, fire or ambulance services.

Telstra answers calls to the emergency service numbers 000 and 112 and transfers the call, and information about your location, to the emergency service you request.

- You should only call 000 when:
- someone is seriously injured or in need of urgent medical help
- your life or property is being threatened
- you have just witnessed a serious accident or crime
- If a situation is not urgent, you should look up the number of your local police, fire or ambulance service.

Other emergency service numbers

Australia also has 2 other emergency service numbers, but they only work on some services:

- **112** can only be dialled on a mobile phone
- **106** can only be used with a teletypewriter (TTY) or a device for the deaf. 106 is a text-based emergency service number for people who are deaf, or who have a hearing or speech impairment

State Emergency Service (SES)

You cannot contact the SES by dialling **000**. Calls to **000** can only be transferred to police, fire or ambulance services.

The phone number for all SES units is **132 500**.

Work Health and Safety (WHS) Policy and Procedure

Purpose and Scope

This policy outlines the company's commitment to fostering a culture of safety and providing clear guidelines for managing risks in community nursing services delivered at clients' homes.

This policy and procedure apply to all employees, contractors, and visitors at all workplaces where services are provided.

This policy is developed in compliance with the following legislation and guidelines:

- Work Health and Safety Act 2011
- Work Health and Safety Regulations 2011
- Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers

Procedures

1. WHS Responsibilities

1.1. Management Responsibilities

- Ensure compliance with WHS laws, regulations, and standards.
- Provide training, information, and supervision to employees to ensure safe work practices are followed.
- Conduct regular risk assessments and safety audits for all client home environments where services are provided.
- Ensure incidents, hazards, and near-misses are reported, investigated, and addressed promptly.
- Promote a culture of continuous improvement in workplace health and safety.

1.2. Employee Responsibilities

- Comply with all WHS policies, procedures, and safe work practices.
- Take reasonable care of their own health and safety and that of others.
- Report any incidents, hazards, or unsafe practices to management.
- Participate in WHS training and follow instructions for safe work practices.
- Use personal protective equipment (PPE) as required.

1.3. Client and Family Responsibilities

- Ensure the home environment is free from foreseeable hazards that may endanger the health and safety of nursing staff.
- Notify the nursing provider of any known hazards or risks in the home environment.

2. Hazard Identification

2.1. Routine Inspections:

- Conduct regular inspections of client homes to identify potential hazards such as:
  - Slippery floors
  - Inadequate lighting
  - Trip hazards
  - Unsafe equipment or environments
- Document findings using a hazard identification checklist.

2.2. Incident Reporting:

- Promptly report hazards and incidents through the designated reporting system.
- Review and investigate incident reports to identify systemic issues.

2.3. Client-Specific Risks:

- Assess unique risks associated with individual client needs and home environments, including:
  - Mobility challenges
  - Exposure to hazardous materials
  - Unsafe handling of medical equipment

3. Risk Assessment and Control

3.1. Risk Assessment:

- Prioritise hazards based on the severity of potential harm and likelihood of occurrence.
- Use a risk assessment matrix to categorise risks into high, medium, or low levels.

3.2. Control Measures:

- Implement controls following the Hierarchy of Controls:
  - **Elimination:** Remove the hazard, such as repairing unsafe furniture or equipment.
  - **Substitution:** Use safer alternatives, such as non-slip mats.
  - **Engineering Controls:** Provide assistive devices like hoists for manual handling.
  - **Administrative Controls:** Develop safe work procedures specific to community nursing tasks.
  - **Personal Protective Equipment (PPE):** Ensure staff have access to and use appropriate PPE (e.g., gloves, masks, gowns).

3.3. Client Collaboration:

- Work with clients and their families to address hazards identified within their homes.

4. Training and Education

4.1. Onboarding and Refresher Training:

- Deliver comprehensive WHS training for new staff during onboarding.
- Provide annual WHS refresher courses covering:
  - Hazard identification
  - Safe handling of medical equipment
  - Infection control and prevention

4.2. Toolbox Talks:

- Conduct monthly toolbox talks addressing common hazards and safety strategies in community nursing, such as:
  - Manual handling techniques
  - Safe disposal of sharps
  - Emergency procedures

4.3. Client Awareness:

- Educate clients and their families on their role in maintaining a safe home environment.

5. Incident Response

5.1. Reporting and Investigation:

- Require immediate reporting of all incidents, injuries, and near misses using the company's WHS Incident Report Form.
- Investigate incidents to:
  - Identify root causes
  - Document findings in an Incident Report

5.2. Corrective Actions:

- Develop and implement action plans to address identified risks.
- Monitor the effectiveness of corrective actions.

5.3. Support for Affected Individuals:

- Provide support to employees, clients, or others affected by incidents, including access to counselling services if necessary.

6. Monitoring and Continuous Improvement

6.1. Performance Monitoring:

- Collect and analyse WHS data, including incident trends and hazard reports, to assess the effectiveness of safety measures.
- Use KPIs, such as incident response times and reduction in hazards, to track progress.

6.2. Annual Review:

- Review WHS policies and procedures annually to ensure they reflect:
  - Current legislation
  - Industry best practices
  - Feedback from employees and clients

6.3. Staff and Client Feedback:

- Solicit regular feedback from employees and clients to identify potential improvements in WHS practices.
- Actively involve staff in safety discussions and decision-making.

Section 7

Information Management

Purpose and Scope

This policy outlines the principles and practices for managing information, privacy, documentation, and record-keeping to ensure compliance with the DVA Notes for Community Nursing Providers, Aged Care Quality Standards, and relevant Australian privacy laws. The policy ensures that all client information is managed confidentially, securely, and in accordance with legal and regulatory requirements.

This policy applies to all staff, contractors, and third-party service providers involved in community nursing services provided to clients in their homes.

Key Legislative and Regulatory Frameworks

- Privacy Act 1988 (Cth)
- Australian Privacy Principles (APPs)
- Aged Care Quality Standards
- DVA Notes for Community Nursing Providers
- State and Territory Health Records Acts

Procedures

1. Privacy and Confidentiality

1.1. Collection of Information

- Collect only information necessary for the delivery of high-quality community nursing services.
- Obtain informed consent from clients before collecting any personal or health information.

1.2. Use and Disclosure

- Use client information solely for its intended purpose or as required by law.
- Share information only with authorised personnel or as agreed upon with the client.

1.3. Access and Correction

- Allow clients access to their information upon request, in compliance with the APPs.
- Correct inaccuracies in client records promptly.

1.4. Breach Management

Report and investigate any data breaches in line with the Notifiable Data Breach Scheme.

2. Documentation Standards

2.1. Timeliness

Document all client interactions and care provided immediately or within 24 hours.

2.2. Accuracy

- Ensure documentation is clear, factual, and free from errors.
- Avoid subjective or personal opinions unless relevant to care.

2.3. Professionalism

Use professional language and approved abbreviations in all documentation.

2.4. Client Involvement

Engage clients in documenting care plans and service agreements whenever possible.

3. Record-Keeping and Management

3.1. Types of Records

3.1.1. Client Records

All records and information related to the client and the care service provision are categorised as client records. Client records include:

- valid referrals
- assessments
- nursing care plans
- clinical nursing notes
- dated reviews of care and the outcomes
- related care documentation
- claiming history

3.1.2. Staff Records

- All information related to the workers and employees is categorised as staff records. These include:
- Employment Agreement
- Performance Appraisal
- Background Checks
- Academic Records or Degrees
- Certification or Licensing Records

3.1.3. Governance Records

All company related documentation is categorised as governance records. This includes:

- Policies and procedures, protocols, templates
- Business plan
- Reports
- Compliance records
- Risk register

3.1.4. Financial Records

Financial records include:

- Annual Budget
- ACFR and QFRs
- P&L Reports
- Monthly Expense Reports

3.2. Storage

- Store all records securely in locked filing systems or encrypted electronic databases.
- Back up electronic records daily to prevent data loss.

3.3. Retention

- Retain records for at least seven years or as required by law.
- Ensure secure destruction of records no longer required.

3.4. Access Control

- Restrict access to client records to authorised personnel only.
- Implement role-based access controls for electronic records.

3.5. Auditing and Monitoring

- Regularly audit records to ensure compliance with documentation and privacy standards.

4. Staff Training

4.1. Provide all staff with mandatory training on:

- Privacy laws and principles.
- Documentation and record-keeping practices.
- Reporting and managing data breaches.

4.2. Conduct annual refresher courses and updates on changes to regulations or company policies.

5. Continuous Improvement

5.1. Feedback Mechanisms

- Collect feedback from clients and staff regarding information management practices.
- Use feedback to improve processes and policies.

5.2. Policy Review

- Review this policy annually or following significant legislative changes.
- Engage stakeholders, including staff and clients, in the review process.

References

- Privacy Act 1988 (Cth)
- Australian Privacy Principles (APPs)
- Aged Care Quality Standards
- DVA Notes for Community Nursing Providers
- Notifiable Data Breaches Scheme (Office of the Australian Information Commissioner)
- Data Retention and Disposal Guidelines

Section 8

Feedback and Complaints Management

Purpose and Scope

The purpose of this policy and procedure is to establish a clear, accessible, and professional approach to managing feedback and complaints related to the delivery of nursing care to Veteran Card Holders.

This policy applies to all staff involved in providing or supporting nursing care services, including administrative staff, nursing staff, and management. It is designed to address feedback and complaints from clients, their families, carers, and other stakeholders.

Policy Statement

The company values and encourages feedback, both positive and negative, as it is essential for improving the quality of care and service delivery. All complaints will be handled respectfully, fairly, and confidentially, with a focus on resolving issues effectively and implementing improvements to enhance client satisfaction.

Definitions

- **Feedback:** Any comment, suggestion, or compliment provided by a client or stakeholder that is not a complaint but provides insights into service delivery.
- **Complaint:** Any expression of dissatisfaction by a client or stakeholder about the quality of care or services provided, or any other aspect of the company's operations.
- **Complainant:** The individual or representative providing the complaint.
- **Resolution:** The process of addressing a complaint to the satisfaction of the complainant and the company.

Procedure

1. Feedback Collection and Documentation

1.1. Receiving Feedback

- Encourage clients, families, and carers to provide feedback through multiple channels, such as verbally during visits, via email, or through feedback forms provided in client welcome packs or on the company website.
- Accept feedback graciously and thank the individual for their input.

1.2. Documenting Feedback

- All feedback, including compliments, suggestions, and observations, must be documented in the client's file and the feedback log by the receiving staff member.
- The feedback log should be reviewed periodically to identify potential service improvements.

2. Complaints Management Process

2.1. Receiving a Complaint

- Listen to the complaint respectfully, acknowledging the client or representative's concerns.
- Record the details of the complaint, including:
  - Complainant's name, relationship to the client, and contact details.
  - Date and time the complaint was received.
  - Description of the issue or concern.
  - Desired resolution, if stated by the complainant.

2.2. Complaint Acknowledgment

- Acknowledge the complaint in writing within 48 hours, expressing appreciation for bringing the concern to our attention and providing information on the next steps in the resolution process.
- Provide contact information for further communication and the expected timeframe for resolution.

2.3. Assessment and Investigation

- The designated staff member will assess the complaint to determine its nature and urgency.
- Investigate the issue by:
  - Reviewing relevant documentation, including the client's care records.
  - Interviewing any involved staff members.
  - Collecting any additional information needed for a thorough understanding of the issue.

2.4. Resolution and Response

- Based on the investigation, determine an appropriate course of action to resolve the complaint.
- Communicate the resolution to the complainant within 14 days of receiving the complaint. If additional time is needed, inform the complainant of the expected resolution date.
- Resolution may include actions such as:
  - An apology or acknowledgment of error.
  - Corrective actions (e.g., adjustments to care plans or staff reassignment).
  - Process improvements to prevent recurrence of the issue.
- Document the resolution in the complaints log, noting the resolution date and outcome.

3. Escalation and External Review

3.1. Internal Escalation

- If the complainant is not satisfied with the initial response, offer to escalate the complaint to a senior manager.
- The senior manager will review the complaint and provide a final decision on the matter.

3.2. External Review Options

- If the complainant remains dissatisfied, inform them of their right to escalate the complaint externally, such as to the DVA or an appropriate ombudsman.
- Provide contact details and guidance on accessing these resources.

4. Documentation and Record-Keeping

4.1. Complaints Log

- Maintain a secure, centralised complaints log documenting:
  - Date and time the complaint was received
  - Complainant's details and relationship to the client
  - Description of the complaint

- Actions taken and resolution details
- Date the complaint was resolved

- Review the complaints log periodically to identify patterns or recurring issues and implement service improvements as needed.

4.2. Client Record Documentation

- Ensure that all complaints and feedback related to a client's care are recorded in their file and referenced in care reviews if applicable.

5. Continuous Improvement

- Management will review feedback and complaints data regularly to identify trends, areas for improvement, and opportunities for staff training.
- Summarise trends in periodic reports to inform staff about service improvements and encourage ongoing quality enhancement.

6. Staff Training and Compliance

- All staff must receive training on this Feedback and Complaints Management Policy and Procedure during onboarding and through annual refresher training.
- Training will include skills in handling complaints, respecting client perspectives, and following the documentation and resolution process.

Section 9

Version History

Version	***Revised By***	***Review Date***	***Amendments***
1.0	MR, PT	15/03/2025	Initial Draft
1.1	MR, PT	01/04/2025	First Review
1.2	MR, PT	22/05/2025	Second Review
1.5	MR, PT	29/05/2025	Third Review
1.75	MR, PT	05/06/2025	Fourth Review
2.0	MR, PT	12/06/2025	Fifth Review
2.15	MR, PT	25/06/2025	Sixth Review
2.25	MR, PT	08/07/2025	Seventh Review
2.5	MR, PT	22/07/2025	Eight Review
2..7	MR, PT	31/07/2025	Nineth Review
2..8	MR, PT	06/08/2025	Final

Section 10

Appendix A - Procedures

Procedures

The following Procedures are supplied as a ZIP file:

- ACare WA - Emergency Response Policy and Subcontractor Guide for Support & Clinical Staff via Mable.pdf
- ACare WA - Working Expectations for Support & Clinical Staff via Mable.pdf
- **ACWA CSP2205** - Health and Wellbeing Procedure.pdf
- **ACWA CSP2210** - PPE for Support Activities.pdf
- **ACWA CSP2240** - Uridome Application and Care - Procedure.pdf
- **ACWA CSP2255** - Responding to Unexplained Bruising or Injury - Procedure.pdf

Section 11

Appendix B - Guides

Guides

The following Guides are supplied as a ZIP file:

- ACWA CSP2250 - Continence Product Reference Guide.docx
- PAS Test - Blank.pdf
- PAS User-Guide.pdf

Section 12

Appendix C - Templates

Templates

The following Templates are supplied as a ZIP file:

- ACare WA - Consent to Care and Emergency Contact Form.pdf
- ACare WA - Medication Administration Record (MAR) Sheet.pdf
- ACare WA - PRN Medication Protocol.pdf
- ACare WA – Contact & Emergency Information (For Home Care Clients).pdf
- **ACWA CSP2215** - Health Plan Essentials Checklist.pdf
- **ACWA CSP2235** - Personal Care Plan.pdf
- **ACWA CSP2280** - Bowel Movement Log.pdf
- Audit Schedule Template.docx
- Continence Assessment.docx

DVA Government Forms

- Incident Register.xlsx
- Incident Report Form.docx
- Infection Control Checklist.docx
- Risk Assessment Form.docx
- Risk Register.docx
- Waste Disposal Log .xlsx

Section 13

Appendix D - Declarations

Declarations

The following Declarations are supplied as a ZIP file:

- **ACWA CSP2200** - Support Plan Staff Declaration.pdf

Section 14

Appendix E - Onboarding

Onboarding

The following Onboarding documents are supplied as a ZIP file:

- ACare WA Onboarding Form_2025_v1.docx
- ACare WA pricing schedule V7 Apr 2025.pdf
- Clients Register.docx
- Community Nursing Care Plan Template.docx
- Complaints Log.xlsx
- DVA Guidance on Community Nursing Care Plans.docx
- DVA_Community Nursing Referral Form.pdf
- Staff Induction Checklist .docx

ACare WA

Smart Choice Local Care