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RESIDENT RIGHTS DIGNITY & CHOICE

Residents Rights

Springhaven Lodge is committed to developing an organisation culture that supports the legal and human rights of residents and ensures they are able to exercise those rights as outlined in the relevant legislation including the:

- Quality of Care Principles (2014) Commonwealth Department of Health and Ageing
- Aged Care Quality Standards 2019
- The Charter of Aged Care Rights
- Age Discrimination Act 2004
- Australian Human Rights Commission Act 1986
- Disability Discrimination Act 1992
- Racial Discrimination Act 1975
- Sex Discrimination Act 1984

Springhaven Lodge understands and supports the principles of fairness and human rights in all aspects of service delivery. It will ensure that services are provided in an environment free from discrimination, financial, sexual, physical and emotional abuse, neglect or exploitation.

Each resident has the right to freedom of speech and to select and maintain social relationships with any person. Each resident has the right to speak the language of their choice and continue their cultural and religious practices.

Provision of Information

Springhaven Lodge will provide easily understood and accessible information to all residents at admission about what the organisation does, how family/resident representative can contact the facility, the service standards residents can expect and opportunities to provide feedback or make a complaint.

Each Resident should be given timely information about care and service in a form and language that they understand so they have the ability to make an informed choice. This assists them to get the most out of their care and services.

The facility will involve the residents in the development of policies and procedures that impact on their service.

Each resident should also be given information on external advocacy services. Printed multi-lingual information via the Department of Health and Ageing can be ordered by telephoning 1800 700 600 or downloading an order form via the Department's website.

Each resident will be given a signed copy of the Charter of Aged Care Rights and supported to understand the contents.

Sharing Information

Each resident shall be supported and encouraged to nominate those persons with whom information about the resident can be shared. These are people who may

ask the staff of the facility questions about the resident's current health or lifestyle status, and provide the home with the guidance as to who this information can be disclosed to. This is different to the preferred contact who is the person the facility will contact in the event of the resident having a fall, being transferred to hospital etc.

DECISION MAKING

Springhaven Lodge acknowledges that all residents have a human right to make decisions about their own life and to have those decisions respected. The facility understands and affirms that cognitive impairment is not a reason for a person to be excluded from the decision making process about their own life.

Springhaven Lodge understands that not all decisions require assistance, and will support residents primarily when they make significant decisions which have immediate or long term consequences regarding their health, finances or lifestyle.

Springhaven Lodge is committed to supporting residents with complex care and communication needs to make their own decisions regarding their life.

The will and preferences of a resident will only be overridden if a decision is deemed by staff or advocates to be dangerous to the wellbeing of the resident or others.

Cultural and Religious Practices

Each resident is encouraged and supported to maintain their cultural, spiritual and religious practices. Where this cannot be supported internally, external support services will be sought.

Gender and Sexual Preference and Diversity Needs

Each resident is encouraged and supported to express and practice their gender preferences in an environment that is safe and welcoming, and non-judgmental. Where staff are not able to provide the required support internally, external expertise is to be sought.

Choice and Decision Making – Risks

Each resident has the right to make their own decisions about their care and services as well as their right to take risks.

If a resident wishes to participate or not to participate in an activity, or to abide by the recommendation of a health professional, and the potential outcome of that choice may be to create risk to the resident, staff will help the resident understand the risk and identify mitigation strategies that are tailored to help the resident live the life they choose. The resident (or their representative where appropriate) then elects whether or not to continue with this choice. Decisions should be documented in detail in the resident progress notes.

CHOICE AND DECISION MAKING

Resident's and their family are provided with the information they need to make decisions about their care. Staff are to take care to explain all information in simple language, and to use an interpreter if necessary.

On admission the resident handbook is explained to each resident.

The handbook includes information on:

- resident rights
- fees
- complaints and feedback
- resident agreement
- advocacy services
- care plans
- therapy programs, activities and outings.

Residents are reminded of this information at resident meetings and at re-assessment.

Residents are also informed that they do not have to sign an agreement and that they have the right to refuse treatment. The implications of refusing treatment are explained by a doctor and the resident's refusal is noted in their file.

(Refer Section 4: Medication Management)

Residents, family and community members are encouraged to provide feedback on the service through:

- Tell Us What You Think Form
- requests for feedback at meetings
- informal feedback
- interview with residents on admission and during case conferences
- specific issue discussions
- inclusion of an explanation of feedback mechanisms in the regular newsletters.

All feedback is reported to the Manager, collated and discussed at staff meetings. Appropriate recommendations are discussed at the monthly Staff, Quality & OSH meeting.

Civil Rights

Each resident has the right to choose whether they wish to continue to vote in local, State and Federal elections. Residents are assisted to attend polling booth that is held at Springhaven Lodge.

Alternate Decision Making – Guardians, Administrators, Powers of Attorney, Supportive Attorneys, Medical Decision Makers

On admission information is sought from each resident (and/or representative where appropriate) regarding who, if anyone, has the legal right to act for the resident, and if the resident has appointed any supportive attorneys. This information must be clearly documented with a copy of any legal authority placed in the resident's file.

Where a resident becomes unable to make decisions for themselves, representatives are encouraged to put arrangements in place for a guardian, administrator or power of attorney, if these do not already exist. In the absence of such arrangements, and if the resident is unable to consent to medical or dental treatment, the appropriate "person responsible", as defined by the Office of the Public Advocate, will be referred to.

National Decision-Making Principals

1. All adults have an equal right to make decisions that affect their lives and to have those decisions respected.
2. Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
3. The will, preferences and rights of persons who may require decision-making support must direct decision that affect their lives.
4. Laws and legal framework must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.

PRIVACY AND DIGNITY

Each resident's rights to privacy and dignity is respected through:

- encouraging family members to stay, especially when the resident is sick
- limiting the collection of personal information by staff to information that is necessary to provide appropriate care to the resident
- providing private spaces within the service for residents and their family to go to
- ensuring the confidentiality of resident information
- residents are encouraged to spend time with family and friends. Family and friends are encouraged to visit the service
- independence in undertaking the activities of daily living such as bathing, toileting and dressing is encouraged. Bathroom doors are closed during showering and toileting when assisted by staff unless the resident has an objection, in this case care to maintain privacy will be taken. For example, not allowing others in the bathroom at this time
- residents who do not require assistance with showering, toileting and dressing are encouraged to undertake personal activities in private

- residents who require assistance with the personal activities are treated with respect
- staff members knock and announce themselves before entering rooms
- residents are treated with respect and dignity at all times
- staff are advised in the Staff Handbook and reminded on a continuing basis that information regarding residents is to remain confidential at all times.

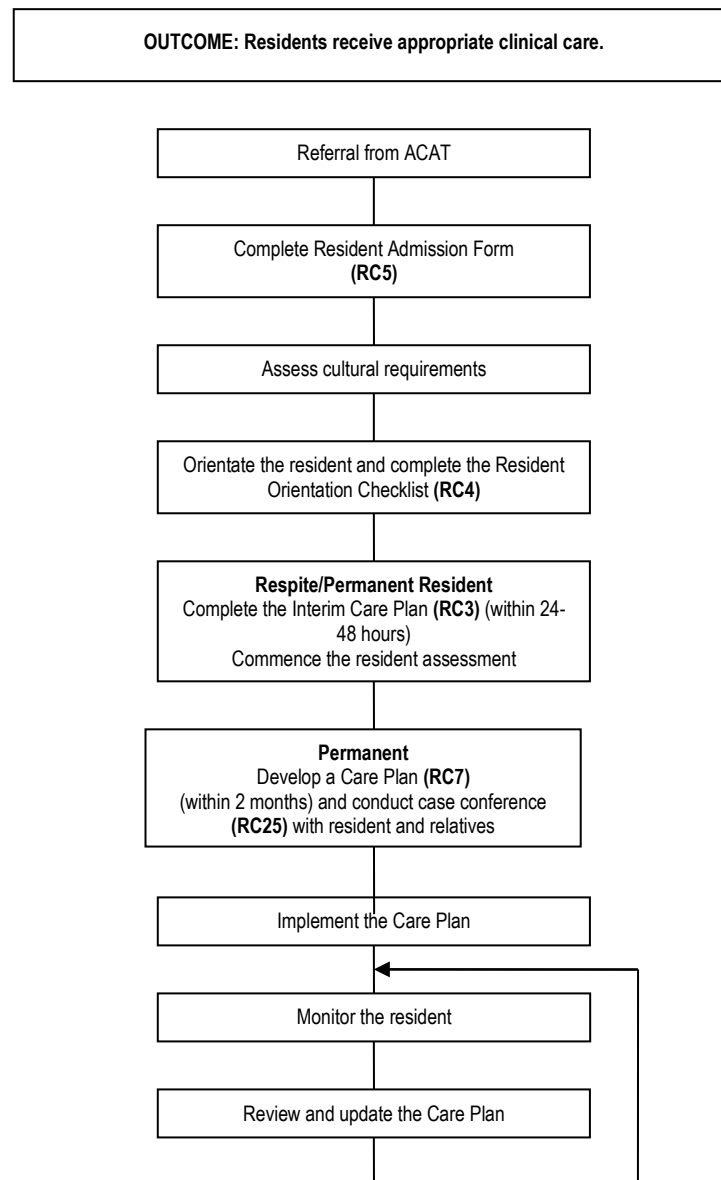
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RESIDENT ADMISSION

RESIDENT ADMISSION

The admission process is summarised in the flow chart below.

Resident Admission



INITIAL ENQUIRY

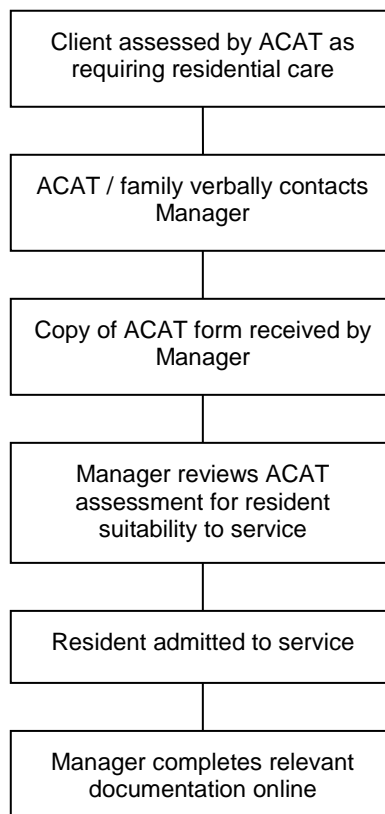
When an initial enquiry is received it is recorded on an Initial Enquiry for Accommodation form (**Form RC2**).

This form is then filed in the enquiries file in the Manager's office. Each prospective resident is given an Information Pack that gives them information about the hostel and terms and conditions.

REFERRAL

An ACAT referral is needed for admission into the service. See ACAT referral process below.

ACAT Referral Process



INTERVIEW PROSPECTIVE RESIDENT/FAMILY

Having received an ACAT referral to the service, the prospective resident and his/her family are interviewed to assess whether the resident would like to reside at the service. Residents may be interviewed a number of times to suit their needs and allow time to ask questions.

Interviews

At the first interview the following points are covered:

1. Show the person a room if they wish to see one and if one is vacant. A tour of the service may be conducted by the Manager.
2. If applicable, explain the payment of the bond.
3. Explain the direct debit facility for the payment of daily fees and provide the person with a copy of the information.
4. If the person queries the Conditions of Occupancy or requests more details provide them with a copy of the Conditions of Occupancy included in the blank Agreement.
5. Explain to the person the importance of meeting their needs should they decide to become a resident.
6. Explain to the person that they can take the information sheets to read and think about them and that they are most welcome to come in for another interview or ring up for additional information.

Decision to Reside

Once a person has decided they would like to reside at Springhaven Lodge the following applies:

1. Show the person a room if one is vacant.
2. Explain that if they do decide to become a resident they should fill in the financial forms as admission cannot proceed with their room application if these forms are not returned. Care forms are to be returned on entry day, in order to be sure of meeting the person's needs from day one.
3. Provide the person with a copy of the Conditions for Occupancy and other documents in the Agreement and explain the key points (Refer to the **Resident handbook and Springhaven strategic plan**).
4. Explain that the person should read the documents and complete as much as possible.
5. Give the resident a copy of the Resident Handbook.
6. For people wishing to take up permanent residency after respite, a permanent agreement is completed.

We always ensure that we only seek information that is pertinent to providing appropriate care whilst meeting our duty of care to residents. We are aware of the need to respect individual residents' privacy at all times.

RESIDENT ADMISSION

When a resident is admitted they are encouraged to sign either a 'Respite Stay Agreement' or a 'Permanent Resident's Agreement'. Residents are not required to sign these documents, but are encouraged to do so. Both copies of the Agreement are returned to CEO for signing – one copy is filed with the Shire of Kojonup and the other is returned to the resident.

The Resident Admission Form (**Form RC5**) is completed by the resident prior/or on admission. The admitting staff member reviews the form on admission and assists with completion when required.

On admission, residents are provided with a resident handbook that outlines how they can participate in decision making and exercise choice and control over their lifestyle. This includes information on how they can provide input into the running of the service via resident forums, continuous quality improvement suggestions and the comments and complaints procedure.

TRANSFER TO SPRINGHAVEN LODGE

Transfers to Springhaven Lodge should occur before 11am on weekdays to ensure that residents and families are given adequate support when they arrive. Residents should have with them a copy of a Patient Transfer Form provided by the hospital if they are coming from a hospital. When the hospital rings to advise of the resident transfer, ensure that the transfer form, medication orders and prescriptions are accompanying the resident.

It is also expected that the daily living activities such as a shower and fresh clothing will have been attended to prior to transfer to Springhaven Lodge. The Manager will liaise with the hospital if this is not the case.

ORIENTATION

Within 48 hours of admission to the service, the carers provide a full orientation to the service as per the Resident Orientation Checklist (**Form RC4**). The Clinical Coordinator determines the timeframes for completion of each of the assessment forms on the Resident Orientation Checklist and these are provided to staff in an admission pack. Staff tick off as each of the assessments are completed.

INITIAL ASSESSMENT – RESPITE RESIDENTS

Each resident (and/or their representative where appropriate) is encouraged and supported to develop an interim care plan(**Form RC3**)on admission, to undertake assessments of care needs and to be part of the development of care plans to address those assessed needs in conjunction with the Clinical Coordinator, allied health professionals and care staff . Residents are supported and encouraged to identify goals of care and a collaborative approach is taken between the resident and the staff to develop and deliver the care plan to meet those goals. The relevant staff member must complete the Mobility/Transfer Assessment (**Form RC19**) ,Shower/Personal Care Assessment (**Form RC20**) and the Visual Care Plan(**RC49**), within 24-48 hours of admission as part of the assessment; the Physiotherapist completes the Falls Risk Assessment (**Form RC19A**) ,The Manual Handling Instruction Card and the Sensory Assessment(**Form 50A**) as part of the assessment.

The Sensory Assessment (**Form 50A**) is to be completed by the Physiotherapist before a heat pack treatment can be commenced. The Manual Handling Instruction Card and Visual Care Plan are placed outside/inside the cupboard of the individual's bedroom

LIFESTYLE CHOICES

Each resident (or their representative where appropriate) is to be asked for their preference around:

- times of the day for showering or bathing
- frequency of showering or bathing
- rising times
- settling/retiring times
- how they wish to be referred to – title/name
- participation in activities; and
- meals and drinks

Additional assessments are only completed if a need is identified that requires intervention.

The Manager also completes a Respite Agreement with the resident/representative.

INITIAL ASSESSMENT – PERMANENT RESIDENTS

An interim care plan is completed initially using the above assessment as for respite. All other assessments are completed within the first 2 months of admission and a comprehensive care plan is developed. Each resident (and/or their representative where appropriate) is invited to participate in a consultation meeting approximately 30 days after admission to review the completed assessments and care plans. A formal consultation meeting is held thereafter at least annually.

Care staff document that assessments/referrals are completed in the appropriate sections of the Interim Care Plan and the Permanent/Respite Admission Assessment Schedule (**Form RC44**). The completion dates will be flexible dependent on each resident's assessed needs and wishes and allied health professional opinion regarding the most urgent assessments.

Resident's weight is charted using the Weight Chart (**Form RC16**). If specific observations, such as lying and standing blood pressures need to be monitored, a Specific Observation Chart (**Form RC39**) is used.

The Manager also completes a Resident and Accommodation Agreement with the resident (and/or their representative where appropriate)

PERSONAL CARE PLAN

A Care Plan (**Form RC7**) is developed by the RN in consultation with the resident (and/or their representative where appropriate) within 2 months of admission. The appropriate ACFI documentation is also completed within this timeframe. Care staff document the care delivered to residents during this period in the progress notes and also note the assessments that are being conducted. The Clinical Coordinator and care staff work together to analyse the assessments and

use the information written in the progress notes and the assessments to develop the personal care plan. Each resident (and/or their representative where appropriate) is encouraged and supported to develop an Care Plan (**Form RC 7** , and undertake assessments of care needs and to be part of the development of care plans to address those assessed needs in conjunction with the Clinical Coordinator/RN to review all relevant assessments and the care plan and develop the a care plan as appropriate to the needs of the resident. Each resident (and/or their representative where appropriate) is invited to participate in a consultation meeting to review the completed assessments and care plans.

~~The care plan is used to describe the specific care requirements of the resident and is completed as the assessments are completed by the Clinical Coordinator/RN. The care plan is a living document that is updated (by the Clinical Coordinator) as care needs change and reviewed at least six monthly.~~

Each resident has the right to request that an interpreter be used when undertaking assessments, developing care plans or discussing care or lifestyle needs in general.

A Specific Care Plan (**Form RC6**) is completed for any specific care needs and the existence of these specific care plans are noted on the Care Plan. A Shower Schedule (**Form RC43**) is completed to document personal care delivery.

~~A team meeting is conducted with the Clinical Coordinator, RN, Occupational Therapist, Physiotherapist, care staff and other health professionals as applicable within the first three months of admission. The purpose of this meeting is to review the assessments and care plans.~~ A Resident Assessment Survey (**Form MA 20**) is completed after the first three months either with the resident or their family and is managed by Administration. The resident and/or family is interviewed by the RN/MACS/ Clinical Coordinator during a case conference using the Case Conference Checklist (**Form RC25**) or Case Conference via Telephone (**Form RC25A**) within the first three months following admission. This is a good time to clarify any issues that the resident or family member may have regarding the service or care provided and review the care plan that has been developed. If an interpreter is needed, this is arranged.

The service aims to involve the resident and their family as much as possible in care planning and will ensure that family members have the opportunity to participate in the care planning process if desired.

In addition to involving the resident, the care planning process may involve:

- the resident's family
- the resident's General Practitioner
- Nurse Practitioner
- Occupational Therapist
- Physiotherapist
- Podiatrist
- Mental Health Nurse
- visiting specialists as appropriate

- Hospitals and Community Health Agencies.

When a new resident is admitted the appropriate health professionals are contacted and a visit/appointment arranged as soon as possible, if required. The Referral/Appointment Form (**Form RC30**) or service specific referral form can be used for the referral.

SPECIALISED CARE

Specialised care procedures are planned and implemented under the direction of a Registered Nurse or allied health professional (as applicable). The Nurse Practitioner provides specialised advice as required. A Treatment Chart (**Form RC41**) is commenced to describe specialised care or, if the care is a directive from a Registered Nurse, allied health professional or Doctor a Complex Care Directive (**Form RC27**) is completed by the relevant health professional. Such procedures may include, but are not limited to, wound care, ostomy care, and specific skin treatments, pain management interventions.

Any issues that require review by a Registered Nurse are referred to the Clinical Coordinator/Registered Nurse and the Clinical Coordinator/Registered Nurse review all resident care plans. Allied health professionals also contribute to the assessment, care planning and delivery of specialised care.

The Specific Observation Chart (**Form RC39**) is used to record specific observations as ordered by doctor on regular basis. The Observation Chart (**Form RC39A**) is RN directed and generally used for post Adverse Event if full neuro observation is not required. If a resident has hit their head then the RN/MACS/Doctor will direct care staff to implement Neuro Observation Chart (**Form RC55**). If there is a decline in residents health the RN/Clinical Coordinator may initiate Acute Treatment Chart (**Form RC45**).

Staff receive training to ensure they are competent to fulfill their roles safely and effectively. Care staff are aware of their clinical limitations and are encouraged to consult with the registered nurse when necessary. Care may be delegated, by the Clinical Coordinator/Registered Nurse or allied health professionals to appropriately trained care staff. Care staff complete skill level updates yearly and these are recorded in the training management system.

DOCTOR

Residents have a choice of doctors. The doctor completes a Doctor Diagnosis Form (**Form RC42**) on the resident's admission.

If the resident's doctor is not available in an emergency the resident is transferred to a hospital for treatment.

Doctors may complete a Comprehensive Medical Assessment if necessary, but the Doctor will provide any information required by the service. The staff will administer the medications and treatments (where possible) and consult with allied health professionals and other outside agencies to assist when appropriate. Changes in clinical care are documented by the Clinical Coordinator, RN, doctor or other health professionals in the Progress Notes (**Form RC11**). If the RN or Clinical Coordinator is not present carers will document changes in clinical care in Progress Notes (**Form RC11**) and then notify RN/Clinical Coordinator.

Doctor's medical records are maintained by the Doctor in separate records contained in the Treatment Room. If a review by a doctor is required, staff ring the doctor and visits are recorded on the handover notes.

REVIEW

Each resident (and/or their representative where appropriate) is encouraged and supported to take part in the review and the evaluation of their care every six months, or more frequently if required, in conjunction with Clinical Coordinator/RN, Allied health professionals & care staff. Each care plan is a living document.

The resident (and/or their representative where appropriate) may request an earlier reassessment at a mutually agreeable time.

~~Ongoing monitoring of resident's needs is carried out by the Clinical Coordinator, RN, carers and allied health professionals and care plans are reviewed periodically.~~ All residents are reviewed 6 monthly and as required, using Resident of the Day Chart (**Form RC1**). Any changes to the resident's needs or concerns are noted by the carers and are reported to the Clinical Coordinator/RN or allied health professionals.

Staff complete Handover Notes (**Form RC48**) that outlines the condition of each resident, including any appointments they are attending. Staff are required to review the handover sheet together at the end of each shift. Any ongoing concerns/events that need to be brought to the RN/Clinical Coordinator/MACS attention should be recorded in red pen in the Handover Notes and in Daily Diary. If urgent and out of hours MACS should be contacted by telephone.

Information is recorded in the resident's file on the Progress Notes (**Form RC11**).

Residents see the doctor on an as needs basis or as assessed by the Clinical Coordinator/RN, allied health professionals and carers. Allied health professionals review residents annually.

This comprehensive review is conducted annually and all assessments are recompleted. ACFI submissions are made as required by changes in care needs and coordinated by the ACFI Coordinator in consultation with RN, MACS, Clinical Coordinator, Physiotherapist, OT and care staff. RN uses Resident Review Chart (**Form RC1**) as a checklist. The Physiotherapist uses Checklist for Annual Review – Physio (**Form MA40**).

CASE CONFERENCES

It is preferred that a doctor reviews all residents at least every three months. Case conferences are coordinated by the Clinical Coordinator ~~following admission, yearly and as required~~ and documented on the Case Conference Checklist (**Form RC25**) or Case Conference via Telephone (**FORM RC25A**). These involve the resident, their families or representatives, doctors and staff from the service. The case conference is also noted in the Progress Notes (**Form RC11**).

The resident (and/or their representative where appropriate) may also request and earlier consultation meeting at a mutually agreeable time.

REFERRAL/EXTERNAL PROVIDERS APPOINTMENTS

Residents are referred to specialist and allied health services when appropriate (**Form RC30**). The need for referral is noted in the progress notes, care plan and identified at initial assessment and re-assessments.

For specialist services:

- Clinical Coordinator/RN will assess need and refer
- the doctor will confirm need and make a referral (if necessary).

Referrals to other health professionals are made by the Clinical Coordinator, RN, MACS by fax or phone. These health professionals use their own assessment tools which are copied and included in the resident's notes.

An External Provider Appointment Form (**Form MA39**) is to be sent to referred practitioner/specialist/medical provider to be completed with details of treatment provided and any ongoing resident treatment. The resident is provided with a Patient Profile by Pack form to take with them to appointments; these are forwarded to the pharmacy on return to ensure that medications are amended as required. All documentation is returned to the service for filing.

Residents are advised of available services in the resident handbook and when the need for services is identified. Examples of internal and external health service providers are: optometrist, podiatrist, physiotherapist, occupational therapist, speech pathologist, dietician, dentist etc.

PROGRESS NOTES

Any issues which arise in services to a resident must be recorded immediately in the resident's Progress Notes (**Form RC11**). Issues include:

- changes in the resident's health or well-being
- changes to medication
- Incidents/accidents or communication with family/representatives.

WRITING PROGRESS NOTES AND DOCUMENTING CARE GUIDELINES FOR CARE STAFF

- make sure you are writing in the correct resident's file
- write legibly and neatly and in language appropriate to the Springhaven team members
- start your entry with the time and date – never backdate entries – if you are writing about something you forgot to enter earlier, state that is what you are doing in the notes, but put the actual date and time of entry in the notes
- write exactly what care you have delivered, what you observed, who reviewed the resident, changes in resident status or care planning, accident details, etc. (See examples below)
- for the scheduled care plan reviews, head your entry CARE PLAN REVIEW, and make comments about each of the outcomes you have reviewed in an objective, accurate manner. Head each outcome so your colleagues can easily read the information relevant to the care they will deliver. State examples of improvement or deterioration in care, for example, 'resident able

to walk 20m unassisted – at last review resident required assistance of one staff member to walk at all times’

- if you are just reviewing one outcome, for example, continence, head your entry CONTINENCE REVIEW and make your entry
- sign and print your name after each entry.

Example Case Notes

EPISODE ONE

(Date/Time) Resident observed to have a 2cm skin tear to the back of her left calf. She stated she didn’t know when it occurred. Bleeding stopped when a dry dressing applied. Doctor informed, he will attend at approximately 2pm. Resident complained of pain. Analgesia given with effect. (Sign and print name)

(Date/Time) Doctor attended at 2.45pm. Dressing attended by doctor – waterproof dressing applied. Dressing not to be changed for three days. Care plan changed to reflect care and RN notified to attend dressing on Friday. (Sign and print name)

EPISODE TWO

(Date/Time) Whilst showering resident I noticed a red rash extending from under right arm, across chest and down to groin. Rash seems raised and red – no broken skin observed. Resident showered without soap as he stated the rash was stinging and sore. Area pat dried and loose clothing applied. RN advised to review rash. Wound Care Assessment form (**Form RC14**) completed. (Sign and print name.)

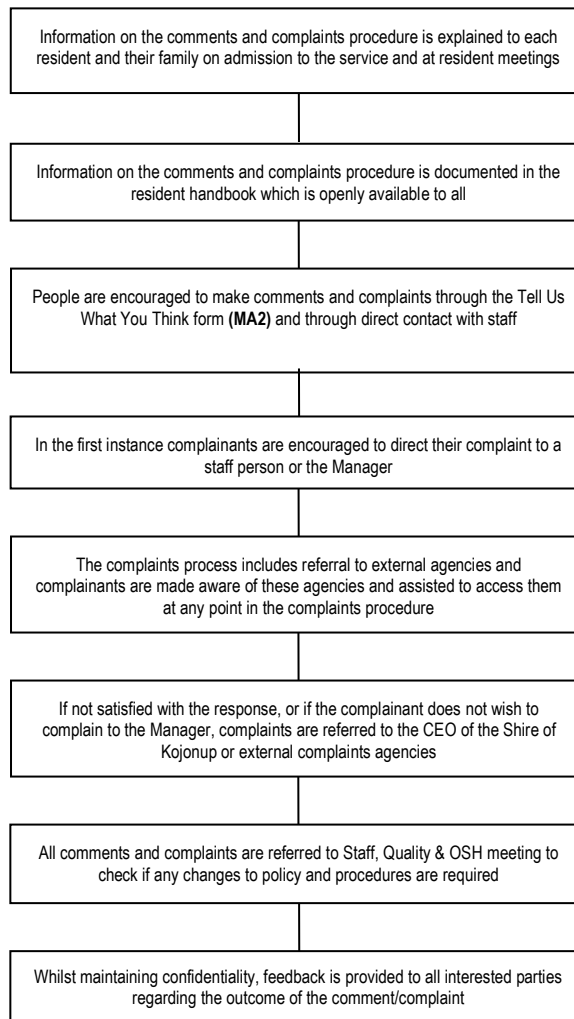
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COMMENTS AND COMPLAINTS

COMMENTS AND COMPLAINTS

Comments and Complaints Mechanism

OUTCOME: Each resident or representative and other interested parties have access to internal and external complaints mechanisms.



The service welcomes comments and complaints as these help improve all services provided.

Residents have a right to complain about the service they are receiving without fear of retribution and can expect complaints to be dealt with fairly and promptly.

Information on how to provide feedback and on the complaints procedure is explained to residents and representatives at the time of admission and detailed in the resident handbook.

The resident has the right to use an advocate of their choice to negotiate on their behalf with the staff and/or management of the service. This may be a family member or friend, or a representative from an agency such as Advocare.

All feedback or complaints are recorded on the Tell Us What You Think form (**Form MA2**). A tracking form is on the reverse of this form to document the follow up. This is to be completed by the Manager. An Improvement Project Log (**Form MA1**) is completed if an issue raised requires further intervention and analysis.

Person/s affected by the complaint are fully informed of all facts and given the opportunity to be involved in the resolution process.

Staff are trained in the comments and complaints procedure and are encouraged to seek feedback on their work.

Springhaven Lodge ensures all complaints are handled in a timely manner with full transparency and impartiality while maintaining confidentiality at all times.

COMPLAINTS PROCEDURE

The procedure for handling complaints¹ is outlined in the flow chart above and includes the following steps:

1. Residents are encouraged to raise their complaint with the staff member concerned in the first instance.
2. If the resident is not satisfied with the outcome, or not happy to discuss the issue with the staff member concerned, they should contact the Manager, or use an advocate to negotiate on their behalf. A 'Tell Us What You Think' form (**Form MA2**) outlining the complaint should be completed to document the complaint.
3. All complaints lodged using this form should be responded to by the Manager within two working days of receiving the form. The complainant will be phoned by the Manager in the first instance to arrange a family conference or a meeting to discuss the issues. Written confirmation of the actions taken in response to the complaint shall be provided to the complainant within 7 working days. All comments and complaints are referred to the next SQ & OSH meeting to check whether changes to policy and procedure are required.

¹ Department of Health *Better Practice Guide to Complaint Handling in Aged Care Services*

4. If the issue is still not satisfactorily resolved, the resident may raise the issue with the CEO of the Shire of Kojonup. The Manager should help the resident with this or offer to arrange an advocate for them.
5. The resident should be informed of the outcome of their complaint and asked for their feedback.
6. If the complaint is still not satisfactorily resolved or the complainant does not feel comfortable in raising the complaint with the service, the resident, their family or advocate can take the issue to Advocare or the Aged Care Complaints Scheme.

CONFIDENTIALITY OF COMPLAINTS

As far as possible, the fact that a resident has lodged a complaint and the details of that complaint should be kept confidential amongst the staff directly concerned. The resident's permission should be obtained before any information is given to any other parties who it may be necessary to involve in the complaint.

ADVOCACY SERVICES

Advocacy services available for residents/representatives include:

- Advocare 1800 655 566
- Aged Care Complaints Commissioner on 1800 550 552.

Advocare are always ready to listen to your problems when you live in an aged care facility.

Other external avenues of complaint also exist via:

WA Department of Commerce - Consumer Protection Advice Line
Phone: 1300 30 40 54

State Ombudsman
Phone: 08 9220 7555 or 1800 117 000 (toll free for country and interstate callers).

Commonwealth Ombudsman
Phone: 1300 362 072

MANAGEMENT OF UNREASONABLE COMPLAINT CONDUCT

Springhaven Lodge offers the following guide to managing unreasonable complaint conduct from residents, their representatives or others that behave in a challenging or unreasonable way. This may include aggression, making threats, swearing or using abusive language, dishonesty when making a complaint, unreasonable persistence with a complaint that has closed and unrealistic or disproportionate demands.

Staff have the right to be treated with dignity and respect during the complaints handling process and to work in an environment free from harassment.

Objectives of managing unreasonable conduct:

- Ensure equity and fairness
- Improve efficiency in the use of resources
- Ensure staff safety and comply with occupational health and safety requirements and duty of care obligations.

Managing unreasonable conduct:

- Exercise ownership and control of the complaint
- Focus on specific, observable conduct – the problem not the person
- Use clear terminology that focuses on the conduct of the complainant, not the person. (Use unreasonable conduct not difficult complainant).
- Apply relevant management strategies appropriate to the situation including setting limits or conditions, saying no or using risk management protocol.
- Respond with consistency to individual complaints and across complaints.
- Respond to the complaint with clear, timely and firm communication.

Preventing unreasonable conduct:

- Manage complaint expectations from the beginning
- Insist that the complainant shows respect – set boundaries by not tolerating rudeness, anger or aggression.

Organisational responsibility

- Maintain a commitment to the service's approach to dealing with unreasonable conduct
- Provide staff with adequate supervision and support in their dealings with unreasonable conduct
- Give staff sufficient time and resources to deal with unreasonable conduct

Staff responsibility

- Remain calm in the face of unreasonable conduct
- Show respect to all complainants including those acting unreasonably
- Act impartially in all matters
- Demonstrate professionalism in dealing with complainants including those acting unreasonably.

OPEN DISCLOSURE

Open disclosure is the open discussion we have as providers with residents when something goes wrong that has harmed or has the potential to harm a resident. Harm may be physical, psychological or social resulting in the loss of quality of life, impairment, suffering injury, disability or death.

Open disclosure is the practice of communicating with residents when things go wrong, addressing any immediate needs or concerns and providing support, apologising and explaining the steps the provider needs to take to prevent this happening again. It could also involve the resident's family, carers and other support people and representatives when a resident would like them to be involved.

Honest and timely disclosure to residents is ethically, morally and professionally expected at Springhaven Lodge and is the first stage in promoting and fostering an environment and culture that through honest discussion will improve the care and services at the facility in partnership with our residents.

Four principles underpin open disclosure and are linked to the Charter of Aged Care Rights. They are as follows:

- Dignity and respect
- Privacy and confidentiality
- Transparency
- Continuous quality improvement

The five main elements of open disclosure are as follows in no particular order:

- Identify when things go wrong
- Find out and explain what happened
- Address immediate needs and provide support
- Acknowledge and apologise or express regret
- Learn from the experience and make improvements

If there is a conflict between the resident and their family, partners or friends during open disclosure the resident's wishes takes precedence. When a representative is appointed to make decisions for a person who requires decision making support, the representative should be directed by the will, preferences and rights of the person. They should do whatever they can to support the person to make their own decision, or if not possible use a "substitute judgement" motivated by what the person would have wanted had they been able to make the decision themselves.

COMPULSORY REPORTING OF REPORTABLE OFFENCES

The Office of Aged Care Quality and Compliance has developed Compulsory Reporting Guidelines for Aged Care Providers (June 2007) in line with amendments to the *Aged Care Act 1997*. These guidelines are followed by Springhaven Lodge. A synopsis of the guidelines are included below. Springhaven maintains, a separate record for each reportable offence that includes:

- The date the Approved Provider received the allegation or started to suspect on reasonable grounds that a reportable assault had occurred
- A brief description of the allegation or the circumstances that gave rise to the suspicion and
- Information about whether a report of the allegation or suspicion has been made to the police and the Department of Health, or whether the allegation or suspicion has not been reported to the police or the Department because of the discretion under subsection 63-1AA(3) of the Act applies.

5 KEY ELEMENTS TO COMPULSORY REPORTING REQUIREMENTS

1. All approved providers of Australian Government subsidised residential aged care must encourage staff to report alleged or suspected reportable assaults to enable approved providers to comply with their responsibility under the Act. This requirement recognises that in many cases, it may be staff who first notice assaults. The legislation therefore requires that approved providers not only give staff information about how to report assault, but also to actively require staff to make reports if they see, or suspect, an assault on a resident.
2. The Act requires that, except in very specific and sensitive circumstances involving residents affected by cognitive or mental impairment, and where there are repeated allegations of the same assault, all approved providers of residential aged care, must report all allegations or suspicions of reportable assaults. An approved provider should not wait until an allegation is substantiated – the fact that a person has alleged that someone has assaulted a resident is sufficient to trigger the reporting requirements.
3. Reports must be made to both the Police and the Department within 24 hours of the allegation being made or the approved provider becoming suspicious that an assault may have occurred. These tight timeframes ensure that alleged assaults are acted upon immediately.
4. If a staff member makes a disclosure qualifying for protection under the Act, the approved provider must protect the identity of the staff member and ensure that the staff member is not victimised. This is important in encouraging ongoing reporting by staff members.
5. The legislation is underpinned by possible sanctions for non-compliance. If an approved provider is found to be non-compliant with any of the compulsory reporting requirements, the Department may issue a notice requiring the approved provider to take certain actions and may also impose sanctions.

WHAT IS A REPORTABLE ASSAULT?

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

- Unlawful sexual contact with a resident of an aged care home; or
- Unreasonable use of force on a resident of an aged care home.

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

The definition of reportable assault used in the Act provides a simple, readily understood and universally accepted definition. It avoids the difficulties of applying legalistic definitions that vary widely throughout Australia.

1. Unlawful sexual contact

The term 'unlawful sexual contact' is intended to capture any sexual contact, without consent, that is unlawful under any Commonwealth, State or Territory law.

The legislation is intended to cover any unlawful, or unwanted, sexual contact with residents for which there has been no consent. If the contact involves residents with an assessed cognitive or mental impairment, it should be noted that the resident may not have the capacity to understand their circumstances and may not be able to provide consent.

The term 'unlawful sexual contact' has been used to avoid the use of specific terms, such as sexual intercourse, rape and sexual assault which are all defined differently in different pieces of Commonwealth, State and Territory legislation and to ensure that all unlawful sexual conduct, no matter how described, is captured. It is not intended to cover situations where there is no physical contact.

2. Unreasonable use of force

Unreasonable use of force as defined in the Act is intended to capture assaults ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force on a resident. For example, the definition captures hitting, punching or kicking a resident regardless of whether this in fact causes visible harm, such as bruising.

It is recognised that in the aged care environment, there may be circumstances where a staff member could be genuinely trying to assist a resident, and despite their best intentions the resident is injured because the person bruises easily or has weak skin. Injury alone therefore may not provide conclusive evidence of either the use of unreasonable force or the seriousness of an assault.

- captures use of force where such force is not warranted; and
- avoids difficulties associated with utilizing legalistic definitions.

REPORTING TO THE DEPARTMENT OF HEALTH

Compulsory reports are made to the Department of Health via the Aged Care Complaints Commissioner on 1800 550 552 or email compulsoryreports@health.gov.au. This line also receives external information about Australian Government subsidised aged care services and any concerns and complaints about such services.

Departmental Officers manage the line from 9.00am – 5.00pm AEST Monday to Friday and 10.00am – 5.00pm AEST Saturday, Sunday and Public Holidays. Outside these hours, an answering machine is available for people to leave a message that is regularly checked and actioned.

The Department may receive information about alleged or suspected assaults on a resident through varied means; for example, from an approved provider, from a staff member either anonymously, confidentially or openly, from residents and their families and from other health professionals.

MISSING RESIDENTS

Actions to be taken in response to missing residents are included in Manual 4 Section 6 Resident and Staff Safety.

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RESIDENT'S LIFESTYLES

RESIDENT'S LIFESTYLES

Springhaven Lodge supports and enables each resident to participate in their community within and outside the facility, to have social and personal relationships and to do the things of interest to them, resulting in the opportunity to have the best day possible, each and every day.

Each resident (and/or their representative if appropriate) to complete assessments relating to leisure and lifestyle during the first 28 days of admission with a suitably qualified staff member. The creation of the care plan includes collection of some of the basic information about the resident's lifestyle, cultural and spiritual needs. These assessments include, but not limited to:

- The residents previous and current hobbies and interests and their functional and / or cognitive capacity to continue to pursue such interests;
- People and events of significance to the resident and their responses to such events;
- The resident's cultural and spiritual needs
- The residents preferences regarding participating in activities, and
- The role of external providers (such as hairdressers, delivery of newspaper or other activities).

This information assists staff to provide the appropriate lifestyle support and develop a care plan suited to the resident's individual needs. On admission all resident's lifestyle choices, social history and preference for activities are assessed.

Goals/aims are what the resident wants to achieve in the specific assessed area of lifestyle. The goal is not what the staff want for the resident, nor what the staff think the resident would want. Where the resident and their representative express different goals, the resident's goals are to be noted and a discussion had with the representative about this.

Strategies are the actions that are going to be put into place in order to meet the goals/aims of the assessed need. Strategies are to be developed in collaboration between the staff member and the residents) and/or their representative if applicable).

Interpreter services should be offered to residents (and/or their representative) where language barriers impact on undertaking this process.

LEISURE INTERESTS AND ACTIVITIES

Each resident and family are encouraged to complete a 'Personal and Social History' (**Form RC22**) to assist in the planning of appropriate lifestyle choices and activities programs. **All residents/families are provided with weekly activity plan that outlines the therapy and social programs available at the service.** The planners are available around the service for residents to refer to on an ongoing basis.

On admission residents are asked what interests or activities they would like to be involved in, and these are included in the care planning. The 'Personal and Social History' (**Form RC22**) is used to record these preferences. Attendance at activities is recorded daily on the OT Monthly Stat form (**Form RC56**) by the Activity Coordinators, recording the lifestyle activities the resident was involved in and his/her level of participation. All residents are assessed by an Occupational Therapist and a Therapy Care Plan completed. The assessment is comprehensive and determines both the therapy needs and individual activities and leisure interests relevant to the resident to promote socialization and cognitive and functional wellbeing. Reassessment will occur when there is a change in the resident's condition or at least annually.

A range of therapeutic and leisure interest and activities are provided for residents to participate in and these are posted on a planner for residents to see throughout the facility. All programs are evaluated regularly, including individual review and evaluation of individual plans by the Occupational Therapist as required, comprehensive annual reviews and evaluation of programs periodically. The Occupational Therapist conducts these evaluations and has documentation to support their conduct.

Resident feedback, comments and suggestions on the activities program are sought at resident meetings, and informally on an ongoing basis. Resident feedback is acted on whenever possible. (See Choice and Decision Making below)

RESIDENT PARTICIPATION & SOCIAL INCLUSION

Springhaven Lodge is committed to empowering and supporting residents to fully participate in the community and this organisation.

The organisation will:

- support residents to participate in the community and activities of choice
- enable residents to be involved in decisions that affect them and the services they receive;
- encourage and support residents to be involved in service development, evaluation, planning and organisational management;
- seek resident input regarding resident participation information strategies, assistance and support, service involvement and development;
- develop links with other groups to promote greater opportunities for connections and meaningful participation in the community.

ACTIVITIES

A range of activities in the service and community are arranged for residents. These include:

- craft
- painting
- concerts/concerts at the facility
- barbecues and picnics

- church activities
- family visits
- community events
- in-house celebrations
- cultural events

Contact with family is encouraged in the following ways:

- unrestricted visiting times
- Allow residents to use the phone to contact family members
- lots of space for families and residents to talk in private – can use their room or any other area
- residents are free to go out with family/friends at any time.

EMOTIONAL SUPPORT

All staff are responsible for ensuring that all residents and, where relevant their family, receive the emotional support required. This is achieved through:

- residents are welcomed into the facility, introduced to staff and other residents and shown around
- the resident occupancy agreement is explained to the resident and/or their representative
- the residents are interviewed on admission to the service this ensures that their interests, preferences and needs are cared for by staff helping the resident to feel more settled. Background information is collected to make sure cultural needs are respected
- resident's linguistic, cultural and religious needs are met where possible
- staff members make themselves available for a chat with residents while they are working or at morning tea times etc.

INDEPENDENCE

Residents are encouraged to retain maximum independence and to continue with activities in the community.

Resident's needs, preferences and interests are identified in the assessment process.

Social Independence

Residents are encouraged and supported to receive visits from their friends and families at all times that are suitable to them.

Residents may entertain guests in their rooms or in the lounge area the facility. Residents may organise through a telecommunications service for a telephone connection. Staff may assist residents with their independence by offering privacy to residents and their guests.

RESIDENT'S FINANCES

Where possible the residents are encouraged to maintain control of their financial affairs.

Residents who normally manage their funds on their own are encouraged to continue doing this. Families are encouraged to assist their family members to manage their finances.

Staff cannot accept any money/gifts from residents under any circumstances.

DRINKING

Alcohol is permitted at the service in moderation if not contraindicated due to medical conditions.

~~PRIVACY AND DIGNITY~~

~~Each resident's rights to privacy and dignity is respected through:~~

- ~~■ encouraging family members to stay, especially when the resident is sick~~
- ~~■ limiting the collection of personal information by staff to information that is necessary to provide appropriate care to the resident~~
- ~~■ providing private spaces within the service for residents and their family to go to~~
- ~~■ ensuring the confidentiality of resident information~~
- ~~■ residents are encouraged to spend time with family and friends. Family and friends are encouraged to visit the service~~
- ~~■ independence in undertaking the activities of daily living such as bathing, toileting and dressing is encouraged. Bathroom doors are closed during showering and toileting when assisted by staff unless the resident has an objection, in this case care to maintain privacy will be taken. For example, not allowing others in the bathroom at this time~~
- ~~■ residents who do not require assistance with showering, toileting and dressing are encouraged to undertake personal activities in private~~
- ~~■ residents who require assistance with the personal activities are treated with respect~~
- ~~■ staff members knock and announce themselves before entering rooms~~
- ~~■ residents are treated with respect and dignity at all times~~
- ~~■ staff are advised in the Staff Handbook and reminded on a continuing basis that information regarding residents is to remain confidential at all times.~~

~~(Refer to policy and procedures described above and in the Manual 1: Management and Administration.)~~

USE OF FACILITIES BY FAMILY

Visitors can stay as long as they like and are encouraged to visit regularly.

People can sleep over with palliative patients at the Manager's discretion.

Residents are assisted to go to the funerals of previous residents if requested.

~~CULTURAL AND SPIRITUAL LIFE~~

CULTURAL, DIVERSITY AND SPIRITUAL LIFE

Springhaven Lodge is committed to:

- ensuring a supportive workplace that respects and values diversity of customs, cultures and beliefs
- ensuring that its services are delivered in a manner that respects and values the customs, cultures and beliefs of the residents
- preventing harassment or discrimination of any kind.

Springhaven is committed to creating and maintaining a workplace and a culture that is respectful of all people. In particular this applies to:

- aboriginal and torres strait islander people
- people from non- english speaking backgrounds
- people from diverse racial, religious or cultural backgrounds
- people with a disability
- gay, lesbian, transgender/gender divers, bisexual or intersex people.

Residents are encouraged and supported to maintain cultural, linguistic and religious customs and traditions.

The service makes an area available when necessary, for cultural, spiritual or religious ceremonies as required.

The facility encourages active recruitment of staff from diverse backgrounds and actively consults people from diverse cultural and linguistic backgrounds to identify and prioritise needs and in planning service.

On entry to the service residents are interviewed about cultural, spiritual and linguistic preferences and issues using the 'Personal and Social History' (**Form RC22**). The activities of the service are planned according to this information. Members of staff are encouraged to foster resident's interest in cultural, spiritual and linguistic activities.

Residents' cultural background and language are identified on admission (**Form RC5**) to the service and residents are supported in their efforts to remain in contact with members of their community. Assistance is sought from the Multicultural Society as required and the Occupational Therapist assists in sourcing materials as required. Residents are supported in observing significant personal events where known and possible.

The service encourages residents to participate in events where they can enjoy their dietary customs.

Other cultural activities include:

- cultural theme days; and
- observance of the Christian calendar.

(Refer to Independence and Resident Admission above.)

SEXUAL EXPRESSION & INTIMACY

Springhaven supports all residents in the right to intimacy and sexual expression providing it does not impinge upon the rights of others. Residents have the rights to be treated and accepted as an individual and to have his/her preferences taken into account and be treated with respect.

Care staff will maintain a non-judgmental and respectful attitude. Staff beliefs and values will not interfere with the rights of residents.

Staff to provide and support residents in the right to uninterrupted privacy with a loved one, by providing a "Do not Disturb" sign upon request. (Except where impractical or impossible for medical reasons). Staff must knock and wait for permission before entering a resident's room, except in emergency situations (i.e. fire, call bell ringing, medical issue)

For residents that do not have a cognitive impairment, information and decisions about sexual expression are treated with confidentiality and are not discussed with family members unless requested by resident.

Staff to assist residents to feel good about themselves by assisting them with grooming and dressing in favourite clothing.

Appropriate mediation/counselling /education will be sought to assist family to understand the rights of the person with cognitive impairment in situations where the family's wishes appear to conflict with the residents wishes or interests.

Staff to always report to Manager or RN if they feel inappropriate behavior is occurring toward a cognitive impaired resident.

Support will be provided to staff members who feel uncomfortable about a resident's sexual expression and training will be provided to staff.

CHOICE AND DECISION-MAKING

~~Resident's and their family are provided with the information they need to make decisions about their care. Staff are to take care to explain all information in simple language, and to use an interpreter if necessary.~~

~~On admission the resident handbook is explained to each resident.~~

~~The handbook includes information on:~~

- ~~resident rights~~
- ~~fees~~
- ~~complaints and feedback~~
- ~~resident agreement~~
- ~~advocacy services~~
- ~~care plans~~
- ~~therapy programs, activities and outings.~~

~~Residents are reminded of this information at resident meetings and at re-assessment.~~

~~Residents are also informed that they do not have to sign an agreement and that they have the right to refuse treatment. The implications of refusing treatment are explained by a doctor and the resident's refusal is noted in their file.~~

~~(Refer Section 4: Medication Management)~~

~~Residents, family and community members are encouraged to provide feedback on the service through:~~

- ~~Tell Us What You Think Form~~
- ~~requests for feedback at meetings~~
- ~~informal feedback~~
- ~~interview with residents on admission and during case conferences~~
- ~~specific issue discussions~~
- ~~inclusion of an explanation of feedback mechanisms in the regular newsletters.~~

~~All feedback is reported to the Manager, collated and discussed at staff meetings. Appropriate recommendations are discussed at the monthly Staff, Quality & OSH meeting.~~

~~SECURITY OF TENURE~~

~~Residents may continue to live at the service until they require a greater level of nursing care than the service is able to provide or unless his/her behaviour places staff, other residents or themselves at risk, and this behaviour cannot be managed effectively.~~

~~In this case, alternative options will be discussed with the resident and his/her next of kin and with their permission, suitable alternative accommodation will be arranged. Before any decision is made to transfer a patient, a re-assessment of their medical and social needs will be undertaken by their doctor and other health professionals as required.~~

~~The Resident Handbook and resident agreement outline the resident's rights including their right to security of tenure.~~

~~These are explained to the resident on admission and at annual case conference. The resident's rights are not affected if he/she does not wish to sign the resident agreement.~~

PERSONAL BELONGINGS

Residents are encouraged to bring personal belongings with them to the facility and staff try to ensure that these are kept safe.

Residents keep cash/valuables on the premises at their own risk. In each resident's room, a small lockable cupboard is provided in each residents room for their private use.

Residents/family are encouraged to complete in detail Residents valuables/personal belongings form (**Form RC43**) on admission.

Personal photographs and artwork can be displayed in the resident's room.

CLOTHING

Resident's clothing and other personal items such as blankets are labeled and returned to the resident after laundering.

DEATH OF A RESIDENT

~~On the death of a resident within the facility, the procedures is as follows:~~

- ~~■ call an Manager/ RN on duty~~
- ~~■ the doctor is contacted to confirm the death (if possible).~~
- ~~■ If the doctor is unable to certify the death, 2 x RN's may complete the "extinction of life" form.~~
- ~~■ on confirmation of the death the next of kin are to be contacted, the phone number and/or address will be in the resident's file~~
- ~~■ wait for directions from the next of kin on how next to proceed with regard to the belongings of the resident. Confirm the residents/relatives choice of funeral director~~
- ~~■ contact the funeral director~~
- ~~■ the funeral director will remove the body~~
- ~~■ If it is out of hours and the funeral director will not collect the body, contact the Manager~~
- ~~■ if the body needs to be identified, this is the responsibility of the Manager~~

- ~~■ residents' family are encouraged to remove clothing and other possessions belonging to the deceased resident from the room.~~

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ANTIMICROBIAL STEWARDSHIP

Antimicrobial Stewardship

PURPOSE AND SCOPE

The purpose of the Antimicrobial Stewardship policy is to promote optimal management of antimicrobials in order to maximize the effectiveness of treatment and minimise potential for harm (including drug resistance and toxicity).

PRINCIPLES OF ANTIMICROBIAL MANAGEMENT

- Decisions about antimicrobial prescribing should be based on careful clinical assessment, ensuring that the benefits of antimicrobial use are always weighed against the potential for harm.
- Decisions regarding the prescribing of antimicrobials should be based on the best available evidence. National guidelines such as the Therapeutic Guidelines: Antibiotic should form the basis of prescribing recommendations, with adjustment for individual resident factors (allergies, comorbidities).
- Documentation for all antimicrobial prescriptions should be clear to enable effective communication between all staff members.
- Residents should always receive clear information about their clinical condition and treatment in a form they can understand.
- Regular review and refinement of the antimicrobial therapy should occur based on the resident's clinical progress (improvement or deterioration) and available clinical information (investigation results).

POLICY:

1. Management will ensure an effective program to prevent and control infections is implemented, thereby minimising the need for antimicrobial use. This may include elements such as vaccination, hand hygiene, etc.
2. Management will ensure that all clinical staff are informed about the importance of safe antimicrobial use. Resources to raise awareness should be available (posters, pamphlets) for staff, residents and families.
3. Management will ensure that clinical staff are educated about the recognition of signs and symptoms of infection and know how to escalate concerns to medical staff in a timely manner.

4. Management will ensure that staff know how to access individuals with antimicrobial prescribing expertise (pharmacist or general practitioner) to discuss concerns about medication.
5. Management will ensure that all clinical staff can access current endorsed national guidelines on antimicrobial prescribing.
6. Management will ensure that mechanisms are in place to enable staff to access antimicrobials in a timely way for patients with acute infections.
7. Management will ensure a system is in place that enables diagnostic test results to be reviewed in a timely way.
8. Management will require that if an antimicrobial is prescribed all key prescribing elements are clearly documented to facilitate good communication.
9. Management will require that if an antimicrobial is prescribed, the resident should be clinically assessed by the prescriber within a reasonable timeframe eg.48 hours.
10. Management will require all new antimicrobial prescriptions to have a clear treatment plan (especially after seven days) and all prolonged (long term) antimicrobial prescriptions to be reviewed at least half yearly to determine if ongoing use is still appropriate.
11. Management will ensure a resident with a suspected infection, and /or their relative, receives information on their health condition and treatment options in a format and language that they can understand.
12. Management will specify a person who is responsible for leading and coordinating AMS initiatives.
13. The nominated AMS person has the authority to review all procedures and guidelines that contain recommendations for the use of antimicrobials to ensure that the advice is evidence-based where possible and concordant with AMS principles.
14. The nominated AMS person has the authority to lead at least annual audits of infections and antimicrobial prescribing practices.
15. The nominated AMS person is expected to provide reports to management and clinicians where relevant regarding prescribing safety and quality.



01

GOVERNANCE

CLINICAL GOVERNANCE

Clinical Governance is a set of relationships established by Springhaven and its relevant stakeholders to ensure the best possible clinical outcomes.

Springhaven is committed to developing and implementing a clinical governance framework that ensures the provision of safe, effective, high quality, consistent and resident-centered clinical care for residents.

Springhaven will strive to include residents, clinicians, clinical review, training, risk management, workforce management and continuous improvement in its clinical governance framework. The purpose of this policy is to ensure that everyone is accountable to residents and the community for delivery good clinical outcomes and meeting clinical indicators.

In order to achieve the goal of providing safe and high- quality, person-centered care, Springhaven Clinical Governance Policy includes the following elements:

- Roles and responsibilities of residents, governing bodies, clinical leaders/managers and health service staff;
- The importance of culture in establishing good clinical governance;
- Resident partnerships;
- Workforce procedures;
- Processes that identify and manage clinical risk, safety and quality, and
- Clinical practice procedures.

Communication of this Policy

The Manager is responsible for ensuring that members of the clinical workforce understand the organisation's approach to, as well as their own responsibility for, delivery safe and high quality healthcare.

Springhaven's Management Team

- Assist in the delivery of the governing body's strategic direction and vision to provide quality care;
 - Support the development of workers to become leaders in the championing safe and quality care for all residents using services;
 - Assist the governing body with monitoring by ensuring accurate reporting and analysis occurs regularly;
 - Be aware of key areas of potential risk and act responsibly when the safety of a resident or worker is compromised; and
 - Determine the effectiveness of clinical governance systems through continuous evaluation.
-

Clinical leaders are responsible for:

- Supporting clinicians through a culture of safety, transparency, accountability, teamwork and collaboration;
- Developing effective working partnerships with other health service organisations, clinical groups, clinicians and residents;
- Providing useful performance data and feedback to clinicians.
- Identifying and mitigating areas of potential risk, and reporting to the governing body any incidents where safety has been compromised; and
- Developing an operations policy and procedures framework which address:
 - Risk management
 - Quality improvement
 - Incident management
 - Open disclosure
 - Feedback and complaints; and
- Ensuring staff understand their roles and responsibilities and are held accountable for the care they provide.

All health service staff are responsible for:

- Providing the highest quality of clinical care possible within the parameters of the clinical governance framework;
- Providing feedback if they are harbouring concerns over anything related to clinical care and the delivery of safe services.
- Education themselves and frequently refining their skills to ensure they are providing the best care possible;
- Complying with relevant care standards, protocols and procedures; and
- Contributing to an organisational culture of delivering high-quality care, safety, teamwork, collaboration and transparency.

Governance, Leadership and Culture

Springhaven Lodge understands the importance of workplace culture in ensuring both patients and residents receive safe and high- quality care. We will endeavour to create an organisational culture with:

- Strong and effective strategic and cultural leadership of clinical services;
- Clear responsibilities for managing safety and quality care;
- Reliable monitoring systems to ensure delivery of care is effective;
- Data and information that are used to monitor and report on performance; and
- Systems in place for identifying and managing clinical risk.

Partnering with residents

Resident partnerships will be promoted across Springhaven Lodge in planning, policy development, guidelines, training and care delivery.

Systems are in place to ensure:

- Delivering resident-centred care is a key priority;
- Residents are encouraged to give feedback on the care they receive;

- All workers within the health system establish respectful and transparent lines of communication with residents;
- The diverse needs, including communication needs, of residents and the community are met;
- Feedback on clinical care from residents is acted upon to make improvements;
- The rights and responsibilities of residents are respected and promoted, as required by the *Australian Charter of Healthcare Rights*; and
- Resident complaints are responded to in a timely way and competently, and are used to improve care and services.

Clinical performance and effectiveness

Springhaven is committed to providing a physically and emotionally safe workplace. Staff at all levels of the organisation will undergo training and receive information on improvement tools and methods. Human Resources will ensure staff feel supported to develop and consolidate their skills.

Springhaven Lodge will strive to provide a physically and psychologically safe workplace by ensuring:

- Procedures are in place to ensure suitable workers are hired based on their qualification and prior experience, to deliver the highest standard of resident-centred care
- Procedures are in place to foster a safe, respectful and collaborative working environment;
- Workers are clear on their responsibilities and workplace expectations, and are held accountable for meeting those expectations;
- Workers strive to improve their own practice and organisational processes through continuous learning; and
- An effective complaints management system is in place and regularly reviewed.

Safe environment for the delivery of care (risk management)

Springhaven Lodge will ensure safety and quality improvement systems are central to creating a safe working environment and support clinicians to deliver the highest standard of safe and quality care for residents.

Springhaven Lodge will create a safe environment for the delivery of care by:

- Implementing effective quality improvement processes;
- Identifying opportunities to improve the safety and quality of the working environment; and
- Ensuring appropriate resources, facilities, staff, training tools and equipment are available to satisfy the highest standard of care delivery.

Resident Safety and quality improvement systems

To strive for the highest level of clinical practice, Springhaven Lodge will ensure that:

- Research and evidence-based clinical care forms the basis for clinical practice;
- Clinicians endeavour to inform residents on the care they receive, and are transparent and open in communication;

- Clinicians receive the support they need to work safely and effectively, through training, skills and technology;
- Clinicians strive to improve their peers' and their own clinical care and actively participate in the review of clinical systems and processes;
- Data is collected on clinical care to ensure that there is organisational accountability and continuous improvement; and
- When new procedures for clinical practice and methods are introduced, they are safeguarded and potential risks are managed.

Springhaven Lodge will implement an effective risk management system which;

- Identifies and documents organisational risk in an effective risk register;
- Uses data collection to support risk assessments;
- Acts to reduce risks by ensuring clinical incidents are investigated and reported to address root causes;
- Reviews and attempts to improve the effectiveness of the risk management system;
- Reports on risks to the workforce and residents;
- Plans for, and manages, internal and external emergencies and disasters; and
- Complies with and adheres to risk-related legislation and relevant National standards.

Report, review and respond to performance

The Manager is responsible for monitoring and reporting on the clinical outcomes and performance of the clinical governance framework.

Reports will be used to inform review and improvement of the organisation's clinical governance and clinical risk systems.

SECURITY OF TENURE

Residents may continue to live at the service until they require a greater level of nursing care than the service is able to provide or unless his/her behaviour places staff, other residents or themselves at risk, and this behaviour cannot be managed effectively.

In this case, alternative options will be discussed with the resident and his/her next of kin and with their permission, suitable alternative accommodation will be arranged. Before any decision is made to transfer a patient, a re-assessment of their medical and social needs will be undertaken by their doctor and other health professionals as required.

The Resident Handbook and resident agreement outline the resident's rights including their right to security of tenure.

These are explained to the resident on admission and at annual case conference. The resident's rights are not affected if he/she does not wish to sign the resident agreement.

4

SERVICE MANAGEMENT

Springhaven Lodge was established in 1982 and is owned and managed by the Shire of Kojonup. Our workplace is our resident's home and we value each person we care for and every colleague we work with.

We are proud to live and work within a close knit rural community.

Our Mission

Springhaven is a rural based community residential facility.

We encourage physical, emotional and spiritual wellbeing in constant consultation with our residents and their families.

We will help our residents live the life they choose at Springhaven Lodge.

Our Vision

To assist our residents in leading a meaningful life in a homely and caring environment and encourage them to maintain their identity.

Our Values

Respect

Understanding

Reliability

Accountability

Loyalty



PHILOSOPHY

At Springhaven Lodge we believe:

- each person is an individual with unique needs
- care services must be holistic and should recognise the physical, emotional and social needs of the individual
- residents of our service have the same rights as they would in their own home including the right to be treated with dignity and respect and the right to make decisions and choices regarding their lives and
- residents have a right to safe and secure accommodation free from harassment and fear regardless of age, race, sexual preference or religion.

COMMITMENT TO CONTINUOUS IMPROVEMENT

Springhaven Lodge is committed to providing quality services and to continually improving the services for residents. In pursuing the highest quality of services we continually seek the involvement of our staff, residents and their families and other key people in the community whenever appropriate.

OBJECTIVES

The objectives of the Springhaven Lodge are as follows:

1. Deliver care appropriate to support the individual needs of residents.
2. Provide a safe working environment for our staff.
3. Ensure staff are appropriately trained and are part of the multidisciplinary care team.
4. Ensure the building is properly maintained and is fit for purpose.
5. Operate within the budget and maintain a viable service.
6. Meet the standards expected by residents, relatives, the community and government.
7. To support the Council to develop strategies to respond to the needs of the community.

ROLE OF THE CEO AND SHIRE OF KOJONUP COUNCIL

As owner and operator of Springhaven the Shire via Council is to:

- Establish effective corporate policies, systems and processes aligned with the provision and delivery of sustainable aged care accommodation at Springhaven.
- Ensure achievement of performances and compliance standards via the following essential functions:

Strategic Direction

Participate with management in setting policies, goals, strategic and performance targets for Springhaven to meet both legislative and community expectations.

Resources

Make available to management the human/physical/financial resources to achieve the Strategic Plan.

Performance

Monitor Springhaven's performance against its strategies and targets.

Compliance

Ensure there are adequate processes in place to comply with statutory requirements.

Risk

Ensure that the risks to which Springhaven is exposed are clearly identified and suitable processes are in place to manage those risks.

Accountability to Stakeholders

Report and align the collective interests of residents, their families, community, Council, Management and employees.

ROLE OF THE MANAGER

The Manager is delegated authority to run the day-to-day operations of Springhaven Lodge on behalf of the Shire of Kojonup and in line with the policy and procedures established by the organisation.

The Manager reports to the Shire of Kojonup Council in writing at quarterly council meetings and to the CEO at fortnightly at Senior Management meetings.. The Manager's reports include:

- a report on service operations
- a report on staff issues
- a report on resident issues
- legislation update
- continuous quality improvement
- complaints and compliments
- any other issues.

The Manager along with staff and residents develop the strategic plan for Springhaven Lodge and then is submitted to the CEO and Shire of Kojonup Council for approval and adoption.

The Manager is responsible for developing and modelling the values and culture of the facility and for overseeing and monitoring operational plans and activities.

(the above highlighted area needs to be placed in the Quality Plan & Strategic Priorities 2017/2022)

ORGANISATION STRUCTURE

Springhaven Lodge employs the following staff:

- | | |
|----------------------------|-------------------------|
| ▪ Manager/Registered Nurse | ▪ Cook |
| ▪ Registered Nurse | ▪ Cook (Other) |
| ▪ Clinical Coordinator | ▪ Cleaner/Domestics |
| ▪ Enrolled Nurse | ▪ Carers |
| ▪ Volunteers | ▪ Activity Coordinators |
| ▪ Facility Coordinator | |

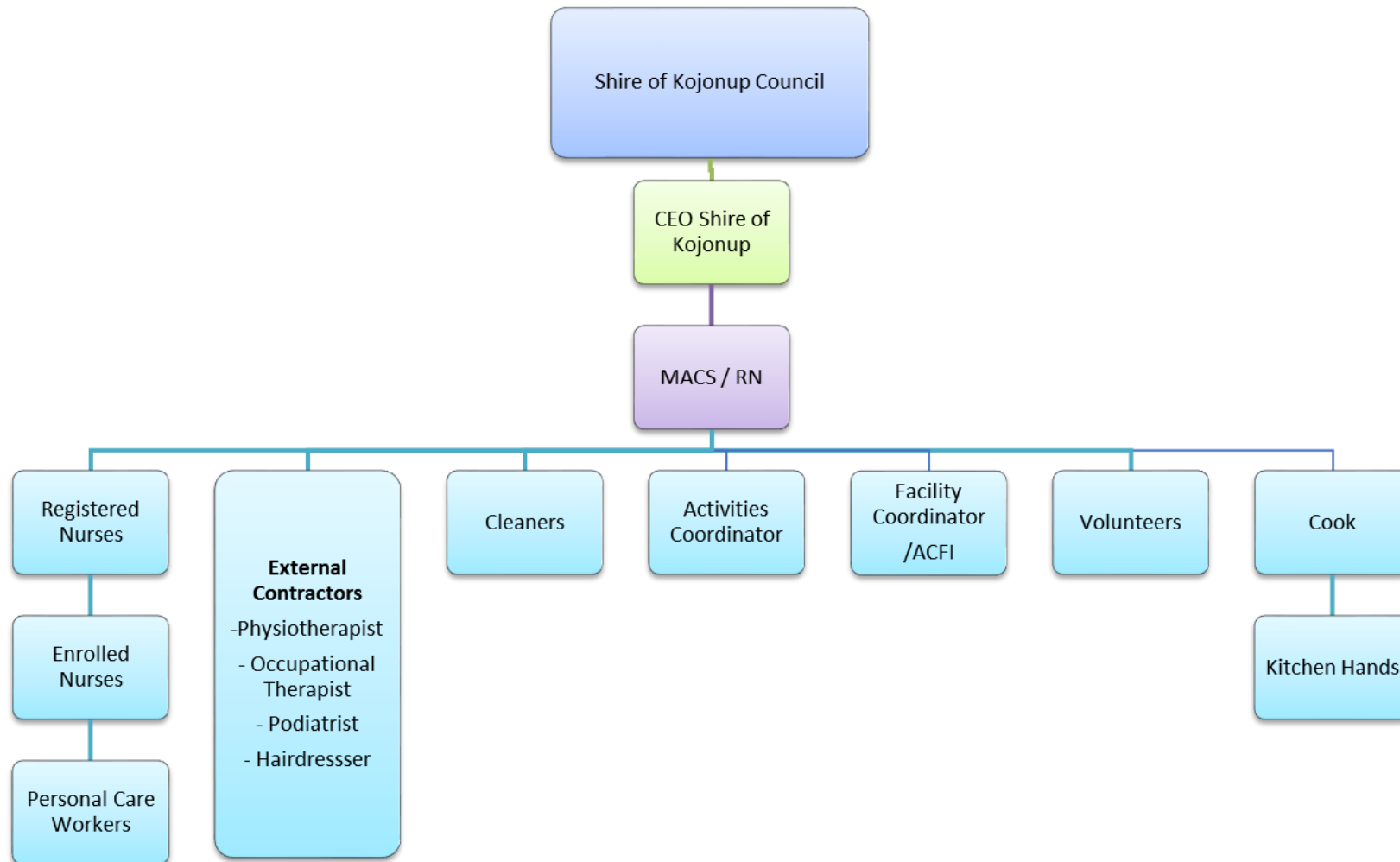
Springhaven Lodge has the following external service providers:

- Podiatrist
- Occupational Therapist
- Physiotherapist
- Handyperson
- Gardener/Maintenance
- Hairdresser.

The Manager is responsible for the day-to-day management of the service.

The organisational structure for Springhaven Lodge is shown in the figure below.

Springhaven Lodge Organisation Chart – July 2019



MEETINGS

Management of Springhaven Lodge involves the following meetings.

Meeting	Frequency	Attendees	Purpose
Shire of Kojonup Council meeting	Quartely or when invited.	<ul style="list-style-type: none"> ■ Manager of Springhaven ■ Council delegates ■ CEO Shire of Kojonup. 	<ul style="list-style-type: none"> ■ Provide a link between Springhaven and the community ■ Allow for discussion and consultation between Shire personnel, council delegates and community members regarding the operations of Springhaven ■ Provide a forum for discussing the Manager's report.
CEO/Senior Management Meetings	Fortnightly	<ul style="list-style-type: none"> ■ CEO ■ Manager of Engineering & Works ■ Manager of Regulatory & Community Service ■ MACS ■ Manager of Corporate Services 	<ul style="list-style-type: none"> ■ Provide a link between Springhaven and Shire of Kojonup ■ Allow for discussion and consultation between Shire managers and CEO regarding the operations at Springhaven Lodge.
Staff, Quality & OSH Meeting	Monthly	<ul style="list-style-type: none"> ■ Manager (Chair) ■ Facility Coordinator ■ Clinical Coordinator /RN ■ Occupational Safety and Health representative/s ■ Staff 	<ul style="list-style-type: none"> ■ Two way communication ■ Identification of issues ■ Training ■ Health and safety, including risk identification ■ Monitor the quality of service provision ■ Make recommendations for changes in service ■ Review the continuous improvement process ■ Oversee staff training and development ■ Oversee the implementation of new strategies and programs ■ (See also Section 2: Continuous Improvement for more information on the SQ & OSH meeting).
Residents meeting	Monthly	<ul style="list-style-type: none"> ■ Seniors Mental Health Nurse/OT/OTA (Chair) ■ Residents ■ Relatives ■ (Manager attends the meeting by invitation). 	<ul style="list-style-type: none"> ■ Identification of resident issues ■ Resident/relative feedback ■ Planning outings/activities ■ Information dissemination.

AGENDAS FOR MEETINGS

Standard agendas are in use for key meetings. The agenda for the SQ & OSH meetings is:

STAFF, QUALITY & OSH MEETING

1. Attendance
2. Apologies
3. Minutes of the last meeting
4. Business from the last meeting
5. Staff Communication
 - 5.1 Manager's Feedback to Staff
 - 5.2 Regulatory Compliance
 - 5.3 Staff Management Issues
 - 5.4 Infection Control Report
 - 5.5 Training Report
6. Occupational Safety and Health
 - 6.1 Correspondence
 - 6.2 Review of hazard information
 - 6.3 Review of resident adverse events
 - 6.4 Review of staff accidents
 - 6.5 Review of audit reports
 - 6.6 Review of 'Open' reports from previous months
7. Infection Control
 - 7.1 Correspondence
 - 7.2 Review of infection information
 - 7.3 Review of audit reports
 - 7.4 Review of 'Open' reports from previous months
8. Medications
 - 8.1 Correspondence
 - 8.2 Review of medication incidents
 - 8.3 Review of audit reports
 - 8.4 Review of 'Open' reports from previous months
9. Review of other continuous improvement information
 - 9.1 Review of Tell Us What You Think forms
 - 9.2 Review of maintenance requests/hazards
 - 9.3 Review of Survey/Audit Reports
 - 9.4 Review of 'Open' reports from previous months
 - 9.5 Identification of risks to organisation
10. Review of open Continuous Improvement Logs
11. Review of Plan for Continuous Improvement
12. New Business
13. Next Meeting
14. Close of meeting.

11

EMPLOYEE MANAGEMENT

EMPLOYEE MANAGEMENT

ROSTERS

The service is staffed 24 hours per day. A fortnightly roster is drawn up for staff to ensure that all shifts are covered. The Manager/Acfi Coordinator develops the rosters for all staff. If staff have particular times when they are not available, they should discuss these with the Manager and/or fill in a Leave Application Form (**Shire Form**) and provide it to the Manager. The Manager is responsible for checking all rosters.

Rosters are developed by the Manager using the following guidelines:

- rosters are based on fairness and equity
- the skill level of staff is considered to ensure resident and organisational goals are met.

Dissatisfaction with rosters should be discussed with the Manager or a 'Tell Us What You Think' form (**Form MA2**) completed.

Rosters are developed at least a fortnight in advance.

Rosters are reviewed at least once a week to accommodate staff changes.

Staff on leave are listed on the roster and are highlighted.

The current roster is displayed in the carers office.

Staff wishing to swap a shift should discuss it with the Manager before discussing it with any other staff person. The Manager's approval is required for a swapped shift.

Staff who will be absent from a shift are required to give as much notice as possible to assist in ensuring that a replacement staff member can be sourced and to ensure resident care is not compromised.

TIMESHEETS

Timesheets are located in the timesheet folder in the Carer's office. It is the responsibility of staff to ensure that they enter their times. The wages cut off is Tuesday night.

APPLICATIONS FOR LEAVE

1. If staff have holidays available, they are requested to use these rather than swap shifts.
2. Staff are to request leave by putting their request in writing using the Leave Application form (**Shire Form**) to the Manager.

3. Preference will be given to staff requesting holidays from December 1st to mid January who have not taken holidays in this period in recent times.
4. Macs may request Leave Applications (**Shire Form**) for December/January be in before 30th September, so Christmas/New Year roster can be initiated.
5. Applications for December/January leave after 30th September will not always be accommodated.

PROVISION OF A MEDICAL CERTIFICATE

A medical certificate must be provided if leave is for more than 2 consecutive days (including if caring for another person or personal leave). Poor attendance, work record or taking of excessive leave may result in management requesting a medical certificate for all leave requests. Unpaid sick leave may be taken with a medical certificate until such time as the employee returns to normal rostered shifts.

STAFF DEVELOPMENT AND TRAINING

Springhaven is committed to providing opportunities for staff members to increase their skills, raise professional standards and improve productivity. Springhaven aims to support its staff in undertaking appropriate training and education to enhance their knowledge and skills, job satisfaction, job performance and confidence.

This is in accordance with Shire of Kojonup Policy Manual;

- 2.2.3 Employee conferences, Seminars and Workshops
- 2.2.2 Education Assistance
- 2.2.12 Employee Training

Springhaven requires all staff to undertake mandatory training annually. This includes Fire & Evacuation Training and Manual Handling along with a number of other training modules as per the Springhaven training matrix.

Staff will receive training and education in cultural diversity and demonstrate respect for cultural or religious customs and health practices including beliefs and taboos.

Management regularly reviews staff levels to ensure appropriate levels of care for the residents.

DOMESTIC AND FAMILY VIOLENCE

Domestic and family violence (DFV) in the home or the workplace is a serious and unacceptable workplace issue. Springhaven Lodge is committed to providing awareness to all staff around the issues of domestic violence, supporting staff who

experience domestic violence and that they are not discriminated against. Springhaven has in place the following measures:

- strict confidentiality for staff who choose to disclose that they are experiencing DFA;
- leave entitlements for staff to access services or make arrangements;
- flexible working conditions to meet staff needs;
- a safe and supportive workplace environment, including a workplace safety plan if necessary;
- return to work support for staff who have taken extended leave relating to domestic violence;
- support to access counselling or other relevant services;
- procedures for staff who perpetrate abuse or violence at/from the workplace.

Counselling and Support Services are available

- **1800RESPECT (1800 737 732)** - 1800RESPECT is the national sexual assault, domestic and family violence counselling service. Providing free and confidential information and support to people in Australia 24 hours a day, every day of the year.
- **Daisy** – Daisy is a free app made by 1800RESPECT to connect women to support near them. Daisy can link to service phone numbers and websites, which you can access from within the app so they don't show in browser history. There is also information on what to expect when contacting a service.
- **Domestic Violence Advocacy Support Services** – is a free service that provides support and advocacy to adult victims of family and domestic violence. Based in Katanning, covers all communities within a 100km radius. **1800 818 593**

6

RESIDENT AND STAFF SAFETY

RESIDENT AND STAFF SAFETY

All staff are responsible for carrying out their duties safely and for monitoring resident safety.

Any hazard or potential hazards must be reported to the Manager by completing a Hazard Report (**Form SS6**).

In situations where the safety of staff or residents is at immediate risk, staff must report the issue to the Manager.

The Manager must take immediate action to remedy the situation. The health and safety representative and Manager must be informed of the incident as soon as possible.

HEALTH AND SAFETY REPRESENTATIVE

The health and safety representative is responsible for monitoring accidents or near accidents and monitoring staff training in health and safety issues. A copy of incident/hazard reports are to go to the health and safety representative for assessment and investigation (see Incident/Hazard reports below).

The health and safety representative is also responsible for carrying out six monthly safety audit checks and advising management of any issues.

The health and safety representative attends OSH Committee meetings at the Shire every second month to represent any health and safety issues at Springhaven Lodge, Issues of an urgent nature will result in discussion with the Manager and may result in an extraordinary meeting being held.

EMERGENCIES

In an emergency, the first responsibility of the on-duty staff is the safety of the residents.

The senior staff person on-call is responsible for coordinating the activities required to manage the situation. The person on-call is called by phone.

- MACS *Sue Northover*
- CC/RN if MACS not contactable

If the senior staff person cannot easily deal with the emergency they should call for assistance as appropriate from the:

- Shire of Kojonup 9831 2400
- Police 000

- Fire Brigade 000

All staff must obey the lawful directive of the FESA personnel who come to the service.

MISSING RESIDENTS

If a resident should not be able to be located, the Manager or senior staff member should be notified immediately. The whole service should be searched in a coordinated manner by all staff members on duty.

If after a reasonable search, the resident is not found the next of kin and police should be notified. Police should be given a description of the resident, including, if possible a description of what the resident was wearing when last seen. The photograph in the residents file should be given to the police to assist in identifying the resident.

Staff are to follow the directives of the police, if involved in the search.

Missing residents, if reported to the Police, are reported to the Department of Health by the Manager and an Adverse Event form completed and details of the event entered in the progress notes.

RESIDENT SAFETY AND SECURITY

Springhaven is committed to personal safety and the right of people to live in dignity and security without fear of threat or harm and to be free from exploitation and abuse. The facility will:

- Ensure the physical environment is safe;
- Conduct thorough screening of both staff and volunteers working with residents;
- Assist and support residents to assess and manage risks;
- Support residents to safely and effectively manage medication;
- Provide all staff with information and training of duty of care;
- Ensure that residents are protected from abuse or neglect, and that any incidents of harm are promptly addressed and investigated;
- Provide staff induction and training and regularly review staff levels to ensure appropriate levels of care.

RESIDENT/VISITOR ADVERSE EVENT REPORTS

A Resident/Visitor Adverse Event Report (**Form SS1**) must be completed by staff when there is:

- an accident to residents or visitor
- a near accident to residents or visitors
- an incident threatening the safety of residents or visitors.

If staff require assistance in completing the form, the Manager or health and safety representative will assist. The adverse event report must be given to the Manager for immediate action. The health and safety officer must be informed at the SQ & OSH meeting.

STAFF ACCIDENT/INCIDENT REPORT AND INVESTIGATION

The Staff Accident/Incident Report (**Form SS5**) must be completed when a staff member has an accident or near miss at work.

The form must be completed as soon as possible and given to the Manager. The Manager can assist staff to complete the form if necessary.

The Manager will ensure that the staff member receives appropriate medical care and assistance and will liaise with the doctor and insurer to manage the injury management process if required. (Refer to Policy and Procedures Manual 4: Safety, Security, Cleaning and Laundry - Section 7: Occupational Safety and Health for more details regarding the Injury Management process.)

The accident report form is given to the occupational health and safety representative who will investigate the accident and make appropriate recommendations to prevent a re-occurrence. The form may be completed in consultation with the Manager.

A summary of Resident and Staff Accidents and Incidents is compiled at the end of each month by the Manager and entered into spreadsheets to assist in the collation and analysis of the data.

The data is reviewed by the Shire of Kojonup Occupational Safety and Health Committee and an improvement log commenced if further action is required. The Manager is responsible for closing out all staff accident/incident forms.

PETS

VISITING PETS

Residents are encouraged to have visiting pets at provided the following guidelines are followed:

- pets must be under the control of a responsible person whilst in any part of the Lodge or grounds
- animals must be clean and are not permitted to visit at meal times or enter the dining room at any time
- the owner is responsible for cleaning up after their animals whilst on site.

EQUIPMENT SAFETY

Equipment includes laundry and kitchen equipment and equipment for use in caring for residents such as wheelchairs and commodes.

The safety of service equipment is ensured through:

- purchasing quality equipment through a reputable supplier
- following manufacturer's instructions in the use and maintenance of equipment
- ensuring staff are trained in the use of equipment
- the regular checking and maintenance of equipment
- making sure that maintenance and repairs are carried out by a qualified tradesperson. (Refer to Policy and Procedures Manual 1: Management and

Administration, Section 4: Asset Management for information on external contractors.)

USING EQUIPMENT

Always read the instructions provided by the manufacturer if they are available.

- **Wheelchairs** *Brakes* must be used every time you leave the resident on their own unless they are able to control the chair's movements on their own. Brakes must be used when you assist a resident in getting in and out of the wheelchair. *Footrests* are on most wheelchairs; some of these are removable. Make sure that resident's feet are on the footrests before moving the wheelchair. If there are no footrests on the wheelchair warn the resident so that their feet do not drag while the wheelchair is moving.

Removable armrests are on some wheelchairs; these can be removed to make it easier to move the resident in and out of the chair.
- **Commode with pan** Make sure the height is adjusted correctly. If using a commode with wheels take care that it does not move while in use. Some commode chairs have a safety bar to secure residents so that they don't fall forward, make sure this is across the resident if left on the toilet alone.
- **Shower chair** Stand the resident in a secure position and move the chair into position behind them.
- **Walking frames** Ensure the frame is set to the correct height for the resident. Most residents who use walking frames use the same frame all the time.
- **Urinal bottles** Empty urine bottles in a toilet whenever they have been used. Do not wait until they are full. Put through the pan and bottle sanitizer, and leave to dry on the rack.
- **Washing machines** See instructions in the laundry on use and care.
- **Drier** See instructions in the laundry on use and care.
- **Gophers** Residents are responsible for the maintenance and safe use of their gophers. The battery packs must be checked by an electrician yearly and tagged, as per other electrical equipment paid for by residents. The physiotherapist can assess the ability of the resident to use their gopher. Large gophers are only used outside to ensure the safety of all.
- **Hoses** Must be turned off carefully and wound up properly after use. If any wet patches are on walking areas a 'Wet area' safety sign must be put out, until the area is dry.

ELECTRICAL EQUIPMENT OWNED BY RESIDENTS

All used electrical appliances brought to the service for use by residents must first be checked and tagged by a qualified electrician. The cost of this service must be borne by the resident. Electric blankets, personal irons and jugs/kettles are not permitted.

All electrical items in the facility are tagged within 12 months of purchase.

The use of 'double adaptors' is not permitted, but authorised 'multi-point' devices (with a cut-off switch) may be used.

Extension cords, if required, should be safely installed in consultation with the maintenance person employed by the service and electrically tagged. The resident/representative remains responsible for maintaining the electrical appliances in safe working order. The service will remind residents/representatives of this annually, and provide assistance where necessary.

USE OF CHEMICALS

Chemicals used for cleaning or infection control may be hazardous if used incorrectly.

The service adopts the principle that the least possible quantity and variety of appropriate chemicals will be used to achieve hygiene and infection control standards.

POLICY

All chemicals are to be stored and used according to the manufacturer's directions.

All storage and in-use containers must be clearly and correctly labeled with labels prepared by the manufacturer.

Material Safety Data information is to be continuously displayed in the bulk storage area.

The bulk storage room is to be locked when not in use.

Incidents or errors associated with chemicals handling or use are to be reported immediately to the Manager and a Hazard Report (**Form SS6**) completed within 24 hours.

Training and information regarding the safe or appropriate use of chemicals is given to staff on orientation to the service and annually for all cleaning staff and OSH representatives. See the training register for details.

POWER FAILURE

Electrical power is required to maintain a range of services, including refrigeration and lighting.

Interruptions to electrical supplies may therefore interfere with safety. The emergency lighting installation should be checked according to the relevant maintenance schedule.

Torches are kept in rec room, staff room and carers office for use during a power failure. These batteries are to be changed yearly on April 1st.

The cool room and refrigerator doors should be kept closed during power failures.

Staff on duty are to notify the Shire.

PREVENTION AND MANAGEMENT OF VIOLENCE AND DISRUPTIVE BEHAVIOUR

This policy refers to episodes of violence or aggression by residents or their visitors towards staff.

Service management is mindful of the duty of care to both residents and staff and will therefore take all necessary steps to minimize the situations in which violence is likely to occur. These steps include staff education, resident assessment and referral.

It is recognised that violence or aggression by confused or residents with dementia is often associated with fear or anxiety.

The Manager is responsible for assessing residents with a history of, or potential for violence, and for developing and implementing or delegating an appropriate behaviour management plan.

All staff must approach residents courteously and quietly, and provide care without hurrying or roughness.

Residents with dementia who are resistive or combative must have a specific, written plan of care for behaviour management. This is developed in consultation with the doctor and other health professionals as required.

All episodes of violence or aggression must be reported to the Manager.

The Manager must act to ensure the safety of both residents and staff.

The service promotes a restraint free environment. (See the procedures on restraint in the Policy and Procedures Manual 3: Resident Care, Section 9: Behaviour Management.)

All aspects of the incident must be recorded appropriately, but only relevant aspects should be written in the resident's notes. The incident details should be written on a Resident/Visitor Adverse Event Report (**Form SS1**) for the Manager to review.

Cross reference to other policies:

- Resident assessment
- Accident/incident reporting
- Behaviour management
- Duty of care.

FIRE AND EVACUATION PROCEDURES

Instructions are displayed next to the fire control panels and in the Emergency Procedures Manual. See the Emergency Procedures Manual for details.

Instructions include *Fire, Evacuation Procedures, Armed Hold Up and Robbery, Bomb Threat and Other Emergencies*.

Management of Wandering and Missing Residents is outlined in the behaviour management section in the Resident Care Manual Section 10.

A list of current residents including their mobility status is kept near the fire panel at the front entrance. There are individual photo ID lanyards, listing relevant evacuation information. In the event of an evacuation the lanyard will be used in conjunction with the lanyards.

The Facility Coordinator/Admin Assistant is responsible for maintaining the list up-to-date & current lanyards.

FIRE PROCEDURE - GENERAL

On discovering a fire:

1. Remove any persons from immediate danger.
2. If the alarm has not sounded, break the glass on the manual point; this will summon the fire brigade.
3. Close the doors to contain the fire.
4. Fight the fire with appropriate equipment, if safe to do so.
5. Stand by for further orders to evacuation if required.

Automatic alarm sounds:

1. All staff to gather in front foyer when fire alarm sounds.
2. Source of fire is located on the indicator panel in the main entrance.
3. Manager or Supervisor (when manager not present) will direct staff.
4. Proceed to area of fire.
5. Assess fire.
6. Follow instructions as above. (**ON DISCOVERING A FIRE 3-5**)

Recreation room:

1. Follow instructions as above. (**ON DISCOVERING A FIRE 3-5**)
2. Staff will direct residents out of nearest exit and assemble on the front lawn.
3. Staff will stay with residents until all clear is given.

FIRE PANEL INSTRUCTIONS

Under normal conditions the fire indicator Panel should have only one green light showing (power on).

ALARM = RED FLASHING LIGHT
Fire Brigade will be on the way

Day time:

1. All staff together in front foyer when fire alarm sounds.
2. Manager or RN/MCC (when manager not present) will direct staff.
3. One person will be allocated to turn off oxygen bottles if required.

Recreation room:

1. Staff will direct residents out of nearest exit and assemble on the front lawn.
2. Staff will stay with residents until all clear is given.

Afternoon / Night:

UNLOCK FRONT DOOR

1. Inspect the area, which the alarm is located. This can be determined by matching the zone number with the zone number on the mimic located adjacent to the Fire Panel.
2. After locating the fire area, evacuate the area if safe and is required.
3. Staff may turn bells off **BUT NOT Alarms.**
4. Fire Brigade will isolate the alarm zone.

Westside Fire service to be called if any problems with system.

Office Hours on: (08) 9248 4824

After Hours on: (08) 9248 4825

Reset alarm:

1. Open panel door, alarm bell will stop automatically.
2. Press buzzer silence.
3. Press master reset button top left-hand corner.

Note: Before carrying out any testing or isolating any zones on the Fire Indicator Panel the key must be placed in the Fire Brigade Isolating end of line (red box) located in the bottom of the fire panel and turned to the test position.

Fault = Yellow Flashing Light

1. Fire Brigade will not turn out to a fault but will ring you to make sure it is fixed.
2. Open panel door press buzzer silence.
3. Press the isolate button on the zone that has the fault lights.
4. Call Westside Fire Services on (08) 9248 4824 for service.

Isolate:

- Open Fire Panel Door and press buzzer isolates.
- To isolate an area of the building to enable work to be carried out, locate the correct zone in the mimic panel. This will give you the number for the zone. Find that zone number on the fire indicator panel and press the isolate button.
- After testing or isolating has been completed make sure that there are no alarms on the Fire Panel (red-flashing lights on the zone cards) and return the Fire Brigade key to the normal position and remove it.
- **If fire is small and presents no risk** – remove any residents from the area and put out the fire using the appropriate fire extinguisher.
- **If the fire is serious and presents IMMINENT danger:**
 1. Close the door.
 2. Notify all other staff to evacuate residents to the appropriate area (as per evacuation plan).
 3. Check that all residents and staff are accounted for.
 4. Await instructions from the Fire Brigade.

If the Manager deems there to be a false alarm – they can then call Communications Division at DFES – 93959209 to report the reason for activation. But only the Manager can make this call.

ACTION CARD

KITCHEN STAFF

WHEN FIRE ALARM IS ACTIVATED

1. Ensure all electrical and gas appliances have been turned off and windows and doors closed.
2. Report to assembly area (FOYER) for further instruction, which will be:
 - a) Stand down, in which case staff will carry on their normal duties
OR
 - b) Search the area and report back to Manager or Supervisor on duty at completion of search
OR
 - c) Evacuate, you will be advised if staff are required to assist with evacuation of residents.

COMMON SENSE MUST PREVAIL

IF A FIRE IS DISCOVERED BY YOU

1. Remove persons from immediate danger to safe area, operate the nearest fire alarm, (if fire alarm has not sounded) and notify senior person on duty of fire.
2. Turn off all appliances.
3. Turn gas bottles off – situated outside.
4. Turn off gas stove – turn off lever – is situated outside back of kitchen between the two water tanks.
5. Attack fire only if you think you can control it, IF NOT close all doors and windows to isolate the fire. NB: Use correct fire extinguishers or fire blanket for stove fire.
6. If the fire cannot be controlled, persons in danger area must be evacuated to nearest safe area.
7. Advise person in charge of action taken, and that person will decide if major evacuation is necessary.
8. Don't panic.
 - Look after residents
 - Follow instructions of senior person.

If a fire is noticed and no alarm has gone off:

Use the Break Glass alarm on the fire panel to raise the alarm. The Fire Brigade will attend immediately.

Ring 000 as well, in the event that the fire brigade is on another call.

A written report of all fire or security risk incidents must be documented and filed in the Hazard File.

The staff orientation kit includes a map of service layout and reference to the Emergency Procedures Manual. This is part of the orientation program.

Types of Fire Equipment Available

Type	Use
CO2 Extinguisher	Electrical or Flammable Liquids
Dry Chemical Powder Extinguisher	Multipurpose
Fire Blanket	Where smothering is appropriate
Fire Hose Reels	Class A fires (bedding, furnishings)

The service is protected by a monitored fire panel, smoke alarms in all resident and public areas, automatic smoke doors and fire doors.

FIRE DRILLS

A six monthly fire drill is carried out to ensure that staff members understand fire and evacuation procedures.

It is the responsibility of the Manager to run and document Fire Drills. Documentation should include a list of staff present. If any staff is absent, they should be provided with a 1:1 update of procedures.

The fire drill report should be discussed at staff and management meetings and any issues identified and rectified.

The fire and evacuation procedures have been assessed and approved by the Western Australian Fire Brigade. The Fire Brigade should be consulted before any changes are made to these procedures.

FIRE EQUIPMENT

Fire equipment is checked and stamped every six months by the approved supplier and recorded on the maintenance schedule.

ARMED HOLD UP

See the EMPLOYEE MANUAL for details.

BOMB THREAT

In the event of receiving a bomb threat, remain calm and obtain as much information as possible from the informer. Use the Bomb Threat Checklist situated in the Emergency Procedures Plan as a guide to questioning and recording details from the informer.

It is essential that you do not hang up the phone if you have received a bomb threat by telephone, as the Police may be able to track the call after the event. Leave the telephone off the hook until Police arrive.

See the Emergency Procedures Plan for details.

SMOKING

Smoking is not permitted inside any of the buildings. Staff are permitted to smoke in designated areas.

Any resident that smokes must be supervised by staff and require doctor's review to evaluate whether nicotine patch may be beneficial.

FIRST AID

As part our commitment to ensuring a safe and healthy workplace environment, Springhaven will:

- Ensure first aid treatment is available as required for staff, volunteers, visitors and contractors if injury or acute sickness occurs on its premises.
- That there is adequate provision of staff with first aid qualification to render first aid treatment during its usual hours of operation.
- First aid training is offered to all care staff by an accredited trainer and recorded on the training register.
- Ensure that fully stocked first aid kits and facilities appropriate to its size and location.
- Maintain regular review and replenishment of first aid kits as necessary.
- Comply with all relevant legislation regarding First Aid.

First aid kits are kept in the kitchen, rec room & treatment room. They are clearly defined by a sign with a green cross on a white background.

The OSH rep ensures that the kits have appropriate supplies and reports to the manager when/if new supplies are required.