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RECORD OF REVISIONS: SECTION 2: ASSESSMENT AND PLANNING

Date	Section/s Revised and Notes	Authorisation
October 2023	Policy and procedures implemented	Management Committee

2.1 ASSESSMENT AND PLANNING GUIDE

2.1.1 CONSUMER OUTCOME[1]

"I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and wellbeing."

2.1.2 ORGANISATION STATEMENT[2]

CHNC:

- Always undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer (the consumer's representative is consulted with permission of the consumer, or in the case where the consumer is unable to participate, the consumer's representative is consulted)
- Ensures assessment and planning has a focus on optimising health and wellbeing in accordance with the consumer's needs, goals and preferences
- Ensures infection prevention and control strategies are in place in the planning and delivery of care and services.

2.1.3 OUR POLICY[3]

- Assessment and planning, including consideration of risks to the consumer's wellbeing, informs the delivery of safe and effective care and services
- Assessment and planning identify and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes
- The assessment and planning process:
    - Is based on an ongoing partnership with the consumer and others that they wish to involve in assessment, planning and review of their care and services
    - Includes other providers, organisations and individuals involved in the care of the consumer
    - Considers the infection prevention and control strategies necessary to ensure the safety and wellbeing of consumers and staff
- The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided
- Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

2.1.4 RESPONSIBILITIES

- Management ensures processes and practices achieve an ongoing partnership with consumers in the assessment, planning and review, and safe delivery of their care and services including the employment of staff both qualified and experienced in assessment and support planning.
- Staff follow policies and procedures, participate in development opportunities, work to establish partnerships and deliver safe care and services that address the consumer's current needs, goals and preferences.
- Consumers and/or their representatives support a partnership approach and provide input on their needs and preferences for care and services.

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1 Australian Government Aged Care Quality and Safety Commission, Guidance and resources for providers to support the Aged Care Quality Standards (September 2022). Website accessed May 2023

2 Ibid., p.23. Note that ibid means 'in the same source last referenced in the footnote above.'

3 Ibid., p.23.

2.1.5 MONITORING ASSESSMENT AND PLANNING

Assessment and planning processes and systems are regularly audited as part of our audit program and staff, consumers and other stakeholders are encouraged to provide ongoing feedback on issues and areas where improvements can be made (see Corporate Calendar[4]).

[4] See Forms/Governance Documents and 8.9 Continuous Improvement

2.2 RECEIVING CONSUMER REFERRALS

2.2.1 MY AGED CARE REFERRALS

Commonwealth Home Support Programme (CHSP)

Entry and assessment for the Commonwealth Home Support Programme (CHSP)[5] is through My Aged Care. People coming directly to CHNC for CHSP support are referred to, and assisted to contact, My Aged Care for screening and assessment via the My Aged Care Contact Centre using the referral form available on the My Aged Care website (www.myagedcare.gov.au), or we may assist them to make contact by telephone.

In person supports are also available at dedicated Services Australia service centres. Appointments can be made with an Aged Care Specialist Officer (where one is available) at a Services Australia service centre.

The My Aged Care Contact Centre registers the consumer, conducts a screening process over the phone (where possible) and then may:

- Refer the consumer directly to CHSP service(s)
- Refer the consumer for a face-to-face home support assessment conducted by the My Aged Care RAS

  Face-to-face assessments are best practice and conducted whenever possible, however a phone, video conference, telehealth or teleconference assessment may be undertaken where appropriate
- Refer the consumer to an ACAT if needs indicate a higher level of care is required
- Provide information about non-Commonwealth funded services, as appropriate.

All referrals from My Aged Care are based on the consumer's selection of a service provider and can be:

- Directly to a service provider electronically and including a link to the consumer record (National Screening and Assessment Form – NSAF). The service provider accesses the consumer record and decides whether to accept the referral
- The consumer can be provided with the contact details of service providers along with a referral code to give to the provider. The provider can then access the consumer record to aid in discussion and acceptance of the referral.

Note: All clients must be entered into the CHSP through My Aged Care. In addition, where an existing client's needs change, including where there is a need for a new service type or a significant increase to their existing service level, the client must be referred to My Aged Care for an assessment before any additional services are provided.

CHSP referral before assessment

CHSP service delivery can also commence prior to completion of a face to face assessment:

- Where a person is eligible for CHSP and screening at the contact centre identifies there is no further assessment necessary
- Where a consumer has an urgent need for services but also requires face-to-face assessment. In these cases, a consumer may begin to receive services before they are assessed as eligible (e.g. meals or transport), while they wait for a face-to-face assessment
- Where urgent care is required, for example the delivery of meals due to the unplanned absence of a carer, service delivery may be provided before a consumer has contacted My Aged Care.

Referrals prior to assessment are for:

- A one-off intervention (such as transport to a GP appointment); or
- A short period of time only (not ongoing service provision).

[5] Most of the information around assessments and referrals for CHSP is taken from: Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023

HCP Consumers - Access to CHSP

Where a HCP client needs additional services as a short-term or time limited arrangement, they can access certain CHSP subsidised services under specific conditions. These conditions are specified in the CHSP Manual.[6]

Home Care Packages

Entry and assessment for the Home Care Packages Programme (HCPs)[7] is through My Aged Care. People coming directly to CHNC for HCPs are referred to, and assisted to contact, My Aged Care for screening and assessment via the My Aged Care Contact Centre using the referral form available on the My Aged Care website (www.myagedcare.gov.au). Alternatively, we assist them to make contact by telephone.

The steps for a consumer to access a Home Care Package are:[8]

1. Consumer registers with My Aged Care and is triaged
2. ACAT and consumer complete a Comprehensive Aged Care Assessment using the National Screening and Assessment Form (NSAF)
3. Eligible consumers join the national priority system
4. Consumer receives readiness letter, completes income assessment and researches providers (An income assessment can be completed at any time and are valid for 120 days. It is recommended consumers do this when they receive the readiness letter)
5. Consumer is assigned a HCP by the national priority system and chooses a provider
6. Consumer and approved provider enter into a Home Care Agreement
7. Provider accepts the My Aged Care referral and notifies Services Australia of a consumer starting care
8. Provider and consumer develop package budget and care plan within two weeks of the start date.

2.2.2 RECEIVING CONSUMER REFERRALS PROCESS

Commencing CHSP services

The relevant team member receives the referrals and decides to accept the consumer or not, based on the information in the consumer record and our capacity to deliver the services required. When a referral is accepted, the team member contacts the consumer and arranges a Service Commencement Meeting (see 2.3.6 Assessment and Support Planning Process/Service commencement meeting).

Commencing a home care package[9]

For a home care package consumer to successfully take-up their package they must enter into a Home Care Agreement with an approved provider by the take-up deadline. The take-up deadline is 56 days from the date a package is assigned to the consumer.

To enter into a Home Care Agreement the consumer and provider must jointly agree to:

- Receive/deliver the services

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6 Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023, 4.1.1 Interaction with specific programs and services/ Home Care Packages (HCP). This section describes all interactions between CHSP and other health services

7 Most of the information around assessments and referrals for HCPs is taken from: Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023

8 Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 6 Eligibility for care recipients to receive Australian Government funded packages

9 Australian Government Department of Health and Aged Care Aged Care Update Help Your Home Care Package Consumer Start their Package Successfully 11 October 2018

- The consumer's rights and responsibilities
- The services to be provided by the provider
- The fees and other charges to be paid under the agreement
- All other administrative details.

Once a Home Care Agreement has been entered into, and the consumer has agreed to receive services, services can be delivered to the consumer at the start date agreed upon and documented in the Agreement.

Key points to remember to prevent package withdrawal:

- The consumer and provider must enter into a Home Care Agreement before the take-up deadline.
- The provider must advise Services Australia of the agreed entry date of services through an Aged Care Entry Record (ACER) or through the Aged Care Online System (ACOS) within 56 days from the date the package was assigned.
- The consumer may request an addition of 28 days to extend the overall take-up deadline to 84 days. The extension may only be requested once per package and before the initial 56 days expire.
- Providers must show the date of the Agreement as the entry date for the consumer when submitting the ACER or ACOS.

HCP consumers transferring from another provider[10]

When HCP consumers transfer from another service provider to CHNC the following process applies:

- Accept the consumer referral from My Aged Care and develop a Home Care Agreement
  - Accept the referral code in the provider portal in My Aged Care to access the consumer's record
  - Work in partnership with the new consumer to develop a Home Care Agreement and support plan based on their needs
- The start date for the new provider must be on or after the agreed cessation day. Before providing home care services, confirm the cessation day with both the consumer and the previous provider to ensure there are no overlapping claims for home care subsidy. Where two or more service providers claim subsidy for the same consumer on the same day, payment is made to the provider that first entered into a Home Care Agreement with the consumer
  - Accept the consumer's referral in My Aged Care and submit the ACER within 28 calendar days of the cessation day. A new Home Care Agreement must be entered into within 56 calendar days from the agreed cessation day before their package is withdrawn.

[10] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 13: Changing home care providers

2.3 ASSESSMENT AND PLANNING PROCESSES

The assessment and planning processes in CHNC focus on the person, recognise each person's strengths and abilities and aims to empower the person to identify their own support needs and goals.

To ensure our care and services are effective and reflect the needs, goals and preferences of consumers, we:

- Establish an ongoing partnership with consumers (see 2.3.2 Partnering with Consumers)
- Utilise information from the My Aged Care Comprehensive Aged Care Assessment[11]
- Foster choice and independence (see 1.4.3 Fostering Choice and Independence)
- Conduct a service commencement process that focuses on the consumer with consideration to strategies to promote health and wellbeing
- Consider infection prevention and control strategies
- Conduct comprehensive assessments and develop support plans that include advanced care planning and end of life planning, and
- Conduct regular reviews of consumer's needs and refer consumers to relevant health professionals and other agencies as required.

2.3.1 WELLNESS AND REABLEMENT

Assessments, planning and service delivery are underpinned by a wellness and reablement approach. These approaches are defined in the Home Care Packages Program Operational Manual 2023 as follows:[12]

> *"Wellness is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home. Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.*
>
> *Reablement involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. Supports could include training in a new skill or re-learning a lost skill, minor modification to a person's home environment or having access to equipment or assistive technology."*

We recognise that implementing a wellness and reablement approach at the earliest opportunity, and focussing on client goals to maintain or regain functional capacity and social connectedness can have significant long-term benefits for clients including:

- Improved sense of purpose, autonomy and self-worth
- Improved physical and emotional health and wellbeing
- Reduction in service delivery needs
- Increased ability to remain living independently and safely in their own homes for longer

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[11] For information on the areas covered by the Comprehensive Aged Care Assessment see: Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 6.2 What is a comprehensive aged care assessment and how does it work? This information can be applied to all programs

[12] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers 1.4 – August 2023, 2.4 How are a care recipient's ageing related care needs and goals established? And 7.3.1 Wellness approach. This information can be applied to all programs

- Greater quality of life and retention of pride and dignity
- Improved connection with community
- Reduced strain on family and carer relationships.[13]

Our assessment and planning processes apply the principles identified in the wellness and reablement framework to all consumers. These include:

- **Promote Independence** – people value their independence, loss of independence can have a devastating effect, particularly for older people who may find it more difficult to regain
- **Identify clients' goals** – a person's independence requires more than just services to help them remain in their home and maintain their current capacity. Service delivery should focus on supporting the client to actively work towards their goals and improved independence wherever possible
- **Consider physical and psychological needs** – independence is not limited to physical function, it includes both social and psychological function
- **Encourage client participation** – being an active participant, rather than a passive recipient of services, is an important part of being physically and emotionally healthy. Service delivery should focus on assisting a person to complete tasks, not taking over tasks that a person can do for themselves
- **Regular assessment** – client assessment should be ongoing, not one-off. It should focus on progress towards client goals and consider the support and duration of services required to meet these goals
- **Focus on strengths** - the focus should be on what a person can do, rather than what they can't. Wherever possible, services should aim to retain, regain, or learn skills rather than creating dependencies
- **Consider risks** – review the consumer support plan for any inherent risks and plan and implement appropriate strategies to address known risks
- **Support clients to reach their potential** – help clients to maintain and extend their activities in line with their capabilities
- **Individualised support** – service delivery should be individualised and suited to the goals, aspirations and needs of the individual.[14]

As part of applying a wellness and reablement approach to service delivery we:

- Ensure services are targeted towards assisting clients to achieve their agreed goals as outlined in the assessment support plan
- Offer time limited interventions where appropriate
- Monitor changes in client needs and regularly review support services
- Comply with wellness and reablement reporting requirements.
- Have developed and are implementing a plan outlining our approach to embedding wellness and reablement in service delivery
- Utilise the Living well at home: CHSP Good Practice Guide, and other resources provided by the Department
- We participate in the CHSP Reablement Community of Practice to learn, share and engage with other providers across the CHSP sector.[15]

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[13] Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023, 2.3 Benefits of a wellness and reablement approach. Benefits for service providers and families and carers are also described in this reference. This information can be applied to all programs

[14] Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023, 2.4 Principles of wellness and reablement. This information can be applied to all programs

[15] Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023, 2.1 Introduction. Note: The first seven points are CHSP requirements but can also be applied to other programs

We are embedding a cultural shift from 'doing for consumers' to 'doing with consumers' across service delivery. We ensure:

- Support plans focus on strategies to promote and foster consumer choice and independence (see 1.4.3 Fostering Choice and Independence)
- The strengths of consumers are recognised and built on and not undermined through the delivery of support in areas where the consumer can manage
- Consumers and their carers are supported to maximise their independence and autonomy
- The strengths, capacity and wishes of individuals are foremost in assessment and support planning and we encourage actions that promote self-sufficiency
- We are alert to changing circumstances and goals of the consumer and consulting with My Aged Care where appropriate to review the consumer's support plan
- Consumers are encouraged to use resources such as the LiveUp website (www.liveup.org.au), which enables Australians over 65 years of age to check their health and find personalised suggestions for products and services that promote healthy ageing

All staff complete wellness and reablement training. The importance of the approaches and what they mean for the consumer is discussed with the consumer at the service commencement visit.

2.3.2 PARTNERING WITH CONSUMERS

Consumers and other people they wish to involve in their care, are engaged as partners in all aspects of the care and services consumers receive from CHNC, including assessment, support planning and service delivery. The partnership is based on ongoing consultation with the consumer that includes the following principles:

- Effective communication and partnership with consumers during intake, assessment, care, support, escalation, monitoring, review and referral processes as part of our service delivery processes that emphasise consumer choice and control in all aspects
- The provision of information, and support in understanding and utilising the information
- Ensuring the cultural safety of consumers
- Working together with other providers, organisations and individuals involved in the care of the consumer
- Working with consumers to identify ways to address any issues
- Encouraging feedback and ideas for improving services and service processes

2.3.3 DELIVERING SAFE AND EFFECTIVE SERVICES

We ensure our services are safe and effective, culturally safe, meet the consumer's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life, through:

- Maintaining a partnership approach with consumers (see above)
- Conduct comprehensive assessments in partnership with the consumer (see 2.3.6 Assessment and Support Planning Process)
- Actively encouraging consumers to exercise choice and independence including having their say in the care and services they access (see 1.4 Consumer Choice and Independence)
- Developing a support plan based on a holistic assessment that identifies a person's needs, preferences and goals through their direct involvement in the process (see 1.4.2 Consumer Preferences and this section)
- Regular monitoring and review of support plans (12-monthly at a minimum) (see 2.3.7 Support Plans)
- Recognising special needs of consumers including cultural, spiritual, emotional, psychological and physical needs (see 1.3.7 Consumers with Special Needs, 1.3.3 Spiritual Support and 1.3.4 Emotional and Psychological Support)
- Providing support through a wellness and reablement framework that builds on consumers strengths to promote and maintain independence

- Providing a wide range of options to consumers to ensure greater choice and variety of the services and supports they need and want
- Supporting consumers to maintain their links in the community (see 1.4.4 Inclusion in Community)
- Referring consumers to other agencies when necessary to access services and supports that we cannot provide (see 1.4.4 Inclusion in Community)
- Ensuring the cultural safety of consumers (see 1.3.2 Cultural Safety of Consumers and 1.3.7 Consumers with Special Needs)
- Respecting the consumer's rights and informing them of their responsibilities (see 1.3.6 Consumer Rights and Responsibilities)
- Ensuring the safety and comfort of consumers in our facilities (see 5.3 A Safe Environment) and in their homes and other venues (see 5.3.11 Safety audits external venues)
- Managing risks from equipment (see 5.4.7 Monitoring and Maintaining Equipment and Facilities), infections (see 2.7 Infection Prevention and Control) and food (see 4.4 Food Services).

Assessment and planning procedures and practices (see 2.3.6 Assessment and Support Planning Process and 2.3.7 Support Plans) also support this outcome for consumers.

Section 5: Service Environment describes the procedures and practices CHNC has in place to ensure a safe and comfortable service environment that promotes the consumer's independence, comfort and enjoyment.

Missing Consumers

If a consumer goes missing from the service environment (e.g. from the service premises or on an outing) and staff are unaware of the reasons for their absence the relevant manager is notified immediately and the whole service environment is then searched in a coordinated manner by all available staff members. (See below Figure 2.3.1 Missing Consumer Flow Chart.)

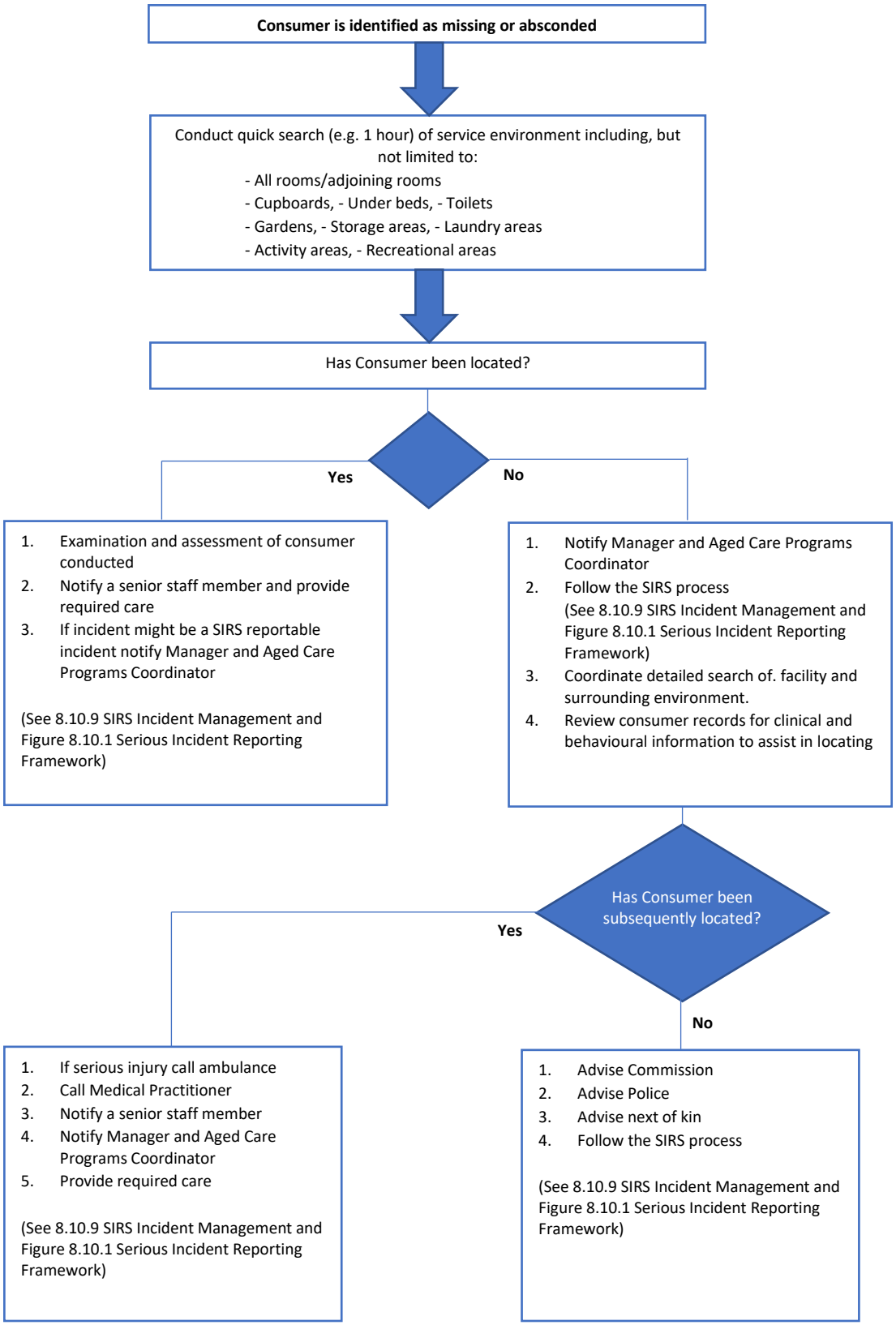
If after a reasonable search (e.g. one hour,) the consumer is not found, **the requirements of the Serious Incident Response Scheme (SIRS)** will apply (See 8.10.9 SIRS Incident Management).

Police are notified ASAP so appropriate action can be taken to locate the consumer. Police are given a description of the consumer including, if possible, a description of what the consumer was wearing when last seen.

If a consumer returned to the service before we become aware that they were missing, there is no requirement to notify this to the Commission. However, we must notify the absence to the Commission if the police are aware of the consumer's absence or where the consumer has been returned to the service environment by the police.

The next of kin are also notified ASAP.

Figure 2.3.1 Missing Consumer Flow Chart



Action in the event of a consumer not responding to a scheduled visit[16]

Each consumer is consulted regarding what they want CHNC to do if they do not respond to a scheduled visit. This is documented in their Support Plan/s. Generally, if consumers do not respond to a scheduled visit, staff and volunteers:

- Knock and shout at the door
- Check the boundaries of the property and/or check with neighbours (if applicable and appropriate)
- Notify the Aged Care Programs Coordinator, or the Aged Care Programs Assistant who will ring the consumer and/or representative or next of kin and make a note in the Progress Notes of the outcome
- If a meal delivery, the meal is not left (due to food safety requirements and the need to understand why the consumer is not responding).

If necessary, the Aged Care Programs Coordinator will ring the Police and ask them to check the house.

2.3.4 CONSENT[17]

Principles of consent

We support consumers to be fully informed regarding the consumer-centric care and services we provide. We are guided by the following principles:

- Consumers have the right of self-determination regarding care and services
- We are committed to engaging in sensitive, two-way communication to support the consumer to make decisions regarding care and services, including the right to refuse services
- Provision of information in language/format the consumer can understand with consideration to language, culture and sensory/literacy impairments
- The decision-making hierarchy is used to assist us to determine the most appropriate decision maker
- Verbal informed consent must be given for the provision of care and services
- Health professionals must warn consumers/decision makers of the material risks of the proposed treatments so they can make decisions about associated risks and whether they wish to proceed.

Consent and privacy of information are closely aligned; we ensure that consent has been gained to manage the privacy of consumer information by ensuring:

- Information relating to a consumer is only shared with the consent of the consumer or their representative or guardian (with consideration to capacity).
- We have a Consumer Consent Form that details approved consent and our privacy statement
- We seek consent from consumers to disclose personal information to other health service providers in an emergency as appropriate to provide emergency care or services
- We seek consent from consumers to provide access to consumer records to government officials (or their delegates) in the conduct of quality reviews or the investigation of complaints. We advise consumers that these individuals are required to keep all information accessed through this process confidential
- We advise consumers that information is required to be provided to government bodies as a requirement of service delivery
- Consent to share personal information can be withdrawn at any time by the consumer.

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[16] Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023, 6.1.6 Client not responding to a scheduled visit or service. Refers to Guide for Community Care Service Providers on How to Respond when a Community Care Consumer does not Respond to a Scheduled Visit 2009

[17] This information is based on the Government of Western Australia Department of Health WA Consent to Treatment Policy 2016. The information can be applied to all States and Territories as an example of a good practice definition or can be replaced with another example. Note that this policy is under review as at November 2020

Valid consent

Consent is valid if it is:

- Voluntary: the consent is made by the consumer/decision maker without undue influence from others
- Informed: made after receiving sufficient information about the care or treatment to enable an informed decision
- Given with capacity: the person giving consent must understand the information presented to them in order to decide
- Current: consent must be reviewed if, after consent is obtained, the consumer's circumstances (including treatment options and risks) have changed or the scope of consent becomes otherwise inadequate
- The scope of consent is clear: the care or treatment provided must fall within the consent that has been given.

Consent is valid until the consumer/decision maker withdraws it or the proposed treatment or care is no longer appropriate due to a change in circumstances.

Types of consent

Consent can be implied or explicit. Implied consent is where the consumer indicates through their actions that they are willing to proceed with the care or treatment offered (e.g. the consumer prepares for assistance with personal care). If it is unclear if the consumer has provided consent for care or treatment, the care provider should validate with the consumer that they consent for care or treatment.

Explicit consent is required where more complex care or treatment is being provided (such as insertion of a catheter). The health professional is required to note consent in the consumer's record after explaining the risks and benefits to the consumer.

Written consent should be obtained for vaccinations. Other health care procedures may require written consent, at the discretion of the medical practitioner.

Seeking consent

The following steps should be taken in gaining consent:

- Determine who is responsible for giving consent (decision making hierarchy)
- Verify the consumer has capacity to consent (if it is suspected they do not, we consult with representatives and/or the consumers medical practitioner)
- Provide sufficient information to the consumer: if the consumer has limited comprehension of the English language, seek support from a professional interpreter
- Verify the consumer's understanding including answering any questions the consumer has
- Seek a decision from the consumer regarding consent (ask the consumer to sign the consent form for overarching service provision consent, or in the case of health care professional invasive treatments, document the consumer's consent to treatment in the consumer's record).

Consent procedure

Consent is explained to consumers/representatives at service commencement/assessment and they are assisted to complete the Consent form that identifies where we can obtain information about the consumer and who information can be provided to. This includes the provision of information to representatives. All occasions of sharing information are recorded in the consumers Progress Notes with details of the information and consent.

The Consent Form is reviewed at reassessments and before any information is shared with agencies not specifically covered by the consents in place. Details of access to consumer information are provided below (see Table 2.3.1: Access to Consumer Information with Consent).

Health professionals explain health care interventions and gain verbal/implied consent before proceeding with care procedures. If these procedures are invasive (i.e. catheter insertion), consent is documented in the progress notes (e.g. 'consent gained for catheter insertion after discussion with consumer regarding risks and benefits'). Support workers

discuss support interventions and gain verbal/implied consent (e.g. when supporting a consumer with personal care). At no time is care or support provided without implied consent; consumers can withdraw consent for care and services.

Table 2.3.1: Access to Consumer Information with Consent

Records	Consumer/ Guardian	Representatives and Support Network	Clinical Staff	Supervisory Staff	Support Workers	Other Aged Care Agencies	Medical Agencies	Emergency Agencies
Assessment	●	SPR[18]	●	●			●	
Support Plan	●	SPR	●	●	●	●	●	
Clinical Assessments	●		●	●			●	
Clinical Support Plans	●	SPR	●	●	●	●	●	
Progress Notes	●	SPR	●	●	●		●	
Transfer Form	●	SPR	●	●	●		●	●
Advance Health Directives	●	SPR	●	●	●		●	
Agreements/Financial Information	●	SPR		●				
Paper Files	●	SPR	●	●	●			
Electronic Files	●	SPR	●	●	●			

(See also 2.6 Consumer Documentation and Information Sharing.)

2.3.5 SUBSTITUTE DECISION-MAKERS

Consumers are encouraged to make choices and direct the support that they need; however, some consumers may have difficulties engaging with their program. This applies particularly where people may need to make choices about their care goals and services, including the development of an advance care directive to document their care and health service provision wishes.

In these cases, substitute decision makers are important, and a range of options are explained to consumers and/or their representative. These include the following.

Representative[19]

A person may appoint a representative to assist with their decision making or be authorised to make decisions on their behalf. This may take various forms, such as an informal arrangement with a friend, family member or ally, or someone with a formal power of attorney or a legal guardian (see below).

[18] SPR: Specific Consumer Permission Required

[19] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 12.3 How do I manage issues related to changing cognition? This information can be applied to all programs

Supported decision-making[20]

In supported decision-making specific decisions are addressed, weighed and concluded by the consumer, while drawing on the support of a network of people or an individual.

Potential supporters may be friends, family, volunteers, community members or any other trusted person. These unpaid supporters may help the person to gather, understand and consider relevant information about the decision in question, assist them to weigh pros and cons, predict likely outcomes and consequences or evaluate the available options. With this support, the person then makes the decision themselves.

This process can be formally facilitated, for instance by creating written supported decision-making agreements. It often occurs informally, however, within the community, both to support people with impaired decision-making capacity and to support anyone in making a challenging decision. This model of support aims to build and extend the decision-making skills of those using it, developing the ability of people to make and communicate decisions with more independence and confidence.

For consent to the use of restrictive practices see 3.5 Restrictive Practices.

Advance care directive (ACD)[21]

Consumers are encouraged to develop an advance care directive to document their care and health service provision wishes.

Staff are required to follow the advance care directives provided by consumers (see 2.3.8 Advance Care Planning). We advise the consumer on service commencement that they need to have four copies of their ACD: one for the consumer to keep, two to be placed with the support plan, (one of these to be available to take to hospital, if necessary) and one to be stored in our main office.

If the consumer is referred to a health service (e.g. hospital) we advise the health service that the consumer has an Advance Care Directive (see Consumer Details and Transfer Form) and send a copy with the consumer if we are present when they transfer. Should the consumer not yet have an Advance Care Directive, we refer them to their medical practitioner to discuss the option of completing one. (See also 2.3.8 Advance Care Planning and 3.2.5 Documenting Advance Care Planning.)

If a consumer does not have to make decisions about their care and support their 'Person Responsible' is consulted.[22]

Person responsible and hierarchy of decision making

Where a consumer has appointed a Person Responsible that person has authority to make decisions on the consumer's behalf. The Person Responsible is obliged to make decisions in accord with a consumer's Advance Care Directive if one exists.

If a consumer has not appointed a Person Responsible the following process applies:[23]

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[20] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 12.3 How do I manage issues related to changing cognition? Note: The source for Supported Decision-making is Disability Advocacy Network Australia. This information can be applied to all programs

[21] NSW Ministry of Health Making an Advance Care Directive May 2022. See also Advance Care Planning Australia Accessed August 2023

[22] NCAT Guardianship Division Fact Sheet: Person responsible (April 2016) Website accessed August 2023, NSW Guardianship Act 1987

[23] Ibid.

Figure 2.3.2: How to identify the Person Responsible

Enduring guardian and enduring power of attorney[24]

An enduring guardian is the person a consumer appoints to act on their behalf by completing an Appointment of Enduring Guardian form. The consumer determines the extent of the Enduring guardian's powers to make personal, lifestyle and treatment decisions on the consumer's behalf.

An enduring power of attorney is a legal document where a consumer nominates a person to manage property and financial decisions. They cannot make personal, lifestyle and treatment decisions on the consumer's behalf.

At service commencement, the consumer is asked if these documents are available, and if so, we take a copy for our office (with permission). We consider these documents in our interactions with the consumer and consult as necessary.

Consumers are directed to the Department of Communities and Justice if they wish further information on these issues.

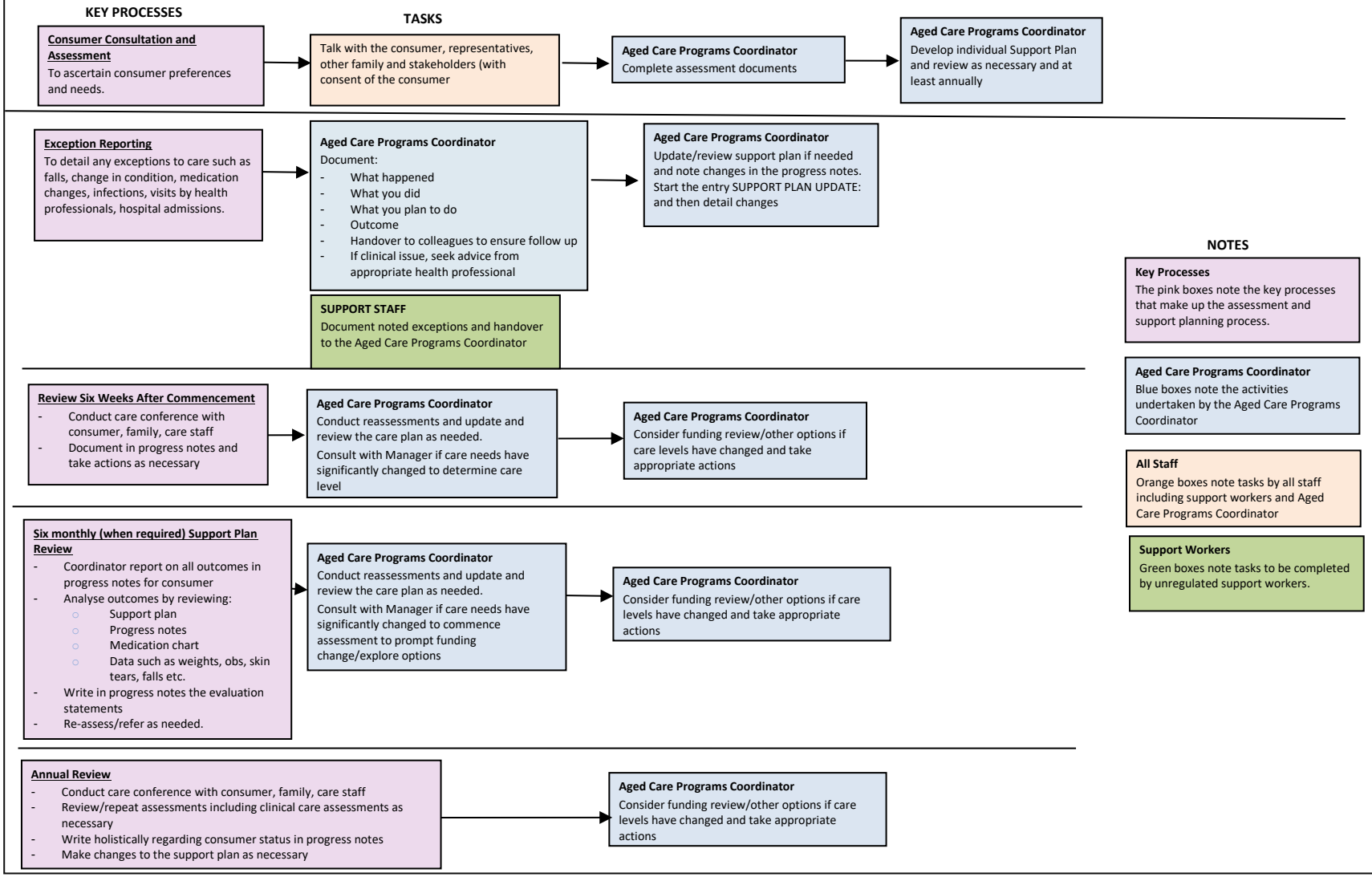
[24] Government of New South Wales Planning for end of life Website Accessed September 2023

2.3.6 ASSESSMENT AND SUPPORT PLANNING PROCESS

Assessment and support planning are conducted following the principles of assessment and support planning (see 2.3 Assessment and Planning Processes) and include a clear process. Figure 2.3.3 Assessment and Support Planning Process Flow Chart below outlines the process. This is further described in the Assessment and Support Planning Practice.

(See also 2.4 Consumer Reviews and Reassessment.)

Figure 2.3.3 Assessment and Support Planning Process Flow Chart



Consumer advocates in assessment and planning[25]

Consumers or their representative are advised at the time the commencement meeting is being arranged that they can have an advocate to help them understand their rights and choices within their package, and to support them through decision-making processes. If requested, an advocate is arranged through NACAP to attend the Commencement Meeting.

Service commencement meeting

Once a consumer agrees to accept services from CHNC a Service Commencement Meeting is arranged and conducted by the relevant team member.

In home care, the service commencement meeting is guided by the Service Commencement Practice Home Care to ensure all necessary information is collected, provided to and explained to the consumer and/or their representative.

Key assessment and planning process steps and timelines

The key process steps in the assessment and support planning process always includes:

- **Consumer consultation and assessment** (this commences with a Service Commencement Meeting and continues on an ongoing basis to ensure consumer preferences and needs are met). Relevant assessment forms are used to determine the consumer needs (including clinical care needs) and preferences
- **Exception reporting** when something out of the ordinary happens (adverse events or a change in condition) that requires consideration to a change in care
- **Six-week review** (this is a care conference process conducted six weeks after commencement, to ensure the consumer is happy with the support outcomes and provides an opportunity to reassess any clinical needs the consumer may have)
- **Six monthly and when required**, support plan review (depending on the complexity of the consumer's support needs, this process ensures a systematic consumer review process occurs at least six monthly and when required as care needs change)
- **Annual review** an annual care conference is conducted with consumers. (See 2.3.7 Support Plans/Care conferences for further detail.):
    - If complex clinical care is not being provided this can be conducted by telephone with the consumer and representative (as applicable) to ensure support and care are meeting the needs of consumers. If complex clinical care is being provided, this is conducted face to face.

Planning consumer care and support requirements[26]

Planning consumer care and support requirements occurs in partnership with the consumer with consideration of their assessed care needs and care goals, and the supports that will optimise their health and wellbeing. The Inclusions and Exclusions Framework, from the Home Care Packages Program Operational Manual, is used to support decision making when it comes to determining what can and cannot be included as part of a package. The Framework is included in the Service Commencement Practice Home Care for completion as appropriate.

2.3.7 SUPPORT PLANS

General

CHNC utilises a support plan format that reflects the support needs of each consumer and is readily understood and easily followed by staff. In developing the support plan, we ensure that:

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[25] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 12.4 What do I do if care recipients need additional support in exercising their choice? Note: NACAP = National Aged Care Advocacy Program delivered by the Older Persons Advocacy Network (OPAN). This information can be applied to all programs

[26] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 9.1 How do I work out what services can be included in a care recipient's care plan?

- Referral information provided by My Aged Care in the comprehensive aged care assessment and any other referral information is used to understand the consumer's needs and is validated with the consumer/representative/s to reduce assessment burden
- The support plan is based on a wellness and reablement approach (see 2.3.1 Wellness and Reablement)
- Consumers are consulted regarding their expressed goals of care and each consumer's personal and health circumstances are given consideration
- The consumers representatives are involved in deciding the support the consumer receives and their goals, to the extent expressed by the consumer
- We work directly with the consumer to break down the broader goals in their support plan into achievable steps and strategies that will assist the consumer to reach their goals
- The support plan is detailed enough to ensure the strengths of consumers are recognised and built on and not undermined through the delivery of support in areas where the consumer can self-manage
- Care and support is provided with consideration to the consumer's personal and clinical care needs and based on appropriate clinical (conducted by the Registered Nurse/Health Professional) assessments where necessary and with a focus on wellness and reablement (see 2.3.1 Wellness and Reablement)
- A risk assessment is conducted as necessary if it is identified there are consumer risks that require support planning (See 3.2.2 Risk Assessment: Minimising Harm)
- Consumers needs and goals are reviewed regularly in consultation with the consumer/their representative when these needs and goals change, to ensure effectiveness of care and support is provided
- Consumers are referred to appropriate health professionals (or other supports) to ensure appropriate care and support strategies are provided particularly when deterioration is identified, or the care required is not within the scope of practice of care providers. Other supports include:
    - Allied health services
    - Dental services
    - Vaccinations
    - comprehensive health assessments
- Key processes that contribute to the provision of safe quality care include care review and evaluation, identifying deterioration and the associated escalation of care, care conferences, the conduct of clinical review and handover processes
- Individual needs and preferences are considered and include:
    - Physical needs
    - Spiritual needs (see 1.3.3 Spiritual Support)
    - Emotional needs (see 1.3.4 Emotional and Psychological Support)
    - Cultural safety needs (see 1.3.2 Cultural Safety of Consumers)
    - Linguistic needs
    - Socio-economic needs
    - Preferences in the provision of care and support (balanced against resources) (see 1.4.3 Fostering Choice and Independence)
    - Advance care planning and end of life planning if the consumer wishes (see 2.3.8 Advance Care Planning)
    - Care alerts (including environmental safety, risks to staff, infection etc)
- The support plan includes consideration of risks to the consumer's health and well-being to inform the delivery of safe and effective care and services (see 8.10.7 Consumer Choice and Risk)
- The support plan includes responses to individual, provider and community emergencies and disasters to ensure their safety, health and wellbeing. This information is included in the support plan and the Consumer Details and Transfer Form. Support workers are briefed on these to ensure their understanding

- The consumer is made aware of and able to choose from available support in the community
- When the support plan is finalised, it is again explained to the consumer and the consumer agrees to it by signing/acknowledging it. The supports delivered are those specified in the support plan. If a consumer requests additional or different support, then their support plan is reviewed before additional or different support is provided
- The support plan is available to relevant team members to ensure all support workers understand all aspects of the support plan and deliver consistent support in accordance with the support plan
- We coordinate care to ensure timely reviews (see Support plan review schedule below), follow up of consumer identified issues and challenges, consultation with other providers, including family, and appropriate referrals.

Home care[27]

A copy of the support plan is maintained in the consumer's home (for in-home services) to ensure that support workers and the consumer understand:

- The supports provided
- Areas where a service/support is not provided
- The consumer's role in the support process and in ensuring their independence.

(See 1.4.3 Fostering Choice and Independence/Wellness and reablement. See also Consumer directed care; and Consumer management of home care packages.)

CHSP

- The relevant team member discusses with consumers the recommended support plan provided by My Aged Care and further develops it in consultation with the consumer with consideration to the consumer's expressed goals and wishes.
- Where stipulated CHSP services are provided in accordance with specified timelines
- If appropriate a referral for re-assessment is made to My Aged Care.

HCPs[28]

- The ACAT Guidance Framework for HCP[29] is reviewed to inform consumer's current needs
- For Level 3 and 4 HCP consumers with complex clinical care needs the support plan is developed by the Aged Care Programs Coordinator with support from the Clinical Governance Committee in consultation with the consumer based on relevant clinical and care assessments
- The relevant team member develops the support plan for all other HCP consumers
- Consumers are made aware of available services and excluded services
- All services that the consumer will receive are detailed in the support plan and align with the package budget
- A copy of the support plan is provided to all new consumers within 14 calendar days of them commencing service delivery
- If appropriate a referral for re-assessment is made to My Aged Care.

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[27] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, Section 7: Care Planning

[28] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 7.8 What do I need to provide to the care recipient at the end of their first care planning process?

[29] The ACAT Guidance Framework cited: Australian Government Department of Health and Aged Care Questions and Answers Aged Care Legislation Amendment May 2016 p 9.

Consumer access to support plans

(See 2.6.2 Access to Support Plans and Other Documentation.)

Consumers requiring clinical support

(See 3.2.4 Clinical Support.)

Support plan review schedule

Support plans are reviewed on a regular schedule (at least 12 monthly); the process includes consultation with the consumer/representative, reassessment of need, changes in the health and wellbeing of the consumer, adverse events and information from referrers (e.g. medical practitioners, hospitals).

Referral and updated health information (from medical practitioners, hospitals, other health professionals) is noted and integrated into the support plans as necessary. Actions to inform, train and develop staff are taken by the Registered Nurse/health professional as necessary to implement the required clinical care interventions.

Identifying deterioration and escalation

Support staff follow the support plan and identify deterioration in the consumer (such as a change in mobility, complaints of feeling unwell, or a change in their mental state) and advise the Aged Care Programs Coordinator. Support workers do not give health advice.

All staff receive training appropriate to their position in identifying and responding to deterioration and escalation of care.

(See 2.3.7 Support Plans/Care conferences and Managing Deterioration and Escalation Practice and Managing Life Threatening Events Practice)

The Aged Care Programs Coordinator contact the consumer and advise they contact their medical practitioner/health professional as appropriate. If the consumer appears seriously unwell or displays signs of a life-threatening event (e.g. collapse, chest pain) the support worker calls an ambulance and follows the instructions from the ambulance personnel. The support worker then advises the Aged Care Programs Coordinator of the event and awaits instructions.

Care conferences

In addition to annual care conferences, the Aged Care Programs Coordinator conducts a care conference following the identification of deterioration that is complex, significantly impacts on the wellbeing of the consumer or impacts on the consumer's ability to remain living at home. This process can involve all relevant parties (depending on the issue) including the consumer, representatives (if the consumer wishes), the Coordinator, Registered Nurse, medical practitioner, other health professionals, and support workers. The aim of care conferences is to ascertain if the support plan is appropriately meeting the needs of the consumer and supporting them to live in their home.

All care conferences are documented in the consumer's record and actions identified at the care conference are followed up by the Coordinator and reviewed to ensure they have been appropriately actioned.

Clinical review

As part of clinical care, a Registered Nurse conducts a clinical review process if necessary (e.g. where consumer outcomes are not being met or following a serious adverse event) to investigate if any care interventions can be improved. Clinical review includes a review of consumer records, identification of improvement areas and discussion with relevant staff (including the medical practitioner as necessary). Following clinical review, an entry is made in the progress notes to outline findings and necessary actions. Clinical review findings are also tabled at the Clinical Care Committee Meeting to inform improvements.

Handover

The iSoBAR[30] handover process is used for all formal handovers as relevant for support workers and health professionals. This process is used when handover occurs between agencies, health professionals and support workers. The information provided during handover is based on the knowledge and skill of the person providing the handover; for example, support workers may not have recorded vital signs, but can provide other pertinent information such as observation of the consumer. All staff are provided with information on how to use the iSoBAR handover process (see Handover Practice).

In addition to this formal handover process, support workers send case notes to the Aged Care Programs Coordinator to note any general information about the consumer.

Handover information is filed in the consumer record.

(See also Assessment and Support Planning Practice.)

2.3.8 ADVANCE CARE PLANNING

An Advance Care Directive is a voluntary, person-led document completed and signed by a competent person describing the person's values and preferences for future medical treatment decisions, including their preferred health outcomes and care. They may include binding instructions regarding consent, refusal, or withdrawal of medical treatment. They may also be used to appoint a substitute decision-maker who can make decisions about health or personal care on the person's behalf.

Advance Care Directives only come into effect when the person loses decision-making capacity. If the loss of capacity is only temporary (e.g. delirium related to illness or treatment), the Advance Care Directive will only be in effect until the person regains decision-making capacity. Advance Care Directives are an important mechanism of informed consent for those without capacity.[31]

Consumers are assisted to access support to complete an advance care directive or end of life plan if they wish to. In the first instance the Aged Care Programs Coordinator or Social Support Worker asks the consumer whether they have an advance care directive, and if not, whether they would like to discuss it with their doctor. If they prefer assistance from CHNC, the relevant team member discusses the following points:

- What advance care planning is, with a focus on future health care planning, consent, and identification of a substitute decision-maker, making sure to recognise advance care planning is a voluntary process
- The benefits of advance care planning and receiving preference-aligned care
- What is involved in the advance care planning process, including that these conversations and documents can be revisited and revised at any time
- What a substitute decision-maker is and what their role is
- Who should have a copy of the Advance Care Directive and the best place to store it (including a copy for us)
- The circumstances that activate an Advance Care Directive
- What will happen if the Advance Care Directive is activated
- What happens if a person regains capacity after an Advance Care Directive is activated.[32]

We also discuss with the consumer and note their response in the support plan:

- Their values, goals and wishes regarding advance care planning and end of life care

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30 Based on iSoBAR — a concept and handover checklist: The National Clinical Handover Initiative Jill M Porteous, Edward G Stewart-Wynne, Madeleine Connolly and Pauline F Crommelin MJA 2009; 190 (11): S152-S156

31 Advance Care Planning Australia Advance Care Planning: Aged Care Implementation Guide 2020 Austin Health p 6 Website accessed January 2023

32 Advance Care Planning Australia Advance Care Planning: Aged Care Implementation Guide 2020 Austin Health p 19 Website accessed January 2023

- The importance of letting people know what their wishes are and the use of an Advance Care Directive to ensure their wishes are carried out
- If the consumer wants to complete an Advance Care Directive the relevant team member downloads the required Advance Care Directive forms[33] and runs through them with the consumer, noting key points and items the consumer may want to think about, including particular care directives and substitute decision-makers
- The relevant team member encourages the consumer to discuss the Advance Care Directive notes with their medical practitioner and other persons who they may want involved. The medical practitioner can finalise the Advance Care Directive
- The Coordinator follows up with the consumer to obtain a copy of the Advance Care Directive.

Staff involved in advance care planning have the training and experience to explore with consumers their values, goals and wishes regarding advance care directives and end of life care. Training is based on the Advance Care Planning Australia - Advance Care Planning: Aged Care Implementation Guide, with a focus on:

- Affirming life, worth and uniqueness by enabling consumers to reflect on their life contribution, and
- Confirming dying as a normal process and positioning palliative care planning, advance care planning and death preferences within that context[34]

(See also 2.3.5 Substitute Decision-Makers and 2.3.6 Assessment and Support Planning Process/Service commencement meeting.)

2.3.9 DECEASED CONSUMERS AND AUSTRALIAN DEATH NOTIFICATION SERVICE

When a consumer passes away, we notify My Aged Care through the My Aged Care portal with the reason, 'Consumer Deceased'. This makes the consumer record read only and any unaccepted service referrals are recalled and the consumer's access to the consumer portal is revoked.

We also advise the consumer's representative/s of the Australian Death Notification Service. This service provides a free national service to help consumer representatives notify many organisations at once, of a person passing away. We also provide assistance to representatives who require it.

[33] Advance Care Planning Australia website provides a broad range of forms and supporting information for each State and Territory including New South Wales September 2023

[34] Australian Government Aged Care Quality and Safety Commission, Guidance and resources for providers to support the Aged Care Quality Standards (September 2022). Website accessed May 2023

2.4 CONSUMER REVIEWS AND REASSESSMENT

2.4.1 REVIEW AND REASSESSMENT PROCESS

IMPORTANT: For consumers receiving clinical care see 3.2.2 Risk Assessment: Minimising Harm.

CHSP consumers

CHNC reassesses CHSP consumers on an on-going basis with a focus on progress towards client goals and consideration of the support and duration of services required to meet these goals.[35]

Support plan review

If there are changes in a client's circumstances or an increase in the client's service delivery needs the client is referred to the RAS who may require a support plan review to be undertaken. This may result in a new assessment.

A support plan review is a check of the effectiveness and on-going appropriateness of the services the client is receiving. A review may take place where:

- A client has received restorative care interventions under CHSP and has made a functional gain or improvement to remain independent
- Short-term or time-limited assessment support/coordination utilising a wellness and reablement approach has been undertaken by the RAS
- the My Aged Care assessor sets a review date in the support plan for a short-term service. For example, where the client is referred for time limited support under the CHSP whilst a client is waiting for access to a home care package
- We identify a change in the client's needs or circumstances that affects the existing support plan, such as informal care arrangements have changed or ceased.
- A client identifies a change in their needs or circumstances or seeks assistance to access new services or change their service provider.

CHNC has an on-going responsibility to monitor and review the services we provide to our clients under their care plan to ensure that their needs are being met. Where the My Aged Care assessor recommends short term or time limited services, we incorporate suitable review points in the client's support plan. Where there is no recommended review date included in the My Aged Care support plan, we undertake a review of services we are delivering at least every 12 months. The outcome of this review is recorded on the My Aged Care client record.

Where the client requires a different service or a significant increase in services, or where our review highlights needs or goals not identified on the client's support plan, we request a support plan review from the RAS through the My Aged Care portal. A client completing a restorative care program may also be referred to the RAS, for identification of any on-going services needed following the end of the program.

CHNC reassessment processs

Reassessments are conducted by the relevant team member using the consumer's Support Plan and a Review Checklist as a basis for determining if significant changes may have occurred. Changes are documented in the progress notes. As noted above, the RAS is advised of significant changes. A new support plan is developed if only minor changes are necessary. The type of reassessment may vary depending on the services provided; however, if significant changes appear to have occurred a face to face reassessment is completed.

The range of reassessments may include:

- Consumers only receiving meals/transport are reassessed by telephone annually

[35] Australian Government Department of Health and Aged Care Commonwealth Home Support Programme (CHSP) Manual 2023-2024 Published 10 July 2023, 2.4 Principles of Wellness and Reablement and Review of Client Needs

- Consumers receiving in-home support are reassessed annually; if additional reassessments are scheduled within the year, they may be conducted by telephone, depending on the consumer's requirements. However, if a reassessment occurs a year after the last review, it is conducted face to face

Reassessments for CHSP consumers include the following:

- Consultation with the consumer throughout the reassessment process highlighting the partnership approach
- Explanation of the purpose of the reassessment including wellness and reablement principles
- The consumer's living situation – who lives with them, do they have anyone to support or assist them, the living environment and safety concerns
- Identification of carer supports and any needs in this area
- Medical issues and medications (as appropriate) and whether medication support is required
- A review of the Support Plan, including goals, in consultation with the consumer
- An evaluation of the quality and success of the services and supports in supporting the attainment of consumer goals that have been provided
- An assessment of physical resources required for adequate care and support
- Identification of required changes to the support plan based on promoting consumer control, wellness and reablement in consultation with the consumer, and agreed to by the consumer
- An explanation and review of fees for CHSP consumers including fee increases
- Discussion of the option of 'topping up' service delivery with services paid for directly by consumers if requested or required
- An explanation of information in the Consumer Handbook to the consumer to the extent necessary to ensure understanding
- A review of the Home Safety Checklist which is updated at least annually (this can be informed through discussion with the consumer regarding any changes, hazard reports and staff feedback).

Following the reassessment:

- A summary of the reassessment, the Review Checklist for CHSP consumers and updates to the support plan, are included in the consumer records
- The RAS is advised if a Support Plan Review is required
- The updated support plan is provided to the Aged Care Programs Coordinator or support worker to explain any changes to consumers and to place a copy in the home notes file
- The result of the reassessment is recorded in the consumer record on My Aged Care.
- The next reassessment date is recorded in the consumer record. At the end of each month Aged Care Programs Administration Assistant runs a Consumer Management System report to advise the Aged Care Programs Coordinator of pending reviews to ensure all scheduled reassessments are completed in the month in which they are scheduled. Any missed reassessments are given a priority in the coming month.

HCP Consumers

HCP consumers are reassessed face-to-face at least annually and as frequently as required depending on their level of care and requirements. Consumers receiving Home Care Levels 3 and 4 are generally reassessed more often due to their higher care and support needs.

The need for a more frequent reassessment is triggered by[36]:

- A request by the consumer

[36] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 10.6 How often does the care plan need to be reviewed

- A change to a higher-level package
- A change in condition or health/wellness episode
- A change in care need that cannot be met within the budget available for the package
- A change in living or carer arrangements
- Ongoing or increasing use of clinical services by a consumer
- A change in the costs of providing the care and services.

We also complete a reassessment if we receive a report of a decline in physical or mental health from:

- The consumer
- The carer, family or other representatives
- The support worker/s
- A medical practitioner/health professional or
- Another agency.

The reassessment of HCP consumers is based on their last assessment and support plan and is guided by the Review Checklist. If significant changes are indicated a new Reassessment is completed and the Care Plan updated.

The relevant team member reassesses Level 1 and 2 consumers. The Aged Care Programs Coordinator reassesses Level 3 and 4 consumers routinely (and Level 1 and 2 consumers' clinical care needs if necessary). A Registered Nurse or health professional may conduct additional assessments if deemed appropriate (e.g. continence assessment, behaviour assessments etc).

The reassessment has a reablement and wellness focus that does not assume a decline in the consumer's health and functioning. It involves:[37]

- A review of current care needs, care goals and preferences
- An evaluation of the quality and success of the services and supports that have been provided
- A renegotiation and update of the care plan and individualised package budget and
- Support for the consumer to continue to make informed choices about their care and services, and the life they choose to live, including whether they wish to change their level of involvement and decision-making in the management of the package.

The review looks at:

- Their last assessment
- Current Support Plan and individualised budget (including goals)
- Feedback from the consumer and/or representative
- Input from other health care professionals/agencies and
- Consumer records including observations from the support workers and other staff.

The review includes the following:

- Consultation with the consumer throughout the review process highlighting the partnership approach
- Explanation of the purpose of the review/reassessment including wellness and reablement principles
- A check on the consumer's living situation – who lives with them, do they have anyone to support or assist them, the living environment and safety concerns

[37] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 10.6 How often does the care plan need to be reviewed?

- Identification of carer supports and any needs in this area
- A review/reassessment of the consumer's medical issues and medications (as appropriate) and whether medication support is required
- A review of the Support Plan, including goals, in consultation with the consumer
- An evaluation of the quality and success of the services and supports in supporting the attainment of consumer goals that have been provided
- An assessment of physical resources required for adequate care and support
- Identification of required changes to the Support Plan based on promoting consumer control, wellness and reablement in consultation with the consumer, and agreed to by the consumer
- Review of the individualised budget and/or fees in consultation with the consumer and agreed to by the consumer
- Discussion of the option of 'topping up' service delivery with services paid for directly by consumers if requested or required
- Referrals to other services using the Referral to Another Agency form if required and agreed to by the consumer
- An explanation of information in the Consumer Handbook to the consumer to the extent necessary to ensure understanding
- Completion of a new Assessment/Reassessment form if significant changes to the consumer's support are indicated. If no changes are indicated this is noted on the current Assessment/Reassessment form and the update date is entered
- Support for consumers to continue to make informed decisions, including discussion of whether they wish to change their level of involvement and decision-making in the management of the package
- A review of the Home Safety Checklist which is updated at least annually (this can be informed through discussion with the consumer regarding any changes, hazard reports and staff feedback).

Following the review/reassessment:

- A summary of the review/reassessment, the Assessment/Reassessment form for HCP consumers and the Review Checklist and updates to the support plan, are included in the consumer records
- The updated support plan is provided to the relevant team member or support worker to explain any changes and to place a copy in the home notes file
- The result of the review is recorded in the consumer record on My Aged Care.
- The next review date is recorded in the consumer record. At the end of each month the Aged Care Programs Coordinator checks Lookout for pending reviews to ensure all scheduled reviews are completed in the month in which they are scheduled. Any missed reviews are given a priority in the coming month.

If a reassessment identifies that a consumer may require a higher-level package My Aged Care is advised. If the consumer is already in receipt of a Level 4 package, they may need to consider other options including: [38]

- Reviewing their care plan to identify alternatives and priorities (for example, reducing higher cost services, such as support on weekends, and replacing it with informal supports)
- Purchasing additional services
- The benefits of residential care, either as short-term respite to complement their package or as a long-term option.

The consumer retains security of tenure of their package and must continue to receive care and services as agreed, until they notify the provider in writing that they wish to terminate their Home Care Agreement.

[38] Australian Government Department of Health and Aged Care Home Care Packages Program Operational Manual A Guide For Home Care Providers Version 1.4 – August 2023, 10.10 What happens when a care recipient's care needs have increased?

Requests for support plan reviews from health professionals to My Aged Care

When the My Aged Care contact centre receives a request for a support plan review from a health professional or GP, the contact centre liaises directly with CHNC. They advise us of the new referral information and we determine if the changed care needs can be serviced through the existing package, or if the client requires a reassessment for a higher level package.

Upgrades to Home Care Packages[39]

When a consumer, who has accepted an interim HCP at a lower level, receives an upgrade the following process applies:

1. My Aged Care advises both the consumer and CHNC of the approval of the higher-level package.
2. We discuss the upgrade with the consumer, including additional services, they would like to receive with the additional funding.
3. Their Support Plan and Home Care Agreement are updated, and signed copies provided to the consumer.
4. Services are delivered in accordance with the new support plan and agreement.
5. The My Aged Care Record is updated to reflect the new service information. **Do not** submit entry or exit information to My Aged Care as it may lead to the package being withdrawn.

Note: When a consumer has been assigned a higher-level package, it is unable to be 'downgraded' as it is based on the needs identified in the consumer's assessment. If a consumer has decided they are happy with an interim lower level package, they must opt-out of the national queue by calling the My Aged Care contact centre. They must do this before they are assigned a higher package level, as after it is assigned it cannot be declined in favour of the interim package. We assist the consumer to opt out if that is their wish, by supporting them to call the My Aged Care Contact Centre.

(See also 2.3.6 Assessment and Support Planning Process.)

[39] Australian Government Department of Health and Aged Care Provider Fact Sheet Manage an Upgrade to your Consumer's Home Care Package January 2018

2.5 REFERRAL TO OTHER PROVIDERS PROCESSES

2.5.1 REFERRAL PROCESS

Consumers requesting information and/or assistance to contact other community services such as social groups, information providers or government agencies are provided with assistance as needed and the referral is noted in their consumer record.

Consumers who want or require referrals in relation to their assessed needs and current support plan are referred to appropriate agencies or providers. The relevant team member:

- Liaises with the consumer and/or their representative to clarify the requirements from another agency
- Identifies appropriate agencies with the consumer,
- Identifies referral options and discusses these with the consumer
- Obtains consent to liaise with other agencies on behalf of the consumer
- Contacts other appropriate agencies to discuss the needs of the consumer
    - For clinical care referrals to health professionals an ISoBAR Handover is provided (See Handover Practice and Clinical Referral Form) and referral is noted in the progress notes. Once clinical assessment/care has been provided, the health professional provides an ISoBAR (Clinical Referral Form) handover regarding care, support and clinical interventions provided/recommended and an appropriate assessments and support plan if required.
- Refers the consumer to the agency via email and consent from consumer to share information
- Follows up with the consumer and/or provider referred to, to check on the outcome of the referral
- Provides any further information to the other provider as required
- Documents the referral in the consumer records
- Advises the relevant staff of any new agencies that should be included in our community resources information or of changes to current information on agencies.

2.6 CONSUMER DOCUMENTATION AND INFORMATION SHARING

2.6.1 CONSUMER DOCUMENTATION

All consumers accessing services and supports for daily living have:

- A comprehensive assessment/s or reassessment/s
- A detailed support plan based on their assessment
- Clinical assessments and support plans including complex care support plans, and specific care plans (see 3.2.4 Clinical Support)
- Other consumer information forms
- Copies of correspondence
- Progress notes
- Paper and electronic files.

2.6.2 ACCESS TO SUPPORT PLANS AND OTHER DOCUMENTATION

For consumers receiving in-home services, relevant documentation including assessments and support plans is retained in the office, either electronically or on paper. A copy of the support plan (including the CDC Plan for HCP consumers) is held in the office and a copy kept in the consumer's home, if they agree, to ensure:

- The consumer/representatives understand the supports provided
- Areas where a service/support is not provided are clear to the consumer
- The consumer's role in the support process and in ensuring their independence is clear, and
- All support workers deliver consistent support in accordance with the support plan.

A support worker or Aged Care Programs Coordinator takes a copy the support plan to the consumer's home on the first visit for signing and leaves a copy in the consumer's home file and returns the other copy to the office. The in-home support workers read the support plan to identify the relevant supports provided. The support plan is also recorded in the consumer's electronic record.

Where the consumer (and/or representative) does not want the support plan to detail all of the strategies used to deliver support (for example, the support plan may detail responsive behaviours displayed by the consumer and strategies staff use to support the consumer when displaying these behaviours), the support plan will contain the basic support and services delivered and specific supports will be detailed in the consumer's electronic record. Staff are advised of these additional supports verbally and can ring the office for further clarification if unsure on arrival or in the consumer's home.

If the consumer does not wish the support plan to be stored in the home arrangements are made for the staff delivering care to take the support plan into and out of the home each visit.

Home care file contents

Consumers who have in-home services can access:

- A Consumer Details form that includes the consumer's details, contacts and transfer information
- The relevant support plan/s (for nursing care or short-term care such as wound care)
- Progress notes
- Medication documents (as applicable) including Medication Error Report forms
- Hazard Report form
- Tell Us What You Think form
- Consumer Handbook

- Aged Care Charter of Rights
- Home Safety Checklist
- Other documents as required.

Home care: Social Lunch

For consumers attending Social Lunch services, relevant documentation including assessments and support plans are retained in the office. Support plans are kept in the centre and a copy of the Consumer Details Form is kept in the file that is taken on the bus to transport consumers so that staff have information to hand should they require it (the 2nd page of the Consumer Details Form is not completed unless required).

2.6.3 PROGRESS NOTES

Progress Notes for in-home consumers are maintained in the centre, or on Lookout, as applicable. Progress notes entries are based on exception reporting that requires support staff to record events such as:

- Comments on changes in health made by the consumer
- Change in condition noted by support staff and actions taken to inform supervisor
- Falls or other adverse events
- Medication changes
- Visits by health professionals
- Any other events out of the ordinary
- Notes on escalation including to whom and the response.

Ad-hoc reports from consumers regarding satisfaction with services or activities and their participation in programs is documented at least monthly in the Progress Notes and on a Tell Us What You Think form, to assist in evaluating the program (see 8.9 Continuous Improvement).

Incident/Accident Reports are completed as required and noted in the progress notes.

2.6.4 CONSUMER ACCESS TO INFORMATION

(See 1.6.4 Consumers Right to Access Information.)

2.6.5 INFORMATION SHARING

Subject to consumer consent, information is shared with staff, other people and other agencies involved with the consumer's care in order to achieve the consumer's expressed goals and outcomes. All staff involved in the care of consumers have appropriate qualifications and experience and have received orientation and training in delivering services and care to consumers utilising available resources and information. (See Section 7: Human Resources.)

Staff can access information relevant to their role from the paper and electronic records maintained by CHNC. Staff also share consumer information in meetings and through handover processes to ensure staff are aware of consumer goals and outcomes.

Information necessary to other agencies in supporting consumers is made available on the request of the consumer or following a request from another person or agency. Consent by the consumer is documented in the signed Consent Form or consent is directly obtained from the consumer.

Paper copies of the Consumer Details, which includes information relevant to emergency situations, are sent with the consumer to hospital and are provided to emergency personnel as required.

Requests for information

Requests for consumer information may be submitted by the Coroner, police, the Aged Care Complaints Commissioner or other statutory body. These are referred to the Manager, who logs the request and liaises with the Aged Care Programs Coorinator to collect, copy and provide the requested information. If required (and time permits), legal review of the submitted information is sought. Information is sent via an encrypted email to ensure privacy.

(See also 6.2.7 Working with External Complaints Agencies.)

2.7 INFECTION PREVENTION AND CONTROL (IPC)[40]

Information outlined in this section is based on the information contained in the NHMRC Guidelines. Infection control processes are implemented to ensure the safety and wellbeing of consumers, our staff and the community.

It is essential to involve consumers in their care to assist them to understand what they can do to prevent the spread of infection and keep themselves infection free. To do this we:[41]

- Explain the processes of infection prevention and control (e.g. importance of hand hygiene, reasons for wearing personal protective equipment (PPE), importance of appropriate handling and disposing of sharps) to consumers and their carers
- Engage consumers and their carers in the decision-making process regarding their care and how it is delivered
- Ensure all consumers and their carers are aware that they can ask questions of healthcare professionals.

For other safety information such as manual handling, household safety precautions and first aid see Section 5: Service Environment.

2.7.1 INFECTION PREVENTION AND CONTROL OVERVIEW

Healthcare-associated infections (HAIs) can occur in any healthcare setting including aged care. The basic principles of infection prevention and control can be applied in all settings.

Standard and transmission-based precautions are used to prevent and control infections and provide protection for consumers, staff and the community at large. Infectious agents (also called pathogens) are biological agents that cause disease or illness to their hosts. Infection requires three main elements—a source of the infectious agent, a mode of transmission and a susceptible host.

Consumers and healthcare workers are most likely to be sources of infectious agents and are also the most common susceptible hosts. Other people visiting and working in health care may also be at risk of both infection and transmission. In healthcare settings, the main modes for transmission of infectious agents are contact (including blood borne), droplet and airborne. Consumers are informed of the precautions our staff take to prevent and control infections.

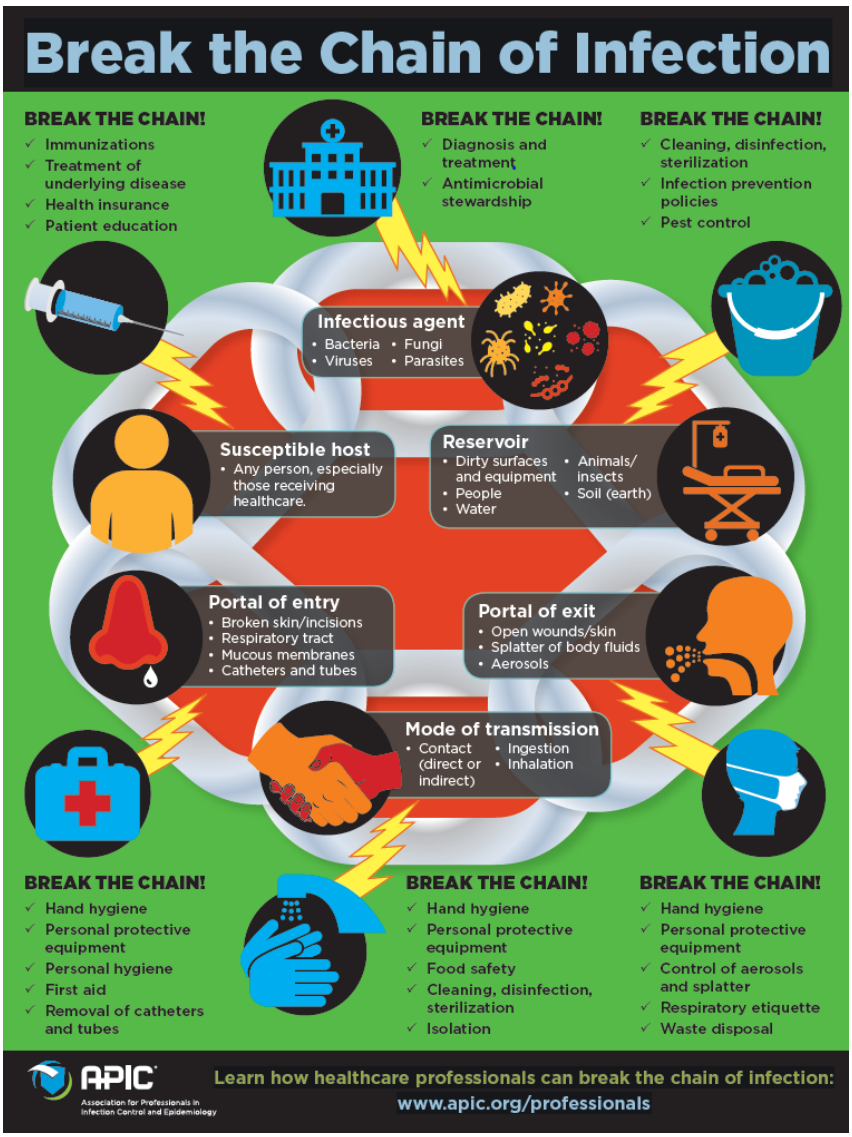
We train staff in the concepts of Breaking the Chain of Infection[42] (see Figure 2.7.1) as part of our training programs.

[40] Australian Government National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019 Last accessed January 2023

[41] Ibid 2.3.1 Involving patients in their care

[42] Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) Break the Chain of Infection Website accessed January 2023

Figure 2.7.1 Breaking the Chain of Infection



2.7.2 STANDARD PRECAUTIONS

Standard precautions are applied to all; irrespective of whether it is known the person has an infection, to provide a basic level of infection prevention and control.

Standard precautions include:

- Hand hygiene
- Use of personal protective equipment (PPE)
- Waste management including the appropriate handling and disposal of sharps and linen
- Environmental controls such as cleaning and management of spills
- Appropriate cleaning of reusable equipment and the use of single-use only instruments
- Practicing respiratory hygiene and cough etiquette
- The use of aseptic non-touch techniques when appropriate (such as the insertion of catheters by a Registered Nurse)

These are further discussed below and in practice documents[43]

2.7.3 TRANSMISSION-BASED PRECAUTIONS[44]

Transmission-based precautions are used in addition to standard precautions where the use of standard precautions may not prevent transmission of an infection. These precautions are tailored to the specific infectious agent and we seek the input of a Infection Control Consultant to develop a management plan if they are advised that transmission-based precautions are necessary (such as in the event of an outbreak of gastroenteritis in the day centre).

Transmission-based precautions can include (in addition to standard precautions) the following:

- Contact precautions are used when there is a known or suspected risk of direct or indirect contract transmission of infectious agents that are not effectively contained by standard precautions alone (e.g. C. difficile or highly contagious skin infections)
- Droplet precautions are used for consumers known or suspected to be infected with agents transmitted over short distances by large respiratory droplets (e.g. influenza, norovirus, pertussis)
- Airborne precautions are used for patients known or suspected to be infected with agents transmitted person to person by the airborne route (e.g. measles, chickenpox and tuberculosis).

2.7.4 ROUTINE HAND HYGIENE

Routine hand hygiene is described in the Hand Hygiene Practice.

2.7.5 USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

Personal protective equipment (PPE) is always available to all staff. The use of PPE is described in the Use of Personal Protective Equipment Practice.

Staff collect PPE from the office as they require it; gloves, plastic aprons and eyewear are available.

2.7.6 WASTE MANAGEMENT

Waste management including the management of sharps and linen is described in the Waste Management Practice.

2.7.7 ENVIRONMENTAL CONTROLS

Environmental controls include the cleaning of the environment, pest control and spills management. Cleaning practices are described in the Cleaning Practice and spills management is described in the Spills Management Practice.

Pest control (centre offices)

The Manager is responsible for ensuring the premises are free from pests. Regular inspections for pests are carried out and any infestations treated, and records retained.

Procedure for decontamination of blood and body fluid substance spills (centre)

Prompt removal and cleaning of the contaminated area following spots or spills of blood and body fluids is sound infection control practice and detailed in the Spills Management Practice.

[43] See 'Practices' folder

[44] See 3.2 Transmission-based precautions and Appendix 2 Section 6.4 for specific guidance in Australian Government National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019

2.7.8 CLEANING OF REUSABLE EQUIPMENT/SINGLE USE EQUIPMENT

Equipment (such as hoists, shower chairs etc) that is used by consumers is cleaned on return to the equipment store with a neutral detergent and warm water and dried. Hoist slings are used for one consumer only and laundered in hot water.

All medical equipment is wiped down with alcohol wipes following use and between consumers. All other medical equipment (such as wound dressings and needles) are single use only.

Handling and disposal of sharps

Inappropriate handling of sharps is the major cause of incidents involving potential exposure to blood-borne diseases. The use of sharps should be minimised using blunt drawing up needles, needle-less intravenous access delivery systems and retractable needle and syringe systems.

The following principles apply:

- Sharps use should be minimised
- Sharps should be handled by the person using them only and not passed between workers
- Sharps (such as needles and syringes) should be carried in a puncture-proof container
- Sharps should not be handled unnecessarily and re-sheathing or manipulating the sharps by had should be avoided
- Sharps should be disposed of at the point of use, if possible
- Needles, blades, single-use razors and other sharp items must be discarded in a clearly labelled, puncture-proof container that conforms with AS 40312 or AS/NZS 4261 as appropriate
- Sharps containers should, wherever possible be fixed to a wall or trolley to reduce the risk of spill or puncture.

Further details of sharps disposal is included in the Waste Management Practice.

2.7.9 HYGIENE AND COUGH ETIQUETTE

Anyone with signs and symptoms of a respiratory infection, regardless of the cause, should follow the respiratory hygiene and cough etiquette as follows:

- Cover the nose/mouth with disposable single-use tissues when coughing, sneezing, wiping and blowing noses
- Use tissues to contain respiratory secretions
- Dispose of tissues in the nearest bin after use
- If no tissues are available, cough or sneeze into the inner elbow rather than the hand
- Practice hand hygiene after contact with respiratory secretions and contaminated objects/materials
- Keep contaminated hands away from the mucous membranes of the eyes and nose.

2.7.10 ASEPTIC TECHNIQUE

The Registered Nurse will use aseptic technique when required using sterile gloves and non-touch techniques where relevant. These practices are within each nurses' scope of practice.

2.7.11 COMMUNICABLE DISEASES

Managing communicable diseases

Staff use standard precautions and use hygiene and cough etiquette to reduce the risk of contracting or passing on a communicable disease. Staff who have a communicable disease (such as a cold, flu or gastroenteritis) are not permitted to work as our consumer group are vulnerable to such infections. Staff must stay off work until the symptoms have passed.

Outbreak management

We seek the support of a Infection Control Consultant to assist us in the management of an outbreak (e.g. in the day centre) or to provide support in managing infectious diseases in the community. We also refer to the following:

- Australian Government Department of Health and Aged Care 2010 Guidelines for the public health management of gastroenteritis outbreaks due to norovirus or suspected viral agents in Australia.

Gastroenteritis

We use the Australian Government Department of Health and Aged Care 2010 Guidelines for the public health management of gastroenteritis outbreaks due to norovirus or suspected viral agents in Australia to guide our practice in the management of a suspected outbreak of gastroenteritis. Full details on practices we follow are include in the abovementioned document.

If there is a suspected gastroenteritis outbreak[45], we:

1. Inform

- Report outbreak to PHU and Department of Health and Aged Care.
- Inform staff, consumers and visitors of the outbreak.
- Provide handouts about gastroenteritis.
- Put up advisory notices.
- Advise visitors not to attend (especially young children, the immuno-compromised or any with gastroenteritis symptoms).
- Ask visitors to report any symptoms to staff.
- Advise visiting general practitioners and other health staff.

2. Handwashing

- Ensure that all consumers have their hands washed after going to the toilet, before meals and after any episode of diarrhoea or vomiting.
- Ensure all staff and visitors wash their hands before and after all resident contact.
- Ensure sufficient soap and/or alcohol-based hand rubs or gels, and hand-drying facilities are available.

3. Additional infection control measures

- Train staff in additional contact precautions.
- Provide sufficient gloves, gowns, aprons, masks, goggles, face shields and ensure that they are easily accessible.
- Ensure cleaning and other relevant staff members are aware of the correct cleaning procedures and the importance of handwashing.
- Ensure catering staff members are aware of the precautions required in food service area and the importance of handwashing.

4. Cohorting

- Allocate dedicated staff to care for unwell consumers.
- Allocate dedicated staff to clean affected areas.
- Do not allocate catering staff members to care for infected consumers or to clean affected areas.

[45] Australian Government Department of Health and Aged Care Guidelines for the public health management of gastroenteritis outbreaks due to Norovirus or suspected viral agents in Australia 2010 Website accessed January 2023

5. Restrict movements

- Suspend communal activities, excursion, visiting programs to the centre.

6. Exclude sick staff

- Exclude staff with gastroenteritis for at least 48 hours after resolution of symptoms.

7. Cleaning

- Implement additional (in addition to detergent and water) cleaning procedures, including increased cleaning requirements.
- Cleaning of body fluid spills.
- Instruct cleaning and other relevant staff about correct cleaning procedures and the importance of handwashing.

8. Linen

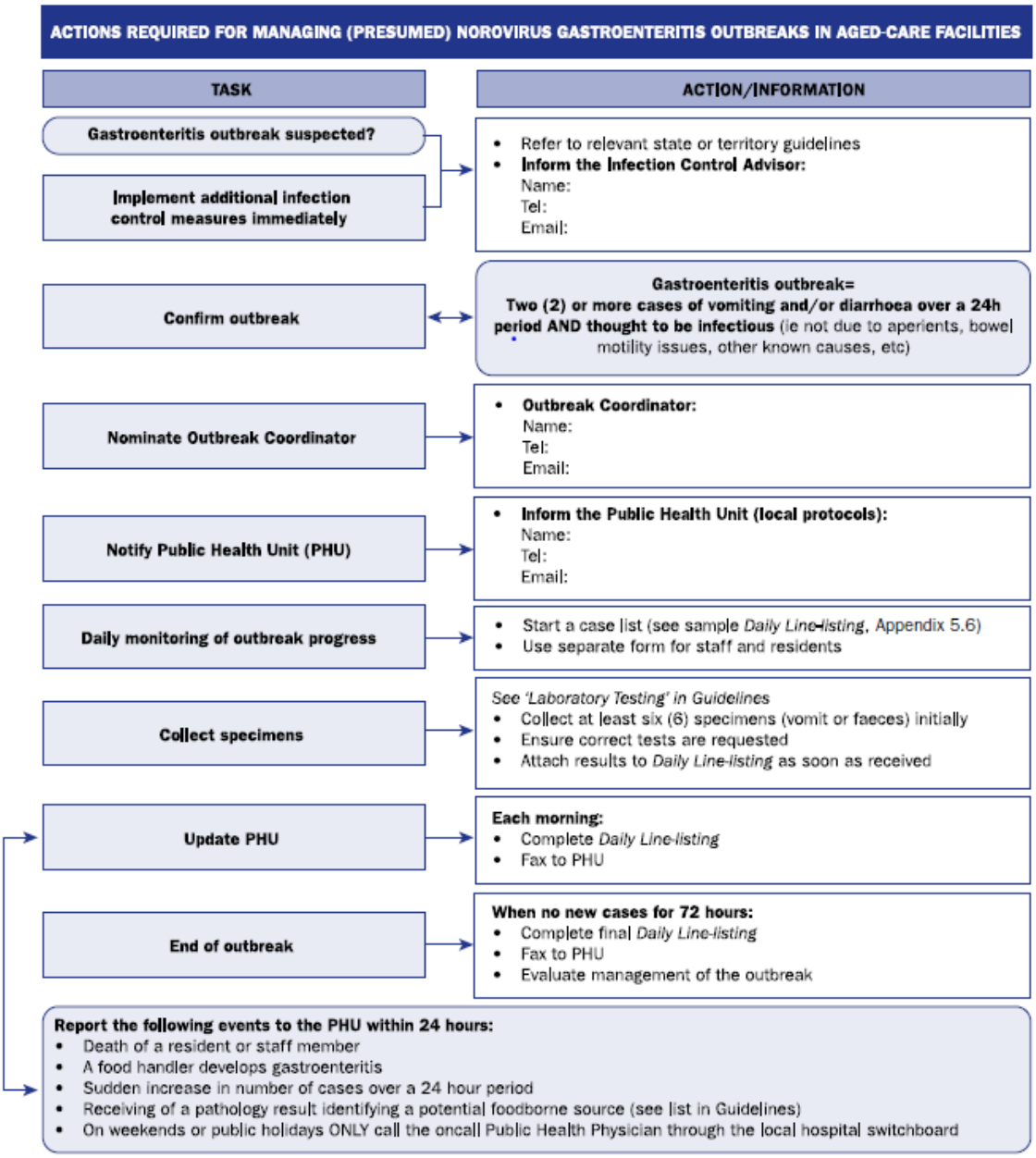
- Instruct staff about precautions required when handling soiled linen.

9. Transfers

- Restrict admissions of new consumers until outbreak is over.

We use the following flowchart to guide our practice in the event of a suspected viral gastroenteritis outbreak.

Figure 4: Flow chart to guide aged-care facilities actions for managing (presumed) norovirus gastroenteritis outbreaks



Influenza

In the event of a suspected influenza outbreak we use the Communicable Diseases Network Australia 2017 Guidelines for the prevention, control and public health management of influenza outbreaks in residential care facilities in Australia and complete the following:

- Notify – ALL staff, consumers, PHU, GPs, visitors (and others).
- Implement infection control measures.
- Arrange testing of consumers with influenza like illness
- Collate information onto a line list.
- Confirm and declare an influenza outbreak.
- Continue infection control during the outbreak.

- Vaccinate during an outbreak, as needed.
- Use antiviral medication during an outbreak, as advised.

The abovementioned resource has full guidance to ensure appropriate management of an influenza outbreak and this is consistently followed.

Staff and volunteer vaccination

Staff/volunteer vaccination (unless contraindicated) is an important element of supporting infection prevention and control principles. CHNC pay for the vaccination for staff for:

- Influenza (Each year we encourage and support staff to receive their vaccination if not contraindicated.)
- Hepatitis B (if the staff person is health care worker who may have contact with blood or body fluids as part of their role).

Staff access their GP for the vaccinations and CHNC reimburses them. Volunteers are not reimbursed for vaccinations but are made aware of the importance of vaccination and are supported to access vaccinations if requested. We aim for 95% vaccination rate for staff and volunteers.

Hepatitis B vaccination program

A primary vaccination course for Hepatitis B vaccination is advised for health care workers and is available to those workers with regular exposure to blood and body fluids.

- 0 month 1st vaccination
- 1 month 2nd vaccination
- 6 months 3rd vaccination
- 8-10 months blood test to determine immunity
- 5 years booster vaccination

Those people who fail to seroconvert after a primary vaccination course will be tested for Hepatitis B Surface Antigen to exclude carrier state. A fourth (4th) dose will then be given followed by a booster dose at 5 years.

Recording and Reporting of Staff/Volunteer vaccinations[46]

Staff/volunteers are asked to advise us of their vaccinations and this is recorded in their personnel file.

We report annually (by the end of February) through the My Aged Care provider portal, on the number of aged care staff who reported that they received an influenza vaccination.

Consumer and significant other influenza vaccination

Vaccination is the most effective tool for preventing influenza.

Each year we highlight the importance of influenza vaccination in our newsletter and support consumers to access their GP to discuss vaccination and receive their vaccination if not contraindicated.

Sharps injury and body fluid exposure

If staff are exposed to a sharp's injury or body fluid exposure, they:

- Seek/apply first aid (wash the skin well with soap and water, flush eyes with water/normal saline, spit and then rinse mouth out several times if fluids splashed into the mouth)
- Report the incident to their supervisor
- Complete an Incident Form

[46] Other than Covid-19, see COVID-19 vaccination policy below.

- Are supported by their supervisor to access appropriate health care including accessing medical attention and support as necessary.

COVID-19 responses

Infection prevention and control

The above procedures on infection prevention and control are based on the Australian Government National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019.

In managing the COVID-19 pandemic, CHNC continues to implement these policies and procedures and follows any additional advice and guidelines advised by the Australian Government and the State Government.

We have implemented the following:

Management

- Advised management, consumers and consumer representatives that grief and trauma support services are available free of charge through the Aged Care COVID-19 Grief and Bereavement Service operated by the Australian Centre for Grief and Bereavement. Resources include written resources, bereavement counselling, support groups, webinars, and online courses.[47] Where necessary we also support people to access these resources.
- Revised and updated our Risk Management Plan and Business Continuity Plan – these are reviewed and updated as necessary at each Working Group meeting

Staff support

- Provided relevant information to staff from the advice and information provided by the Australian or State Government
- Ensured adequate Personal Protective Equipment (PPE)is available for staff at the point of care including hand sanitiser, masks (discarded 15 minutes after application), gloves, gowns, goggles or face shield for clients identified or suspected of COVID-19 infection
- Supported all staff to access the influenza vaccine and keep records of all staff immunisation
- Provided hand washing facilities and alcohol-based rub at the entrance to our centre for the use of all visitors and staff
- Provided hand sanitizer for all community care workers and encouraged the use of home handwashing facilities (with consumers requested to provide a clean towel or paper towels for the use of each individual staff person visiting the home)
- Provided staff with Australian Government COVID-19 training videos and other relevant information
- Reiterated (verbally, signage, emails, newsletters) social distancing requirements for staff and consumers (1.5m from others) where practicable (i.e. when staff not providing direct and personal care).

Consumer support

- Developed a generic COVID-19 support plan for each consumer that includes Australian Government advice including:
    - promoting regular handwashing/sanitizing
    - social distancing
    - stay at home advice
    - covering coughs and sneezes
    - advising our office if the consumer (or people living in the home) has cold or flu symptoms, including fever.
- Support and encourage consumers to complete their Advance Health Directive

47 Australian Government Department of Health and Aged Care COVID-19 aged care grief and trauma support services Website accessed January 2023

- Ensure consumers and/or their representatives are aware that if they need support, they can contact the Older Person's Advocacy Network on 1800 700 600[48] or the Aged Care COVID-19 Grief and Bereavement Service
- Reiterated (verbally, signage, emails, newsletters) social distancing requirements for staff and consumers (1.5m from others) where practicable (i.e. when staff not providing direct and personal care).

COVID-19 vaccination policy[49]

All staff are strongly encouraged to stay up to date with their COVID-19 vaccination to assist in protection against both infection and severe disease for themselves and the people they care for.

In addition, staff must advise us of their vaccination status as we are required to keep records and report[50] on the number of workers who have received a COVID-19 vaccination, including booster doses. Second booster doses are voluntary, and staff are not required to report this dose. (See Vaccination Reporting below.)

Aged care workers can call the dedicated COVID-19 Helpline on 1800 020 080 (select option 4) for any questions about vaccination and for assistance on how to book an appointment.

We also monitor and follow any requirements specified at a State/Territory level.

Vaccination Reporting[51]

We advise the Commonwealth Department of Health of the COVID-19 vaccination status of the CHSP and HCP aged care workforce.

The reporting process requires all staff to advise the Aged Care Programs Coorindator of their vaccination status and of any change to that status from receiving a vaccination.

[48] Australian Government Department of Health and Aged Care Protecting Older Australians (Newsletter) - 16 February 2022 Website accessed January 2023

[49] Australian Government Department of Health and Aged Care Information for aged care providers, workers and residents about COVID-19 vaccines Last Updated 28 October 2022 Accessed January 2023

[50] Reporting requirements on workforce COVID-19 vaccination status are in place for residential, in-home and community aged care providers. See Australian Government Department of Health and Aged Care Mandatory COVID-19 vaccination reporting Accessed January 2023

[51] Australian Government Department of Health and Aged Care Mandatory COVID-19 vaccination reporting Accessed January 2023