FULL CARE LIFETIME

NDIS POLICIES AND PROCEDURES MANUAL

MODULE ONE

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COMPLEX BOWEL CARE POLICY AND PROCEDURE

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including complex bowel care. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

Background

For the purposes of this document, bowel care refers to the care and management of the process of the elimination of faecal matter from the body. Bowel care can encompass personal hygiene, assistance with toileting, medications to promote bowel function, and the administration of same.

Historically, bowel care was provided in a hospital or facility setting or by a community nurse. This was due to lack of guidelines or legislation regarding support workers safe practice in community service delivery. However, risk analysis by government departments and changes in the way community services are delivered has identified the skills and competencies required for this task. This has led to significant shifts in practice. It is now acceptable for support workers with appropriate competency training and assessment to provide bowel care.

As participant involvement and service direction has increased it is imperative to involve the participant in all aspects of the service delivery and the direction of their services to their ability. It is further acknowledged that dignity of risk is an important part of this choice and control.

POLICY

All complex bowel care support will be delivered by appropriately trained staff and in line with a Complex Care Plan that is developed with the relevant health practitioner and the participant and/or family.

Full Care Lifetime ensures that all participants requiring complex bowel care receive the best quality support relevant to their individual needs.

PROCEDURES

- Our service delivery model is based on person centred approaches. As such all participants and or their family/carer are involved in the assessment and development of the plan for their complex bowel care management.
- If a participant requires complex bowel care a Complex Care Plan will be developed in partnership with a nominated health practitioner specifically for the participants needs. This care plan will be developed in partnership with the participant, their family/carer and any relevant health professional (with the consent of the participant/family). The plans include nature and frequency of the procedure, who will deliver it, timeframes for review by a health professional, any potential or actual risks involved and how incidents and emergencies are managed and actions/procedures to refer any situation that requires further expertise to the appropriate agency or health professional.
- Wherever possible it is the preference of Full Care Lifetime to have any form of complex care delivered by qualified nursing staff. Where this is not possible, or not the preference of the participant/family, we will ensure that the preferred support worker(s) is provided with the appropriate training from a qualified and experienced health professional. This training will encompass the specific needs of each participant's, the type of complex bowel care required and will comply with the NDIS High Intensity Support Skills Descriptor for providing complex bowel care.
- All staff required to deliver complex bowel care will have a training plan devised to ensure they can competently deliver the type and nature of bowel care required and that they have a good understanding of the basic anatomy of the digestive system, the importance of regular bowel care and an understanding of stool characteristics indicating healthy bowel functioning and related signs and symptoms. As well as a basic understanding of related conditions including autonomic dysreflexia; symptoms/indications of need for intervention and when to refer to health practitioner e.g., overflow, impaction, perforation; infection, understanding of intervention options and techniques including administering enemas and suppositories, digital stimulation, massage etc. and related guidelines and procedures, nutrition and hydration requirements.
- All training and training plans will be delivered and devised by and in partnership with a qualified health practitioner.
- All Complex Bowel Care must be done in accordance with the Full Care Lifetime Waste Management and Infection control Policy and Procedures.
- As a part of the community service or support delivered by Community Support Professionals, Full Care Lifetime will:
    - Assess the initial care needs with the participant

  - Determine the areas of bowel care that the Community Support Professional may attend
  - Develop plans with identified outcomes
  - Provide written procedures on the provision of bowel care by the Community Support Professional - this may be included as part of the plan.
  - Policies and procedures for bowel care should be clearly documented in the home and only changed by the participant's doctor or a registered nurse
  - Identify education needs for Community Support Professionals. Provide relevant competency-based training and assessment processes for the Community Support Professional/s to ensure they are competent to perform the prescribed duties, tasks and interventions.
  - Monitor, review, evaluate and adapt as required the service, plans and outcomes with the involvement of the participant
- It is recommended wherever possible, that initial bowel care training should be provided by the discharging hospital or specialist registered nurse.

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

DEFINITIONS

Term	Definition
Constipation and poor bowel emptying	It is described as difficulty or pain when passing faeces or passing faeces infrequently.
Diarrhoea	loose watery faeces and is usually frequent.
Faecal Incontinence	uncontrolled passing of faeces and creates social or hygiene problems for the person.

PRINCIPLES OF COMPLEX BOWEL CARE

- To follow personal hygiene and infection control procedures.
- To maintain dignity, respect and consent throughout all activities in complex bowel care management
- To observe and record changes to bowel habits and report issues arising from the delivery of bowel care.

- To administer laxatives, enemas or suppositories including non-routine medication as required according to procedure
- To identify when to seek health practitioner advice.

ROLES AND RESPONSIBILITIES

Full Care Lifetime's Registered nurse is responsible for the overall clinical management and medication management of the high intensity support activities for participant's care. This policy is to be used in conjunction with Full Care Lifetime's Management of Medication Policy (where required).

Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. A participant's Complex Bowel Care Plan is overseen by Registered nurse and health practitioners (e.g., Medical doctor, Bowel care specialist, Registered Nurse). This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate and Registered nurse.

Please Note: Any changes to a Complex Bowel Care Plan regarding medication management will be conducted by Registered nurse and health practitioners (e.g., Medical doctor, Bowel care specialist, Registered Nurse).

Nursing (Registered Nurse)

- Completes a bladder and bowel assessment within 7 days of commencement of service, quarterly (13 weeks) and any change in condition that affects continence
- Initiates and communicates a plan of care to address the participant's bladder and bowel issues
- Makes referral to other interdisciplinary team members
- Provides education to family/participant/carer about bladder and bowel management
- Evaluates the plan of care and updates as necessary
- Assesses Community Support Professional's skills and encourages staff development, e.g., transfer skills
- Review bladder and bowel record and addresses constipation with interdisciplinary team
- Responds to Community Support Professional's assessment, re: bladder and bowel management concerns.

Community Support Professionals

- Offers privacy and develops rapport with participant when toileting/changing.
- Encourages fluid and nutritional intake, e.g., 1500 ml of fluid daily.
- Follows procedure and care plan to promote continence.
- Assists participant when transferring, ambulating or walking to the toilet.
- Maximizes mobility and passive exercises

- Toilets the participant as per care plan
- Completes the voiding and bowel record and reports concerns or changes to the Coordinator
- Recognizes and reports participant verbalisations and behaviours indicative of discomfort
- Reports any signs and symptoms of bladder and bowel discomfort to the Coordinator.

SUPPORT PLAN

Plan means a Care Plan or Individual Plan (however titled – the plan) and is a document developed in response to a request for service. It is developed by a registered nurse (or other appropriately, similarly skilled professional) from the Full Care Lifetime, prior to the commencement of service delivery. It outlines the expected outcomes of the requested care/services and the tasks, duties and interventions required to meet the care and service needs of the participant (within the parameters of the funding program). The plan guides and directs the individual support worker in their day-to-day delivery of the services.

Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate and Registered nurse and health practitioners (e.g., Medical doctor, Registered Nurse). Included in the plan is:

- Information on normal stool appearance for the individual participant.
- how to identify symptoms that require action.
- the timing of interventions (how long before action is taken) and the action required.
- detailed instructions on medication selection and administration procedures.
- emergency management options and procedures.

Registered nurse will confirm consent prior to complex bowel care and the administration of medications; according to the Complex Bowel Care Plan received from the participant/carer/advocate. The participant's bowel care will have regular reviews by Registered nurse and a qualified health practitioner (e.g., Medical doctor, Registered Nurse). The support plan will identify how to exercise judgement in complex bowel care, when to administer medication. It will also include how to manage risks, incidents and emergencies including required actions and escalation to ensure participant wellbeing and safety.

A participant's Complex Bowel Care Plan will be reviewed weekly to ensure there are updated strategies in place for acting upon information from the participant/carer/advocate, Registered nurse and health professionals.

Registered nurse is to follow documentation procedures which include:

- Monitoring and recording changes in bowel habits
- Administration of laxatives, enemas or suppositories according to procedure
- Administration of non-routine medication as required
- Emergency management procedures

- Recording any changes requested by a health practitioner (e.g., Medical Doctor, Registered Nurse)
- Documentation and communication to <director> and participant/carer/advocate when there is a request for a change in Bowel Care.

Any of the following signs require immediate referral to the GP or local hospital:

- vomiting blood or faecal matter
- diarrhoea and/or vomiting that is more than a one-off event
- bleeding from the bowel
- fresh (red) or old (black) blood in faeces
- unusual pain before, during or after a bowel action.

*NOTE: Black faeces occur when a person is taking iron supplements.

STAFF TRAINING

Community Support Professionals/ support workers may:

- Perform any task on the plan apart from those that must be performed by a registered nurse

Community Support Professionals/support workers must:

- Complete competency training and assessment in the task prior to undertaking said task. Skills-based competency shall be reassessed annually by Full Care Lifetime
- Follow the plan as provided by Full Care Lifetime
- Report to their supervisor/coordinator any changes or variations for advice
- Not change any plan
- Report any issues arising from the delivery of bowel care (such as: bowels not open, bleeding, constipation, diarrhoea) to their Full Care Lifetime coordinator for further advice
- Identify and report to their supervisor any gaps in their ability to deliver the required service

Full Care Lifetime Registered nurse will have received training (according to their training plan), relating specifically to each participant's needs and their Complex Bowel Care Plan. This training will also include the following:

- basic anatomy of the digestive system.
- the importance of regular bowel care and understanding of stool characteristics indicating healthy bowel functioning with related signs and symptoms.
- when to refer to health practitioner e.g., overflow, impaction, perforation, infection, blockage
- understanding of intervention options and techniques
- administering enemas and suppositories, digital stimulation, massage
- nutrition and hydration requirements.

- Alteration in bowel habits that can result from decreased mobility, altered nutrition, medications and decreased fluid intake.
- Safe work practices to prevent and control infection and PPE
- Troubleshooting common contingencies
- Waste management
- Documentation

Upon successful completion of this training, a Statement of Attainment is required to be sighted and a copy retained by Full Care Lifetime. In addition, it is recommended that the Community Support Professional be assessed in the workplace within one month of the completion of this course, by a suitably experienced registered nurse or healthcare professionals.

Full Care Lifetime training system complies with the high intensity support activities skills descriptor for providing complex bowel care including how to follow procedures and exercise judgement on when to respond/report problems such as blockages, signs of deteriorating health or infection. Full Care Lifetime has policies and procedures in place which identify, plan, facilitate, record and evaluate the effectiveness of training for their frontline staff. This system facilitates training which is mandatory in relation to staff obligations under the NDIS Practice Standards and NDIS rules.

Authority by a Medical Practitioner

If the participant needs a bowel care plan, the general practitioner (GP) develops one with the person, their families and/or their carer. Before leaving the surgery, the person and carer should be certain that they understand how to implement the bowel management plan.

It is important to confirm with the GP what should happen following implementation of the bowel management plan, and how long it should take for the problem to be resolved.

Prior to the decision to allow a community support professional to administer an invasive bowel care procedure, the Full Care Lifetime should consider and ensure:

1. That the treating doctor who prescribed the bowel care medication/management program to the participant has agreed in writing to support the arrangement of a trained and supervised community support professional administering same to the participant
2. The procedure and doctor’s approval are retained in the home of the participant with a copy retained by Full Care Lifetime
3. They (the medical practitioner) recognise consumer directed care and dignity of risk
4. A registered nurse provides support and supervision of the participants’ program and bowel care administration

Doctor’s order for bowel care to be administered by community support professionals as per the Full Care Lifetime Bowel Care Guidelines and to be in place prior commencing any care for the participant.

Authority is only to be sought for adult participants of Full Care Lifetime.

*Community Support Professionals are not permitted to administer invasive bowel care procedures on paediatric participants.

PPE required for Bowel care

- Disposable gloves (powder free)
- Disposable apron
- Lubricant (water based)
- Gauze swabs
- Incontinence pad or kylie
- Commode
- Bag for waste
- Medications

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

ENTERNAL FEEDING & MANAGEMENT POLICY AND PROCEDURE

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including enteral feeding and nutrition management. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

DEFINITIONS

Term	Definition

Enteral feeding	is a method of supplying nutrients directly into the gastrointestinal tract Enteral feeding describes Orogastric, Nasogastric and Gastrostomy tube feeding. The reasons for this to occur can be due to a participant: • Who is unable to consume adequate nutrients. • Has impaired swallowing. • Facial or oesophageal structural abnormalities. • Eating disorders. • Congenital anomalies.
Enteral feeding tubes can be used to	• Administer bolus, intermittent feeds and continuous feeds. • Medication administration. • Drainage and aspiration of the stomach contents. • Feeds can be administered with a syringe, via gravity or a pump.
Orogastric Tube	a thin, soft tube passed through the participant's mouth to the oesophagus and into the stomach.
Nasogastric Tube	is thin, soft tube passed through the participant's nose, down the back of the throat, through the oesophagus and into the stomach.
Gastrostomy Tube	a feeding tube which is inserted through the abdominal wall and directly into the stomach
Percutaneous Endoscopic Gastrostomy tube	a gastrostomy tube which is held in place with an internal fixator.
Gastrostomy-Button	a skin level button gastrostomy tube inserted into a pre-formed stoma.

Background

Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a participant's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate (for example, because of dysphagia or sedation).

PEGs can become encrusted with feed or medications and colonised with bacteria or yeasts if not flushed regularly. This can result in damage to the tube, and the need for premature replacement. Even when the PEG is not currently being used for feeds it should be flushed with water at least once per day.

Taking care of the PEG site is important to reduce the risk of skin breakdown and infection – the site is really a type of wound, and as such it is normal for the skin to be slightly red around the edge of the hole. Other than this slight redness, within a few days after insertion a healthy PEG site should look like normal skin, without excessive irritation, pus or blood.

The PEG site should be washed daily as part of normal hygiene using warm soapy water, and then rinsed and dried thoroughly. The external flange will need to be lifted to clean around the tube. The PEG site should not be covered with a dressing or ointments, as this can cause dampness, skin damage and infection.

Enteral feeding can be given in 3 different ways:

1. via a pump - used for continuous or intermittent feeds where the formula is given without stopping over 8-24 hours.
2. via gravity drip - used to give larger amounts of formula over a shorter period of time usually 4 to 6 times each day.
3. via a syringe – this is the fastest method where larger amounts of formula are given at a time. Feeding using a syringe or gravity drip can also be called bolus feeding.

PRINCIPLES OF ENTERAL FEEDING AND MANAGEMENT

- To follow personal hygiene and infection control procedures.
- To confirm the need and consent for enteral feeding,
- To introduce food via a tube according to the support plan.
- To monitor the rate and flow of feeding and take appropriate action to adjust if required.
- To keep the stoma area clean and monitor and report signs of infection.
- To check that the tube is correctly positioned, and monitoring equipment is in operation.
- To follow procedures to respond to malfunction
- To document a request to review mealtime plan where required.
- To liaise with health practitioners to explain/demonstrate requirements
- To recognise and respond to symptoms that could require health intervention

POLICY

All enteral feeding and nutrition management support will be delivered by appropriately trained staff and in line with a Complex Care Plan that is developed with the relevant health practitioner and the participant and/or family.

This policy has been developed to ensure that all participants at Full Care Lifetime requiring enteral feeding and nutrition management receive the best quality support relevant to their individual needs.

This policy will also guide the actions of our staff by providing a framework for competency and action to promote the delivery of best practice supports in this area.

PROCEDURES

- Our service delivery model is based on person centred approaches. As such all participants and or their family/carer are involved in the assessment and development of the plan for enteral feeding and nutrition management.

- If a participant requires enteral feeding and nutrition management a Complex Care Plan will be developed in partnership with a nominated health practitioner specifically for the participants needs.
- This care plan will be developed in partnership with the participant, their family/carer and any relevant health professional (with the consent of the participant/family). The plans include nature and frequency of the procedure, who will deliver it, timeframes for review by a health professional, any potential or actual risks involved and how incidents and emergencies are managed and actions/procedures to refer any situation that requires further expertise to the appropriate agency or health professional.
- Wherever possible it is the preference of Full Care Lifetime to have any form of complex care delivered by qualified nursing staff. Where this is not possible, or not the preference of the participant/family, we will ensure that the preferred support worker(s) is provided with the appropriate training from a qualified and experienced health professional. This training will encompass the specific needs of each participant's, the type of enteral feeding and nutrition management required and will comply with the NDIS High Intensity Support Skills Descriptor for providing enteral feeding and nutrition management.
- All staff required to deliver enteral feeding and nutrition management will have a training plan devised to ensure they can competently deliver the type and nature of enteral feeding and nutrition required including an ability to:
- confirm need and consent for enteral feeding,
- introduce food via tube according to plan.
- monitor rate and flow of feeding and take appropriate action to adjust if required, keep stoma area clean and monitor and report signs of infection.
- check that the tube is correctly positioned, monitor equipment operation.
- follow procedures to respond to malfunction e.g., blockages, follow procedures to document a request to review mealtime plan where required.
- liaise with health practitioners to explain/demonstrate requirements (e.g., hospital staff),
- recognise and respond to symptoms that could require health intervention e.g., reflux, unexpected weight gain or loss, dehydration, allergic reaction, poor chest health.
- Understand basic anatomy of the digestive system.
- equipment components, function, cleaning and maintenance procedures.
- stoma care requirements and procedures, awareness of risks associated with departing from plan and ability to explain these risks to others including carers,
- the impact of associated health conditions and complications that interact with enteral feeding e.g., related cardiac or respiratory disorders, very complex physical disability, severe epilepsy, symptoms that indicate the need for intervention e.g., poor chest health, dehydration, reflux, factors that may require immediate adjustment e.g., rate, flow and quantity of food. When working with people who have very complex physical disability, workers will also be trained in positioning and turning to maintain airway safety and avoid choking risk and in pressure care.

All training and training plans will be delivered and devised by and in partnership with a qualified health practitioner.

All enteral feeding and nutrition management must be done in accordance with the Full Care Lifetime Waste Management and Infection control policy and procedures.

As part of the development of a Complex Care Plan contingencies and actions will be documented by the attendant health professional to manage any emergency or actions that require escalation. If staff are ever in doubt about the health and wellbeing of a participant, they must contact the attendant health professional and/or the Ambulance service immediately.

Processes for using enteral feeding tubes

Summary of processes for using enteral feeding tubes	
Preparation	• Perform hand hygiene before starting feed preparation • Wherever possible, use pre-packaged, ready-to-use feeds • Decanting, reconstitution and diluting is NOT recommended. • If decanting, reconstitution or dilution is required, use a clean working area and equipment dedicated for enteral feed use • Mix feeds with cooled boiled water or freshly opened sterilised water using an aseptic non-touch technique
Administration	• Perform hand hygiene immediately before administration • Use minimal handling and aseptic non-touch technique to connect the administration system to the enteral feeding tube • For nursing staff only: Use aseptic non-touch technique for the administration of medications • Discard administration sets and feed containers appropriately and as per the care plan
Care of insertion site and enteral feeding tube	• Perform hand hygiene immediately before commencing • Wash the stoma daily with water and dry thoroughly • Flush the enteral feeding tube with fresh tap water before and after feeding or administering medications (use cooled boiled water or sterilised water for people who are immunosuppressed)

1. Medication Administration via an Enteral tube

Only nursing staff who are trained in the administration of medication may deliver medications via an enteral tube, including a PEG or nasogastric tube.

If the feeding tube dislodges:

Community support professionals are not to remove or replace any type of enteral feeding tube.

Should a nasogastric or PEG tube fall out, contact your supervising registered nurse or immediate supervisor to advise of the situation. In younger participants, their parent will be familiar with

replacing the tubing. In other circumstances, do not panic – a nasogastric tube can be replaced by the participant's doctor. A PEG tube is also readily replaced – cover the stoma with a piece of gauze secured with Micropore tape (if available) and arrange for the participant to see their local doctor or the emergency room for replacement of their feeding tube

2. Formula Storage

Formula should be stored following the steps below:

- Store unopened tin/bottle/cartons of formula in a dry, cool place
- Keep unused, opened formula in the fridge
- Throw away any formula not used in 24 hours
- Do not heat the formula

3. Feeding position

Participant positioning during a feed is vital to the assistance of digestion throughout the procedure and reduces risks associated with enteral feeding. Always, where possible, assist the participant into a sitting position. They should never be lying flat whilst having a feed. If the participant is unable to sit in a chair with their head must be raised to at least a 30-degree angle or on three pillows to maintain elevation whilst they are having their feed. This position should be maintained for 30-60 minutes after their meal to further assist in the digestive process and reduce feeding risks.

4. Medication administration

Following the participant's support plan and Full Care Lifetime Management of Medication Policy take the following steps to administer medication via an Enteral tube. Medications should be in a liquid form, if possible, if not, tablets should be crushed and mixed with water to make a soup-like mixture. Do not mix medicine with the feeding formula and do not mix medicines together. Each one should be given separately. Flush the feeding tube before and after each medication. Some medications should not be given while the feeds are running as they can react with the feed, this will be specified in the participant support plan.

5. Oral Care

Oral care is very important to participants who have enteral tubes for feeding. Some eating through their mouth and some are not, it is still important to maintain a healthy oral environment. The following points are suggestions for maintaining good oral hygiene.

- Brush their teeth at least twice daily with toothpaste and a soft brush.
- If tolerated, ice chips or sugarless gum can be used to prevent a dry mouth.
- Use a lip cream to prevent dry lips. And encourage participant to breathe through their nose.
- Report any bleeding or mouth problems to the Registered nurse.

6. An Enteral tube may become blocked for the following reasons:

- medications have not been crushed sufficiently before giving through the feeding tube.
- An insufficient flush that is <40mL of water before, between and after giving medications.

Constipation means bowel movements that are hard, or difficult to pass. Possible causes of constipation are, not enough fluid, not enough fibre in the formula, not enough exercise and some medications.

The Enteral tube is coming out. If this happens the Support worker must not reuse this tube. They must follow the procedures in the participant support plan and contact the Registered nurse and appropriate health practitioner or Registered Nurse. The support worker may need to organise the participant to go to the emergency department of the nearest hospital. **(call 000 if unsure, do not move the participant in the case that there is no guideline in the support plan)**

In all these cases everything should be documented and further communicated to the Registered nurse and appropriate health professionals who will be contacted to adjust the care and treatment of the participant and their support plan.

7. Roles and Responsibilities

Full Care Lifetime's Registered nurse is responsible for the overall clinical management and medication management of a high intensity supported participant's care. This policy is to be used in conjunction with Full Care Lifetime's Medication Policy (where required). The participant's support plan and mealtime preparation and delivery plan are also included and overseen by a relevant health practitioner (e.g., Dietician, Speech Therapist, Occupational Therapist). This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate. Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. Full Care Lifetime will ensure that each participant requiring enteral feeding and management will receive nutrition, fluids and medications, relevant and proportionate to the individual needs.

Please Note: The replacement of Nasogastric tubes is high risk and will be only done by Registered nurse or a qualified health practitioner. In some cases, support workers Registered nurses may respond when PEG tubes become dislodged. This is only appropriate when the balloon device tube is in position and stable (after the initial tube has been replaced by balloon device), and there is active oversight by a health practitioner.

Registered Nurses **may:**

- Replace a PEG tube
- Supervise and guide the community support professional in the provision of nutritional or enteral stoma care
- Only work within the scope of their practice and prior experience

Community Support Professionals **may**:

- Perform any task on the care plan apart from those that must be performed by a registered nurse as nominated above
    - Assist with the administration of enteral feeds and flushes once assessed as being competent in this skill
    - Clean stoma site
    - Observe and report if stoma site red, painful or swollen
    - Observe and report if tubing becomes dislodged

Community Support Professionals **must**:

- Follow the care plan as provided by Full Care Lifetime
- Report to their supervisor/coordinator any changes or variations for advice
- Not change any care or feeding plan
- Take part in training on use of equipment, manual handling and risk management as determined by Full Care Lifetime
- Report any issues arising from the delivery of care to their Full Care Lifetime coordinator for further advice
- Identify and report to their supervisor any gaps in their ability to deliver the required service.

8. Support plan

Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate, Registered nurse and health practitioners (e.g., dietician, speech therapist, occupational therapist). Included in the plan is the mealtime preparation and delivery of the Percutaneous Endoscopic Gastrostomy (PEG) feeding or Nasogastric (NG) feeding regime.

Frontline workers will confirm consent for the need for enteral feeding from the participant/carer/advocate. The participant's health status will have regular reviews by Registered nurse or a qualified health practitioner (e.g., Dietician, Speech Therapist, Occupational Therapist). The support plan will identify how risks, incidents and emergencies will be managed, including required actions and escalation to ensure participant safety and wellbeing.

A participant's mealtime preparation and delivery plan are to be reviewed weekly monthly to ensure there are strategies in place for acting upon information from the participant/carer/advocate, support worker and health professional (e.g., Dietician, Speech Therapist, Occupational Therapist).

Frontline staff are to follow documentation procedures this includes:

- Recording the length of time allocated for mealtime assistance, this will provide an indication of the intensity of support required for Full Care Lifetime.
- Document and monitor the rate and flow of feeding.
- Record the daily input and output, monitoring for dehydration.

- Document and communicate to Registered nurse a participant/carer/advocate request for a change of mealtime.
- Record any changes requested by a health practitioner (e.g., Dietician, Speech Therapist, Occupational Therapist).
- Record and communicate to Registered nurse any signs or symptoms of unexpected weight gain or weight loss.

9. Staff training

Full Care Lifetime's frontline staff providing support for enteral feeding and management have relevant additional qualifications and experience. Frontline staff are trained to be aware of the impact of associated health conditions and complications that interact with enteral feeding such as severe epilepsy, severe dysphagia, complex physical disability. Full Care Lifetime's frontline staff will have received training (according to their training plan), relating specifically to each participant's needs and their support plan / mealtime preparation and delivery plan. Frontline staff will be trained in behaviours of concern where a participant may frequently dislodge their feeding tubes becoming high risk participants and the associated risks. This training will also include the following:

- people who are unable to feed themselves.
- people with complex communication.
- basic anatomy of the digestive system.
- equipment components, function, cleaning and maintenance procedures.
- stoma care requirements and procedures.
- awareness of risks associated with departing from the plan
- communication techniques to explain risks to participant/carer/advocate and other support workers
- the impact of associated health conditions and complications that interact with enteral feeding e.g., related cardiac or respiratory disorders.
- very complex physical disability; severe epilepsy.
- symptoms that indicate the need for intervention e.g., poor chest health, dehydration, reflux.
- factors that may require immediate adjustment e.g., rate, flow and quantity of food.
- positioning and turning to maintain airway safety and avoid choking risk and in pressure care.
- Positioning the participant during and after the PEG feed
- Safe work practices to prevent and control infection and PPE
- Waste management
- Documentation

Observe, document and report

Should any of the following conditions or symptoms be observed by the community support professional, they are to document what has been observed, and report same to their supervising registered nurse or line manager, who should then arrange for a medical review:

- Skin breakdown or excoriation about the stoma site
- Signs of infection – redness, swelling, bleeding, discharge, odour
- Folliculitis (inflamed hair follicle)
- Tube placement is too tight or too loose
- Gastric fluid leaking from stoma site
- Tube or device displacement, discolouration or blockage
- Diarrhoea, constipation, nausea, vomiting
- The incorrect port (balloon port) is used to administer feed or medication

PPE required for PEG feed

- Disposable gloves (powder free)
- Feeding pump
- Feeding pump frame
- Tube feed
- Giving sets and accessories
- Spare feeding tubes
- Syringes
- Carriers packs
- Connecters
- Liquid formula
- Measuring cup

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

TRACHEOSTOMY POLICY AND PROCEDURE

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including tracheostomy management. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

Background

A tracheostomy is usually done for one of several reasons: to bypass an obstructed upper airway (an object obstructing the upper airway will prevent oxygen from the mouth to reach the lungs); to clean and remove secretions from the airway; to more easily, and usually more safely, deliver oxygen to the lungs. This procedure aims to implement best practice recommendations set by Full Care Lifetime's Clinical Practice Guideline in the use of Tracheostomy Tube inserted in a tracheal stoma in adult participants and provides further instruction on clinical practice management of adult participants on:

- Tracheostomy Emergency
- Changing a Tracheostomy tube
- Removal of a Tracheostomy tube
- Suction
- Oral Hygiene
- Decannulation
- Humidification

Term	Definition
Decannulation	Removal of a tracheostomy tub.
Endotracheal tube (ETT):	An artificial airway inserted into the trachea for the purpose of mechanical ventilation.
Passy Muir speaking valve (PMV)	Aqua speaking valve that can be used for both ventilator and non-ventilator dependent tracheostomy participants to facilitate speech in select participants who meet a specific criterion.
Tracheal Suctioning	A means of clearing the airway of secretions or mucus through the application of negative pressure via a suction catheter.
Tracheostomy	An artificial opening in the trachea, which may be permanent or temporary
Tracheostomy tube	A tube placed through a tracheostomy to provide an airway and to remove secretions from the lungs
Trachea	The anatomical structure used for breathing
Stoma	An opening, either natural or surgically created, which connects a portion of the body cavity to the outside environment

Cannula	A tube that can be inserted into the body, often for the delivery or removal of fluid or air
Suction	The use of devices to clear airways of materials that would impede breathing or cause infections
Aseptic non-touch technique	Prevents microorganisms on hands from being introduced into a susceptible site
Ventilator	A mechanical device utilised to deliver and support the participant's respiratory effort via an artificial airway.

Principles

- To follow personal hygiene and infection control procedures.
- To monitor skin condition and keep stoma area clean.
- To follow procedures (in support plan) to perform routine suctioning to maintain clear airways.
- To monitor report abnormal secretions.
- To clean and maintain suctioning equipment.
- To support routine tube tie changes (as outlined in plan and in support of an appropriate health practitioner).
- To maintain charts/records.
- To recognise and respond to signs that airways are obstructed.
- To implement emergency procedures deteriorating health or infection.

Policy

All tracheostomy management support will be delivered by appropriately trained staff and in line with a Complex Care Plan that is developed with the relevant health practitioner and the participant and/or family.

This policy has been developed to ensure that all participants at Full Care Lifetime requiring wound care management receive the best quality support relevant to their individual needs.

Procedures

- Our service delivery model is based on person centred approaches. As such all participants and or their family/carer are involved in the assessment and development of the plan for tracheostomy management.
- If a participant requires tracheostomy management a Complex Care Plan will be developed in partnership with a nominated health practitioner specifically for the participants needs.
- This care plan will be developed in partnership with the participant, their family/carer and any relevant health professional (with the consent of the participant/family). The plans include nature and frequency of the procedure, who will deliver it, timeframes for review by

a health professional, any potential or actual risks involved and how incidents and emergencies are managed and actions/procedures to refer any situation that requires further expertise to the appropriate agency or health professional.

- Wherever possible it is the preference of Full Care Lifetime to have any form of complex care delivered by qualified nursing staff. Where this is not possible, or not the preference of the participant/family, we will ensure that the preferred support worker(s) is provided with the appropriate training from a qualified and experienced health professional. This training will encompass the specific needs of each participant's, the type of enteral feeding and nutrition management required and will comply with the NDIS High Intensity Support Skills Descriptor for providing tracheostomy management.
- All staff required to deliver tracheostomy management will have a training plan devised to ensure they can competently deliver the type and nature of tracheostomy management including: basic anatomical knowledge of the eliminatory system, skin and stoma care, equipment types, components and functions, this includes speaking valves, common risks and indicators of malfunction; indications of need for suctioning, monitoring and recording requirements, common complications and action required e.g. when to inflate and deflate cuffs, and understanding when to involve a health practitioner, signs of infection, both in respiratory system and the stoma site.
- All training and training plans will be delivered and devised by and in partnership with a qualified health practitioner.
- All tracheostomy management must be done in accordance with the Full Care Lifetime Waste Management and Infection Control Policy and procedures.
- As part of the development of a Complex Care Plan contingencies and actions will be documented by the attendant health professional to manage any emergency or actions that require escalation. If staff are ever in doubt about the health and wellbeing of a participant, they must contact the attendant health professional and/or the Ambulance service immediately.

1. Roles and Responsibilities

Full Care Lifetime's Registered nurse is responsible for the overall clinical management of a high intensity supported participant's care. This policy is to be used in conjunction with Full Care Lifetime's Ventilation Support Policy and Stoma Care Policy (where required). The participant's support plan is also included and overseen by a relevant health practitioner (e.g., Medical doctor, Registered Nurse). This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate. Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. Full Care Lifetime will ensure that each participant requiring Tracheostomy Care will receive support for care of their tracheostomy and ventilation where required, relevant and proportionate to the individual needs.

Please Note: That any cares required outside of what's written in this policy and procedure must be performed by a qualified health practitioner (e.g., Medical Doctor or Registered Nurse). In some cases, frontline workers may respond when a tracheostomy requires emergency procedures to be implemented; there must be active oversight by a health practitioner such as a Registered Nurse.

2. Support plan

Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate, Registered nurse and health practitioners (e.g., Registered Nurse). Included in the plan is how to care for the participant's tracheostomy and ventilation requirements.

Frontline workers will confirm consent for the need for any cares to be performed on the tracheostomy from the participant/carer/advocate. The participant's health status will have regular reviews by Registered nurse or a qualified health practitioner (e.g., Medical doctor, Registered Nurse). The support plan will identify how risks, incidents and emergencies will be managed, including required actions and escalation to ensure participant safety and wellbeing.

A participant's tracheostomy care plan is to be reviewed Monthly to ensure that there are strategies in place for acting upon information from the participant/carer/advocate, frontline worker and health professional Registered nurse. Support staff are to follow documentation procedures this includes:

Signs and symptoms

Below is a list of signs and symptoms that are required to be reported:

- Unexplained dyspnoea; difficult or laboured breathing
- Severe coughing.
- Bleeding around tracheostomy site.
- Haemoptysis; the coughing up of blood
- Changes in consistency and colour of secretions.
- Erythema or soreness around stoma: superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries.

Signs and symptoms for immediate intervention

- Pulsing of tracheostomy tube (danger of eroding into innominate artery).
- Inability to pass a suction catheter down tracheostomy tube (deflate cuff and have tracheostomy tube replaced).

Dressing changes

{Registered nurse} will maintain and record on the participant's care plan, the date of the last change of tracheostomy, stoma integrity, suction methods, communication methods.

Tracheostomy Plan and Clinical Communication

- participants with a long-term tracheostomy require an appropriate clinical management plan customised to the level of self-care provided and any additional assistance indicated

Staff training

Full Care Lifetime's will train their Registered nurse in tracheostomy care; they will also hold relevant and additional qualifications and experience. For example, the following qualifications: Provide cardiopulmonary resuscitation and/or Provide basic emergency life support and/or Provide first aid. Full Care Lifetime's Registered nurse will be competent in the high intensity support descriptor: support a person dependent on ventilation and can implement emergency procedures e.g., an obstructed airway or when to inflate and deflate cuffs. Full Care Lifetime's {Registered nurse} are trained to be aware of the impact of associated health conditions and complications that impact on participants who have a tracheostomy.

Registered nurse will have knowledge of basic anatomy of the respiratory system as well as:

- skin and stoma care.
- equipment types, components and functions, this includes speaking valves (PMV).
- common risks and indicators of malfunction.
- indications of need for suctioning.
- monitoring and recording requirements
- common complications and action required e.g., when to inflate and deflate cuffs, and understanding when to involve a health practitioner.
- signs of infection, both in the respiratory system and the stoma site.

Competency of Clinical Staff in Tracheostomy Management & Tracheostomy Emergencies

- All clinical staff providing direct care must be trained and assessed in this tracheostomy management procedure, including the clinical response to a tracheostomy emergency
- Participants with a tracheostomy must be cared for in an environment where staff are competent in the clinical management of tracheostomy and the clinical response to a tracheostomy emergency
- All clinical staff providing direct care must be familiar with this tracheostomy management procedure, including the clinical emergency response to airway emergencies
- All RNs, ENs, and support workers caring for a participant with a tracheostomy must be educated in tracheostomy management by a designated assessor (nurse educator, clinical nurse consultant or senior physiotherapist with the appropriate clinical expertise). Provision of education is required to include all facets of tracheostomy care, including airway emergencies within practice limitations
- Senior clinicians responding to participants that require airway and/or breathing assistance with an artificial airway must be provided with ongoing education and training to manage difficult airway situations and undertake 'difficult airway drills'

Transfer of Care and Clinical Handover

- Written communication and verbal bedside, clinical handover regarding potential risks, relevant respiratory history including baseline respiratory rate, work of breathing, chest sounds, tube patency, cough/swallow reflex, oxygenation and oxygen administered must also be handed over

- Specific information re management and nursing care required by the receiving staff is to be provided during the transfer of care. The handover process must include a visual check to ensure that the tracheostomy tube is patent, aligned and secure

Observation

- Vital signs, respiratory rate, respiratory pattern (including auscultation), oxygen saturations, heart rate, blood pressure and temperature level of consciousness, to be monitored in critical care areas at frequency dictated by clinical condition and on the wards at a frequency not less than every 6 hours. Consider continuous pulse oximetry for participants with a new tracheostomy and/or any respiratory compromise
- Participants who require continuous pulse oximetry should be cared for in a suitable clinical environment where staff can continually observe the participant
- Monitor sputum and record amount, colour and consistency on Tracheostomy Management and Observation chart.

Minimum Frequency Tracheostomy Checks and Care

(Document Assessment and Care Provided on Tracheostomy Management and Observation Chart)

1-2 Hourly	2- 4 Hourly	6 Hourly	Once per Shift	Daily
Assess adequacy of humidification	Inner cannula removes, check for secretion build up; clean and replace	Document: Airway - skin colour, air entry - bilateral at axilla, expired air felt from tracheostomy tube Breathing - bilateral chest movement, and depth of respirations	Check and restock Emergency bedside equipment	Trache tapes changed (more frequently if soiled)
Assess need for suction. Document amount, viscosity and colour of secretions	Normal saline nebulisers 4hourly/prn , (more frequently for participants with thick secretions)	Vital Signs: Respiratory rate Oxygen Saturation Heart rate BP Temperature	Cuff pressure measurement	Assess systemic hydration (fluid balance)
For adjustable flange tracheostomy tubes – observe and document the position of the flange to	Check Heat Moisture Exchanger (HME)		Clean stoma site	Change heat/moisture exchanger (HME) NB more frequently if soiled

the tube at the skin following each suction to detect tube migration				
Assess position and alignment of the tracheostomy tube	Mouth care		Stoma site – Observe for bleeding in new stomas; note crusting, signs of infection, smell, discharge	

Signs of Respiratory Distress

- **Difficult, laboured or noisy breathing** - In complete tracheostomy tube occlusion, there are no breath sounds heard - however in partial obstruction air entry is diminished and often noisy.
- **Use of accessory muscles** - A sign of airway obstruction. In complete airway obstruction participants often develop a see-saw pattern of breathing in which inspiration is concurrent with outward movement of the abdomen and inward movement of the chest wall and vice-versa.
- **No or Limited expired air from the tracheostomy tube. Reduced chest movement or reduced air entry upon auscultation** - All indicate a lack of air movement into and out of the respiratory tract.
- **Pale/cyanosed skin colour** - Central cyanosis is a sign of late airway obstruction.
- **Anxiety / Agitation** - The participant will become anxious and agitated as they struggle to breathe and become hypoxic.
- **Increased pulse/respiratory rate** - Increased respiratory and pulse rate are signs of illness and an indicator that the participant may suddenly deteriorate.
- **Clammy / diaphoretic skin** - Associated with an increased work of breathing from an occluded airway and stimulation of the sympathetic nervous system causing vasoconstriction
- **Stridor** – Is caused by an obstruction above or at the level of the larynx

SIGNS OF RESPIRATORY DISTRESS	Potential Causes

Increased work of breathing i.e., participant acutely distressed/restless, tachypnoea, stridor, accessory muscles use, diaphoretic, cyanotic	Airway partially/completely obstructed due to blockage
Decreased/gurgling breath sounds	Tracheostomy dislodgement
High inspiratory airway pressures/low tidal volumes if mechanically ventilated	Persistent cuff leak
Oxygen desaturation	Faulty oxygen source or ventilation device
No breath sounds	Ineffective humidification
Unable to pass a suction catheter or inner cannula	Tracheostomy in false passage. Consider non-tracheostomy related causes for distress

Equipment required for Tracheostomy management

- One tracheostomy tube of the same size in-situ (with introducer if applicable)
- One tracheostomy tube one size smaller (with introducer if applicable)
- Spare inner tubes for double lumen trachea tubes (if applicable)
- Spare ties (cotton and/or Velcro)
- Scissors
- Resuscitation bag and mask (appropriate size for participant)
- One-way valve (community use only)
- Wall or portable suction equipment
- Appropriate size suction catheters
- 0.9% sodium chloride ampoule and 1ml syringe
- One Heat Moisture Exchanger filter (HME) or tracheostomy bib
- Fenestrated gauze dressing
- Cotton wool applicator sticks
- Water based lubricant for tube changes
- Mucous trap with suction catheter for emergency suction
- Occlusive tape (i.e., sleek)
- 10 ml syringe if cuffed tube in-situ

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

URINARY CATHETER MANAGEMENT POLICY AND PROCEDURE

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including urinary catheter management. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

Definitions

A catheter is a tube which is inserted into the body to remove fluid. There are three types of urinary catheter commonly encountered within the home care setting:

Term	Definition
Indwelling Catheter (IDC)	An **indwelling catheter** is inserted via the urethral opening of the penis or vulva and held in place via a small balloon which is inflated with water. Also known as an IDC, this type of catheter is changed every 4-12 weeks. A drainage bag is attached to the tube to collect the urine.
Suprapubic Catheter	A **suprapubic catheter**, or SPC, is inserted into the body and is situated below the belly button in the lower abdominal area. Urine drains from the bladder via a drainage bag of the same type used with an IDC. An SPC catheter is changed every 4-12 weeks.
Uridome	A **uridome** is in essence a condom-like device which attaches directly to the penis. It is attached each evening before bed and removed upon wakening each morning. It is attached to a drainage bag overnight to collect urine.
Intermittent Catheter	is the insertion and removal of a catheter several times a day to empty the bladder

Catheter Types

A urinary catheter is a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag. Urinary catheters come in many sizes and types. They can be made of rubber, plastic (PVC) or silicone. There are 3 types of urinary catheters:

- **Indwelling or Suprapubic**: a thin, flexible tube used to continuously drain urine from the bladder either via the urethra (indwelling) or via an insertion site in the lower abdomen above the pubic bone (suprapubic). It is kept in the bladder via a balloon inflated with a specified amount of sterile water.
- **Intermittent:** involves inserting and removing a catheter into the bladder via the urethra several times a day, emptying into a container (then emptied in the toilet), or directly into the toilet.

- **External:** A condom catheter is a catheter placed outside the body. It's typically necessary for men who don't have urinary retention problems but have serious functional or mental disabilities, such as dementia. A device that looks like a condom covers the penis head. A tube leads from the condom device to a drainage bag.

PRINCIPLES OF URINARY CATHETER MANAGEMENT

- To follow infection control procedures.
- replace and dispose of catheter bags.
- maintain charts/records.
- monitor catheter position.
- monitor skin condition around catheter.
- recognise and respond/report blockages, dislodged catheters, signs of deteriorating health or infection.

POLICY

All urinary catheter management support will be delivered by appropriately trained staff and in line with a Complex Care Plan that is developed with the relevant health practitioner and the participant and/or family.

This policy has been developed to ensure that all participants at Full Care Lifetime requiring urinary catheter management receive the best quality support relevant to their individual needs.

This policy will also guide the actions of our staff by providing a framework for competency and action to promote the delivery of best practice supports in this area.

PROCEDURES

- Our service delivery model is based on person centred approaches. As such all participants and or their family/carer are involved in the assessment and development of the plan for urinary catheter management.
- If a participant requires urinary catheter management a Complex Care Plan will be developed in partnership with a nominated health practitioner specifically for the participants needs.
- This care plan will be developed in partnership with the participant, their family/carer and any relevant health professional (with the consent of the participant/family). The plans include nature and frequency of the procedure, who will deliver it, timeframes for review by a health professional, any potential or actual risks involved and how incidents and emergencies are managed and actions/procedures to refer any situation that requires further expertise to the appropriate agency or health professional.
- Wherever possible it is the preference of Full Care Lifetime to have any form of complex care delivered by qualified nursing staff. Where this is not possible, or not the preference of the participant/family, we will ensure that the preferred support worker(s) is provided with the appropriate training from a qualified and experienced health professional. This training

will encompass the specific needs of each participant's, the type of enteral feeding and nutrition management required and will comply with the NDIS High Intensity Support Skills Descriptor for providing urinary catheter management.

- All staff required to deliver urinary catheter management will have a training plan devised to ensure they can competently deliver the type and nature of urinary catheter management including: Basic understanding of urinary system for males and females, hydration, types of catheters, procedures and challenges in inserting catheters in males and females (intermittent catheters only), common complications associated with using different types of catheters, indicators of complications that require intervention and understanding when to involve a health practitioner.
- All training and training plans will be delivered and devised by and in partnership with a qualified health practitioner.
- All urinary catheter management must be done in accordance with the Full Care Lifetime Waste Management and Infection control policy and procedures.
- As part of the development of a Complex Care Plan contingencies and actions will be documented by the attendant health professional to manage any emergency or actions that require escalation. If staff are ever in doubt about the health and wellbeing of a participant, they must contact the attendant health professional and/or the Ambulance service immediately.

As a part of the community service or support delivered by Full Care Lifetime each office delivering catheter care services will:

- Engage a registered nurse to assess the initial care needs with the participant, and
    - Determine the areas of catheter care that the Community Support Professional may attend within the scope of this Procedure.
    - Develop care or catheter management plans with identified outcomes
- Provide written procedures on the provision of catheter care by the Registered nurse - this may be included as part of the plan.
- Policies and procedures for care should be clearly documented
- Identify education needs for all direct care staff. Provide relevant competency-based training and assessment processes for staff to ensure they are competent to perform the prescribed duties, tasks and interventions.
- Monitor, review, evaluate and adapt as required the service, plans and outcomes with the involvement of the participant.

Registered nurses **may**:

- Attend to catheter care management, including the insertion or change of catheters
- Supervise and guide the community support professional in the provision of catheter care
- Only work within the scope of their practice and prior experience.

- With regard to catheter management, this specifically means that the registered nurse has extensive practical experience in inserting or changing a catheter in both male and female participants. Should a nurse employed by Full Care Lifetime not have experience in, for example, catheterising a man, the task is to be completed by another suitably experienced registered nurse or medical practitioner.

Community Support Professionals **may**:

- Perform any task on the care plan apart from those that must be performed by a registered nurse as nominated above
- Catheter care:
  - Empty the drainage bag
  - Change a drainage bag
  - Clean around the catheter entry site
  - Ensure no obvious kinks are in the catheter tubing
  - Attach the night bag into the day bag (afternoon staff)
  - Observe and report:

– If urine is not clear

– If urine has an unusual odour

- If participant seems to be agitated, anxious or confused

– If there is debris in the urine

– If urine output is reduced

– If the catheter entry site is red

Community Support Professionals **must**:

- Follow the care plan as provided by Full Care Lifetime
- Report to their supervisor/coordinator any changes or variations for advice
- Not change any care or catheter management plan
- Take part in training on use of equipment, manual handling and risk management as determined by Full Care Lifetime
- Report any issues arising from the delivery of personal care to their Full Care Lifetime coordinator for further advice
- Identify and report to their supervisor any gaps in their ability to deliver the required service.

Catheter care

- Ensure the catheter tubing is not tugged or pulled whilst providing assistance to the person for whom you are caring
- Ensure that the catheter tubing is secured to the participant's thigh with an appropriate catheter strap
- Perform strict hand hygiene when attending to catheter care, including emptying of the drainage bag
- Wash the catheter entry point daily, using downward strokes away from the entry area to avoid introducing microorganisms into the body
- Encourage an adequate fluid intake to promote a healthy urine output
- Empty the drainage bag regularly, never allowing it to overfill as backflow may occur, sending urine back towards the bladder. This can cause infection and pain.

SUPPORT PLAN

Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate and Registered nurse and health practitioners (e.g., Medical doctor). It will be reviewed regularly where procedures and information will be provided to the participant using a range of suitable communication methods (where applicable). Included in the plan is how to:

- maintain infection control procedures.
- specific type of catheter being managed (IDC, suprapubic, intermittent)
- replace and dispose of catheter bags.
- maintain charts/records; (output and intake, bag changes)
- monitor catheter position.
- monitor skin condition around catheter.
- recognise and respond/report blockages, dislodged catheters, signs of deteriorating health or infection.

Registered nurse will confirm consent prior to commencing care of a participant's urinary catheter. The participant's health status will have regular reviews by Registered nurse and a qualified health practitioner (e.g., Registered Nurse, Enrolled Nurse). A participant's Urinary Catheter Management Plan will be reviewed weekly Monthly or as needed to ensure there are updated strategies in place for acting upon information from the participant/carer/advocate, Registered nurse and health professionals.

Roles and Responsibilities

Full Care Lifetime's Registered nurse is responsible for the overall clinical management of high intensity supported activities to support participant's care. Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. A participant's urinary catheter management plan is overseen by Registered nurse and health practitioners. This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate.

Please Note: Any changes to a urinary catheter and management plan will be conducted by Registered nurse and health practitioners.

STAFF TRAINING

Full Care Lifetime's frontline staff will have relevant and/or additional qualifications and experience for the participant's needs. Full Care Lifetime will train their support staff (according to their training plan), in how to care for a urinary catheter. Frontline staff will be made aware of associated health conditions and complications that can impact on a participant who has a urinary catheter. The common risks and indicators of a malfunctioning urinary catheter and understanding when to involve their Registered nurse and a qualified health practitioner (e.g., Registered Nurse, Enrolled Nurse). Full Care Lifetime Frontline staff will have received training, relating specifically to each participant's needs and the type of urinary catheter support required including the following:

- Basic understanding of urinary system for males and females.
- appropriate hydration.
- types of catheters.
- procedures and challenges in inserting catheters in males and females (intermittent catheters only).
- common complications associated with using different types of catheters,
- indicators of complications that require intervention and understanding when to involve a health practitioner.
- infection control procedures, how to respond/report signs of deteriorating health and monitor hydration requirements.
- Emergency management of a catheter

Observe, document and report

Should any of the following conditions or symptoms be observed by the community support professional, they are to document what has been observed, and report same to their supervising registered nurse or line manager, who should then arrange for a medical review:

- Persistence or worsening of lower abdominal pain
- Persistent localised pain
- Any new pain since catheter insertion
- Any minor bleeding post insertion and ongoing 12 hours after being initially reported and investigated

- Absence of urine flow - If there has been no urine collected in the drainage bag for more than 4 hours, or the person's abdomen is swollen and tender, contact the supervising registered nurse or line manager to advise. They should then organise a medical review as a matter of urgency
- Strong odour or cloudy urine
- Blood in urine
- Chills, fever above 38 degrees
- Lower back pain
- Abnormal leakage around the catheter
- Swelling at catheter insertion site, especially in men
- Disorientation or change in mental status

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

VENTILATION MANAGEMENT POLICY

Scope

This policy applies to all staff who use Ventilation equipment for participants.

Policy

All ventilation management will be delivered by appropriately trained staff and in line with the relevant health practitioner and the participant and/or family.

This policy has been developed to ensure that all participants at Full Care Lifetime requiring ventilation management receive the best quality support relevant to their individual needs.

This policy will also guide the actions of our staff by providing a framework for competency and action to promote the delivery of best practice supports in this area.

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including Ventilation management. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

Definitions

Term	Definition
Non-invasive mechanical ventilation	a simple method of assisting a participant's breathing without using an invasive airway (tracheostomy tube) e.g., Continuous positive airway pressure (CPAP or BiPAP) – 1. CPAP (continuous positive airway pressure) 2. BiPAP (bilevel positive airway pressure)
Invasive mechanical ventilation	Invasive ventilation is when a person is attached to the ventilator by way of an artificial airway, either an endotracheal tube or tracheostomy.
Ventilation	carried out via an artificial airway (tracheal cannula) to the trachea.

Principles for Ventilation management

- To improve oxygenation and ventilation
- Confirm the need for ventilation and recognise the need for suctioning and follow procedures to clear airways as required.
- To follow personal hygiene and infection control procedures.
- To operate a ventilator for operation (identify and connect or assemble components of ventilation equipment according to instructions, fit the breathing mask)
- To start ventilation and monitor that it is working effectively,
- Trouble-shooting procedures to respond to alarms and maintain equipment.
- To maintain charts/records.
- To recognise and respond to signs that airways are obstructed.
- To implement emergency procedures, deteriorating health or infection.

Roles and Responsibilities

Full Care Lifetime's Registered nurses and support workers (with relevant training) are responsible for the overall clinical management of a high intensity supported participant's care. This policy is to be used in conjunction with Full Care Lifetime's Tracheostomy Care and Management Policy and Stoma Care Policy (where required). The participant's support plan is also included and overseen by a relevant health practitioner (e.g., Medical doctor, Registered Nurse). This support plan will be regularly reviewed where procedures and information will be given to the

participant/carer/advocate. Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. Full Care Lifetime will ensure that each participant requiring Ventilation Management will receive support for care of their equipment and components as well as their tracheostomy and/or stoma, relevant and proportionate to their individual needs.

Please Note that any cares required outside of what's written in this policy and procedure must be performed by a qualified health practitioner e.g., Medical Doctor or Registered Nurse. In some cases, Registered nurses may respond when a tracheostomy and/or ventilation requires emergency procedures to be implemented; there must be active oversight by a health practitioner Registered Nurse.

Support Plan

Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate, Registered nurse and health practitioners (e.g., Registered Nurse). Included in the plan is how to care for the participants tracheostomy and ventilation requirements. Registered nurse will confirm consent for the need for any cares to be performed with ventilation from the participant/carer/advocate. The participant's health status will have regular reviews by Registered nurse or a qualified health practitioner (e.g., Medical doctor, Registered Nurse). The support plan will identify how risks, incidents and emergencies will be managed, including required actions and escalation to ensure participant safety and wellbeing.

A participant's ventilation schedule (invasive and non-invasive) is to be reviewed annually or when is required to ensure there are strategies in place for acting upon information from the participant/carer/advocate, Registered nurse and health professional Registered Nurse. Registered nurse are to nature and consequences of a participant's respiratory condition follow documentation procedures, including:

- How to identify and connect or assemble components of ventilation equipment according to instructions, and operate a ventilator and cleaning procedures,
- How to fit the breathing mask and equipment,
- How to monitor that the ventilation is working effectively, following trouble-shooting procedures to respond to alarms and maintain equipment, and recording requirements
- Reporting on signs and symptoms such as: unexplained dyspnoea; severe coughing; bleeding around tracheostomy site; haemoptysis; changes in consistency and colour of secretions; erythema or soreness around stoma.
- Immediate intervention strategies for: signs of respiratory distress, pressure sores and discomfort, common problems with ventilation and the actions required,
- Incident and emergency procedures

Equipment required to provide ventilation

The equipment in the home may include:

- Access to a continuous supply of electricity
- Ventilator and equipment

- Oxygen cylinder and tubing, adapters and bags
- Humidifier
- Tracheostomy kit (where applicable)
- An available mobile phone with emergency contact numbers
- Suction unit, equipment and batteries
- Spare batteries for all equipment
- Sodium Chloride 10mL X 5
- Water for Irrigation 10mL X 5
- Syringes 5mL, 20mL X 5
- Lubricating Jelly
- Scissors
- Gloves
- Yankauer Sucker

PROCEDURE

Securing of the ETT can be done in one of three ways:

- Tapes such as Sleek or Transpore are used only for participants in theatre or who are in the process of being transported to ICU or Operating Theatre
- Cotton white tape changed at least daily
- An Endotracheal Tube Attachment Device ETAD (Anchor fast) which must be changed every 5 days and PRN

Assessing of ETT position must be done each shift by:

- Checking and documenting the level of the ETT at the lips (usually 19 – 23 cm)
- Ensure equal, bilateral chest movement and air entry on auscultation
- Verify the tip of the ETT is 2-4cm above the carina on chest X-ray.
- Repositioning of the oral ETT to prevent pressure areas.
- Assessing and maintaining a tracheal cuff seal
- A minimum occlusion volume is achieved on first inflation of the cuff at intubation
- The cuff pressure is subsequently measured via a cuff pressure manometer and documented once each shift and as required
- A cuff pressure of 20-30 mmHg is usually required to maintain an adequate seal. If a pressure > 30mmHg is required to eliminate a cuff leak notify ICU medical staff. A pressure > 40mmHg may cause mucosal injury.
- Listen for cuff leaks and monitor low ventilator pressure and tidal volume alarms which may indicate an air leak. Arterial Blood Gas (ABG) sampling and analysis
- An initial ABG is performed 15–30 minutes post intubation. Further ABG sampling is indicated when:
    - A deterioration in O2 saturation
    - Clinical signs of hypoxia
    - Significant changes to ventilator settings

- Changes in participant's respiratory effort and ventilator observations e.g., low tidal volume, increased or decreased minute volume

Suction

Suctioning of the ETT is performed using a closed or 'in-line' suction device only. It must be replaced daily or when overtly soiled along with the suction tubing and receptacle liner. Regular suctioning is not recommended and should be performed only when clinically necessary or at approximately eight hourly intervals.

Procedure:

- Explain procedure to participant
- Pre-oxygenate participant with 100% oxygen
- Observe hand hygiene principles and PPE
- Unlock catheter and advance as far as possible without force, or until participant coughs
- Withdraw the catheter 1 – 2 cm so as to be free of the bronchial wall or carina
- Apply continuous suction while withdrawing the catheter in one continuous motion not longer than 15 seconds
- Use a maximum of two suction passes
- Flush the catheter via the irrigation port with a 10ml syringe of Normal saline
- Lock the suction catheter
- Auscultate lung fields to assess effects of interventions
- Document colour, volume and tenacity of sputum.

Humidification of the ventilator circuit

A Heat Moisture Exchanger (HME) is used for a dry circuit and a heated water bath system (Fisher & Paykel) for a wet circuit.

Changing from a dry to a wet circuit is not routinely undertaken unless:

- Tenacious sputum
- Haemoptysis
- Bronchospasm
- Bronchorrhea (excessive discharge of watery mucous from the lungs)
- ICU Consultant preference

Management of the ventilator circuit

- All circuits, including Laerdal, wet or dry, should be changed weekly or more frequently if soiled.
- The HME needs to be changed daily and more frequently if wet or soiled.

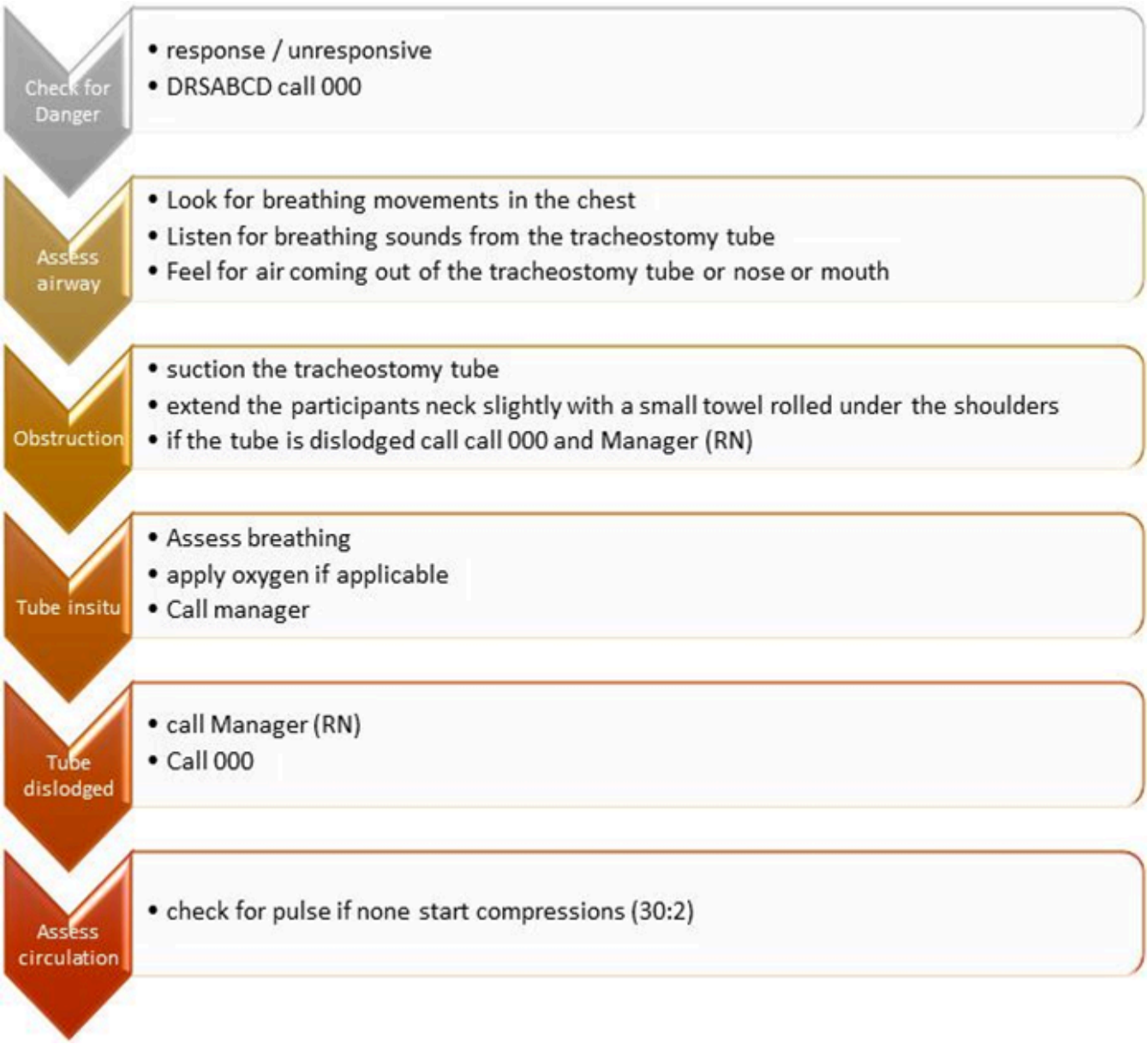
IMPLEMENTATION OF THE "VAP BUNDLE"

Mouth care

- Assessment and Maintenance of Mouth Care Flow Chart

Always follow mouth care with Oropharyngeal suctioning

Emergency Management


Check for Danger
• response / unresponsive
• DRSABCD call 000
Assess airway
• Look for breathing movements in the chest
• Listen for breathing sounds from the tracheostomy tube
• Feel for air coming out of the tracheostomy tube or nose or mouth
Obstruction
• suction the tracheostomy tube
• extend the participants neck slightly with a small towel rolled under the shoulders
• if the tube is dislodged call call 000 and Manager (RN)
Tube insitu
• Assess breathing
• apply oxygen if applicable
• Call manager
Tube dislodged
• call Manager (RN)
• Call 000
Assess circulation
• check for pulse if none start compressions (30:2)

SIGNS OF RESPIRATORY DISTRESS	Potential Causes
Increased work of breathing i.e., participant acutely distressed/restless, tachypnoea, stridor, accessory muscles use, diaphoretic, cyanotic	Airway partially/completely obstructed due to blockage
Decreased/gurgling breath sounds	Tracheostomy dislodgement
High inspiratory airway pressures/low tidal volumes if mechanically ventilated	Persistent cuff leak
Oxygen desaturation	Faulty oxygen source or ventilation device
No breath sounds	Ineffective humidification
Unable to pass suction catheter or inner cannula	Tracheostomy in false passage
Ventilator Failure	due to: Power failure, ventilator malfunction, accidental disconnection, circuit obstruction, mask fit.

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

SUBCUTANEOUS INJECTION POLICY AND PROCEDURE

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including the administration of subcutaneous injections. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

Background

Injections given via the subcutaneous route deposit a drug dose into adipose tissue immediately below the dermal layer. Blood supply to this layer is lower than to muscle tissue so medication given this way acts as a depot and is absorbed slower that via intra-muscular injection.

Medication administered via subcutaneous injection include anticoagulants such as heparin and tinzaparin, and insulin. Medications administered this way must be water soluble and low volume, typically below 2 ml.

This process is only for workers that have completed the necessary training and competencies to administer medication via subcutaneous injection.

DEFINITIONS

Term	Definition
Subcutaneous	The area just below the skin (fatty tissue).
Injection	the process of using a syringe with a needle and inserting into the skin.
Insulin	a natural hormone made by the pancreas that controls the levels of glucose in the blood.
Insulin pen	A reusable or disposable pen-like device that has a disposable needle attached, used for injecting a regulated dose of insulin to control blood glucose levels in people with diabetes.

PRINCIPLE OF SUBCUTANEOUS INJECTION

- To follow personal hygiene and infection control procedures.
- To confirm participant details (using the "7 rights") and need for injection,
- To follow safe injecting procedures using pumps and pens,
- To monitor participants for any adverse reactions,
- To maintain accurate and safe records of medication administration.

POLICY

All subcutaneous injections support will be delivered by appropriately trained staff and in line with a Complex Care Plan that is developed with the relevant health practitioner and the participant and/or family.

This policy has been developed to ensure that all participants at Full Care Lifetime requiring subcutaneous injections receive the best quality support relevant to their individual needs.

PROCEDURE

- Our service delivery model is based on person centred approaches. As such all participants and or their family/carer are involved in the assessment and development of the plan for subcutaneous injections.
- If a participant requires subcutaneous injections a Complex Care Plan will be developed in partnership with a nominated health practitioner specifically for the participants needs.

- This care plan will be developed in partnership with the participant, their family/carer and any relevant health professional (with the consent of the participant/family). The plans include nature and frequency of the injection, dosage (including potential variable dosage), who will deliver it, timeframes for review by a health professional, any potential or actual risks involved and how incidents and emergencies are managed and actions/procedures to refer any situation that requires further expertise to the appropriate agency or health professional. The plan must identify the health practitioner responsible for overseeing the injecting process and describe the checking procedure to be followed so that the worker confirms calculations and dose measurement prior to administering injection.
- Wherever possible it is the preference of Full Care Lifetime to have any form of complex care delivered by qualified nursing staff. Where this is not possible, or not the preference of the participant/family, we will ensure that the preferred support worker(s) is provided with the appropriate training from a qualified and experienced health professional. This training will encompass the specific needs of each participant's, the type of enteral feeding and nutrition management required and will comply with the NDIS High Intensity Support Skills Descriptor for providing subcutaneous injections.
- All staff required to deliver subcutaneous injections will have a training plan devised to ensure they can competently deliver the type and nature of subcutaneous injection including that they: confirm participant details and need for injection, follow personal hygiene and infection control procedures; follow safe injecting procedures using pumps and pens (containing pre-measured dose), monitor for any adverse reactions, maintain records. administration by pens and pumps. Understand different injection methods and related equipment; medication checking and recording requirements; impact of variables that affect take up such as site location and rotation (related to specific medication), timing etc.; safe needle disposal; signs of adverse reactions and action required including common symptoms of overdose and withdrawal; common risks of injecting and related control methods; quality check protocols when calculating and delivering a variable dose.
- All support workers responsible for administering high risk medications will have an understanding of the purpose of the medication. For example, workers who give insulin injections require diabetes awareness and management training.
- Staff will also have or be trained in a basic understanding of diabetes types 1 and 2; factors that can affect blood sugar levels, methods of managing insulin levels including different types of insulin (fast/slow release),variables that affect insulin delivery such as timing, site selection and rotation, common symptoms and risks of low or unstable blood sugar levels and related responses, common complications and sources of expertise e.g., podiatrist.
- All training and training plans will be delivered and devised by and in partnership with a qualified health practitioner.
- All subcutaneous injections must be done in accordance with the Full Care Lifetime Waste Management and Infection Control Policy and procedures.
- All needles must be disposed of in an appropriate sharp's container provided and disposed of in accordance with State Health Guidelines.
- As part of the development of a Complex Care Plan contingencies and actions will be documented by the attendant health professional to manage any emergency or actions that require escalation. If staff are ever in doubt about the health and wellbeing of a participant,

they must contact the attendant health professional and/or the Ambulance service immediately.

ROLES AND RESPONSIBILITIES

Full Care Lifetime's Registered nurse are jointly responsible for the overall clinical management of a high intensity supported participant's care with the health practitioner (e.g., Medical Doctor, Registered Nurse, Enrolled Nurse). This policy is to be used in conjunction with Full Care Lifetime's Management of Medication Policy and Diabetes Management Policy. The participant's support plan is also included and overseen by a health practitioner (e.g., Medical Doctor, Registered Nurse, Enrolled Nurse).

This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate. Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. Full Care Lifetime will ensure that each participant requiring subcutaneous injections will receive support for care of their medication management, skin integrity and subcutaneous injections, relevant and proportionate to their individual needs.

Please Note: That any cares required outside of what is written in this policy and procedure must be performed by a qualified health practitioner (e.g., Medical Doctor, Registered Nurse, Enrolled Nurse). In some cases, Registered nurse may respond when a participant requires emergency procedures to be implemented; there must be active oversight by a health practitioner (Medical Doctor, Registered Nurse, Enrolled Nurse).

SUPPORT PLAN

Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate, {Registered nurse} and health practitioners (e.g., Medical Doctor, Registered Nurse, enrolled Nurse). Included in the plan is detailed instructions on medication requirements, dose calculation (where required), injecting procedure and incident and emergency management. There is documented, written and/or phone orders, by the health practitioner (Medical Doctor) prescribing the medications, that Full Care Lifetime trained Registered nurse can administer via subcutaneous injection. This is always kept in the support plan.

Registered nurse will confirm consent from participant/carer/advocate prior to any subcutaneous injections to be performed on the participant. The participant's medication/s will have regular reviews by a qualified health practitioner (e.g., Medical doctor, Registered Nurse, Enrolled Nurse). The support plan will identify how risks, incidents and emergencies will be managed, including required actions and escalation to ensure participant safety and wellbeing.

Participant's support plans are to clearly identify the types of subcutaneous injection used e.g., pens and /or pumps which will administer a pre-measured medication. Where a participant's support plan requires the {Registered nurse} to calculate and draw up the required dose of medication, this procedure must be under direct clinical supervision of a Registered Nurse or Enrolled Nurse. The plan must identify the health practitioner responsible for overseeing the injecting process and describe the checking procedure to be followed so that the worker confirms calculations and dose measurement prior to administering injection.

Full Care Lifetime require all their {Registered nurse} who are administering medications to follow the "7 rights" process in checking as listed below:

1. Right Participant
2. Right Drug
3. Right Route
4. Right Dose
5. Right Time
6. Right Documentation
7. Right to Refuse

STAFF TRAINING

Full Care Lifetime's will train their Registered nurse in Subcutaneous Injections in conjunction with the Management of Medication Policy and Diabetes Management Policy. The {Registered nurse} will hold relevant and additional qualifications and experience. It is desirable that all Registered nurses will have further education in medication procedures taking due care and diligence to comply with legislative requirements e.g., Training in first aid, healthy body systems and the administration of medication; delivered by a Registered Training Organisation (RTO) in accordance with Australian Qualification Framework (AQF) standards.

Full Care Lifetime's Registered nurse are trained to be aware of the impact of associated health conditions and complications that impact on participants who have require medication administration via subcutaneous injections. Staff will have knowledge of basic anatomy of the integumentary system as well as:

Full Care Lifetime's training system complies with the high intensity support activities skills descriptor for providing subcutaneous injections including how to follow procedures and exercise judgement on when to respond/report problems such as adverse reactions, signs of deteriorating health or infection. Full Care Lifetime has policies and procedures in place which identify, plan, facilitate, record and evaluate the effectiveness of training for the frontline staff. This system facilitates training which is mandatory in relation to staff obligations under the NDIS Practice Standards and NDIS rules.

Full Care Lifetime **does not permit** this procedure to be carried out by a support worker, as additional training and clinical reporting and oversight arrangements are required so that the calculation and measurement of the dose is checked by a health practitioner prior to being administered. Only a **registered nurse**, or an enrolled nurse who has received the appropriate training may carry out this procedure.

Full Care Lifetime will deploy staff with knowledge of:

- administration by pens and pumps.

- Understand different injection methods and related equipment.
- medication checking and recording requirements.
- impact of variables that affect take up such as site location and rotation (related to specific medication), timing etc.
- safe needle disposal.
- signs of adverse reactions and action required including common symptoms of overdose and withdrawal.
- common risks of injecting and related control methods.
- quality check protocols when calculating and delivering a variable dose

Technique

The size and angle of insertion of the needle used for injection, and the need for a lifted skinfold, should be determined according to a health practitioner (Registered Nurse, Enrolled Nurse) clinical examination and consideration of the likely composition of skin and subcutaneous tissue.

Below is a generic guide to administering a subcutaneous injection.

1. Use thumb and index finger (or middle finger) to gently lift (not grab) the skin fold and avoid lifting accompanying muscle.
2. Inject into the raised tissue at 90 degrees.
3. Keep the skin fold raised as the medication is administered.
4. Maintain a steady rate in injecting the solution
5. Hold the needle in situ for 10 seconds, or as per the support plan instructions
6. Withdraw the needle and release the skin fold
7. Observe for trauma, leakage or pain at the site
8. Dispose of the needle as per Full Care Lifetime's Waste Management Policy

Variable dose context

The health plan allows for support workers to calculate and draw up the required dose under clinical supervision. The plan must identify the health practitioner responsible for overseeing the injecting process and describe the checking procedure to be followed so that the worker confirms calculations and dose measurement prior to administering injection.

Support workers responsible for administering high risk medications need an understanding of the purpose of the medication. For example, workers who give insulin injections require diabetes awareness and management training.

Assessment, Plan Development and Review

In the event that a participant requires subcutaneous injections, they must undergo an assessment with an appropriately qualified health practitioner. The health practitioner must develop an accurate

subcutaneous injection plan, in consultation with the service user, that can be utilised by Full Care Lifetime staff to guide support.

The subcutaneous injection plan must also include an Action Plan to address any incident or emergency in relation to the injection, where applicable. The Action Plan must also identify a clear path for the escalation of any incident or emergency in a timely manner.

This subcutaneous injection plan will continue to be overseen by a health professional. The regularity of plan reviews is at the discretion of the health professional and will be supported by Full Care Lifetime.

Any changes in the participants' needs, including any incidents or emergencies, will require a plan review.

Training of Support Staff

Full Care Lifetime requires participant specific training to be completed by all support workers supporting participants requiring subcutaneous injection. Training will relate specifically to the participants' needs, type of subcutaneous injection regime and cover any specific support requirements the participant may require. Training shall also cover how to manage all incidents and procedures relating to subcutaneous injections.

Training plans will be developed and delivered by an appropriately qualified health practitioner or person that Full Care Lifetime deems has the high skills set relevant to the participant's specific care needs.

Training plans must also allow for the provision of on-going training support.

Risk Management

Both the training plan and the management support plan will include the identification of risks including actions and escalations. This will include both Full Care Lifetime internal reporting and identified reporting requirements within the participants' treating team.

Training and management support plans will detail how to manage a related incident, including the development of an emergency management plan covering emergencies.

All incidents will be recorded and reported as per Full Care Lifetime Incident Management Policy.

PPE Required for Subcutaneous injections

- Disposable gloves (powder free)
- Insulin pen
- Insulin vile/ampule
- Lancet or needled device for finger pricking
- Glucometer
- Test strips

- Tissues
- Other Medications
- Needles, syringes (for insulin administration)
- Clinical sharps container

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

WOUND MANAGEMENT POLICY AND PROCEDURE

The purpose of this policy is to demonstrate that Full Care Lifetime understands that some of our participants may require additional support with their activities of daily living including wound care management. Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

DEFINITIONS

Term	Definition
Burns	Injuries to tissues caused by heat, friction, electricity, radiation or chemicals.
Chronic Wounds	A failure to heal in an orderly and timely manner.
Pressure Injuries	A localised injury to the skin and/or underlying tissue, usually over a bony prominence, because of pressure, friction or a combination of these factors.
Surgical Wounds	a clean cut or puncture of the skin deliberately during a surgical procedure
Trauma Wounds	a stressful event caused by either mechanical or chemical injury resulting in tissue damage

PRINCIPLES OF PRESSURE CARE AND WOUND MANAGEMENT

- To follow personal hygiene and infection control procedures
- Recognise risk and symptoms of pressure areas,
- To identify when to refer to health practitioner.
- To follow planned instructions to inspect/replace dressings (under health practitioner supervision and only when indicated in wound management plan

Policy

All wound care management support will be delivered by appropriately trained staff and in line with a Complex Care Plan that is developed with the relevant health practitioner and the participant and/or family.

This policy has been developed to ensure that all participants at Full Care Lifetime requiring wound care management receive the best quality support relevant to their individual needs.

Procedures

- Our service delivery model is based on person centred approaches. As such all participants and or their family/carer are involved in the assessment and development of the plan for subcutaneous injections.
- If a participant requires wound care management a Complex Care Plan will be developed in partnership with a nominated health practitioner specifically for the participants needs.
- This care plan will be developed in partnership with the participant, their family/carer and any relevant health professional (with the consent of the participant/family). The plans include nature and frequency of the procedure, who will deliver it, timeframes for review by a health professional, any potential or actual risks involved and how incidents and emergencies are managed and actions/procedures to refer any situation that requires further expertise to the appropriate agency or health professional.
- Wherever possible it is the preference of Full Care Lifetime to have any form of complex care delivered by qualified nursing staff. Where this is not possible, or not the preference of the participant/family, we will ensure that the preferred support worker(s) is provided with the appropriate training from a qualified and experienced health professional. This training will encompass the specific needs of each participant's, the type of enteral feeding and nutrition management required and will comply with the NDIS High Intensity Support Skills Descriptor for providing wound care management.
- All staff required to deliver wound care management will have a training plan devised to ensure they can competently deliver the type and nature of wound care required including an ability to: Recognise risk and symptoms of pressure, identify when to refer to health practitioner, follow plan instructions to inspect/replace dressings (under health practitioner supervision and only when indicated in wound management plan), common skin integrity risks, common indications of infection and required response, implications of prolonged or worsening infection, purpose and methods for positioning and turning to manage pressure and choking risks and the implications of wound management for delivering daily support activities such as showering, toileting, mealtime assistance and mobility.
- All training and training plans will be delivered and devised by and in partnership with a qualified health practitioner.
- All wound care management must be done in accordance with the Full Care Lifetime Waste Management and Infection Control Policy and procedures.
- As part of the development of a Complex Care Plan contingencies and actions will be documented by the attendant health professional to manage any emergency or actions that

require escalation. If staff are ever in doubt about the health and wellbeing of a participant, they must contact the attendant health professional and/or the Ambulance service immediately.

Procedure

As a part of the community service or support delivered by {Full Care Lifetime} each office delivering wound care services will:

- Engage a registered nurse to assess the initial care needs with the participant, and
    - Determine the areas of skin care that the Community Support Professional may attend
    - Develop care or wound management plans with identified outcomes
- Provide written procedures on the provision of wound care by the nurse - this may be included as part of the care plan.
- Policies and procedures for care should be clearly documented
- Identify education needs for registered and enrolled nurses. Provide relevant competency-based training and assessment processes for the nurse to ensure they are competent to perform the prescribed duties, tasks and interventions.
- Monitor, review, evaluate and adapt as required the service, plans and outcomes with the involvement of the participant.
- Attend to wound care management, including dressing selection and changes
- Supervise and guide the community support professional in the provision of skin care
- Only work within the scope of their practice and prior experience.

Wound management

Wound assessment and management are a specialised area of nursing and should only be undertaken by skilled and experienced practitioners. Nursing staff involved in the management of wounds should consult evidence-based best practice guidelines with regard to the selection of available wound dressing products and the recommended wound-specific techniques.

All wounds must be documented, with photographic evidence, using a Wound Assessment Chart. Skin tears should be classified using the STAR Classification system, whilst pressure injuries should be classified using the Pressure Injury Classification System.

Nursing staff must evaluate and document the following:

- Cause, site, type and classification of wound
- Depth: superficial, partial or full thickness
- Size: trace and calculate area on first presentation, then on each review/dressing change

- Wound edge: sloping, punched out, raised, rolled, undermining, purple, calloused
- Wound bed: necrotic, sloughy, infected, granulating, epithelialisation
- Exudate: serous, haemoserous, purulent
- Surrounding skin: oedema, cellulitis, colour, eczema, maceration, capillary refill time
- Any signs of infection: heat, redness, swelling, pain, odour, delayed healing
- Pain: associated with disease, trauma, infection, wound care practices, products
- Wound healing and health outcomes, including pain management and the management of any infections
- The potential or actual psychosocial impact of the wound/s
- Any changes to the wound prevention and/or management plan, including rationales for same
- Any adverse events associated with the management of skin integrity

As part of the collaborative care framework, the participant should be provided with ample education regarding their wound management regime and be encouraged to communicate their medical needs with other members of the healthcare team, including their general practitioner and any allied health professionals involved in their ongoing care.

Roles and Responsibilities

- Full Care Lifetime's Registered nurse is responsible for the overall clinical management of a high intensity supported participant's care. The participant's support plan is overseen by a relevant health practitioner (e.g., Registered Nurse, Enrolled Nurse). This support plan will be regularly reviewed where procedures and information will be given to the participant/carer/advocate.
- Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained. Full Care Lifetime will ensure that each participant requiring pressure care and/or wound management supports will receive support, relevant and proportionate to their individual needs; overseen and developed by a health practitioner (e.g., Registered Nurse, Enrolled Nurse) with specific instructions to be implemented by a Registered nurse.

Support plan

- Full Care Lifetime's participant support plan is developed with the involvement of the participant/carer/advocate, Registered nurse and health practitioners (e.g., Registered Nurse, Enrolled Nurse). Included in the plan is how to recognise risk and symptoms of pressure areas and when to refer to a health practitioner.
- Registered nurse will confirm consent for the need for any wound management to be performed with the participant/carer/advocate. The participant's health status will have regular reviews by a health practitioner (e.g., Registered Nurse, Enrolled Nurse). The support plan will identify how risks, incidents and emergencies will be managed, including required actions and escalation to ensure participant safety and wellbeing.
- A participant 's pressure area/wound management care plan will be reviewed Weekly or as needed to ensure there are updated strategies in place for acting upon information from the participant/carer/advocate, Registered nurse and health professionals. Full Care Lifetime's

Registered nurse will work in alignment with Full Care Lifetime Documentation Policy; which will instruct all recording aspects of pressure care and wound management including the assessment, treatment and management plans and implementation and evaluation methods; recognising risks and symptoms of pressure areas.

- All pressure area/wounds will be assessed regularly, and outcomes will be recorded in the participants progress notes. Registered nurse can/will use some/or the following types of documentation in relation to pressure are and wound management:
- Progress/file notes
- Wound care plans/charts
- Skin integrity assessments
- Water low scores
- Risk assessments
- Documentation with their {Registered nurse} and participant/carer/advocate to request for a change in a pressure are/wound care plan.

Staff Training

Full Care Lifetime's will train their Registered nurse in how to care for a pressure area and wound management. Registered nurse will be made aware of associated health conditions and complications that can impact on a participant who has a pressure area or wound. The common risks and indicators of infection and understanding when to involve their Registered nurse and a qualified health practitioner (e.g., Registered Nurse, Enrolled Nurse). Full Care Lifetime Registered nurse will have received training, relating specifically to each participant's needs that are affected by their wound management regime (e.g., showering, toileting and mobility). Further specific training will involve the following areas:

- Common skin integrity risks.
- Common indications of infection and required response.
- Implications of prolonged or worsening infection.
- Purpose and methods for positioning and turning to manage pressure and choking risks.

Equipment required for Wound management

Equipment in the home environment may include:

- Pressure area descriptor chart
- Disposable gloves (powder free)
- Disposable apron
- Gauze pads
- Normal saline or distilled water
- Cotton tipped swabs
- Basic dressing pack
- Additional dressing as per the participants pressure are/wound care plan

Monitoring and Review

Full Care Lifetime Management Team will review this policy and procedure at least annually. This process will include a review and evaluation of current practices and service delivery types, contemporary policy and practice in this clinical area, the Incident Register and will incorporate staff, participant and another stakeholder feedback. Feedback from service users, suggestions from staff and best practice developments will be used to update this policy.

Full Care Lifetime Continuous Improvement Plan will be used to record and monitor progress of any improvements identified and where relevant feed into Full Care Lifetime service planning and delivery processes.

SEVERE DYSPHAGIA MANAGEMENT POLICY AND PROCEDURE

The purpose of this policy & procedure is to ensure that each participant requiring severe dysphagia management receives appropriate support that is relevant and proportionate to their individual needs and preferences.Full Care Lifetime will ensure that any support provided to a participant of this nature is done in partnership with that participant to ensure their needs and preferences are given priority.

DEFINITIONS

Term	Definition
Dysphagia	Dysphagia is a medical term for any difficulty with swallowing.

POLICY

Full Care Lifetime is committed to comply with the NDIS Code of Conduct when providing supports or services to participants with dysphagia or swallowing difficulties.

Full Care Lifetime is committed to make sure that identify each participant requiring severe dysphagia management.

Full Care Lifetime provides supports and services in a safe and competent manner with care and skill

Full Care Lifetime is committed to make sure that with their consent, their individual severe dysphagia management needs are assessed by appropriately qualified health practitioners, including by practitioners conducting regular and timely reviews if needs change or difficulty is observed.

Full Care Lifetime promptly takes steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability.

Full Care Lifetime is committed to make sure that each participant requiring severe dysphagia management is involved in the assessment and development of their severe dysphagia management plan. The plan identifies:

(a) their individual needs and preferences (such as for food, fluids, preparation techniques and feeding equipment); and

(b) how risks, incidents and emergencies will be managed to ensure their wellbeing and safety, including by setting out any required actions and plans for escalation.

PROCEDURES

Full Care Lifetime is committed to delivery of safe, quality supports and services, and the management of risks associated with the supports Full Care Lifetime provide to participants.

Full Care Lifetime is committed to make sure that appropriate policies and procedures are in place in relation to the support provided to each participant requiring severe dysphagia management, including training plans for workers supporting them.

Full Care Lifetime is committed to make sure that each worker responsible for providing severe dysphagia management to participants has received training, relating specifically to each participant's needs, managing any severe dysphagia related incident and the high intensity support skills descriptor for severe dysphagia management, delivered by an appropriately qualified health practitioner with expertise in severe dysphagia management.

What is dysphagia?

Dysphagia is a medical term for any difficulty with swallowing. A person may have dysphagia if they show signs and symptoms such as:

- difficult, painful chewing or swallowing
- a feeling that food or drink gets stuck in their throat or goes down the wrong way
- coughing, choking, or frequent throat clearing during or after swallowing
- having long mealtimes e.g., finishing a meal takes more than 30 minutes
- becoming short of breath when eating and drinking
- avoiding some foods because they are hard to swallow
- regurgitation of undigested food
- difficulty controlling food or liquid in their mouth
- drooling
- having a hoarse or gurgly voice
- having a dry mouth
- poor oral hygiene

- frequent heartburn
- unexpected weight loss
- frequent respiratory infections.

A range of disabilities and medical conditions are associated with dysphagia, such as congenital syndromes, neuromuscular dysfunctions such as cerebral palsy, neurological disorders such as stroke, cancer, and chronic lung disease.

Many people with disability are also prescribed medications on a long-term basis, which can increase risk of swallowing problems.

Risks associated with dysphagia

Because of the high rates of dysphagia in people with disability, they have an increased risk of respiratory problems or choking as well as poor nutrition. Swallowing problems can allow food, drinks or saliva to get into lungs rather than the stomach, which can cause aspiration pneumonia. Studies have found that aspiration pneumonia and choking were among the most common respiratory causes of death for people with disability in NSW, QLD and VIC.

The risk of accidental choking can be reduced by following expert advice from speech pathologists and other specialists. Early identification and management of swallowing problems can minimise risks of health complications.

How is Dysphagia diagnosed?

Several Health Practitioners are involved in diagnosing and managing Dysphagia. These may include but are not restricted to:

General Practitioners When a person suspects that they have a swallowing problem Full Care Lifetime discuss this with their GP. A GP will begin the assessment process to determine the cause of the swallowing problem. The GP will often co-ordinate management between all the specialists involved and has a key role in monitoring management. The GP may arrange some tests to aid in diagnosis, depending on the symptoms presented (e.g., barium swallow, modified barium swallow), and may at this stage refer the person to a specialist for further investigations. The referral might be to a Speech Pathologist, Neurologist, Surgeon or Gastroenterologist depending upon the type of Dysphagia suspected.

Speech Pathologist Speech Pathologists have a pivotal role to play in the assessment and management of oral-pharyngeal Dysphagia. The role of the speech pathologist is to diagnose and manage the swallowing difficulty. This includes taking a case history, examining the oral structures, assessing the muscles of the mouth and throat and doing a mealtime assessment. Other assessments that may follow include a modified barium swallow (x-ray of the swallowing process while the person is eating or drinking). Once the person has been fully assessed the speech pathologist will develop a management plan tailored to an individual's needs. Speech Pathologists liaise with other team members to ensure holistic management and are involved in educating people with Dysphagia and their family on how to manage the condition.

Gastroenterologist The Gastroenterologist predominantly assesses the oesophageal phase of the swallow. Following their assessment, they will decide whether further assessment is required. This may include an x-ray test (barium swallow) or endoscopy/ gastroscopy. In some cases, a surgical procedure may be required to treat the condition causing the dysphagia.

Dietitian The Accredited Practising Dietitian (APD) provides nutritional assessment, monitoring and a management plan for people with swallowing difficulties, whilst working closely with other health professionals. This helps the person with Dysphagia to meet their nutrition and fluid needs while enjoying food variety and nutritionally balanced and safe meals. The Dietitian advises on the most appropriate form of nutrition and provides guidance on the need for vitamin and mineral supplements and commercial and non-commercial food supplements. The Dietitian may give advice on other diets such as high energy, high protein, diabetic, low lactose or high fibre as needed. The Dietitian can also assist with shopping tips, menu planning and food preparation to increase variety and help achieve a healthy diet.

Other Team Members May include Nurses, Ear Nose and Throat Specialist and Surgeon, Neurologist, Respiratory Specialist, Dentist, Chemist/Pharmacist, Occupational Therapist and Physiotherapist.

Risk factors & problems associated with Dysphagia

If Dysphagia is not identified or managed properly it can affect a person's quality of life. Together with the participant, the Dysphagia health care team aims to minimise the health risks of Dysphagia whilst still providing essential nutrition. This includes maintaining adequate hydration and nourishment whilst encouraging food enjoyment and safe swallowing

Malnutrition People who have Dysphagia may not be able to eat a balanced and nutritionally adequate diet. This may be due to difficulty communicating their food preferences or dependence upon others for help with eating, cooking and/or shopping. The person may limit the variety in their diet, selecting only the foods that are easy to swallow. In addition, slow eating and the extended time taken to complete meals may also contribute to malnutrition. As a result, the person may not receive all the nutrition they need to maintain a desirable weight. It is recommended that a GP or other health care team member monitors weight and that a Dietitian is consulted to provide advice on maintaining or gaining weight and to ensure the person is receiving an adequate diet.

Dehydration In some types of Dysphagia, liquids can be the hardest to swallow. This can lead to not enough fluids being consumed and may result in dehydration and/ or constipation. Sometimes, fluids may need to be thickened to make swallowing easier. This should only be done if recommended by a Speech Pathologist. Dehydration can also occur because of drooling, which may result from a coexisting or additional disease. Thus, fluid needs may be much higher than usual.

Aspiration Aspiration occurs when food, fluid, saliva or stomach contents enter into the airway. This can happen to anyone, regardless of whether they have Dysphagia or not. The body's natural response is to cough. Coughing clears the airway and prevents material from entering the lungs. Aspiration is a concern when a person cannot cough or can only cough weakly. "Silent Aspiration" where even though the food and fluid has gone down the wrong way, the person doesn't cough at all, and the only indicator may be recurring chest infections. It is also a concern when a person aspirates frequently or in large amounts. In these instances, "aspiration pneumonia" may result. If you think you or someone you care for may have any or all the above problems, please discuss this with a doctor as soon as possible.

Oral Hygiene Oral hygiene is important for stimulating salvia flow and taste. It is essential that the mouth and teeth are cleaned after meals as food residue in the mouth can be inhaled posing a choking risk after the meal has finished. Research shows that poor oral care can increase the harmful bacteria in the saliva, which if aspirated, can lead to pneumonia. Painful gums and teeth can also affect the ability to chew. Everyone should have ongoing oral care, regardless of whether they only eat small frequent meals, have only a few teeth or only dentures. Even if a person receives most of their nutrition through a tube, regular oral care is important. Regular visits to the dentist and an oral care plan will help to reduce complications.

How manages Dysphagia?

The way in which Dysphagia is managed depends on the cause of the dysphagia; that is, whether the swallowing difficulties are related to the mouth and throat or to the oesophagus.

There are many successful treatment and management alternatives available. In some cases, treatment may not cure the Dysphagia but will improve a person's ability to eat and drink safely. Some issues can be dealt with easily. If chewing is difficult because of loose dentures, consultation with a Dentist may be all that is required. Sometimes it is advisable to change the texture of the diet, alter seating and positioning during meals, or use special cutlery or crockery.

A set of techniques or exercises may also be recommended. If narrowing of the food passage is identified, this can nearly always be treated successfully by stretching the oesophagus with an instrument at the time of gastroscopy. In severe cases where these recommendations do not help and nutrition and hydration are compromised, a feeding tube may be inserted directly into the nose or the stomach to provide the fluids and/or nutrition.

It is always recommended that a person with swallowing difficulty have an individual plan developed. Listed below are some of the recommendations that may be made.

1. **Posture and positioning Correct**

positioning is one of the simplest yet most effective forms of management for people who have swallowing problems. Correct positioning helps to protect the airway from aspiration and helps improve swallowing and breathing efficiency. An Occupational Therapist or Physiotherapist may be involved in helping a person achieve good positioning. Some general principles include:

- Ensure the person is sitting up as straight as possible with shoulders level.

- The person should be comfortable with their head tilted slightly forward when eating or drinking

- If food feels like it is sticking in the food passage / chest area, for even a short time, getting up and stretching may help the food to slip down into the stomach. Other changes to head position may be recommended as part of an individual management plan. For this reason, it is important to follow any professional guidelines provided.

2. **Eating environment**

Creating a positive mealtime environment can be a simple but effective way to assist the person experiencing swallowing difficulty. Some of the following ideas are worth considering.

- Where possible allow the person to eat independently. A range of adaptive equipment is available. An Occupational Therapist can advise on what is most suitable.

i. Ensure that the person can reach food and fluids

ii. Ensure that a participant who is at risk of coughing and choking or aspirating is not left to eat on their own

- Make sure there is plenty of time to eat so the person is not rushed.
- Provide a peaceful and quiet surrounding that enables the person to relax.
- If the person appears tired allow for short rests, they may be able to start again.
- If the person has dentures, make sure they fit properly.
- To reduce the risk of reflux, eat the main meal approximately two to three hours before going to bed.

3. Food and drink modification

Changes to food texture may assist in the management of Dysphagia. The appropriate consistency of food for each person will depend on the type and severity of Dysphagia. Food may need to be chopped or blended after specific recommendations are made by a speech pathologist. A dietitian can explain in greater detail how the different foods and meals can be modified. Some general principles for texture modified foods include:

- Make sure the food looks as appetising as possible.
- Puree, and serve meat and vegetables separately, so they look appetising and can be appreciated for their own tastes.
- Use deep-coloured vegetables such as broccoli and sweet potato or carrot and pumpkin, to enhance appeal.
- Make sure the food is not too solid or sloppy. In some cases, food may need to be chopped or cut up. Textures must be tailored to suit individual needs.
- Serve foods at the correct temperature as this maximises taste
- Ensure a variety of foods are eaten from all food groups. • Changing the size of the mouthful (reducing it or increasing it according to the person's needs) may help.
- Encourage intake of fluids (thickened or thin as recommended by the Speech Pathologist).

Thickening of fluids is an example of texture modification. Thickening of fluids may increase swallowing difficulty in some conditions. Altering the consistency of fluid or texture of food should only be done after a speech pathology evaluation. For people on long term texture modified diets it is recommended that they are regularly monitored by their Doctor and a Dietitian, to ensure that they are eating a well-balanced and nutritionally adequate diet.

4. Assisting someone to eat

Some people may be unable to eat independently and will require assistance with eating. Recommendations should be tailored to suit the needs of the individual. Below are some general tips that will assist in feeding someone:

- Do not rush or hover over the person. • Sit in front of the person so they can see you. This also promotes good positioning for the person you are assisting.
- Let the person see and smell the food before you start feeding and describe it to them if they cannot see it.
- Experiment with different amounts of food, some people do better with teaspoon amounts, other with larger quantities.
- Place food in the middle of the mouth on the front third of the tongue and push the tongue down to prevent the tongue getting in the way of swallowing. Others will find it easier to eat if food is placed into the side of the mouth.
- Encourage the person to close their lips when swallowing.
- Ensure the mouth is empty before offering next portion.
- Ensure the person is upright for at least 20 minutes after they have finished their meal.

5. Proper utensils for safe eating

There are several specialised utensils that have been developed to assist carers and people with Dysphagia at mealtime. Plate guards and scoop bowls may allow a person to remain independent and eat by themselves. Built up handles for forks and spoons are useful for people eating independently who have a poor grip. Devices such as slings, arm and finger cuffs can all be useful to promote independence. Modified cups assist individuals so that they do not have to tip their head as far back to get the drink into their mouth. Referral to an Occupational Therapist will assist individuals to choose appropriate utensils and a Physiotherapist can assist in advising on correct positioning of the participant.

6. Rehabilitation and Compensatory techniques

In addition to some of the other strategies mentioned, the Speech Pathologist may recommend techniques to improve or assist with swallowing. These may include exercises to strengthen the muscles used in swallowing, changes to head position, use of biofeedback devices or techniques to assist with swallowing. Discuss these options with your speech pathologist.

Severe Dysphagia Management Process

If required and with the participant's consent, an assessment will be conducted for each participant to develop a Severe Dysphagia Management plan by a qualified health practitioner.

A Registered Nurse, Clinical Nurse Consultant, Pharmacist, General Practitioner, Medical Specialist deemed competent by training can be the health practitioner relevant to this work.

A qualified health practitioner will assess the participants if they require a Severe Dysphagia management.

A Severe Dysphagia Management Plan using Severe Dysphagia Management plan will be developed by the health practitioner in consultation with the participant to guide and utilise the support provision by the Full Care Lifetime.

Before healthcare professionals examine, treat or care for any participant, Full Care Lifetime must obtain their valid consent using Participant Consent Form through Participant Information Consent section of Information Management Policy & Procedure.

In the process of a personal care provision, if the workers role involves a routine Severe Dysphagia management, a different level of support will be required when the participant has been assessed as 'at risk' of faecal incontinence or severe constipation through Severe Dysphagia management plan.

An individualised Severe Dysphagia management plan for each participant enables Full Care Lifetime to manage the specific Severe Dysphagia management.

The participants will be provided with the support of required Severe Dysphagia management by one of Full Care Lifetime's workers. In the Severe Dysphagia Management Plan, the requirements of a bowel management will be documented and checked qualified with health practitioner.

Any incident or emergency related to the Severe Dysphagia is addressed in the Severe Dysphagia management plan. In addition, the escalation of any incident or emergency in a timely manner will be identified in the Severe Dysphagia management plan.

The Severe Dysphagia management plan will include the identification of risks including actions and escalations. This will include both Full Care Lifetime internal reporting and identified reporting requirements within the service users' treating team.

Health status of participants will be checked and reviewed regularly by a qualified health practitioner.

All incidents will be recorded and reported as per Incident Management Policy & Procedure.

All complaint will be recorded and reported as per Feedback and Complaints Management Policy & Procedure.

It is Full Care Lifetime's commitment to provide the required equipment as well as an appropriate training to the relevant staff to know how to use it.

Monitoring and Review

A health practitioner and workers will monitor, review and update and oversee the Severe Dysphagia management plan regularly. The health professional will decide about the regularity of the Severe Dysphagia management plan revision and Full Care Lifetime will support it.

Also, the Severe Dysphagia management plan will be reviewed if there is any change in the participants' needs like any incidents or emergencies.

Reports will be provided about the Severe Dysphagia management plan based on a regular monitor by the workers.

Training of Staff (Health Practitioner and Workers)

For provision of Severe Dysphagia management services to the participants, Full Care Lifetime will provide all workers with the specific required trainings.

Training plans will be developed and delivered by an appropriately qualified health practitioner or person that meets the high intensity support skills descriptor for Severe Dysphagia using Staff Training Tracker and through Human Resource Management Policy & Procedure.

A qualified trainer will train the support workers with all clients specific Severe Dysphagia management training.

The service users' needs and expectations as well as type of bowel management will be addressed in the training to cover any support requirements of the participant.

Training and management support plans will detail how to manage any incidents or emergencies including the development of an emergency management plan covering emergencies.

Also, the training plan will include the identification of risks including actions and escalations.

Records of induction, Mandatory Checks, training and organisational and professional development provided to all workers will be kept on each worker's record and on Staff Training Tracker or the Worker's file.

The workers will be notified by the Management Team to complete their refresher training in these areas regularly and keep track of the workers training currency through Staff Training Tracker.

Severe Dysphagia management training will be provided in accordance with the Annual Training Schedule, maintained by the Management Team.

An ongoing opportunity for Severe Dysphagia management training and development of workers will be provided by Full Care Lifetime that enhance and extend their capabilities as well as providing them with the chance of advancement in their organisation.

Every worker and Management Team member would be able to have the opportunity of participation in Severe Dysphagia management training and development activities.

On-the-job training, internal or external courses, support for research and fieldworks, conference and seminar attendance, networking and mentoring programs relevant to Severe Dysphagia management are available to workers as a part of training and development methods.

Performance Reviews will motivate workers to play an active role in their ongoing improvement by identifying their training and development needs in consultation with their manager using Worker Performance Appraisal.

A health practitioner who has been deemed competent, will undertake the competency assessment using the Form Severe Dysphagia Management plan for all workers.

Training will relate specifically to the service users' needs, type of bowel management and cover any specific support requirements the service user may require.

All practitioners will have a working knowledge of relevant current legislation, national guidelines, organisational policies and procedures via using Participant Handbook.

Communication with each participant and the provision of supports which is responsive to their needs is provided in the language, mode of communication and terms that the participant is most likely to understand. Where necessary, staff members should provide participants with advocates or interpreters. Interpreters would be available as below:

ways to support participants with dysphagia

There are several steps Full Care Lifetime can take to provide safe and competent supports to participants with dysphagia to try to avoid the risks of choking or aspiration pneumonia, which could lead to the participant's death or serious health complications.

While every participant will have different support needs for their dysphagia, there are some steps the NDIS Commission recommends, detailed below.

Ensure staff know dysphagia symptoms and risks

Staff have training to improve their knowledge and develop skills so they can support participants who may have dysphagia.

Staff must understand how to identify and respond to early signs and symptoms of dysphagia and how to support the person to have safe and enjoyable meals.

Support participants with possible swallowing difficulties to be assessed for dysphagia

If a participant shows any sign or symptom of swallowing difficulty, Full Care Lifetime should support them to consult a GP and a speech pathologist promptly, so they can assess their swallowing and mealtime assistance needs as well as review their general health.

Support participants with dysphagia to have a mealtime management plan

Full Care Lifetime should support a participant with dysphagia to have a mealtime management plan written by a health professional. A speech pathologist can prescribe and recommend specific actions for a person to eat and drink safely and develop a mealtime management plan for their needs. They will also specify when plans need to be reviewed.

A dietitian may contribute to the mealtime management plan by ensuring there is enough nutrition and hydration in the recommended modified meals.

Mealtime management plans may include recommendations to:

- improve the seating and positioning supports for a person's safe positioning during meals
- modify food textures to make the food easier to chew and swallow
- provide specific mealtime assistance techniques, including any reminders about a safe rate of eating, or a safe amount of food in each mouthful
- respond to coughing or choking and make sure risks are monitored while a person is eating or drinking
- use feeding equipment for people who have severe dysphagia, including assistive technology such as spoons, plates, cups and straws; and tube feeding equipment for those with severe or profound difficulty swallowing who require tube feeding.

Support people with dysphagia to eat and drink safely during mealtimes

Full Care Lifetime ensure that:

- staff receive the necessary training and support to implement a mealtime management plan or other mealtime recommendations for swallowing safely and mealtime management
- meals for participants with dysphagia, and medication taken orally, are prepared as directed and mealtime supports, and assistance are provided as recommended by health professionals.
- trained staff are available to monitor people with dysphagia during mealtimes

- staff know how to respond if a participant starts to choke during mealtimes, including when they should call an ambulance

- mealtime safety issues for people with dysphagia are regularly considered in staff meetings and addressed in day-to-day procedures, participants' documentation, and plans for transition to hospital

Ensure mealtime management plans are regularly reviewed

Mealtime management plans need to be reviewed regularly. Full Care Lifetime support a participant with dysphagia to arrange this.

The speech pathologist who develops a mealtime management plan will include how often it should be reviewed and may specify the circumstances in which Full Care Lifetime should request a review.

Ensure medications are regularly reviewed

Full Care Lifetime supports a participant with dysphagia to have their medications regularly reviewed by a GP, the prescribing medical practitioner, or a pharmacist to assess whether the medications may affect their swallowing.

The review can also determine if the medications are suitable when managing risks around swallowing. Several medications have impacts on swallowing, particularly medications for epilepsy or mental health conditions.

Medicines associated with swallowing problems

What you should consider

People who take medicines associated with swallowing problems may be at risk of choking while eating or drinking.

People taking antipsychotic medicines may be at a particular risk of muscular reactions that can affect swallowing:

- in the first few days after starting the medicine
- after an increase in the dosage of antipsychotic medicine or
- when they have been taking antipsychotic medicines for a long time, or taking combinations of antipsychotic medicines or antipsychotic medicines in combination with other drugs that can affect swallowing

To minimise the person's risk of choking, a mealtime management plan is recommended when a person is having trouble swallowing that may be a result of taking these medicines. A mealtime management plan may consider:

- when the person should be assessed, monitored and reviewed by a speech pathologist for mealtime and swallowing safety and support needs
- whether the person should be supervised or assisted during mealtimes
- changing the foods offered to the person, such as foods and drinks that are easy to chew and swallow, or other food and drink modifications as recommended by a speech pathologist
- how the person is positioned during and after mealtimes
- the amount of food and pace of each mouthful during mealtimes
- the environment during mealtimes, for example avoiding a noisy environment which can be distracting
- regularly reviewing mealtime management plans, especially if there are ongoing issues with aspiration.

If a person's swallowing problems persist while continuing to take these medicines, speak to the prescribing medical practitioner to get a medical review.

Also consider:

- whether the medicine should continue to be prescribed to the person
- whether the current medicine could be changed to another medicine of the same type
- if the medicine is to continue - whether the dose can be reduced, or if dividing the dose over the day may reduce swallowing problems
- whether to seek an independent medical review, particularly if the person requires medical attention for aspiration pneumonia, experiences frequent coughing or sounds 'gurgly' or chesty during or after meals.

What medicines are associated with swallowing problems?

The major types of commonly prescribed medicines that have the potential to affect swallowing and cause problems while eating or drinking are:

Antipsychotic medicines associated with swallowing problems

The antipsychotic medicines listed below can cause swallowing problems.

- Aripiprazole (e.g., Abilify)
- Asenapine (e.g., Saphris)
- Chlorpromazine (e.g Largactil)
- Flupentixol (e.g., Fluanxol)
- Haloperidol (e.g., Haldol, Serenace)
- Lurasidone (e.g., Latuda)
- Olanzapine (e.g., Zyprexa, APO-Olanzapine)
- Paliperidone (e.g Invega)
- Quetiapine (e.g., Seroquel)
- Risperidone (e.g., Risperdal, Rixadone)
- Trifluoperazine (e.g., Stelazine)
- Ziprasidone (e.g., Zeldox)

Benzodiazepine medicines associated with drowsiness

The benzodiazepines listed below can cause drowsiness, and therefore have the potential to influence swallowing by association, especially during eating.

- Alprazolam (e.g., Alprax, Kalma, Xanax, Zamhexal)
- Bromazepam (e.g., Lexotan)
- Clobazam (e.g., Frisium)
- Clonazepam (e.g., Rivotril, Paxam)
- Diazepam (e.g., Ducene, Valpam)
- Flunitrazepam (e.g., Hypnodorm)
- Lorazepam (e.g., Ativan)
- Midazolam (e.g., Hypnovel)
- Nitrazepam (e.g., Mogadon, Alodorm)
- Oxazepam (e.g., Alepam, Murelax, Serepax)
- Temazepam (e.g., Normison, Temaze, Temtabs)

Antiepileptic medicines associated with drowsiness

The antiepileptic medicines listed below can cause drowsiness, and therefore have the potential to influence swallowing by association, especially during eating.

- Carbamazepine (e.g., Tegretol, Teril)
- Clonazepam (e.g., Rivotril, Paxam)
- Gabapentin (e.g., Neurontin, Nupentin, Pendine, Gabaran, Gantin)
- Lamotrigine (in combination with other medicines, e.g., Elmendos, Lamictal, Lamidus, Lamitrin, Lamogine)
- Phenobarbital (e.g., Phenobarb)
- Pregabalin (e.g., Lyrica)

- Valproate (in combination with other medicines, e.g., Epilim, Valpro)
- Vigabatrin (e.g., Sabril)

Commonly prescribed medicines which can affect swallowing

Preliminary data reported to us has identified that the three most prescribed medicines used for the purposes of behaviour support are types associated with swallowing problems. These medicines are:

- Risperidone (antipsychotic)
- Sodium valproate (antiepileptic)
- Olanzapine (antipsychotic)

DIABETES MANAGEMENT POLICY AND PROCEDURE

PURPOSE

Our service is committed to providing a safe and healthy environment that is inclusive for all participants that are at diagnosed with diabetes.

SCOPE

This policy applies to diabetic participant of the service.

POLICY

Full Care Lifetime is committed to comply with the NDIS Code of Conduct when providing supports or services to participants with diabetes.

Full Care Lifetime is committed to make sure that identify each participant requiring diabetes management.

Full Care Lifetime provides supports and services in a safe and competent manner with care and skill

Full Care Lifetime promptly takes steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability.

Full Care Lifetime is committed to make sure that each participant requiring diabetes management is involved in the assessment and development of their diabetes management plan. The plan identifies:

(a) their individual needs and preferences

(b) how risks, incidents and emergencies will be managed to ensure their wellbeing and safety, including by setting out any required actions and plans for escalation.

DESCRIPTION

- Type-1 Diabetes is an autoimmune condition, which occurs when the immune system damages the insulin producing cells in the pancreas. This condition is treated with insulin replacement via injections or a continuous infusion of insulin via a pump. Without insulin treatment, type-1 diabetes is life threatening.

- Type-2 Diabetes occurs when either insulin is not working effectively (insulin resistance) or the pancreas does not produce sufficient insulin (or a combination of both). Type-2 diabetes affects between 85 and 90 per cent of all cases of diabetes and usually develops in adults over the age of 45 years, but it is increasingly occurring at a younger age. Type-2 diabetes is unlikely to be seen in participant under the age of 4 years old.

PROCEDURES

We will involve all participant or their advocates in regular discussions about medical conditions and general health and wellbeing throughout our curriculum. The Service will adhere to privacy and confidentiality procedures when dealing with individual health needs.

Participant diagnosed with Diabetes will not be enrolled into the Service until the participant's medical plan is completed and signed by their Medical Practitioner and the relevant staff members have been trained on how to manage the individual participant's diabetes.

Management, Nominated Supervisor/ Certified Supervisor will ensure:

- The participant/parents/guardians of an enrolled participant who is diagnosed with diabetes are provided with a copy of the Medical Conditions

- All staff members provided with a copy of the Diabetes policy that is reviewed annually.

- A copy of this policy is provided and reviewed during each new staff member's induction process.

- All staff members have completed first aid training, with each staff members' certificate held on the Service's premises

- When a participant diagnosed with diabetes in enrolled, all staff attend regular training on the management of diabetes and, where appropriate, emergency management of diabetes

- At least one staff member who has completed accredited training in emergency diabetes first aid is present in the Service at all times whenever participant with diabetes are being cared for in the Service

- There is a staff member who is appropriately trained to perform finger-prick blood glucose or urinalysis monitoring and knows what action to take if these are abnormal

- A Medical Conditions Risk Minimisation plan is completed for each participant diagnosed, outlining procedures to minimise the risks involved. The plan will cover the participant's known triggers and where relevant other common triggers which may lead to a Diabetic emergency

- All staff members are trained to identify participant displaying the symptoms of a diabetic emergency and location of the Diabetic Management Plan as well as the Emergency Management Plan.

- All staff, including casual and relief staff, are aware of participant diagnosed with diabetes attending the Service, symptoms of low blood sugar levels, and the location of diabetes management plans and emergency management plans

- Each participant with type-1 diabetes has a current individual Diabetes Management Plan prepared by the individual participant's diabetes medical specialist team, at or prior to enrolment

- Ensure that a participant's Diabetes Management Plan is signed by a Registered Medical Practitioner and inserted into the enrolment record for each participant. This will describe any prescribed medication for that participant as well as the emergency management of the participant's medical condition

- Before the participant's enrolment commences, the family will meet with the Service and it's educators to begin the communication process for managing the participant's medical condition in consultation with the registered medical practitioners instructions

- A staff member accompanying participant outside the Service carries the appropriate monitoring equipment, any prescribed medication, a copy of the Diabetes Management and Emergency Medical Management Plan for participant diagnosed with diabetes, attending excursions and other events

- The programs delivered at the Service are inclusive of participant diagnosed with diabetes and that participant with diabetes can participate in all activities safely and to their full potential

- That no participant diagnosed with diabetes attends the Service without the appropriate monitoring equipment and any prescribed medications
- Availability of meals, snacks and drinks that are appropriate for the participant and are in accordance with the participant's Diabetes Management plan at all times.

Staff and support worker will:

- Read and comply with this Diabetes Management Policy and the Medical Conditions Policy
- Know which participant are diagnosed with diabetes, and the location of their monitoring equipment, Diabetes Management and Emergency Plans and any prescribed medications
- An appropriately trained staff member will perform finger-prick blood glucose or urinalysis monitoring and will take action by following the participant’s diabetes management plan if these are abnormal
- Communicate with parents/guardians regarding the management of their participant’s medical condition
- Ensure that participant diagnosed with diabetes are not discriminated against in any way and are able to participate fully in all programs and activities at the Service.
- Follow the strategies developed for the management of diabetes at the service
- Follow the Risk Minimisation Plan for each enrolled participant diagnosed with diabetes
- Ensure a copy of the participant’s Diabetes Management Plan is visible and known to staff in a service
- Take all personal Diabetes Management Plans, monitoring equipment, medication records, Emergency Management Plans and any prescribed medication on excursions and other events outside the service
- Recognise the symptoms of a diabetic emergency, and treat appropriately by following the Diabetes Management Plan and the Emergency Management Plan
- Regularly check and record the expiry date of the prescribed medication relating to the medical condition
- Ensure there are glucose foods or sweetened drinks readily available to treat hypoglycemia at all times (low blood glucose), e.g. glucose tablets, glucose jellybeans, etc.

Participant/advocates/guardians will ensure they provide the service with:

- Details of the participant's health problem, treatment, medications and allergies
- Their doctor's name, address and phone number, and a phone number for contact in case of an emergency
- A Diabetes Care Plan and Emergency Medical Plan following enrolment and prior to the participant starting at the Service which should include:
- When, how and how often the participant is to have finger-prick or urinalysis glucose or ketone monitoring
- What meals and snacks are required including food content, amount and timing
- What activities and exercise the participant can or cannot do
- Whether the participant is able to go on excursions and what provisions are required.
- What symptoms and signs to look for that might indicate hypoglycemia (low blood glucose) or hyperglycemia (high blood glucose)
- What action to take including emergency contacts and what first aid to implement
- An up-to-date photograph of the participant
- Develop an individual Medical Conditions Risk Minimisation Plan in conjunction with Service staff
- A copy of the participant's Diabetes Management Plan and an Emergency Medication Management Plan developed and signed by a Registered Medical Practitioner for implementation within the Service
- condition and provide a new Diabetes Management Plan in accordance with these changes
- All relevant information and concerns to staff, for example, any matter relating to the health of the participant

DIABETIC EMERGENCY

A diabetic emergency may result from too much or too little insulin in the blood. There are two types of diabetic emergency

A. Very low blood sugar (hypoglycemia, usually due to excessive insulin);

B. Very high blood sugar (hyperglycemia, due to insufficient insulin).

The more common emergency is hypoglycemia. This can result from too much insulin or other medication, not having eaten enough of the correct food, unaccustomed exercise, or a missed meal.

In a medical emergency involving a participant with diabetes, the Service staff should immediately dial 000 for an ambulance and notify the family in accordance with the Regulation and guidelines on emergency procedures and administer first aid or emergency medical aid according to the participant's Diabetes Management or Emergency Plan.

SIGNS & SYMPTOMS

HYPOGLYCEMIA

If caused by **low blood sugar**, the person may:

- Feel dizzy, weak, tremble and hungry
- Look pale and have a rapid pulse
- Sweating profusely
- Numb around lips and fingers
- Appear confused or aggressive
- Unconsciousness

HYPERGLYCEMIA

If caused by **high blood sugar**, the person may:

- Feel excessively thirsty
- Have a frequent need to urinate
- Have hot dry skin, a rapid pulse, drowsiness
- Have the smell of acetone (like nail polish remover) on the breath
- Unconsciousness

Monitoring and Review

A health practitioner and workers will monitor, review and update and oversee the Severe diabetes management plan regularly. The health professional will decide about the regularity of the diabetes management plan revision and Full Care Lifetime will support it.

Also, the diabetes management plan will be reviewed if there is any change in the participants' needs like any incidents or emergencies.

Reports will be provided about the diabetes management plan based on a regular monitor by the workers.

SEIZURE MANAGEMENT POLICY AND PROCEDURE

POLICY

Full Care Lifetime is committed to comply with the NDIS Code of Conduct when providing supports or services to participants with seizure.

Full Care Lifetime is committed to make sure that identify each participant requiring seizure management.

Full Care Lifetime provides supports and services in a safe and competent manner with care and skill.

Full Care Lifetime promptly takes steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability.

PROCEDURE

PURPOSE

Our service is committed to providing a safe and healthy environment that is inclusive for all participants that are at diagnosed with diabetes.

SCOPE

This policy applies to participant with seizure and the relevant support worker. This procedure outlines the steps to be taken by the Full Care Lifetime. Support Team to support participants with epilepsy.

Who does it apply to?

This procedure applies to participants with a diagnosis of epilepsy and their Full Care Lifetime support team.

Definition

A seizure is a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations. Epilepsy is a condition characterized by recurrent seizures that may include repetitive muscle jerking called convulsions. Some participants may have regular seizures, but other participants may only experience them episodically. See table below for a description of the different types of seizures and the symptoms associated with them.

Please note that epilepsy is not the only cause of seizures - for example, they can sometimes occur when someone has a very high temperature.

Seizures are unpredictable, and the participant may not be aware they are having one.

Seizure Types and Symptoms

Generalized Seizures	Symptoms
Grand mal or generalised tonic-clonic	Unconsciousness, convulsions, muscle rigidity
Absence	Brief loss of consciousness
Myoclonic	Sporadic (isolated), jerking movements
Clonic	Repetitive, jerking movements
Tonic	Muscle stiffness, rigidity
Atonic	Loss of muscle tone
Partial Seizures	**Symptoms**
Simple (awareness retained)	Jerking, muscle rigidity, spasms Sensations affecting vision, hearing, smell Memory or emotional disturbances
Complex (awareness impaired)	Automatisms e.g. lip smacking, chewing fidgeting, involuntary coordinated movements
Partial seizure with secondar generalization	Initial preservation of consciousness that evolve into loss of consciousness and convulsions

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

- lack of sleep or disturbances in the participant's normal sleep cycle
- rapid visual stimulation, for example from TV, motion pictures, videos, disco, or strobe lighting
- drugs such as caffeine, alcohol, antidepressants, and some tranquillisers
- menstruation
- constipation
- excessive increase in body temperature, for example a fever.
- If a participant has known triggers, they must be included on the epilepsy management plan.

Seizure triggers

Triggers are specific situations that can either bring on a seizure or significantly increase the risk of a seizure. Common triggers include:

- Lack of sleep
- Missed medication
- Fever or other illness

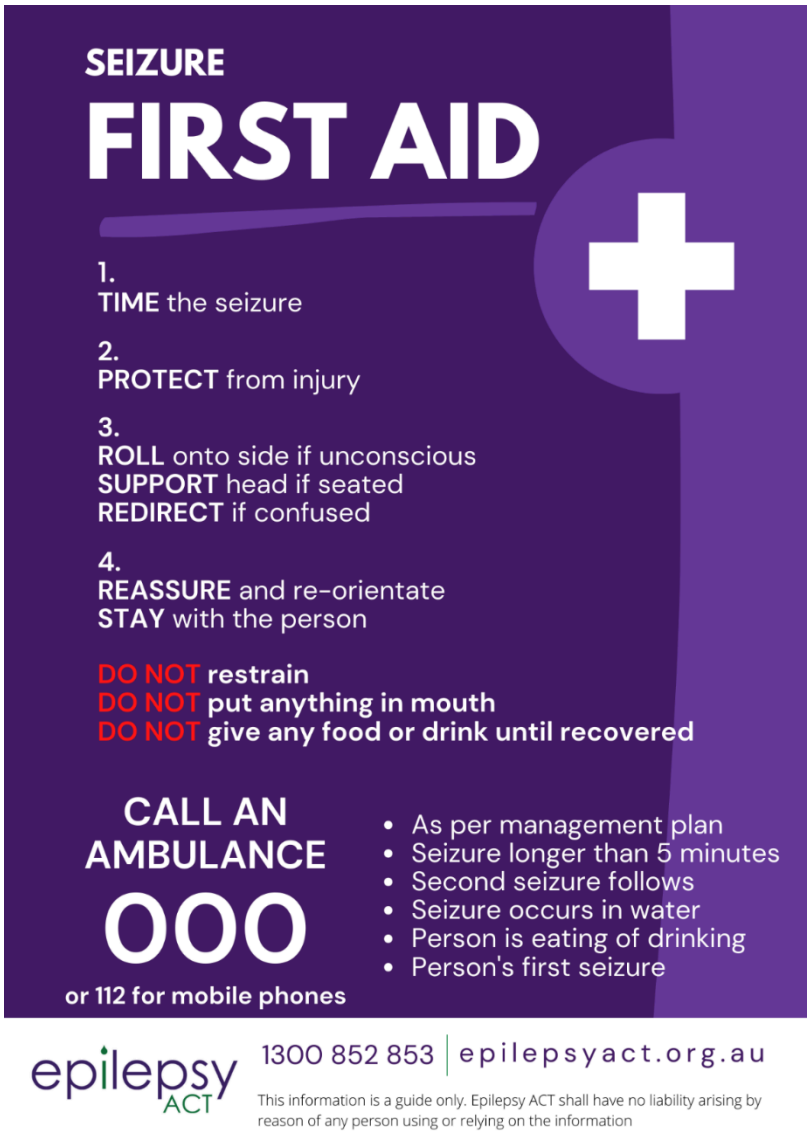
What to do if the participant has a seizure?

- **Act quickly** and follow the instructions outlined in the participant's Epilepsy Management Plan and Epilepsy First Aid (shown on the next page).
- **Stay with the participant** – do not leave them alone and protect them from injuries (especially their head).
- **Monitor them closely including**:
  - their vital signs (breathing etc.)
  - the timing and frequency of the seizures
- **Call an ambulance (000)** if:
  - the seizure lasts more than 5 minutes
  - the participant sustains an injury
  - there is food, fluid, or vomit in the mouth
  - The PRN medication does not stop the seizure activity
  - any other reasons identified in their Epilepsy Management Plan
  - if you are in doubt about what do.
- **Try to provide some privacy for the participant.**

What to do after the PARTICIPANT has a seizure?

- Stay with the participant and place them in the recovery position
- Monitor their recovery and if they experience another seizure call the ambulance
- Provide reassurance
- If this was a major seizure and the participant required medical attention, notify their emergency contact as soon as possible.
- Write up what happened in the participant's files.
- If medical attention was required and or the participant sustained any injury complete an Incident Report.

Diagram: First Aid for Seizures -General instruction



Epilepsy Management Plan Preparation

1. It is important that the participant understand that:

- they will be attending the health appointment when it is scheduled and what is involved
- If it is likely consent will be required during the appointment, and the participant is unable to provide this, the person responsible should attend, or be available by telephone.

2. The following items should be taken to the health appointment:

- The participant's Medicare card and pension card
- The current Medication Summary
- The most recent Emergency Information Sheet
- Their weight records
- The most recent nutrition and swallowing checklist (if applicable)
- The health appointment sheet
- Any other information relevant to their health care.

At the appointment

At the appointment staff should:

a) Provide a copy of the Epilepsy Management Plan template to the Doctor
b) Inform the Doctor of their role in supporting the participant
c) Support the participant to communicate (using if required communication aids etc.) directly with the Doctor
d) Help the Doctor to understand the participant's disability and what has been observed or reported about their health and the environment in which they live
e) Provide any supporting documentation that assists in developing the plan
f) Partner with the participant and the health professional to ensure a high-quality plan is developed
g) Request the plan be appropriately detailed and provide clear step by step guidance to support staff about what is required and the steps to be taken in the event the participant's health significantly deteriorates and requires urgent medical attention.
h) Take notes using the Health Appointment Sheet
i) Seek clarification about anything that is unclear, or they do not understand
j) Require the doctor to review, update (if required) the Medication Summary and make sure all the required fields are completed. It should be clear what medication is to be given routinely and any PRN medications, when they are to be given, and how and for how long the medication is to be taken.
k) Follow up requirements for the doctor or health professional to sign.

Epilepsy Plan Implementation

- The Epilepsy Management Plan should be recorded
- A Medical Alert should be clearly identified on the participant's file
- This plan is regularly reviewed.
- All support workers rostered to support this participant have been trained in epilepsy

management and receive refreshers.
- All support workers know where to find the Epilepsy Management Plan in the Participant's File.

All support staff working with participants with epilepsy are to make sure:

- That they are very familiar with the participant's Epilepsy Management Plan, and know where to find it quickly
- That they understand any early warning signs or environments that may trigger a seizure (e.g. strobing lights) and know what to do if the participant has a seizure.
- If in doubt, refer to the participant's Epilepsy Management Plan
- They take any emergency information and medication (if prescribed as part of an emergency response) with them when supporting the participant in the community
- Treat all seizures seriously and understand the risks associate with them.
- Ensure the participants is supervised and never left alone in water.

Supporting participants with epilepsy around water

There is a high risk of drowning for participants with epilepsy. The level of support and supervision a participant needs will vary depending on the severity and regularity of their seizures and other physical support needs. Activities including bathing, showering and swimming should be considered as part of Epilepsy Management Planning.

Unless otherwise specified in writing by the doctor, staff must always remain with the participant with epilepsy while they are showering, bathing, or swimming.

The doctor should be asked if swimming is a safe activity for the participant as the severity or number of seizures a participant has may mean that the risks of swimming outweigh the benefits. If the doctor advises that swimming can be a positive activity for the participant then: It is recommended that individuals with epilepsy should only swim in patrolled areas, preferably a swimming pool with clear water

The lifeguard on duty should be made aware that the individual has epilepsy

Staff must always keep the individual under visual observation and be able to get to the individual quickly if a seizure occurs. This may require the staff to be in the water.

Participants must be accompanied by staff who can swim

If a group of individuals with epilepsy are swimming, support must be provided on a one-to-one basis.

Life jackets may be used when swimming if appropriate.

Specific safety measures for swimming will be assessed by the participant's Team Leader who will conduct an individual risk assessment prior to the participant being supported to participate in any activities that may be a risk to the participant's health and safety. Specific safety

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

Epilepsy Management Review

The treatment of epilepsy requires regular medical review to ensure the management strategies provide the best possible seizure control while minimising the impact on general wellbeing.

When supporting participants to attend appointments to review their epilepsy management it is important that they attend with the following:

- Seizure records and observation charts
- PRN administration record
- Medication records
- Documents relating to any observations or changes in their:
    - in sleeping patterns
    - movement, e.g., balance or fine motor skills, including if any falls have occurred
    - general alertness and communication
    - general mood or behaviour.

Monitoring and Review

A health practitioner and workers will monitor, review and update and oversee the seizure management plan regularly. The health professional will decide about the regularity of the seizure management plan revision and Full Care Lifetime will support it.

Also, the seizure management plan will be reviewed if there is any change in the participants' needs like any incidents or emergencies.

Reports will be provided about the diabetes management plan based on a regular monitor by the workers.

Stoma Care Policy

Purpose

Full Care Lifetime is committed to providing the highest standard of care and support for a participant requiring stoma care. Full Care Lifetime has developed the Stoma Care Policy and Procedure for a high intensity support activity consistent with legislative requirements, ensuring we provide our participants with a safe, efficient and effective management service.

Scope

All relevant Staffs are required to implement this policy when working with participants who require stoma care.

Definitions

- **Stoma**: An artificial opening made into the abdomen on the surface of the body leading to the intestines or trachea.

- **Colostomy**: Refers to a surgical procedure where a portion of the colon is brought through the abdominal wall to carry faeces out of the body.

- **Ileostomy**: Refers to a surgical procedure where the lower portion of the small intestine is brought through the abdominal wall to carry faeces out of the body.

- **Tracheostomy**: A surgical formation of an opening into the trachea through the neck to allow the passage of air.

Principles of stoma care

- To follow personal hygiene and infection control procedures.
- To monitor the skin condition and keep the stoma area clean, replacing and disposing of bags as required.
- To maintain charts and records.
- To recognise and respond/report problems such as blockages, signs of deteriorating health or infection.
- Procedures are to be performed only by Full Care Lifetime staff with appropriate training and knowledge of stoma care.

Roles and responsibilities

Full Care Lifetime's Director and/or nurse is responsible for the overall clinical management of high intensity supported activities to support participant care.

Full Care Lifetime's participants are ensured their desired level of involvement is respected and maintained at all times. A participant's stoma care plan is overseen by the DIRECTOR and relevant health practitioners (e.g. registered nurse, enrolled nurse). The support plan is regularly reviewed, and information and revisions to procedures are provided to the participant and their carer/advocate.

Note: Any change to a stoma care plan is conducted by the Director and health practitioners (e.g. registered nurse, enrolled nurse).

Support plan

Full Care Lifetime's participant support plan is developed with the involvement of the participant, the carer/advocate, the DIRECTOR and health practitioners (e.g. registered nurse, enrolled nurse). Included in the plan is how to:

- follow personal hygiene and infection control procedures
- replace and dispose of bags and appliances as required
- maintain charts/records
- monitor participant skin condition and keep stoma area clean
- recognise and respond/report problems such as blockages, signs of deteriorating health or infection.

The Staff will request the participant's consent before commencing care of a participant's stoma. The participant's health status is regularly reviewed by the DIRECTOR and a qualified health practitioner (e.g. registered nurse, enrolled nurse). A participant's stoma care plan is reviewed quarterly, or as needed, to ensure updated strategies are in place which act upon information received from the participant, their carer/advocate, the Staff and health professionals.

The Staff is to follow Full Care Lifetime documentation procedures which include:

- bowel charts
- progress notes
- wound care plans/charts
- communicating with the Director and the participant and their carer/advocate to request a change in a stoma care plan.

Staff training

Full Care Lifetime trains the Staff in how to care for a stoma. The Staff is aware of associated health conditions and complications that can impact on a participant who has a stoma, together with the common risks and indicators of a malfunctioning stoma. Staff understand when to involve the Director or a qualified health practitioner (e.g. registered nurse, enrolled nurse). The Staff will receive training specifically relating to each participant's needs and the type of stoma care support they require, including:

basic anatomical knowledge of the eliminatory system

- skin and stoma care
- common conditions associated with stomas
- equipment and related functions
- procedures for safe positioning and monitoring.

Full Care Lifetime's training system complies with the high intensity support activities skills descriptor for providing stoma care, including how to follow procedures and exercise judgement regarding when to respond/report problems such as blockages, signs of deteriorating health or infection.

Full Care Lifetime has policies and procedures in place which identify, plan, facilitate, record and evaluate the effectiveness of training for the Staff. This system facilitates mandatory training in relation to staff obligations under the NDIS Practice Standards and NDIS rules.

Safety considerations

Full Care Lifetime ensures that the Staff is trained in infection control procedures as per the *Management of Waste Policy and Procedure*, including how to correctly remove and apply stoma-related equipment including the safe disposal of bags, as required. To monitor, chart and record participants stoma care, the Staff uses Full Care Lifetime's *Information Management Policy and Procedure.*

The Staff will consult with the participant, carer/advocate to identify, recognise and respond/report problems such as blockages, signs of deteriorating health or infection. The Staff will involve a qualified health practitioner (e.g. registered nurse, enrolled nurse) if any of the above risk factors are present with the participant.

Equipment in the home

The equipment in the home may include:

Colostomy or Ileostomy

- disposable gloves (powder free)
- disposable apron
- stoma bags and other appliances (flange extenders, washers, belts, filter covers, stoma measurement guides)
- relevant stoma products (adhesive remover, barrier wipes, protective pastes, hydrocolloid powder, filler paste, ostomy deodorant, thickening agents)
- toilet paper and/or disposable soft cloth for cleaning faeces
- bag for waste
- disposable gloves (powder free)
- disposable apron
- gauze pads
- normal saline or distilled water
- cotton-tipped swabs
- washcloth
- towels
- trach tube ties
- clean scissors
- bag for waste