VILLAGE BAXTER

every person cared for, every person valued

Policy Number:	101
Title:	Standard 1 – Dignity and Choice
Owner:	Director of Nursing
Review Date:	December 2022 **Policy Risk Rating:** Low

1. PURPOSE

To recognise the importance of the Resident's sense of self and being able to act independently, make their own choices and take part in their community as part of fostering social inclusion, health and well-being.

2. **POLICY**

Village Baxter will provide care and services that

a) Maintain a culture of inclusion and respect for Residents; and
b) Support Residents to exercise choice and independence; and
c) Respect Residents' privacy

To enable Residents or their representatives to be able to confirm that they are

a) treated with dignity and respect; and
b) can maintain their identity; and
c) make informed decisions about their care and services; and
d) live the life they choose.

3. PROCEDURE

Relevant Assessments & procedures

- Pre-application meeting with Admissions Coordinator
- Pre-admission meeting with Don or Senior RN
- Leecare form: Life story Assessment
- Leecare form: Resident / Client details Assessment
- Diversity plan
-

How we provide information to Residents and Representatives

- Pre-application meeting with Admissions Coordinator
- Pre-admission meeting with DON or Senior RN
- Charter of Aged Care Rights contained in Contract documents, welcome kit and on notice boards
-

How we educate and inform our workforce

- Charter of Aged Care Rights on Staff noticeboards and in welcome kit
- Friday five update provided to Staff July 2022 focused on Standard 1

Compliance Monitoring

- Leecare report: Life Story Completion Audit

-

Governance

- Resident survey results reported to CEO monthly and included in Board Clinical Governance Report
-

4. RELATED POLICIES AND DOCUMENTS

This section of our Policy Manual is moving to the Complicare platform, Please follow the links below

- Communicating with **Consumer**s
- Decision-Making
- Dignity and Choice
- Emotional Support
- Independence
- Risk Taking
- Spirituality
- Anti-Discrimination
- Diversity and Inclusion
- LGBTIQA+
- Sexuality, Intimacy and Sexual Expression

Policy Number:	102		
Title:	Standard 2: Ongoing Assessment and Planning		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	Low

This section of our Policy Manual is moving to the Complicare platform, Please follow the links below

Ongoing Assessment and Planning with is Standard 2 of the Aged Care Quality Standards.

This section of our includes the following policies and procedures:

- Inquiry and Admission
- Security of Tenure
- Assessment and Planning Care
- Care and Services Planning
- Advance Care Planning
- Palliative and End of Life Care
- Voluntary Assisted Dying (VAD) Policy and Procedures

Policy Number:	102
Title:	Standard 2 – Assessment and Planning
Owner:	Director of Nursing
Review Date:	December 2022 **Policy Risk Rating:** Low

1. PURPOSE

To ensure that planned care and services meet each consumer's needs, goals and preferences and optimise their health and well-being

2. POLICY

Village Baxter will provide care and services that

a. Include initial and ongoing assessment and planning for care and services in partnership with consumers; and

b. Focus on optimising health and wellbeing in accordance with consumer needs, goals and preferences.

To enable Residents or their representatives to be able to confirm that they are

a. Included in their assessment and planning; and

b. Get the care and services they need for their health and wellbeing.

3. PROCEDURE

This section of our Policy Manual has moved to Complicare,
Please follow the links below

Ongoing Assessment and Planning with is Standard 2 of the Aged Care Quality Standards. This section of ourCare Module includes the following policies and procedures:

- Inquiry and Admission
- Security of Tenure
- Assessment and Planning Care
- r Care and Services Planning
- Advance Care Planning
- Palliative and End of Life Care
- Voluntary Assisted Dying (VAD) Policy and Procedures

Relevant Assessments & procedures

- Leecare forms located under the "Assessments / Plans" tab
- Leecare forms located under the "Admission Assessment" tab
- Leecare forms located under the "Care Evaluation" tab

How we provide information to Residents and Representatives

- Pre-application meeting with Admissions Coordinator
- Pre-admission meeting with DON or Senior RN

- Family and Resident meetings
- Resident of the Day contact
- Providing copies of medication charts and care plans to Residents and Representatives

How we educate and inform our workforce

- Friday 5 update to staff in July 2022 focused on Standard 2
- Staff education and orientation procedures
- Toolbox training

Compliance Monitoring

- Documentation audits of form completion in Leecare
- Resident satisfaction

Governance

- Audit results reported to CEO monthly and included in Board Clinical Governance Report

4. **RELATED POLICIES AND DOCUMENTS**

Policy Number:	103
Title:	Standard 3 – Personal & Clinical Care
Owner:	Director of Nursing
Review Date:	December 2022 **Policy Risk Rating:** Low

1. PURPOSE

Purpose is to ensure that personal and clinical care is safe, effective and meets the Residents needs.

2. POLICY

Village Baxter will provide care and services that

a. Include initial and ongoing assessment and planning for care and services in partnership with consumers; and

b. Focus on optimising health and wellbeing in accordance with consumer needs, goals and preferences.

To enable Residents or their representatives to be able to confirm that they are

a. Included in their assessment and planning; and

b. Get the care and services they need for their health and wellbeing.

3. PROCEDURE

- **This section of our Policy Manual is moving to the Complicare platform,**
- **Please follow the links below**
-
- **Personal Care**
- Dysphagia and Meal Assistance
- Oral and Dental
- Nutrition and Hydration
- Sleep Management
- Sensory Loss Management
- Hot and Cold Packs
- Manual Handling
-
- **Clinical Care**
-
- Anaphylaxis Management
- Blood or Body Substance Exposure
- Bowel Management and Constipation
- Care Conference
- Colostomy and Ileostomy
- Continence Management
- Continuous Positive Airway Pressure & Bi-Level Positive Airway Pressure
- Death of a Consumer
- Delirium
- Deteriorating Consumer
- Diabetes Management
- Enteral Nutrition Management

- Female and Male Urinary Catheterisation
- Medication Management
- Niki T34 Pump
- Oxygen Management
- Pain Management
- Respiratory Assessment and Management
- Specialised Nursing
- Suprapubic Catheter Care and Management

- Tracheostomy Care and Management
- Vaccine Management
- Wound Management and Skin Integrity
-
- **Consumer Safety and Behaviour**
- Identifying Consumer Safety Hazards
- Procedures for Identifying, Responding, and Reporting Elder Abuse and Neglect
- Falls Prevention and Management
- Missing Consumers and Unexplained Absences
- Management of Behaviours that Require Support
- Restrictive Practices Prevention and Management
- Self-Harm and Suicide
- Management of Behaviours that Require Support
    - Management of Behaviours that Require Support Policy and Procedure
    - Behavioural Assessment – Recognising Triggers
    - Behaviour Support Plans Policy and Procedure
- Restrictive Practices Prevention and Management
    - Restrictive Practices Prevention and Management Policy and Procedure
    - Requirements for the Use of Any Restrictive Practice
    - Requirements for the Use of Chemical Restraint
    - Repeated Use of Restrictive Practices
- Self-Harm and Suicide

Relevant Assessments & procedures

- Leecare forms located under the 'Assessments / Plans' tab
- Leecare forms located under the 'Daily Forms' tab
- Leecare forms located under the 'Admission Assessment' tab
- Leecare forms located under the "Care Evaluation" tab

How we provide information to Residents and Representatives

- Pre-application meeting with Admissions Coordinator
- Pre-admission meeting with DON or Senior RN
- Family and Resident meetings
- Resident of the Day contact
- Providing copies of medication charts and care plans to Residents and Representatives

How we educate and inform our workforce

- Friday 5 update to staff in July 2022 focused on Standard 3
- Staff education and orientation procedures
- Toolbox training

Compliance Monitoring

- Clinical indicators
- Incident reports
- Resident satisfaction
- AHPRA Registration Audits
-

Governance

- Audit results reported to CEO monthly and included in Board Clinical Governance Report

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	104		
Title:	Standard 4 – Services & Supports for daily living		
Owner:	Director of Nursing		
Review Date:	August 2022	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is ensure we deliver services and supports that improve Residents well-being and quality of life

2. POLICY

Village Baxter will provide safe and effective services and supports for daily living that optimise the Resident's independence, health, well-being and quality of life.

To enable Residents or their representatives to be able to confirm that they are

- able get the services and supports for daily living that are important for their health and well-being; and
- that enable Residents to do the things they want to do.

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

Services and supports for daily living
Lifestyle and Wellbeing Policy and Procedures
Consumer Lifestyle and Wellbeing
Private Companions
Laundry Services
Food Services
Contractor Brokerage and Management
External Services and Consumer Referral
Personal Privacy and Dignity

3. **PROCEDURE**

Relevant Assessments & procedures

- Leecare forms located under the 'Assessments / Plans' tab
- Leecare forms located under the 'Allied Health' tab
- Leecare forms located under the 'Admission Assessment' tab
- Leecare forms located under the "Care Evaluation" tab

How we provide information to Residents and Representatives

- Pre-application meeting with Admissions Coordinator
- Pre-admission meeting with DON or Senior RN
- Family and Resident meetings

- Resident of the Day contact
- Providing copies of medication charts and care plans to Residents and Representatives
- Food forums meetings
- Published menus

How we educate and inform our workforce

- Friday 5 update to staff in July 2022 focused on Standard 4
- Staff education and orientation procedures
- Toolbox training

Compliance Monitoring

- Incident reports
- Resident satisfaction
- Action items from Food Forums

Governance

- Audit results reported to CEO monthly and included in Board Clinical Governance Report

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	105
Title:	Standard 5 – Service Environment
Owner:	Director of Nursing
Review Date:	August 2022 **Policy Risk Rating:** Low

1. PURPOSE

Purpose is to ensure we provide a safe and comfortable service environment.

2. **POLICY**

Village Baxter will provide a safe and comfortable service environment .

To enable Residents or their representatives to be able to confirm that supports their independence, function and enjoyment of life.

3. **PROCEDURE**

Relevant Assessments & procedures

- Leecare forms located under the 'Allied Health' tab
- Leecare forms located under the 'Daily Forms' tab
- Leecare forms located under the 'Admission Assessment' tab
- Leecare forms located under the "Care Evaluation" tab

How we provide information to Residents and Representatives

- Pre-application meeting with Admissions Coordinator
- Pre-admission meeting with DON or Senior RN
- Family and Resident meetings
- Resident of the Day contact
- Food forums meetings
- Published menus

How we educate and inform our workforce

- Friday 5 update to staff in July 2022 focused on Standard 3
- Staff education and orientation procedures
- Toolbox training

Compliance Monitoring

- Clinical indicators
- Incident reports
- Resident satisfaction
- Audits

Governance

- Audit results reported to CEO monthly and included in Board Clinical Governance Report

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	106
Title:	Standard 6 – Feedback and Complaints
Owner:	Director of Nursing
Review Date:	August 2022 **Policy Risk Rating:** Low

1. PURPOSE

Purpose is to ensure that people feel encouraged and supported to give feedback and complaints that are actioned appropriately.

2. POLICY

Village Baxter will:

- regularly seek input and feedback from consumers, carers, the workforce and others: and
- use the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

Residents or their representatives will

- feel safe, encouraged and supported to give feedback and make complaints.
- Be able to confirm they feel engaged in processes to address their feedback and complaints, and that appropriate action was taken.

3. PROCEDURE

Relevant Assessments & procedures

- Leecare forms located under the 'Admission Assessment' tab
- Leecare forms located under the "Care Evaluation" tab
- Carepage website (starting September 2022)

How we provide information to Residents and Representatives

- Family and Resident meetings
- Resident of the Day contact
- Open disclosure conversations

How we educate and inform our workforce

- Friday 5 update to staff in July 2022 focused on Standard 3
- Staff education and orientation procedures
- Toolbox training

Compliance Monitoring

- Staff satisfaction
- Incident reports
- Resident satisfaction
- Audits
- Carepage website (starting September 2022)

Governance

- Feedback CEO monthly and included in Board Clinical Governance Report
- Feedback to be a Board Meeting Agenda item commencing October 2022

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	107
Title:	Standard 7 – Human Resources
Owner:	Director of Nursing
Review Date:	August 2022 **Policy Risk Rating:** Low

1. PURPOSE

Purpose is to ensure our staff are skilled, qualified and sufficient to provide safe, respectful and quality care and services

2. POLICY

Village Baxter will provide care and services by a workforce that is sufficient, skilled and qualified

Residents will be able to confirm that they receive care and services when they need them from people who are knowledgeable, capable and caring,

3. PROCEDURE

Relevant Assessments & procedures

- Humanforce onboarding procedures
- Onboarding documents in HR files

How we provide information to Residents and Representatives

- Family and Resident meetings
- Newsletters

How we educate and inform our workforce

- Friday 5 update to staff in July 2022 focused on Standard 3
- Staff education and orientation procedures
- Toolbox training
- Education & Training Programs
- Emails, texts, Humanforce chats,

Compliance Monitoring

- HR Manager monthly report
- Incident reports
- Staff satisfaction
- Resident Satisfaction
- AHPRA Registration Audits

Governance

- CEO monthly and included in Board Clinical Governance Report

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	108		
Title:	Standard 8 – Organisational Governance		
Owner:	CEO		
Review Date:	December 2022	**Policy Risk Rating:**	Low

This section of our Policy Manual is moving to the Complicare platform, Please follow the links below

Our Corporate Governance Framework of policies and procedures includes:

- Corporate Governance Framework Overview
- Clinical Governance Framework
- Continuous Improvement Program
- Incident Management
- External Reporting Obligations
- Feedback & Complaints
- Open Disclosure
- Enterprise Risk Management
- Compliance Program
- Quality Standards Compliance Mapping
- Consumer Engagement Statement
- The Code of Conduct for Aged Care (the Code)
- Information and Policy Management
- Workforce Governance Statement
- Care Minutes Policy and Procedure
- Financial Governance
- Organisational Governance Policies
- Internal Audits and Suitability Assessments

Policy Number:	109
Title:	Bed Sticks
Owner:	Director of Nursing
Review Date:	December 2022 **Policy Risk Rating:** Low

1. PURPOSE

Purpose is to ensure the safe use of bed sticks for Residents who wish to use them as mobility aids

2. POLICY

Policy is

2.1. Bed sticks will be provided for Residents who request them who are assessed by the Physiotherapist as being safe to use the bed stick as an in bed mobility aid.

2.2. If the Resident is not assessed by the Physiotherapist as safe to use a bed stick, an alternative mobility aid such as a bed ladder will be offered.

3. PROCEDURE

Procedure is

3.1. The Physiotherapist will review the Resident's request for a bed stick to be attached to their bed to assist with mobility.

3.2. If the Physiotherapist deems the Resident as capable of safely using a bed stick, the bed stick will be sourced and attached to the bed in a position as determined by the physiotherapist.

3.3. The physiotherapist will review the use of the bed stick each 6 months or as the Resident's condition changes

3.4. Staff must not alter the position of the bed stick

4. RELATED POLICIES AND DOCUMENTS

Leecare form – Physiotherapy Assessment form

Leecare report – bed stick use

Policy Number:	109		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	110		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	111		
Title:	Falls		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

3.1. Assessment and Prevention

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

The aim assessment is to:

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

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

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

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

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

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

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

3.2.2. Fallout mat in situ.

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

3.3. In the Event of A Fall

3.3.1. Notify Nurse In Charge

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

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

3.4. Neurological Observations Protocol

Neurological Observations are to be conducted:

3.4.1. half hourly for 2 hours;

3.4.2. hourly for 2 hours;

3.4.3. 4 hourly for 24 hours.

3.4.4. If clinically indicated increase the frequency of observations.

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

3.6. Refer to allied health

3.7. Review/update care plan and relevant assessments.

4. RELATED POLICIES AND DOCUMENTS

- 101 Accidents/Incidents
- 112 Falls Related Deaths

Policy Number:	112		
Title:	Falls Related Deaths		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. PURPOSE

1.1. If a resident dies soon after a fall or as a result of injuries sustained in a fall, the treating hospital are likely to report the death to the State Coroner for investigation. The following policy outlines the documentation that the coroner will require and that shall be prepared for all residents whose death could be related to a recent fall.

1.2. It is possible that a request for information from the Coroner could be made some years after the resident has died, so it is necessary to prepare all of the required documentation and archive it with the resident history.

1.3. This is an internal policy - nothing in this policy detracts from the incident being reported as a "SIRS" and that process must be followed.

2. POLICY

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

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

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

3. PROCEDURE

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

3.1. A list of all the staff involved in:

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

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

3.1.3. Those staff who have knowledge of the incident

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

- What they did
- What they saw
- What position the resident and any associated equipment or furniture was in (drawings are ok)
- What they heard
- Who they may have telephoned
- What they observed others doing

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

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

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

3.5. What previous initiatives, if any, has the facility undertaken in the last 2 years regarding risk screening for falls and falls prevention and management of clients following a fall?

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

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

3.8. Environmental factors, including:

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

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

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

3.10. Relevant equipment or work practice

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	114		
Title:	Resident Funds and Petty Cash		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

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

2. **POLICY**

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

3. **PROCEDURE**

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

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

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

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

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

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

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

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

Policy Number:	118		
Title:	Behaviour Management		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

Behaviour Management strategies are identified by the following methods:

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

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

4. RELATED POLICIES AND DOCUMENTS

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

Consumer Safety and Behaviour

Identifying Consumer Safety Hazards
Procedures for Identifying, Responding, and Reporting Elder Abuse and Neglect
Falls Prevention and Management
Missing Consumers and Unexplained Absences
Management of Behaviours that Require Support
Restrictive Practices Prevention and Management
Self-Harm and Suicide

Management of Behaviours that Require Support

Management of Behaviours that Require Support Policy and Procedure
Behavioural Assessment – Recognising Triggers
Behaviour Support Plans Policy and Procedure

Restrictive Practices Prevention and Management

Restrictive Practices Prevention and Management Policy and Procedure
Requirements for the Use of Any Restrictive Practice

Policy Number:	
Title:	Behaviour Support / Restrictive Practices
Owner:	DON
Review Date:	Decembner 2022 **Risk Rating:** High

1. PURPOSE

Purpose is to provide residents who display behaviours of concern with appropriate care and support that only includes the use of restrictive practices as a last resort.

2. POLICY

2.1 Restrictive practices must only be used where the Resident has documented behaviours of concern and an approved behaviour support plan. The Restrictive practices should only be applied when alternative strategies are unsuccessful and must be in the least restrictive form

2.2 Definitions

Restrictive Practice: The term “restraint” has been replaced with “restrictive practice”. A restrictive practice is now defined to mean 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a residential care recipient' in alignment with the definition in section 9 of the *National Disability Insurance Scheme Act 2013*

The Quality of Care Principles define five types of restrictive practices.

- chemical restraint,
- mechanical restraint,
- physical restraint,
- environmental restraint
- seclusion.

Behaviour Support Plans: The use of restrictive practices must be detailed in a behaviour support plan and is required for

- consumers who are or may be subject to use or application of a restrictive practice based on existing health/ clinical needs.
- consumers who require or are receiving alternative behaviour support interventions
- The Behaviour Support Plan must include
  - A description of the behaviour of concern that creates a risk of harm
  - A list of assessments that have been undertaken regarding the behaviours
  - Evaluation of the behaviour assessment identifying triggers and successful and unsuccessful alternative strategies
  - Alternative strategies that should be used first
  - The restrictive practice that can be used if the alternative strategy fails
  - The impact of the restrictive practice on the Resident and monitoring requirements
  - Medical Practitioner or specialist endorsement and Consent of the Resident (or appropriate decision maker)

Chemical restraint: Chemical restraint is the use of medication or a chemical substance for the primary purpose of influencing a consumer’s behaviour,

This does not include the use of medication prescribed for treatment of

- a diagnosed mental disorder;
- a physical illness;

- a physical condition;
- end of life care for the consumer

Environmental restraint: Environmental restraint is the practice or intervention that restricts, a Resident's free access to all parts of the Resident's environment, including items and activities, for the primary purpose of influencing a consumer's behaviour.

The Manor and Lodge both contain a type Perimeter restraints such as :

- Outdoor gardens with fences and with locked gates;
- Entry doors that require opening via a coded keypad.
- The Manor has a memory support house with doors that open via a coded keypad.

The purpose and intention of these "perimeter restraints" is not to unnecessarily or unduly restrain a Residents' movement in and out of the Manor or Lodge, but to instead provide appropriate entry and exit for Residents and Visitors and to prevent unauthorised entry into the Home. Where a Resident due to physical or cognitive limitation may not be able to easily operate the keypad system this is considered a form of environmental restraint and will be included in the Resident's Behaviour Support Plan to ensure the appropriate authorisations and safety precautions are in place.

Mechanical restraint: Mechanical restraint is a practice that involves the use of a device to prevent, restrict or subdue a Resident's free movement for the primary purpose of influencing the consumer's behaviour. It does not include the use of a device for therapeutic or non-behavioural purposes in relation to the consumer.

The capacity to mobilise should be assessed by a Physiotherapist or Occupational Therapist who is familiar with the Resident and must be included in the support plan.

Seat belts used to safely transport a resident in a wheel or princess type chair from one area to another while in motion would not generally be considered a mechanical restraint.

Movement limiting clothing, lap belts and bed rails are not restrictive practices permitted to be used at Village Baxter

Princess style chairs used by Residents who are capable of being mobile are considered a restraint and need to be included in a behaviour support plan. When these chairs are used by Residents who are bed bound to provide comfortable seating they are being used as a restrictive practice.

Low beds used by Residents who are capable of operating the bed control remote are generally not considered a restraint. If the bed control remote is removed or not able to be operated by the Resident and the Resident is capable of being mobile then the use of the bed in the low position does restrict movement and should be included in the behaviour support plan.

Physical restraint: Physical restraint is an intervention that involves the use of physical force to prevent, restrict or subdue movement of a Resident's body, or part of their body, for the primary purpose of influencing the consumer's behaviour.

This does not include the use of a hands-on technique in a reflexive way to move Resident away from potential harm or injury if it is consistent with what could reasonably be considered to be the appropriate exercise of care towards the Resident.

Physically holding a Resident in a specific position to enable personal care issues such as showering to be attended to prevent biting, kicking or other behaviour is restraint and needs to be documented in the behaviour support plan. Supporting a Resident's limbs to

enable personal care where they cannot hold or move the limbs independently where there is no intention of influencing behaviour is not generally considered physical restraint.

Seclusion: Seclusion is an intervention that involves the solitary confinement of a Resident in a room or a physical space at any hour of the day or night where voluntary exit is prevented for the primary purpose of influencing a consumer's behaviour.

Seclusion is only to be used in an extreme emergency where Staff or other Residents are at imminent risk of physical harm. It is expected that if seclusion is used that Staff would have called 000 seeking immediate police and ambulance response and the seclusion should only be used while the imminent threat to safety remains and until the emergency services arrive. The DON or oncall DON must be notified immediately if this type of restraint is used.

3. PROCEDURE

Restrictive practices can only be used where a behaviour assessment has been completed and shows behaviours of concern for the consumer that have been assessed by

- approved health practitioner who has day to day knowledge of the consumer, or
- a behaviour support specialist,

and the practitioner or specialist approves the use of the practice within the framework of a behaviour support plan that includes

- alternative strategies that must used prior to the use of any restrictive practice,
- the details of the restrictive practice
- and the Resident or appropriate decision maker give informed consent to the support plan

Alternative behaviour support strategies must be used or applied before considering any form of restrictive practice. These interventions must be documented in a behaviour support plan and include a hierarchy of actions taken leading up to the use of the restrictive practice and any strategies used to prevent the need for the restrictive practice

The Behaviour Support plan must be regularly reviewed and practices no longer required removed from the plan as soon as practicable.

Documentation requirements

All Residents

- The myagedcare support plan should be reviewed for behaviours of concern prior to admission for consideration of appropriate room location
- Medical History obtained from the current Medical Practitioner including list of current medications
- Admission Assessment: Emotional / Stress / Relationships / Behaviour completed
- Physio / OT review of mobility capacity for consideration of potential mechanical restraint
- PAS completed for consideration of environmental / mechanical restraint
- Medication list reviewed for psychotropic medications

If any of the above indicate behaviours of concern or restrictive practice implications:

- Psychotropic medication review for indications, diagnosis and assessment of chemical restraint
- A full Behaviour Assessment should be completed

- Behaviour Assessment Evaluation

Development of Behaviour Support Plan

- Assessment information should be reviewed in consultation with the Resident (or appropriate decision maker) and medical practitioner
- Behaviours of concern clearly identified in the Leecare Behaviour Support Plan
- Successful alternative strategies identified for each behaviour of concern
- Restrictive Practices identified and appropriate use documented
- Endorsement / consent to the Behaviour Support Plan by the Resident (or appropriate decision maker) and medical practitioner

Review

Chemical Restraint

- Review of effectiveness of alternative strategies during care plan review
- Review of effectiveness of prn medication after each dose is given
- Overall medication review as directed by Specialist or Medical Practitioner
- Residential Medication Management Review at least 12 monthly or following a significant change in condition

Other restrictive practices

- Review of effectiveness of alternative strategies during care plan review
- Change in PAS or Mobility status or significant change in condition should trigger a review of environmental and mechanical restraint.

4. RELATED POLICIES AND DOCUMENTS

- www.agedcarequality.gov.au/sites/default/files/media/fact-sheet-restrictive-practices-key-changes-for-providers-1-july-2021.pdf
- www.agedcarequality.gov.au/sites/default/files/media/rb-2021-13-regulatory-bulletin-regulation-restrictive-practices-role-snr-practitioner.pdf
- www1.health.gov.au/internet/main/publishing.nsf/Content/83ED8AB93D72770FCA257BF0001E3633/$File/RMMR%20Info%20for%20RACF%20factsheet%20PDF.pdf
- www.agedcarequality.gov.au/minimising-restrictive-practices/restrictive-practices-resources#provider-resources
- www.agedcarequality.gov.au/sites/default/files/media/consent-for-medication-in-aged-care-fact-sheet_0.pdf

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

Consumer Safety and Behaviour

Identifying Consumer Safety Hazards
Procedures for Identifying, Responding, and Reporting Elder Abuse and Neglect
Falls Prevention and Management
Missing Consumers and Unexplained Absences
Management of Behaviours that Require Support
Restrictive Practices Prevention and Management
Self-Harm and Suicide

Management of Behaviours that Require Support

Restrictive Practices Prevention and Management

Policy Number:	124		
Title:	Unexplained Absence		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. PURPOSE

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

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

2. POLICY

Where a resident is identified as absent from the care facilities and the absence cannot be explained, then a thorough search / investigation is to take place to locate the resident. If the resident's whereabouts cannot be established within one hour, then the police are to be notified of a missing resident and the Department of Health is to be notified via the SIRS protocols.

3. PROCEDURE

3.1. Notify and Search

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

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

- 3.2.1. Refer to Behaviour Management policy-118

3.3. Resident is not located.

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

4. RELATED POLICIES AND DOCUMENTS

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

Missing Consumers and Unexplained Absences

Policy Number:	125		
Title:	Care Planning		
Owner:	Director of Nursing		
Review Date:	August 2022	**Policy Risk Rating:**	Low

1. PURPOSE

To ensure all residents have their care needs thoroughly assessed upon entry and at regular intervals according to best practice to ensure that their clinical needs and changing needs are managed according to their individual needs.

2. POLICY

All residents will have a care plan developed in consultation with the resident and/or their representative which reflect their needs and choice of care provision.

3. PROCEDURE

3.1. Prior to admission to the facility, the admission co-ordinator provides the resident and family with admission documentation. This ensures that the facility can provide the right skill mix of staff with the clinical expertise to meet the resident's predicted needs. The facility can also ensure that any equipment that the resident may need to available on admission.

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

3.3. The ***Detailed Care Plan*** is completed within 8 weeks of admission using the information gathered from the assessments, charts, and consultation with the resident if they have capacity or representatives.

3.4. Any changes to a resident's care will trigger a change in the appropriate related assessment that will then update the care plan.

3.5. Bi-monthly the Resident, with capacity, or representative will receive a copy of the resident's mini care plan and medication chart. This is to ensure transparency around the care provision. Staff will then follow up with a care consultation telephone call, or chat with the resident to ensure that they are happy with the planned care for the resident.

3.6. Staff will also monthly log the resident's weight and vital signs.

3.7. The RSC will complete a Resident satisfaction survey with any issues or concerns raised be added to the CQI system to be followed up.

3.8. The Lifestyle team will check their activity log and update their lifestyle /social and spiritual needs plans as required.

Policy Number:	127	
Title:	Catheter Care	
Owner:	DON	
Review Date:	December 2022	**Risk Rating:**

1. PURPOSE

To ensure staff have clear guidelines regarding care of residents with catheters

Definition

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

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

2. POLICY

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

Urinary Tract Infections (UTI) are common side effect of long-term catheter use so staff are to be aware of the signs and symptoms of a UTI.

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

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

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

Contamination should be prevented when emptying the catheter bag including wearing disposable gloves and staff are to use an alcohol wipe to clean the tubing below the tap on the continence bag.

Night bags to be disposed of in the morning and new one replaced all day.

Urine output should be recorded for residents as required.

The resident's catheter is to be changed regularly as per resident's individualized care plan.

Catheter leakage can occur due to IDC blockage, UTI or bladder spasms, which may occur in residents with long term IDCs. Spasming of the bladder creates a force that overwhelms the drainage capacity of the catheter, resulting in leakage.

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

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

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

In the event of a catheter blockage irrigation of the catheter is not to be performed. The catheter is to be changed as per the procedure set out below.

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

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

3. PROCEDURE

3.1 Procedure for Female Catheterisation

Equipment

The following equipment is required [4]:

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

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

3.1.1. Explain the procedure, answer questions and prepare the resident.
3.1.2. Resident or nurse should shower the resident or wash the resident's pubic area with soap and water.
3.1.3. Ensure the resident's bed or examination table is at the correct height to prevent strain on your back whilst performing the procedure. Place the resident in a recumbent position, knees flexed and wide apart with incontinence sheet under resident.
3.1.4. Ensure adequate amount of light available for procedure.
3.1.5. Open disposable catheter pack.
3.1.6. Wash hands.
3.1.7. Open and add extra equipment to the catheter pack using aseptic technique. Place catheter in the receiver.
3.1.8. Saturate cotton wool balls with normal saline.
3.1.9. Put on glove.

3.1.10. Using forceps and cotton wool balls cleanse the resident's labia majora using a downward stroke. Hold labia part with gloved hand and cleanse the resident's labia minora and urethral opening.
3.1.11. Place a small amount of lubricant into the receiver.
3.1.12. Discard one glove and syringe.
3.1.13. Position the sterile towel to establish a sterile field between the resident's legs.
3.1.14. Using forceps, place receiver and drainage bag on the sterile field.
3.1.15. With fingers, remove the cap from the drainage bag and place the sterile end into the receiver.
3.1.16. With fingers, pick up catheter, remove distal sheath and connect catheter to the drainage bag.
3.1.17. Fill the syringe with the required amount of sterile water. Inflate the catheter balloon and check for leaks. Deflate the balloon and leave syringe attached.
3.1.18. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.
3.1.19. Using gloved hand, lubricate the catheter tip. Separate the resident's labia and gently insert the catheter directly into the resident's urethra without contaminating the catheter. Check for flow of urine to confirm correct positioning.
3.1.20. Inflate the catheter balloon and gently withdraw the catheter until resistance is felt.
3.1.21. Remove the remaining plastic sheath from the catheter.
3.1.22. Dry the resident. Secure the catheter on the resident's thigh in a position that will minimise dragging or kinking of the catheter. Hang the catheter bag below the level of the resident's bladder.
3.1.23. Ensure the resident is comfortable and clear the area.
3.1.24. Wash hands.
3.1.25. Document the date of the catheter insertion in the resident's notes and care plan.

3.2 Procedure for Male Catheterisation

In most instances a medical practitioner performs male catheterisation, however the procedure may be delegated to a registered nurse Division 1 with adequate training/experience in performing procedure.

Equipment

The following equipment is required:

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

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

3.2.1. Explain the procedure, answer questions and prepare the resident.

3.2.2. Ensure the resident's bed or examination table is at the correct height to prevent strain on your back whilst performing the procedure. Place the resident in a supine position with incontinence sheet under resident.
3.2.3. Open disposable catheter pack.
3.2.4. Wash hands.
3.2.5. Open and add extra equipment to the catheter pack using aseptic technique. Place catheter and 1 pair of forceps into the receiver. Attach syringe to centre of nozzle and open lignocaine anaesthetic jelly.
3.2.6. Saturate cotton wool balls with normal saline.
3.2.7. With a paper towel, pick up the resident's penis and retract the resident's foreskin if necessary.
3.2.8. Clean the resident's meatus and glans using the forceps and saturated cotton wool balls.
3.2.9. Position a second paper towel under the resident's penis and lower the penis onto the towel. Discard the first paper towel.
3.2.10. Position the sterile towel leaving only the cleaned part of the resident's penis exposed.
3.2.11. Using the drape, hold the resident's penis in a vertical position. Place a small amount of lubricant into the receiver and slowly insert the anaesthetic lignocaine jelly into the resident's urethra. Hold the jelly insitu for 3 minutes. Discard syringe.
3.2.12. Using forceps, place receiver and drainage bag on the sterile field.
3.2.13. With fingers, pick up catheter, removal distal sheath and connect the catheter to the drainage bag.
3.2.14. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.
3.2.15. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.
3.2.16. Lubricate the catheter tip. Using the drape, hold the resident's penis vertically and use the forceps to gently insert the catheter into the resident's urethra. Check for urine flow to ensure correct positioning.
3.2.17. Inflate the catheter balloon and gently withdraw the catheter until resistance is felt.
3.2.18. Dry the resident's penis to remove all anaesthetic lignocaine jelly. Replace foreskin if necessary. Secure the catheter on the resident's lower abdomen or thigh in a position that will minimise dragging or kinking of the catheter. Hang the catheter bag below the level of the resident's bladder.
3.2.19. Ensure the resident is comfortable and clear the area.
3.2.20. Wash hands.
3.2.21. Document the date of the catheter insertion in the resident's notes and care plan.

3.3 Procedure for Suprapubic Catheterisation

Equipment

The following equipment is required:

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

- Adhesive tape; and
- Disposable gloves.

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

3.3.1. Explain the procedure, answer questions and prepare the resident.
3.3.2. Ensure the resident's bed or examination table is at the correct height to prevent strain on your back whilst performing the procedure. Place the resident in a supine position with incontinence sheet under resident.
3.3.3. Open disposable catheter pack.
3.3.4. Wash hands.
3.3.5. Open and add extra equipment to the catheter pack using aseptic technique. Place catheter and 1 pair of forceps into the receiver. Attach syringe to centre of nozzle and open lignocaine anaesthetic jelly.
3.3.6. Saturate cotton wool balls with normal saline.
3.3.7. Using forceps, place receiver and drainage bag on the sterile field.
3.3.8. With fingers, pick up catheter, removal distal sheath and connect the catheter to the drainage bag.
3.3.9. Fill the syringe with the required amount of sterile water. Inflate the catheter balloon and check for leaks. Deflate the balloon and leave syringe attached.
3.3.10. Clean the resident's catheter insertion site with forceps and saturated cotton wool balls.
3.3.11. Remove previous catheter by deflating the balloon and with a swift movement remove catheter from site
3.3.12. Insert catheter site with Lignocaise jelly (if using – refer to residents care plan if required), discard syringe
3.3.13. With fingers near the serration, remove the proximal end of the catheter sheath, or use scissors if necessary.
3.3.14. Lubricate the catheter tip. Use the forceps to gently insert the catheter into the resident's catheter site. Check for urine flow to ensure correct positioning.
3.3.15. Inflate the catheter balloon and gently withdraw the catheter until resistance is felt.
3.3.16. Dry the resident's catheter site to remove all anaesthetic lignocaine jelly. Secure the catheter on the resident's lower abdomen or thigh in a position that will minimise dragging or kinking of the catheter. Hang the catheter bag below the level of the resident's bladder.
3.3.17. Ensure the resident is comfortable and clear the area.
3.3.18. Wash hands.
3.3.19. Document the date of the catheter insertion in the resident's notes and care plan.

3.4 Removing a Catheter

Equipment

The following equipment is required:

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

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

3.4.1. Explain the procedure, answer questions and prepare the resident.
3.4.2. Place the receiver between the resident's thighs.
3.4.3. Wash hands and put on the non-sterile gloves.
3.4.4. Attach the syringe to the balloon valve and withdraw the entire contents of the balloon.
3.4.5. Remove the catheter and place it in the receiver.
3.4.6. Ensure the resident is comfortable and clear the area.
3.4.7. Measure any remaining urine in the urine collection bag; disconnect the catheter from the drainage bag and dispose of catheter equipment in an appropriate infectious waste bin.
3.4.8. Wash hands.
3.4.9. Document in the resident's notes, care plan and fluid balance chart (if applicable).

4. RELATED POLICIES AND DOCUMENTS

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

Colostomy and Ileostomy
Continence Management
Female and Male Urinary Catheterisation
Suprapubic Catheter Care and Management

Policy Number:	130		
Title:	Diabetes		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

4. RELATED POLICIES AND DOCUMENTS

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

- Diabetes Management
-

Policy Number:	132		
Title:	Medical Care		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

3.3. Residents are also able to visit their Doctor of choice outside the Facility. Relatives/Representatives may be required to accompany the resident. Home Care Services may be purchased if there is no relative able to assist with transportation. Staff can assist residents with making such arrangements.

3.4. A record of assessment, diagnosis and treatments is to be readily available to enable other medical practitioners are able to treat the resident appropriately in emergency situations. It is recommended that doctors and allied healthcare providers write their progress notes and directives on the day of review and avoid providing notes at later date.

3.5. Medical care is to be reviewed as required for ongoing assessment / adjustment of the treatment program and / or referral to appropriate specialists in accordance with any change in the resident's care needs.

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	133		
Title:	Voluntary Assisted Dying		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. POLICY

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

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

2. PROCEDURE

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

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

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

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

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

3. RELATED POLICIES AND DOCUMENTS –

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

Voluntary Assisted Dying (VAD) Policy and Procedures

Policy Number:	147		
Title:	Call System		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

3.2. Call Buttons

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

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

3.2.3. The personal carers in the Lodge and Manor are to carry pagers on their person at all times when on duty. When a resident presses their call bell, the number of the room appears on the pager and enunciator in the corridors and nurses station.

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

3.2.5. Failure or breakdowns of the nurse call system is an emergency maintenance request and urgent attention should be sought 24 hours a day. Failure to report a problem with the nurse call system will result in disciplinary action.

4. RELATED POLICIES AND DOCUMENTS

- Nil.

Policy Number:	150
Title:	Committees – Residents and Friends
Owner:	Director of Nursing
Review Date:	February 2022 **Policy Risk Rating:** Low

1. PURPOSE

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

2. POLICY

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

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

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

3. PROCEDURE

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

3.2. Matters of interest are discussed.

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

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

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

4. RELATED POLICIES AND DOCUMENTS

- Nil.

Policy Number:	151		
Title:	Consent		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	High

2

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

3.1. There are three types of consent:

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

3.2. Consent is only valid if:

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

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

3.4. Consent is to be sought:

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

3.5. Informed Consent

- 3.5.1. Explanation of proposed treatment including inherent risks, benefits and alternatives,
- 3.5.2. Adequate time given for questioning by resident,
- 3.5.3. The option to withdraw at any time.
- 3.5.4. If a resident has an intellectual impairment, and is not able to comprehend the nature and consequences of the proposed treatment, the Legal Guardian may be called for consultation and consent.

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	157		
Title:	Continuous Improvement / Quality		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

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

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

2. POLICY

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

3. PROCEDURE

3.1. Quality System:

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

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

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

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

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

3.2. Continuous/Quality Improvement Form (CQIF)

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

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

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

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

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

Aged Care	Aged & Community Care	Community Care
Aged Care Quality and Safety Commission Telephone: 1800 951 822 Web: http://www.agedcarequality.gov.au	Elder Rights Advocacy Level 4, 140 Queen Street Melbourne VIC 3000 PH: (03) 9602 3066 1800 700 600 - free call in Victoria except from mobile phones Fax: (03) 9602 3102 Email: era@era.asn.au	Department of Health Southern Metro Region Home & Community Care Level 5 165-169 Thomas Street Dandenong 3175 Telephone: 8765 5444 Email: enquiries@dhhs.vic.gov.au

4. RELATED POLICIES AND DOCUMENTS

- Nil

Policy Number:	158a
Title:	Incident Management including the Serious Incident Reporting Scheme (SIRS)
Owner:	Director of Nursing
Review Date:	December 2022 **Risk Rating:** High

1. PURPOSE

The Village has requirements under section 54-1(1)(e) of the Aged Care Act 1997 (the Aged Care Act) and Part 4B of the Quality of Care Principles 2014 to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system. Our approach to managing incidents must focus on the safety, health, wellbeing and quality of life of Residents and meet the requirements of the aged care legislation and best practice guidance.

The scope of our Incident Management System includes reportable incidents under the SIRS. This policy related to Resident Incidents only - Staff / Visitor incidents are covered under Policy 101 – Accidents and Incidents

2. POLICY

Incident Management System Definition:

Incident management system requirements relate to any acts, omissions, events or circumstances that occur in connection with the provision of care and services to a Resident that have, or could reasonably be expected to have, caused harm to a Resident or another person. Incident management system requirements also relate to any acts, omissions, events or circumstances that the Village Staff become aware of in connection with the provision of care that have caused harm to the consumer.
https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf page 20

Reportable Incidents

A "reportable Incident" for the purposes of the SIRS is any of the following incidents that have occurred, are alleged to have occurred, or are suspected of having occurred to a Resident, in connection with the provision of care:

- unreasonable use of force against a consumer
- unlawful sexual contact or inappropriate sexual conduct inflicted on a consumer
- psychological or emotional abuse of a consumer
- unexpected death of a consumer
- stealing from, or financial coercion of, a consumer by a staff member of the provider
- neglect of a consumer
- use of physical or chemical restraint of a consumer (other than in the circumstances set out in the Quality of Care Principles)
- unexplained absence of a consumer from the service

Use the decision Support Tool to assess the incident:

www.agedcarequality.gov.au/sirs/decision-support-tool

Priority 1 Reportable Incidents:

A ***priority 1 reportable incident*** is an incident that falls within the scope of one the 8 categories of reportable incident identified above:

(a) that has caused, or could reasonably have been expected to have caused, a residential care recipient physical or psychological injury or discomfort **that requires medical or psychological treatment to resolve;** or

(b) where there are reasonable grounds to **report the incident to police**; or

(c) an **unexpected death** or **unexplained absence**.

Quality of Care Principles 2014, Part 4B, Division 4, Section 15NE
www.legislation.gov.au/Details/F2021C00685

Priority 2 Reportable Incidents
A ***priority 2 reportable incident*** is an incident that falls within the scope of one the 8 categories of reportable incident identified above that was not reportable under the Priority 1 criteria.

3. PROCEDURE

3.1 The Village Baxter Incident Management System includes the following key components:

Policy / Procedures:
Policy 101: Incidents / Accidents
Policy 158a Incidents including the Serious Incident Reporting Scheme (SIRS)
Policy 320: Open Disclosure

Incident Recording Tools
- Leecare form "Incident" found under the Care evaluation tab on the Residents Home Screen
- Leecare form "Serious Incident Response Scheme" found under the Care evaluation tab on the Residents Home Screen
- The MyagedcareSIRS Portal available on the Myagedcare provider portal

Staff Training
- Induction includes reading and acknowledging the policy. 1:1 tool box training if required
- Annual Staff Training Includes reading and acknowledging the policy. 1:1 tool box as required
- Periodic reminders include – tool box training. Updates through the electronic Leecare messaging system
- Staff Meeting Agenda item and discussion

Resident and Representative information sharing
- New Residents are provided with information on our Incident Management System in their welcome kits – This needs to be added to the information book
- De-identified, combined incident data is reported in the Resident Newsletter sent to nominated MPOA
- Resident meeting agenda – discuss comments and complaints but not incidents
- Communication and Open Disclosure occurs with Residents and Representatives about their individual incident experiences

Governance & Accountability

Direct care Level
- All Staff are required to report any incidents to the RN in charge of the shift
- The RN in charge of the shift when the incident occurred is responsible for creating the initial incident report that is recorded in the Residents electronic care planning system and notifying the next of kin, GP or emergency services as required.
- As part of the creation of the incident form, the RN must assess the incident against the SIRS categories. If the answer to any of these questions is Yes – the DON or DON on call must be notified immediately.
- The incident report and accompanying progress notes can seen by all Nursing Staff and enables other staff to continue to respond to the incident including recording who was notified about the incident and a review of the cause and action taken.
- All RNs are responsible for adding in relevant information into the incident report and implementing any follow up action and review. If any RN assesses that an incident has been miscategorized, and that it does fall within the scope of the SIRS the DON or DON on call must be notified immediately
- The RN in charge must contact the DON or after hours, the DON oncall if any incident could potentially fall within the scope of the SIRS or requires the involvement of the Coroner, Police or the Emergency Services

Management Level

- The Leecare system provides alerts to the Director of Nursing (DON) about new incidents through the unresolved incidents alert tab
- The DON reviews all incidents and when satisfied with the investigation and response can close out the incident.
- The DON or DON on call will receive all reports of incidents suspected to fall within the scope of the SIRS and will assess if they fall within a Priority 1 or 2 notification and take appropriate action as required
- Incident statistics, graphs and trends are included on the monthly clinical governance report provided to the CEO and included in the bi-monthly Board reports
- Incidents within the scope of mandatory clinical indicators are reported by the DON through the Myagedcare provider portal
- Any Coroner or Victorian Institute of Forensic Medicine request for information about deceased Resident must be discussed with the Resident's Doctor and the CEO to determine if it falls within the scope of the SIRS and if so, reported by the DON through the Myagedcare provider portal.
- Audits :
    - The DON or senior RN under the guidance of the DON, will conduct regular review of all incidents to assess if any incidents on the Incident Management Register are within the scope of the SIRS need to be reported through the Myagedcare provider portal.
    - Staff Training compliance is audited Annually & on commencement of employment.

Governance Level

- Clinical Governance is a standing item on the Board Meeting Agenda where all Directors are provided with a comprehensive Clinical Governance Report.
- The Board composition includes a former Registered Nurse with aged care experience
- The CEO is an RN and has access to all Leecare files and records and can review incidents and responses as required
- Policies and Procedures are reviewed at least bi-annually or as legislation, guidelines and best practices changes
- The content of the Clinical Governance Report is reviewed each month and new items added if deemed relevant by the DON and CEO or at the request of Board Members.

3.2 Categories Of Serious Incident Response Scheme Incidents:

3.2.1 Unreasonable use of force:

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

What is not unreasonable use of force?	What is unreasonable use of force?
• Gently touching a consumer to attract theirattention or to guide them. • Gently touching a consumer to comfort themif they are distressed. • Accidental contact (unless it is carelessor negligent). • Physical contact that has lawful justification. For example, pushing a consumer out of harm'sway (such as out of the way of an oncoming carthat would otherwise hit them or out of the wayof a falling item). • Reasonable management or care of a consumertaking into account any relevant code of conduct or professional standard. For example, where a staff member is genuinely trying to assist a consumer and is acting in accordance with applicable professional standards and, despite the staff member's best intentions, the consumer receives a smallscratch that causes them no discomfort. • Minor disagreements between consumers. For example, where one consumer taps another consumer on the hand as the resultof a disagreement over a card game. • Potential incidents. For example, where a consumer is prevented from harming anotherconsumer through the intervention of a staff member or other person.	• The use of unwarranted or unjustified physical force against a consumer, including any rough handling of the consumer in the delivery of care and services. • Physical force including actions such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects towards consumers or making threatsof physical harm. • Deliberate physical attacks or assaults on a consumer. • Any physical behaviour towards a consumer that is an offence under the law of a state or territory. • Incidents of physical contact that in isolation may not be significant but when they occur over an extended period of time, have an impact on the consumer.

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf page 24

3.2.2 Unlawful or in appropriate sexual contact:

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

What is not unlawful sexual contact or inappropriate sexual conduct?	What is unlawful sexual contact or inappropriate sexual conduct?
• Consensual acts of affection such as greeting someone with a kiss on thecheek or a hug. • Consensual sexual relations between consumers, or between a consumer andtheir partner who is not a consumer at the service. • Gestures of comfort, for example a carer rubbing a consumer's back or patting a consumer on the knee where this aligns with the consumer's personal preferences. • Helping a consumer to wash anddry themselves, where the carer is acting in accordance with applicableprofessional standards.	• Any conduct or contact of a sexual nature inflicted on the consumer by a staff member or a person who provides care or services forthe provider, while that person is providing such services (e.g. while volunteering). • Sexual contact without the consumer's consent, against their will or where consent is negated for other reasons such as lack of capacity to consent. • Having sexual intercourse or sexually penetrating a consumer (with a body part or an object) without consent. • Touching consumer's genitals (or otherprivate areas) without a care need. • A person masturbating, showing their genitals to a consumer or exposing themselves in the presence of a consumer. • Undressing in front of a consumeror watching consumers undress in circumstances where supervisionis not required. • Inappropriate exposure of consumersto sexual behaviour of others. • Sexual innuendos, sexually explicit languageor showing pornography to a consumer or using a consumer in pornography. • Grooming, stalking or making sexual threatsto or in the presence of a consumer. • Forcing, threatening, coercing or trickinga consumer into sexual acts. • Unlawful sexual contact encompassesany behaviour of a sexual nature that is an offence under any criminal statute of a state, territory or the Commonwealth.

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf p28

3.2.3 Psychological or emotional abuse:

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

What is not psychological or emotional abuse?	What is psychological or emotional abuse?
• A person raising their voice to attract attention or speak with a consumer whohas hearing difficulties. • Minor disagreements between consumers. • Making reasonable requests of a consumerto enable the safe and effective delivery of care and services (for example, asking a consumer to cooperate or encouraging a consumer to eat their dinner).	• Yelling, name calling, bullying or harassing, humiliating or intimidating a consumer. • Making threatening or aggressive gesturestowards a consumer or feigning violence. • Unreasonably ignoring a consumer, threatening to withhold care or services from a consumer or threatening to mistreata consumer. • Unreasonably refusing a consumeraccess to care or services (including as a punishment). • Taunting, making disparaging comments about a consumer's gender, sexual orientation, sexual identity, cultural identityor religious identity or constantly criticizing a consumer. • Making repeated actions such as flicks, tapsand bumps to a consumer (which of itself does not constitute physical assault but the repetitive nature causes psychological or emotional anguish, pain or distress). • Any action inflicted on a consumer where the individual is knowingly causing anguishor distress to a consumer (for example, calling a consumer by the wrong name or ignoring a consumer's expressed(and reasonable) preferences).

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf p31

3.2.4 Unexpected death:

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

What is not an unexpected death?	What is an unexpected death?
• Where a consumer dies as a result of an ongoing illness, disease or condition that was appropriately assessed, monitoredand managed (including where the consumer was receiving palliative care and appropriate end-of-life medications). • Where a consumer is involved in an incidentand later dies as a result of an unrelated condition or illness. • Deaths resulting from outbreaks of disease (for example, separate reporting processes have been established in relation to outbreaks of COVID-19).	• Where a consumer falls while being movedor shifted, with the injuries sustained resulting in the consumer's death. • Where poor quality clinical care is providedto a consumer resulting in their death. For example, a pressure injury or woundis untreated or not regularly tended to and becomes infected resulting in the consumer's death. • Where medical assessment or treatment is delayed, resulting in a consumer's death. For example, a consumer falls and is not assessed immediately afterwards and later dies as a result of injuries sustained from thefall.

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf p34

3.2.5 Stealing or financial coercion by a staff member

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

What is not stealing or financial coercion?	What is stealing or financial coercion?
• Where a consumer willingly, of their own volition, buys a staff member a coffee whileout for an appointment. • Where a consumer or their family give a carer a gift to thank them for their support. • Where items go missing but are quicklyfound to have been misplaced.	• Where a staff member coerces a consumerto change their will in favour of the staff member. • Where a staff member steals moneyor valuables from a consumer. • Where a staff member asks or coerces a consumer to buy something for themor another person. • Where a staff member uses power of attorney to steal money from a consumer. • Where an item goes missing and the consumer (or their family) have alleged or suspect that a staff member is involved.

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf p37

3.2.6 Neglect

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

What is not neglect?	What is neglect?
• An isolated incident of late or missed administration of medications where thereis no significant impact on the consumer. • Rapid weight loss as a result of disease,where all reasonable efforts are made to ensure the consumer is receiving adequate nutrition. • Where a consumer chooses not to receive care and services in line with their assessedcare need, for example: — where a consumer with dysphagia chooses not to eat a liquified diet and is appropriately supervised while eating — where a consumer with diabetes choosesnot to eat a diabetic diet — where a consumer with liver diseasechooses to drink alcohol — where a consumer chooses not to shower,brush their teeth or brush their hair — where a consumer with a chroniccondition or disease chooses not to undergo clinical treatment — where a consumer chooses to smoke despite having a chronic respiratory condition or other condition exacerbatedby smoking.	• Depriving a consumer of basic necessities,including food, drink or clothing. • Withholding personal care, such as showering, toileting or oral care. • Regular late or missed administration of medications, or failure to administer correct or time critical medications. • Failing to supervise a consumer in an environment that leaves them susceptible to injury. For example: — leaving a consumer outside unprotectedin the sun resulting in significant burns — leaving a consumer enclosed in a vehicle on a hot day where the temperature in thevehicle is likely to increase rapidly and cause significant harm to the consumer — failing to supervise consumers where theymay wander into unsafe environments such as busy roads, construction sites or bodies of water. • Failing to monitor a consumer's nutrition andhydration, resulting in rapid weight loss and clinical complications. • Failing to seek appropriate medical assessment and treatment for a consumer where they appear unwell or are injured. For example: — failure to treat injuries or wounds — failure to assess and manage pain — failure to seek medical diagnosis or treatment when a consumer shows signs of illness — failure to call an ambulance when the consumer's injuries or illness require treatment in hospital. — Failing to ensure a consumer is reviewed regularly by a health professional — or specialist in line with their documented care needs. — Failing to appropriately modify a consumer's meals to account for their difficulty — of swallowing as recorded in their care plan, or failure to give sufficient assistance to a consumer to eat their food, resulting — in the consumer not being able to eat meals or choking. — Lack of consistent clinical oversight exacerbating conditions requiring acute care, such as, lymphedema, contractures, catheter care and infections.

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf p40-41

3.2.7 Inappropriate physical or chemical restraint

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

What is not inappropriate use of physicalor chemical restraint?	What is inappropriate use of physicalor chemical restraint?
• Where a provider uses physical or chemicalrestraint on a consumer consistent with the requirements in the Quality of Care Principles. • Where a provider uses physical restraint without consent in an emergency situation and informs the consumer's representativeas soon as practicable after the restraint starts to be used. • Where a provider administers a drugto a consumer as prescribed for the treatment of a diagnosed health condition(and this is documented, and the consumer's representative is informed in advance of administering the drug).	• Restricting a consumer's movement other than in line with the appropriateuse of physical restraint, for example, inappropriate use of bed rails or a loweredbed that makes it difficult for a consumer to get out; placing a table or something in front of a consumer in order to limit theirability to move; using vortex illusions (such as floor rugs) that prevent the consumer from moving out of fear of the illusion. • Seclusion or confinement of a consumerwhere voluntary exit is prevented or not facilitated. • Use of a bed belt or lap sash restraint. • Physically blocking a consumer's path, holding onto a consumer preventing theirmovement or holding a consumer down. • Removing the battery out of consumer's electric wheelchair or putting mobility aidsout of a consumer's reach, in order to limittheir movement. • Physical restraint used in an emergency that does not comply with the requirementsin the Quality of Care Principles. • Any drug that is used to control, sedateor restrict the movement or behaviour of a consumer instead of for the treatmentof a diagnosed health condition.

https://www.agedcarequality.gov.au/sites/default/files/media/sirs-guidelines-june-2021.pdf p44

3.2.8 Unexplained absence from care

Reporting will occur where the:

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

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

4. RELATED POLICIES AND DOCUMENTS

- Aged Care Act http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/aca199757/s54.3.html
- Quality of Care Principles https://www.legislation.gov.au/Details/F2021C00685
- SIRS Page on the Aged Care Quality website https://www.agedcarequality.gov.au/sirs
- Policy 101: Incidents / Accidents
- Policy 158a Incidents including the Serious Incident Reporting Scheme (SIRS)
- Policy 320: Open Disclosure

Policy Number:	159
Title:	Visitors' Code of Conduct
Owner:	Director of Nursing
Review Date:	February 2022
Policy Risk Rating:	Medium

1. PURPOSE

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

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

2. VALUES

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

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

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

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

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

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

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

3. EXPECTATION

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

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

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

- × Shouting;
- × Abusing;
- × Threatening;
- × Swearing (in English or any other language);

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	162		
Title:	Homelike Environment		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

3.3. Animals are welcome to visit. Animals must be on a leash when in communal areas and are not permitted in the Kitchen and dining room.

3.4. Staff are to be mindful of noise levels in the residents' common rooms (e.g. from sound systems / TV) and to keep these at an acceptable level.

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

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

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

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

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

Policy Number:	163		
Title:	Diversity		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	165		
Title:	Privacy and Dignity		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	Low

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

3.3. Residents are to be allowed privacy when speaking with visitors and during phone conversations. Mail is not to be opened or read by staff unless the resident requests or requires assistance.

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

3.5. The environment within the Facility is to be free from undue noise. Residents may be asked to use earphones if their sound equipment is too loud.

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

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

Inquiry and Admission

Security of Tenure

Assessment and Planning Care

r Care and Services Planning

Advance Care Planning

Palliative and End of Life Care

Voluntary Assisted Dying (VAD) Policy and Procedures

Policy Number:	167		
Title:	Resident Alcohol Consumption		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

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

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

3. PROCEDURE

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

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

3.3. Staff are not to supply alcohol to residents.

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	168		
Title:	Restraint		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

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

This section of our Policy Manual is moving to the Complicare platform,

Please follow the links below

- Restrictive Practices Prevention and Management
  - Restrictive Practices Prevention and Management Policy and Procedure
  - Requirements for the Use of Any Restrictive Practice
  - Requirements for the Use of Chemical Restraint
  - Repeated Use of Restrictive Practices

3. PROCEDURE

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

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

Policy Number:	170		
Title:	Medication Advisory Committee		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	171
Title:	Medication Administration for Enrolled Nurses and trained Personal Care Assistants
Owner:	Director of Nursing
Review Date:	February 2022 **Policy Risk Rating:** High

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

3.6. It is Village Baxter policy that:

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	182		
Title:	Staff Medication Competency		
Owner:	Director of Nursing		
Review Date:	January 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

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

3. PROCEDURE

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	173		
Title:	Medication Charts and Orders		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

3.2. Each Medication Order must include:

i. Medication name (brand or generic),

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

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

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

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	184		
Title:	Dose Administration Aid		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

- Nil

Policy Number:	175		
Title:	Injectable Medications		
Owner:	Director of Nursing		
Review Date:	June 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

2.1. Administration of Medication via Injection

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

2.2. Insulin Administration

2.2.1. Only Registered and authorised Enrolled Nurses can administer insulin

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

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

2.2.4. Infrequent injectables (Vitb12, Prolia) are to have co-sign activated in the electronic medication system.

3. RELATED POLICIES AND DOCUMENTS

- 130 – Diabetes
- 173 - Medication Orders and Medication Charts
- 179 - Self-Administration of Medications

Policy Number:	176		
Title:	PRN Medication Administration		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	177
Title:	Nurse Initiated Medicines (NIM)
Owner:	Director of Nursing
Review Date:	June 2022 **Policy Risk Rating:** Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

AFFIX BRADMA

APPROVED NURSE INITIATED MEDICATION LIST

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

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

I, Dr……

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

RESIDENT NAME……

DATE……

GP SIGNATURE: ……

Authorised by: Medication Advisory Committee Issue: 28/6/22

Policy Number:	179		
Title:	Self-Administration of Medication		
Owner:	Director of Nursing		
Review Date:	February 2021	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	180		
Title:	Imprest Medication Management		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Policy Number:	181		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	181		
Title:	Fax and Telephone Orders		
Owner:	Director of Nursing		
Review Date:	July 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide guidance for the management of Medication Orders received by Fax or Telephone order.

2. POLICY

Only Telephone and faxed orders from an authorised prescriber will be accepted by The Village Baxter.

3. PROCEDURE

Faxed Orders

1. Faxed orders are preferred to Telephone Orders.

2. If a GP decides to fax/scan a medication order, a photocopy of a blank medication chart is faxed to the G.P. for the drug and administration details to be completed and faxed back to the facility.

3. The faxed order and a copy of the resident's current Medication Chart is sent to the Pharmacy for the medication to be dispensed.

4. Faxed orders are then treated as follows:

4.1 The original faxed order is photocopied and labelled "ORIGINAL" or "COPY" as appropriate.

4.2 The original is filed in the Resident's History in Section 7 as proof of the faxed order.

4.3 The order is cut out from the COPY and attached it securely to the original Medication Chart in the appropriate place.

4.4 At all times the original faxed order is to be retained as a complete document so that the origin of the faxed order can be confirmed and an audit trail of the order can be demonstrated. If no copy of the original faxed order is retained, then the order is NOT acceptable.

5. If a faxed order is not in the format above, the fax itself is an acceptable order, as are the directions on the resident's Webster pack. The GP is to attend the RACF & provide a medical order in the resident's drug chart as soon as practicable.

Telephone Orders

Telephone orders are only acceptable in an emergency situation. Staff are not permitted to accept telephone orders for routine medications.

1. The person receiving the telephone order must be a Registered Nurse.

2. All telephone orders must be read back to the prescriber for verification.

3. As a further check, the prescriber is required to repeat the order to a second person.

4. Telephone orders are recorded on the designated area of the Medication Chart and MUST be signed by the prescriber, or otherwise confirmed in writing, within 72 hrs or as soon as practicable. A reminder note may be written in the Doctor's Request Book.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	182		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	183		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	184		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	185		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	186		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	187		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	188		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	189
Title:	Management of Controlled Substances
Owner:	Director of Nursing
Review Date:	February 2022 **Policy Risk Rating:** High

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	190		
Title:	Warfarin Management		
Owner:	Director of Nursing		
Review Date:	February 2022	**Policy Risk Rating:**	Medium

1. PURPOSE

To provide guidelines for the management of Warfarin therapy.

2. POLICY

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

3. PROCEDURE

3.1. Warfarin is dispensed directly from the original packaging.

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

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

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

1. PURPOSE

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

2. POLICY

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

3. PROCEDURE

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

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

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

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	192		
Title:	Medication Incidents		
Owner:	Director of Nursing		
Review Date:	December 2022	**Policy Risk Rating:**	High

1. PURPOSE

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

2. POLICY

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

Nothing in this policy detracts from the SIRS process and all medication related incident reporting should be managed in accordance with the SIRS requirements. The DON on duty or on call must be notified of medication related incidents immediately

3. PROCEDURE

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

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

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

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

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

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

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

4. RELATED POLICIES AND DOCUMENTS

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

Policy Number:	193		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	194		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here

Policy Number:	195		
Title:	BLANK		
Owner:	Director of Nursing		
Review Date:	July 2019	**Policy Risk Rating:**	Low

1. PURPOSE

Purpose is

2. POLICY

Policy is

2.1. X
2.2. Y
2.3. Z

3. PROCEDURE

Procedure is

3.1. A
3.2. B
3.3. C
3.4.

4. RELATED POLICIES AND DOCUMENTS

- List here