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RSPM application to service type

Each instruction has **service type** and **instruction application** codes to assist to identify how the specific instruction applies to supported accommodation by service type.

Service type:

STAA /FBR	Short term accommodation and assistance / Facility based respite	GH	group homes
STJ	short term justice	LTRP	long term rehabilitation program
I	Colanda	RTF	residential treatment facility (DFATS)

Instruction application:

Y	instruction applies in full
N	instruction does not apply to service type
P	Partial application. Service required to implement principle of instruction but service not generally directly responsible for planning, monitoring and reviewing components of instruction
LD	Locally determined based on client plans, service model and protocols. <i>Applicable to STJ, LTR and RTF only</i>

5.1 Promoting health

Issued: August 2012

FBR – P GH/I/STJ/LTR/RTF – Y

Contents

Why promote health?
How are health priorities decided?
Health status of people with an intellectual disability
What activities promote health?
Health promotion in Disability Accommodation Services
Role of all staff
Resources

Why promote health?

Being healthy enables participation in family and community life. Health is a complete state of physical, mental and social wellbeing, not merely the absence of disease, or infirmity. The most disadvantaged groups have the poorest health outcomes and highest exposure to health damaging risk factors. The overarching aim of health promotion is to improve health and reduce health inequalities by:

- promoting physical activity and active communities
- promoting accessible and nutritious food
- promoting mental health and wellbeing
- reducing and minimising harm from alcohol and other drugs
- creating safe environments to prevent unintentional injury
- promoting sexual and reproductive health.

The poorer health status of people with an intellectual disability is sometimes wrongly attributed to a pre-disposition to certain health conditions. Many differences in health status are due to avoidable issues such as:

- less favourable social opportunities
- less participation in work and education
- reduced opportunities to utilise generic health services
- lack of inclusion in public health awareness campaigns
- living arrangements which promote inactivity and poor lifestyle choices.

How are health priorities decided?

Health priorities for the community are decided through research such as the Victorian Population Health Survey. This survey provides information about the health and wellbeing of Victorians. In 2009, a specific version of the Victorian Population Health Survey was conducted about people with an intellectual disability.

Health status of people with an intellectual disability

The survey of people with an intellectual disability found they are:

- less physically active, 21.7% compared to the general population 60.3%
- less likely to drink water when thirsty, 44.7% compared to 72.5%
- three times more likely to drink soft drinks when thirsty, 30.4% compared to 10.1%
- more likely to drink fruit juice when thirsty, 5.0% compared to 3.0%
- more likely to have had depression, 30.4% compared to 19.9%
- less likely to wear sunglasses when in the sun, 40.3% compared to 74%
- less likely to report changes in vision, 13% compared to 41.0%
- less likely to have had a mammogram in the 2 years previous, 55.2% compared to 75.9%
- less likely to have had a Pap smear in the 2 years previous, 14.8% compared to 71.1%
- more likely to have a higher Body Mass Index (BMI) between 35.0 to 39.9 (7.4% compared to 3.4%) and 40.0 and over (4.7% compared to 1.7%).

Other research shows people with a disability:

- have epilepsy rates 25 times the level in the general population
- have an average of 5.4 significant medical conditions
- are 20 times more likely to be blind
- are 11 times more likely to be deaf
- have 5 times higher incidence of mental health issues
- have 7 times more dental disease
- will experience a significant nutrition and swallowing issue at some time in their life (between 80-95%).

What activities promote health?

Health promotion activities focus on strengthening individual skills and capabilities. Examples of health promotion campaigns and strategies include:

- Quit Victoria
- Slip Slop Slap Seek and Slide
- Just Add Fruit & Veg
- Community inclusion activities such as 'come and try' days and neighbourhood renewal events.

Health promotion activities aim to change economic and social and environmental conditions to improve health and wellbeing outcomes. Research shows the following factors outside the traditional health sector also improve health outcomes:

- education and workforce participation
 - community inclusion
 - public transport access.
-

**Resident inclusion
in health
promotion**

Staff should assist residents to understand health promotion campaigns and strategies and encourage their participation in health promotion activities such as:

- eating healthy food
- reducing tobacco related harm
- drinking responsibly.

Health promotion activities should be informed by:

- a resident's annual health review
- advice of relevant health professionals.

The Person Centred Active Support (PCAS) approach to support provides a means to ensure residents are involved in daily activities which promote health and wellbeing such as participating in:

- Walk, or Ride to Work Days
 - Volunteer, or paid work
 - activities at local leisure and recreational clubs.
-

Role of all staff

Staff are required to work in partnership with residents and health services to maintain health and wellbeing. They should also support residents in activities to promote health by:

- encouraging community involvement
 - encouraging a more healthy lifestyle
 - monitoring known health conditions
 - supporting participation in annual health assessments and screening programs.
-

Resources

- Being a healthy woman – A resource developed by the New South Wales Health Department, designed to assist women with an intellectual disability learn more about looking after their health and wellbeing. Available at: http://www.health.nsw.gov.au/pubs/2010/being_healthy_woman.html
 - Better health Channel-provides a range of health and lifestyle information and advice for the community. Available at: <http://www.betterhealth.vic.gov.au/>
 - Gardens – a range of resources including edible gardens and sensory gardens. Available on the Better Health Channel at: http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/hl_physicalactivity?open&cat=Physical_activity_-_Gardening
 - Travel smart – a range of resources about travel. Includes cycling, walking planning and access information. <http://www.transport.vic.gov.au/research/travel-behaviour-change/travelsmart/travelsmart-resources>
 - Victorian Government Health Information – Health promotion information and strategies. Available at: <http://www.health.vic.gov.au/healthpromotion/index.htm>
 - Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.1.1 Promoting physical activity

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FBR – P GH/I/STJ/LTR/RTF – Y

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Importance of physical activity
How much physical activity is enough?
What is moderate-intensity physical activity?
What are the benefits of physical activity?
How active are people with a disability?
Resident inclusion
Staff should be physically active
Role of the supervisor
Barriers to physical activity and strategies to overcome them
Getting help from local council to promote physical activity
Resources

Importance of physical activity

Physical activity is important for everybody. The benefits of physical activity are widely publicised, especially, the reduced risks of:

- heart disease
- diabetes
- cancer.

Residents have much lower levels of physical activity than the general population. Including physical activities in daily routines is one way to support residents remain active.

How much physical activity is enough?

If concerns exist about a resident's ability to participate in physical activity, their doctor should be consulted. To achieve health benefits adults should accumulate 30 minutes of moderate-intensity physical activity per-day. People who are not used to physical activity should commence with low-level activity and increase the intensity and duration over time.

What is moderate-intensity physical activity?

Moderate-intensity physical activity should cause a slight, but noticeable breathing and heart rate increase. A good bench mark is to be able to walk briskly and at a pace which enables talking, but not singing.

What are the benefits of physical activity?

Regular moderate-intensity physical activity improves:

- physical health by helping to reduce constipation and increase bone density
- mental health by reducing anxiety symptoms
- social health by providing opportunities for social connections.

Residents can gain additional benefits from physical activity as it:

- reduces boredom
 - assists with balance
 - assists with sleeping
 - maintains healthy weight
 - decreases behaviours of concern
 - increases general wellbeing and mental health
 - provides opportunities for meaningful interactions.
-

How active are people with a disability?

Research shows only 21% of people with an intellectual disability experience sufficient physical activity to maintain health.

Resident inclusion

Residents should be encouraged to increase physical activity levels. Ways to do this include:

- walking, or catching public transport to work, day programs, or shops
- doing household tasks, such as gardening
- taking part in active leisure pursuits, such as dancing, swimming, or cycling
- doing active paid work, such as delivering advertising materials, or newspapers.

Staff are to assess any proposed physical activity as far as possible, to manage risks for:

- manual handling requirements
 - their own, resident, or the health and safety of others.
-

Staff should be physically active

Staff should aim to be physically active and fit as this:

- assists in managing the effects of shift work
 - helps to reduce the risk of manual handling injury
 - increases the capacity to manage stress
 - reduces health risks
 - provides a good role model to residents.
-

Role of the supervisor and manager

Supervisors should assist staff and residents to understand the importance of physical activity by:

- placing physical activity on the agenda at resident and house meetings
 - ensuring a resident's physical activity needs are discussed at their annual health assessment, and specific requirements are documented in their health plan
 - including physical activity in resident's daily support information
 - liaising with the wider community to identify resident opportunities to participate in physical activity
 - reporting a need for and making, organisational changes to enable staff to promote resident physical activity opportunities.
-

Barriers to physical activity and strategies to overcome them

Potential barriers to participating in physical activity and ideas for overcoming them are listed below:

- A resident cannot walk:
 - chair exercises, or gentle weights.
- The house does not have access to a car:
 - share transport with another house
 - use public transport
 - walk instead of drive, where possible
 - investigate community buses, or volunteer transport.
- Staff levels make it difficult to meet resident needs:
 - 'pool' staff with another house
 - involve family members and neighbours
 - build household jobs into resident routines
 - use a treadmill, or work in the garden to promote home-based physical activity
 - work with small groups of residents instead of individuals, where possible.
- Cost is a factor:
 - walk (it is free)
 - check local papers for free community activities, or events
 - ensure eligible residents have a Companion Card.
- Residents are unmotivated:
 - identify what motivates them
 - identify rewards and celebrate their achievements

It is important staff:

- recognise they are powerful role models, especially when showing an interest in resident physical activity
 - build on resident's personal interests and skills, for example, if they like music suggest they listen to it when walking.
-

Getting help from local council to promote physical activity

Local councils provide information about events and activities in which residents can participate. To find out more contact your local council to:

- enquire about services they provide
- obtain information about Access for All Abilities, MetroAccess and RuralAccess workers.

The local resource template can be used to summarise opportunities provided by local councils. A template can be completed for each local government and distributed to residential services in that area.

Resources

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- Access for All Abilities (AAA) providers – develop and support a diverse range of sport and recreational environments which are inclusive of and accessible to people with disabilities. Available on the DAS Hub.
 - Companion Card – allows free admission to transport and events for attendant carers of eligible people with disabilities. Available at: <http://www.vic.companioncard.org.au>
 - Gardens – a range of resources including edible gardens and sensory gardens. Available on the Better Health Channel at: http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/hl_physicalactivity?open&cat=Physical_activity_-_Gardening
 - Active at home – a checklist for ways to increase physical activity at home. Available on the DAS Hub.
 - Active day activities – a checklist for ways to increase physical activity during the day. Available on the DAS Hub.
 - Active Leisure time – a checklist for ways to be more active during leisure time. Available on the DAS Hub.
 - Active transport – a checklist for ways to increase physical activity by changing methods of travel. Available on the DAS Hub.
 - Local councils for information about local events and activities. For links to local councils go to: <http://www.mav.asn.au>
 - Local resource template – a tool for identifying local community activities and resources. see: *Available on the DAS Hub.*
 - Travel smart – a range of resources about travel. Includes cycling, walking planning and access information. <http://www.transport.vic.gov.au/research/travel-behaviour-change/travelsmart/travelsmart-resources>
 - Victorian Sport and Recreation Association for Persons with an intellectual disability (VICSRAPID). Available at: <http://www.vicsrapid.org.au>
 - Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.1.2 Promoting healthy eating

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What is healthy eating?
Healthy drink choices
Role of all staff
Resources

What is healthy eating?

Healthy eating is an eating pattern which is varied and balanced and meets individual need. In general, healthy eating includes:

- large amounts of vegetables, fruit and wholegrain breads and cereals
- moderate amounts of meat, chicken, fish, eggs and dairy produce
- small amounts of fats and oils
- occasional amounts of soft drink, take-away and fried foods, pastries and confectionary.

Healthy drink choices

The Victorian Population Health Survey of People with an Intellectual Disability showed people with an intellectual disability are:

- much less likely to drink water when thirsty, 44.7% compared to the general population 72.5%
- three times more likely to drink soft drinks when thirsty, 30.4% compared to 10.1%
- more likely to drink fruit juice when thirsty, 5.0% compared to 3.0%.

Frequent acidic and sugary drinks increase the risk of dental decay. To reduce these risks Dental Health Services Victoria suggests people follow the Drink Well guidelines which include:

- drinking plenty of tap water
- avoiding acidic and sugary drinks such as:
 - soft and sports drinks
 - cordials
 - fruit juices
 - flavoured, or carbonated water
- having plain instead of flavoured milk.

If acidic and sugary drinks are consumed, they are best in small quantities with meals, rather than between meals.

What are the benefits of healthy eating?

Healthy eating improves health and wellbeing outcomes. Residents who eat a healthy range of food are likely to have increased energy levels and feel better. Healthy eating reduces the risk of preventable health problems such as:

- constipation
 - over, or under weight
 - diabetes
 - heart disease.
-

Role of all staff

The Role of all staff is to:

- involve residents in a range of food related activities such as menu planning, shopping, and cooking
- encourage residents to make healthy meal choices as outlined in Good food for all
- encourage residents to drink water instead of fruit juice and soft and sports drinks
- meet individual food and nutrition needs
- include recommended dietary requirements in resident health plan menus
- include food preferences and requirements in resident health plan menus
- include strategies to address food preferences in resident daily support information and household routines.

Set an example by:

- eating well balanced meals
 - sitting at the table to eat.
-

Resources

- Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au> and search under 'Healthy eating'
 - Easy Cook Books are a series of books with simple recipes presented in an easy English format featuring clear photographs of each recipe. Available at: <http://www.easycookbook.org/>
 - Good food for all – a guide to food, nutrition and meal planning for staff supporting people with a disability. Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
 - To find out about seasonal fruit and vegetables each month check the Better Health Channel. Also go to: the Market Fresh website located at <http://www.marketfresh.com.au/mf.asp>
 - Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.1.3 Promoting good mental health

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FBR – P GH/I/STJ/LTR/RTF – Y

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Overview
Factors that promote good mental health
How to promote good mental health
What is mental illness?
The Role of all staff
Resources

Overview

Good mental health is a state of mind which enables people to cope with everyday life and generally be positive about life.

Mental health issues are three to five times more common in people with a disability than the general population. There are many reasons for this difference including:

- biological
- psychological
- social
- developmental.

It is important to support residents to develop and maintain good mental health by ensuring they are involved and participate in all aspects of their own lives.

Factors that promote good mental health

Factors which promote good mental health include:

- Biological:
 - having good physical health
- Social:
 - belonging to a community
 - having access to adequate housing, finance, transport and employment
 - having strong social networks, friendships and trusting relationships
- Psychological:
 - being in a secure relationship with a consistent caring adult
 - having well developed communication and social skills
 - being provided with opportunities to take risks and try new things (to develop a sense of self-sufficiency and ability to cope)
 - being provided with opportunities to develop new skills, independence and self-confidence.

How to promote good mental health

Initiatives should be considered and developed that are:

- compatible with resident skills, abilities, goals and aspirations
- incorporated into resident support information.

Staff are required to assist residents achieve and maintain good mental health by incorporating strategies into daily routines and activities that promote the following wellbeing factors:

- Biological:
 - support residents to participate in at least 30 minutes of physical activity a day
 - support residents to get adequate sun exposure
 - ensure residents eat healthy food.
- Social:
 - support residents to develop and maintain friendships within the residential service and general community
 - support residents to maintain relationships with family and friends, as appropriate
 - maximise resident’s communication and social skills opportunities.
- Psychological:
 - support residents to develop and maintain functional communication skills
 - support residents to learn and develop new skills and achieve positive outcomes
 - residents receive positive feedback
 - residents have someone in which to share their feelings
 - support residents to participate in relaxation techniques and enjoyable pastimes.

What is mental illness?

Mental illness is impairment of a person’s state-of-mind which means they struggle to cope with daily life events. Mental illness is sometimes called psychiatric disorder. Mental illness includes, but is not limited to, conditions such as:

- depression
- mania
- psychosis
- obsessive compulsive disorder
- anxiety disorders
- personality disorders.

Specific planning is required when residents are diagnosed with a mental illness.
See RSPM 5.2.1.

The Role of all staff

Staff should:

- promote resident engagement in activities which support good mental health, using the Person Centred Active Support approach
 - support residents to have choice and control over their own lives as far as possible
 - be alert to resident behavioural changes
 - consult, and use as appropriate, the depression checklist for carers
 - arrange a doctor's appointment if residents display behavioural changes
 - refer to *RSPM 5.2.1*, if concerned a resident may have or is diagnosed with a mental illness.
-

Resources

- Better Health Channel – provides online health and medical information for the Victorian community. Available at: [//www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au) and search under 'mental health'
 - Centre for Developmental Disability Health Victoria (CDDHV) – provides better health outcomes for people with developmental disabilities through research, education and clinical activities. Available at: <http://www.cddh.monash.org/>
 - Depression in adults with intellectual disability – checklist for carers. Developed by CDDHV. Available at: <http://www.cddh.monash.org/>
 - Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.1.4 Reducing tobacco-related harm

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Applies to all

Contents

Overview
Smoking is banned in public indoor venues
Health impact to the smoker
Health impacts to others
Role of all staff
Resources

Overview

Smoking is extremely addictive and has a significant impact on the health and wellbeing of those who:

- smoke
- are exposed to cigarette smoke.

There is no safe level of smoking, or safe cigarettes. Fifty per cent of long-term smokers die usually in middle-age from smoking related illness. In Victoria, road accidents cause the death on average of eight people per-week. Smoking directly causes the death of seventy six people per-week.

Smoking is banned in workplaces and public indoor venues

Smoking is banned in workplaces and public indoor venues due to the high level of risk created by:

- the concentration of smoke which goes into the air from side-stream smoke (smoke which comes directly off cigarettes)
- mainstream smoke (smoke which is exhaled).

Smoking places every person in the vicinity at risk of disease.

Health impact to the smoker

Cigarettes contain a number of dangerous chemicals which are extremely toxic and can cause cancers and tumours. These include:

- tar which has chemical particles that coat the lungs, teeth and fingernails
- carbon monoxide which binds to red blood cells more than oxygen, and reduces the level of oxygen which gets to:
 - the brain
 - the heart
 - other organs
- hydrogen cyanide which damages the cilia (small hair like parts of the lungs which help to remove foreign substances)
- metals including arsenic, cadmium and lead.

The impact of smoking on the circulatory system includes:

- hardening of the arteries
- reduced blood flow to extremities, such as fingers and toes
- increased blood pressure.

These impacts greatly increase the risk of:

- heart attack
- stroke
- infections in extremities which can result in gangrene and amputated body parts.

Smoking also increases the risk of:

- gum and mouth disease
 - blindness
 - reduced bone density.
-

Health impacts to others

Passive smoking is when people are exposed to smoke:

- that drifts from lit cigarettes
- expelled by smokers.

The effect of passive smoking is significant as:

- smoke which lingers in the air has a higher concentration of chemicals
 - people exposed to passive smoking experience the same health impacts as those who smoke.
-

Role of all staff

Staff are to:

- direct residents and others in the residential service to the designated outside smoking area, *see RSPM 3.7*
 - raise the health impacts of smoking with residents, during the health planning process, to ensure they are informed of the risks and health impacts
 - provide residents who smoke with stop smoking information and support (Quitline, or Quit Victoria)
 - document strategies to assist residents to quit smoking (in their health plan)
 - not smoke in vehicles, or near residents when on outings
 - not expose residents to passive smoking by sitting in outdoor venues where smoke can drift across tables.
-

Resources

- Better Health Channel – A-Z Fact sheets index, under 'smoking'. Available at: <http://www.betterhealth.vic.gov.au>
 - 'I can quit' facilitators manual – a guide to running smoking cessation courses for people with a developmental disability. This resource is available on the website of the Centre for Developmental Disability Health Victoria under 'products and resources'. Available at: <http://www.cddh.monash.org>
 - Quitline – a confidential telephone services providing information, advice and support for quitting smoking, telephone: 13 78 48.
 - Quit Victoria – comprehensive information and resources on quitting smoking. Available at: <http://www.quit.org.au>
 - Smoke-free environment – smoke-free information and policy. Available on the DAS Hub.
 - Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.1.5 Reducing and minimising harm from alcohol

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FBR/GH/I – Y STJ/LTR/RTF – LD

Contents

Alcohol consumption in residential services
Recommended daily maximum alcohol intake
Role of all staff
Resources

Alcohol consumption in residential services

Residents over 18 have a right to drink alcohol and the decision to do so must be documented and kept with the health file. Any strategies to reduce a resident's alcohol use must be:

- developed in conjunction with their doctor
- documented in their health plan.

Recommended daily maximum alcohol intake

Recommended alcohol use for the general population is:

- up-to- four standard drinks per-day for men
- up to two standard drinks per-day for women.

This amount of alcohol is associated with lower health risks. For some residents, no amount of alcohol use is safe, as some medications and conditions can influence alcohol effects on the body.

Role of all staff

Staff are required to:

- not permit residents to drink alcohol in residential services if they are under 18 years of age
- provide information about reasonable alcohol use in ways residents understand
- seek advice from the person's doctor about the level of alcohol that is safe for the resident and document this in their health file.
- ensure medical advice is sought if a resident has medication, or health condition changes which may impact on their alcohol response (this information must be included in their Health support needs summary)
- arrange drug and alcohol service referrals for residents with problematic alcohol use
- ensure strategies are developed with a resident's doctor to address problems associated with their alcohol use.

Resources

- Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au>
- Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>

5.1.6 Sun and heat exposure

Issued: August 2012

Applies to all

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When sun exposure should be avoided
When is sun exposure needed?
Avoiding heat exposure
What is heat stroke?
Supporting people with frail health
Role of all staff
Resources

Overview

Sun and heat over exposure can be life threatening. Residents are at increased risk of heat-related illnesses due to:

- a lack of understanding of heat exposure risks
- chronic health conditions
- medications which impact on hydration
- their capacity to regulate body temperature
- a reliance on others for fluid intake and heat protection.

Activity planning must take into account weather conditions to ensure residents are not exposed to sun and heat during high risk times.

When sun exposure should be avoided

The SunSmart recommendations from the Cancer Council of Victoria should be followed. These include avoiding exposure when the Ultraviolet (UV) level is over 3 and:

- slipping on sun protective clothing which covers as much of the body, as possible
- slopping on liberal amounts of SPF 30+ broad spectrum sunscreen to dry skin, at least 20 minutes before sun exposure (this should be re-applied every two hours when outdoors)
- slapping on a broad brimmed hat to shade the face, neck and ears
- seeking shade, whenever possible
- sliding on sunglasses.

Exposure on extreme heat days should be avoided. Other forms of ultraviolet radiation, for example, sun lamps, or solariums, have similar levels of skin cancer risk so should not be used except under medical direction and supervision.

When is sun exposure needed?

Sunlight is an important source of vitamin D which is required for a range of bodily functions, such as protecting against osteoporosis. Residents may spend little time outside and not get sufficient vitamin D. The amount of sun exposure needed for vitamin D requirements, will vary from resident-to-resident, and must be balanced with sun exposure risk. Staff should consult the resident's doctor to:

- confirm the amount of sun exposure they require
- document the advice provided on their health support needs summary.

The amount of sun exposure required to guard against vitamin D deficiency varies according to the season:

- during September to April, most people need only a few minutes a day of ultra violet exposure, before 10am and after 3pm, to maintain vitamin D levels
- during May to August, most people need about 2-3 hours of sunlight to the face, arms, or equivalent area of skin, spread over a week to obtain sufficient vitamin D.

The amount of sun exposure required to guard against vitamin D deficiency also varies according to skin colour:

- darker skin requires 3–6 times more sunlight to produce vitamin D.

Exposure should be limited at the times the UV level is over 3.

Heat exposure

Victoria experiences extreme heatwave events most summers. Heat exposure can occur:

- by direct exposure to the sun
- during extreme hot weather events, if sufficient care is not taken to minimise the impact of high temperatures.

To reduce the impact of sun and heat, resident activities and outings during the summer months should be reviewed daily, based on the weather forecast. On hot days staff should ensure the residential service is kept cool by:

- closing curtains during the day
- using air-conditioning, where available
- open windows at night, if there is a cool breeze
- keep physical activity to a minimum
- ensure resident water intake is increased
- ensure cold, or cool meals are eaten

Residents are to be encouraged and supported to keep cool by:

- using wet towels
- placing their feet in cool water
- having cool (not cold) showers, or baths
- physical activities only being undertaken early in the morning, or later in the evening, where possible.

Staff should not:

- take residents on outings where they remain in the vehicle
- leave residents, or pets in parked vehicles
- plan outings to forests, or parks which have fire risk potential, *see RSPM 3.8.1.*

What is heatstroke?

Heatstroke is a life-threatening condition which develops when a person is exposed to extreme heat causing their body temperature to rise. A resident suffering heatstroke may experience the following:

- a very high core (internal) temperature
- red, hot or dry skin (without sweating)
- a dry swollen tongue
- a rapid pulse
- a throbbing headache
- dizziness, confusion, nausea, or vomiting
- eventual unconsciousness.

Any of the above signs must be treated as an urgent medical emergency and staff should call an ambulance and cool the resident down by:

- placing them in a cool bath
 - covering them with cool wet towels, until medical assistance arrives.
-

Supporting people with frail health

Residents will require additional monitoring to ensure they drink sufficient fluids during extreme heat conditions. Residents taking thickened fluids will require extra support and monitoring to ensure sufficient fluid is consumed. Speech pathologists can recommend strategies to be incorporated into meal assistance plans and routines. Some residents may experience difficulty regulating their body temperature, meaning they are at increased risk of quickly over-heating and requiring being placed:

- in a cool water bath
- in front of an air-conditioner.

The Health support needs summary and personal profile must include alerts for these residents.

Role of all staff

Staff are to ensure:

- resident's maintain adequate fluid intake to avoid dehydration
 - specific alerts are documented on the health support needs summary, such as:
 - sun sensitivity, or increased risk of heat related illness caused by particular medications
 - body temperature regulation issues
 - increased risk to specific health conditions, for example, asthma, or epilepsy.
 - they set a good example by applying sunscreen, when outdoors
 - residents consult their medical practitioner if skin changes are noted which may indicate the early stages of skin cancer. These include:
 - new freckles
 - moles
 - sunspots
 - changes to the colour, shape, or size of existing freckles, moles, and sunspots.
-

Resources

- Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au>
 - StrongBones: Osteoporosis awareness strategy – a collection of resources addressing osteoporosis risk for people with a disability. Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
 - SunSmart – the Cancer Council of Victoria skin cancer prevention program. Available at: <http://www.sunsmart.com.au>
-

5.1.7 Healthy Ageing

Issued: July 2013

FBR – P GH/I/STJ/LTR/RTF – Y

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Maintaining health and wellbeing as residents age
Support plans change as people age
Role of all staff
Role of the manager
When a person can no longer be supported in the residential service
Resources

Overview

People with an intellectual disability experience the same age related health and wellbeing issues as those in the general population. They can also experience additional challenges because of their disability. People with an intellectual disability are living longer as a result of better access to healthy lifestyle support. Generally, people with a mild-to-moderate disability live as long as others in the community. However, those with more severe, or multiple disabilities continue to experience lower-life expectancy. Some causes of disability, such as Down syndrome, also increase the risk of developing early dementia. See RSPM 5.2.2.

Maintaining health and wellbeing as residents age

As people age, physical activity and a healthy diet are important to maintaining good quality-of-life. For ideas for supporting residents in these areas, see RSPM 5.1.1 and RSPM 5.1.2. Ageing residents also need opportunities to participate in social and community activities suited to their changing interests and abilities. As residents retire from work, or day programs, staff play a role in supporting them to identify new activities to:

- reduce social isolation
- address mental health issues which may be developing.

As residents age, managers need to tailor support and access options to enable:

- flexible day supports
- activities to be pursued which:
 - are appropriate to a resident's changing needs
 - reflect resident choice
 - promote social and community inclusion.

Support plans change as people age

Planning is central to the monitoring, assessment and review of a resident's needs. Planning remains important as residents' age because of its impact on accommodation, support and care requirements. Most people in the general population start thinking about retirement when aged in their fifties. It is important 'older age' planning for people with a disability takes place at around this time, or sooner, if early ageing issues are identified.

Planning should consider opportunities for residents to participate in a range of activities which are available to others of the same age in the general population. Residents should not continue doing the same routines and activities through a lack of choice, or inadequate planning opportunities. Later-life support planning should include a review of a resident's:

- health plans
- day programs, or employment
- recreation and leisure activities
- accommodation needs.

Planning should consider the need for:

- health and other assessments
- changes in day programs, or employment, including part-time options or retirement
- home modifications, equipment, or alternative accommodation, as required
- activities which promote physical and mental health
- financial planning
- end-of-life planning and decision making.

Palliative care and end of life decisions may also need some discussion with the resident and their personal network of family and friends to ensure choices and decisions are clear, *see RSPM 5.16*.

Also see RSPM 5.2.2.

Role of all staff

It is important staff understand the resident ageing process; however, it is not their role to diagnose age-related conditions, *see RSPM 5.2.2*. Staff should:

- support residents to participate in social and community activities suited to their changing interests, abilities and preferences
 - arrange a support plan review with residents and their family, as appropriate
 - be alert to changes in a resident's health, capabilities, behaviour, or interests and record and discuss these with their supervisor and manager and the resident's family, as appropriate
 - arrange a GP, or health professional appointment, as required, and ensure the Health professional appointment form includes a record of observations and concerns to assist with the appointment
 - ensure the home environment remains safe, particularly if physical and sensory abilities change
-

Role of the manager

Managers should ensure:

- families are involved, as appropriate, as residents age and their accommodation and support needs change
- staff are supported to develop knowledge and skills related to working with ageing residents
- staff understand the ageing process, and discussions of any ageing related issues for residents are regularly included at team meetings
- housing design, or modifications are appropriate for residents with diminishing physical and sensory abilities
- possible care and support options are considered prior to recommending alternative accommodation arrangements within disability services, or an ACAS referral is made. See RSPM 5.2.2

When a person can no longer be supported in the residential service

Some residents may reach a stage where it is decided their support needs may be better met in a different accommodation setting. This may involve relocating to:

- another residential service
- a residential aged care facility.

Before this happens:

- all possible support and care options should be explored
- the need for aids and equipment and home modifications, should be explored.

See RSPM 5.2.2

Resources

- Aged Care in Victoria – provides information for the Victorian community about the range of services and supports for aged care. Available at: <http://www.health.vic.gov.au/agedcare/>
- Disability and Aged Care protocol – When people under 65 may require placement in residential aged care. Available at: <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/aged-care-assessment-services-protocol-young-disabled-people>
- Disability residential services palliative care guide – a guide to assist understanding of palliative care in disability residential services. Available at: http://www.health.vic.gov.au/palliativecare/disability_palliative_care_guide.pdf
- My future, my choice – information for younger people at risk of entry to aged care. Available on the Department of Human Services website at: <http://www.dhs.vic.gov.au/for-individuals/disability/accommodation/community-living-options-for-people-with-a-disability>

5.2 Developing a health plan

Issued: August 2012

FBR – P GH/I – Y STJ/LTR/RTF – LD

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Specific health management strategies
Relationship between health plans and other plans
Resident inclusion
Who should be involved in preparing a health plan?
People who have multiple complex health needs
Implementing a health plan
Updating and reviewing a health plan
Resources

What is a health plan?

A health plan is a compilation of assessments and plans required to manage resident health needs. Health plans are comprised of:

- the Health support needs summary
- plans required to manage specific health issues.

The Health support needs summary lists a resident's health needs and where plans, or instructions for addressing each need are located.

Why health plans are required

People with a disability usually experience poorer health than the general population and have significantly more complex health needs. Planning is required to ensure:

- health issues are not overlooked
- specific health management requirements are implemented.

Residents with minimal health support needs should also have a health plan containing the required Health support needs summary and associated attachments. If a resident manages their own health with no staff support, the Health support needs summary and personal profile is to clearly state this.

Information included in the Health support needs summary

The Health support needs summary is used as the 'contents page' of a resident's health plan. The summary contains:

- general information including, the name, role, or relationship of the person who generally supports the resident at health appointments
 - the name of the 'person responsible' for treatment decisions
 - an alerts section
 - a list of current health plans and other documents
 - medical, health professionals and services involved in the resident's health support.
-

What must be included in the Alerts section?

The alerts section on the Health support needs summary contains health related information which may have an immediate impact on resident health and wellbeing. Alerts are used for serious issues such as:

- allergies
- aspiration risk
- known ill health triggers which may result in challenging behaviours.

Alerts listed must have the required emergency response noted including the requirement to call an ambulance for people:

- with swallowing issues who develop a raised temperature
- who are prone to fall and:
 - hit their head
 - have any change in normal responses

Alerts should note if a resident has an increased sun or heat exposure risk due to specific health conditions or medications.

Also see RSPM 5.14.

What must be kept with the Health support needs summary for all residents?

A resident's Health support needs summary should be kept with:

- their most recent CHAP assessment
- other health assessments used by their doctor.

The Health support needs summary should also list the location of the:

- oral health care plan
 - most recent Weight monitor printout
 - most recent Nutrition and Swallowing Issues Checklist (NASIC)
 - medication record
 - epilepsy management plan, if applicable.
-

Other plans or instructions that must be noted

The Health support needs summary lists health support needs requiring specific and regular action. Each area requires a specific health management plan which explains support requirements. For example, the Health support needs summary is required to note, as appropriate, the existence and location of:

- a swallowing and meal assistance plan
- a peg feeding plan
- pressure care instructions

Other relevant information

The Health support needs summary lists other relevant resident health, or wellbeing information. For example, if a resident uses specialised footwear. This section is also required to include a snapshot of the resident’s medical history including:

- vaccinations they have had
- operations they have had
- the diagnosis of major conditions, or medical investigations.

List of medical and health services involved in the person’s health care

The contact details of medical and other health professionals and services involved in a resident’s health care is also required in this section. The list needs to be reviewed each time the Health support needs summary is up-dated, so it remains current.

Specific health management strategies

Any health area which requires staff to undertake specific tasks or particular steps which must be followed to manage the health issue, require a specific health management plan. Epilepsy management, oral health care and mental health plans must be created using the specific templates. Other specific health management plans must be created using the Specific health management plan template. If a health professional has already created a plan in another format which is sufficiently clear for staff to follow, it can replace the specific health management plan. *See RSPM 5.13.*

Relationship between health plans and other plans

The health plan and other plans, such as a Behaviour Support Plan (BSP), must be consistent with the information provided and be cross-referenced, as appropriate. For example, if a change in a resident’s health status impacts on their behaviour, it should also be noted in their BSP, and on their Health support needs summary.

Resident inclusion

Residents have a right to direct their own supports. They must be involved and present in the development of their health plan and can decide if family, friends or others are involved. Information must be provided in a format which supports them to understand:

- their health support needs
- the impact of health conditions
- ways lifestyle choices affect health outcomes.

Residents should be able to sign their health support needs summary, if appropriate. Where a resident has a medical guardian, they will provide formal agreement to health support decisions; however, the resident should still be involved, as much as possible.

Who should be involved in preparing a health plan?

The key worker, or house supervisor should prepare the resident for the health planning process by:

- discussing it with them
- inviting those important to them such as:
- their family, guardian or advocate
- relevant health professionals.

Planning can occur via a single meeting or through consultation with relevant people to ensure:

- health issues are included in the Health support needs summary
- support requirements are identified and agreed.

Specific health management instructions and plans must:

- be agreed to and signed by the treating doctor and relevant health professionals
 - include required review dates.
-

People who have multiple complex health needs

Assistance may be required to co-ordinate the range of health professionals involved with residents who have multiple complex health needs. In the first instance this should be discussed with the resident's doctor. If the doctor identifies the resident has a chronic medical condition and complex care needs, they may use Medical Benefits Schedule (MBS) items for GP Management Plans and Team Care Arrangements.

Implementing a health plan

The contents of the health plan must be used to implement and monitor resident health. The entire health plan should be taken to medical and health appointments. This includes:

- the Health support Needs Summary
- specific management health management plans
- the current medication record.

Supervisors should ensure:

- strategies to support residents with their health plan are in place
- staff, including casuals, are aware of:
 - the information contained in the health plan
 - ways to implement required actions
 - the need for appropriate training to implement required health plan actions
 - the need to monitor strategies implemented in the health plan.

Staff should ensure they:

- are familiar with health requirements detailed in resident health plans
- discuss health support needs with residents before providing support
- implement resident health plans
- report health plan issues or concerns to their supervisor and resident doctors, as appropriate.

Updating and reviewing a health plan

The Health support needs summary and specific health management plans are required to be regularly reviewed to:

- ensure they contain current information
- check required management strategies are being implemented.

The Health support needs summary must be up-dated:

- each time a strategy is reviewed
- as changes in resident health status and support requirements occur.

Health support needs summary and specific health management plan reviews are required at minimum three monthly and include residents, those important to them, the supervisor and staff.

Reviews can occur more frequently, as requested, by relevant medical, or health professionals, or as needs change.

A resident's health needs may not alter over time. In this case, a new document does not need to be written, however, the current document must include evidence of it being reviewed. This means the staff reviewing the document are to:

- write their name on the document, sign and date it
 - list the names of those consulted and the date this occurred.
-

Resources

- Health support needs summary template – a form which is used to identify and oversee management of a resident's health needs. Available on the DAS Hub.
- Specific health management plan template – a form used to document procedures or instructions to meet a specific health need. Available on the DAS Hub.
- Epilepsy management templates – templates and guides for epilepsy management including emergency management, *see RSPM 5.13*. Available on the Epilepsy Foundation Victoria website at: <http://www.epinet.org.au>

5.2.1 Mental health planning

Issued: August 2012

FBR – P GH/I – Y STJ/LTR/RTF – LD

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Why a mental health plan is required
Symptom descriptions are critical
Documenting signs and symptoms
Documenting actions that must be taken
Other actions and information that may be required
Role of all staff
Resources

Overview

Mental health issues are three to five times more common for people with a disability than the general population. While many causes are the same as for the general population research has shown that people with an intellectual disability have risk increased due to the following factors:

- Biological:
 - genetic risks
 - medical and sensory disorders
 - impact of medications.
- Psychological:
 - limited coping mechanisms due to an impaired ability to make sense of, rationalise, or talk through events
 - limited functional communication, social understanding and participation
 - low self-esteem resulting from stigma, failure, or rejection.
- Social
 - lack of social support
 - impaired acquisition of social, recreational and interpersonal skills
 - adverse life events, such as repeated loss, separation, abuse, or bereavement
 - limited access to education, social and health (including mental health) services.
- Developmental factors

Mental illness is commonly overlooked, or misdiagnosed in people with an intellectual disability and can be further complicated if a resident is not able to inform staff, or their doctor of symptoms they are experiencing. The most common way mental illness is identified in people with an intellectual disability is by changes in their usual behaviour patterns. Staff must be mindful of any behavioural changes as generally this is a symptom of an underlying issue. Identifying and treating the underlying cause, which may be related to physical or mental health, is important to resolving the issue.

Signs that can indicate mental illness

Behavioural changes which indicate signs of mental illness include:

- Changed mood:
 - being in a low mood (sad, tearful, withdrawn or irritable)
 - not smiling or laughing)
 - Showing an elevated mood, for example:
 - extreme excitement
 - hyperactivity
 - inappropriate laughing or giggling
 - being loud and intruding into the personal space of others
 - sleeping very little.
 - Irritable mood:
 - being easily annoyed
 - being verbally, or physically aggressive
 - being easily frustrated.
 - Loss of interest or pleasure:
 - refusing, or needing more encouragement, or prompting than usual, to participate in routine activities and household tasks
 - not being engaged in previously enjoyed activities, for example, favourite TV shows, hobbies, interests.
 - Increased anxiety:
 - seeking reassurance
 - repetitive questioning and behaviours.
 - Changes in eating or sleeping patterns:
 - sleeping more, or less, changing waking and sleeping routines, experiencing disturbed sleep
 - eating more, or less and losing, or gaining weight.
 - Other behavioural change:
 - spending more time alone and interacting less with others
 - losing skills
 - no longer completing tasks
 - self-injurious behaviour
 - disinhibited behaviour, including sexual disinhibition
 - wearing dramatically different clothing
 - Increased activity levels, for example:
 - pacing
 - walking long distances
 - rearranging furniture.
-

Other causes must be investigated

Some physical health problems cause similar symptoms to some mental illnesses. For example:

- a urinary tract infection can cause confusion and symptoms similar to early psychosis
- thyroid problems can cause similar symptoms to anxiety and depression.

It is important medical checks are completed to rule out physical health problems when residents present with possible mental health illnesses. A doctor will generally do this, but sometimes staff may need to request investigation of symptoms.

Mental health support

When a resident is diagnosed with a mental illness the Mental health plan template provides instruction to staff about necessary supports.

The plan should be developed with:

- residents
- their family, or advocates
- the primary mental health contact.

The mental health service should be asked if a mental health nurse educator is available to provide education and information to the resident and staff about the specific illness. The resident should be:

- included in discussions and planning which occurs about their mental illness
- provided with information in a format they understand.

The Area Mental Health Service can provide information about local support groups.

Why a mental health plan is required

Documenting the support needs of a resident with a diagnosed mental illness is as important as documenting their other health support needs. It is critical the signs, symptoms and support actions are clearly documented. The plan also needs to include emergency responses and information to ensure staff are able to communicate appropriately with mental health and emergency services, as required.

Symptom descriptions are critical

Mental health services use visual descriptors to describe what is seen when observing a person. Assessments also use 'self reports' where a person describes what they are seeing, hearing or feeling. Self reporting can be difficult or impossible for many people with a cognitive disability so there is a reliance on observation. Mental health workers will make visual observations such as stating a person is perspiring, despite it being cold, or moving rapidly, pacing in circles and using quick speech with unrelated statements. Mental health workers will describe only observable signs and symptoms, not opinions.

Disability staff often use broad descriptors of what they think maybe occurring, rather than describing what is actually being observed. For example, disability staff may note a resident is anxious or behaving dangerously. The difference in terminology and descriptions used by mental health and disability services may impact on access to assessment and treatment options. Mental health services do not 'treat' behaviours of concern, or intellectual disability. Disability staff need to understand how to:

- describe what they are seeing
- report what they are seeing to mental health services, as required.

When other causes have been ruled out, the remaining group of symptoms, known as a 'presentation' is assessed by a psychiatric nurse, doctor or psychiatrist, to determine if referral for further investigation, or treatment, is required. An actual diagnosis can take time as the person may need to 'present' with a group of symptoms over a few days, weeks or months, before their presentation is consistent with a specific mental illness. Where there is a lack of capacity for residents to 'self report' what they are experiencing, the visual description becomes crucial.

Documenting signs and symptoms

Signs and symptoms which staff observe need to:

- be described simply and clearly
- free from clinical terms.

A description of what is observed is required:

- when a resident is well
- when they are starting to become unwell
- when they are unwell.

The signs and symptoms describe:

- what the resident looks like, for example, their eyes appear glazed, or unfocussed
- what they are doing at the time, for example, pacing or self-injuring.

Signs and symptoms need to be observable, so it is clear to the person reading the mental health plan, or observing the resident, they are unwell.

Documenting actions that must be taken

There are two parts in the plan concerning actions staff are required to implement. These include:

- general actions – this section describes what is required when signs, or symptom first appear. These may range from engaging the resident in tasks or activities to medication interventions
- emergency management – this section describes what staff may observe that indicates an emergency response is required.

Not all residents with a mental illness will require emergency management instructions, but some may require the support of emergency services such as an ambulance, or the police. It is important to:

- document the required response as simply and clearly as possible
 - provide a 'script' for staff to use in an emergency situation when seeking mental health assistance.
-

Other actions and information that may be required

Mental illness is a complex issue and a range of strategies and information is required to ensure residents are well supported. On-going monitoring or recording of specific symptoms may be required to assist:

- staff to determine if a review is needed sooner than planned
- medical professionals with treatment decisions.

Medications may have side-effects which require monitoring or specific routines. For example, some psychotropic medications can cause:

- a dry mouth and oral problems requiring additional oral health care support
- dietary problems requiring dietary modifications.

These requirements will need to be included in relevant routines and plans, to ensure they are implemented.

Role of all staff

Staff are to:

- raise any concerns about a resident's mental health with the resident's doctor
 - ensure, as far as possible that underlying physical illness has been ruled out
 - be mindful of language and descriptions of the problem when liaising with mental health services
 - document the information required to support the resident
 - request that the person's condition is reviewed on a regular basis
 - seek a review with the relevant medical professional if the resident's needs change
 - support the person to remain engaged with people, activities and routines that are meaningful and important to them.
-

Resources

- Accessing mental health services for people with a cognitive disability. An information sheet developed by the Centre for Development Disability Health Victoria (CDDHV). Available at: <http://www.cddh.monash.org/>
 - Depression in adults with intellectual disability – checklist for carers. Developed by CDDHV. Available at: <http://www.cddh.monash.org>
 - Victorian Population Health survey – for people with an Intellectual Disability-report and fact sheets. Available on the Department of Health website
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5.2.2: Dementia Support

Issued: July 2013

Applies to all

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Role of the supervisor and manager
Resources

What is Dementia?

Dementia is a progressive decline of brain function due to damage or disease beyond what is expected in normal ageing. One of the major causes of dementia is Alzheimer's disease but dementia may also be related to acquired brain injury (ABI) or other less common conditions. A decline in memory, language, problem solving, attention span and the usual performance of daily living tasks may indicate dementia.

How does Dementia impact on people with a disability?

The incidence of dementia in people with cognitive disability (intellectual disability or acquired brain injury) is higher than in the general population. People with Down syndrome, the most common cause of intellectual disability, have a high incidence of dementia caused by Alzheimer's disease. 50% of people with Down syndrome will develop the disease by the age of 60.

Assessing change by collecting baseline information

The diagnosis of dementia in people with a cognitive disability can be difficult and collecting or retrieving information about a resident's level of functioning over time, allows the nature and degree of any decline to be assessed.

The following information should be collected for residents with Down syndrome starting prior to the age of 30 where possible. This is to assist staff to determine if deterioration has occurred and clinicians to make a diagnosis. Documents and materials include:

- personal profiles, communication strategies and other information that describes the level of support or independence with tasks
- dated samples of spontaneous handwriting, artwork and/or drawings
- dated photographs, audiotapes and/or videotapes of the resident participating in activities.

This information should also be collected for other residents identified by their doctor as having a higher risk of dementia, for example significant acquired brain injury or other causes of disability that may increase risk.

Staff observations are important to assist diagnosis

Staff should observe and identify whether any resident displays the following signs of dementia:

- Impaired short-term memory and other cognitive functions (the resident may increasingly repeat questions, forget names and rummage around looking for things)
 - Decline in activities of daily living, for example, loss of ability to complete dressing tasks
 - Increasingly getting lost in familiar places.
 - Changes in behaviour, personality and mood
 - These signs must be discussed with the resident's doctor.
-

Monitoring and adjusting support for dementia

People with dementia are more likely to experience loss of weight and changes in swallowing ability so staff will need to follow the RSPM instructions for:

- the Nutrition and Swallowing Issues Checklist (NASIC). *RSPM 5.7*
- monitoring of a resident's weight. *RSPM part 5.8.*
- annual health reviews with the resident's GP, *see RSPM part 5.3.*
- Appropriate follow up and advice from the GP and relevant health professional such a speech pathologist or dietitian, must be sought.

Dementia may also create or increase behaviours such as wandering, agitation, delusions, aggression, sexual inappropriateness, or resistance to being assisted. If this occurs, a Behaviour Support Plan may need to be developed or adjusted, *see RSPM 7.4.*

Staff will need to adjust the resident's support plan and health plans as required for any changes in support needs, *see RSPM part 4.3.*

Role of support staff

Staff should collect and retain baseline information, observe and identify whether the resident displays early signs of dementia and discuss these with the person's GP.

If dementia has been diagnosed the role of staff will change as the condition progresses. Staff should support residents to continue to fully participate in their usual activities with adjustments, as required.

As dementia progresses and function decreases, support will need to be adjusted with a shift towards the maintenance of skills and relationships as much as possible and developing strategies to compensate for the loss of functioning. Relevant health, aged care or palliative care services will need to be engaged to assist as required, *see RSPM 5.1.7 and 5.16.*

Aged care assessments

Aged care assessments are conducted by an Aged Care Assessment Service (ACAS). The assessment occurs after a referral, usually from the doctor or hospital. Referral can be made by a doctor when a resident has later stage dementia, or whose support needs can only be met by on-site clinical or nursing support. For people with a disability under the age of 65 years, the Disability Services – Aged Care Assessment Services Protocol describes the collaborative planning process which is required to be followed.

The family and support network should be informed and involved to ensure any decisions are the most appropriate outcome for the ongoing support of the resident. If a resident has an appointed legal guardian with responsibility for accommodation and living arrangement decisions, they must be involved as they are responsible for making decisions including working with ACAS when alternate accommodation is required.

When residential aged care is the best option

The aged care assessment may determine that residential aged care is the best option for the resident. When this occurs a transition plan should be developed. The plan will need to include the provision of support information to the aged care facility including:

- copies of current health management plans
- copies of the personal profile
- a contact point with a departmental staff member who knows the resident well to assist with additional information, as required
- arrangements for co-residents who may wish to maintain on-going contact

Role of the supervisor and manager

The supervisor and manager should ensure:

- the need to collect and keep baseline information is noted in the Support Plan or in the Health Support needs Summary for all people with Down syndrome who are at highest risk of dementia
- that baseline information is collected and reviewed for obvious changes in functioning, as part of each review of the Support Plan or annual health assessment (CHAP)
- where staff report that a resident may be experiencing a deterioration in functioning, an appointment with the resident's GP is made for further assessment
- relevant information and support is provided to staff working with residents who have, or are at high risk of developing dementia
- the resident is referred to ACAS by their GP or others as relevant
- a transition plan is developed if resident is to move to alternative accommodation

Resources

- The Cognitive, Dementia and Memory Service (CDAMS) - a specialist diagnostic clinic which aims to assist people with memory loss, or changes to their thinking, and those who support them. Discuss the suitability of referral to CDAMS with the resident's GP. For further information see: <http://www.health.vic.gov.au/subacute/cdams.htm>
- Victoria's Dementia Behaviour Management Advisory Service (DBMAS) - aims to improve the quality of life for people with dementia whose behaviour is impacting on support which is being provided by family members, workers or service providers. DBMAS can be contacted 24 hours a day, seven days a week, on 1800 699 799 or see: http://dbmas.org.au/Your_state/victoria
- Centre for Developmental Disability Health Victoria (CDDHV) - 'Down syndrome and Alzheimer's disease' booklet - <http://www.cddh.monash.org/assets/dsad-booklet-final.pdf>
- Alzheimer's Australia Vic - offers a range of information, resources, safety tips and education (including training for disability support staff) <http://www.fightdementia.org.au>
- For people with a disability under the age of 65 years, the Disability Services – Aged Care Assessment Services Protocol describes the collaborative planning process which is required for people at risk of entering residential aged care. Available on the DHS website.

5.3 Annual health review

Issued: August 2012

FBR – N GH/I – Y STJ/LTR/RTF – LD

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Resources

What is an annual health review?

An annual health review is a once yearly thorough health assessment completed by a resident's usual doctor. The health review is in addition to other visits during the year to the resident's doctor, specialist or other health professionals. New residents must have a health review completed within a month of entering the residential service.

Why is an annual health review required?

The annual health review with the resident's usual doctor is required to:

- monitor their health
- co-ordinate management advice from medical specialists, and other health professionals
- review their medications and ensure routine immunisations, and vaccinations are up-to-date
- identify their risk of disease at an early stage through health screening, for example, pap tests, vision and hearing tests
- identify health promotion strategies to reduce the risk of disease
- provide information for up-dating their health plan including:
 - the Health support needs summary
 - specific health management requirements.

Comprehensive Health Assessment Program

The Comprehensive Health Assessment Program (CHAP) is an annual health assessment format developed specifically to monitor the health needs of people with an intellectual disability. CHAP is the preferred annual health assessment format for residents of department managed long-term residential services. People with an intellectual disability are often unable to adequately recognise, or report health concerns and CHAP provides an opportunity to ensure health issues are not overlooked. The CHAP template is up-dated regularly based on research and evidence, so staff must ensure the current version is used.

Preparing for the annual health review

Staff must:

- ask residents if they would like family, or others important to them to go to the annual health review (and support them to arrange this)
 - arrange for the person responsible to attend the appointment, or be available by telephone to provide consent, as required, *see RSPM 5.5*
 - when making the appointment, explain it is for an annual health review, and request extended time, if required
 - check if the doctor would like CHAP in advance
 - take the following:
 - a copy of the CHAP, with Section: 1 completed
 - a copy of the Information sheet for medical and health professionals
 - the resident's current Health support needs summary, *see RSPM 5.2*
 - the most recent medication record
 - the weight record
 - the most recent nutrition and swallowing issues checklist
 - other management plans or information relevant to their health care.
-

During the annual health review

Medicare includes items a doctor can claim when providing an annual health assessment. The doctor conducting the assessment is required by Medicare to provide a written report and recommendations. The preferred format for department managed services is CHAP, however, some doctor's will prefer to use a template from their own Medical Director software. Staff must complete CHAP Section 1 and provide the entire CHAP document to the doctor, even if another template for the assessment component is used by the doctor. During the annual health review the doctor will review CHAP Section 1 and complete CHAP Section 2, or the equivalent, while examining the resident. The Role of all staff is to:

- assist the doctor to communicate with the resident, as required
- work with the doctor to complete CHAP Section 2, or equivalent
- work with the doctor to develop required management and actions plans
- request the medication record be up-dated including non-prescription medications.

The doctor may provide a copy of CHAP Section 2 or equivalent, and is not obliged to provide anything other than:

- recommendations
- actions plans, required by staff

Recommendations and action plans must be placed with CHAP Section 1 and be attached to the Health support needs summary.

After the annual health review

After the annual health review staff are required to:

- up-date the Health support needs summary if necessary
 - attach CHAP, or equivalent, and recommendations provided by the doctor to the Health support needs summary
 - ensure specific health management requirements are clearly documented, for staff to follow
 - implement required actions
 - up-date the relevant occupational health and safety assessments, if support needs have changed.
-

Breast screening for women aged 50-69

Every two years women on the electoral roll aged between 50 to 69 years of age are sent a letter regarding free breast cancer screening. Women with a disability not on the electoral roll do not receive this notification. Doctor's are prompted to offer breast screening when using CHAP, but research shows the rate of breast screening of women with an intellectual disability is low due to:

- perceived difficulties with obtaining consent
- co-operation issues.

If a woman with a disability has not been screened, or if there have been difficulties with screening, BreastScreen Victoria, offers advice and resources to assist.

Pap tests for women aged 18 to 70

Research shows the rate of Pap testing for cervical cancer in women with an intellectual disability is very low. PapScreen Victoria recommends women aged between 18 to 70 years of age, who have been sexually active, should have a Pap test every two years. This includes women who:

- have only been sexually active once in their lives
- have only ever had one partner
- are no longer sexually active
- have gone through menopause
- are lesbian.

Women who have had a hysterectomy may still require a Pap test and should be advised by their doctor, as required. The requirement for Pap testing is prompted by the annual health review. PapScreen Victoria provides advice about local health services with:

- appropriate disability access
 - equipment, such as adjustable beds.
-

Resources

- BreastScreen Victoria – provides breast x-ray screening at over 40 centres and 16 mobile sites throughout Victoria, telephone: 13 20 50. Available at: <http://www.breastscreen.org.au>
 - Comprehensive Health Assessment Program (CHAP) – for the annual health review. Available on the DAS Hub.
 - Information for medical and health professionals' sheet – contains information about the support provided in residential services and resources that may aid the health professional with the consultation Available on the DAS Hub.
 - Medicare benefits schedule – a table which provides information about Medicare rebates for specific health care items for target groups such as people with a disability. Available at: http://www.health.vic.gov.au/community_health/doctors/mbs.htm
 - PapScreen Victoria – provides an online search for local Pap test providers with disability access and gender choice of practitioners. Available at: <http://www.papscreen.org.au/where.asp>
 - PapScreen booklet – an easy read booklet developed by CDDHV and PapScreen Victoria for women with intellectual disabilities. Go to products – resources on the CDDHV website at: <http://www.cddh.monash.org>
 - Undertaking client related manual handling tasks with safety – a tool for assessing and controlling manual handling risks. Available by emailing EMSONline@dhs.vic.gov.au.
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5.4 Attending health appointments

Issued: August 2012

FBR – N GH/I – Y STJ/LTR/RTF – LD

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Health appointment form
Access to allied health services
Preparing for the appointment
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Resources

Definition of a health professional

A health professional has a recognised university degree, or postgraduate qualification in a particular health area. Health professionals include, but are not restricted to, doctors and medical specialists such as psychiatrists, dentists, nurses and allied health professionals.

Making an appointment

When making a resident health appointment staff are to:

- book a double appointment, as required
- arrange for someone who knows the resident well to accompany them
- ensure the clinic is aware if the resident experiences difficulty waiting, and may become agitated.

Health appointment form

The Health appointment form:

- provides information to health professionals about the reason the resident is attending the appointment
- documents a plan of action developed by the doctor for staff to implement.

This form replaces the requirement to complete an appointment health file note.

Access to allied health services

People with a disability can access a range of allied health services. Access to allied health professionals generally occurs via:

- community health centres where people with an intellectual disability are identified as a high priority group, for services which are provided at low cost and without referral.
- private practitioners eligible for a Medicare rebate. See: Resources below for Medicare item information. The resident's doctor will need to assess if they are eligible for Medicare rebates. Residents with private health insurance may be able to make a claim for private allied health services
- hospital admission or outpatient services.

A resident's doctor should always be informed of allied health service involvement if it occurs without their referral. This requirement ensures information is shared between the medical and health professionals, so consistent health care is provided.

Preparing for the appointment

It is important residents know:

- they will be attending the health appointment
- what will be involved
- the time it will occur.
- they may have to wait in the waiting room with other people for some time.

If it is likely consent will be required during the appointment, and the resident is unable to provide this, the person responsible should attend, or be available by telephone. The following items should be taken to the health appointment:

- the resident's Medicare card and pension card
- the most recent CHAP assessment
- the most recent Health Support Needs Summary and health plan
- the current medication record
- the weight record
- the most recent nutrition and swallowing checklist
- the Information for medical and health professionals sheet
- the health appointment form with Part: A completed
- other information relevant to their health care.

Where the appointment is to review specific health area, staff are to refer to other relevant instruction, for example, for an epilepsy review, *see RSPM 5.13.1*

If staff attend the appointment

If the appointment is for a resident who experiences difficulty waiting, staff should telephone the clinic to check the doctor is running on time.

At the appointment staff should:

- inform the health professional, as required, of their role in supporting the resident
- assist the health professional to understand the resident's disability
- work in partnership with the health professional to reach a satisfactory outcome by helping them to understand the environment in which the resident lives.
- offer to write down the outcomes or follow up requirements for the doctor or health professional to sign.

Staff can provide the Information for medical and health professionals' sheet which contains information about:

- residential services
- the Role of all staff
- informing them of how to best understand and be understood by the resident
- asking them to communicate directly with the resident, whenever possible
- assisting with providing information based on observations, if the resident has no, or little, verbal communication, or they are reluctant to assist.

Staff should use Part: B of the health appointment form to make notes during the appointment and ask the medical or health professional for assistance, as required. If the resident's is visiting a doctor or medical specialist, ask them to review and sign the medication record. If there is a medication change ensure this is noted on the medication record.

If another person attends the appointment

Before the appointment staff are to:

- provide the person with relevant information and documentation
- gain agreement from the person about the reason for the appointment
- request the person completes Part: B of the health appointment form, if appropriate.

Following the appointment, staff must ensure the person provides:

- information about any medication changes
- the completed health appointment form, if used.

If a written summary is not provided, this should be documented and addressed by staff.

If the resident attends the appointment independently

Before the appointment staff should ensure:

- the health professional knows how to understand, and be understood by the resident
- the resident has their preferred communication device, if required
- the resident has relevant information and documentation, including the health appointments form, with Part: A completed
- the resident requests a written summary of key issues and follow-up advice
- the resident asks the health professional to complete Part: B of the health appointments form.

Following the appointment staff should, as far as possible, ensure:

- the health professional has provided information in a format which can be understood by the resident
- the resident provides a written summary of key issues and follow-up advice. The health appointments form Part: B, if completed by the health professional, will provide the summary. If a summary has not been provided it must be documented in the resident's health file.

Residents who do not require staff support with health care or medication issues have the right to manage their own appointments. Where a resident chooses to manage their health needs independently, the decision to do so must be documented in their support plan, personal profile and Health support needs summary to ensure:

- it is clearly understood that staff do not provide support in this area
- privacy is maintained.

After the appointment

Staff are to:

- make any follow-up appointments or referrals requested by the health professional
 - up-date the resident's health and medication information. The health appointment form replaces the health file notes for appointment information
 - up-date the resident's specific health management plan, if necessary
 - inform relevant people such a day programs staff of important resident health care changes
 - implement required actions
 - up-date relevant occupational health and safety assessments, if support needs have changed.
-

Concern the health issue is not sufficiently addressed

If staff are concerned a health issue has not been sufficiently addressed they must raise it with their manager.

Resources

- Allied health table – provides information about what health professionals do and how to contact the relevant professional body. Available on the DAS Hub.
 - Allied Health Medicare rebate items for allied health consultations – a list which can be accessed online:
http://www.health.vic.gov.au/communityhealth/doctors/mbs_doctor/
 - Community Health Services in Victoria – a resource to assist in locating a local community health service. Available at:
<http://www.health.vic.gov.au/communityhealth>
 - File/health note template – a template to record file and health notes. Available on the DAS Hub.
 - Find a health professional – a resource on the Betterhealth channel. Available at: <http://www.betterhealth.vic.gov.au>
 - Health appointment form – a form to document the reason for an appointment and the outcomes. Available on the DAS Hub.
 - Information for medical and health professionals' sheet – contains information about the support provided in residential services and resources that may aid the health professional with the consultation. Available on the DAS Hub.
 - Occupational Violence Risk Assessment – a tool for assessing and managing occupational violence risk in the EMS system. This is available by emailing: EMSONline@dhs.vic.gov.au
 - Undertaking client related manual handling tasks with safety – a tool for assessing and controlling manual handling risks. This is available by emailing: EMSONline@dhs.vic.gov.au
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5.5 Consent to medical and dental treatment

Issued: August 2018

Applies to all

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Who determines capacity to consent?
Recording consent
When a person is unable to provide consent
What happens if there is no medical treatment decision maker?
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Appointment of a support person
Refusal of treatment
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Resources

When is consent required?

Consent is required before a resident can receive medical and dental treatment, except in an emergency. Doctors, dentists and other health practitioners such as podiatrists, dietitians and physiotherapists will determine consent requirements. Consent is usually not needed to share health information required for on-going treatment. For example, a podiatrist supporting a resident with diabetes related foot care does not need consent to provide information about treatment to their doctor.

What constitutes emergency medical treatment?

A health practitioner may administer medical treatment to a person who does not have decision-making capacity without consent if the medical treatment is necessary to:

- save the person's life;
- prevent serious damage to the person's health; or
- prevent the person from suffering or continuing to suffer significant pain or distress.

Emergency treatment must not proceed if the health practitioner is aware that the patient has refused the particular medical treatment or procedure, whether by way of an instructional directive (one kind of advance care directive), or a legally valid and informed refusal by or under another form of informed consent such as under a Refusal of Medical Treatment Certificate made before 12 March 2018 (further information is available of the Office of the Public Advocate website).

Who determines capacity to consent?

It is the responsibility of the health practitioner to determine if a resident has decision making capacity and to obtain this consent. More information is available from the Office of the Public Advocate website.

Recording consent

Confirmation that consent has been obtained by the health professional prior to treatment must be documented in the residents' Accommodation Services File (ASF).

When a person is unable to provide consent

Where a person is unable to consent to treatment, the health practitioner can seek consent from the medical treatment decision maker in the following order and the first person who is willing and available to make the decision:

1. A medical treatment decision maker appointed by the person
2. A guardian appointed by VCAT to make decisions about medical treatment
3. The first of the following people who is in a close and continuing relationship with the person.
 - a) the person's spouse or domestic partner
 - b) the person's primary carer (an adult who is in a care relationship with the person and has primary responsibility for the person's care. Note – this cannot be a paid DHHS staff member)
 - c) an adult child of the person (if more than one, the eldest)
 - d) a parent of the person (if more than one, the eldest)
 - e) an adult sibling of the person (if more than one, the eldest).

Note - If a person already has an enduring power of attorney (medical treatment), it will automatically become a valid appointment of medical treatment decision maker under the Act. However, the person will become known as a medical treatment decision maker.

Parents are the legal guardians and persons responsible of people under 18 years of age unless a court order specifies otherwise, see RSPM 1.1.1.

The name and contact details of the medical treatment decision maker should be documented in the resident's health support needs summary and the hospital admissions form. Currency of the medical treatment decision maker should be checked on review of these documents.

DHHS staff **cannot** provide consent to medical treatment on behalf of a resident.

What happens if there is no medical treatment decision maker?

If the health professional has made reasonable efforts to locate an advanced care directive and/or medical treatment decision maker, but is unable to locate either, the health practitioner must determine if the medical treatment is routine or significant.

Significant treatment is any medical treatment that involves any of the following:

- a significant degree of bodily intrusion
- a significant risk to the person
- significant side effects
- significant distress to the person.

Routine treatment is any treatment that is not significant treatment. If the medical treatment is routine, a health practitioner may proceed to provide the treatment without consent, noting this decision in the clinical record. If the treatment is significant the health practitioner will need to obtain consent from the Public Advocate. The Public Advocate is required to make a decision through the same process as a medical treatment decision maker. Staff do not have a role in this process.

Appointment of a medical treatment decision maker

A person who has decision making capacity may formally appoint a medical treatment decision maker. A medical treatment decision maker can be appointed by a person to make medical treatment decisions on the person's behalf if they do not have the capacity to make the decision. A person may appoint more than one medical treatment decision maker, but there will only be one medical treatment decision maker with authority to make a decision about a medical treatment. The person must list the medical treatment decision makers in the order they would like them to act as the decision maker.

The appointment of a medical treatment decision maker must:

- be in writing and in English
- include the full name, date of birth and address of the person appointing the medical treatment decision maker/s;
- include the full name, date of birth, address and contact details of the medical treatment decision maker/s;
- be witnessed by two people, one of which must be a registered medical practitioner;
- an acceptance of appointment on the same document must be signed by the medical treatment decision maker/s seeking to be appointed which will include a statement about their obligations. This will also need to be witnessed as well.

Appointment of a Support person

A person who has decision making capacity may formally appoint a support person. The role of the formally appointed support person is to help the person make their own decisions. The role will vary depending on the type of support that is required. Appointing a support person will give the support person automatic access to the person's medical information to allow the support person to compile and help interpret information.

It is important to note that the formal appointment of a support person will not preclude others from supporting the person informally (eg, staff).

Refusal of treatment

In the event a resident refuses treatment, information to assist understanding of the circumstances and requirements for refusal of treatment can be found on the department intranet, see RSPM 5.16.

If there is a disagreement about whether the medical treatment decision made by a medical treatment decision maker is consistent with the preferences, values, personal and social wellbeing of the resident who is unable to consent themselves, a health practitioner can notify the Public Advocate who can make an application to VCAT.

The Role of all staff

Staff cannot provide consent on behalf of a resident. Staff can assist, as required by:

- supporting communication between the health professional and the resident
- completing and attaching the Medical treatment decision makers contact form to the medical appointment and hospital admissions forms
- preparing the resident for the health appointment, and explaining what is likely to happen beforehand
- where appropriate arranging a visit to the health service before the day of the appointment, so the resident can familiarise themselves with the environment, if needed.

Resources

Forms and templates are available on the department's internet.

5.6 Medication

Issued: August 2012

Applies to all

Contents

Definitions and abbreviations
Resources

Definitions and abbreviations

The following list provides explanation of some of the most commonly used definitions and abbreviations used by medical and health professionals.

These are:

- ampoule – small sealed plastic or glass container for liquid medication
- bd./bid. – twice a day
- blister pack (Webster Pak, Medico Pak) – type of heat-sealed, tamper evident 'blister' packs that divide solid medication, such as tablets and capsules, into prescribed doses to be taken at specific times over a period. Blister packs are prepared by or under the direct residential supervision of a registered pharmacist
- complementary medicines – are also known as 'traditional' or 'alternative' medicines that are ingested or inhaled for a therapeutic benefit. Examples include vitamins, minerals, nutritional supplements and herbal and homoeopathic products. This also includes aromatherapy which is the use of smell (aroma) from health plant oils, including essential oils, for psychological and physical wellbeing. Methods of aromatherapy include topical application, massage, inhalation or water immersion
 - Note 1: These must still be approved by the medical practitioner on the medication record
 - Note 2: oil burners must not be used in residential services due to fire risk.
- Contraindication – When a medication should not be taken as it may impact negatively due to being incompatible with a residents' health condition or other medication
- enemas – liquids placed in the rectum (the part of the bowel closest to the anus). Most commonly used to assist in emptying the bowel
- intermittent medication – medication administered at regular intervals, although less frequently than daily
- mane/o.m. – in the morning
- medication administration record – forms signed by staff confirming administration has occurred – there are Pink, Blue and yellow forms
- medication record – a document that has a resident's authorised medications, specific dose and monitoring requirements recorded and signed by the doctor. May be a print out from the doctor or the department's Treatment Sheet
- medications – chemical substances used to treat medical conditions. When taken in prescribed or recommended doses, they are intended to benefit the resident using them and dispensed by a pharmacist.
- nocte/on – at night
- oral – taken by mouth

Definitions and abbreviations (cont)

- over the counter medication –Over the counter means items can be purchased without a prescription at a pharmacy or other retail outlet. Medication is any item that has dose requirements, contraindications or restrictions on use.
 - pessaries – medications in a solid form that are placed in the vagina
 - prescription medication – medications that must be prescribed by a doctor and
 - PRN ('pro re nata') – medication to be administered when certain circumstances occur. It is often prescribed for recurring conditions such as hay fever, migraines, epilepsy, asthma and sometimes chemical restraint
 - qid – four times a day
 - self-administration – when residents administer their own medication without any supervision or assistance from staff. Where people are not yet fully independent, they are not 'self- administering' medication
 - side effects – undesirable or unwanted actions of a medication
 - statim/stat – a medication ordered to be given statim (which means 'at once')
 - suppositories – solid substances that are placed into the rectum and are used for the slow absorption of certain medications (such as painkillers) or to assist in emptying the contents of the bowel
 - suspension/suspended medication – medication partly dissolved in a liquid base
 - tds/tid– three times a day
 - topical – on the skin
 - transdermal patch – an adhesive patch applied to the skin that is impregnated with medication for controlled release.
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Resources

- Medication definitions and abbreviations – a printable version is available on DAS Hub.
 - Mediworld Live – DVD medication training resource. Available on the DHS Hub.
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5.6.1 Authorisation and review of medication

Issued: August 2012

Applies to all

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Resources

Prescription medication

When a resident's doctor writes a prescription for a new medication, information about the medication must be written on either the medication treatment Sheet or printed from the doctor's medical software. Many doctors prefer to use a print out from their medical software as it is more efficient, easier to up-date and clearer to read. The instructions in this part of the manual refer to both formats as medication records. Doctors must be asked to sign all medication records. Whichever format is used staff must ensure that the following information is provided:

- date
- name of medication
- reason the medication is being prescribed
- dosage
- frequency
- route of administration
- how long the resident must take the medication for
- possible side effects to monitor
- date the medication is to be reviewed or discontinued.

In addition if transdermal patches are prescribed the following information must be requested:

- the site that the patch is to be located
- the length of time a patch is to be applied.

Staff should use the medication notes section provided on the treatment sheet or health appointments form to capture this information.

If a new prescription is commenced by a doctor who is not the resident's usual doctor, for example, a locum or a hospital doctor, staff must ask them to complete a medication record. If a short-term situation arises where more than one medication record is used, they must be stapled together. Staff are to ensure a new single medication record is completed as soon as is possible.

Respite variation if no medication authorisation is provided

Respite users are required to have the same written authorisation of all medication as people living in residential services. If a resident presents to respite without the required written authorisation of medication and a decision is made to still provide the service, respite staff must telephone the resident's doctor to request a copy of this documentation be faxed or emailed to the facility.

If this is not possible confirmation that all medications and dosages have been authorised by the doctor can be obtained verbally from the doctor or from the resident's regular pharmacist. This confirmation discussion is to be clearly documented and will need to be followed up in writing the next business day.

Additional documentation required for prescribed PRN

Pro Re Nata (PRN) is medication to be administered when specific circumstances occur, for example, pain or in the event of an epileptic seizure. In addition to the documentation on the medication record required for on-going medication, staff must ask the doctor the following information and write it on the medication record:

- when the medication should be administered
- the expected treatment outcome
- procedures to be followed if the medication does not have the expected treatment outcome
- monitoring requirements, for example, temperature or behaviour changes
- safe interval between doses if a further dose is required
- maximum number of doses within a 24 hour period
- when the doctor should be notified, for example, if the resident's condition does not improve as expected within a defined timeframe.

Staff are to use the medication notes template which is provided on the back of the treatment sheet or the Health appointments form, to ask the doctor the questions listed and to document the information provided. Staff must ask the doctor to check and sign the information is correct.

Statim medication

Statim or 'stat' medication is medication that is administered immediately and usually only once. This is ordered by the treating doctor and in many cases administered by the doctor. The medication, the reason for administration and any observation or monitoring requirements must be documented. The yellow dose administration sheet is used to record stat medication.

Chemical restraint medications

The administration of chemical restraint must follow all relevant medication practice instruction in conjunction with a resident's behaviour support plan (BSP) instructions. There are additional requirements for chemical restraint medications and staff must follow instructions contained in section 7 of this manual, the resident's BSP and any direction from the Authorised Program Officer or the Office of the Senior Practitioner. The Senior Practitioner also provides a guide on chemical restraint medications that includes frequently asked questions.

Non-prescription medication

Non-prescription medication includes any over-the-counter and complementary medications. These may include:

- cough syrups
- cold, flu and hay-fever preparations
- pain killers
- antacids
- vitamin and mineral supplements
- herbal preparations and other natural remedy medicines.

Non-prescription medication can be dangerous as it can mask health problems, interact adversely with a residents prescribed medications or health conditions. It may also 'hide' a high body temperature due to illness or infection and inappropriate administration can delay medical treatment and may lead to death. For example, staff must never administer medications such as paracetamol, ibuprofen, aspirin, codeine or similar products to reduce a resident's body temperature, except where the symptoms and the resident's general and current health status have been reported to a medical professional, such as a doctor or NURSE-ON-CALL, and they advise the immediate administration of this medication. This is critical for people with nutrition and swallowing issues as an increased or raised temperature even with no other obvious symptoms may be a sign of aspiration pneumonia, which requires immediate medical assessment and intervention and is life threatening if not immediately treated.

Pre-approval by the doctor to administer these medications for pain and fever, is NOT an approval to administer for a raised temperature in supported accommodation due to the described risk.

Approval of non-prescription medication

People must have a doctor's approval for all over-the-counter oral, nasal and transdermal (patch) delivery medication to ensure it is appropriate for the resident and will not interact negatively with other medications. This also enables the doctor and pharmacist to maintain a clear record and history of all medications and treatments provided.

Many non- prescription medications can be prescribed by the doctor and may then be available for the pension cost. Staff should discuss this with the doctor. Non-prescription medications can be discussed during the regular medication review appointments and included on the medication record. For example, a resident who needs occasional hay fever medication can have it authorised on the medication record to enable administration when required. The resident's doctor is not required to approve each individual dose of an authorised medication.

Instructions for administration should include:

- when it is appropriate for the resident to take the medication
- the desired effects
- the dosage including maximum doses in 24 hours
- the number of doses that can be taken, and number of days the medication can be used, before the doctor is consulted
- any other issues that the doctor thinks staff need to be aware of about the medication.

If a resident is unable to communicate clearly to all staff that a health issue is occurring, then staff who know the resident well are to document the recognised signs a resident displays when a health concern occurs. This information can be provided to the doctor to approve as the circumstances where administration of medication is approved. For example, a resident who is non-verbal may not be able to communicate to all staff providing support that they are experiencing pain. If the signs the resident gives that indicate they are in pain are clearly documented then the resident will receive treatment as authorised and the doctor will be clear about the circumstances that will indicate administration can occur.

If the use of appropriate oral, nasal or transdermal delivery non-prescription medication as PRN, for example, to treat pain, is not documented on the medication record and the doctor is not available to provide approval, for example, after clinic hours, NURSE-ON-CALL (NOC) should be contacted to discuss the resident's symptoms and what actions staff may take. Staff must provide information as requested and inform NOC of the resident's current medications to ensure advised actions will not interact negatively with the resident or medications the resident may be taking. If NOC advises administration of a non-prescription medication, for example paracetamol, it may be administered as advised by NOC and documented. Approval for use of PRN non-prescription medication should be discussed at the next appointment with the doctor. The use of NOC in this circumstance is to ensure appropriate support is provided when the doctors' approval is not available on the medication record and is not to be used routinely to replace doctors' approval. Also *see RSPM 5.14*. Administration is recorded on the PRN/STAT administration recording sheet (yellow form).

Topical non-prescription medication

Topical medications are applied to the surface of the body, for example creams, ointments and drops. Staff must discuss the proposed use of topical non-prescription medication with a pharmacist to ensure that it is appropriate for the resident and their condition. If other symptoms are present such as a raised temperature, the doctor or NURSE-ON-CALL must be consulted. Staff must inform the pharmacist of the resident’s current medications and health issues as some topical medication may be contraindicated, for example many creams that treat inflammation cannot be used if a resident has or is being treated for high blood pressure. Advice provided by the pharmacist, in addition to the standard application instructions on the pack, must be documented. For example, the pharmacist may advise seeking medical attention if the condition has not improved after 24 hours.

Topical medication that has already been authorised by the doctor must be administered according to the instruction provided by the doctor, for example cream to treat tinea.

Respite staff must not purchase or apply any topical or non-prescription medication unless it is authorised on the medication record.

The authorisation required for use of topical non-prescription medication is as follows:

Treatment period	Authorisation requirements
First 48 hours	Staff do not require authorisation from the resident’s doctor. Staff must follow the advice provided by the pharmacist and the product instructions. Should symptoms unexpectedly worsen within the first 48 hours staff should seek advice from the residents’ doctor or Nurse-On-Call.
After 48 hours	Staff must receive authorisation from the resident’s doctor before continuing to administer topical medication after 48 hours. This may not always require an appointment however this authorisation must be recorded. This is to ensure that the medication is safe, appropriate and is not masking an unidentified issue.

Staff must consult the doctor or NURSE-ON-CALL if there are any concerns with the topical medication use.

What is not topical medication?

Application of first aid such as topical treatment of an insect bite or a scratch is exempt from these requirements.

Items that are not considered medication for the purpose of this instruction include:

- cosmetics
- sunscreen
- personal hygiene items such as shampoo and toothpaste.

The labels on items should be checked and where there are no limits on the use of the product or warnings that state it should not be used with some medications or by people with certain health conditions, it does not require authorisation for use. More detail is available from the Tip sheet ‘What is not a topical medication’.

Laxatives

Laxatives are a medication used to treat constipation. A doctor must authorise use of any laxatives. There are two main types of laxative:

- bowel stimulants, which increase the movement of the bowel, for example Benefibre and Movicol
- bulk forming laxatives, which absorb fluid to swell and form a gel, for example Metamucil, Fybrogel, Nucolox, Agiofibre, Normacol and Normafibe.

Bulk forming fibre laxatives must not be given to people with eating or swallowing issues because of a high risk of choking due to the gel forming and swelling action of these medications when mixed with liquids.

Diet, exercise and behavioural change are first line management options for people with constipation. If these are not effective, and a laxative is required, bowel stimulants should be used instead.

Liquid medications for people with swallowing issues

Syringe administration of liquid medications is often advised by prescribing doctors. This may increase the risk of choking and aspiration if the liquid is squirted into the back of the mouth.

When it is recommended by the doctor that a resident with swallowing issues have liquid medication delivered orally by syringe, the resident's swallowing issue is to be discussed with the prescribing doctor as a safer alternative may be available.

If it is determined that this is the only medication option then the speech pathologist should be consulted and information directing the safest method of administering the medication by syringe, documented and kept with the medication record. An alert must be included on the Health support needs summary, stating the 'administration by syringe' information must be followed.

Clarifying information

Pharmacists sometimes identify potential issues, or possible interactions, with medications prescribed by doctors. In these cases the pharmacist will almost always contact the doctor to clarify. Pharmacists may also add to doctor's advice regarding how to administer medications. If staff believe any issue or information has not been clarified they should request the pharmacist contact the doctor to resolve the matter. If the matter is still unclear they should discuss the issue with their manager.

Changes to medications

When there is a change to a resident's medications it can take time to identify the most appropriate treatment. The doctor may need to alter the medication or the dose on one or more occasion. The resident may be required to attend follow up appointments so that the doctor can assess the resident's response to the medication. It is important to communicate with the resident's doctor during this process if there are any concerns.

Frequency of reviews

Review of medication is an important part of a resident's health management. Review of medication should be conducted at least every six months, or as directed by the resident's doctor. People prescribed medications for chemical restraint require a medication review every four months or more frequently if directed by the doctor, Authorised Program Officer or Office of the Senior Practitioner.

If there are no changes to medications it is sufficient that the doctor sign and date the medication record as current. If multiple changes are required, ensure the doctor is provided with a new treatment sheet to complete or they print out a new medication record. Records with multiple changes done by hand are not easily read or checked so should be avoided.

Accessing the Home Medicines Review service

A Home Medicines Review (HMR) involves an accredited pharmacist visiting the house to review a resident's medication. Only a doctor can make a referral for a HMR. The HMR generally costs the same as the doctor's usual consultation. The aim of the HMR is to improve the health and wellbeing of the resident by providing advice, support and training on issues such as medication administration and side effects. The review should include the resident, a staff member who knows the resident well and any other relevant resident. After the review the pharmacist writes a report to the resident's doctor.

Staff should ask the resident's doctor if they think a HMR might benefit the resident. Occasionally a doctor may be hesitant to recommend an HMR if they feel the resident's medications are already being well managed. If staff believe the support, advice or training the HMR service offers would be valuable to staff they can discuss this with the doctor.

If it is difficult to find a pharmacist accredited in HMR contact the local Division of General Practice. See Resources for details.

Side effects

Side effects can be caused by all kinds of medication, including prescription, over-the-counter and complementary medicines, herbal preparations, vitamins and products dispensed by naturopaths or other complementary medicine practitioners. Residents should never be given any product not approved by their doctor (except for topical non-prescription medication on advice from a pharmacist).

Many people with a disability take more than one medication. This increases the risk of side effects because the ingredients in the various medications can interact. Many people with a disability take medications that may have serious side effects, such as anti-psychotics and anti-epileptics. Side effects can be minimised if managed appropriately.

Staff must:

- ask the doctor to note possible side effects on the medication record
- request a print out of information about the medication from the pharmacist
- ask the pharmacist if there is anything else that may impact the resident when taking the medication, for example, food or alcohol
- record on the resident's health file notes any specific alerts about side effects that need to be monitored based on advice from the doctor or pharmacist
- where appropriate remind the resident about possible side effects that they should tell staff about
- when administering medication observe the resident as noted by the doctor or pharmacist
- seek medical advice if the resident appears to experience any of the possible side effects, or other symptoms that are not usual for the resident such as tremors or twitching, nausea, unusual change, increase or decrease in appetite, change in sleeping habit, or mood change.

- check the site of transdermal patches for skin reactions to adhesives or medications, such as redness or swelling.

Role of all staff

Staff have a responsibility to act on behalf of the resident they are supporting and ask the doctor what the medication is being prescribed to treat and if there are any specific instructions about administration. When attending appointments where medications are prescribed staff are required to:

- ask the questions provided on the medication notes page of the treatment sheet and appointments form. These are questions that any resident should ask when being prescribed medication.
 - document the doctors responses in the sections provided
 - ask the doctor to check the information and sign as correct
-

Role of the supervisor and manager

The supervisor and manager must check that all staff follow requirements by putting a system in place to ensure:

- all medications each resident is receiving are listed on the resident's medication record and no medications are being administered without authorisation. Authorisation includes a signed medication record; or direction provided by NURSE-ON-CALL or other medical professional to administer medication to manage an immediate issue, that is recorded in file notes or communication book.
 - there is only one medication record for each resident (short term situations such as time between hospital discharge and doctor review excepted)
 - all medications exactly match the medication record including the drug name, dose, frequency and route, or confirmation is available that the medication supplied is the same as the medication on the record, for example a drug information sheet that lists the alternative medication names
 - non-prescription oral, nasal and transdermal medication is recorded on the medication record signed by the doctor
 - non-prescription topical medications are clearly documented and application is recorded and signed for on a blue medication form
 - administration requirements for PRN medication are clearly documented
 - possible side effects are communicated to all staff
 - medication administration recording forms are available and filled in correctly.
-

Resources

- Client Treatment Sheet and Doctor's Medication Notes – a double sided form for medical practitioner use. One side is to document medication and treatment directions the other is to document advice about current treatment and follow up requirements. Doctor's may use medication record forms provided on the clinic computer. Available on DAS Hub.
 - Home Medicines Review – This service reviews the medications of people living at home. It is on the Australian Government Department of Health and Ageing website at: <http://www.health.gov.au>. Click on the 'A-Z Index' and search under 'H'.
 - Locate your local general practice division and find the contact details for the Home Medicines Review facilitator - http://www.doctordv.com.au/doctordv/documents/VictorianDivision_Contact.htm
 - Medication administration recording form – original containers – blue form – this form must be printed on blue paper. Available on DAS Hub.
 - Medication administration recording form – blister packed – pink form – this form must be printed on pink paper. Available on DAS Hub.
 - Medication administration recording form – PRN/STAT – yellow form -this form must be printed on yellow paper. Available on DAS Hub.
 - Respite medication information – an information sheet to provide to carers about requirements for providing medications when accessing respite.
 - What is not medication- Tip Sheet. Available on the DAS Hub
 - Working effectively with GP's – Tip sheet. Available on the DAS Hub
-

5.6.2 Obtaining and storing medication

Issued: August 2012

Applies to all

Contents

How to obtain medication
Respite variation if no blister packaging is provided
Checking medication
Generic medications
How to store medication
Role of the supervisor and manager

How to obtain medication

When obtaining medication, staff must ensure:

- medications are picked up, or delivered, without delay after the doctor authorises them.
- solid medication (tablets and capsules) are packed in pharmacy sealed blister packs, including PRN medication in a separate blister to regular daily medications.
- prescribed medications are not accepted in bottles of loose tablets or capsules.
- medication identified by the pharmacist as not suitable for blister packing, such as liquids and medications in factory sealed foils that will quickly deteriorate if removed from the packing, must be obtained in the original container or other suitable dosage container. Containers should be clearly labelled by the pharmacist with:
 - resident's name
 - name of medication
 - strength and frequency of dosage
 - times medication should be taken
 - instruction for administration
 - date dispensed
 - storage instructions
 - name, address and phone number of the pharmacist
- Midazolam, which is used as PRN for epilepsy, must be obtained in single dose plastic ampoules. It must not be drawn up using a syringe
- a recent passport size photograph of the resident who takes the medications is attached to each blister pack and other medication containers.
- newly commenced medications are blister packed within 24 hours
- blister and single dose medication packs should be collected weekly where possible, so no more than more 7 days requirements are held at the group home at any time
- the medication manufacturer's information is obtained from the pharmacist and stored with the medication record
- the pharmacist is asked if there is any other information about the medication, such as interactions or side effects to be aware of.

Respite variation if no blister packaging is provided

Medications for respite users must be provided in pharmacy sealed blister packs, or as described above for medications that cannot be blister packed. If a respite service accepts a resident at short notice whose medication is not blister packed then the medication must be blister packed within 24 hours. If the resident is staying at respite for less than 48 hours regions may apply discretion, however more than 7 days supply of the authorised medication cannot be accepted and held at the respite service as loose tablets, capsules or similar. Regular respite users must use blister packing.

Checking medication

On receipt of medication, staff must check:

- that all medication has been provided
- the medications listed on back of the blister pack and original containers match the medications listed on the medication record.

If there is a problem, staff must raise it immediately with the pharmacist for advice.

Staff in respite services must check medication against the medication record when the resident arrives at the respite facility. If the medication is not provided in an appropriate, labelled container, the family must be requested to remedy the problem immediately.

Generic medications

Generic or alternative brand medications may be offered by the pharmacy. If the pharmacist supplies a generic or alternative medication this must be identified on the label as an equivalent to the prescription. The pharmacist will also need to update the information on the blister pack, for example the name and colour of the tablet.

How to store medication

All prescribed and over the counter medication must be stored according to the manufacturer's instructions and:

- away from temperature extremes and sunlight
 - in a locked medicine cupboard, drug trolley, safe or drug transportation box fixed to a particular location
 - kept locked to prevent loss and to avoid accidental ingestion by people.
 - medication that requires refrigeration must be placed in a key locked container in the fridge. Ensure temperature control is adequate by checking weekly with a thermometer.
 - should not be opened or exposed to the air, earlier than necessary.
 - keep medications in the container until just before giving the medication.
-

Role of the supervisor and manager

The supervisor and manager are to establish a system for managing medication collection and storage to ensure:

- medication for each resident exactly matches their medication record
- medication, including PRN, is blister packed and has a photo of the resident attached.
- medication that cannot be blister packed is in an appropriately labelled container
- medications are stored securely and in accordance with manufacturer's instruction, for example in the refrigerator
- the pharmacist has provided a copy of the manufacturer's product information
- the keys to the medication cabinet are clearly labelled and stored safely
- a spare set of keys to the medication cabinet is kept in a secure location on site
- a process to check and account for medications held is implemented, particularly PRN medications.

Resources

- Medication Management – practice alert. Describes the most common medication management errors and presents a list of questions as a quick reference for checking local practice. Available on the DAS Hub.
-

5.6.3 Administration of medication

Issued: August 2012

Applies to all

Contents

Who can administer medication?
What administration methods cannot be used
Administration methods not specified
Before medication is administered
How to administer medication
If the resident wants to administer their own medication
Role of all staff
Role of the supervisor and manager
Resources

Who can administer medication?

Staff who have been assessed as competent for the general Administration of Medication training can administer the following medications:

- oral, this includes tablets, capsules and liquids
- eye, eye drops or cream
- nose, sprays or drops
- ears, drops
- skin, application of ointments in lotion, cream or liquid, sprays and transdermal adhesive patches.

In addition to general administration of medication training, staff are to receive training specific to a particular resident to administer medication via the following methods:

- Inhalation through nose or mouth using appliances such as nebulisers, masks, vaporisers, and nasal prongs.
- Rectal or vaginal using enemas, suppositories, pessaries and syringe nozzles inserted in to rectum or vagina.
- Nasogastric, PEG or other tubes inserted into the gastrointestinal tract.
- insulin injector pen.
- Epipen, a set dose injector pen to deliver adrenaline for severe allergic reactions. Note: *use of Epipen in an emergency situation may occur as per first aid requirements.*
- Medication that is automatically loaded into an injection pen with a subcutaneous length retractable needle.

The following medications (with training focussed on monitoring and side effects):

- Midazolam.
- Palliative care medications

What administration methods cannot be used

Staff must not administer medication by:

- injections by a standard syringe or an injection device that has a standard length non-retractable needle. This includes intramuscular, intravenous and subcutaneous injections
 - injection by any means into IV lines, or similar equipment that is sited intravenously.
 - manually drawing up or loading injection devices with medication.
-

Administration methods not specified

Where a resident requires medication administration by a method where the training and practice requirements are not clearly described in this instruction, for example, by a type of injection pen where the dose has to be drawn up by eyesight, or administered by pushing a plunger/button for a specified time period managers will need to assess the appropriateness of staff administering this medication. Consideration should include:

- the risk the administration method may present for over or under dosing
- whether the dose is set and the same every time, or has to be determined prior to each dose based on other clinical information
- the feasibility of having all staff trained in this administration, and a second staff member on shift at all times to witness the safe administration of this medication

Where managers decide the risks cannot be effectively mitigated, it would be more appropriate to engage a health professional such as RDNS or equivalent to administer this medication, see RSPM 5.13.

Before medication is administered

Before administering medication, staff must as far as possible, understand:

- the reasons a resident is taking each medication
 - how the medication is administered
 - possible major side effects of the medication
 - how to recognise possible major side effects.
 - be familiar with the location of all first aid equipment and how to use it.
-

How to administer medication

The following steps must be taken during the administration of medication:

Step	Action
1	Pay attention to the administration of medication and do not attend to any other task at the same time. Have a second staff member witness the whole process where possible.
2	Follow infection control procedures: <ul style="list-style-type: none"> • Wash and dry hands before and after administering medications to each resident. • Ensure that the work area and any other equipment to be used are clean. • Wear gloves to apply ointments, creams and lotions. See RSPM 3.10
3	Collect all information and equipment required.
4	Check the medications are in suitable condition and have been stored properly. Check use by dates on original container medications.
5	Check the medication against the medication record and the medication notes. Check the '6 Rs': <ul style="list-style-type: none"> • right medication • right date • right time • right dose • right resident • right route.
6	Check that the resident is able to receive medication. Do not give medication by mouth if a resident is unable to receive it, such as if they are asleep, unconscious, drowsy, vomiting or having a seizure.
7	Give the resident clear instructions about how to take the medication, for example swallow, hold under tongue, using methods the resident understands, for example gestures or photos.
8	Administer the medication strictly according to the prescribing doctor's instructions.
9	As far as possible, ensure the entire dose is taken by the resident.
10	Record the administration of each medication. The staff member who administered the medication must do the recording.
11	Monitor and if there appears to be an unusual or adverse reaction notify the resident's doctor.

Liquid medications for people with swallowing issues

Where syringe administration of liquid medications is required, staff must follow the recommendations provided by the doctor or speech pathologist to minimise the risk of aspiration, *see RSPM 5.7*.

Liquid medication must never be squirted into the back of the throat. Re using the same syringe for the same resident should be avoided where possible and syringes should never be used with another resident as traces of different medications may remain and syringes may not be adequately cleaned.

If the resident wants to administer their own medication

If the resident wants to administer their own medication, the supervisor must ensure the following process occurs:

- An assessment by the supervisor, in consultation with the resident and the resident's doctor, must assess the resident's ability to administer their own medication without any supervision or assistance from staff. This assessment must consider:
 - how much the resident wants to self-administer medication
 - the resident's understanding of the purpose of the medication
 - the resident's awareness of the consequences of incorrect or missed doses
 - the resident's knowledge of safe storage methods
 - the likely benefits of having the resident self-administer medication and whether these benefits outweigh the risks
 - the likelihood of incorrect administration occurring and the risk of harm this may cause to the resident or others
 - any precautions that should be taken to prevent incorrect administration.
 - All decisions made in relation to self-administration of medication, as well as the factors contributing to this decision, are recorded in the resident's file
 - if required, develop and implement strategies to assist the resident build their skills towards self administration
-

Role of all staff

All staff are to ensure they have:

- completed the staff signature record
 - attended the required medication administration training
 - resident specific training for medications and administration routes that require it
 - followed any instructions specific to the resident.
-

Role of supervisor and manager

The supervisor and manager are to ensure a system is established for managing medication administration, for example, assigning administration as a specific shift responsibility.

Resources

- Administration of medication best practice- tip sheet. Available on the DAS Hub.
-

5.6.4 Recording and communicating about medication

Issued: August 2012

Applies to all

Contents

Why administration of medication is recorded
Where to record administration
How to record administration
Recording non-prescription, and PRN and stat medication
Recording the absence of a resident from the residential service
Ceased medication
New medication record
Accounting for PRN medication
Communication at the end of a shift
Communicating medication changes
Role of the supervisor
Resources

Why administration of medication is recorded

All administration of medication must be recorded:

- to ensure that residents are receiving medications prescribed
- because the department is accountable for the administration of medication by its staff.

Documentation is also important because it provides a record of what has been administered and when. Administration sheets are also used to check medications to ensure they are accounted for.

Where to record administration

Administration is recorded on the Medication administration form. This record consists of three forms to be filled in by staff when they administer all types of medication. The forms are:

- Medication administration – blister pack – the pink form. This form is used when administering blister packed medication.
- Medication administration – original containers – the blue form. This form is used when administering any ongoing or short course of medication that must be kept in the original container. For example creams, drops and some types of antibiotics.
- Medication administration – PRN/STAT medication – the yellow form. This form is used when administering any PRN, that is as required, or single dose medications

In addition all staff must sign the staff signature record to ensure signatures on the medication administration forms can be verified and identified if necessary.

How to record administration

To record medication administration:

- Each staff member who will administer medication to a resident must print their name and sign their initials once on the staff signature record. This is so that the initials can be cross checked with those on the Medication administration form when necessary.
 - The staff administering the medication must be the person who signs the record.
 - Where available, a second staff member is to witness the administration process and co-sign the administration record
 - Where a second staff member is not available to witness administration this must be noted. NWA (No Witness Available) is the suggested code.
 - Staff must use a blue or black pen only.
-

Recording non-prescription and PRN and stat medication

Only medication authorised by a medical practitioner may be administered and the details about what was administered, by whom, at what time and for what purpose must be recorded in the shift report and the resident's file. Where the medication has limits on the number of doses that may be given in a 24 hour period or for administration over consecutive days, staff must document on the relevant day or days in communication book or diary:

- The time and date of the first dose
- The time and date the next dose may be given if required

All PRN medication must be recorded on the yellow PRN/STAT Medication administration form.

Recording the absence of a resident

If a resident is absent from the residential service, for example, on holidays, visiting family or in hospital, staff on duty must mark a line through the dates or times the resident is absent on the Medication administration form and note the reason for absence. An entry indicating the absence should also be made in the resident's file, the staff communication book.

Where a single dose is not administered by staff for any reason, staff are to use the abbreviation key shown at the bottom of the Medication administration recording forms, to record the reason.

Ceased medication

When a medication is ceased, staff must mark a line through the medication on the Medication administration form (the form signed by staff when medication is administered) and write 'ceased'. A note must also be written in the resident's file and the staff communication book.

New medication record

If a resident has a new medication record (the record of current authorised medication provided by the doctor) staff are required to:

- check that the doctor records details of all current medications, including PRN, topical, over-the-counter and complementary medication, on the new sheet
- alert other staff that there is a new medication record
- print and sign their name once at the bottom of the new medication record
- put a line across the old medication record and do the following:
 - note the date it was replaced
 - note the name and signature of the staff member confirming the changes in the medication records
- file the old record in a way that means it cannot be confused with the new medication record.

Staff must never alter details written by the doctor on a medication record.

Accounting for PRN medication

PRN medication must be accounted for. The number of doses given and the remaining medication must balance to ensure that monitoring and accountability requirements are met. Tablets and capsules must be in pharmacy sealed blister packs or, if the pharmacist advises they cannot blister packed, left in the factory packed and sealed strips. Tablets and capsules must not be held as bottles of loose tablets or capsules. The level of liquid medications should equate visually, as near as possible, to the number of doses administered. Accounting for PRN medication should include:

- visual checks conducted at the end of each shift
 - discrepancies are reported and addressed as a Critical Client Incident or non-critical client event, except where the issue is identified as dropped or spilt medication which can be accounted for, *see RSPM 6.4*
 - documentation that checks have occurred, for example a note as part of the shift report.
-

Communication at the end of a shift

At the end of a shift, staff must:

- check that all medication documentation is completed
 - check that all medication has been administered during the shift
 - inform incoming staff of any changes to a resident's medication made by a doctor
 - inform incoming staff of any people exhibiting effects or side effects of medication and any action taken or to be taken
 - note that medications have been checked and accounted for.
-

Communicating medication changes

Staff are required to ensure information about medication changes is effectively communicated to the resident and others who support the resident. Alerts to notify staff of changes must be documented in the communication book.

Role of the supervisor and manager

The supervisor and manager are to establish a system to ensure:

- all staff have completed the staff signature record
 - administration is recorded correctly
 - medication is checked weekly against medication administration forms
 - issues with medication have been documented and addressed
 - regular checks of medication, in particular PRN medications, occur to ensure that all medication is accounted for and not out of date.
-

Resources

- Administration of medication best practice- tip sheet. Available on the DAS Hub.
 - Medication administration – blister pack – the pink form. This form must be printed on pink paper. Available on the DAS Hub.
 - Medication administration – original containers – the blue form. This form must be printed on blue paper. Available on the DAS Hub.
 - Medication administration – PRN/STAT – the yellow form. This form must be printed on yellow paper. Available on the DAS Hub.
 - Staff signature record – a form to register the signatures used by staff when signing for and witnessing medication administration. Available on the DAS Hub.
-

5.6.5 Medication when the resident is away from home

Issued: August 2012

FBR – P GH/I – Y STJ/LTR/RTF – P

Contents

Planning for absences
Medication on outings with departmental staff
Medication on outings without department staff present
Medication at regular daytime activities

Planning for absences

When a resident is going to be absent from a residential service, staff are required to ensure:

- the resident or the person supporting them has the required information about the administration of medication as well as relevant health issues
- there is sufficient medication for the entire period of any temporary absence.

Medication on outings with departmental staff

On outings, departmental staff are required to ensure:

- medications are stored securely and according to the manufacturer's instructions
- if medications need to be stored in a refrigerator, they must be stored in an insulated container during the outing
- medications are administered correctly
- all medication administered are recorded by the staff who administered the medication immediately on return from the outing.

Medication on outings without department staff present

Staff on duty prior to an outing departmental staff will not be attending are required to ensure:

- all people (friends, families and non-departmental staff) who may support a resident who needs medication while away are aware of, and able to clearly follow the instructions for, administration of medication
- any medication leaving the house is noted and signed off in the shift report at the residential service
- people who will be administering medications know how to store them securely and correctly
- any medication being returned to the residence (as may be the case with PRN medication) is noted and signed for in the shift report
- all medication administered on an outing by a support resident is recorded in the shift report and Medication Administration Record at the residential service immediately on return from the outing.

**Medication at
regular daytime
activities**

Staff are required to:

- ensure that people responsible for administering the medication at the daytime activity are provided with a copy of the medication record when a resident first attends the activity or whenever a medication record is changed or updated
 - request that medications are stored securely and according to manufacturer's instruction
 - alert staff at the daytime activity to any change in the resident's medication on the first day the resident next attends the activity and provide an updated copy of the medication record and any specific instruction or information
 - ensure that staff at the day activity are provided with medication in a separate blister pack or container specifically for daytime doses
 - never transfer medication from one container to another container for administration at a resident's daytime activity.
-

5.6.6 Problems with medications

Issued: August 2012

Applies to all

Contents

Administration errors and refused medication
Dropped or spilt medication
Damaged, contaminated or out of date medication
Accounting for medication
Disposal of medication
Role of the supervisor

Administration errors and refused medication

An error of medication administration includes:

- giving the wrong medication
- giving the wrong dose
- missing a dose
- giving a dose at the wrong time
- administering via the wrong route.

Refused medication is when the resident will not take any, or all, of the dose required.

If an error is made when administering a medication, or if a resident refuses to take medication, staff must:

- Obtain and follow advice from the pharmacist or doctor.
- Call the Poisons Information Centre (Phone 13 1126, 24 hours a day) if the pharmacist or doctor cannot be contacted.
- Record the error or refusal and the advice provided in the resident's health notes
- Record refusal of medication with the code 'R' on the medication administration record. If it was missed for another reason write the code 'M'.
- Alert other staff at the house of the error or refusal and observe any changes in behaviour or wellbeing and report these to the supervisor or manager.
- Complete a Critical Client Incident Report or non-critical client event as required and cross reference it to the shift report. *See RSPM 6.4*
- Have the blister pack repacked if too much medication, or the wrong medication, was administered from it.

Dropped or spilt medication

If medication is dropped or spilt it must never be put back into the container or administered. Staff must:

- Dispose of the entire contents of the dropped or spilt blister section. Mark it 'return to pharmacy'. If the medication is a liquid, wipe up with a disposable paper towel. Bag the towel and place in the outside rubbish bin.
 - Give the resident the contents of a blister that is identical to the one dropped (check on the back of the blister to ensure the types and number of tablets or capsules is the same). If the medication is a liquid, ensure the resident receives the full dose as per the doctor's instructions.
 - If staff are unsure about the dose in another compartment of the blister pack, they must seek advice from the pharmacist or doctor.
 - Make arrangements for the resident's medication to be replaced, for example the blister pack to be repacked, and to return any dropped or spilt tablets or capsules to the pharmacy.
-

Damaged, contaminated or out of date medication

If medication is damaged, contaminated or out of date, it must be returned to the dispensing pharmacist.

Medication must never be placed in the bin or flushed down the toilet.

Disposal of medication

The following must occur when medications require disposal:

- label all medications that are to be disposed of as 'For return to pharmacist/Not for use' and store in the locked medication cupboard separately from the current medication
 - document the return of all medication in the resident's notes and the shift report after return to the pharmacy.
-

Role of the supervisor

The supervisor is required implement a system to ensure:

- medication errors are managed as required
 - damaged medication and medication for disposal is returned to the pharmacist for disposal
 - where refusal of medication becomes an issue it is referred to the resident's doctor to have the medication reviewed.
-

5.7 Nutrition and swallowing

Issued: August 2012

FBR – P GH/I/STJ/LTR/RTF – Y

Contents

Overview
What can go wrong with eating and drinking?
What may cause Nutrition and swallowing issues?
What is aspiration?
What are malnutrition, starvation and dehydration?
Nutrition and Swallowing Issues Checklist
How is NASIC completed?
Signs and symptoms of nutrition and swallowing issues
Management of Nutrition and swallowing issues
Laxative use by people with swallowing issues
Role of all staff
Resources

Overview

Nutrition and swallowing issues are common and very serious in people with an intellectual disability. Swallowing issues can cause death. Research shows 90 per cent of people with an intellectual disability will have a swallowing or nutrition issue at some time in their life. The Victorian Population Health Survey of People with an Intellectual Disability showed adults with an intellectual disability are more likely to be under, or over weight, or obese than the general population. Dysphagia (difficulty with swallowing) is common in people with developmental disability. It is estimated 76 per cent of adults with multiple disabilities have swallowing issues. People with a severe physical disability, for example, as a result of cerebral palsy, are likely to:

- experience difficulty swallowing
- be poorly nourished.

Illnesses of the respiratory system are the most common cause of resident death. Respiratory illnesses, such as aspiration pneumonia, are most often related to swallowing difficulties and are often avoidable, if they are identified and treated early. Choking is a rare cause of death in the general population, but more common in people with multiple disabilities.

What can go wrong with eating and drinking?

The eating and swallowing process involves the lips, tongue, jaws and throat working together, so food and liquids travel down the food pipe (oesophagus) into the stomach and not down the wind pipe (trachea) into the lungs. Most people can cough to clear small amounts of food which may enter the windpipe. Some people are unable to swallow safely and are unable to cough adequately to clear their airway. Dysphagia is a term used to describe difficulties with swallowing food, fluids or medications. The term 'food aspiration' describes breathing food into the windpipe and 'aspiration pneumonia' is an infection which develops when food, fluid or medication is breathed into the lungs. Swallowing issues combined with some medications, oral health issues and degenerative conditions create a high 'aspiration pneumonia' risk.

What causes Nutrition and swallowing issues?

The most common causes of nutrition and swallowing issues are:

- development disability
- physical disability such as cerebral palsy
- poor oral health, broken or rotting teeth, gum inflammation and disease
- mouth, throat or gastrointestinal system damage or impairment
- impaired muscle control or weakness
- medications which cause nutrition and swallowing issues
- Acquired Brain Injury (ABI)
- degenerative neurological diseases such as Motor Neurone Disease, Parkinson's Disease or Multiple Sclerosis
- cancers or tumours
- dementia
- normal ageing processes
- stroke.

Early identification and intervention is vital

Some people with developmental disability experience a deterioration in swallowing skills after 30 years of age. Early identification of nutrition and swallowing issues is vital to assist residents to manage serious health issues. Any resident with an identified nutrition and swallowing issue must have:

- a specific health management plan developed in conjunction with relevant health professionals
- alerts in their personal profile and health support needs summary.

The Nutrition and swallowing issues checklist

The Nutrition and Swallowing Issues Checklist (NASIC) has been designed to assist staff to identify and follow-up signs and symptoms associated with nutrition and swallowing issues. The NASIC must be completed within seven days of a resident entering a residential service, and reviewed in the month prior to annual health review so the most current information is provided at the appointment. Residents with multiple disabilities may have changing needs and develop issues over time. The NASIC looks for emerging issues, so they can be identified and assessed. The NASIC must also be reviewed as new signs, or symptoms appear.

How is NASIC completed?

The NASIC is to be completed by staff who know the resident well in conjunction with their family or previous carers, (if they are new to the residential service). The resident's current weight and height is required. A 'YES' response to any question raised in the NASIC may indicate:

- a known nutrition and swallowing issue
- a new nutrition and swallowing issue.

If it is a known issue staff should ensure a documented management plan is in place to address it. Any new issue should be raised with the resident's doctor who may refer them to an allied health professional for further investigation and assessment.

Signs and symptoms of nutrition and swallowing issues

The NASIC lists a number of signs and symptoms which indicate possible nutrition and swallowing issues. The signs and symptoms of aspiration that must be treated as a medical emergency are:

- choking on food, fluid or saliva
- chronic wheezing
- recurrent chest infections
- raised temperature

In some residents the symptoms may be less obvious. For example, some residents do not cough, even if they aspirate food, fluid or saliva into their lungs, *see RSPM 5.14.*

Management of Nutrition and swallowing issues

The NASIC must be taken to the doctor to be included as part of the annual health assessment. If a resident's nutrition and swallowing has altered or deteriorated, an earlier medical review must be sought.

The doctor may need to arrange medical tests and assessments to ensure an underlying medical cause is not the issue, and will most likely refer the resident to a speech pathologist and dietitian, for assessment and management advice.

Management strategies may include:

- a texture modified diet
- positioning advice
- mealtime assistance guidelines
- nutrition advice
- alteration to the food quantities, timing or pacing of the meal
- use of prompts or reminders regarding a 'safe' swallow (e.g. cough, swallow again, chin down)
- alternative eating methods such as Percutaneous Endoscopic Gastrostomy (PEG) tube.

Some residents may be assessed as 'Nil Orally', meaning that they cannot eat or drink anything via the mouth. Others may receive most of their nutrition through alternative feeding, but may be able to eat some modified foods.

Poor oral health can also lead to aspiration pneumonia. It is important to ask the speech pathologists and dentist for assistance in developing an oral health care plan for residents with swallowing difficulties, *see RSPM 5.10*.

Laxative use by people with swallowing issues

Laxatives are a medication used to treat constipation. A doctor must authorise the use of all laxatives. The main types of laxatives are:

- bowel stimulants, which increase the movement of the bowel, for example, Benefibre and Movicol
- bulk forming laxatives, which absorb fluid to swell and form a gel, for example, Metamucil, Fybrogel, Nucolox, Agiofibre, Normacol and Normafibe.

Bulk forming fibre laxatives must not be given to residents with eating or swallowing issues, because of the high risk of choking due to the gel forming and swelling actions of these products when mixed with liquid.

Liquid medications

The doctor may advise use of syringe administration of liquid medications for residents with swallowing issues. When residents have swallowing issues that require thickened fluids this may create a risk of aspiration so staff should discuss this with the doctor and seek advice from the speech pathologist.

The recommendations provided by the speech pathologist are to be incorporated into the meal assistance plan to minimise the risk of aspiration.

Liquid medication must never be squirted into the back of the throat. Re using the same syringe for the same resident should be avoided where possible and syringes should never be used with another resident as traces of different medications may remain and syringes may not be adequately cleaned.

Role of all staff

Staff are required to:

- report any nutrition and swallowing changes to the resident's doctor
- review the NASIC annually, or as changes are noticed
- follow meal assistance plans
- adhere to review requirements specified by the resident's doctor and speech pathologist.

Resources

- Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au>
 - Good food for all – a guide to food, nutrition and meal planning for staff supporting people with a disability. Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
 - Nutrition and swallowing issues checklist (NASIC)– a checklist to identify a person's risk of nutrition or swallowing problems. Available on the DAS Hub.
 - PEG guide – a guide on PEG feeding to be used in conjunction with training that is specific to the resident. Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
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5.7.1 Supporting people with pica behaviour

Issued: July 2013

Applies to all

Contents

What is pica?
Factors that increase the risk of pica behaviour
Health risks of pica behaviour
Strategies to manage pica behaviour
Role of staff
Role of supervisors and managers
Resources

What is pica

Pica is defined as a behaviour where inedible objects or non-nutritious foods are eaten by a person and the behaviour occurs more than once over a period of at least one month.

Pica behaviour can be:

- Food-based;
- eating rotten food, frozen food or scavenging for food in the rubbish.
- Non-food based;
- seeking out inedible objects in their environment, placing the object in the mouth and then either chewing the object or immediately swallowing it. Common non-food items include clay, dirt, sand, stones, grass, hair, faeces, plastics, rubber, paper, chalk, cloth, paint chips, wood, bark, twigs, laundry products, matches and cigarette butts.

Some people will engage in pica behaviour with several different types of objects, and other people will only ingest one specific type of object.

Pica behaviour can vary greatly in its frequency, the intensity with which an object is pursued and what is ingested.

Factors that increase the risk of pica behaviour

People with more severe intellectual disability and those with autism have a higher risk of having or developing pica behaviour than other people.

The risk of pica behaviour is also increased in people who are already at risk, where there is:

- Boredom - lack of participation in meaningful activities
- Social isolation - insufficient interaction with others
- Environmental – uncomfortable, lacking stimulation, access to trigger objects.

Health risks of pica behaviour

The risks of pica behaviour are often under-recognised. It is important that the residents' doctor is aware of and consulted about pica behaviour as it may be increased by an underlying health issue, or the behaviour may cause health issues that require testing and treatment. Health issues may include:

- mineral deficiencies
- malnutrition
- neurological conditions
- dental problems
- infection and disease.

The ingestion of some objects present a medical emergency and can be potentially life threatening. This includes objects that:

- may cause blockages or damage to the gastrointestinal tract
- may cause vomiting or choking
- are toxic, for example, chemicals, lead based paints, poisons

Pica behaviour is of particular concern because even one instance of the behaviour may cause harm.

Strategies to manage pica behaviour

Some strategies to assist in managing pica behaviour include:

- Environmental enrichment which uses different types of sensory stimulation. Refer to the Office of the Senior Practitioner Practice guide 'Using Sensory Focussed Interventions to Help Reduce Restraint'.
- Reducing boredom and keeping the person occupied, interested and busy with structured activities.
- Increasing engagement with other people including providing physical activity and social interaction using the Person Centred Active Support approach, see RSPM 4.4.
- Diversion to preferred safe activities in place of higher risk environments. For example a pica behaviour box could be developed containing items which are safe for the individual to chew, mouth and/or ingest so there is a supply of safe items on hand as an alternative to non-edible items. Items should resemble the appearance or texture of the items the individual has shown a preference for in the past.
- Consider replacing non-food items with foods which are similar in texture and taste. For example, if a resident likes to eat twigs then mini breadsticks may be a safe substitution.
- Ensuring the person's support network is aware of the potentially serious consequences of pica behaviour and interventions to reduce risks are being consistently implemented in all settings.
- Supporting residents with complex communication needs as required, see RSPM 4.10.
- Supporting the person to differentiate between food and non-food items. This is referred to as discrimination training.
- Maintaining an environment that minimises exposure to the non food items most likely to be ingested by the person. For example, if a person is known to ingest dirt or grass consider replacing pot plants with hanging baskets that cannot be reached, or covering soil with decking etc.

In conjunction with the above strategies, some removal or restriction of access to areas or items may be required for the person's safety. This may require an authorised Behaviour Support Plan (BSP) with the restrictive intervention reported to the OSP, see RSPM 7.3 and 7.4.

Note: Simply blocking a person's attempts to place non-food items in their mouth may increase physically aggressive behaviour and has been found to be unsuccessful unless it is paired with redirection to a preferred food item.

Role of staff

Staff are to ensure they report and act on suspected pica behaviour by:

- completing the Nutrition and Swallowing Issues Checklist (NASIC) with particular attention given to question 7 which asks 'Does the person attempt to eat non-food items such as dirt, grass, faeces or poisonous materials?', see RSPM 5.7
- documenting pica behaviour in the alerts sections of the personal profile and the health support needs summary
- ensuring the residents doctor is made aware of pica behaviour
- ensuring dental reviews occur as recommended as pica behaviour can cause damage to teeth or infection.

Staff must:

- Use a Person Centred Active Support approach to engage the person in meaningful activity and interactions to reduce boredom and reduce risks.
 - Participate in a functional behaviour assessment by collecting data using tools and charts such as the standard ABC or Setting, Trigger, Action Result (STAR) charts, and the Motivation Assessment Scale (MAS) tool.
 - As far as possible, remove objects or access to objects that the person targets and report any restrictive interventions.
 - Raise issues and concerns with support strategies with the supervisor or manager.
-

Role of supervisors and managers

Supervisors and managers are to ensure that the NASIC is completed and actions taken for all 'yes' responses, in particular question 7 relating to Pica, see RSPM 5.7. Actions for this question include ensuring:

- Urgent assessment occurs by the residents doctor
 - If required, referral to Behaviour Support Service (BSS) is made via Intake and Response on 1800 783 783.
 - Development of a behaviour support plan (BSP) occurs
 - Staff understand the risks of pica behaviour
 - pica behaviour is included in the alerts section of the personal profile and the Health support needs summary.
 - Staff implement Positive Behaviour Support
 - Implementation of all support recommendations occurs
 - An environmental assessment is conducted and any changes required are actioned, for example replacement of toxic garden plants with non toxic where a resident's pica behaviour includes consuming plants.
-

resources

- Office of the Senior Practitioner – established by the Disability Act 2006 to protect the rights of people with disabilities subject to restrictive intervention and compulsory treatment. The Office can also provide advice to improve practice. Available on the Department of Human Services website: <http://www.dhs.vic.gov.au/for-individuals/your-rights/offices-protecting-rights/office-of-the-senior-practitioner>
- Positive behaviour support framework – a practice framework designed to reduce use of restrictive interventions and improve quality of life for people with behaviours of concern. Available on the Department of Human Services website at http://www.dhs.vic.gov.au/__data/assets/pdf_file/0004/603463/pbs_facilitators_manual.pdf

5.7.2 Preventing Dehydration

Issued: August 2018

Applies to all

Contents

Overview
Recommended daily fluid intake
What is dehydration?
What causes dehydration?
Signs and symptoms of dehydration
Sources of fluid
Role of all staff
Resources

Overview

The human body can last weeks without food, but only days without water. The body is made up of 50 to 75 percent water. Water forms the basis of blood, digestive juices, urine and perspiration, and is contained in lean muscle, fat and bones. As the body can't store water, fresh supplies are needed.

Water is needed for most bodily functions to:

- Maintain the health and integrity of every cell in the body.
- Keep the bloodstream liquid enough to flow through blood vessels.
- Help eliminate waste.
- Regulate body temperature through sweating.
- Moisten mucous membranes such as those of the lungs and mouth.
- Aid digestion and prevent constipation.
- Keep the bladder clear of bacteria.
- Carry nutrients and oxygen to cells.

Recommended daily fluid intake

Approximate adequate daily intakes of fluids (including plain water, milk and other drinks) are:

- Women – 2.1 litres (about 8 cups)
- Men – 2.6 litres (about 10 cups)

This includes all fluids but it is preferable that the majority of the intake is from plain water. Sedentary people, people in cold environments, or people who eat a lot of high-water content foods (such as fruits and vegetables) may need less water.

Some people may need to increase their fluid intake when they are:

- On a high protein diet.
- On a high fibre diet, as fluids help prevent constipation.
- Vomiting or have diarrhoea.
- Physically active.
- Exposed to warm or hot conditions.

What is dehydration?

- Dehydration is a condition that occurs when the body loses or uses more fluid than it takes in, and the body doesn't have enough water and other fluids to carry out its normal functions.

What causes dehydration?

- Many conditions may cause rapid and continued fluid loss and lead to dehydration:
 - Not drinking enough water.
 - Increased sweating due to hot weather, humidity, exercise or fever.
 - Vomiting, diarrhoea and increased urination due to infection.
 - Increased output of urine due to a hormone deficiency, diabetes, kidney disease or medications.
 - The inability to access appropriate water and food.
 - An impaired ability to drink.
 - Significant injuries to skin, such as burns or infections.
- In addition to drinking water, the body also needs the replacement of electrolytes (for example potassium and sodium) lost with the above conditions, so drinking water alone may not balance the water and electrolytes that have been lost.

Signs and symptoms of dehydration

The signs and symptoms of dehydration in adults range from minor to severe. Mild to moderate dehydration may include the following:

- Thirst.
- Headaches.
- Tired or sleepy.
- Decreased urine output.
- Dark coloured urine.

The above symptoms may quickly worsen and indicate severe dehydration:

- Severely decreased, or no urine output.
- Dizziness or light-headedness that does not allow the person to stand or walk normally.
- Rapid heart rate.
- Fever.
- Confusion and hallucinations.

If dehydration is not corrected by fluid intake, eventually urination stops, the kidneys fail and the body can't remove toxic waste products. In severe dehydration immediate medical treatment is required, usually in hospital where fluids are given through an intravenous drip. In extreme cases, dehydration may lead to death.

Sources of fluid

Fluids include fresh water and all other liquids like milk, tea, coffee, soup, juice and even soft drinks. Fresh water is the best drink because it does not contain kilojoules and is best for hydrating the body.

Most foods, even those that look hard and dry, contain water. The body can get approximately 20 percent of its total water requirements from solid food alone. The digestion process also produces water as a by-product and can provide around 10 percent of the body's water requirements. The rest must come from liquids.

Role of all staff

Staff are required to:

- Ensure all residents are receiving adequate daily fluid intake.
- Seek immediate medical treatment if a resident is displaying signs or symptoms of dehydration.
- Where an individual is at risk of dehydration (see causes of dehydration above), discuss individual fluid intake requirements with the resident's GP and document the resident's fluid intake on an oral fluid intake chart.

Resources

Forms and templates are available on the department's internet.

5.8 Weight monitor

Issued: August 2012

FBR – N GH/I – Y STJ/LTR/RTF – LD

Contents

Overview
When should staff investigate weight change?
How is a resident's weight recorded?
How to obtain an accurate weight
Role of all staff
Resources

Overview

People with a disability are at risk of significant unplanned weight change. Significant unplanned weight change is a reliable sign of underlying medical, health, or psychosocial issues.

When should staff investigate weight change?

Staff should investigate weight changes where there has been an unplanned increase or decrease in a resident's body weight, of at least three kilograms within three months, or 10 per cent of their body weight over six months.

How is a resident's weight recorded?

Residents must have their weight recorded once a month on the weight monitor tool, unless a health professional recommends they be weighed more or less frequently. The weight monitor tool is designed to alert staff to significant weight changes based on monthly weight data.

Should a health professional require a resident be weighed more frequently than once a month, the additional weight data will need to be recorded on a hard copy weight record as the weight monitor tool functions on data being entered once a month and will lose the alert function if used more frequently.

How to obtain an accurate weight

To obtain a more accurate weight measure:

- weigh the resident without shoes and preferably in light clothes
- weigh the resident at the usual time – early morning after going to the toilet, and before breakfast, is best
- if the resident wears a helmet, take it off, or subtract its weight from their weight
- use the same scales each time.

Role of all staff

The Role of all staff is to:

- weigh each resident monthly
- record their weight on the Weight Monitor form

If there is a significant change in the resident's weight, staff will need to know if the weight change is planned or unplanned.

If the weight change is planned and the person is deliberately trying to increase or decrease their weight as part of their health plan and under the guidance of a dietitian or the doctor, then no further action is required.

If it is unplanned then complete the Weight change questionnaire and make an appointment with the doctor to review.

Staff are to ensure that all current health information, a print out of the weight monitor and the completed Weight change questionnaire are taken to the doctors appointment.

Resources

- Good food for all – a guide to food, nutrition and meal health planning for staff supporting people with a disability. Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
 - Weight monitor form – a PDF form for monitoring weight. Available on the DAS Hub
 - Weight change questionnaire – ten questions to assist in providing information to doctors about unplanned weight change. Available on the DAS Hub
 - VPHS –ID fact sheet – obesity. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.9 Supporting a resident to eat

Issued: August 2012

Applies to all

Contents

Overview
Providing meal support
Safe seating position
Reducing the risk of choking
What to document
Resources

Overview

Mealtimes are a significant part of life. Eating and drinking:

- is a source of pleasure, which has a major impact on physical and psychological health
- is an important social opportunity
- can be part of religious or cultural identity.

Many residents have difficulty eating food and drinking liquids and require mealtime assistance, *see RSPM 5.7*.

Providing meal support

Staff must support residents to eat in a way which enables their physical, psychological, social, cultural and religious needs to be met. Staff are to:

- include residents in menu planning, food shopping and preparation
- communicate the mealtime process to residents and ask:
 - what they would like to eat
 - how they wish to eat it.
- identify food types as they are placed into a resident's mouth
- not vitamise, or mix different foods together. Residents who require modified texture food have the right to experience meals presented as normally, as possible
- encourage residents to eat and drink as independently, as possible, by preparing finger food, if they can eat with their hands, and as appropriate, providing cutlery and crockery to enable independence
- support residents to eat and drink the amount and type of food and liquids they need for physical health
- assess if a resident is left, or right-handed and assist from the dominant side
- use an adjustable chair, or stool to ensure the correct seating position when providing eating assistance. Staff should not stand over residents as this:
 - can create a choking risk
 - is disempowering for residents
 - is impolite.

Safe seating position

The safest position for residents with swallowing issues is to be positioned when eating food and drinking liquids is determined by a health professional based on an assessment of their individual circumstances. Residents must always be positioned as instructed by their health professionals. Generally, an up-right position is safest, as it does not allow the resident's head to roll back and inadvertently open their airway.

Reducing the risk of choking

People with an intellectual disability are more likely to choke on food and drink than the general population. Other causes of disability may also increase risk factors, see RSPM 5.7. Staff are required to reduce the risk of choking as far as possible by ensuring:

- the resident is alert before eating food or drinking liquids
- environmental distractions which may cause the resident to move suddenly, laugh, talk or be distracted when eating, are minimised
- the environment is calm and relaxed
- the resident is not rushed when eating food
- the meal plan is followed
- food is the correct texture (if the resident has dental, mouth or swallowing issues, they may require texture modified food and liquids)
- the resident sits as up-right and straight as possible, when eating food
- the resident places only small amounts of food in their mouth (suggest they use a teaspoon, to avoid over-filling)
- the resident eats slowly (suggest they put down utensils between mouthfuls, to slow down the eating pace)
- the resident is monitored throughout the eating process.

If choking occurs, first aid is to be immediately applied and emergency services contacted, *see RSPM 5.14*.

What to document

The following must be documented in a resident's health plan:

- the reason they require support when eating
- eating recommendations provided by relevant health professionals
- information relevant health professionals have asked to be recorded
- issues which indicate an immediate review by a health professional, is required
- the review date.

Resources

- Better Health Channel – provides online health and medical information for the Victorian community including information about healthy eating and easy meals such as finger food. Available at: <http://www.betterhealth.vic.gov.au> and
- Fluid intake chart – a chart to record fluid intake if fluid intake requires monitoring. Available on the DAS Hub.
- Good food for all – a guide to food, nutrition and meal health planning for staff supporting people with a disability. Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
- Undertaking client related manual handling tasks with safety – a tool for assessing and controlling manual handling risks. The tool is available by emailing: EMSONline@dhs.vic.gov.au.
- VPHS-ID fact sheet fruit and veg. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>

5.10 Oral health

Issued: August 2012

FBR/STJ – P GH/I/LTR/RTF – Y

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What is good oral health
Good oral care is important
Residents with teeth or dentures need daily oral care and regular dental
Residents without teeth still need oral care
Residents who do not eat or drink still need oral care
Behaviour change can indicate oral pain
Role of all staff
General instructions for supporting daily teeth cleaning
General instructions for denture Care
Annual oral Health assessment requirements
Daily oral health care plan
Resources

What is good oral health?

Good oral health means looking after the whole mouth including the teeth, gums, tongue and inside of the cheeks. Residents who do not have teeth also need daily oral care. A person with good oral health has:

- moist lips without chapping
- a pink, moist and uncoated tongue
- pink firm gums
- breath, without offensive odour
- watery and plentiful saliva
- white unbroken teeth, without cavities
- no build-up of food, tarter, or plaque
- no dental pain.

Good oral care is important

While people with an intellectual disability have up to seven times more oral health issues than the general community, other people with significant health and wellbeing issues also have a higher level of poor oral health. Good oral health is important as it can impact on a resident's:

- ability to eat
- physical appearance
- comfort, cleanliness and wellbeing
- breath, which may affect their interactions with others
- risk of chest infections (aspiration pneumonia develops if food, drink, medication or teeth plaque is breathed into the air pipe instead of the food pipe and poor oral hygiene can increase the risk of aspiration pneumonia in people with swallowing problems, regardless of whether they have natural teeth, or dentures)
- overall health and quality of life.

Residents with teeth or dentures need daily oral care and regular dental checks

Residents with teeth, or dentures need to:

- brush their teeth with fluoride toothpaste, or clean their dentures at least twice daily (unless stated otherwise in their oral health care plan)
 - have an annual oral health assessment completed in the week before their annual dental check-up, to assist the dentist detect oral disease
 - attend a routine dental check-up at least once a year, or as advised by their dentist
 - have a daily oral health care plan developed, or up-dated, as required.
-

Residents without teeth still need oral care

Residents who no longer have natural teeth need to see a dentist for a thorough mouth check, to ensure their gums remain healthy and disease free. The dentist will:

- advise how often they should be reviewed
 - when to develop an appropriate daily oral health care plan.
-

Residents who do not eat or drink still need oral care

Residents who are fed by a gastrostomy tube, who do not eat food or drink fluids by mouth, require daily oral care. An oral health care plan needs to be developed, so daily oral care does not lead to aspiration pneumonia. It is important to discuss the needs of these residents with their dentist particularly, if it is appropriate to:

- use a face washer to wipe their gums
 - use suction toothbrushes (ask the dentist to demonstrate how to do this)
 - brush their teeth and gums gently, without toothpaste and with little fluid.
-

Behaviour change can indicate oral pain

Oral pain can be extremely intense. Residents who cannot communicate oral pain may display behaviours of concern as a form of communication. It is important to have a resident's oral health status assessed, if their behaviour changes, without explanation.

Role of all staff

Staff are required to support residents as far as possible, to:

- have adequate fluid intake especially water
 - eat a healthy diet with minimal sugary drinks and confectionary
 - brush their teeth with fluoride toothpaste, or clean their dentures at least twice daily
 - have a routine dental check-up at least once a year, or as advised by the their dentist
 - visit their dentist as soon as possible, if dentures do not fit well
 - complete an oral health assessment annually
 - access appropriate medical, or dental services, as soon as possible, if the oral health assessment indicates their mouth, or teeth are in poor condition, or if dental pain is experienced
 - have a completed individualised oral health care plan to guide staff in their daily oral health care routine,
 - take the oral health assessment form and oral health care plan to dental appointments, and ask they be reviewed
 - include additional oral health recommendations made by the dentist in the plan.
-

General instructions for supporting daily teeth cleaning

Staff are required to follow infection control procedures when supporting residents to clean their teeth. Residents should be assisted to gather the following items as required, prior to teeth cleaning:

- a soft toothbrush
- toothpaste
- a cup of fresh water
- a towel
- a towel to protect clothing, as required.

If the resident is unable to use the washbasin, a bowl of water placed in an accessible position may be necessary.

Before commencing resident oral health care it is important to:

- read the resident's oral health care plan to understand their preferred routine
- explain what will be occurring and show the tools to be used
- let the resident familiarise themselves with the feel of the toothbrush on their hands or around the mouth.

When positioning the resident it is important to:

- ensure they are relatively upright, but can relax their mouth and jaws
- ensure they can see who is supporting them
- be as close to their level as possible. A stool may be required for this purpose
- assist from behind, the side or in front depending on the area which best suits them
- ensure their head is in a comfortable position.

Some practical techniques and tips for cleaning teeth include:

- never place fingers between residents teeth
 - do not force resident's who do not wish to have their teeth cleaned
 - use only a pea-sized amount of toothpaste, to avoid excessive foaming
 - remove any food which may have pocketed in the cheeks prior to brushing with mouth swabs or a toothbrush
 - request the resident relax their lips and cheeks, rather than open their mouth. The hand not holding the brush can be used to gently lift back the lips to access the gums. A second brush may be used for this purpose. A bite block may also be used when the insides of the teeth are brushed
 - ask the resident to open and close their mouth during the procedure. Having a wide open mouth throughout the entire procedure is not conducive to accessing certain areas of the mouth
 - introduce the brush at the corner of the mouth, whilst it is closed or slightly open
 - work from the front to the back of the mouth, two teeth at a time
 - gently brush all surfaces of the teeth and gums using a gentle, thorough and methodical approach
 - monitor the resident's comfort and stop as required so they can relax
 - clean the mouth including both gums and teeth to remove any food tucked under the tongue or inside the cheeks
 - avoid brushing if the gums are bleeding
 - minimise horizontal brushing, as it is not recommended
 - brush teeth and gums gently in circular movements
 - be aware of loose teeth and brush with care
 - it is not necessary for the resident to spit or rinse, it may be better to leave a small amount of toothpaste in their mouth. Alternatively, if it is safe to do so, support them to drink a glass of water following the cleaning routine
 - dry their lips and chin.
-

General instructions for denture care

Residents who wear partial dentures are also susceptible to decay in their natural teeth, so maintaining good oral hygiene standards is very important.

Residents with full dentures need to have their gums, tongue and mouth cleaned daily. Dentures are to be:

- clearly and permanently labelled with the residents name. This should occur at the time of manufacture, or to existing dentures at the resident's denture clinic
- removed at night and cleaned to allow the mouth to rest, and prevent fungal infections such as thrush developing
- stored in a labelled container of cold water in a safe, but accessible place.

Staff must not glue, bend or modify denture clasps in any way. Modification and repairs must only be completed by a dentist.

The equipment required to clean dentures includes:

- a hard denture brush
- denture toothpaste or mild soap
- a basin of water, or a handtowel in the washbasin in preparation for denture cleaning, to reduce the risk of breakage, if the denture is dropped.

Hot water, detergents, abrasives, bleaches, methylated sprits, or antiseptics, should not be used on dentures unless instructed by the dentist.

To prepare dentures for cleaning:

- ask the resident to remove their dentures, as appropriate
- ask the resident to open their mouth to check for ulcerations, or signs of ill-fitting dentures.

To clean dentures:

- hold them over a basin of water and brush them carefully with water and denture toothpaste, or mild soap
- brush all surfaces removing plaque and food debris.

Whenever possible store dentures in a container of water overnight. To remove stain built-up, or plaque, soak plastic dentures over-night in a cup containing one third white vinegar and two thirds water. Metal dentures should not be soaked in vinegar as they will corrode.

Annual oral Health assessment requirements

Staff must complete an oral health assessment form for each resident in the week before their annual dental review and take the completed form to the dental appointment. Oral health assessment forms are designed to:

- monitor oral health
 - evaluate oral hygiene care interventions
 - initiate a dental visit when required
 - assist with individual oral hygiene care planning
 - prioritise dental needs.
-

Daily oral health care plan

An individualised oral health care plan must be developed for each resident in consultation with their dentist. Following a clearly documented care plan will help to ensure consistency when multiple staff are responsible for oral health care needs. It is also a valuable resource for staff to communicate strategies which have been effective in supporting dental hygiene routines. The oral health care plan needs to reflect:

- the resident’s ability to participate in their oral care routine, for example:
- what they can do independently
- the support to be provided by staff
- the environmental set-up including tools, products and positioning
- daily routine preferences and timing
- preferred communication approaches
- specific management approaches to overcome behavioural and cognitive issues.

Resources

- How to look after you mouth – an easy read document developed by SCOPE, to assist people with a disability look after their oral health. Available on the DAS Hub
 - Oral health assessment and care plan template – a form to document oral health care requirements. Available on the DAS Hub
 - Oral health – Dental products – information about dental products to assist with dental care. Available on the DAS Hub
 - Oral health care services in Victoria – information on how to access dental services. Available on the DAS Hub.
 - Oral health – the impact of medications – information to assist staff to understand these impacts. Available on the DAS Hub
 - Oral health – preparing a care plan – information to assist in developing the plan. Available on the DAS Hub
 - Brushing up on oral health – an online video develop jointly by Dental Health Services Victoria and Disability Services to assist staff to promote good oral health care. Available on the DHS Hub.
 - VPHS-ID drinks fact sheet. Available on the Department of Health website at: <http://www.health.vic.gov.au/healthstatus/survey/vphs-id.htm>
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5.11 Menstrual management

Issued: August 2012

FBR/STJ – P GH/I/LTR/RTF – Y

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What is menstrual management?
About menstrual management
Role of all staff
Resources

What is menstrual management?

Menstrual management is management of a woman's period. This may, or may not involve support from staff. Menstrual suppression is only acceptable if the woman has been assessed by a relevant health professional, such as a gynaecologist or family planning practitioner, and suppression is deemed the best option in consultation with:

- the woman
- the person responsible for medical decisions.

Application of any treatment, such as suppression of menstruation by skipping the 'sugar pills' of the oral contraceptive, without appropriate assessment, planning and consent is unacceptable and is a restrictive intervention.

About menstrual management

Menstruation impacts on the physical and psychosocial health and wellbeing of women. For example, hormones involved in the menstrual cycle impact on bone and heart health. A woman's experience of the menstrual cycle may be influenced by her:

- lifestyle
- culture and religion
- understanding of the menstrual cycle and menstrual management
- physical symptoms associated with the menstrual cycle, such as premenstrual syndrome, which may cause fluid retention, abdominal, or lower back pain, mood swings and headaches.

Role of all staff

Staff are required to:

- refer women who cannot manage their period independently to a doctor, or health professional with relevant experience
- assist women to manage pre-menstrual pain or discomfort; prescribed medication may be needed
- support women to be fully informed of menstrual management options, so they can choose those most appropriate
- assist women to access management options best suited to them
- document specific support requirements in their health plan
- follow infection control procedures.

Hot water bottles should not be used for managing menstrual pain, or discomfort, because of scalding risks. Heat packs may be appropriate provided they are used according to the manufacturer's directions, and not over-heated.

Resources

- Being a healthy woman – A resource developed by the New South Wales Health Department, designed to assist women with an intellectual disability learn more about looking after their health and wellbeing. Available at: http://www.health.nsw.gov.au/pubs/2010/being_healthy_woman.html
 - Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au>
 - Supporting women. Resources for GP's and carers to assist women with disabilities manage menstruation. Available at: <http://www.cddh.monash.org/>
 - Family Health Planning Victoria – provides clinical services, therapy, information, advice and referral. The Family Health Planning website is located at: <http://www.fpv.org.au/>
 - Menstruation recording chart – a chart to assist in recording when menstruation occurs. Available on the DAS Hub.
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5.12 Continence

Issued: August 2012

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What is continence?
What is continence assessment?
Symptoms of and reasons for urinary incontinence
Reasons for faecal incontinence
Role of all staff
Resources

What is continence?

Continence is the ability to exercise voluntary control over bladder and bowel functions. The National Continence Helpline is an information service which can provide advice to anyone affected by, or caring for, someone with a bladder or bowel problem, in particular:

- bladder and bowel control problems such as constipation, bedwetting, frequency, or urgency issues
- continence products and subsidies
- local continence services.

What is continence assessment?

There are many causes of urinary and faecal incontinence. A continence assessment is completed by a doctor, or via referral to a specialist continence clinic, to identify the incontinence cause and possible contributing factors. During a continence assessment the resident will be asked questions about their:

- diet
- weight
- medical history
- general health.

The doctor may also complete tests and conduct a physical examination.

Symptoms of and reasons for urinary incontinence

Urinary incontinence is caused by a weak pelvic floor. It can lead to:

- leakage of urine when a person sneezes, laughs, strains, lifts, or plays sport
- a sudden strong urge to urinate, which may be due to conditions such as:
 - stroke
 - enlarged prostate gland
 - Parkinson’s disease
 - constipation
 - the outcome of a long-history of poor bladder habits
 - bladder nerve problems.

Reasons for faecal incontinence

Common reasons for faecal incontinence include:

- weakness of anal sphincter muscles
 - severe diarrhoea
 - constipation and impaction
 - disorders of the nervous system such as spina bifida or dementia
 - disorders of the lower bowel, such as haemorrhoids.
-

Role of all staff

Staff are required to support residents to:

- use the toilet in a timely manner
 - participate in a continence assessment, as required
 - manage continence issues, as recommended by their doctor, or health care professional
 - access financial assistance for continence aids and equipment from the Continence Aids Assistance Scheme and the Victorian Aids and Equipment Program
 - document specific support requirements as part of the health plan
 - follow infection control procedures.
-

Resources

- Continence Aids Assistance Scheme – assists eligible people who have permanent and severe incontinence to meet the cost of continence products. Information is on the Australian Government Department of Health and Ageing website at: <http://www.health.gov.au>. Click on the 'A-Z Index' and search under 'Continence Management'.
 - Continence recording chart – a chart to assist in monitoring continence. Available on the DAS Hub.
 - The National Continence Helpline – provides advice on continence issues including access to support, aids and equipment. Phone 1800 33 00 66. Available at: <http://www.continence.org.au>
 - Victorian Aids and Equipment Program – provides a product subsidy for continence aids, not including disposable nappies and pants. Available on the Department of Human Services website at: <http://www.dhs.vic.gov.au/disability>
 - Victorian Aids and Equipment Program brochure – assists children and adults to access subsidised aids, equipment and home modifications. Available on the Department of Human Services website at: <http://www.dhs.vic.gov.au/disability>
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5.13 Specific health management

Issued: August 2012

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RDNS is available to people living in disability residential services
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RDNS charges a fee for service
RDNS can be contacted 24 hours a day
Resources

What is specific health management?

Specific health management means that a health condition requires specific routine actions and procedures, or a structured emergency response to ensure the condition is managed. The management of a specific health condition may be undertaken by staff, a relevant health professional or a combination of health services.

When is a specific health management plan required?

A specific health management plan is required if a resident has an ongoing or recurring healthcare condition that requires staff to support them in a particular way, or if detailed instructions or training are required to support management of the condition.

Specific templates are provided in the RSPM section 5 for:

- mental health, see RSPM 5.2.1
- oral health, *see RSPM 5.10*
- epilepsy, see RSPM 5.13.1

A generic specific health management plan template is provided for all other conditions that require specific health management. This template should have the heading adjusted to meet the specific needs of the resident and the health condition to be supported.

Not all health conditions require a specific health management plan. If a resident has a short term health issue from which they are expected to recover fully and quickly, this does not require a specific health management Plan. Some examples might be:

- a minor cold
- a minor cut that takes a few days to heal.

These health issues and their management can be documented on the Health Professional Appointment form or health file notes.

Management of some minor issues may be better incorporated into routines, for example, ongoing monitoring of a resident's feet for tinea may be better incorporated into the bathing and showering routine with instructions documented in the general support information.

How ongoing health needs are met must be noted on the Health support needs summary, for example, the monitoring for tinea would be noted on the summary as being incorporated into bathing routines or located in a specific health management plan.

How information is written on the specific health management plan template

Instruction to guide support should be written as simply as possible. The generic specific health management plan template has two parts.

Part A of the template is to document the resident's details and to make note of any training that is required and which staff are currently trained. If training is not required to implement this plan, then the rows of the table provided to document this can be deleted.

Part B of the template has six sections:

- preparation is required
 - this section is to document any preparation that needs to be done, for example, if the plan is about blood glucose level testing (BGL), this part will contain a list of the items required and how staff are to prepare the resident for the test.
- steps required
 - this section is to describe the steps that staff take to implement the support required, for example, taking the sample and using the machine that assesses the BGL, and the safe clean up.
- specific alerts or risks and their management
 - this is to note any alerts specific to implementation of the procedure, for example, with BGL an alert that a particular reading requires immediate medical intervention.
- monitoring and recording requirements
 - this section describes what is to be documented, for example with BGL the result and the time will need to be recorded.
- signs or symptoms that indicate the need for the resident to be reviewed earlier than planned
 - this is to document any issue that the treating practitioner has noted as a trigger that the person needs the health condition or the management of the condition reviewed. For example, with BGL a particular test result may be the noted as a trigger to make an appointment for review.
- any other important information
 - this section is to note any other information that has not already been noted in the plan, for example, with BGL testing, checking that the testing is not done on the same spot to ensure the skin does not become damaged or inflamed.

The headings may need to be altered to better reflect the actual health condition being managed, for example if the plan is related to support that is implemented at specific times, the preparation section may be retitled to reflect the time rather than preparation.

Training required for specific health conditions

All staff who will be required to support residents with a specific health condition are to have general training about the condition and broad support strategies required, for example, general epilepsy training provides information about epilepsy and safety.

Staff should then be:

- trained specific to the individual resident and this training is to ensure staff can implement the management plan, including emergency management, required by the individual resident.
- assessed annually, or more frequently if a resident's health needs change, to ensure they maintain the skills necessary to provide the specific support and monitoring required.

Assessment may be undertaken by a relevant health professional or in consultation with a Disability Regional Learning and Development Coordinator. Training is to be provided based on the identified gaps in skill and knowledge.

Training specific to the resident for specific health conditions

Staff are required to be trained specifically to the needs of each resident they support in the following areas:

- Epilepsy
 - emergency management procedures which includes administration of Midazolam, rectal valium, oxygen or other emergency interventions.
- Asthma;
 - Use of nebulisers, inhalers and spacers.
- Diabetes;
 - Blood glucose testing including use of the equipment, use of insulin dose injector pens, dietary needs
- PEG feeding;
 - use of the specific PEG type, preparation and administration of food replacement and medication, PEG care including process to manage a dislodged tube.
- Catheter and stoma care
 - Changing collection bags, care of the entry site and monitoring requirements including process to manage a dislodged tube.
- Administration of enemas, suppositories and pessaries
- Use of Epipens for anaphylaxis
- Shallow suctioning
- Palliative care including use and monitoring of medication
- Any other specific health condition where training needs have been identified by a health professional.

NOTE: any person trained in first aid should attempt the use of an Epipen or inhaler in an emergency situation even if they have not been trained specific to the person.

Variation for Respite

It may not be possible for respite staff to be trained specific to each person who may access respite. To ensure that respite staff are able to provide appropriate support, respite staff should refresh their skill and knowledge in the general information annually. The refreshment is to include the use of different equipment and techniques specific to implementing management of health conditions and procedures.

Where a person has equipment that is not familiar to staff, the person's usual carers should be asked to orientate staff to the use in the first instance. The technique must be documented and a training provider must be requested to add this to future training.

Who can provide training?

General and specific training can be provided by a medical or health professional from an organisation with specialist expertise in the area and approved by Disability Workforce Development and Learning.

Resident inclusion

Where possible, the resident should be given the opportunity to learn how to manage their health including any procedures that may be required. This can occur if their doctor or relevant health professionals have:

- provided specific training to the person
- assessed and documented the person is competent in the procedure.

Strategies to support the resident to perform their own health procedures need to be detailed in their specific health management plan.

Staff must never perform certain procedures

Staff must never:

- insert feeding tubes, or catheters
- perform deep suctioning
- give injections by standard syringe, includes intramuscular, intravenous and subcutaneous
- take blood samples
- monitor, manage, remove or inject into IV lines, or similar equipment
- use their finger to perform manual evacuation of faeces from a resident's rectum
- perform procedures for which they have not been trained, also see *RSPM 5.6.3*.

Royal District Nursing Services can perform some procedures staff cannot

The Royal District Nursing Service (RDNS) can perform some procedures staff are not permitted to perform. The RDNS provides a range of health services in the home including:

- general and specialist nursing services
- acting as a care manager to assess a resident's needs and liaising with healthcare facilities and community services, such as hospitals and health centres
- arranging for health and welfare professionals such as social workers, physiotherapists and health aids to visit the residential service.

Specialist nursing services provided by RDNS

RDNS provides the following specialist nursing care:

- aged care
 - diabetes
 - continence management
 - wound management
 - care for those recently discharged from hospital
 - haemophilia
 - breast cancer management
 - stomal therapy
 - cystic fibrosis
 - HIV and AIDS
 - palliative care.
-

RDNS is available to people living in residential services

The RDNS is available to residents throughout greater Melbourne. A similar service to RDNS is available in most areas outside of greater Melbourne. To find out more contact the local hospital.

Anyone can refer to RDNS

Anyone can make a RDNS referral. Staff can contact RDNS via their line manager, or referral can be made by a family member, the resident's doctor, hospital, or other health service.

RDNS charges a fee for service

The RDNS charges a minimal fee for service. The cost is based on income.

RDNS can be contacted 24 hours a day

The RDNS can be contacted 24 hours a day, seven days a week, on: 1300 33 44 55. The RDNS is not an emergency service and does not provide telephone advice.
If medical advice is required, contact NURSE-ON-CALL.

Resources

- Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au>
 - Tube feeding: supporting a person with a disability in residential services – a guide for disability support workers supporting people who receive liquid nutrition through a tube inserted directly into the digestive system. . Available on the Department of Health website at: <http://www.health.vic.gov.au/nutrition/>
 - Royal District Nursing Service website – this site provides more information about RDNS centre locations and telephone numbers, services and costs. Available at: www.rdns.com.au
 - Specific health management plan template – this document is used to record specific support requirements for health support needs. Available on the DAS Hub.
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5.13.1 Supporting a person with epilepsy

Issued: August 2012

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Contents

Overview
What is epilepsy?
What are seizures?
Types of epileptic seizures
Epilepsy management planning
Emergency management procedures
Management reviews
Factors that may affect seizures
Bathing, showering and swimming
Resources

Overview

Most people with epilepsy can do all that people without epilepsy can, such as participating in social, recreational, work and school activities. However, without a high level of medical review and implementation of management plans, epilepsy can restrict opportunities to participate in some activities and may be life threatening. Every resident who has epilepsy must have a management plan to ensure their epilepsy is managed and treatment is reviewed as required.

What is epilepsy?

Epilepsy is the tendency to have recurring seizures. Epilepsy occurs in about 1 per cent of the general population. People with a disability are more likely to have epilepsy than other people in the population and are also more likely to have more than one type of seizure. Residents in supported accommodation have epilepsy at 25 times the rate of the general population.

What are seizures?

Seizures are sudden intermittent alterations in body movements, behaviour, sensation, emotion or a combination of these. They are caused by an uncontrolled surge in electrical activity in all or part of the brain. The effect of a seizure depends on which part of the brain is involved.

Types of epileptic seizures

Generalised seizures:

Generalised seizures involve both halves of the brain at the same time and are associated with loss of consciousness. They include:

- Tonic: the body stiffens and a person may fall. Recovery is usually quick.
- Tonic-clonic seizures: the body stiffens and then jerks repeatedly.
- Absence seizures: the person stares blankly for a few seconds.
- Myoclonic seizures: involves the abrupt jerking of muscle groups. In their severe form they can throw the individual to the ground.
- Atonic seizures: involve a sudden loss of posture or tone in limbs or the whole body.

Partial seizures:

Partial seizures may remain in one part of the brain or may spread to produce a generalised seizure. They are not associated with a complete loss of consciousness. Partial seizures include:

- Simple partial seizures: people do not lose consciousness.
- Complex partial seizures: consciousness is disturbed but not lost. People may behave in odd ways (such as walking around without apparent purpose and plucking at their clothes) and they may not respond appropriately to questions or requests.

Epilepsy management planning

To safely and effectively manage epilepsy, there must be an individualised epilepsy management plan that clearly documents:

- a description of the types of seizures the person has and the management required for each type
 - background information relating to that person's epilepsy, for example specific triggers that might cause a seizure
 - any other alerts specific to the person
 - the monitoring or supervision level required including when:
 - participating in physical activity
 - bathing or showering
 - sleeping overnight, *see RSPM 4.15*
 - the recording required by the treating doctor, for example, seizure charts.
-

Emergency management procedures

Emergency medication may not be required for all residents with epilepsy, however, other strategies may be recommended such as oxygen therapy or seeking urgent medical assistance by calling an ambulance. Some residents may have very well controlled epilepsy and emergency management procedures may not be provided by the doctor, however, staff must ask the doctor to specify if there are circumstances when an ambulance is to be called, for example, if a seizure lasts longer than previously known or the seizure type appears to be different than the resident's usual seizure pattern.

Pro Re Nata (PRN) medication is the most common emergency management strategy to stop or reduce some types of seizure activity. Staff must be trained to administer and monitor the effects of PRN medication for epilepsy as the medications may suppress respiratory function in some people. The emergency management procedure must clearly state:

- the name and dose of the emergency medication
 - what triggers the need to administer emergency medication, for example, if a specific seizure type occurs or when the length exceeds a certain time
 - the administration route
 - post administration monitoring
 - the minimum time between doses
 - the number of doses within a 24 hour period
 - if an ambulance must be called when PRN does not stop the seizure activity or other specific changes are observed.
-

Management reviews

Epilepsy requires regular medical review to ensure the management strategies provide the best possible seizure control while minimising the impact on general wellbeing. When supporting residents to attend appointments to review epilepsy management it is important that a range of specific information is provided. The following should be taken to epilepsy review appointments:

- Seizure records and observation charts
- PRN administration record
- Medication record

Document on part A of the Health appointments form, any observations relating to changes:

- in sleeping patterns
- to steadiness of movement, for example, balance or fine motor skills including if any falls have occurred
- to general alertness and communication
- in general mood or behaviour

Change is any alteration, either an improvement or decline, to what is generally normal for the resident.

Factors that may affect seizures

Seizures can occur with no apparent trigger but the following factors are known to affect seizure activity for some people:

- lack of sleep or disturbances in the person's normal sleep cycle
- rapid visual stimulation, for example from TV, motion pictures, videos, disco or strobe lighting
- drugs such as caffeine, alcohol, antidepressants and some tranquillisers
- menstruation
- constipation
- excessive increase in body temperature, for example a fever.

If a resident has known triggers they must be included on the epilepsy management plan.

Bathing, showering and swimming

There is a high drowning risk for people with epilepsy. The level of support and supervision a person needs will vary depending on the severity and regularity of their seizures and other physical support needs. Staff cannot decide the level of supervision required. Unless otherwise specified in writing by the doctor, staff must remain with a resident who has epilepsy at all times while they are showering.

The doctor should be asked if swimming is a safe activity for the resident as the severity or number of seizures a resident has may mean that the risks of swimming outweigh the benefits. If the doctor advises that swimming can be a positive activity for the resident then:

- It is recommended that people with epilepsy should only swim in patrolled areas, preferably a swimming pool with clear water
- The life guard on duty should be made aware that the person has epilepsy
- Staff must keep the resident under visual observation at all times and be able to get to the resident quickly if a seizure occurs. This may require the staff to be in the water
- Residents must be accompanied by staff who can swim
- If a group of people with epilepsy are swimming, support must be provided on a one to one basis.
- Life jackets may be used when swimming if appropriate.

Specific safety measures for swimming are to be included on the epilepsy management plan.

Resources

- Annual seizure activity record – a form to map annual seizure activity that may assist medical professionals with epilepsy management planning. Available on the DAS Hub.
 - Better Health Channel – provides online health and medical information for the Victorian community. Available at: <http://www.betterhealth.vic.gov.au>
 - Centre for Developmental Disability Health Victoria – provides better health outcomes for people with developmental disabilities through research, education and clinical activities. Search under 'Fact sheets'. Available at: <http://www.cddh.monash.org/>
 - Epilepsy Foundation of Victoria – a website providing comprehensive information about epilepsy. Available at: <http://www.epinet.org.au>
 - Epilepsy Management planning – general and emergency plan templates and guides for disability accommodation services. Available at: <http://www.epinet.org.au>
 - Epilepsy seizure observation chart – a form to record seizure observations of seizure activity that may be required by the doctor. Available on the DAS Hub.
 - Epilepsy seizure record – a form to record the date time and duration of seizures. Available on the DAS Hub.
 - Oxygen cylinders – checklist for care and maintenance. Available on the DAS Hub.
-

5.13.2 Managing pressure sores

Issued: August 2012

Applies to all

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What is a pressure sore?
Health problems from pressure sores
Factors that increase the risk of pressure sores
Prevention of pressure sores
High risk areas
Early signs of pressure sores
What staff must do

What is a pressure sore?

A pressure sore is an area of damage to the skin, and tissue under the skin, caused by constant pressure or rubbing. Pressure sores are sometimes called bed sores or pressure ulcers.

Health problems from pressure sores

Untreated pressure sores can lead to serious health problems, some of which can contribute to death. Problems include:

- maggot infestation
- general infection
- inflammation of the bone
- abscess (collection of pus)
- inflammation of tissue causing swelling and redness
- meningitis (infection and inflammation of membranes and fluid which surround the brain and spinal cord).

Factors that increase the risk of pressure sores

The following factors increase the risk of pressure sores:

- age
- immobility
- incontinence
- poor physical condition
- poor mental health
- being restricted to sitting or lying down
- being over or underweight.

Prevention of pressure sores

Pressure sores are preventable, but difficult to treat. Staff supporting a resident confined to a bed, or chair including a wheelchair, for any period of time, need to be mindful of preventing pressure sores. To prevent skin damage staff must:

- relieve pressure on the area
- reduce the amount of time pressure is applied to the area
- improve skin quality.

To prevent pressure sores in residents at risk:

- check the resident's skin at least daily
- turn, or move the resident regularly
- use pillows, or specially designed pressure care pillows, as soft buffers between the resident's skin and bed, or chair, and between areas of the body which cause pressure, for example, the knees. These must only be used after assessment and recommendation by an appropriate health professional.
- follow good hygiene practices (if a resident is incontinent, ensure they are kept clean of faeces and urine)
- keep the resident's skin at the right moisture level, since damage is more likely to occur if their skin is too dry or too moist (use moisturising creams for dry skin care)
- ensure the resident eats a healthy diet (if they do not eat a balanced diet, or are over, or underweight, a dietitian assessment may assist)
- have the bedding system including the mattress assessed by an appropriate health professional (the use of pillows, bolsters and air mattresses must only be used after assessment of the total bedding system by a relevant health professional, *see RSPM 3.3.1*)

Day program staff must be made aware of these precautions.

High risk areas

Areas of the body which support a resident's weight, especially where underlying bones, or joints are close to the skin are pressure sore risk areas. Common risk areas include:

- hips
- inside knees
- buttocks
- the base of the spine.

Other risk areas depend on a resident's sitting or lying positions and may include heels, or shoulder blades.

Early signs of pressure sores

Signs which indicate a pressure sore is developing include:

- redness or a pale purple mottled appearance
- discolouration of the skin at the site where constant pressure, or rubbing occurs.

By the time these skin changes are noticed considerable damage to the tissue underneath may have already occurred. The resident's doctor needs to assess the area and provide advice as soon as pressure sores signs are noticed.

What staff must do

Staff are required to:

- note in the resident's health plan if they have a known pressure sore risk
- monitor the resident's skin and seek immediate review if discoloured areas are found
- ask the doctor to routinely check any risk areas when the resident attends appointments
- seek immediate medical attention if early signs of a pressure sore are noticed
- adhere to infection control procedures.

Staff may seek assistance with pressure care management from the Royal District Nursing Service, or equivalent, (without a doctor's referral), *see RSPM 5.13*. The resident's doctor should be informed the service has been requested.

5.13.3: Supporting residents with Prader-Willi syndrome

Issued: July 2013

Applies to all

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What is Prader-Willi syndrome (PWS)?
Behavioural features associated with PWS
Health issues associated with PWS
Monitoring weight, nutrition and exercise is crucial
Support strategies for people with PWS
Role of staff
Role of supervisors and managers
Resources

What is Prader-Willi syndrome?

Prader-Willi syndrome (PWS) is a genetic disorder that has the following characteristics and behaviours:

- Specific facial features
- Early childhood onset obesity
- Intellectual disability
- Short stature.
- Under-development of the genitals
- An insatiable appetite caused by physiological issues, which is not within the individual's control.

Behavioural features associated with PWS

People with PWS are more likely to have:

- fixations on food, and anger when the strong drive for food is blocked
- reduced mood control, which can appear as temper outbursts
- repetitive questioning
- obsessions
- increased risk of mental health problems including increased risk of developing psychosis.
- increased risk of self injury (particularly picking and scratching at skin)

Health issues associated with PWS

There are a range of health issues associated with PWS that require careful observation and management, with regular reviews by the doctor and health care team.

The most common issue is the tendency to overeat (hyperphagia). Other health impacts of PWS include:

- a high risk of obesity and the subsequent risks associated with obesity such as diabetes and sleep apnoea.
- musculoskeletal system problems including arthritis and osteoporosis
- respiratory problems
- blood pressure issues
- oedema and swelling of the legs
- injury and infection which may be difficult to identify due to the high pain threshold.

Monitoring weight, nutrition and exercise is crucial

Staff must calculate the resident's Body Mass Index by entering the resident's weight and height on the NASIC and providing this to the resident's health professional, see *RSPM 5.7*.

The resident's doctor or dietitian may require the resident to follow specific dietary plans and be weighed more frequently than monthly, see *RSPM 5.8* in which case an alternate tool to the 'weight monitor' will need to be used.

Exercise is crucial to achieving and maintaining a healthy weight and general wellbeing and is particularly important for people with PWS.

Support strategies for people with PWS

A specific health management plan must be developed for all residents with PWS. A behaviour support plan may also be required.

General principles for supporting residents with PWS, that should be described in a management plan include:

- providing specific and clear routines, with consistent implementation
- using visual timetables to help people understand daily routines and expectations.
- ensuring effective communication strategies are in place and being used (see *RSPM 4.10*)
- planning major activities and appointments in the mornings where possible, as people with PWS are more likely to tire easily and may fall asleep during the day
- carefully monitoring the resident for any undetected injury, as people with PWS have a higher pain threshold
- planning adequate exercise every day.

Insatiable appetite in people with PWS is part of the syndrome and is physiological not psychological. This is usually the primary concern for both the individual with PWS and those who support them. The support provided should be detailed in the specific health management plan / behaviour support plan, and should include:

- Careful management of nutritional needs and exercise, as people with PWS have a lower calorie need than the average person; and have a lower recognition that they have eaten, leaving them with an insatiable appetite and food related stress.
 - All food-related activities being structured and consistent (including meal times, the particular food served, portioning and availability of second helpings).
 - Actively involving the resident in food related activities as far as they are able, as this will provide cues that food is not being denied and will still be available. This may include menu planning, setting the table, and participating in shopping and cooking. For example, a resident may not be able to assist in food preparation but could still get the pots and other implements ready for food preparation.
 - The resident's support network being aware of the critical need for a consistent approach to food and eating for the resident.
 - A physical environment structured so that food access is strictly supervised. Any restrictions to access to food that are required, due to other strategies to manage food intake not being effective, need to be authorised and reported in accordance with *RSPM 7.3*.
-

Role of staff

Staff are to follow the Support Plan, BSP and other health plans for residents with PWS. In particular:

- PWS should be noted on the resident's health support needs summary, see RSPM part 5.2.
 - A specific health management plan should be developed through collaboration between the GP, dietitian and an exercise physiologist or physiotherapist, that outlines a lifelong restricted-energy diet and regular exercise program to maintain a healthy weight.
 - Follow any authorised restrictions in place and implement strategies outlined in the BSP.
 - Use the Person Centred Active Support approach and involve the resident in a structured routine that includes meaningful activities
 - Gather evidence to evaluate and review the effectiveness of any support strategies.
 - Refer concerns to the supervisor or relevant specialist
-

Role of supervisors and managers

Supervisors and managers are to ensure, as far as possible, that staff access and use:

- Learning and development opportunities to learn about PWS
 - The skills developed in 'Inclusive Communication and Behaviour (ICAB)' and/or 'Positive Behaviour Support (PBS) - getting it right from the start' training that enables them to undertake functional behaviour assessment (FBA) and collect data using the standard ABC or Setting, Trigger, Action Result (STAR) charts and the Motivation Assessment Scale (MAS) tool.
 - Data and information to develop, implement and evaluate management strategies for behaviours common to residents with PWS, in conjunction with the resident's health care team.
-

Resources

- Office of the senior practitioner – oversees and provides information and resources on the use of restrictive intervention and compulsory treatment. Available on the Department of Human Services website: <http://www.dhs.vic.gov.au/for-individuals/your-rights/offices-protecting-rights/office-of-the-senior-practitioner>
 - Centre for Developmental Disability Health Victoria (CDDHV) fact sheet for Prader-Willi : <http://www.cddh.monash.org/assets/fs-prader-willi.pdf>
 - Prader-Willi Association of Australia http://www.pws.asn.au/general_guide.html
 - UK Prader-Willi Syndrome Association: <http://www.pwsa.co.uk/>
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5.14 Managing deteriorating health

Issued: August 2012

Applies to all

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What is deteriorating health?

Deteriorating health is a state which is unusual for a resident compared to their usual state of health. As many residents have a health status which may be considered poor compared to the general population so staff should be aware of what is usual for a resident and respond to changes in their health. This includes a deterioration of the physical or mental health state that is usual for the resident.

Why is it important to recognise deteriorating health?

Many residents have a higher risk of minor ailments which can deteriorate into life-threatening situations rapidly. There are also Public Health reporting requirements for some infectious diseases and additional precautions required in the event of suspected gastroenteritis or influenza, *see RSPM 3.10.3*.

How to recognise deteriorating health

Deteriorating health may be indicated by a resident:

- saying or gesturing they are unwell
- having symptoms, for example, a high temperature
- having visible changes in appearance, or behaviour.

If a resident has known signs which indicate deteriorating health, these must be documented as alerts on their Health support needs summary.

Staff are required to seek a health review for residents who are experiencing increases, or changes to behaviours of concern, as this may indicate pain or discomfort. Residents with behaviours of concern have been placed at serious risk when it has been assumed an increase in their behaviours was unrelated to health concerns, and staff have continued to implement restraint and seclusion strategies, *see RSPM 7.4*.

What signs may indicate deteriorating health?

Visible changes indicating deteriorating health include:

- coughing
 - vomiting
 - shivering
 - attempts at self-injury
 - changes in:
 - eating or drinking
 - breathing
 - skin colour
 - behaviour
 - toilet habits
 - sleeping patterns
 - mobility
 - sweating (unrelated to activity or exercise)
 - skin changes (for example, rash, blisters and swelling)
 - facial expressions or body actions which indicate pain or distress
 - mood changes, for example, lethargy or aggression.
-

What requires urgent medical attention?

In accordance with first aid training, *see RSPM 3.12*, any circumstance that may be life threatening must be treated as an emergency. An ambulance must be called in the event of:

- breathing difficulties
 - significant bleeding
 - loss or alteration of consciousness that is unexplained or after a fall or bump on the head
 - deterioration of a current condition that has any of the above symptoms, even when treatment is occurring
 - any symptoms specified in a specific health management plan as requiring emergency treatment
 - any other incident specified by first aid training as requiring urgent medical attention.
-

Get advice when unsure

Where the situation does not appear to be an emergency, staff are to seek advice from the resident's doctor. If an appointment is not available or it is after hours, advice is to be sought from NURSE-ON-CALL.

Staff must contact NURSE-ON-CALL for advice and not book a locum doctor unless advised to do so by the usual doctor or NURSE-ON-CALL.. Locum services often take time to respond, potentially delaying diagnosis and treatment.

When calling NURSE-ON-CALL, staff must:

- have the resident's health file on hand
 - be able to answer questions about the current symptoms.
-

**Special
Instructions if a
resident has
swallowing risks**

Residents who live in supported disability accommodation have a much higher risk of swallowing issues than the general population, *see RSPM 5.7*. Swallowing issues significantly increase the risk of aspiration pneumonia which is a life threatening infection caused by inhaling small amounts of food, fluid, saliva or vomit into the lungs. A resident who is identified by the Nutrition and Swallowing Issues Checklist (NASIC) as having a swallowing issue must have an alert placed on their Health support needs summary, *see RSPM 5.2*, as this condition can:

- occur suddenly
- progress quickly with minimal symptoms, apart from the resident appearing 'unwell'.

Signs which indicate a resident may be developing aspiration pneumonia can be subtle, and include new or changed symptoms of:

- a cough with sputum, pus, or blood (however, coughing may be absent, or weak)
- a discharge of fluid from their mouth, or nose
- a change in their skin colour (blue or grey) due to a lack of oxygen, breathing changes, wheezing, or shortness of breath
- foul smelling breath
- fatigue
- increased difficulty swallowing
- being hot and sweaty and experiencing chest pain.

Signs of fever include:

- shivering with teeth chattering
- a flushed face
- excessive sweating
- pale or clammy skin
- a temperature above 38 degrees.

Fever usually indicates an infection is present and must be investigated. Staff must not give any medications to reduce a resident's fever except where directed to do so by:

- a doctor
- NURSE-ON-CALL.

These medications do not treat the cause of the fever and will 'hide' further deterioration for up to four hours while the cause of infection continues untreated.

If any symptoms are noticed then staff must either:

- seek immediate advice from the resident's doctor. It is not adequate to wait for an appointment or a locum doctor in this circumstance as aspiration pneumonia can cause death within hours

OR

- call an ambulance. If unsure for any reason, contact Nurse-On-Call and follow the advice provided.
-

Role of all staff

When a resident's health is deteriorating, staff are to:

- provide required first aid, *see RSPM 3.12*
- seek medical attention
- provide emergency health support according to directions provided by the resident's doctor or NURSE-ON-CALL.

Where a resident's health deteriorates staff must ensure all relevant information provided by the doctor or NURSE-ON-CALL is clearly documented. If the doctor requests a resident be monitored, staff need to:

- obtain clear instructions about the level and type of monitoring needed
- follow the advice provided.

The residents family should be informed of significant deterioration in health unless otherwise specified in the support plan.

Where additional staff support is required, staff must discuss this with their manager according to regional procedures.

What is NURSE-ON-CALL?

NURSE-ON-CALL is a telephone health line which is available 24 hours a day, seven days a week, every day of the year. The service is staffed by registered nurses who can:

- give general health advice about how to care for an unwell person
- advise taking the person to a doctor, or emergency department, if required
- transfer the call to the Poisons Information Centre, if appropriate.

NURSE-ON-CALL does not:

- provide home visits
- give a diagnosis
- organise referrals
- make appointments
- replace emergency services
- replace the Poisons Information Centre.

When to use NURSE-ON-CALL

Staff should use NURSE-ON-CALL if:

- they are unsure about seeking medical help
 - the resident's regular doctor cannot be contacted for advice
 - they want advice about symptoms being observed
 - the resident is a long way from medical help
 - they want advice, or information about health services in the local area.
-

Information to tell NURSE-ON-CALL

To ensure the nurse understands the environment in which the resident lives it is important to explain:

- your relationship to the resident (disability support staff)
 - the resident has a disability and lives in a supported accommodation service
 - they are unable to communicate their symptoms (if this is the case)
 - known health issues including swallowing problems
 - resident's are supported by a number of staff who are not employed as medical, or health workers.
-

Resources

- NURSE-ON-CALL – a telephone service which provides immediate health advice from a registered nurse, 24 hours a day, 7 days a week, telephone: 1300 60 60 24. Available at: <http://www.health.vic.gov.au/nurseoncall>
 - Emergency services call form – a form to document service location and assist staff to provide the required information to emergency services. Available on the DAS Hub.
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5.15 Hospital admission

Issued: August 2012

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Be prepared for hospital admissions

Staff should ensure resident health information is readily accessible, and up-to-date, so hospital admission goes smoothly. The resident's health information must contain a current completed Hospital admissions information form which can be accessed quickly, as required. Being prepared is important because people with an intellectual disability:

- experience twice as many hospital admissions as the general population
- have a greater risk of experiencing complications during and after admission as they:
 - often have significantly poorer health than the general population
 - can experience difficulty communicating symptoms and basic support needs
 - can have difficulty understanding and complying with hospital processes
 - are more dependent on hospital staff for a range of supports and assistance.

Hospitals are busy and large places and often patients are cared for by many staff on different wards. Being prepared and ensuring good planning and communication occurs before; during and after the hospital admission, is critical to ensuring resident safety.

Emergency admissions

If two or more support staff are on duty, one is required to accompany the resident to hospital in the ambulance, if possible. If one staff is rostered on they must:

- remain with the other residents
- inform ambulance personnel of the resident's condition and provide a copy of their completed Hospital admission information form
- provide a copy of the resident's current medication record and Health support needs summary, if possible (originals must not to be sent)
- contact their supervisor, or manager to arrange another staff member to meet the resident at the hospital, as soon as possible.

It may be an agreed process to contact the resident's family to meet them at the hospital. If this is the case, contact the family before contacting the manager, or after hours support, and let them know a family member will be attending the hospital. For scheduled admissions staff should follow the information provided.

When admission is scheduled

Planning should start as soon as the admission is scheduled. Staff must:

- inform the resident's family of the admission, where appropriate
- ensure a family member, or the person responsible is available to sign the hospital consent form, as required
- communicate with the resident about the hospital admission in a way they can understand, for example, Compic, pictures, or sign
- ensure the Hospital admission information form is completed and the information is current
- ensure the manager is informed
- check required referral letters, or information provided by the doctor, or specialist.

Additionally, staff must ensure information related to the hospital admission is documented in the resident's file and diary including the:

- admission reason
 - planned treatment
 - admission, treatment, pre-admission clinic and other important dates
 - pre-admission instructions
 - hospital name and location
 - name of the doctor performing the procedure (if known)
 - anticipated discharge date.
-

What is the Hospital admission information form?

The Hospital admission information form is designed to help hospital staff provide effective resident health care. It must be completed and provided in addition to the usual admission forms provided by the hospital.

There are two parts to the Hospital admission form. The first part contains information about Disability Residential Services – this is necessary because hospital staff may be unaware of:

- the capacity of residential services to manage health problems after discharge
- the eligibility of residents to access community health and nursing services
- how to obtain consent for medical and dental procedures for residents who lack the capacity to make these decisions.

Staff should give an additional copy, printed on bright orange paper to the ward providing care.

Pre-operative procedures may be required

Pre-operative procedures are procedures a resident is instructed to follow before treatment commences. Examples of pre-operative procedures include:

- fasting
- bowel preparation.

Pre-operative procedures may cause discomfort, or anxiety. If a resident cannot take their usual medications (for example, behaviour management, or epilepsy medications) due to fasting requirements, there may be adverse consequences.

Staff are to ensure:

- the resident understands (to the best of their ability) why they are undergoing pre-operative procedures and what to expect
 - pre-operative procedures are followed
 - information about pre-operative procedures is provided by hospital staff, or the resident's doctor.
-

Items that must be taken with the person

Staff must ensure the following items and documents are taken to hospital:

- toiletries
- suitable clothing
- medication including the current blister pack
- aids, or communication equipment
- personal items to make the resident feel more comfortable
- the Hospital admissions information form
- the Health support needs summary
- the Medication record
- the latest copy of their CHAP
- the referral letter, if required.

Important items which are packed for the hospital admission must be documented in the resident's file. Valuable items, or large amounts of money should not be sent.

Support during admission

A resident must be accompanied to hospital by their family, or familiar staff. If staff accompany them they must:

- ensure relevant documentation is given to relevant hospital staff and have an additional copy of the completed hospital admissions information form to provide to the Nurse Unit Manager.
- demonstrate ways the resident communicates, for example, familiarise hospital staff with communication aides, or communication gestures (the requirement to pass this information onto subsequent shifts must be emphasised)
- check if the resident may be moved to another ward during their admission and when this is likely to occur
- stay with the resident until the admission is finalised and they appear settled (it is not the Role of all staff to stay with the resident once they are settled).

If family accompany the resident to hospital staff must:

- provide them with necessary paperwork and request it be given to relevant hospital staff
- visit the hospital as soon as practical within 24 hours to support the resident and hospital staff are familiar with how they communicate.

Whoever supports the resident during the admission process should stay with them until they are settled and comfortable. It is a good idea to ensure residents have familiar items with them to provide comfort. If the resident does not settle, speak with hospital staff about ways to manage this.

Identify a key hospital contact

During the hospital stay the resident is likely to be transferred to different wards, units or care centres, for example, Emergency, Intensive Care or Cardiac Rehabilitation. Staff should ask for details of the most appropriate hospital contact and when they will be available. The hospital contact may be:

- staff attached to the ward, such as the Nurse Unit Manager, who will be familiar with ward-level happenings (if the resident is moved during the admission process, ensure a new contact is established)
- a specific person not attached to the ward, such as a social worker, patient liaison or discharge planner, who can assist throughout the hospital stay (check with the hospital to determine if someone is employed in this capacity as, depending on the person's role, they may not be available on weekends).

Staff should to encourage the hospital contact to:

- familiarise themselves with the information on the Hospital admission information form
 - ask questions, as required.
-

Role of all staff during the stay

During the hospital stay staff should:

- assist hospital staff to communicate with the resident
- visit regularly to ensure the resident is comfortable
- encourage hospital staff to be familiar with, and act on, the information provided in the Hospital admission information form
- obtain regular up-dates, preferably daily, on the resident's progress and treatment
- liaise with the resident's family, or person responsible, to ensure:
 - consistent information is provided
 - they are notified if the resident is moved to a different ward.

If a resident is moved between wards staff should:

- identify a new ward contact
 - assist the new ward contact to become familiar with the resident (for example, ways they communicate)
 - provide the new ward contact with a copy of the Hospital admission information form, and request it be given to other ward staff.
-

Support that should not be provided

During a hospital stay the hospital is responsible for the health and safety of the resident. Hospital staff are responsible for direct care support such as:

- bathing, or showering assistance
- medication administration
- eating, drinking, or peg feeding assistance
- mobility support
- specific health procedures.

Residential services staff are not required to provide direct care support because:

- a resident's needs may change rapidly during the hospital stay due to treatment, or condition changes
 - they may unintentionally provide support that is inconsistent with the hospital care plan.
-

If there are concerns with the stay

If staff are concerned a resident is not receiving adequate hospital care, they should:

- discuss the issue with their manager
 - follow directions provided by the manager (some issues may need to be addressed by a more senior manager)
 - consult the key hospital contact
 - consult the Nurse Unit Manager, if they are not already involved as the key hospital contact.
-

Resources

- Hospital admissions information form – provides information about the disability residential services environment and a template to record details and support requirements of the resident being admitted to hospital. Available on the DAS Hub.
 - Emergency services call template – a template to document service location and assist staff provide the required information to emergency services. Available on the DAS Hub.
-

5.15.1 Hospital discharge

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Role of the supervisor after discharge
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Start discharge planning at admission

Discharge planning is often complex because many professionals may be involved and the discharge time and date can be unpredictable. Sometimes a decision is made to discharge a resident suddenly, before key people have been notified. During the hospital stay staff must:

- attempt to keep up-to-date with the expected discharge date
- explain to hospital staff a comprehensive discharge plan, is required.
- think about and plan post-discharge requirements including:
 - training specific to new medications, aides, or equipment,
 - or specific health procedures, for example, catheter, PEG, or colostomy management
 - the support of community medical and nursing services, such as the Royal District Nursing Service, or palliative care services, if required
 - transport and staff cover issues.

Obtain a comprehensive discharge plan

Staff will require a comprehensive discharge plan from the hospital to ensure health support is maintained when the resident returns home, especially if there has been significant changes in their health status, or management needs. The hospital may send this information directly to the doctor or specialist who arranged the admission. If staff have not received a discharge plan, or been involved in discharge planning, they should ask the hospital if a plan has been sent to the doctor or specialist. The discharge plan needs to include:

- doctor, or specialist follow-up dates
- altered physical care needs; bathing, dressing, continence management
- medication changes, which may be provided on an interim record provided by the hospital, that can be used until the resident is reviewed by their doctor
- dietary requirements, or changes to the resident's dietary regime
- details of post-discharge visits to, or by the community nurse, doctor, or relevant others
- the required amount of mobility and rest
- the review or completion date.

If there is difficulty in obtaining discharge information, check if the hospital has a General Practitioner Liaison Officer (GPLO). Most hospitals have a GPLO. The GPLO facilitates communication transfer between hospital and community doctors. The GPLO can support hospital discharge by providing the resident's doctor with information about any changes to their health status and health management.

Role of the supervisor after discharge

When a resident returns to the residential service after a hospital stay the supervisor is to check the following has occurred:

- the Health support needs summary has been up-dated, as required
 - other changes are documented as required, for example, the medication record and relevant specific health management plans
 - required medications, aids or equipment are available
 - training is implemented for staff, as required
 - community medical and nursing services, or palliative care services, are in place
 - follow-up appointments or actions are completed, as required.
-

Resources

- Health Services Commission – provides advice and assistance with complaints about health services. Available at: <http://www.health.vic.gov.au/hsc/>
 - Undertaking client related manual handling tasks with safety – a 26 page tool for assessing and controlling manual handling risks. The assessment is available by emailing: EMSONline@dhs.vic.gov.au
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5.16 End of life and Palliative care

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Applies to All

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Implementing an instructional directive (known as Refusal of Medical Treatment Certificate or Not For Resuscitation directive prior to 12 March 2018) in a group home
Role of all staff
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Resources

What is end of life care?

End of life care describes the support needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness, frailty or old age. This period is important to recognise because people may experience rapid changes and fluctuations in their condition and often have repeated contact with a range of health services.

End of life care is provided by a wide range of service providers including those from health, human services, community and local government sectors.

What is palliative care?

Palliative care is an approach that improves the quality of life of residents and their families who are facing problems associated with life-limiting illness such as advanced dementia, cancer or chronic conditions amongst others. It does this by preventing and relieving suffering through early identification and assessment, by treating pain and other physical, psychosocial and spiritual problems and by addressing practical issues.

For residents with a life-limiting condition, active treatment may still be important and can be provided concurrently with a palliative approach.

A palliative approach should begin as early as possible to maximise the quality of the remaining time the resident has, and to prepare for death.

Where is palliative care provided?

Palliative care is provided in many settings including:

- private homes such as the family home
- residential services (group homes)
- hospitals
- specialist inpatient palliative care units.

The decision about where to provide palliative care is based on the needs and wishes of the person with the life-limiting illness. Many people with life-limiting illnesses prefer to be cared for at home. Residents have the right to receive palliative care, as appropriate.

Resident choice and planning the palliative approach

If residents wish to receive home-based palliative care, all possible support options should be investigated.

An assessment of the group home environment needs to be undertaken to ensure that the resident support needs can be met, the group home environment is suitable to provide palliative care and the views of the co-residents in the house are considered.

End of life planning and decisions such as funeral plans, spiritual or religious requirements can commence at any time in a resident's life as part of the support planning process. See *RSPM 4.3 Support Planning*.

Accessing palliative care services

Community based palliative care services provide services to people that wish to die in their own home. They can include medical specialists, nurses, bereavement counsellors, spiritual counsellors, therapists, volunteers and a 24 hour support line for registered residents. Referrals to palliative care services are generally made in consultation with a GP.

When a resident is discharged from the hospital with a life-limiting condition or treatment of a condition has been withdrawn, staff must clarify with the hospital if the resident requires palliative care. The palliative care coordinator or the resident social worker from the hospital should be involved during discharge planning for residents considered to require palliative care to ensure referral/s to the appropriate services.

Palliative approach planning

The palliative care service will assess the needs of the resident and develop a care plan in consultation with the resident and:

- their family
- carers
- guardians
- medical professionals.

The palliative care plan will address the resident's physical, emotional, social and spiritual care needs. It is important that agreement of the palliative care plan is obtained from:

- the resident
- their doctor
- their family, as appropriate.

When a resident is first referred to a palliative care service, it is recommended that a palliative care case planning meeting is held that involves the resident, specialist palliative care provider and other people who will be involved in the implementation of the care plan including the house supervisor, key worker, the resident's family, doctor/s, and their other disability supports, such as the day support service, to discuss and document important issues.

- Planning for palliative care in residential services must address:
 - the capacity for staff to provide care, such as specific health training needs
 - staff supports such as regular staff meetings, debriefing sessions and the Employee Assistance Program, as required
 - the flexibility to temporarily transfer staff or offer alternative work options as required
 - the coping capacity and support mechanisms of co-residents
 - on-going reviews of OH&S requirements, such as manual handling and infection control requirements.

A template to guide the palliative care case planning meeting to ensure that all issues relevant to providing palliative care in a residential service are discussed and documented is available on the department intranet.

Implementing best care for the dying person

'Care plan for the dying person', also referred to as final stage care, terminal care, or 'actively dying', is based on the understanding that death is imminent and a natural part of life. The final stage in a person's life it is a uniquely important time for the dying person and their family and close friends.

The goals of best care for the dying person are:

- to maintain the comfort, choices, and quality of life of a person who is recognised to be in the terminal phase of dying;
- to support their individuality;
- and to care for the psychosocial and spiritual needs of themselves and their families.

Support for families, friends, carers and co-residents, if needed, continues after death as bereavement care. Best care for the dying person also aims to reduce inappropriate and burdensome healthcare interventions and to offer a choice for residents about where they want to spend their remaining time. Specific health support plans are to be developed to manage the medical requirements of the resident's palliative care including, pain management (often referred to as 'break through pain'), symptom management and how best care for the dying person is to be managed. See *RSPM 5.14 Specific health management*.

Refusal of Treatment Certificates in place prior to 12 March 2018

A resident over the age of 18 years has the same right as anybody else to refuse medical treatment for a medical condition. The provision of reasonable pain relief and food and water while the patient is still able to eat and drink cannot be refused when a person is receiving palliative care.

From 12 March 2018 The *Medical Treatment Planning and Decisions Act 2016* came into effect. *The Act* is a single law for medical treatment decision-making for people without decision-making capacity.

If a person currently has a Refusal of Treatment Certificate, this will continue to be recognised when *The Act* commenced on 12 March 2018 (but the certificate retains its original limitation to current conditions only). This means that there is no need to remake existing legal documents.

After 12 March 2018 an advance care directive 'instructional directive' replaces a 'Refusal of Treatment' certificate.

For more information visit <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-act/frequently-asked-questions>.

When can an instructional directive (known as Not for resuscitation (NFR) prior to March 2018) be used?

In the absence of an instructional directive (or a valid Refusal of Medical Treatment Certificate in place prior to 12 March 2018) the decision to withdraw treatment, or not resuscitate can only be made by the treating medical doctor in consultation with:

- the resident
- their formally appointed legal decision maker.

The department and its staff do not have any role in this decision.

When made by a doctor, there is no standard instructional directive form and medical practitioners and hospitals will have their own way of documenting the instructional directive.

The instructional directive must include:

- Written confirmation of the resident's current life-limiting illness and a rationale for the decision not to resuscitate that indicates resuscitation is unduly burdensome or futile and as such active treatment is not warranted.
- The signature of the medical practitioner; and
- the date.

A copy should be:

- Placed in the relevant section of the resident's Accommodation Services File.
- Placed in the resident's health file, if this is kept separate.
- Attached to the resident's hospital admission form.

The existence of an instructional directive should be communicated to the staff team and shown to paramedics or other medical personnel, as appropriate.

Implementing an instructional directive (known as Refusal of Medical Treatment Certificate or Not For Resuscitation directive prior to 12 March 2018) in a group home

If a valid instructional directive (or Refusal of Medical Treatment Certificate or NFR directive prior to 12 March 2018) is in place staff must comply with it and not provide any treatment the resident has refused.

Cardio pulmonary resuscitation (CPR) must not be administered if it is listed on the instructional directive (or Refusal of Medical Treatment Certificate or NFR directive in place prior to 12 March 2018) and is documented in the resident's specific health management or palliative care plan which has been signed by both the treating medical practitioner and medical treatment decision maker (see RSPM 5.5).

In all current life-limiting illnesses there should be a health management plan to guide staff in their role in supporting the resident (see *RSPM 5.2 Developing a health plan*).

If a resident's family disagrees with the withdrawal of treatment they must be referred to the Office of the Public Advocate for advice.

If staff believe withdrawal of medical treatment is not in a resident's best interest they can ask their line manager to obtain independent advice from OPA. Any decision to contact OPA must be based on the resident's best interests and not the personal views or beliefs of staff.

Role of all staff

Staff are required to:

- participate in the direct support component of palliative care planning
- assist in providing end of life and palliative care, where appropriate
- understand co-residents may require extra support (when a resident has a life-limiting illness)
- be open about the process and seek support

Staff must not participate in treatment decision making processes. These decisions can only be made by treating medical practitioners and palliative care services, in conjunction with the resident and their family, medical treatment decision maker or guardian, as appropriate.

Role of the supervisor and managers

Supervisors and managers must ensure:

- residents with life-limiting illnesses are able to access palliative care services
 - the end of life and palliative care training needs of staff are addressed
 - staff and residents are referred to appropriate services for grief and bereavement services, as required
 - necessary information is documented in the resident's health plan
 - the palliative care service and the resident's family understand the requirement to notify the Victorian Coroner when death occurs, see *RSPM 6.8 When a person dies*.
 - staff have an understanding of:
 - the role and authority of legal decision makers
 - advance care planning or instructional directives
 - advance care directives (from 12 March 2018).
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Resources

Forms and templates are available on the department's internet.