Residential Aged Care Services Guideline

1. Guiding Principles

This guideline has been developed to:

- embed the key principles of person-centre culturally safe and responsive care
- promote a common understanding of the roles, responsibilities and accountabilities of residential aged care services in relation to delivering safe, quality care for older people
- ensure older people receive care that is continuous, safe, timely and effective and delivered in the most appropriate setting.

Moving permanently into residential aged care is a major life transition for most people, especially if it is due to a sudden deterioration in health. As with any significant change, feelings of loss, fear and uncertainty are common. Individuals may have difficulty adjusting to unfamiliar surroundings, living near others, loss of independence, loss of important roles in the family and wider community, missing the family home and being unable to bring many of their cherished possessions into their new home. The move can also be especially traumatic for the Forgotten Australians, Former Child Migrants, Aboriginal people and for people living with dementia.

It is important to give the older person time to adjust to this change as a person's care experience can be influenced by the way they are treated. Person-centred care is that which is respectful of, and responsive to the preferences, needs and values of the person and is the foundation to safe, high quality care.

The key principles of holistic person-centred care are:

- Treating people with dignity and respect by being aware of and supporting personal perspectives, values, beliefs and preferences. Listening to each other and working in partnership to design and deliver services.
- Providing services and support that is important for a person's health and wellbeing.
- Autonomy - The provision of informed choice and subsequent respect for choices made. Balancing rights, risks and responsibilities. Optimising a person's control through the sharing of power and decision-making. Maximising independence by building on individual strengths, interest and abilities
- Life experience - Supporting the sense of self by understanding the importance of a person's past, their present-day experience, and their hopes for the future.
- Ensuring that a person is cared for in a safe and comfortable environment, free from abuse and neglect.
- Understanding relationships - Collaborative relationships between the service provider and service user and their carers and staff. Social connectedness through the local community through opportunities to engage in meaningful activities.
- Environment - Organisational values underpinned by person-centred principles. Responsive support that is responsive to individual needs. A planned, organisation-wide effort to individual and organisational learning.

2. Guideline

This guideline is to be read in conjunction with the WACHS Residential Aged Care Policy.

2.1 Comprehensive Care

Residents can expect to receive holistic person-centred care, which meets individual physical, psychological, cultural, emotional and social needs, and acknowledge their personal needs and preferences. A holistic person-centred approach to care is to include activities that match a resident's interests, personal histories, and abilities.

- **Comprehensive initial assessment and social profile** identifies the person's interests, histories, needs, preferences and abilities and enables staff to offer relevant and appropriate opportunities for residents to engage in activities.
- **Assessment and care planning** require a collaborative and interdisciplinary approach which includes consultation and collaboration with the resident, family and/or their representative throughout the care journey, including initial assessment and care planning.
- **Regular resident meetings** provide an opportunity for the person and their representatives to be involved in decision making and planning, to have opinions, share ideas and choices and raise issues or concerns. (Refer to RC25 Care Conference form and Appendix 4 for Letter template for resident family/representative)
- **Regular care conferences** with a multidisciplinary team helps to maintain open communication between staff, the resident, their family and/or representative and provides an opportunity for early identification of issues or concerns which can be addressed before they become problematic.
- **Respecting resident choice** with regards to routines, choice of activity and meals encourages residents' independence and autonomy.
- **Cultural and spiritual care awareness and sensitivities** acknowledges that individuals come from a variety of social and cultural backgrounds. Aboriginal Health Worker/ Liaison Officer, Aboriginal interpreters and CALD Liaison Officer roles form an important link in maintaining cultural competence. Designating a quiet room or place to reflect and worship and celebrating cultural days will assist in creating cultural sensitivity.

2.2 Dignity of Risk

Dignity of Risk is the principle of respecting an individual's right to choose and the right to take reasonable risks. This concept means that all adults have the right to make their own decisions about their health and care unless they have been deemed not to have legal capacity. Dignity of Risk acknowledges that life experiences come with risk, and staff must support individuals in experiencing both success and failure with the emphasis on reducing any identified risk that could potentially cause harm.

Principles of Dignity of Risk

- Adults have the right to make their own decisions and to be assumed to have capacity to do so unless shown otherwise – and capacity is to be viewed as decision-specific.
- A person must understand the consequences of making the informed decision.
- A person is to be offered all reasonable support and assistance in making and following through on their decision before others step in to make decisions for them.
- People have the right to:
  - make decisions that others feel are unwise or disagree with
  - have a different tolerance for the risks associated with a decision
  - fail after making a decision.
- When others are involved in decision making with a person, any decisions are to be made with the person's best interests and preferences in mind.

In residential aged care facilities, there must be a balance between dignity of risk and duty of care, and staff are to accept that duty of care does not exist to create restrictions for residents. The emphasis is to be on reducing the risk that could potentially cause them harm.

Refer to: RC29 WACHS My Choices - Dignity of Risk

2.3 Comprehensive screening, assessment and care planning

The resident, family and/or their representative should be encouraged to participate in care planning to ensure shared decision-making. Comprehensive screening, assessment and holistic person-centred care planning is essential to inform the development of an individualised care plan that is consistent with the resident's needs, wishes and preferences.

It is also important that residents maintain their usual activities and interests as much as possible. This could include visiting the homes of family members and friends and continuing to participate in any family or cultural obligations, hobbies, spiritual activities and any other community activities.

All staff are responsible for developing and applying culturally safe and responsive care of Aboriginal people, and acknowledging the need for the individual, family, and carer to stay culturally and spiritually connected and supporting ageing on country.

Personal Care

- **Assessment and Care Planning:** RC5 WACHS Resident Admission Assessment and RC7 WACHS Resident Care Plan

All staff and volunteers must ensure that individuals receive personal care that is individualised to their specific needs and preferences. Residents should be offered consistency and continuity with their personal care needs wherever possible (e.g. same staff/volunteer, same routine). Both male and female staff should be available (if

staffing mix allows), allowing the resident choice regarding the gender of the staff member who attends to their personal needs.

Staff must promote a culture of independence ensuring that residents are provided with sufficient time, equipment and support to be able to perform some or all aspects of their personal care. Personal care must be provided in an environment that promotes dignity and privacy and should take into account the culture, religion and language preferences of each individual.

Preventing and Managing Pressure Injuries

- **Screening and Assessment:** MR124 WACHS Braden Scale and Pressure Injury Risk Assessment**;** MR124B WACHS Comprehensive Skin Assessment**;** MR122 WACHS Wound Assessment and Management Plan

Processes are required to be in place for preventing and managing pressure injuries. Risk factors and the need for comprehensive and ongoing skin inspections must be documented and details of prevention strategies communicated to all staff caring for an at-risk resident.

Preventing Falls and Harm from Falls

- **Screening and Assessment:** MR521 WACHS Falls Risk Assessment and Management Plan

Residents are to be provided with equipment and devices to promote safe mobility and reduce harm from falls**.**

Nutrition and Hydration

- **Screening and Assessment:** MR60.1.8 WACHS Mini-Nutrition Assessment - Short Form (MNA-SF); RC15 WACHS Dietary Preference Form

All residents are screened for malnutrition and dehydration and any other specific nutritional requirements on admission to the facility and are monitored and reviewed on a regular basis and when any change in nutritional status is detected. Preparation and distribution of food and fluids are based on current evidence and best practice. Resident's nutrition and hydration needs are identified and documented and referrals to appropriate allied health professionals are made based on the outcome of the assessments.

Cognitive Impairment and Behaviour Management

- **Screening**: MR66.17 WACHS 4AT Rapid Assessment Test for Delirium and MR66.4 WACHS Abbreviated Mental Test Score
- **Assessment and Care Planning**: RC13 WACHS Behaviour Assessment and Support Plan

Residents are screened for delirium on admission to the facility and when a change in behaviour is detected. The initial screen will provide a useful baseline for further monitoring.

Individual attention and support is to be given to residents with cognitive impairment including individual therapy activities and specific programs designed to prevent or manage a specific condition or behaviour and to enhance the quality of life of the resident.

Minimising Restrictive Practices

- **Assessment and Monitoring:** RC43 WACHS Restraint Assessment and RC44 WACHS Restraint Chart

Restraint is the restriction of a person's freedom of movement. It includes mechanical, physical, chemical, and environmental restraint and aversive practices.

Alternative strategies must always be trialled in the first instance before any form of restraint is considered. Over sedation of a resident can have serious consequences such as dehydration, falls, respiratory depression, pneumonia and death.

Any use of antipsychotics is to be managed in line with best practice and legislation.

Advance Care Planning / Advance Health Directives

Advance Care Planning (ACP) is the voluntary process of planning for future health and personal care needs. It provides a way for the resident to think about and document their values, beliefs and preferences so that they can guide decision-making at a future time when they may not be able to communicate their decisions. Advance care planning can help residents and their families avoid any non-essential and / or unwanted hospital transfers and inherent risks.

Advance Care Planning can lead to avoidance of non-essential hospital transfers and their inherent risks and is more likely to facilitate a dignified, peaceful death. If an AHD or an Advance Care Plan (ACP) document exists for any resident, staff are to ensure that a copy is filed in the residents record as per the WACHS Advanced Health Directive and Enduring Power of Guardianship Guideline and is easily accessible. The AHD and ACP is to accompany the resident if they are transferred to another hospital for medical care. All clinical care and treatment of the resident should be informed by ACPs and AHDs.

Discussions with residents, their family and/or their representatives about advance care planning should ideally commence before or as soon as practical after the resident's admission to the aged care facility and occur on a regular basis thereafter to ensure the wishes of the resident and their representative remain current (NHMRC 2006).

Advance care planning documents include:

- Advance Health Directive form – a legal document in WA that can only be completed by an adult with full legal capacity (MR00H)

- Enduring Power of Guardianship – a legal document in which a person appoints another person(s) to make a personal lifestyle and health care treatment decisions on their behalf.
- Advance care plans - non-statutory documents such as the ACP for someone with insufficient decision-making capacity or the WA My Values and Preferences Form: Planning for my future care.

Non-statutory ACP documents are not recognised by specific WA legislation, but in some cases may be recognised as a Common Law Directive. These documents are still important in guiding treating health professionals and family members as to how a person wishes to be treated and copies of the documents stored in health records where appropriate.

Refer to:
- Use of Advance Care Planning, Advance Health Directives and Goals of Patient Care in Residential Facilities
- WA Values and Preferences Form
- ACP for someone with insufficient decision-making capacity
- Health Professional Guide to Advance Care Planning in WA
- Advanced Care Planning: Aged Care Implementation Guide 2021

Residential Goals of Care (RGoC)

The Residential Goals of Care form (RC 00H.1) is a goals of care form specifically for residents of aged care facilities. It aims to support shared decision-making between the resident, their family / carers and the health care team. RGoC forms can be completed as part of discussions between the health care team, the resident (if suitable) and their family / carers. These conversations are ideally done during case conferences and family meetings where there is sufficient time for discussion. If a resident has an ACP document, the RGoC should reflect what is written in the ACP document(s). If a resident no longer has capacity to write an AHD or other ACP document, they may benefit from a goals of care discussion.

Once documented, RGoC should still be reviewed regularly with the resident, their family / carers. Some of the appropriate times to review a goals of care document are:

- when a resident's choices or treatment options change
- after diagnosis of a new illness or disease
- after an unplanned admission to hospital
- when general health is poor or deteriorating (troublesome symptoms most of the time despite treatments, general deterioration of health)
- when family or carer asks for palliative care, chooses to reduce treatments and / or wants to focus on quality of life.

A copy of RGoC must be included in transfer documents and filed in resident's health record.

This form does not take the place of the AHD. If a resident has an AHD this remains in effect and current unless the person wishes to revise their AHD following their admission.

For further information refer to:
- Residential Goals of Care Guideline

2.3 Voluntary Assisted Dying

WACHS is committed to providing country Western Australians with culturally, safe and responsive, high-quality end-of-life and palliative care guided by the person's own values and choices. Staff are encouraged to work collaboratively with residents and their family/representatives to plan for Residential Goals of Care and Advance Health Directives. For more information refer to:

- WACHS Voluntary Assisted Dying Policy
- WA Health Managing Voluntary Assisted Dying Policy – MP 0154/21
- WA Voluntary Assisted Dying Guidelines
- Voluntary Assisted Dying Safety and Quality Guidance for WA Health Services

Sexuality and Intimacy

Understanding and respect for diversity must be promoted in all WACHS Residential Aged Care Facilities (RACFs). All staff and volunteers are expected to provide non-judgemental care and services to all residents, regardless of age, race, cultural customs, religion, physical ability or attributes and sexual identity.

Sexual health, which includes sexual identity, sensuality, intimate relations and expressions of sexuality, is supported in a private environment within the facility. This includes lawful, consensual and private intimacy between opposite and same sex residents or partners.

Escalation of care

Refer to:
- Care Location of the Acutely Unwell MPS Aged Care Resident flowchart
- MR184A WACHS Resident Handover Form

2.4 Incident Management and Prevention

As part of the Serious Incident Response Scheme (SIRS), it is the facility's responsibility to manage and take reasonable steps to prevent incidents from occurring. Management of incidents must focus on the safety, health and well-being and quality of life of the resident. When an incident has involved an Aboriginal person, seek the cultural interpretations and insight of an Aboriginal worker to improve management and prevention of future incidents

Data collected in relation to incidents that occur will enable managers to continuously improve management and prevention of incidents, including:
- identifying and addressing systemic issues in the quality of care provided.

- regularly analysing the information to assess the effectiveness of the management of incidents
- providing feedback and training to staff members about managing and preventing incidents
- involvement of the person and/or their representative in the management/prevention of incidents
- use of an open disclosure process.

2.5 Consent to Treatment

Consent to treatment is a person's agreement for a health professional to proceed with a specific proposed treatment. To maintain a consistent, standardised approach to documentation across WACHS, staff are required to seek formal consent from the resident/representative prior to conducting any minor medical procedure. Explicit consent to treatment must be documented in the resident's health record or recorded on the relevant consent form:

- MR30A WACHS Patient Consent to Treatment of Investigation
- MR30C Adults without the Capacity to Consent to Treatment or Investigation

Note: If a resident does not have decision-making capacity, they may still have the ability to communicate their preferences and consent for medical treatment.

Refer to:
- WA Health Consent to Treatment Policy
- WACHS Adults with Impaired Decision-Making Capacity Procedure

2.6 Resident Trust Monies

Residents are to be made aware that they are responsible for the safe-keeping of any money, documents or other valuable possessions, unless they are unable to do so due to a diagnosed cognitive impairment (WACHS Adults with Impaired Decision Making Capacity Procedure).

As a preference WACHS suggests that it is the responsibility of the resident, their family and/or their representative to avoid bringing large sums of money into the facility. If the resident has an Enduring Power of Attorney or other person legally appointed to manage their finances, it would be expected that they manage the resident's money on their behalf.

Should the residential aged care facility receive any monies from a resident, or direct payment from Centrelink, it must be recorded and disbursed in accordance with the WACHS Patient Trust Monies Policy. Regional Finance Managers are responsible for ensuring compliance and monitoring of this policy.

2.7 Complaints Mechanisms

Care recipients have several rights in relation to complaint mechanisms. These include the right to:

- be treated with respect and accepted as an individual, and to have their individual preferences taken into account and treated with respect
- freedom of speech
- complain and take action to resolve disputes
- have access to advocates and other avenues of redress
- be free from punishment, or well-founded fear of punishment, in any form for taking action to enforce their rights.

Service providers are obliged to not act in a way that is inconsistent with these rights. Section 56-4*, Aged Care Act 1997*(Cth)

There are two options available to people wanting to make a complaint about the quality of care or services provided by a service provider:
- internal (using the WACHS complaint handling system)
- external (through the Aged Care Quality and Safety Commission website).

Internal Complaints resolution

WACHS is required to establish and operate an effective system for handling complaints. The system should be accessible, confidential, prompt, fair and well publicised within the service. The internal process established and operated by Approved Providers must meet the requirements set out under*:*

- *Aged Care Act 1997,* section 56-4
- the Aged Care Principles (particularly the Quality of Care Principles and Responsibilities).

Access to external complaint mechanisms

Australian Government standards for aged care require that Approved Providers ensure residents and other interested parties have access to external complaint mechanisms and advocacy support at any time.

The complaint can be made directly to the Aged Care Quality and Safety Commission. The Aged Care Quality and Safety Commission is an independent regulatory body, responsible for the approval, accreditation, assessment, monitoring, compliance and complaints management for all Commonwealth subsidised aged care providers. Refer to: Aged Care Quality and Safety Commission – Making a complaint.

Refer to:
- MP 0130/20 Complaints Management Policy
- WACHS Complaints Management Procedure

2.8 National Disability Insurance Scheme (NDIS) Participants in Residential Age Care

NDIS participants living in RACFs are dual participants of the NDIS and aged care systems. This new approach affords NDIS participants coverage across all NDIS Commission functions, including reportable incidents and behaviour support. The

approach is proportionate, recognising the existing regulation that RACF providers continue to be subject to under the *Aged Care Act 1997*.

Behaviour Support: Aims to improve quality of life through individualised strategies and person-centred supports that:

- are responsive to the person's need
- reduce the occurrence and impact of behaviours of concern
- addresses the underlying causes of behaviours of concern
- minimise the use of restrictive practices
- safeguards the dignity and quality of life of individuals.

Regulated restrictive practices can only be used in the context of:

- reducing the risk of harm to the person with disability or others
- clearly being identified in a Behaviour Support Plan
- authorisation (however described) by the state/territory where it is required
- only being used as a last resort
- being the least restrictive response available
- being proportionate to the potential harm to self or others
- being used for the shortest possible time
- the NDIS participant being given opportunities to develop new skills that have the potential to avoid the need for a restrictive practice.

Providers who use regulated restrictive practices must meet the requirements outlined in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.

3. Definitions

Aboriginal	Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.
Advance Care Plan	A plan that states preferences about health and personal care, and preferred health outcomes. The plan may be made on the person's behalf and should be prepared from the person's perspective to guide decisions about care.
Advance Health Directive	This document is a formal advance care plan, expressed in writing, signed by a competent adult and recognised by common law or legislation.
Aversive Treatment Practices	Use of unpleasant physical, sensory or verbal stimuli (e.g. voice tone, commands, threats) used for the sole purpose of limiting a person's free movement in an attempt to reduce undesired behaviour. Aversive treatment also refers to the withholding of basic human rights or needs (e.g. food, warmth, clothing or positive social interaction); a person's goods or belongings, or a favoured activity for the sole purpose of behaviour management or control.

Carer	A carer is someone who provides unpaid care and support to family members and friends who have disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue, or who are frail aged. Extract*:* Carers Australia In the context of Aboriginal communities and kinship systems, caring is a collaborative act with many people helping care for a single person.
Chemical Restraint	A practice or intervention that is or involves the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness, or End of Life Care
Cognitive Impairment	Refers to diminishing ability in judgement, memory, learning, comprehension, reasoning and/or problem solving and can result from a number of conditions, including dementia, delirium and/or depression. This can also include substance abuse/misuse, including medication mismanagement/electrolyte imbalance. Cognitive impairment can be temporary, fluctuating or permanent.
Decision-making capacity	In the context of medical treatment, a person has capacity if they are capable of understanding the nature, purpose and consequences of any proposed treatment.
Delirium	A disturbance of consciousness and a change in cognition that develops over a short period of time as a consequence of a general medical condition or toxin exposure. It may complicate dementia and often presents with an acute change in behaviour.
Enduring Power of Attorney	A legal agreement that enables a person to appoint a trusted adult to make financial and/or property decisions on their behalf.
Guardian	An adult appointed by the State Administrative Tribunal to make decisions on behalf of a person regarding their health and safety
Mechanical Restraint	A practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour. Note: injuries and death have occurred as a direct complication of the use of mechanical restraint. Improvised restraint arrangements such as bandages, sheets, meal trolleys, must never be used as restraint.
Open Disclosure	Open discussions with consumers, their family, carers and other support people of incidents that have caused harm or had the potential to cause harm to the consumer. It involves an expression of regret and a factual explanation of what happened, the potential consequences and what steps are being taken to manage this and prevent reoccurrence.

Physical Restraint	A practice or intervention that is, or that involves, the use of physical force to prevent, restrict or subdue movement of a person's body, for the primary purpose of influencing the person's behaviour. It does not include: The use of a hands-on technique in a reflexive way to guide or re-direct a person away from potential harm or injury consistent with what could reasonably be considered to be the exercise of care towards a person.
Restraint	**restraint** means any practice, device or action that interferes with a consumer's ability to make a decision or restricts a person's free movement.
Representative **Part 1 section 5 Quality Care Principles 2014**	(1) **Representative**, of a consumer, means: (a) a person nominated by the consumer as a person to be told about matters affecting the consumer; or (b) a person: (i) who nominates themselves as a person to be told about matters affecting a consumer; and (ii) who the relevant organisation is satisfied has a connection with the consumer and is concerned for the safety, health and well-being of the consumer.
Staff	Staff member, of a health service provider, means: (a) an employee in the health service provider (b) a person engaged under a contract for services by the health service provider;(section 6, *Health Services Act 2016)*
Substitute Decision-maker	A person who is permitted under the law to make decisions on behalf of and individual who does not have capacity. An individual can have more than one substitute decision maker who can make decisions about personal or financial matters.

4. Roles and Responsibilities

All staff are accountable for:

- providing care described in this Guideline within their scope of practice and designated role
- developing and applying cultural capabilities to deliver culturally safe and responsive care.

Responsibilities and duties are clearly defined within the registered Job Description Form (JDF) with required competencies and context of practice clearly defined.

5. Compliance

Compliance with this guideline is a mandatory requirement under the *Aged Care Act 1997* (Cth) and the Quality of Care Principles 2014.

Failure to comply with this guideline may constitute a breach of the WA Health Code of Conduct (Code) and the Aged Care Quality and Safety Commission (Code of Conduct and Banning Orders) Rules 2022.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

The residents' health record must contain all relevant clinical information corresponding to each individual and must be adequately detailed to permit continuity of care by attending health professionals. Additionally, the health record must provide appropriate information to allow for clinical reviews and other quality assurance tasks. Accurate documentation is important as the record acts as a communication tool, as evidence in court, in research and in clinical classification.

For further information refer to WACHS Documentation Clinical Practice Standard).

As an Approved Provider, all WACHS residential aged care facilities are to keep the following records relating to residents (Records Principles 2014):

- resident assessments
- consent to treatment
- individual person-centred care plan
- medical records, progress notes and any relevant clinical records
- occupancy Agreements and Security of Tenure between the resident and the approved provider
- resident accounts
- records about a resident's admission, departure and leave arrangements (including death) and
- up-to-date name and contact details of any other representative, according to information given to the approved provider by the resident/representative.

An Approved Provider is to also keep:

- consolidated records of all incidents involving allegations of or suspicions of reportable assaults
- records showing compliance with police clearances and aged care criminal checks for all staff members, volunteers and contractors, and
- a register of flu and COVID vaccinations provided to staff, residents and visitors to the facility.

7. Evaluation

Monitoring of compliance with this document is to be carried out by individual sites using the following means or tools:

- records of consumer feedback/complaints
- quarterly and six-monthly residential audits and surveys
- data obtained from CIMS Datix.

8. Standards

National Safety and Quality Health Service Standards: 1- 8
NSQHS Aged Care Module: Actions 1-6
Aged Care Quality Standards: 1-8
National Standards for Disability Services: Standards 1-6 inclusive
Inclusive Service Standards

9. Legislation

Accountability Principles 2014
Aged Care Act 1997(Cth)
Aged Care Quality and Safety Commission Act 2018 (Cth)
Aged Care Quality and Safety Commission (Code of Conduct and Banning Orders) Rules 2022
Carers Recognition Act 2004 (WA)
Freedom of Information Act 1982 (Cth)
Guardianship and Administration Act 1990 (WA)
Health Practitioner Regulation National Law (WA) Act 2010
Health Services Act 2016 (WA)
Medicines and Poisons Act 2014 (WA)
Medicine and Poisons Regulations 2016 (WA)
Mental Health Act 2014 (WA)
Quality of Care Principles 2014 (Cth)
Therapeutic Goods Act 1989 (Cth)
Work Health and Safety Act 2020 (WA)

10. References

1. AS2828.1 Australian Standard for Paper-based Health Records
2. National LGBTI Ageing and Aged Care Strategy
3. Treasurer's Instructions 806 - Specific Purpose and Other Money (Money Held in Trust)
4. Caring for Forgotten Australians, Former Child Migrants and Stolen Generation
5. Charter of Aged Care Rights
6. Charter of Mental Health Care Principles
7. WA Aboriginal Health and Wellbeing Framework 2015-2030
8. ACSQHC - Person-Centred Care

11. Related Forms

MR184A WACHS Resident Handover
WACHS Consumer Feedback/Complaint Form - general
WACHS Residential Aged Care Forms

12. Related Policy Documents

WACHS Residential Aged Care Services Policy
WACHS Adult Airway Management Clinical Practice Standard
WACHS Approved Provider Compulsory Reporting of Assault on Adult Patients Policy
WACHS Bladder Management Continence Clinical Practice Standard
WACHS Bladder Management Catheters Clinical Practice Standard
WACHS Bowel Management Clinical Practice Standard
WACHS Clinical Observations and Assessments CPS (physiological [vital signs], neurovascular, neurological and fluid balance)
WACHS Cognitive Impairment Clinical Practice Standard
WACHS Complaints Management Procedure
WACHS Decision Making for the Use of Bed Rails Procedure
WACHS Documentation Clinical Practice Standard
WACHS Falls Prevention and Management Clinical Practice Standard
WACHS High Risk Medication Procedure
WACHS Identifying, Preventing and Responding to Abuse of Older People Policy
WACHS Medication Assistance by Unregulated Health Workers Policy
WACHS Medication Handling and Accountability Policy
WACHS Medication Prescribing and Administration Policy
WACHS Missing Aged Care Resident Procedure
WACHS Nutrition Screening, Assessment and Management Procedure
WACHS Nutrition Standards for Adult Inpatients and Residential Aged Care Policy
WACHS Open Disclosure Procedure
WACHS Outbreak Management Action Plan – Gastroenteritis Procedure
WACHS Partnering with Consumers Guideline
WACHS Pressure Injury and Prevention Management Policy
WACHS Recognising and Responding to Acute Deterioration (RRAD) Policy
WACHS Recognising and Responding to Acute Deterioration (RRAD) Procedure
WACHS Restraint Minimisation Policy
WACHS Wound Management Policy

13. Related WA Health System Policies

MP 0095/18 Clinical Handover Policy
MP 0130/20 Complaints Management Policy
MP 0131/20 High Risk Medication Policy
MP 0078/18 Medication Chart Policy
MP 0171/22 Recognising and Responding to Acute Deterioration Policy
MP 0103/19 Reporting of Schedule 4 Restricted and Schedule 8 Medicines Discrepancies Policy
MP 0121/19 Responding to Abuse of Older People (Elder Abuse) Policy

14. Policy Framework

Clinical Governance Safety and Quality

15. Appendix

Appendix 1: WACHS Residential Aged Care Process Flowcharts
Appendix 2: WACHS Residential Aged Care Forms
Appendix 3: WACHS Residential Aged Care Associated Resources
Appendix 4: Care conference letter template

This document can be made available in alternative formats on request for a person with a disability

Contact:	Senior Project Officer		
Directorate:	Aged Care	**EDRMS Record #**	ED-CO-21-464932
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Appendix 4: Care conference letter template

Government of Western Australia
WA Country Health Service

Name
Address
Address
Address

Dear _____

As part of our ongoing care we are committed to offering you the opportunity to attend a family conference on *Day*_____ *Date*: _____
Time: _____.

This is a useful process for us to meet and discuss all aspects of the care and services provided to your loved one and will help us to identify any issues of concern and any areas for improvement.

Family conferences often last around an hour and participants are usually the resident, family member and/or representative. Other health professionals such as physiotherapy and occupational therapy staff can be involved with prior agreement. Family conferencing does not typically involve your General Practitioners, although again should there be the need for their attendance this can be arranged.

Please return the slip attached to this letter for our records, or contact us on Tel: _____

Yours sincerely,

NAME:

POSITION:

_____

Date: .....

I, ..., family member/representative of ....., acknowledge that I have been offered the opportunity for a family conference at _____. I wish/I do not wish *(delete as appropriate)* to attend a conference at this time.

If you are unable to attend, you may call the facility or send a letter/email outlining any concerns you may have.

Healthier country communities through partnerships and innovation
Our Values: Community | Compassion | Quality | Integrity | Justice