Lifestyle Centred Services

centred around you

POLICY AND PROCEDURES

HIGH INTENSITY SUPPORTS

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Introduction

NDIS providers are responsible for ensuring workers have current skills and knowledge, and that the training of workers is documented and regularly audited. It is recommended that a worker's skills and knowledge to carry out high risk of seizure supports are reviewed annually to confirm the worker has current skills and knowledge described in this skills descriptor. Where a worker has not delivered this support for a period of more than three months, or if NDIS Practice Standards: skills descriptors 45 a Client's support needs have changed and/or they have an updated support plan in place, it is recommended the worker be reassessed before supporting the Client and undertake refresher training if required; this timeframe may vary depending on the nature of supports required and worker experience.

- Understands the support plan, confirms it is the correct and current plan for the Client, and checks the Client's specific support requirements.
- Checks with the Client on their expectations, capacity and preferences for being involved in the delivery of support.
- Checks with the Client on their preferences for communication, including the use of aids, devices and/or methods.
- Communicates with the Client using Client-specific communication strategies, communication aids, devices, or resources, including resources in the Client's preferred language.
- Prepares for hygiene and infection control.
- Checks that required equipment and consumables are available and ready for use.

Contents

Module 1. Introduction and Overview

1.0 Quality and safety of care –our care principles

Lifestyle Centred Services Pty Ltd is committed to providing the highest standard of care and support when delivering support under the National Disability Insurance Scheme (NDIS) Module 1 – High Intensity Daily Personal Activities HIDPA. We have developed procedures and processes to ensure that we provide care consistent with all legislative requirements and provide our Clients with a safe, efficient and effective service.

- **Access to appropriate supports:** Each Client can access supports appropriate for their needs.
- **Safe environment for supports:** Each Client can access supports in a safe environment that is appropriate for their needs.
- **Risk Management**: Risks to Clients are identified and managed.
- **Quality Management:** Each Client benefits from a quality management system that promotes continuous improvement of support delivery.
- **Information Management:** Each Client's information is managed to ensure that it is identifiable, accurately recorded, current and confidential. Each Client's information is easily accessible to the Client and appropriately utilised by relevant workers.
- **Incident Management:** Each Client is safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, responded to, well-managed and used as part of our continuous improvement.
- **Human Resource Management:** Each Client's support needs are met by competent workers who have the relevant expertise, experience, and qualifications to provide support.

When providing High Intensity Daily Personal Activities HIDPA, Lifestyle Centred Services Pty Ltd is committed to the following **12 principles of care**:

1. Ensure care is delivered safely.
2. Maintain the standard of quality care provided to Clients.
3. Assess our Clients' needs.
4. Consult with Clients regarding how they would like us to provide HIDPA.
5. Provide an up-to-date Care Plan outlining the tasks and services to the Client.
6. The desired level of Client involvement is respected and always maintained.
7. Ensure our support workers have the appropriate training and skill to deliver HIDPA.
8. Use current evidence-based practice when developing a person-centred Care Plan with the Client.
9. Follow personal hygiene and infection management procedures outlined in the Infection Management Policy and Procedure.
10. Recognise the risk and symptoms of deterioration.
11. Identify when to refer to a health practitioner.
12. Follow planned instructions under health practitioner supervision.

2.0 Purpose of high-intensity support procedures

Lifestyle Centred Services Pty Ltd is committed to providing high-quality care and excellence in support and service. Lifestyle Centred Services Pty Ltd has developed high-intensity support procedures consistent with legislative requirements to provide a safe, efficient and effective management service to our Clients.

3.0 Definitions

Term	Definition
Health practitioner	A general practitioner, allied health practitioner, mental health provider, registered or enrolled nurse.
Registered/enrolled nurse	APHRA registered/enrolled nurse supervises HIDPA and trains support workers to deliver HIDPA.
Support worker	An individual who delivers high-intensity activities, care and supports to a Client.
Training plan	Theoretical training and skills competency assessment.

Documents and process linked to provision of High Intensity Daily Personal Activities HIDPA.

The NDIS High Intensity Personal Supports Skills Descriptor for module 1 are supplementary guidance for NDIS providers and workers supporting Clients with high intensity daily personal activities (HIDPA). They describe the skills and knowledge that NDIS providers should ensure their workers have when supporting Clients who rely on HIDPAs. The High Intensity Personal Supports Skills Descriptor include information relating to:

- Relationship to high intensity daily personal activities (Module 1) NDIS Practice Standards**.**
- Relationship to other skills descriptors: points to any other skills descriptor(s) that are commonly associated with the skills descriptor, depending on the health needs of the Client.
- Context: The arrangements NDIS providers need to have in place to ensure workers delivering HIDPA meet the needs of each Client. This includes, but is not limited to, ensuring that workers are aware of and understand the relevant support plan, appropriate policies and procedures are in place and workers have access to timely supervision, support and resources.
- Scope: When the support outlined in the skills descriptor may apply and the strategies, support and/or equipment covered.
- Training: Guidance on appropriate training, including recommendations on periodic assessment and refresher training

4.0 Roles and Responsibilities

Clients' Care Plans are overseen by Service Coordinator and relevant health practitioners (e.g., general practitioner, registered/enrolled nurse).

The roles and responsibilities of our team are detailed below.

4.1 The Management Team

The Management Team is responsible for the overall clinical and medication management of high-intensity support activities for a Client's care. The Management Team will work with/instruct Lifestyle Centred Services Pty Ltd team members to safely deliver supports and ensure the Clients receive high-intensity care and supports that meets their needs.

The Service Coordinator's roles and responsibilities include:

- discussing changes in the Care Plan with the Client and their family or advocate
- completing the Individual Risk Profile Assessment Form
- giving Clients and their families/advocates a copy of the updated Care Plan
- ensuring procedural updates and information are provided to the Client, their family or advocate and support workers.
- coordinating changes in the medication management, with input from an appropriate health practitioner (e.g., general practitioner, bowel care specialist or a registered/enrolled nurse)
- ensuring Client consent to receive care is current and covers all the HIDPA provided to the Client.
- ensuring staff understand the processes for recognising deterioration in a Client's condition.
- ensuring staff understand how to escalate a situation if they are concerned about a Client's health or condition.
- providing the Client with a voice in our governance policies and practices through meetings, feedback and discussion.

4.2 Registered/enrolled nurse

Lifestyle Centred Services has engaged Critical Second as a provider of ongoing assessment, development and provision of Competency Assessments. Critical Second is a Registered Provider of NDIS Supports, and he registered/enrolled nurse from Critical Second will:

- complete an assessment of the Client's care needs and write the Care Plan for high-intensity support before the Client joins our service.
- review the care assessment and update the Care Plan for HIDPA within seven days of the Client starting services with our organisation.
- undertake ongoing reviews of the Care Plan quarterly (every 13 weeks), or if there are any changes in a Client's condition.
- update the Care Plan, if required, following feedback from support workers
- provide referrals to other health professionals (e.g., general practitioner, community nurse) for management of any complications in care, as required
- ensure the current Care Plan includes care instructions received from general practitioners, medical specialists and allied health practitioners.
- provide instructions and supervision to support workers so that they can implement the care instructions.
- provide education to the Client, their family or carer regarding the delivery of HIDPA.
- listen and respond to Client's feedback on current and previous practices and needs.

- assess our support workers' skills and encourage professional development (e.g., transfer of skills)
- review the Client Medication Plan to ensure the medication prescribed aligns with the HIDPA being provided.
- escalate medication issues to the general practitioner and pharmacist as required.

4.3 Support workers

Lifestyle Centred Services Pty Ltd support workers deliver care to Clients on an ongoing basis. Their responsibilities include:

- attending all training sessions with Critical Second or other Health Practitioners
- clarifying any uncertainties with relevant expert
- completing forms recording how care has been delivered to the Client.
- updating Progress File Notes, including information on the care delivered to the Client.
- following all procedures relevant to the HIDPA being delivered
- reporting to Service Coordinator any concerns or changes in the Client's condition
- recognising if a Client has discomfort and reporting this to Service Coordinator.
- asking for the Client's consent every time care is delivered.
- administering routine medication to the level that they are competent to do so.
- delivering care within their scope of practice
- listening to Clients and sharing this information with relevant person (e.g., RN or administration)
- regularly communicating with Service Coordinator or a registered/enrolled nurse and informing them of changes in a Client's condition.

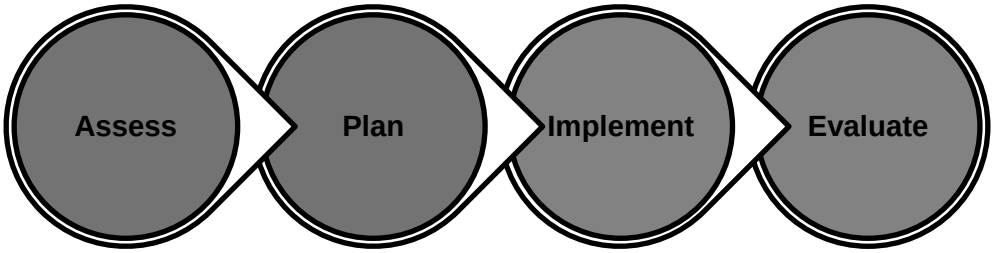
5.0 Care Plan development

The Care Plan can be referred to as a management plan or an individual plan (however titled – the plan) is a document developed in response to a Clients request for support with High Intensity Daily Personal Activities The plan is developed by a health practitioner (registered/enrolled nurse or other appropriately skilled professional).

The Care Plan will include the expected outcomes of the requested services and the tasks, duties and interventions required to meet the care and service needs of the Client (within the parameters of the funding program).

The plan guides and directs the support worker in their day-to-day delivery of the services. Service Coordinator will complete the High Intensity Daily Personal Activities Assessment Form with the Client and consider the Client's feelings, cultural beliefs and values when completing the care plan for High Intensity Daily Personal Activities.

Diagram 1. Care Plan development process



5.1 Assessment

A detailed assessment is conducted by Service Coordinator and the health practitioner (GP, nurse or other health practitioner) to determine the supports required by a Client. The Client is involved in all parts of the assessment, and (with the Client's consent), family members and other health practitioners may be requested to provide information to allow a comprehensive assessment to be undertaken using the Comprehensive High Intensity Daily Personal Activities.

5.2 Plan

Service Coordinator and health practitioner/nurse will review all the information about the Client, including all assessments. Planning includes a review of all risks, incidents and emergencies and how these will be managed, actioned and escalated. All planning is undertaken with relevant parties – e.g., the Client, RN, families, advocates, relevant health professionals, and other providers.

5.3 Implement

Detailed procedures and care management plans are written to ensure care is delivered in a way that meets the Client's needs. Support workers use the plan to guide the implementation of supports and care required for High Intensity Daily Personal Activities HIDPA

5.4 Evaluate

The Care Plan is reviewed three to six-monthly or when there is a significant change in the Clients needs/condition. As part of the evaluation process, the nurse discusses the quality and effectiveness of care delivery with the Client and support workers, with the Client's written consent, health professionals (including general practitioners and allied health providers) may be contacted to provide information that will be considered during care review and evaluation.

Additional assessment that may be completed include the Comprehensive High Intensity Daily Personal Activities HIDPA Support Assessment Form

6.0 Care Plan

The Care Plan identifies:

- information on the Client's normal state of health
- how to monitor:
    - changes in the Client's condition and
    - recording information that a health professional may request.
- how to identify symptoms that require action
- actions required if there is a change in the Client's condition.
- detailed instructions on medication selection and administration procedures
- emergency management options and procedures
- recording changes in the Client's condition
- documenting and communicating information to Service Coordinator and the Client or advocate
- how to exercise judgement when providing HIDPA, including:
    - managing risks, incidents and emergencies
    - responding if a Client's condition deteriorates
    - escalating the situation.

6.1 Care Plan implementation

As a NDIS provider, we ensure that the support plan is up-to-date, readily available, clear and concise and clearly identifies and describes the support needs and preferences of the Client.
Our support workers request the Client's consent before commencing care and check the support plan is up to date. The Clients specific support requirements including the timing, frequency and type of supports are documented in the plan.
Our staff respect and maintain the Client's desired level of involvement in their care.

To deliver supports included in a Care Plan appropriately and safely, support workers must:

- check availability of equipment and consumables required for delivery of care.
- complete competency training and assessment in the task before undertaking the task (skills-based competency shall be reassessed annually by Lifestyle Centred Services Pty Ltd)
- follow the Care Plan as provided by Lifestyle Centred Services Pty Ltd
- report any changes or advice variations to their supervisor/coordinator.
- never change a Care Plan
- report all issues arising from the delivery of care to Service Coordinator or their supervisor for further advice.
- identify and report any gaps in their ability to deliver the required service to Service Coordinator or their supervisor.
- follow safe work practices.
- follow infection prevention and management processes.
- use personal protective equipment as directed and appropriately.
- follow waste management processes.

- document all care provided following Lifestyle Centred Services Pty Ltd processes.

6.2 Documentation

Staff are instructed to follow Lifestyle Centred Services Pty Ltd's documentation procedures as outlined in the Information Management Policy and Procedure which includes:

- completing all necessary charts
- updating Progress File Notes, as required
- communicating with Service Coordinator if the Client and their carer or advocate request a change to the Care Plan or if a change is required to ensure quality care.

7.0 Staff training

Lifestyle Centred Services Pty Ltd training system complies with the NDIS Practice Standards skills descriptors for HIDPA skills descriptors for each of the supports in Module 1, including how to follow procedures and exercise judgement around signs of deteriorating health and the need to escalate care.

Lifestyle Centred Services Pty Ltd has policies and procedures that identify, plan, facilitate, record and evaluate the effectiveness of training for our frontline staff. This system facilitates mandatory staff training to meet our obligations under the NDIS Practice Standards and NDIS Rules. Our organisation conducts internal auditing to monitor the training of workers.

In addition to general training in the knowledge expected to deliver high intensity daily personal activities HIDPA, workers will be trained in the specific needs of each Client they support including the appropriate use of equipment that the Client may use. Training should be delivered by an appropriately qualified health practitioner or a person who meets the expectations of the HIDPA skills descriptor issued Nov 2022.

Training is delivered by an appropriately qualified health practitioner such as a GP or allied health therapist or by a registered nurse who regularly delivers training to support workers. Workers must also have a basic understanding of the Client's related health conditions.

If a support worker has not delivered high intensity daily personal activities to a Client in the last three months, the worker will deliver care under supervision and the support worker will complete refresher training relating to the specific high intensity daily personal activities that they will carry out with the Client.

Support workers are trained to manage the issues that may arise when caring for Clients receiving support under Module 1. Lifestyle Centred Services Pty Ltd staff are provided with training on delivering HIDPA also complete skills and competency assessment training to provide care and supports to Clients, as listed in the Training Plan. Support workers will also complete training on the Clients' specific needs.

Critical Second (external Nursing agency) will train our frontline staff in the associated health conditions and complications that may occur for Clients receiving each high intensity daily personal activities as noted in the training

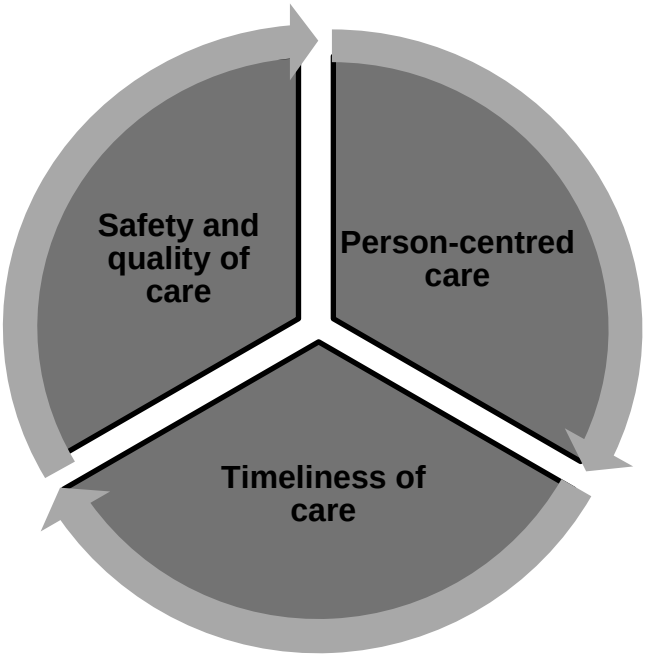
Plans. Upon completing training, a Statement of Attendance or competence must be retained in the employee's file by Lifestyle Centred Services Pty Ltd.

Our support workers may perform any task on a Care Plan within their scope of practice and level of skills competency. Community care support workers will be assessed by a suitably experienced registered/enrolled nurse or healthcare professional. This assessment will occur in the workplace within one month of completing the theoretical information course.

For high-risk support provision (e.g., tracheostomy care, dysphagia and ventilator management), Critical Second provides demonstrations of first aid and cardiopulmonary resuscitation and positioning required during seizures.
As an NDIS provider, (our organisation) is responsible for ensuring workers have current skills and knowledge, and that the training of workers is documented and regularly audited.
Worker's competency to provide high intensity daily personal activities HIDPA are reviewed annually by Critical Second or an appropriate Health Practitioner to confirm the worker has the current skills and knowledge as noted in the HIDPA skills descriptor Nov 2022.
Where a worker has not delivered this support for a period of more than three months, or if a Client's support needs have changed and/or they have an updated support plan in place, as an NDIS provider we will ensure that the worker be reassessed before supporting the Client and undertake refresher training if required. The timeframe for re assessment of support worker skills relating to high intensity daily personal activities, may vary depending on the nature of supports required and worker experience
Staff may be required to undertake additional qualifications to enhance their professional development (e.g., Registered Training Organisation courses in first aid, administering medication).

8.0 Safe care

Diagram 2. Our model of care



8.1 Role of the support worker

Lifestyle Centred Services Pty Ltd ensures that our staff know and are trained in procedures that ensure safe care delivery of the supports delivered in Module 1.
Lifestyle Centred Services Pty Ltd trains support workers in infection control procedures per our Infection Management Policy and Procedure and the Management of Waste Policy and Procedure. This training includes:

- how to identify common risks and indicators of infection and
- understanding when to involve Service Coordinator or a qualified health practitioner (e.g., registered or enrolled nurse).

Support workers are trained to monitor, chart and record care provided per the Information Management Policy and Procedure.

The support worker will consult with the Client, their family or advocate to identify, recognise, respond, and report problems (e.g., constipation, diarrhoea and faecal incontinence, blockages, signs of deteriorating health or infection). Our staff will involve a qualified health practitioner (e.g., general practitioner, registered/enrolled nurse) if any risk factors are present with a Client.

Support workers are provided access to a charged mobile phone during work hours. Support workers are advised of emergency management and communication methods for the Client as detailed in their Care Plan (e.g., writing, sign language, communication aids). Staff are informed of the appropriate method of communication for each Client.

Lifestyle Centred Services Pty Ltd has a Reportable Incident, Accident and Emergency Policy and Procedure (together with associated registers and reports) to ensure our service provision supports Client safety and wellbeing. If there is an incident, accident or emergency, our staff will follow the Reportable Incident, Accident and Emergency Policy and Procedure. Identified risks will be managed following procedures outlined in the Risk Management Policy and Procedure, exercising professional and skilled judgement in each situation.

In a medication-related emergency, staff will follow procedures according to the Management of Medication Policy and Procedure and the Subcutaneous Injections Policy and Procedure (as required). Where required, Service Coordinator will ensure the Client Medication Plan and Consent Form is completed and filed on the Client's record.

Our safe care procedures require our staff to:

- follow personal hygiene and infection management procedures as outlined in the Infection Management Policy and Procedure
- recognise the risk and symptoms of deterioration.
- identify when it is necessary to refer the Client to a general practitioner.
- follow instructions under the health practitioner's supervision.
- ensure that the Client and their advocate understand what is required for provision of high intensity daily personal activities.
- understand the equipment necessary to provide quality care.

Communications With Clients and Their Network.

Our organisation understands that receiving high intensity daily personal activities HIDPA is a private and sensitive experience for Clients and we ensure that staff take the time to consult with Clients and their network to understand how the Client wants care delivered and also prioritise the Clients' comfort and dignity

When completing the assessment and care plans, staff communicate with Clients and their network to understand the Clients feelings, cultural beliefs and values with regards to how private personal care is best delivered to the Client.

When delivering HIDPA, workers will ask Clients their preferences for care delivery. Support workers will also confirm that the Client is comfortable to go ahead with the provision of support prior to undertaking any of the HIDPA activities with Clients. If the Client has the capacity to actively give directions to support workers, these directions will be followed, and support workers will ensure that the care plan is implemented as required.

Our support workers understand Clients preferences for communication, Support workers using Client-specific communication strategies, communication aids, devices, or resources, including resources in the Client's preferred language. Interpreter services may be used as well as translation aids, visual boards and other assistive technology.

Support workers are trained to understand the Client's preferred communication methods (e.g., sign language, writing, communication aids) to ensure they can communicate effectively with a Client during an emergency.

8.2 Person-centred care

Person-centred care focuses on treating Clients receiving high intensity daily personal activities with dignity and respect while involving them in all decisions relating to their health.

Person-centred care places the Client at the centre of their care. It applies a holistic approach that acknowledges wider social, psychological, societal and cultural factors that may affect the Client, including incorporating their family or carer in decision-making to the extent the Client chooses.

Person centred supports are delivered in a safe environment in ways that are least intrusive or restrictive to Clients. Timing of delivery of supports may be altered to fit into the Client's daily routines and preferences.

Diagram 3. Person-centred care principles

Appropriate assessments are undertaken by Lifestyle Centred Services Pty Ltd to understand the needs and requirements of each Client so that we can provide appropriate person-centred care. An Individual Risk Profile Assessment Form and other necessary assessments will be completed by Service Coordinator or their delegate, as required.

8.3 General Practitioner- care plan development and authorisation

For Clients requiring HIDPA, a general practitioner chosen by the Client, their family or advocate will be requested to review and update the existing Care Plan. Lifestyle Centred Services Pty Ltd will confirm with the general practitioner any additional care instructions and how long identified problems should take to be resolved. With the Clients consent/ or the consent of the Clients delegated decision making, our organisation will report changes to the GP.

Before our support workers carry out any additional care instructions, Lifestyle Centred Services Pty Ltd will ensure:

- the treating general practitioner (who developed the Care Plan or prescribed medication for the Client) has agreed in writing to support the arrangement of a trained and supervised support worker administering the care to the Client.
- a copy of the plan and the general practitioner's approval is retained by the Client, and Lifestyle Centred Services Pty Ltd
- the general practitioner has applied person-centred care principles and dignity of risk.
- a registered/enrolled nurse provides support and supervision of the Client's Care Plan and medication administration, as required.
- the adjusted Care Plan is in place before commencing any care for the Client.

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*Members of the multidisciplinary team may also give instructions on **Client**s' supports, these must be in writing and where the **Client** has capacity the care instructions from the allied health provider will be discussed with the **Client**s and their network. The support workers will receive handover from the nurse or allied health therapist and the support workers will verify with the nurse and/or line manager prior to implementation of instructions from the allied health therapist.*

8.4 Handover and communication

8.4.1 Transfer of care and clinical handover

Clinical handover is conducted:

- at each change of shift
- whenever there is a change in a Client's condition
- whenever there is a need to update staff about the care to be provided.

Handover includes written and verbal communication and will include, where possible, a visual check with the Client. At the end of each session with a Client, support workers are expected to write case/shift notes that outline the main things that occurred during the work period.

If, during the delivery of support, staff identifies any change in the Clients condition or any issues that prevent the delivery of services outlined in the Client care plan, the staff member will immediately inform the manager and the health practitioner.

8.4.2 Recognising deterioration.

If the support worker, a registered/enrolled nurse or a staff member is concerned about a Client's condition, they will immediately escalate the issue to Service Coordinator.

If a Client's condition is rapidly deteriorating or in an emergency, our staff are required to call emergency services on 000. Staff are trained to recognise signs of Client deterioration (applicable for each Module 1 indicator), such as:

- if the Client:
    - does not respond in the way they usually would.
    - has a temperature that is over 37.5 degrees Celsius.
    - has extreme pain that is unusual for them.
    - has lost function and cannot perform activities they would normally be able to
- identifying specific issues relating to a Client, including:
    - drowsiness
    - fever
    - altered cognition.
    - increased respiratory rate.
    - shortness of breath
    - a high temperature.

8.4.3 Escalation of care

If there are significant changes in a Client's situation, the support worker or another staff member will contact Service Coordinator. In an emergency, the staff member will immediately escalate the situation by:

- calling emergency services on 000 and requesting an ambulance (only in an emergency)
- calling the general practitioner or locum medical services
- contacting Service Coordinator.

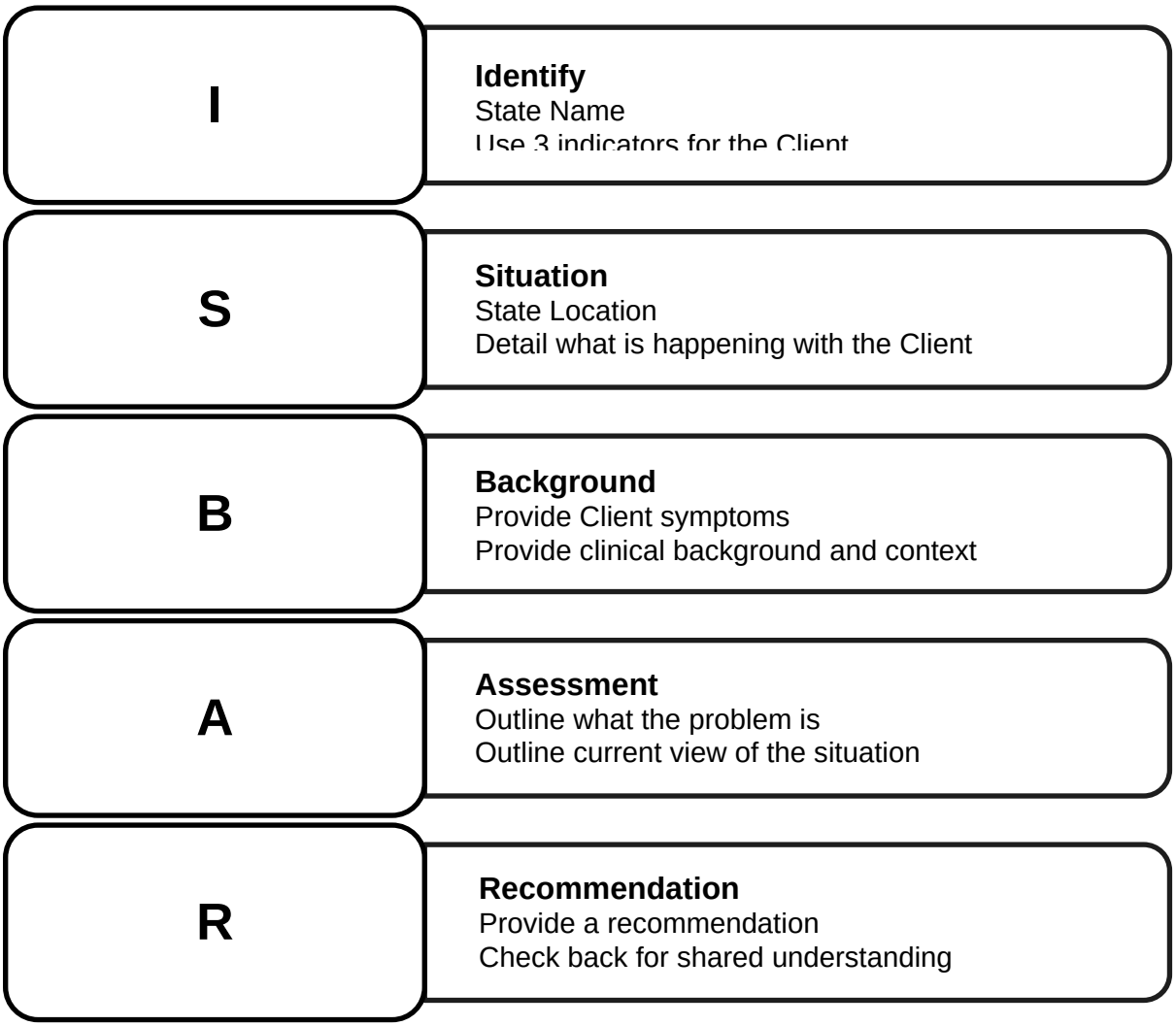
In an emergency, our staff will:

- check the immediate area for signs of danger.
- remove or control the danger (if it is safe to do so) to avoid further risk to the Client or themselves.
- not move a Client unless they are exposed to a life-threatening situation.
- contact emergency services by dialling 000 and request an ambulance, if required.

Staff are trained to use the ISBAR model when managing an emergency. See Diagram 4. ISBAR model.

During training, staff are provided specific information regarding emergency management and all relevant emergency numbers for health practitioners and emergency services.

Diagram 4. ISBAR model



Incident Reporting

If the Client has changes in their condition and deteriorates, then an incident report is raised, following the usual incident management processes used in our organisation.

Infection Prevention and Control

Support workers complete training in and receive information relating to the principles of infection control and personal hygiene, including hand washing, disinfecting, use of appropriate Personal Protective Equipment (PPE) such as gloves and masks etc – see details in the infection control procedure.

Hand Washing- is a very important part of infection prevention, support workers are requested to practice hand washing before assisting the Client and after completing high intensity personal daily activities, hand hygiene is also completed after touching equipment or disposing of waste including disposal of body fluids.

Safe Use of Equipment

Support workers receive training on the care of equipment this may include.

Clean equipment using cleaning techniques noted in the manufacturer manual and the principles.

Test equipment prior to use

Have a spare battery in case of power loss.

Ensure consumables that are within date of use are available for use.

Use stock rotation in use of consumables, using consumables with expiry dates occurring sooner, rather than long dated consumables.

Keep a maintenance record for equipment that requires servicing e.g ventilators, pumps etc.

Waste and disused consumables will be disposed of safely, according to waste management procedure.

9.0 Related documents

- Care Plans
- Comprehensive High-intensity Support Assessment
- High-intensity Support Assessment Form
- High-intensity Consent Form
- Staff Training Plan
- Training Plans
- Clinical Practice Guidelines
- Tracheostomy and Ventilation Observation Chart
- Individual Risk Profile Assessment Form
- Risk Assessment Form – Module 1
- Client Medication Plan and Consent Form
- Progress File Notes
- Infection Management Policy and Procedure
- Information Management Policy and Procedure
- Reportable Incident, Accident and Emergency Policy and Procedure
- Management of Medication Policy and Procedure
- Management of Waste Policy and Procedure
- Risk Management Policy and Procedure
- Enteral Feeding and Management Policy and Procedure
- Ventilator Management Policy and Procedure
- Tracheostomy Management Policy and Procedure
- Urinary Catheter Management Policy and Procedure
- Complex Bowel Care Policy and Procedure
- Stoma Care Policy and Procedure
- Diabetes Management Policy and Procedure
- Seizure Management Policy and Procedure
- Subcutaneous Injections Policy and Procedure
- Complex Wound Management Policy and Procedure
- Easy Read - Module 1 High-intensity Daily Activities Consent Form

10.0 References

- NDIS (Quality Indicators) Guidelines 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS Practice Standards Skills Descriptor - High-intensity Skill Descriptor

- Disability Discrimination Action 1992 (Commonwealth)
- Human Rights and Equal Opportunity Commission Act 1986 (Commonwealth)
- Privacy Act 1988 (Commonwealth)
- Racial Discrimination Act 1975 (Commonwealth)
- Sex Discrimination Act 1984 (Commonwealth)
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- PEG feeding:
    - www.nursingtimes.net/clinical-archive/nutrition/peg-feeding-tube-placement-and-aftercare-12-10-2012
- Ventilation and tracheostomy management:
    - www.aci.health.nsw.gov.au/networks/icnsw/intensive-care-manual/statewide-guidelines/non-invasive-ventilation-guidelines/nursing-care,-nutrition-and-hydration
    - www.thenursepage.com/mechanical-ventilator-basics-for-nurses/
- Multilingual resources for tracheostomy management:
    - www.aci.health.nsw.gov.au/networks/icnsw/
- Catheter care:
    - www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Teaching_and_supporting_Clean_Intermittent_Catheterisation_for_parents_and_children
- Subcutaneous injections:
    - www.registerednursern.com/subcutaneous-injection-technique-how-to-give-a-subcutaneous-sub-q-injection/
- Skin assessment:
    - www.registerednursern.com/nursing-care-plan-and-diagnosis-for-impaired-skin-integrity-risk-for-skin-breakdown-altered-skin-integrity-and-risk-for-pressure-ulcers/
- Diabetes:
    - registerednursern.com/nursing-care-plan-and-diagnosis-for-diabetes-high-blood-sugar-hyperglycemia-dka-and-diabetic-ketoacidosis-fluid-electrolytes-imbalance/

Complex Bowel Care Policy and Procedure

1.0 Introduction

Bowel care is the care and management process of eliminating faecal matter from a Client's body. Bowel care can encompass personal hygiene, assistance with toileting, medications to promote bowel function and administration of the same.

Support workers with appropriate competency training and assessment provide bowel care to our Clients. Lifestyle Centred Services Pty Ltd considers it imperative to involve our Clients in all aspects of their service delivery and the direction of their services to their ability. The dignity of risk is an essential part of this choice and control.

2.0 Scope

This policy applies to all Lifestyle Centred Services Pty Ltd staff working with Clients with complex bowel care requirements.

3.0 Definitions

Term	Definition
Constipation and poor bowel emptying	A condition of the digestive system characterised by hard faeces that is described as difficult or painful when passing faeces and passing faeces infrequently.
Diarrhoea	Loose, watery faeces and is usually frequent.
Faecal incontinence	Uncontrolled passing of faeces creating social or hygiene problems for the Client.

4.0 Principles of complex bowel care

Lifestyle Centred Services Pty Ltd's principles of complex bowel care include:

- following all care instructions noted in the Complex Bowel Care Plan with identified outcomes.
- following personal hygiene and infection management procedures
- maintaining the Client's dignity, respect and consent throughout all activities
- observing and recording changes to bowel habits
- reporting issues arising from the delivery of complex bowel care
- administering laxatives, enemas or suppositories, including non-routine medication as required
- identifying when to seek advice from a health practitioner (e.g., registered/enrolled nurse or general practitioner).
- Aligning with the required for the high intensity skills descriptor for complex bowel care.

5.0 Roles and responsibilities

5.1 Registered/enrolled nurse (Critical Second)

It is the role and responsibility of the registered/enrolled nurse to:

- regularly complete appropriate assessments of the Client
- initiate and communicate a Care Plan to address the Client's bladder and bowel issues.
- evaluate the Care Plan and update the plan as necessary.
- provide referrals to other interdisciplinary team members.
- provide education to the Client, their family or carer regarding bladder and bowel management.
- assess the support workers' professional skills.
- encourage staff development (e.g., transfer of skills)
- review bladder and bowel record/s and address any issues with the interdisciplinary team.
- respond to support worker's assessment, i.e., any bladder and bowel management concerns.

5.2 Support workers

It is the role and responsibility of the support worker to:

- develop a rapport with the Client.
- offer privacy when toileting or changing the Client.
- encourage fluid and nutritional intake (e.g., 1500 ml of fluid daily)
- follow all procedures and the Care Plan to promote continence.
- assist the Client when transferring, ambulating or walking to the toilet.
- maximise mobility and passive exercises.
- toilet the Client as per the Care Plan
- complete the Daily Fluid Intake and Output Form and the 7-Day Bowel Management Chart, as required.
- report concerns or changes to the registered/enrolled nurse or Service Coordinator
- recognise and report Client verbalisations and behaviours indicative of discomfort.
- report any signs/symptoms of the Client's bladder and bowel discomfort to the registered/enrolled nurse or Service Coordinator.

6.0 Care plan

The Complex Bowel Care Plan is developed with the involvement of the Client, their family, carer or advocate, Service Coordinator and a health practitioner (e.g., general practitioner or registered/enrolled nurse).

The Complex Bowel Care Plan includes details such as:

- a bladder and bowel assessment are undertaken within seven days of the Client's commencement of our service.
- signs and symptoms of gastric problems, including constipation.
- frequency and patterns of bowel movements
- signs and symptoms of irregular bowel habits (e.g., constipation or diarrhoea)

- monitoring and recording care requirements
- detailed instructions on medication selection for bowel care
- instructions regarding medication administration procedures for bowel care
- emergency management options and procedures.

Lifestyle Centred Services Pty Ltd conducts appropriate bladder and bowel assessments and updates the Client's Complex Bowel Care Plan every 12 weeks or if a change in the Client's condition affects continence.

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

- vomiting blood or faecal matter
- diarrhoea 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 can occur when a person is taking iron supplements.

7.0 Staff training

Critical Second (external Nursing Training Service) trains support workers according to their Staff Training Plan or the Training Plan - Complex Bowel Care and information relating specifically to each Client's needs and their Complex Bowel Care Plan. The training includes:

- basic anatomy of the digestive system
- importance of regular bowel care
- an understanding of stool characteristics indicating healthy bowel functioning with related signs and symptoms (using the Bristol Stool Chart, a recognised evidence-based practice tool)
- when to refer a Client to a health practitioner (e.g., overflow, impaction, perforation, infection or blockage)
- Relationship between nutrition, hydration, dietary fibre, probiotics, and bowel motions and stoma management
- administering enemas and suppositories, digital stimulation and massage
- nutrition and hydration requirements
- alteration in bowel habits that may result from decreased mobility, altered nutrition, medications and decreased fluid intake.
- recognising, responding to, and reporting problems (e.g., constipation, diarrhoea and faecal incontinence, blockages, signs of deteriorating health or infection)
- safe work practices to prevent and control infection.
- how to correctly wear appropriate personal protective equipment (PPE)
- waste management
- record-keeping and documentation.

8.0 Safe care

Support workers consult with the Client, their carer or advocate to identify and remove or minimise exposure to conditions that may lead to an unsafe environment.

8.1 Bowel care equipment

Equipment required to provide appropriate bowel care may include, but is not limited to:

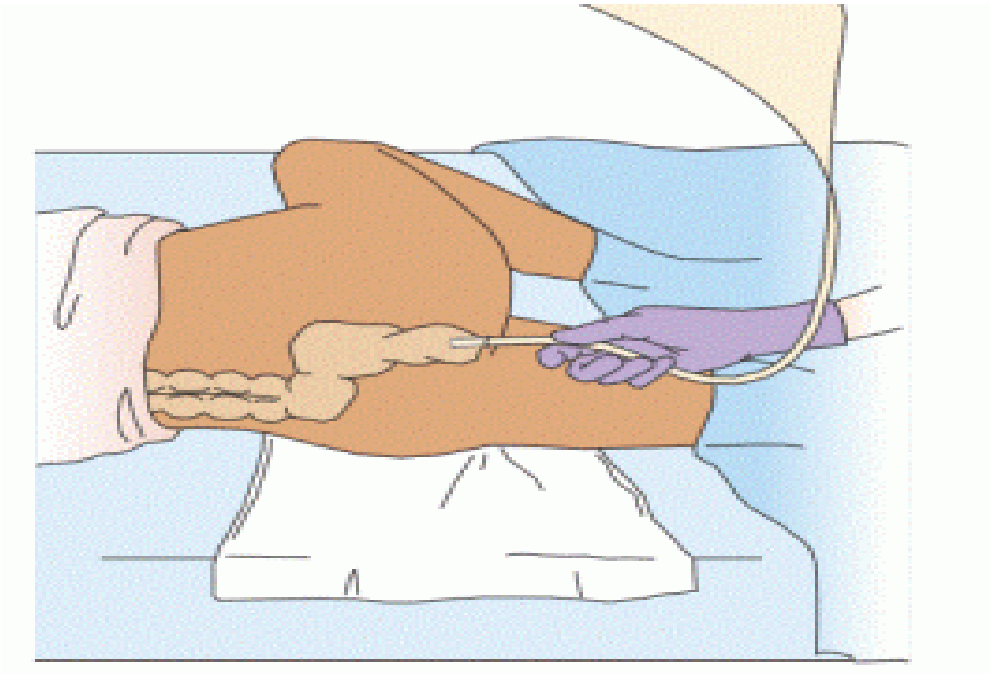
- disposable gloves (powder free)
- personal protective equipment (gloves, face shields and masks)
- disposable aprons
- lubricant (water-based)
- gauze swabs
- incontinence pads or Kylie
- commode
- a medical waste receptacle or bag
- medications.

8.2 Administration of enemas

When administering an enema, the support worker will:

- explain to the Client the steps that will be taken to administer the enema.
- obtain the Client's verbal consent.
- check the Medication Administration Chart to confirm the date and time the enema is due to be administered.
- gather all the equipment needed to administer the enema.
- wash and dry hands and put on disposable gloves.
- place a protective disposable mat or waterproof cover under the Client.
- request the Client lies on their left side with their gently knees drawn up, if possible.
- warm the enema by placing it in a bowl of hot water.
- lubricate the end of the enema tube using water or a smear of paraffin wax.
- insert the tip of the enema nozzle into the rectum (this may cause the Client some discomfort but should not cause pain)
- gently squeeze the enema into the rectum
- stop if there is pain and immediately call the registered/enrolled nurse or Service Coordinator
- dispose of all PPE and disposable mat immediately as per the Management of Waste Policy and Procedure and the Infection Management Policy and Procedure
- be ready to assist the Client in going to the toilet, as they may need to go shortly after the enema is administered.

Image 1. Client lies on their left side for enema administration.



8.3 Administration of suppositories

When administering a suppository, the support worker will:

- explain to the Client the steps required to administer the suppository.
- get the Client's verbal consent.
- check the Medication Administration Chart to confirm the date and time that the suppository is due to be administered.
- have the Client lie on their left side with the knees drawn up, if possible
- insert the suppository into the rectum.
- suppositories may take some time to have a result.
- assist the Client in going to the toilet when they ask or 30 minutes after administering the suppository.
- dispose of all PPE and disposable mat immediately following waste and infection management procedures.

8.4 Stoma Care

Purpose of ileostomy and colostomy stomas and related equipment, and consumables such as stoma bags, skin sealants, barriers or powders.

• Common methods to clean and protect skin around the stoma.

• Characteristics of a healthy stoma and how these can change over time.

• Indicators and action required to respond to common health problems at the stoma site, such as wetness or signs of infection or inflammation.

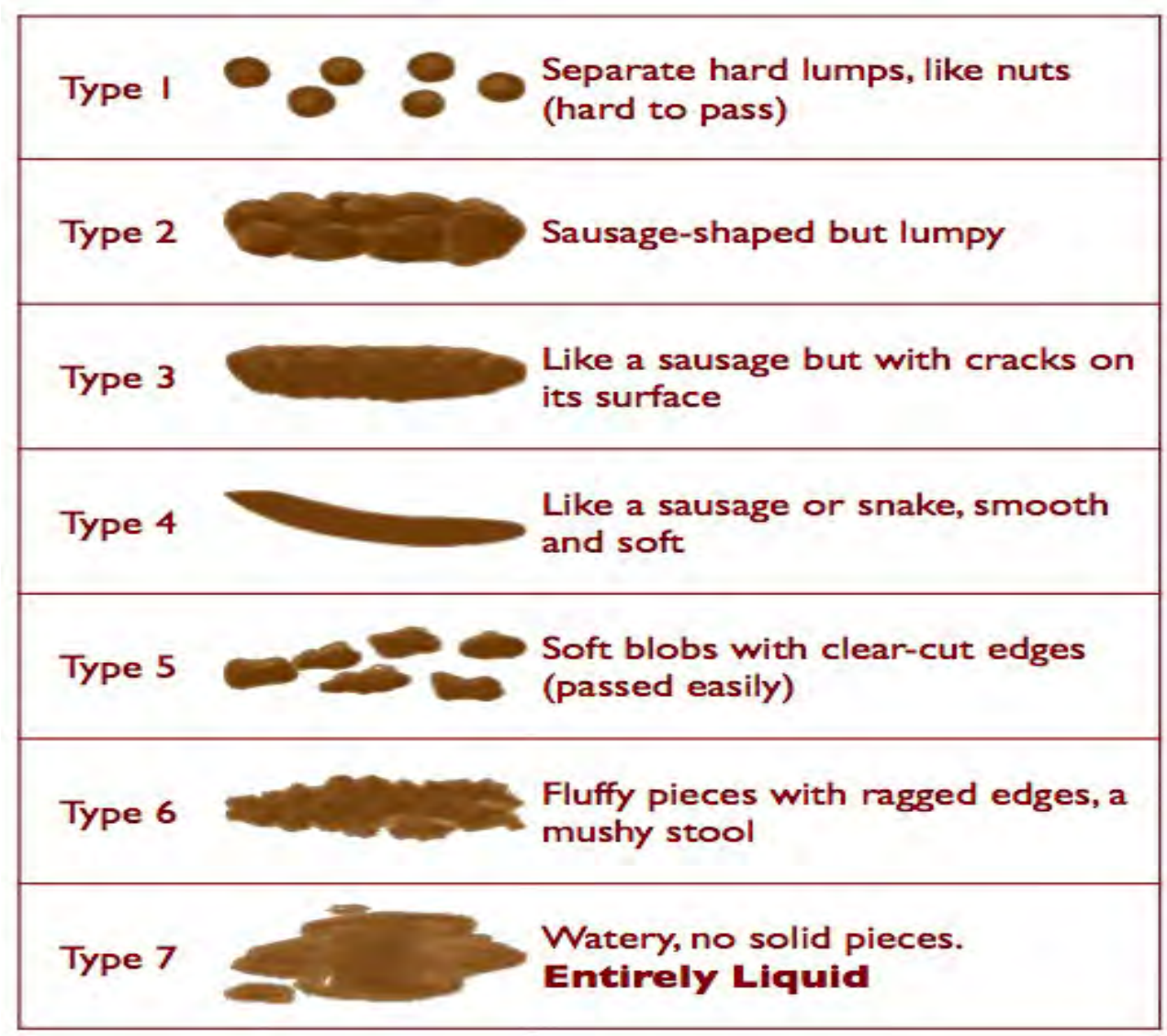
• Reporting responsibilities, including handover, recording observations and incident reporting.

8.5 Recordkeeping

Support workers will:

- assess the bowel movement using the Bristol Stool Chart (which provides a visual guide to the type of stool passed)
- write in the Client's Progress File Notes when the enema or suppository was given.
- update the bowel record (7-Day Bowel Management Chart)
- update the Daily Fluid Intake and Output Form
- complete and sign the Medication Administration Chart relating to the enema or suppository administration.

8.5.1 Bristol stool chart



9.0 Related documents

Generic related documents as listed in the introduction.

- Complex Bowel Care Plan
- Training Plan – Complex Bowel Care
- Clinical Practice Guidelines – Complex Bowel Care

- 7-Day Bowel Management Chart
- Bristol Stool Chart
- Daily Fluid Intake and Output Form

Enteral Feeding and Management Policy and Procedure

1.0 Scope

This procedure applies to all Lifestyle Centred Services Pty Ltd staff who work directly with Clients requiring enteral feeding and management.

2.0 Definitions

Term	Definition
Enteral feeding	A method of supplying nutrients directly into the gastrointestinal tract. Enteral feeding describes orogastric, nasogastric and gastrostomy tube feeding. The reasons for this method of feeding to be required if a Client: ● cannot consume adequate nutrients. ● has impaired swallowing. ● has facial or oesophageal structural abnormalities. ● has eating disorders. ● has congenital anomalies.
Enteral feeding tubes	Enteral feeding tubes can be used to: ● administer bolus, intermittent feeds and continuous feeds. ● administer medication. ● drain and aspirate stomach contents. ● administer feeds with a syringe via gravity or a pump.
Orogastric tube	A thin, soft tube passed through the Client's mouth to the oesophagus and into the stomach.
Nasogastric tube	A thin, soft tube passed through the Client's nose, down the back of the throat, through the oesophagus and into the stomach.
Gastrostomy tube	A feeding tube is inserted through the abdominal wall directly into the stomach.
Gastrostomy button	A button gastrostomy tube was inserted into a pre-formed stoma at skin level.
Percutaneous endoscopic gastrostomy (PEG) tube	A gastrostomy tube is held in place with an internal fixator.

3.0 Principles of enteral feeding and management

Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure that uses a tube (PEG tube) to pass into a Client's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is inadequate (e.g., due to dysphagia or sedation).

3.1 Enteral feeding and management procedure

Lifestyle Centred Services Pty Ltd support workers will:

- follow personal hygiene and infection management procedures.
- confirm the need and consent for enteral feeding.
- introduce food via a tube according to the Care Plan
- monitor the rate and flow of feeding and take appropriate action to adjust, if required.
- keep the stoma area clean.
- monitor and report signs of infection.
- check that the tube is correctly positioned.
- confirm monitoring equipment is in operation.
- follow correct procedures when responding to a malfunction.
- document a request to review the Mealtime Support Plan, as required.
- liaise with health practitioners so they can explain or demonstrate requirements.
- recognise and respond to symptoms that could require health intervention.

4.0 Roles and responsibilities

The Management Team is responsible for the overall clinical and medication management of a high intensity supported Client's care.

The Client's enteral feeding care plan, mealtime preparation and mealtime support plan are overseen by the relevant health practitioner/s (e.g., dietitian, speech therapist, occupational therapist). The Care Plan and Support Plan are regularly reviewed, and updated requirements and procedures will be provided to the Client, their family or their carer/advocate.

Lifestyle Centred Services Pty Ltd ensures that each Client's desired level of involvement in their care is respected and maintained. It is Lifestyle Centred Services Pty Ltd's responsibility to provide nutrition, fluids and medications relevant and proportionate to the individual needs of each Client requiring enteral feeding and management.

4.1 Registered/enrolled nurse (Critical Second)

A registered/enrolled nurse may:

- replace a PEG tube.
- supervise and guide the support worker in the provision of nutritional or enteral stoma care.
- only work within the scope of their practice and prior experience.

Note: The nasogastric tube replacement is considered high risk and will only be done by a qualified health practitioner (i.e., general practitioner or registered/enrolled nurse). In some cases, registered/enrolled nurses may respond when

PEG tubes become dislodged, but this is only appropriate when the balloon device tube is in position and stable (after the balloon device replaces the initial tube). There is active oversight by a qualified health practitioner.

4.2 Support workers

Support workers may:

- perform any task on the Care Plan, apart from those nominated above, that a registered/enrolled nurse performs.
- assist with the administration of enteral feeds and flushes, once assessed as being competent in this skill
- clean stoma site
- observe and report if the stoma site is red, painful or swollen.
- observe and report if tubing becomes dislodged.

Support workers MUST:

- follow the Care Plan as provided by the relevant Health Practitioner
- report to their supervisor or coordinator any changes or variations to advice
- never change any care or feeding plan
- take part in training on the use of equipment, manual handling and risk management as determined by Lifestyle Centred Services Pty Ltd
- report any issues arising from the delivery of care to Service Coordinator for further advice.
- identify and report to Service Coordinator any gaps in their ability to deliver the required supports.

5.0 Care plan

The Enteral Feeding Care Plan is developed with the involvement of the Client, their carer or advocate, Service Coordinator and a health practitioner (e.g., general practitioner or speech therapist, occupational therapist or dietician). The Enteral Feeding Care Plan includes details, such as:

- signs and symptoms of gastric problems
- frequency and patterns of feeds
- signs to check before and after a feed.
- monitoring and recording requirements
- detailed instructions on feed and medication selection and administration procedures
- emergency management options and procedures
- how to manage risks, incidents, and emergencies, including:
    - required actions and
    - escalation to ensure Client wellbeing and safety.

Our support workers will confirm the Client's consent before administering feeds detailed in the Enteral Feeding Care Plan (as agreed with the Client or their carer or advocate). Support workers will complete the daily fluid intake and output form for each Client to inform the enteral feeding care plan on an ongoing basis.

The Client's health status is regularly reviewed by a qualified health practitioner (e.g. a general practitioner or registered/enrolled nurse).

The Client's enteral feeding care plan is reviewed quarterly or when there are changes in the Client's condition. Lifestyle Centred Services Pty Ltd develops care strategies that act upon relevant information from the Client, their family, advocate, our staff and health professionals.

Staff follow Lifestyle Centred Services Pty Ltd documentation procedures for:

- PRN medication
- monitoring and recording of feeds
- emergency management procedures
- recording changes requested by health practitioners (e.g., general practitioner, dietitian or registered/enrolled nurse)
- documenting and informing Service Coordinator, the Client, their carer or advocate when a change in enteral feeding management is requested.

6.0 Staff training

A support worker who provides support and management for enteral feeding will have all relevant additional qualifications and experience. Staff are trained to be aware of associated health conditions and complications that interact with enteral feeding, e.g., severe epilepsy, severe dysphagia, and complex physical disability.

Lifestyle Centred Services Pty Ltd staff are provided training by Critical Second (according to their training plan), relating specifically to each Client's needs and the Client's support plan/mealtime preparation and delivery plan. Staff are trained in behaviours of concern, such as when a Client frequently dislodges their feeding tubes (becoming a high-risk Client) and all associated risks.

Lifestyle Centred Services Pty Ltd's training program instructs our support workers to manage different enteral feeding equipment, components and functions. Support workers receive training specifically related to each Client's needs and the type of feeding support they require (e.g., enteral, PEG). Training includes:

- basic anatomy of the digestive system
- equipment components, function, cleaning and maintenance procedures
- stoma care requirements and procedures
- communication techniques that can be used to explain risks to Client, their carer or advocate and other support workers.
- impacts of associated health conditions and complications that interact with enteral feeding.
- symptoms that may occur with enteral/PEG feeding (e.g., dehydration, reflux)
- factors that may require immediate adjustment (e.g., rate, flow and quantity of food)
- positioning of the Client during and after the PEG feed
- identifying and minimising Client exposure to enteral feeding risk factors (e.g., gastro, constipation).

7.0 Safe care

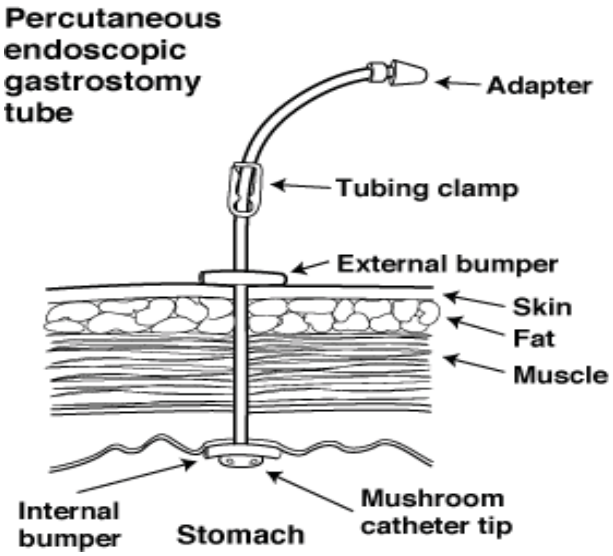
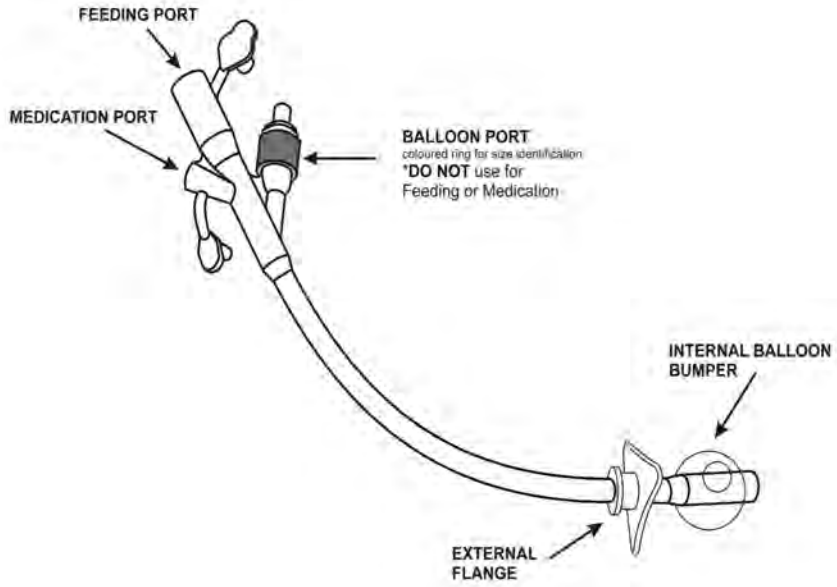
7.1 Observe, document and report.

Should the following conditions or symptoms be observed by the support worker they will document what they have observed and report the same to the registered/enrolled nurse or Service Coordinator, who will then arrange a medical review. The conditions/symptoms include:

- 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 the stoma site.
- tube or device displacement, discolouration or blockage
- diarrhoea, constipation, nausea, vomiting.
- an incorrect port (balloon port) is used to administer feed or medication.

7.2 Processes for using enteral feeding tubes.

Using enteral feeding tubes	
Preparation	1. Perform hand hygiene before starting feed preparation. 2. Wherever possible, use pre-packaged, ready-to-use feeds. 3. Decanting, reconstitution and dilution are NOT recommended. However, if decanting and reconstitution or dilution are required, use a clean working area and equipment for enteral feed use. 4. Mix feeds with cooled boiled water or freshly opened sterilised water using an aseptic, non-touch technique.
Administration	1. Perform hand hygiene immediately before administration. 2. Use minimal handling and an aseptic non-touch technique to connect the administration system to the enteral feeding tube. 3. **For nursing staff only:** Use an aseptic non-touch technique to administer medications. 4. Discard administration sets and feed containers appropriately as per the Care Plan.
Care of insertion site and enteral feeding tube	1. Perform hand hygiene immediately before commencing. 2. Wash the stoma daily with water and dry thoroughly. 3. Flush the enteral feeding tube with fresh tap water before and after feeding or administering medications. 4. Note: Use cooled boiled water or sterilised water for immunosuppressed people).

PEG tube	
Rig feeding tube	

8.0 Procedure

Enteral tube feeding provides liquid nutrition to the Client via tubes, not through the mouth. A nasogastric tube is put up the nose and down into the stomach. During surgery, a gastrostomy, sometimes called a percutaneous endoscopic gastrostomy or PEG, is placed in the stomach. Some PEG tubes protrude from the abdomen while others are flat.

Enteral feeding can be given in three different ways:

1. **Via a pump**: Used for continuous or intermittent feeds where the formula is given without stopping over eight to 24 hours.
2. **Via a gravity drip**: Used to provide larger amounts of formula over a shorter period, usually four to six times each day.
3. **Via a syringe**: This is the fastest method where large quantities of the formula are given simultaneously.

Note: Feeding using a syringe or gravity drip is also called bolus feeding.

Our support workers will check:

- the correct position of the tube
- the surrounding skin at the insertion site
- dates when the feeding tubes and equipment must be changed.

8.1 Care of the percutaneous endoscopic gastrostomy tube

Taking care of the percutaneous endoscopic gastrostomy (PEG) site is vital to reduce the risk of skin breakdown and infection. A healthy PEG site should look like normal skin without excessive irritation, pus or blood within a few days after insertion. If there is a persistent change in the site, the service manager must be contacted.
The PEG site should be washed daily for 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.
If not flushed regularly, a PEG can become encrusted with feed or medications and colonised with bacteria, resulting in damage to the tube and the need for premature replacement. The PEG should be flushed with water at least once daily, even when not used.

8.2 Feeding tube dislodged.

The support worker will not remove or replace any enteral feeding tube. Should a nasogastric or PEG tube fall out, the support worker will cover the stoma with a piece of gauze and secure it with Micropore tape (if available). The support worker will report the issue to the registered/enrolled nurse or Service Coordinator, who will arrange for the Client to see their local general practitioner or visit a hospital emergency room to replace the feeding tube immediately.

Staff may need to arrange for a Client to go to the nearest hospital's emergency department. A staff member will immediately call 000 and ask for an ambulance service in this event. Staff will not move the Client (if there is no guidance in the Care Plan).

8.3 Replacement of nasogastric tube

The replacement of a nasogastric tube is considered high risk and will only be done by a registered/enrolled nurse or general practitioner. Replacement is only appropriate when the balloon device tube is in position and stable (after the balloon device has replaced the initial tube) and there is active oversight by a general practitioner.

The Client's mealtime preparation and delivery will be reviewed monthly to ensure strategies are aligned with information received from the Client, their carer or advocate, the support worker or a health professional (e.g., dietitian, general practitioner, speech therapist, occupational therapist).

8.4 Preparing the formula.

8.4.1 Pump feed

The standard procedure when using a pump feed is:

1. Wash hands.
2. Put on appropriate PPE.
3. Use clean equipment (confirm equipment is connected correctly).
4. Check expiry on the tin/bottle/carton of feed.
5. Follow the dietitian's directions or the feeding plan to determine how much powder and water are necessary to create the formula.
6. When using a liquid formula, shake well to maintain the correct consistency of the feed.
7. Fill the feed chamber and prime the giving set.
8. Turn the pump to the correct speed specified in the Client's feeding plan.
9. Regulate feed including the rate, flow and volume of formula.
10. Monitor the Client until the feed is complete. Alarms may be set to monitor the rate and volume of feed.
11. Check that the Client is comfortable and stop feed if the Client has any discomfort, the feed may be resumed after some time if the Client state settles, any disruption to the feeding plan is documented and the service manager is informed.
12. Dispose of waste and PPE as per Management of Waste Policy and Procedure.
13. Document following all organisational reporting requirements.

8.4.2 Gravity feed

The standard procedure when using a gravity feed is:

1. Wash hands.
2. Put on appropriate PPE.
3. Prepare the equipment.
4. Attach the giving set to the container and hang onto the pole (or a hook 50 cm above the Client's head).
5. Squeeze the drip chamber of the giving set until it is one-third full.
6. Open the flow regulator clamp on the giving set and let the formula run to the end of the giving set tube (to clear the air out), then close the flow regulator.
7. Attach the tip of the giving set tube to the feeding tube.
8. Open the flow regulator clamp to allow the feed to run in by gravity.
9. Use the clamp to adjust the formula flow rate.
10. Once the feed has finished, close the clamp and fill the syringe with the prescribed amount of warm water.
11. Gently push water through the feeding tube.
12. Take the giving set off the container.
13. Wash, dry and store the given set and syringe as directed.
14. Dispose of waste and PPE as per Waste Management Policy and Procedure.
15. Document following all organisational reporting requirements.

8.4.3 Syringe feed

The standard procedure when using a syringe feed is:

1. Wash hands.
2. Put on appropriate PPE.
3. Collect all necessary equipment (e.g., formula, feed container and giving set, water, syringe and measuring cup).
4. Fill the syringe with the set amount of warm water and gently push it through the feeding tube (this is a flush).
5. Measure the set amount of formula into a measuring cup.
6. Remove the plunger from the syringe, rinse the syringe with water and attach it to the feeding tube.
7. Pour formula into the syringe.
8. Hold the syringe higher than where the feeding tube enters.
9. Allow the formula to run in slowly by gravity (if a thin tube is used, a syringe plunger may be required to push the formula through the tube gently).
10. Do not let the syringe empty before refilling it, allowing air to enter the stomach.
11. Each feed should take approximately 15 minutes.
12. Flush the tube with the prescribed amount of water.
13. Disconnect syringe and recap feeding tube.
14. Dispose of waste and PPE as per Waste Management Policy and Procedure.
15. Document following all organisational reporting requirements.

8.4.4 Formula storage

The formula will be stored following the steps below:

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

8.5 Feeding position.

Support workers, where possible, will always assist the Client into a sitting position. The Client will not be left lying flat while having a feed. If the Client cannot sit in a chair, their head will be raised at least greater than a 30 to 45-degree angle from horizontal to maintain elevation while they have their feed. The elevated position will be maintained for 30-60 minutes after the feed has ceased.

8.6 Equipment required to provide care.

Support workers will ensure they have access to the range of equipment used to provide appropriate care may include, but is not limited to:

- disposable gloves (powder free)
- feeding pump
- feeding pump frame

- tube feed
- giving sets and accessories
- spare feeding tubes
- syringes
- carrier packs
- connecters
- liquid formula
- measuring cup
- distilled water.

8.7 Medication administration

Only support workers trained in medication administration may deliver medications via an enteral tube, including a PEG or nasogastric tube. When administering medication, our registered/enrolled nurse or appropriately trained support worker will:

- wherever possible, provide medications in a liquid form.
- crush tablets and mix with water to make a soup-like mixture, if a liquid is not available
- review the Care Plan to determine if medicines can be given with the feeding formula.
- never mix different medicines; each will be provided separately.
- flush the feeding tube before and after each medication.

Note: Some medications must not be given while a feed is running (as they may react with the feed). The support worker will review the Care Plan to determine the appropriateness of mixing medication with the feeding formula.
An enteral tube may become blocked due to:

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

8.8 Mouth care

Even though a Client may not eat through their mouth, it is still essential to maintain a healthy oral environment. To ensure proper mouth care, the support worker will:

- brush the Client's teeth at least twice daily with toothpaste and a soft brush.
- offer ice chips or sugarless gum to prevent a dry mouth (if tolerated by the Client)
- apply lip balm to avoid dry and cracked lips.
- report any bleeding or mouth issues immediately to Service Coordinator.

8.9 Complications

Many issues and complications can arise from enteral tube feeding. However, there are three common issues a support worker will focus on when caring for a Client.

8.9.1 Diarrhoea

When the Client has frequent loose bowel movements that are not normal, which may be caused by:

- medications (i.e., antibiotics or laxatives)
- the formula being given too fast.
- the formula was too cold.
- contamination of the formula due to poor hygiene (e.g., handwashing)
- hanging feeds too long
- flushes are not cleaning the tubing.

8.9.2 Nausea, vomiting, bloating, heartburn and stomach pain.

Nausea, vomiting, bloating, heartburn and stomach pain can be caused by feeding using a cold solution. The Client may also experience these symptoms if lying flat during or just after feeding. Constricting clothing is also a possible cause that can be rectified easily.

8.9.3 Constipation

Constipation is a bowel movement that is hard or difficult to pass, which may be caused by:

- not enough fluid
- not enough fibre in the formula
- not enough exercise
- some medication types.

8.10 Weight chart

A weekly Client weigh-in is required or identified by the health practitioner (general practitioner, registered/enrolled nurse, enrolled nurse, dietitian, speech therapist, occupational therapist). A dietitian may specify in the Client's meal plan how much formula is required to meet specific nutritional needs. The support worker completes the Weight Chart to record the Client’s weight.

8.11 Record Keeping

All support workers are trained in our record-keeping requirements. Staff are required to:

- record the length of time allocated for mealtime assistance (this indicates the intensity of support required)
- document and monitor the rate and flow of feeding.
- record the daily input and output to monitor for dehydration.
- document a request received by the Client or advocate for a change of mealtime.
- communicate any requests regarding a change to mealtime to Service Coordinator
- record any changes requested by a health practitioner (e.g., dietitian, general practitioner, speech therapist, occupational therapist)
- record and communicate to Service Coordinator or registered/enrolled nurse any signs or symptoms of unexpected Client weight gain or weight loss.

9.0 Related documents

- Enteral Feeding Care Plan
- Mouth Care Plan
- Mealtime Support Plan
- Training Plan – Enteral Feeding and Management
- PEG Tube Feeding Assessment
- Clinical Practice Guidelines – Enteral Feeding
- Weight Chart

Tracheostomy Management Policy and Procedure

1.0 Scope

The Tracheostomy Management Policy and Procedure apply in conjunction with the Ventilator Management Policy and Procedure, the Stoma Care Policy and Procedure, the Management of Waste Policy and Procedure and the Infection Management Policy and Procedure. All policies are followed by support workers who care for and manage Clients with a tracheostomy.

2.0 Definitions

Term	Definition
Aseptic non-touch technique	Prevents microorganisms on hands from being introduced into a susceptible site.
Cannula	A tube can be inserted into the body, often for the delivery/removal of fluid or air.
Decannulation	Removal of a tracheostomy tube.
Endotracheal tube (ETT)	An artificial airway is inserted into the trachea for mechanical ventilation.
Passy Muir speaking valve (PMV)	Aqua speaking valves can be used for ventilator- and non-ventilator-dependent tracheostomy individuals to facilitate speech in select Clients who meet a specific criterion.
Stoma	A natural or surgically created opening connects a portion of the body cavity to the outside environment.
Suction	The use of devices to clear the airways of materials would impede breathing or cause infections.
Trachea	The anatomical structure is used for breathing.
Tracheal suctioning	A means of clearing the airway of secretions or mucus through applying negative pressure via a suction catheter.
Tracheostomy	An artificial opening (stoma) into the trachea to facilitate ventilation may be permanent or temporary.
Tracheostomy tube	A tube placed through a tracheostomy provides an airway and removes secretions from the lungs.
Ventilator	A mechanical device delivers and supports the Client's respiratory effort via an artificial airway.

3.0 Principles of tracheostomy management

A tracheostomy is a surgical opening in the trachea below the larynx. A tube is placed in the windpipe (trachea) to assist breathing. Without a steady flow of air (oxygen) through the tracheostomy, it will result in a lack of oxygen and eventual death.

A tracheostomy can be done for one of several reasons, including to:

- bypass an obstructed upper airway (an object obstructing the upper airway will prevent oxygen from the mouth from reaching the lungs)
- clean and remove secretions from the airway.
- efficiently and more safely deliver oxygen to the lungs.
- to facilitate a mechanical ventilator.

The procedure outlined in this policy and the Tracheostomy Care Plan informs staff on how to implement best-practice care, including when:

- dealing with a tracheostomy emergency
- changing a tracheostomy tube
- removing a tracheostomy tube
- suctioning
- oral hygiene
- decannulation
- humidification.

4.0 Roles and responsibilities

The Management Team is responsible for the overall clinical management of all high intensity supported Client care.

Care required (outside of the documented procedure) will be performed by a qualified health practitioner (e.g., general practitioner, registered/enrolled nurse).

If any situation occurs that may be a risk to the Clients tracheostomy care such as abnormal secretion and breathing problems, support workers will contact the relevant health professional.

In some cases, our support workers may respond in an emergency, but only with active oversight by a health practitioner (e.g., registered/enrolled nurse).

Roles and responsibilities of others involved in supporting the tracheostomy needs of the Client including carers, health practitioners and other workers.

5.0 Care plan

A Tracheostomy Care Plan is developed and reviewed by a health practitioner (e.g., registered/enrolled nurse or general practitioner) with the involvement of the Client, their carer or advocate, and Service Coordinator. The Care Plan details how support workers are to provide care for a Client's tracheostomy.

The Care Plan identifies how risks, incidents and emergencies are managed. The plan also outlines the actions and escalations required to maintain the Client's safety and wellbeing.

The Client's health status and Tracheostomy Care Plan are reviewed by a qualified health practitioner (e.g., general practitioner, registered/enrolled nurse) every three months, at a minimum, or whenever there is a change in the Client's condition.

The review aims to ensure strategies are in place to act upon information received from the Client, their carer or advocate, our staff and health professionals (e.g., registered/enrolled nurses, general practitioners).
Adjustments to the Care Plan are discussed with the Client and their carer or advocate. The Care Plan details how risks, incidents and emergencies are managed to ensure Client safety and wellbeing.
Staff have to ensure that they read the advanced care directive where a Client has one in place.

Lifestyle Centred Services Pty Ltd's Clients are ensured their desired level of involvement in their care is respected and always maintained. Lifestyle Centred Services Pty Ltd ensures each Client requiring tracheostomy care receives tracheostomy and ventilation support relevant and proportionate to their individual needs. Before providing care and support for tracheostomy care, support workers will request consent from the Client, their carer or advocate).
The care plan may also list information on the communication devices or protocols to be used with Clients who have limited speech capacity due to their tracheostomy.

6.0 Staff training

Workers will be trained in the specific needs of each Client they support including the appropriate use of equipment by Critical Second or an appropriate Health Practitioner. Lifestyle Centred Services Pty Ltd staff who provide direct care to Clients are trained and assessed in tracheostomy management procedures. Education provision includes all parts of tracheostomy care, including airway emergencies, within practice limitations.

Skills competency assessment is conducted by Critical Second (e.g., nurse educator, clinical nurse consultant or senior physiotherapist) with the appropriate clinical expertise.
Staff may be required to undertake additional qualifications to enhance their professional development (e.g. Registered Training Organisation courses in specialist CPR, administering medication to Clients requiring high risk supports etc.).
Workers who provide tracheostomy supports are reviewed annually to confirm the worker has current skills and knowledge. Where a worker has not delivered this support for more than three months the worker will complete refresher training.

Critical Second Nurses/trainers and support workers are required to have a thorough knowledge of:

- anatomy of the respiratory system
- skin and stoma care
- equipment types, components and functions, including speaking valves (PMV)
- common risks and indicators of malfunction

- indications that suctioning is required.
- 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.
- techniques to respond to tube blockages such as suctioning,
- humidification management
- first aid techniques to check and clear airways,
- how to administer CPR and place a person in a recovery position.

7.0 Safe care

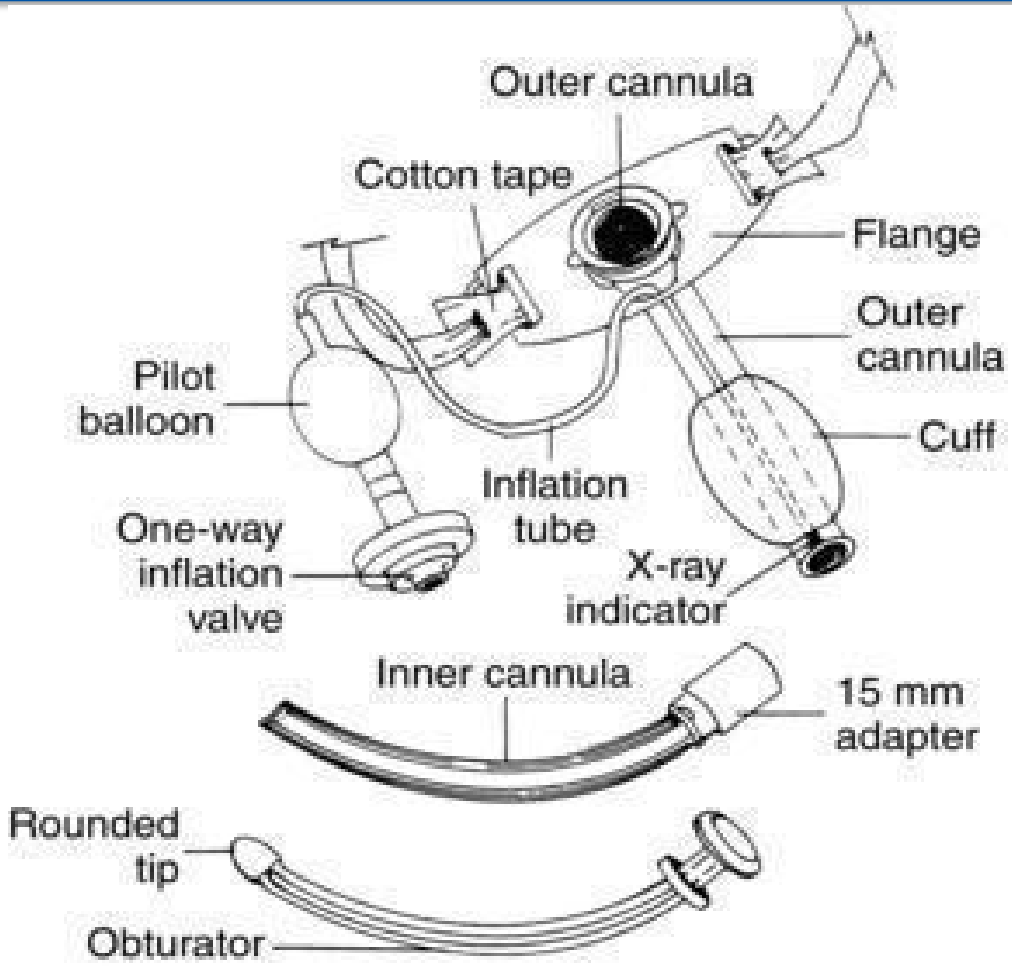
Clients with a tracheostomy are cared for by support workers competent in tracheostomy management, including airway emergencies. Our support workers are trained to identify and minimise Client exposure to risk factors.

Staff use a tracheostomy kit when working in home environments. The kit has the necessary equipment to maintain the care and safety of the Client's tracheostomy, including blocked or partially blocked tracheostomy.

Emergency equipment and extra tracheostomy tube and insertion equipment will be available sp that in the event of an emergency an obstructed tracheostomy tube may be cleared or replaced if that is required.

Infection prevention protocols including hand hygiene and use of personal protective equipment will be followed when providing tracheostomy care,

Figure 1. Tracheostomy tube



7.1 Observations

Vital signs, respiratory rate, respiratory pattern (including auscultation), oxygen saturation, heart rate, blood pressure and temperature level of consciousness are all monitored at a frequency dictated by the clinical condition.

Continuous pulse oximetry for Clients with a new tracheostomy or any respiratory compromise will be conducted. Clients who require continuous pulse oximetry will be cared for in a suitable clinical environment where staff can continually observe the Client.

Support workers will monitor sputum and record the amount, colour and consistency using the Tracheostomy and Ventilator Observation Chart.
Support workers have understanding and skill in stoma care and common risks, problems and signs of infection or deteriorating health such as, sore skin, leakage, ballooning, pancaking, bleeding, hernia, and prolapse.

7.2 Minimum frequency tracheostomy checks and care.

1-2 hourly	2-4 hourly	6-hourly	Once per shift	Daily
Assess the adequacy of *humidification*	*Inner cannula* removed, check for secretion build-up, clean and replace	Document: *Airway:* Skin colour, air entry - bilateral at the axilla, expired air felt from the tracheostomy tube *Breathing:* Bilateral chest movement and depth of respiration	Check and restock *emergency bedside equipment*	*Trachea tapes* changed (more frequently if soiled)
Assess the need for *suction.* Document amount, viscosity, and colour of secretions	Normal saline *nebulisers* four-hourly/PRN (more frequently for Clients with thick secretions)	*Vital signs:* Respiratory rate Oxygen saturation Heart rate Blood pressure Temperature	*Cuff pressure* measurement	Assess *systemic hydration* (fluid balance)
For *adjustable flange tracheostomy tubes* – observe and document the position of the flange to the tube at the skin following each suction to detect tube migration.	Check *heat moisture exchanger*		Clean *stoma site*	Change *heat/moisture exchanger.* (More frequently if soiled)
Assess the *position and alignment* of the tracheostomy tube	*Mouth care*		*Stoma site*: Observe for bleeding in new stomas; note crusting, signs of infection, smell or discharge.	

7.3 General care and hygiene

To prevent sore mucous membranes and lips, a high standard of frequent oral hygiene is required for Clients with a tracheostomy. Topical products prevent and treat oral infections in and around the oral cavity.

Clients are shaved as usual, with care taken around the tracheostomy tube not to dislodge it, introduce soap, water, or shaving cream into the tracheostomy, or cut the securing tapes.

When showering or bathing Clients, care is taken to ensure water is not introduced into the tracheostomy tube.

7.4 Dressing change

A minimum of two support workers (competent in tracheostomy care) must undertake tracheostomy tie changes. Support workers will:

- perform daily tie changes when undertaking stoma care or as required if ties become wet or soiled.
- secure new ties before removing the old ties, as there is a potential risk for tracheostomy tube dislodgement when changing ties.
- keep old ties in situ until the clean ties are secured.
- re-secure loose ties immediately.

Where two workers are working together one of the workers will take the lead

Scope of worker responsibilities, including supervision and delegation arrangements and activities requiring more than one worker.
When existing ties are removed before securing the tube with clean ties, the second worker must hold the tracheostomy tube (to ensure it remains in place until the ties are secured) and will not remove their hand until the new tracheostomy ties are secured. The second worker then inserts the new ties into the flange and secures them around the Client's neck.

When changing ties, our support workers will:

- inform the Client, family, carer or advocate that the tracheostomy ties are about to be changed.
- perform appropriate hand hygiene and wear required PPE (e.g., sterile gloves, safety glasses)
- prepare two equal lengths of ties long enough to go around the Client's neck.
- correctly position the Client (i.e., they should be sitting up in a chair or bed, if able); otherwise, the Client will be lying down with their neck gently extended by placing a small, rolled towel under their shoulders
- insert a clean tie into the holes on each side of the flange.
- tie a single loop on each side approximately 0.5 centimetres from the flange on the tracheostomy tube, and then tie both sides together in a secure bow.
- check the tension of the ties (allowing one finger to fit snugly between the skin and the ties)
- re-tie into a double (reef) knot to secure.
- cut off the excess length of ties (leaving approximately three centimetres)
- remove old ties.

- recheck tension of new ties
- dispose of waste as per the Management of Waste Policy and Procedure
- remove PPE and perform hand hygiene.
- observe the Client's neck to check skin integrity.

7.5 Suctioning a tracheostomy.

Suctioning the tracheostomy tube is necessary to remove mucus, maintain the Client's airway and avoid tracheostomy tube blockages. The support worker will encourage the Client to cough up secretions before suctioning whenever possible.

The frequency of suctioning is based on the Client's assessments. Indications for suctioning include:

- audible or visual signs of secretions in the tube
- signs of respiratory distress
- suspicion of a blocked or partially blocked tube
- inability by the Client to clear the tube by coughing out the secretions.
- vomiting
- desaturation on pulse oximetry
- changes in ventilation pressures (in ventilated)
- request by the Client/family/advocate for suction.

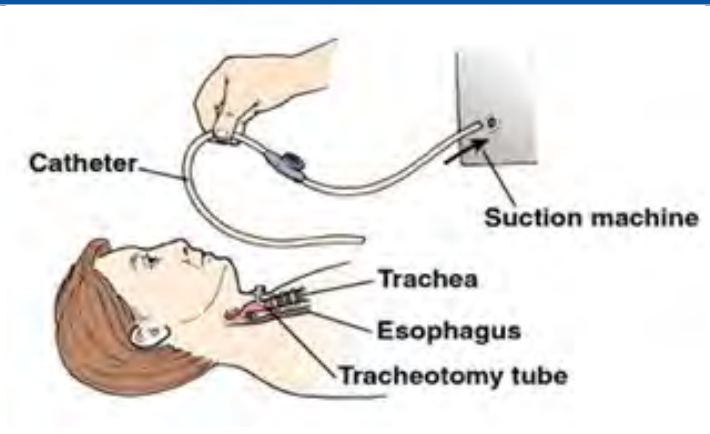
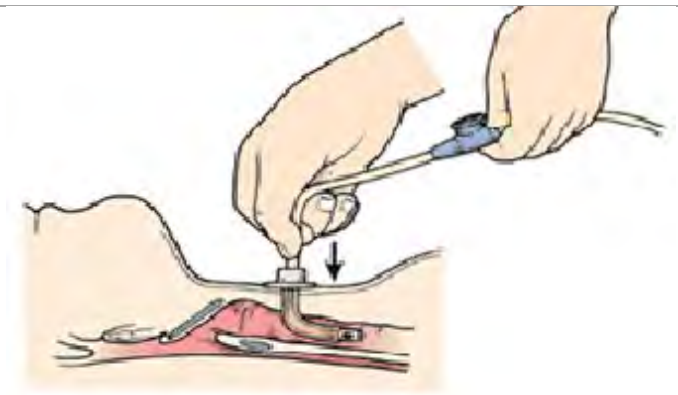
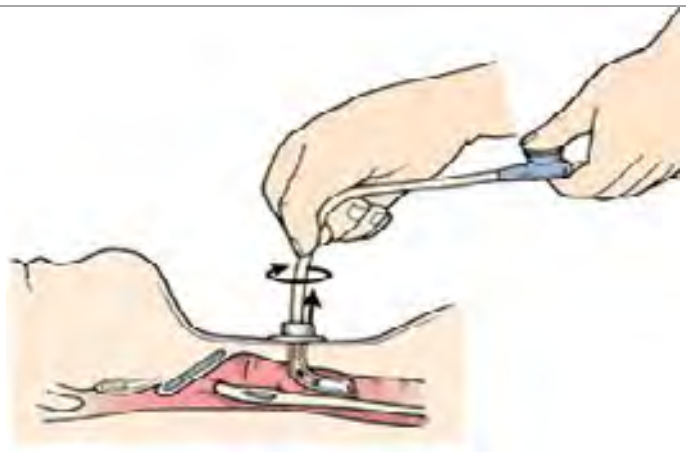
Tracheal damage may be caused by suctioning and will be minimised using the correct size suction catheter, appropriate suction pressures, and only suctioning within the tracheostomy tube.

When suctioning a tracheostomy tube, support workers will perform the steps in Table 1. How to suction a tracheostomy tube. Before performing suctioning, support workers will review the Tracheostomy Care Plan to determine:

- timing for suctioning episode
- depth of insertion of the suction catheter
- pressure setting for the tracheal suctioning.

Staff will use pre-measured suction catheters (where available) to ensure accurate suction depth. To avoid tracheal damage, support workers will be aware of the limits of suctioning pressure. The episode of suctioning (including passing the catheter and suctioning the tracheostomy tube) will be completed within five to 10 seconds.

Table 1. How to suction a tracheostomy tube

Steps	Diagram
1. Connect the catheter to the suction machine, ensuring the end of the catheter that goes into the trach tube is not touched.	
2. Insert the catheter the proper distance into the trach tube (usually the length of the trach tube plus six centimetres).	
3. Apply suction by placing the thumb over the hole in the catheter while gently rolling the catheter between the thumb and forefinger to pull the catheter out.	

7.6 Tracheostomy care in the home

7.6.1 Tracheostomy kit

Support workers providing tracheostomy care in the Client's home require a tracheostomy equipment kit which consists of:

- one tracheostomy tube of the same size in-situ (with introducer if applicable)
- one tracheostomy tube; a size smaller (with introducer if applicable)

- spare inner tubes for double-lumen tracheal tubes (if applicable)
- additional ties (cotton or Velcro)
- scissors
- resuscitation bag and mask (appropriate size for the Client)
- personal protective equipment
    - a one-way valve (community use only)
    - wall or portable suction equipment
    - appropriate size suction catheters
    - sodium chloride ampoule (0.9%) and syringe (1 ml)
    - one heat moisture exchanger (HME) filter or tracheostomy bib
    - fenestrated gauze dressing
    - cotton wool applicator sticks
    - water-based lubricant for tube changes
    - mucous trap with a suction catheter for emergency suction
    - occlusive tape (i.e., sleek)
    - syringe (10 ml) if cuffed tube in situ.

7.6.2 Suction equipment

Suction equipment required to perform tracheostomy care includes:

- suction machine and tubing
- suction catheters
- clean water to flush the suction tubing.
- appropriate PPE (e.g., gloves, apron)
- protective face visor
- humidification devices (if applicable).

7.7 Management of speaking valves

A speaking valve allows a Client with a tracheostomy tube to vocalise. A speech pathology assessment must assess the Client's ability to vocalise and evaluate possible communication problems. The speech pathologist is responsible for establishing phonation and evaluating voice quality.

The **benefits** of a speaking valve include:

- improved Client vocalisation and communication
- reduced potential for infection (when compared to digital occlusion)
- possible improvement of secretion management.

Identified **contradictions** of a speaking valve include:

- upper airway obstruction and oedema
- medical instability
- severe aspirations or copious secretions

- severe dysarthria (muscular speech weakness)
- unconscious Clients

Only a registered/enrolled nurse or support worker deemed competent in tracheostomy care can perform the speaking valve management procedure. The procedure includes:

- deflating the cuff
- removing the valve during sleep or rest periods (it is only used when a Client wishes to talk)
- removing the speaking valve and delivering nebulizers via the tracheostomy tube using a tracheostomy mask and nebulizer reservoir.

7.8 Tracheostomy emergency airway management

Registered/enrolled nurses and senior support workers responsible for responding to Clients requiring breathing assistance using an artificial airway are provided with ongoing education and training to manage emergency airway situations and undertake difficult airway drills.

Emergency airway management includes:

- monitoring vital signs of consciousness (i.e., respiratory rate, respiratory pattern (including auscultation) in critical care areas, at a frequency dictated by the Client's clinical condition (not less than every six hours)
- conducting continuous pulse oximetry for Clients with a new tracheostomy or any respiratory compromise
- ensuring Clients who require continuous pulse oximetry are continually observed in a suitable clinical environment.
- monitoring sputum and recording the amount, colour and type on the Tracheostomy and Ventilator Observation Chart

7.9 Signs and symptoms for immediate intervention

The following signs and symptoms will be reported immediately to the registered/enrolled nurse or Service Coordinator:

- unexplained dyspnoea (i.e., difficult or laboured breathing)
- severe coughing
- bleeding around the tracheostomy site
- haemoptysis (i.e., the coughing up of blood)
- changes in consistency and colour of secretions
- erythema or soreness around the stoma, including superficial reddening of the skin (usually in patches) because of injury or irritation that causes dilatation of the blood capillaries.
- oxygen desaturation
- no breath sounds due to ineffective humidification of the air.
- decreased or gurgling breath sounds due to dislodgement of tracheostomy tube.
- signs of a blocked tracheostomy tube such as, blood or phlegm in the tube, breathing difficulties

7.9.1 Signs of respiratory distress

Our staff are trained to recognise the following signs of respiratory distress:

- **Difficult laboured or noisy breathing:** Incomplete tracheostomy tube occlusion, no breath sounds are heard; however, partial obstruction air entry is diminished and often noisy.
- **Use of accessory muscles:** A sign of airway obstruction; in complete airway obstruction, Clients often develop a seesaw breathing pattern in which inspiration is concurrent with the outward movement of the abdomen and inward movement of the chest wall vice-versa.
- **No or limited expired air from the tracheostomy tube, reduced chest movement or 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 Client will become anxious and agitated as they struggle to breathe and become hypoxic.
- **Increased pulse/respiratory rate:** Increased respiratory and pulse rates are signs of illness and indicate that the Client may suddenly deteriorate.
- **Clammy/diaphoretic skin:** Associated with increased work of breathing from an occluded airway and stimulation of the sympathetic nervous system, causing vasoconstriction.
- **Stridor:** This is caused by an obstruction above or at the level of the larynx.
- Pulsing of tracheostomy tube (danger of eroding into an innominate artery).
- Inability to pass a suction catheter down the tracheostomy tube (deflate the cuff and replace the tracheostomy tube).

7.9.2 Emergency equipment

In an emergency, the following equipment may be required:

- humidified oxygen with a tracheostomy mask
- suction and selection of suction catheters
- two cuffed tracheostomy tubes; one the same size as the Client currently has inside and one a size smaller
- a 10-millilitre syringe to deflate/inflate the cuff.
- gloves
- eye protective equipment and other PPE, as deemed necessary.

7.10 Emergency procedures

7.10.1 Respiratory arrest

- The tube should be used for ventilation and not be removed unless obstructed.
- If removing a cuffed tube is necessary, the cuff should be deflated using a 10-millilitre syringe before removal.
- Emergency ventilation of an uncuffed Shiley™ tracheostomy tube can be affected by ensuring the inner tube is in place and attaching the Air Viva bag with the mask removed.
- Some leakage is expected if the chest is rising and falling.
- The tube should be replaced with a cuffed tube.
- Clients with a total laryngectomy will be ventilated via the tracheostomy tube.

7.10.2 Dislodgement of a tracheostomy tube

- Gently replace the tube if possible.
- Check the Client is breathing spontaneously.

7.10.3 If respirations have ceased.

- Ring emergency services on 000 and ask for an ambulance.
- Establish the Client's airway by covering the stoma with dressing if using the airway and commence resuscitation for a Client with a tracheostomy.
- Resuscitate via a stoma if the Client has a laryngectomy.

7.10.4 If breathing present.

- Replace tube if possible.
- Closely monitor the Client's respiratory status.
- Place the Client in the recovery position.
- Apply oxygen.

Diagram 1. Emergency management response

8.0

Related documents

Standard documents used for all HIDPA are noted in the introduction.

Document specific to this indicator are noted below

- Tracheostomy Care Plan
- Manual Handling Client Care Plan
- Training Plan – Tracheostomy Care and Management
- Staff Training Plan
- Clinical Practice Guidelines – Tracheostomy
- Tracheostomy and Ventilator Observation Chart
- Ventilator Management Policy and Procedure
- Stoma Care Policy and Procedure
- Ventilation Management Procedure
- Client Risk Assessment

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Urinary Catheter Management Policy and Procedure

1.0 Scope

This policy applies to all Lifestyle Centred Services Pty Ltd staff undertaking urinary catheter management and caring for Clients.

2.0 Definitions

There are three urinary catheters commonly encountered which are explained below.

Term	Definition
Indwelling catheter (IDC)	An **indwelling catheter (IDC)** is inserted via the urethral opening of the penis or vulva and held in place via a small balloon inflated with water. It is changed every four to 12 weeks. A drainage bag attaches to the tube to collect urine.
Suprapubic catheter	A **suprapubic catheter** (SPC) is inserted into the body 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 four to 12 weeks.
Uridome	A **uridome** is a condom-like device that attaches directly to the penis. It is attached each evening before bed and removed each morning. Overnight it is attached to a drainage bag to collect urine.
Intermittent catheter	The catheter insertion and removal several times a day to empty the bladder.

3.0 Principles of urinary catheter management

Lifestyle Centred Services Pty Ltd principles of urinary catheter management are:

- follow infection management procedures.
- replace and dispose of catheter bags safely.
- monitor catheter position- drainage and timing of drainage.
- monitor skin condition around the catheter.
- maintain charts and records.

4.0 Role and responsibilities

4.1 Registered/enrolled nurse (Critical Second)

A registered/enrolled nurse will:

- only work within the scope of their practice and prior experience

- attend to catheter care management, including the insertion or changing of catheters, only if they have extensive practical experience in inserting or changing a catheter in both male and female Clients.
- supervise and guide support workers in the provision of catheter care.

4.2 Support Workers

Our support workers will:

- follow the Urinary Catheter Management Care Plan as provided by Lifestyle Centred Services Pty Ltd
- report to Service Coordinator or registered/enrolled nurse any changes or variations to seek advice.
- never change the Care Plan
- take part in training on the use of equipment, manual handling, and risk management as determined by Lifestyle Centred Services Pty Ltd
- report any issues arising from the delivery of personal care to Service Coordinator for further advice.
- identify and report to Service Coordinator any identified gaps in their skills required to deliver supports.

Support workers may:

- perform any task on the Urinary Catheter Management Care Plan, apart from those that must be performed by a registered/enrolled nurse (as nominated above)
- undertake catheter care as follows:
    - empty the drainage bag.
    - change the drainage bag.
    - clean around the catheter entry site
    - ensure no apparent kinks are in the catheter tubing.
- attach the night bag to the day bag (afternoon staff)
- observe and report if:
    - urine is not clear, has an unusual odour.
    - there is debris in the urine, or urine output is reduced.
    - the catheter entry site is red.

5.0 Care Plan

The Urinary Catheter Management Care Plan will be reviewed regularly. The Client will be provided information regarding adjusted procedures using their preferred communication method (where applicable).

The Care Plan includes:

- maintaining infection management procedures
- managing a specific type of catheters (i.e., IDC, suprapubic, intermittent)
- replacing and disposing of catheter bags safely
- maintaining charts/records (i.e., output and intake, bag changes)
- monitoring catheter position
- monitoring skin condition around the catheter

- recognising, responding and reporting blockages, dislodged catheters, and deteriorating health or infection signs.

The Client's health status is regularly reviewed by Service Coordinator and a qualified health practitioner (e.g., registered/enrolled nurse).

The support worker will obtain the Client's consent before commencing urinary catheter management care.

6.0 Staff training

Our support workers receive training from Critical Second (External Nursing Service), a health practitioner or support worker deemed competent, who covers information that specifically relating to each Client's needs and the type of urinary catheter support required, including the following:

- basic understanding of the urinary system for males and females
- appropriate and monitoring of 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 of when to involve a health practitioner.
- infection management procedures
- identify how to respond/report signs of deteriorating health.
- emergency management of a catheter.

7.0 Safe care

Our staff will consult with the Client, their family, carer or advocate to identify, recognise, and respond to or report problems relating to urinary catheter care (e.g., irritation, dehydration, infection, blockages and signs of deteriorating health). Our support worker will involve a qualified health practitioner (e.g., general practitioner, registered/enrolled nurse) if any risk factors are present with the Client.

7.1 Equipment

When providing urinary catheter care, the following equipment is required:

- disposable gloves (powder free)
- disposable apron
- goggles/face mask
- lubricant (water-based)
- catheters (i.e., indwelling, suprapubic, intermittent)
- urine bags (i.e., leg and overnight)
- leg tape
- stand for an overnight bag.

- bag or receptacle for medical waste.

Support workers using equipment will ensure that it is cleaned or that single use disposable equipment is used if that is noted in the care plan and the equipment is available.

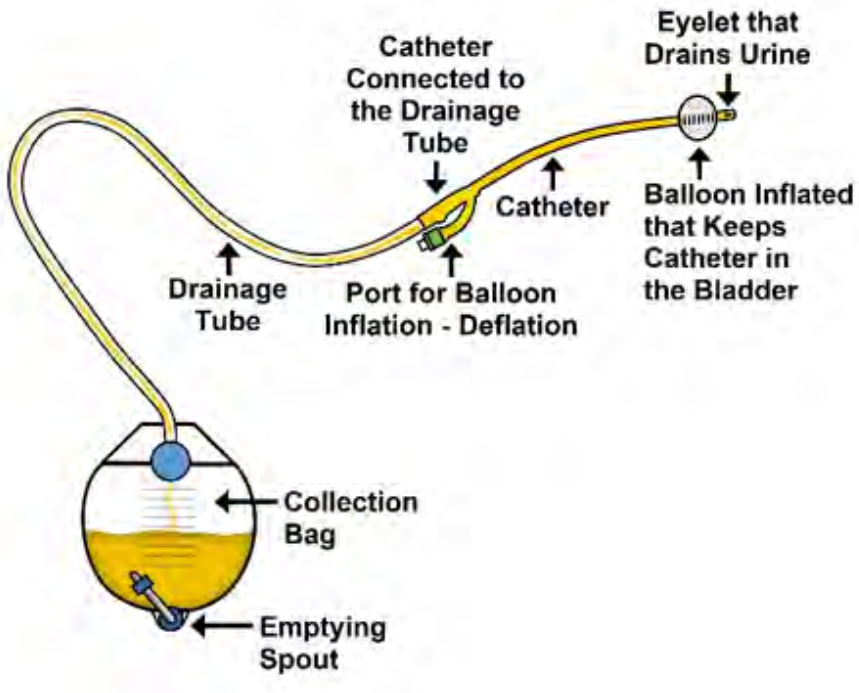
7.2 Procedure

Catheters are generally necessary when someone cannot empty their bladder. If the bladder is not emptied, urine can build up and lead to pressure in the kidneys. The pressure can lead to kidney failure, which can be dangerous and may result in permanent damage to the kidneys.

7.2.1 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' sizes and types vary; they can be made of rubber, plastic (PVC) or silicone.

Diagram 1. Urinary catheter tube



The three most common types of urinary catheters include:

1. **Indwelling or Suprapubic**: A thin, flexible tube continuously drains urine from the bladder via the urethra (indwelling) or 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.
2. **Intermittent:** Involves inserting and removing a catheter into the bladder via the urethra several times a day, emptying contents into a container (then emptied in the toilet) or directly into the toilet.

3. **External:** This catheter is placed outside the body. It is typically necessary for men who do not 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, and a tube leads from the condom device to a drainage bag.

7.2.2 Catheter care and equipment

When providing catheter care, our support workers will:

- perform strict hand hygiene when attending to catheters, including emptying the drainage bag.
- ensure the correct positioning of the catheter tubing so that it is not tugged or pulled by securing the tube to the thigh with an appropriate catheter strap.
- wash the catheter entry point daily, using downward strokes away from the entry area to avoid introducing microorganisms into the body.
- monitor the skin and record any redness or swelling.
- encourage adequate fluid intake to promote a healthy urine output.
- empty the drainage bag regularly, never allowing it to overfill as backflow may occur, which sends urine back towards the bladder and may cause infection and pain.
- record the dates for when the catheter will need to be replaced by a registered/enrolled nurse (usually six to 12 weeks, depending on the type of catheter)
- record when the catheter bag is emptied, and the urine volume may also need to be recorded.

7.2.3 Urinary catheter drainage bag procedure

Two types of bags are used to drain urine – a leg bag and an overnight bag. Different brands have different interlocking clamps and access to drainage. The Client's Care Plan lists the specific type of urinary drainage bags that support workers will use.

Support workers will check that catheters are functioning. Support workers will check bag placement, check urine levels and draining and/or replacing catheter bags.

Leg bag

The leg bag is:

- a sterile bag that must always stay connected unless being changed (weekly)
- is worn under clothing and is usually attached to the leg above the knee with a pair of straps.
- strapped securely to prevent the bag from trailing or dragging on the catheter.
- emptied into the toilet when it is over half full (or every two hours) as indicated on the bag (it is never to be more than three-quarters full).

Before changing the leg bag, the support worker will:

1. Wash hands.
2. Put on appropriate PPE.
3. Hold the catheter firmly at the Y joint, tightening to reduce urine leakage.
4. Carefully twist the leg bag out of the catheter (ensuring not to pull on the catheter).
5. Remove the used leg bag.
6. Connect a new leg bag, ensuring not to touch the tip of the bag, so it remains sterile.
7. Use bottom clamps to close and secure to the Client's leg, as desired.

8. Discard the used bag according to the Management of Waste Policy and Procedure and the Infection Management Policy and Procedure.
9. Remove PPE.
10. Wash hands.

Overnight bag

Before removing the leg, bag and putting it on an overnight bag, the support worker will:

1. Wash hands.
2. Put on appropriate PPE.
3. Empty the leg bag (without removing the leg bag from the catheter).
4. Confirm the night bag clamp is closed and attach it to the outlet of the leg bag.
5. Open the leg bag clamp.
6. Check the night bag is hanging on the bed or the nightstand, so gravity enables the correct flow of urine down the catheter through the leg bag and into the night bag.
7. Remove PPE.
8. Wash hands.

The next morning, the support worker will:

1. Wash hands.
2. Put on appropriate PPE.
3. Clamp the leg bag closed (the leg bag is changed weekly unless otherwise specified in the Care Plan).
4. Remove the night bag.
5. Record the amount of urine, if required, and empty.
6. Clean the overnight bag with warm soapy water (detergents or sterilising agents are not used as they may damage the bag) and rinse with white vinegar, if required.
7. Store the overnight bag.
8. Remove PPE.
9. Wash hands.

7.2.4 Intermittent catheter procedure

The procedure involves passing an intermittent catheter down the urethra into the bladder. Support workers will refer to a Client's Urinary Catheter Management Care Plan to determine the specific size and type of intermittent catheter. The Catheter Care Form will outline catheterisation times and other necessary information.

Male catheters

Support workers will undertake the following procedure:

1. Wash and dry hands.
2. Wear required PPE.
3. Adjust the Client's clothing so that the penis is accessible.

4. Use soap and water (or moistened towelettes) to wash and dry the area.
5. If the Client is not circumcised, the foreskin will be pulled back, and the area washed.
6. Place the unopened catheter packet with the clear side facing downwards on a flat surface.
7. Peel back from the coloured end of the catheter for five centimetres.
8. Gently grasp hold of the funnel to stabilise the catheter and prevent it from flicking out of the packet.
9. Slowly peel the paper side of the packet and remove it altogether (without touching the catheter). The catheter should remain in a clear packet.
10. Drop lubricant onto the tip of the catheter and along the tube for about five centimetres.
11. Without touching the catheter (grasp hold of it through the packet), pick it up and hold it like a pen in their dominant hand and then peel back the clear packet to reveal the tip of the catheter.
12. With the non-dominant hand, grasp the penis and hold it at an angle.
13. Gently but firmly, push the catheter into the penis five centimetres. Hold the shaft of the penis firmly so that the catheter does not fall out.
14. Peel back the paper to expose another five centimetres of the catheter to be inserted.
15. Continue to insert the catheter in this way.
16. Resistance may be encountered where the catheter reaches the neck of the bladder and the closed sphincter muscle. The catheter is not to be forced. The support worker will ask the Client to cough, bear down (as though they want to pass urine), or deep breathe while applying gentle pressure against the resistance and continuing to insert the catheter.
17. Remove the paper entirely and wait for the urine to flow.
18. Return the penis to its natural position and hold onto the catheter until the urine flow stops.
19. Ensure urine flow is directed into the toilet or container.
20. Press gently over the bladder area as more urine may flow out when the urine has stopped.
21. Gently pull the catheter out and dispose of it in the bin or according to the Care Plan.
22. Replace the foreskin, if necessary.
23. Wash and dry the area thoroughly.
24. Discard catheters and packaging as per the Infection Management Policy and Procedure and the Management of Waste Policy and Procedure.
25. Remove PPE.
26. Wash and dry hands well.

Female catheters

Support workers will undertake the following procedure:

1. Wash and dry their hands.
2. Wear appropriate PPE.
3. Assist the Client in a comfortable position and adjust clothing to access the urethra.
4. Use soap and water (or moistened towelettes) to wash the area and then dry.
5. Place the unopened catheter packet on a flat surface, the clear side facing downwards.
6. Peel back from the coloured end of the catheter for five centimetres.
7. Gently grasp hold of the funnel to stabilise the catheter and prevent it from flicking out of the packet.

8. Slowly peel the paper side of the packet and remove it entirely without touching the catheter, and the catheter will remain in the clear packet.
9. Drop lubricant onto the catheter's tip and about five cm along the tube.
10. Without touching the catheter (grasping hold of it through the packet), pick it up and hold it like a pen in their dominant hand and peel back the clear packet to reveal the tip of the catheter.
11. Using the non-dominant hand, the worker gently parts the labia to expose the urethra.
12. Gently insert the catheter into the urethra and push it until urine begins to drain gently.
13. If the catheter appears stuck, remove the catheter and try again.
14. Hold on to the catheter until the flow of urine stops.
15. Make sure to direct the flow of urine into the toilet or container.
16. When the flow has stopped, ask the Client to cough and press gently over the bladder as more urine may flow out.
17. Gently pull the catheter out, place it in a bowl, or dispose of it in the bin.
18. Wash and dry the area.
19. Discard packaging as per the Infection Management Policy and Procedure and the Management of Waste Policy and Procedure.
20. Remove PPE.
21. Wash and dry hands.

7.2.5 Care of skin and urethral care

The urethra and general genital area have soft membranes that are easily harmed. Therefore, the skin surrounding the urethra will be cared for by observing:

- redness or swelling
- infection (discoloured mucus or pus, strong odour, pain or abnormal discomfort).

If any of the above are noted, our support workers will document them appropriately and inform Service Coordinator or the registered/enrolled nurse.

7.2.6 Problems and complications in urinary catheter management

The Client's fluid intake, including alcohol and caffeine (which increase the amount of urine they produce), is monitored and calculated using the Daily Fluid Intake and Output Form. The Client may require extra catheterisation. Urethral strictures may become a problem; if this is the case, Service Coordinator and the registered/enrolled nurse will be informed.

7.2.6.1 Managing urinary bypassing of a catheter.

Urine may be coming from the Client’s urethral opening or leaking around the catheter insertion point. Should this occur, a support worker will assess the catheter for patency and:

- blocked catheter tubing (sediment or blood will be visible in the tube)
- kinked tubing
- over-full drainage bag

- clamped catheter.

The support worker will assess for faecal impaction or constipation. A full rectum can cause pressure on the bladder, leading to unstable bladder contractions and occluding or blocking the catheter.

If a support worker follows the above steps and urinary bypass is still evident, they will notify the registered/enrolled nurse or Service Coordinator as the catheter may require changing.

7.2.7 Observe, document and report.

If specific conditions or symptoms are identified, observations will be documented and reported to the supervising registered/enrolled nurse or Service Coordinator who will arrange a medical review. Conditions and symptoms may include:

- persistence or worsening pain in the lower abdomen
- a persistent, localised pain
- new pain since catheter insertion
- 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 four hours or the Client's abdomen is swollen and tender, the registered/enrolled nurse will be contacted immediately to organise an urgent medical review.
- strong odour or cloudy urine
- blood in urine
- chills or fever above 38 degrees
- lower back pain
- abnormal leakage around the catheter
- swelling at the catheter insertion site, especially in men
- disorientation or change in mental status.

8.0 Related documents

Standard documents used for all HIDPA are noted in the introduction.
Document specific to this indicator are noted below

- Urinary Catheter Management Care Plan
- Manual Handling Client Care Plan
- Training Plan – Urinary Catheter Management
- Staff Training Plan
- Clinical Practice Guidelines – Urinary Catheter
- Catheter Care Form
- Indwelling Urinary Catheter Daily Care Chart
- Daily Fluid Intake and Output Form
- NDIS Continence Related Assistive Technology Assessment Template

Ventilator Management Policy and Procedure

1.0 Scope

The Ventilator Management Policy and Procedure apply to all staff who use ventilation equipment when providing care to a Client. This procedure applies in conjunction with the Tracheostomy Management Policy and Procedure, the Stoma Care Policy and Procedure, the Management of Waste Policy and Procedure, and the Infection Management Policy and Procedure.

This policy is followed by all Lifestyle Centred Services Pty Ltd staff who care for and manage Clients who use a ventilator. Care required (outside of this documented procedure) will be performed by a qualified health practitioner (e.g., general practitioner or registered/enrolled nurse). In some cases, our staff may respond in an emergency, but there will be active oversight by a health practitioner (e.g., registered/enrolled nurse).

The policy ensures Lifestyle Centred Services Pty Ltd provides a safe, efficient and effective ventilator management service to our Clients while meeting their comfort requirements and needs. We work with our Clients to achieve goals for receiving non-invasive and invasive mechanical ventilation supports.
Clients may require support to use ventilation accessory equipment such as Bilevel Positive Airway Pressure (BiPAP), and Continuous Positive Airway Pressure (CPAP) machines, humidifiers, airway clearance devices, suctioning, manual ventilation devices, and oxygen

2.0 Definitions

Term	Definition
Humidification	*Humidification (active):* Inspired air/oxygen is warmed and moistened using a heated water bath. *Humidification (passive):* Inspired air oxygen is warmed and moistened by a filter (i.e., heat moisture exchange) which captures the Client's own expired warm air and moisture to humidify the following inspired breath.
Non-invasive mechanical ventilation	A simple method of assisting a Client's breathing without using an invasive airway (tracheostomy tube): 1. CPAP (continuous positive airway pressure) 2. BiPAP (bilevel positive airway pressure)
Invasive mechanical ventilation	Invasive ventilation is when a Client is attached to the ventilator through an artificial airway (i.e., an endotracheal tube or tracheostomy). It is a life-saving intervention for Clients with respiratory failure.

Ventilation	Breathing is carried to the trachea via an artificial airway (tracheal cannula).

3.0 Principles for ventilation management

Our principles for ventilator management include:

- improving oxygenation and ventilation
- confirming the need for ventilation and recognise the need for suctioning.
- following procedures to clear airways as required
- follow infection management procedures.
- setting up a ventilator for operation (i.e., identify, connect or assemble components of ventilation equipment according to instructions and fit the breathing mask)
- starting ventilation and monitoring that it is working effectively.
- applying troubleshooting procedures to respond to alarms.
- recognising and responding to signs that airways are obstructed.
- implementing emergency procedures (e.g., deteriorating health or infection)
- maintaining equipment
- completing charts/records, as required.

4.0 Roles and responsibilities

The Management Team is responsible for the overall clinical and medication management of high-intensity support activities for a Client's care.

Care required (outside of what is documented in the procedure) must be performed by a qualified health practitioner (e.g., general practitioner or registered/enrolled nurse). In some cases, the support worker may respond when the Client with a tracheostomy or ventilator requires emergency procedures to be implemented. However, a health practitioner will have active oversight (e.g., registered/enrolled nurse).

4.1 Registered/enrolled nurse (Critical Second)

A registered/enrolled nurse will:

- supervise the ventilator management and care for Clients.
- develop and review the Ventilation Management Care Plan
- coordinate care services.

4.2 Support workers

Support workers will monitor and manage the Client's respiratory condition by following procedures, which include:

- identifying, connecting or assembling components of ventilation equipment according to instructions
- operating a ventilator and undertaking cleaning of equipment
- fitting the breathing mask and equipment on the Client

- monitoring that the ventilation is working effectively.
- following trouble-shooting procedures to respond to alarms.
- maintaining equipment
- documenting care and Client requirements
- reporting signs and symptoms (e.g., unexplained dyspnoea, severe coughing, bleeding around tracheostomy site, haemoptysis, changes in consistency and colour of secretions, erythema or soreness around the stoma)
- implementing intervention strategies for signs of:
    - respiratory distress
    - pressure sores and discomfort
    - common problems with ventilation
- engaging incident and emergency procedures, as required.
- assisting Clients to fit and adjust their breathing masks.
- monitoring ventilation circuits
- managing the inflation and deflation of the tracheostomy cuff.

5.0 Care plan

Lifestyle Centred Services Pty Ltd's Ventilator Management Care Plan is developed and reviewed by a health practitioner (i.e., registered/enrolled nurse, general practitioner) with the involvement of the Client, their carer or advocate, and Service Coordinator. The Care Plan details how supports are required to meet the Client's ventilation requirements.

The Client's health status and Care Plan are regularly reviewed, and updated procedures are discussed with the Client and their family, carer or advocate. The Care Plan details how risks, incidents and emergencies will be managed to ensure Clients' safety and wellbeing.

A Client's Ventilator Management Care Plan is reviewed every quarter or as required to ensure strategies are in place to act upon information received from the Client, their carer/advocate, staff and health professionals (e.g., registered/enrolled nurse, general practitioner).

The Tracheostomy and Ventilation Observation Schedule is reviewed regularly and informs the Care Plan. Ventilator settings are noted in the Care Plan and **MUST NOT** be changed without a registered/enrolled nurse or general practitioner reviewing the Client's condition.

The support worker will confirm consent (with the Client or their carer or advocate) before providing care and support for ventilation.

If support workers have any concerns relating to a Client's condition, they will immediately contact the registered/enrolled nurse or Service Coordinator.

6.0 Staff training

Critical Second trains our staff in ventilation management (invasive and non-invasive) using the employee's Training Plan or the Training Plan – Ventilation Management.
Each support worker is provided with Competency Assessments to support a person dependent on ventilation. Support workers can implement emergency procedures (e.g., obstructed airway, knowing when to inflate and deflate cuffs).
Support workers are trained to identify associated health conditions and complications that impact Clients with a tracheostomy and require ventilation management (invasive or non-invasive).

Our support workers understand the basic anatomy of the respiratory system, as well as:

- musculoskeletal problems associated with respiration.
- signs of respiratory distress
- ventilator types and the main equipment components and functions
- basic principles of how a ventilator works (e.g., how to connect to a power supply, understanding of the ventilator settings and alarms, how to connect the exhalation valve and mask)
- Signs and symptoms of respiratory distress for example, drowsiness, reduced alertness, breathing rate, nose flaring, colour changes, wheezing, bracing upper body and large chest movements when breathing.
- various types of breathing masks and techniques for fitting
- how to avoid discomfort or pressure sores
- identifying common problems and taking action to address the issue.
- observation parameters and procedures
- the nature and consequences of a Client's respiratory condition
- how to handle a Client if they are not compliant when receiving ventilation care
- care of the equipment and equipment cleaning procedures
- incident and emergency procedures
- documentation procedures.

7.0 Safe care

The support worker consults with the Client and their advocate to identify and remove or minimise exposure to infection or deteriorating health. Lifestyle Centred Services Pty Ltd staff will take appropriate actions to identify early indicators of obstructed airways and implement emergency procedures.

Staff understand the indicators to initiate emergency procedures including the use of back up and manual ventilators. For example, loss of electricity or battery failure in the ventilator machine

When an incident, emergency or associated risk is identified, staff will follow the Reportable Incident, Accident and Emergency Policy and Procedure, the Risk Management Policy and Procedure and the Ventilator Management Care Plan, applying exercised judgement in each situation.

Support workers are provided access to a charged mobile phone during work hours. Staff are advised of each Client's emergency management and communication methods as detailed in their Support or Care Plan (e.g., writing, sign language, communication aids). Staff are informed of the appropriate method of communication for each Client.

Support workers comply with safety considerations outlined in the Tracheostomy Management Policy and Procedure and the Stoma Care Policy and Procedure.

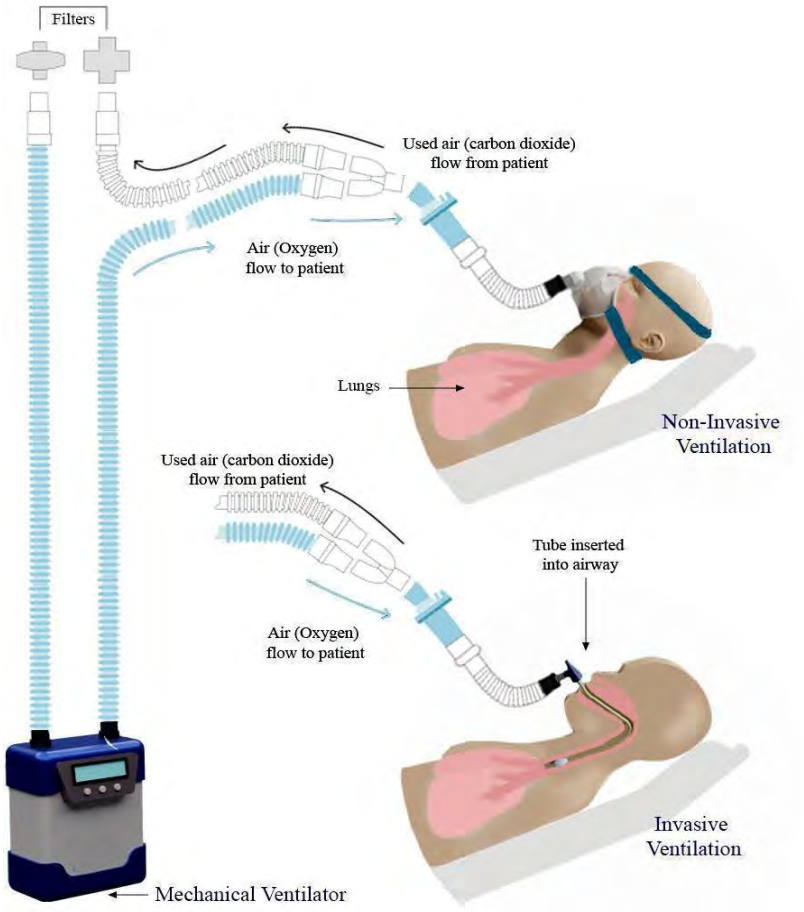
Alterations to the ventilator or ventilator settings occur only with written health practitioner orders and are carried out under registered/enrolled nurse supervision. A second ventilator is implemented with an external battery pack for ventilation periods exceeding 16 hours a day.

A humidifier is mandatory for all Clients requiring invasive and non-invasive ventilation.
Lifestyle Centred Services Pty Ltd has procedures, registers and reporting documents in place to ensure that appropriate care is provided to ensure our Clients' safety and wellbeing.

Management of Non-Invasive Insulation

Clients who use non-invasive ventilation will be assisted to fit and adjust their breathing masks.
Clients who use bi pap and c pap ventilation will be assisted to use the equipment.

Diagram 1. Comparison of invasive and non-invasive methods of ventilation



7.1 Ventilator management equipment in the home

Support workers will ensure that home equipment supplies are maintained and will reorder stock if short. Before reordering stock, a support worker may require Service Coordinator's approval or consent from the Client, family, or advocate. The Client's Service Agreement will be reviewed to determine if equipment stock approval has already been given.

The consumables and equipment must be checked monthly to ensure they are within date and functioning correctly. If they are not in-date and not functioning correctly, this must be documented in the Care Plan and communicated to the registered/enrolled nurse and Service Coordinator. The Client must also be advised.
Support workers maintain records of the equipment checks that they complete on respiratory equipment, Records are maintained of checks carried out on back-up ventilators, as well as oxygen levels in spare tanks and suction equipment,

The equipment in the home may include, but is not limited to:

- appropriate personal protective equipment
- continuous access to electricity supply
- ventilator and equipment (e.g., cuff)
- oxygen cylinder and tubing, adapters and bags
- humidifier
- tracheostomy kit (where applicable), including tracheostomy dilators.
- suction unit, equipment and batteries
- spare batteries for all equipment (back-up power supply via generator is discussed with the Client)
- sodium chloride – 10 millilitres (ml) x 5
- water for irrigation – 10 ml x 5
- syringes – 5 ml and 20 ml x 5
- lubricating jelly
- scissors
- gloves
- Yankauer sucker
- mobile phone with emergency contact numbers and charger.

Daily equipment checks will be completed on all equipment used, including the ventilator. Ventilator settings must be checked against the Client's Care Plan requirements.
The maintenance program for the ventilator will be noted, including the most recent date of ventilator service as required by our organisation's equipment maintenance program.

7.2 Procedure

7.2.1 Securing of the endotracheal tube.

Securing the endotracheal tube (ETT) can be done in one of three ways:

1. Tapes (e.g., Sleek or Transpore) are used only for Clients who are in the process of being transported to ICU or an operating theatre.
2. Cotton white tape, which is changed at least daily.
3. An endotracheal tube attachment device (ETAD) (anchor-fast) is changed every five days or as required.

7.2.2 Assessing endotracheal tube position.

The support worker will assess the endotracheal tube position each shift as follows:

1. Check and document the level of the endotracheal tube at the lips (usually 19-23 centimetres).
2. Ensuring equal bilateral chest movement and air entry on auscultation.
3. Verify the tip of the endotracheal tube is two to four centimetres above the carina on the chest x-ray.
4. Reposition the oral endotracheal tube to prevent pressure areas.

7.2.3 Assessing and maintaining a tracheal cuff seal:

Assessing and maintaining a tracheal cuff seal will involve the following:

1. A minimum occlusion volume is achieved on the first inflation of the cuff at intubation.
2. The cuff pressure is measured via a cuff pressure manometer.
3. Cuff pressure is documented once each shift or as required.
4. Cuff pressure of 20-30 mmHg is usually required to maintain an adequate seal.
5. If a pressure > 30mmHg is required to eliminate a cuff leak, the registered/enrolled nurse will be contacted immediately, as a pressure > 40mmHg may cause mucosal injury.
6. Listen for cuff leaks and monitor low ventilator pressure and tidal volume alarms, which may indicate an air leak.
7. Undertake arterial blood gas (ABG) sampling and analysis.
8. Perform an initial ABG 15-30 minutes post-intubation.
9. Further ABG sampling is required when there is:
    - deterioration in oxygen saturation
    - clinical signs of hypoxia
    - significant changes to ventilator settings
    - changes in Client's respiratory effort and ventilator observations (e.g., low tidal volume, increased or decreased minute volume).

7.2.4 Suction

Suctioning of the endotracheal tube is performed using a closed or in-line suction device only. It is replaced daily or overtly soiled, along with the suction tubing and receptacle liner. Regular suctioning is not recommended and will only be performed by support workers when clinically necessary or at approximately eight hourly intervals.

The suction procedure is as follows:

1. Explain the procedure to the Client.
2. Preoxygenate, the Client with 100% oxygen.
3. Observe hand hygiene principles and use necessary PPE.

4. Unlock the catheter and advance as far as possible without force or until the Client coughs.
5. Withdraw the catheter one to two centimetres to free it from the bronchial wall or carina.
6. Apply continuous suction while withdrawing the catheter in one continuous motion, not longer than 15 seconds.
7. Use a maximum of two suction passes.
8. Flush the catheter via the irrigation port with a 10-millilitre syringe of normal saline.
9. Lock the suction catheter.
10. Auscultate lung fields to assess the effects of interventions.
11. Using the Tracheostomy and Ventilator Observation Chart, document the sputum's colour, volume, and tenacity.

7.2.5 Humidification of the ventilator circuit

The air passing through the ventilator must be passed through either a heat moisture exchanger (HME) for a dry circuit or a heated water bath system for a wet circuit.

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

- sticky sputum
- haemoptysis
- bronchospasm
- bronchorrhea (i.e., excessive discharge of watery mucus from the lungs).

7.2.6 Management of the ventilator circuit

Ventilator settings, including oxygen flow, partial pressure of oxygen and PEEP, are stated in the Care Plan. Support workers conduct ventilator setting checks every shift or, at a minimum, every 24 hours. The ventilator setting can only be changed with a registered/enrolled nurse or general practitioner's input.

7.2.7 Ventilator maintenance

The maintenance of a ventilator varies depending on the make and model. When developing the Ventilator Management Care Plan, the registered/enrolled nurse will determine the maintenance schedule required for the ventilator and all associated equipment.
It is the responsibility of the Client, their family, carer or advocate to ensure that the maintenance schedule of the ventilator is kept up to date. The registered/enrolled nurse may assist if the maintenance plan is not up to date or if a skilled technician requires additional maintenance.

Support workers will change all ventilator tubing and circuits, including Laerdal; wet or dry are changed weekly or frequently if soiled. The heat moisture exchanger is changed daily or more frequently if wet or soiled.

Lifestyle Centred Services Pty Ltd works with the Clients, their family, carer or advocate to ensure that the necessary consumable items (e.g., tubing, circuits) are always available for the support worker to use with the Client. It is also advised that an emergency supply of consumables is kept in the Client's place of residence.

When the Client leaves their residence for short trips, the support worker or registered/enrolled nurse accompanying the Client will ensure that an emergency equipment bag travels with the Client.

7.2.8 Mouth care

Mouth care is important in caring for a Client using a ventilator. Support workers will provide mouth care following the instructions on the Mouth Care Plan. Mouth care includes swabbing the mouth, using a toothbrush with a suction catheter to remove any fluid or saliva in the mouth and applying lip balm to the Client's lips.

7.2.9 Emergency management

All staff must inform the registered/enrolled nurse and Service Coordinator if they are concerned about a Client's condition. In an emergency, such as those noted below, our staff will IMMEDIATELY call 000 and request an ambulance.

Support workers will follow emergency procedures to immediately start, operate and monitor the use of a back-up ventilator, resuscitation bags, oxygen requirements and suctioning equipment.

Table 1. Respiratory distress indicators and possible causes

Signs of respiratory distress	Potential causes
Increased work of breathing (i.e., Client acutely distressed or restless, tachypnoea, stridor, accessory muscle use, diaphoretic or cyanotic.	Airway wholly/partially obstructed due to blockage.
Decreased/gurgling breath sounds.	Tracheostomy dislodgement.
High inspiratory airway pressures/low tidal volumes in mechanically ventilated.	Persistent cuff leak.
Oxygen desaturation.	Faulty oxygen source or ventilation device.
No breathing sounds.	Ineffective humidification.
Unable to pass a suction catheter or inner cannula.	Tracheostomy in the false passage.
Ventilator failure.	Failure may be due to power failure, ventilator malfunction, accidental disconnection, circuit obstruction, or mask fit.

Staff will implement the DRSABCD Action Plan and use the emergency cardiopulmonary resuscitation (CPR) procedure in an emergency. Refer to Table 2. DRSABCD Action Plan.

Table 2. DRSABCD Action Plan

Action Plan
D = DANGER - Ensure the area is safe for yourself, others and the Client.
R = RESPONSE

- Check for response – ask name – squeeze shoulders.
S = SEND for help - Call 000 and ask for an ambulance or get another person to make the call.
A = AIRWAY - Check airway by open mouthing; if foreign material is present, place in recovery position/clear airway. - Open the airway by tilting the head with a chin lift.
B = BREATHING - Check for breathing – look, listen, feel. - Not normal breathing – start CPR. - Normal breathing – place in the recovery position, monitor breathing, manage injuries, treat for shock.
C = CPR - Start CPR – 30 chest compressions: 2 breaths. - Continue CPR until help arrives or the Client recovers.
D = DEFIBRILLATOR (if available) - Apply defibrillator and follow voice prompts. - Call 000 immediately for an ambulance (if they have not already been called).

Non-Invasive Ventilation

BiPAP and CPAP are both non-invasive ventilation therapies to support respiratory distress and insufficiency.

BIPAP therapy is often used to treat respiratory issues such as chronic obstructive pulmonary disease (COPD) or acute respiratory distress syndrome (ARDS). BiPAP delivers two levels of positive air pressure to the Client's airway: a higher-pressure during inhalation and a lower pressure during exhalation.

CPAP delivers a constant level of positive air pressure to the Client's airway during both inhalation and exhalation. The positive air pressure helps to keep the Client's airway open and prevent it from collapsing.

The choice between BiPAP vs CPAP therapy will depend on the individual Client's needs and medical conditions.

Comparison Between CPAP and Bi PAP

Similarities:

- Usage of a mask or nasal prongs to deliver air pressure to the Client's airway.
- Both are non-invasive and can be used to treat a variety of respiratory conditions.
- Requiring close monitoring of the Client's respiratory status, vital signs, and response to treatment.
- Both can be used in a hospital or home setting.

Differences:

- BIPAP delivers two different pressure levels, while CPAP delivers a constant level of pressure.
- BIPAP has a higher-pressure during inhalation and a lower pressure during exhalation, while CPAP delivers the same level of pressure during both inhalation and exhalation.
- BIPAP is often used to treat more severe respiratory distress, such as in Clients with COPD or ARDS, while CPAP is often used to treat sleep apnea or less severe respiratory distress.
- BIPAP may be more uncomfortable or difficult to tolerate for some Clients due to the higher-pressure during inhalation.

Non-Invasive Ventilation High Intensity Supports Interventions

- Assess the Client's respiratory status, vital signs, and need for BIPAP/ CPAP therapy. Assess the Client's comfort level and tolerance for the CPAP mask.
- Prepare the equipment to ensure that the BIPAP or CPAP machine is functioning properly and that the appropriate pressure settings have been selected based on the Client's needs. The nurse should also ensure that the mask or nasal prongs are properly fitted to the Client's face or nose.
- Administer the therapy, starting by placing the BIPAP/CPAP mask or nasal prongs on the Client's face or nose, ensuring a secure and comfortable fit. The support workers then turn on the BIPAP or CPAP machine and adjust the pressure settings as needed to achieve the desired therapeutic effect.
- Monitor the Client's respiratory status, vital signs, and response to therapy.
- Provide Client education on the purpose of the therapy, how to use and care for the equipment, and how to recognize and report any complications or concerns.
- Document the therapy in the Client's care plam, including the duration and pressure settings of the therapy, the Client's respiratory status and response to therapy, and any complications or concerns.

8.0 Related documents

Standard documents used for all HIDPA are noted in the introduction.

Document specific to this indicator are noted below

- Ventilation Management Care Plan
- Mouth Care Plan
- Manual Handling Client Care Plan
- Training Plan – Ventilation Management
- Staff Training Plan
- Tracheostomy and Ventilation Observation Schedule
- Daily Intake Management - Ventilator
- Tracheostomy and Ventilator Observation Chart
- Tracheostomy Management Policy and Procedure
- Stoma Care Policy and Procedure

Complex Wound Management Policy and Procedure

1.0 Scope

This policy applies to all support workers providing Clients with complex pressure care and wound management.

2.0 Definitions

Term	Definition
Burn	Injury to tissues caused by heat, friction, electricity, radiation or chemicals.
Wound	Injury to a part or tissue of the body, especially one caused by physical trauma and characterised by tearing, cutting, piercing, or breaking of the skin or mucous membrane. Wounds may be acute (e.g., cut, graze, burn) or chronic (e.g. leg ulcer, pressure ulcer or diabetic wound).
Chronic wounds	A failure to heal in an orderly and timely manner.
Pressure injuries	A localised injury to the skin or underlying tissue, usually over a bony prominence, because of pressure, friction, or combination.
Surgical wounds	A clean-cut or puncture of the skin deliberately during a surgical procedure.
Trauma wounds	A stressful event is caused by either mechanical or chemical injury resulting in tissue damage.
Pressure ulcer	A localised injury to the skin or underlying tissue is usually over a bony prominence because of pressure combined with shear or friction. Pressure ulcers are staged according to the severity from stage 1 (least severe) to stage 4 (most severe).
Skin tear	A traumatic wound caused by external friction or shearing forces, e.g., tape removal. It separates the dermis from the epidermis or the dermis from the underlying structure and most commonly occurs on the limbs of older adults.

3.0 Principles of complex wound management

Skin is the largest body organ; skin integrity means being whole, intact, and undamaged. When the skin has integrity, it performs important functions, including:

- protecting the body from harmful temperatures, chemicals, radiation and pathogens
- maintaining fluid and electrolyte balance and optimal inner body temperature
- conveying pleasant and unpleasant sensations
- communicating individuality by its texture, colour and characteristics.

Lifestyle Centred Services Pty Ltd support workers will assess a wound and document using the Wound Assessment and Treatment Form. A registered/enrolled nurse (Critical Second) or health practitioner will document written procedures on wound care in the Care Plan. Appropriately qualified and trained staff are responsible for:

- developing Wound Management Care Plans, including identified outcomes
- documenting wound care policies and procedures
- identifying training needs of support workers.
- providing relevant competency-based training and assessment processes for support workers to ensure they are competent to perform prescribed duties, tasks and interventions.
- monitoring, reviewing, evaluating and adapting (as required) the service, plans and outcomes with the Client, their family, carer or advocate.
- attending to complex wound care management, including dressing selection and changes
- supervising and guiding support workers in the provision of skincare
- work only within the scope of their practice and prior experience.
- history of diabetes.

4.0 Roles and responsibilities

The Management Team is responsible for the overall clinical management of high intensity supported Client care. A relevant health practitioner oversees the Client's support plan (e.g., registered/enrolled nurse from Critical Second). The Wound Management Care Plan is regularly reviewed, and updated procedures and information are provided to the Client and their carer/advocate. The Client's desired level of involvement is respected and maintained.

Lifestyle Centred Services Pty Ltd ensures each Client requiring pressure care or complex wound management receives relevant and proportionate support for their individual needs.

5.0 Care plan

The Wound Management Care Plan is developed with the involvement of the Client, their family, carer or advocate, Service Coordinator and relevant health practitioners (e.g., registered/enrolled nurse). The care requirements are developed and overseen by a health practitioner (e.g., registered/enrolled nurse, enrolled nurse), and specific instructions are provided for the support worker to implement.

A health practitioner will regularly review the Client's health status, wound management, and care. The health practitioner understands that Clients are at risk of pressure ulcers if they have:

- restricted mobility
- history of pressure ulcer/s
- indwelling catheter in situ due to incontinence.

The Care Plan identifies how risks and emergencies are managed to maximise the Client's safety and wellbeing.

The Client's Wound Management Care Plan is reviewed weekly/monthly as required by the Client's condition or when there is a change in the Client conditions. The care plan will also consider information received from the Client, their carer or advocate, our staff and health professionals inform their care. Outcomes of the review are recorded in the Client's Notes. If the Care Plan is adjusted, the Client will be provided an updated version.

Support workers document all aspects of pressure care and complex wound management, including assessments, treatments, management plans, implementation and evaluation methods.
Staff use the following documentation methods to record information concerning pressure care and complex wound management:

- progress or file notes
- Wound Assessment Treatment Form
- skin integrity assessments (e.g., Skin Assessment Form)
- Waterlow scores
- risk assessments (e.g., Risk Assessment Form – Module 1).

Support workers contact the registered/enrolled nurse or Service Coordinator to request a change to the Wound Management Care Plan. Any changes must be discussed and agreed upon with the Client, their family, carer or advocate.

6.0 Staff training

Lifestyle Centred Services Pty Ltd's training system complies with the high-intensity support skills descriptor for providing complex wound management. All our staff follow procedures and exercise judgment about when to request an ambulance.

Critical Second provides appropriate training to our support workers who work with Clients requiring skin and wound care. Additional training is provided relating to each Client's specific needs, skin type and required wound support.

Complex wound management training completed by our support workers includes:

- basic understanding of skin and vascular system anatomy
- hand hygiene
- correct PPE to be worn.
- wound cleaning and aseptic technique
- stoma care requirements and procedures
- preferred method of communication techniques to be able to explain identified risks to the Client, their family, carer or advocate and other support workers.
- the impacts of associated health conditions and complications that impact pressure injuries and complex wounds.
- factors that predispose the Client to pressure ulcers such as unable to reposition independently, diabetes, use of steroids or other drugs which reduce circulation and thin the skin.

- factors that may require immediate attention (e.g., infection, ulceration, reduced blood flow)
- positioning the Client to relieve pressure on affected areas or wounds.

7.0 Safe care

Support workers receive training specifically to satisfy each Client's needs and requirements, which their wound management regime may impact (e.g., showering, toileting and mobility).

Further training specific to complex wound management includes:

- common skin integrity risks
- common indications of infection and required responses.
- implications of a prolonged or worsening infection
- purpose and methods for positioning and turning a Client to manage pressure area risks.
- specific techniques for wound dressings.

7.1 Prevention of skin damage and pressure ulcers

To prevent skin damage to Clients, our support workers will:

- undertake daily (or regular) assessment and review of the skin.
- avoid dryness or maceration of the skin.
- use an emollient soap substitute on dry or vulnerable skin.
- use non-soap skin cleansers when cleaning skin following incontinence.
- dry skin thoroughly using a patting technique (a rubbing motion will not be used)
- moisturise skin at least twice daily.
- smooth (not rub) barrier cream or moisturiser on, in the direction of body hair.
- avoid the use of powder (i.e., talcum powder)
- protect skin from friction (e.g., when sliding down in bed or a chair)
- avoid vigorous massage over bony prominences.
- avoid overheating (e.g., when using plastic surfaces, ensure regular repositioning)
- employ correct lifting and manual handling techniques and devices (e.g., slide sheets)
- use disposable continence aids rather than reusable.
- maintain optimal nutrition with adequate protein, calories, carbohydrates, fat, vitamins and minerals
- maintain optimal hydration.
- use a no-sting or hydrogel barrier cream or film for incontinent Clients.

In addition, for skin tear prevention, staff will:

- provide adequate lighting.
- keep edges of furniture and equipment smooth and unobtrusive
- pad wheelchair arms, footrests, bed rails, walking frames, etc.
- ask the Client to wear long-sleeve shirts and long pants to protect their limbs.

For Clients at risk of pressure ulcers, staff will:

- monitor for signs which predispose the Client to pressure ulcers, this includes blistering, swelling, dry patches, a change in colouring, shiny or warm areas all of which may indicate a tendency to development of pressure ulcers.
- provide pressure-relieving surfaces (e.g., high-specification foam mattress or cushion)
- recommend using dense specialised sheepskin.
- keep the Client mobile by regularly re-positioning their body (24 hours/7 days a week)
- reposition a Client who sits for long periods at 15-minute intervals (dependent on tissue tolerance to pressure)
- use a dynamic support surface if the Client 'bottoms out'.
- avoid positioning the Client directly on bony prominences or existing wounds.
- use foam wedges and pillows to reduce pressure on bony prominences, avoiding foam rings and doughnuts.
- avoid using restrictive devices and restraints, if possible
- limit the length of time the bedhead is elevated.
- use skin products that maintain the skin's natural pH level.
- elevate the foot of the bed 20 degrees if the Client slides down the bed.
- aim to reduce the Braden Scale score by managing all risk factors.

Clients with diabetic foot ulcers will be referred to a podiatrist or orthotic specialist, as pressure off-loading may be enhanced by using:

- crutches, walkers, wheelchairs
- custom-made shoes or inserts (e.g., orthotics, diabetic boots, total contact casts).

7.2 Wound assessment

Wound assessment and management are a specialised area of nursing and will only be undertaken by skilled and experienced practitioners. A registered/enrolled nurse must assess the Client's wound care needs. The registered/enrolled nurse will consult evidence-based, best practice guidelines when selecting available wound dressing products and recommending wound-specific techniques for each Client.

Support staff must evaluate and document:

- cause, site, type, and classification of wound
- wound depth: superficial, partial, or full thickness
- wound size: trace and calculate area on the first presentation, then on each review/dressing change.
- wound edge: sloping, punched out, raised, rolled, undermining, purple, calloused.
- wound bed: necrotic, sloughy, infected, granulating, epithelialization.
- 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.
- potential or actual psychosocial impact of the wound
- any changes to the Wound Management Care Plan: including rationales for the same.
- any adverse events associated with the management of skin integrity.
- by taking a photograph of the wound and ensuring the date of the photo is noted on the photo.

7.3 Wound management procedure

As part of the support delivered by Lifestyle Centred Services Pty Ltd, support workers delivering wound care services will consult with the registered/enrolled nurse to understand the required skin and wound management care.

7.3.1 Dressings

The type of wound dressing will depend upon the goal and holistic needs of the Client. Wound dressings should:

- maintain a moist wound healing environment (note: dry gangrene or eschar are best left dry until revascularisation)
- manage wound exudate and protect peri-ulcer skin.
- remain in place to minimise shearing, friction, pressure and skin irritation.
- be non-adherent to reduce skin damage when the dressing is removed.

Hydrocolloid dressings can improve wound healing compared to paraffin gauze or wet/dry dressings. Hydrocolloids are generally more cost-effective and are the dressing for pressure ulcers. Alginate dressings are more effective than other modern dressings for debriding necrotic tissue. Topical antimicrobial dressings may be beneficial when wounds are chronically or heavily colonised.

7.3.2 Wound management steps

When providing wound management care, our support workers will:

- perform appropriate hand hygiene.
- wear appropriate PPE.
- place a clean, sterile drape around the wound area, if available
- cleanse wound site with normal saline.
- irrigate the wound with a neutral, non-irritating, non-toxic solution and cleanse gently.
- remove necrotic or dead tissue.
- apply ointment (i.e., wound healing cream as directed in the Care Plan)
- apply a dressing as directed in the Care Plan
- ensure effective pain management during and before dressing wounds.
- educate the Client and their family, carer or advocate regarding their wound care requirements and progress.

Pressure ulcers are usually complex wounds that require a general practitioner or registered/enrolled nurse assessment. For pressure ulcers with poor progress in healing (or a stage 3-4 ulcer), the Client should use an

alternating pressure, low air loss, continuous low-pressure system or air-fluidised bed.

7.4 Documentation

All wounds are documented using the Wound Assessment and Treatment Form. Skin integrity and risk of pressure injuries will be assessed using the Braden Scale Risk Assessment Tool, a widely used and validated assessment tool. As part of Lifestyle Centred Services Pty Ltd's collaborative care framework, the Client, their family, carer or advocate are provided with comprehensive education regarding their wound management regime. The Client is encouraged to communicate their medical needs to their general practitioner and the Lifestyle Centred Services Pty Ltd support worker involved in their ongoing care.

7.5 Equipment in the home

Equipment needed in the home environment to provide appropriate wound care management may include, but is not limited to:

- personal protective equipment
- 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 requirements, as per the Client's Wound Management Care Plan.

Common consumables used in complex wound management and their function, such as, types of dressings .

8.0 Related documents

Standard documents used for all HIDPA are noted in the introduction.

Document specific to this indicator are noted below

- Wound Management Care Plan
- Training Plan – Complex Wound Care
- Clinical Practice Guidelines – Wound Care
- Wound Assessment and Treatment Form
- Wound Assessment Chart
- Braden Scale Risk Assessment Tool
- Skin Assessment Form

Diabetes Management Policy and Procedure

1.0 Scope

This policy applies to all Lifestyle Centred Services Pty Ltd staff caring for Clients with diabetes.

2.0 Definitions

Term	Definition
Diabetes mellitus	Commonly known as diabetes, a chronic disease associated with abnormally high glucose levels in the blood. There are three types: Type 1, Type 2, and gestational diabetes.
Hypoglycaemia	Low blood glucose level (< 4).
Hyperglycaemia	High blood glucose level (> 8).
Blood glucose	The main sugar that the body makes from food consumed in the diet. Glucose is carried through the body's bloodstream to provide energy.
Insulin	A pancreatic protein hormone secreted by the pancreas is essential for metabolising carbohydrates and regulating blood glucose levels.

3.0 Principles of diabetes management

Diabetes care is performed by support workers with appropriate diabetes management training and knowledge. Principles of diabetes management and care include:

- supporting the Client to implement the Diabetes Care Plan, which is overseen by a health practitioner (e.g., general practitioner, registered/enrolled nurse)
- identifying and minimising the risk of hypoglycaemic and hyperglycaemic episodes
- monitoring and recording blood glucose levels (BGLs)
- following procedures to calculate dose requirements and administer medication.
- following emergency procedures and exercising judgement as to when to call an ambulance.
- knowing how much medication (insulin) to administer to a Client in various situations.
- demonstrating the application of first aid, including correct positioning and cardiopulmonary resuscitation.

4.0 Roles and responsibilities

The Management Team is responsible for the overall clinical and medication management of our Clients' high-intensity support activities. Changes to a Care Plan and medication management are the responsibility of Service Coordinator and relevant health practitioners.

5.0 Care plan

A Client's Diabetes Care Plan is overseen by relevant health practitioners (e.g., general practitioner, registered/enrolled nurse) and Service Coordinator. The Diabetes Care Plan is regularly reviewed. The Client, their family, carer or advocate and support workers are informed of any new information, adjustments or updated procedures.

The Diabetes Care Plan is developed with the Client, their family, carer or advocate, Service Coordinator and any relevant health practitioners (e.g., general practitioner, registered/enrolled nurse). Included in the plan is how to:

- support a Client to implement their Care Plan
- identify and respond to hypoglycaemic episodes.
- monitor and record blood glucose levels (BGLs) **NOTE Lifestyle Centred Services staff do NOT perform Subcutaneous Injections. BGL's should be performed by the client/family/a registered/enrolled nurse**
- follow detailed instructions on medication selection and administration procedures (non-injectible)
- implement emergency management options and procedures.

The support worker will request the Client to take their BGL's or request a family member/RN/EN do this for them.

The instructions will be provided by the health practitioner.
The Client's health status will be regularly reviewed by Service Coordinator and a qualified health practitioner (e.g., general practitioner, registered/enrolled nurse).
The Client's Diabetes Care Plan is reviewed monthly or as required to ensure current strategies reflect all updated information from the Client, their family, carer or advocate, our staff and health professionals.

Note: Changes to a Diabetes Care Plan and a Client's medication are only undertaken by a health practitioner (e.g., general practitioner, registered nurse) and Service Coordinator.

6.0 Staff training

Lifestyle Centred Services Pty Ltd's training system complies with the high-intensity support skills descriptor for providing diabetes management, including how to follow procedures, administer medications, exercise judgement and identify when an ambulance must be called.
Training is delivered by an appropriately qualified health practitioner such as a GP or allied health therapist or by a registered nurse who regularly delivers training to support workers (Critical Second). . Workers must also have a basic understanding of the Client's related health conditions.

Clients with diabetes require support to implement their Diabetes Care Plan and often need regular injections, which some cannot administer. Lifestyle Centred Services will ensure that there are others in the home/RN/EN who can perform these duties.

Staff are trained to identify the associated health conditions and complications that impact a Client's BGL and understand the basic anatomy of the human body. Support workers also receive training relating specifically to each Client's needs relating to their Diabetes Care Plan. The training provided also includes:

- informing difference between the two types of Diabetes - Types 1 and 2
- underlying factors that can affect BGLs
- Common health-related risks and complications associated with diabetes, including reduced ability to heal from cuts or wounds, changes in behaviour, weight fluctuation, and deteriorating eyesight
- methods of managing insulin levels, including different types of insulin (i.e., fast or slow release)
- variables that affect insulin delivery (e.g., timing, site selection and rotation)
- timing and type of medication such as slow and fast acting insulin
- understand the risks associated with incorrect dosage
- risks and common symptoms of low or unstable blood sugar levels
- related responses to low or unstable blood sugar levels
- how to seek expert advice and information from our multidisciplinary team
- factors that increase the risk of hyperglycaemia/hypoglycaemia and appropriate methods of control
- emergency management of hypoglycaemia and the potential side effects
- impact of variables such as food intake

When caring for Clients with diabetes, our support workers are trained to:

- follow all medication and documentation procedures
- complete the Injection Record, if Insulin has been provided during Service Delivery by another person
- complete the Insulin Administration Form, if Insulin has been provided during Service Delivery by another person
- record a Client's BGLs
- follow emergency management procedures
- record changes requested by a health practitioner (e.g., general practitioner, registered/enrolled nurse)
- document medication using the appropriate Medication Administration Chart
- inform Service Coordinator, the Client, their family, carer or advocate when there has been a request for a change to the diabetes management.

7.0 Safe care

Lifestyle Centred Services Pty Ltd trains our staff to identify and minimise Client exposure to risks of hyperglycaemia and hypoglycaemia and implement appropriate control methods. The support worker will consult with a Client, their family, carer or advocate to identify and remove or minimise risks to these conditions.

Support workers observe the Client to identify early indicators of hyperglycaemia or hypoglycaemia and take appropriate action as required, recording BGLs and emergency management.

Staff follow the medication emergency procedures outlined in the Management of Medication Policy. The Medication Incident Report Form will be completed in an incident involving medication.

When responding to an accident, incident or emergency, our staff follow the procedures outlined in the Reportable Incident, Accident and Emergency Policy and Procedure.

Waste will be managed as per the Management of Waste Policy and Procedure.

Identified risks will be managed as per the Risk Management Policy and Procedure. The Client's Diabetes Care Plan will be reviewed for all such events.

7.1 Hypoglycaemia emergency treatment

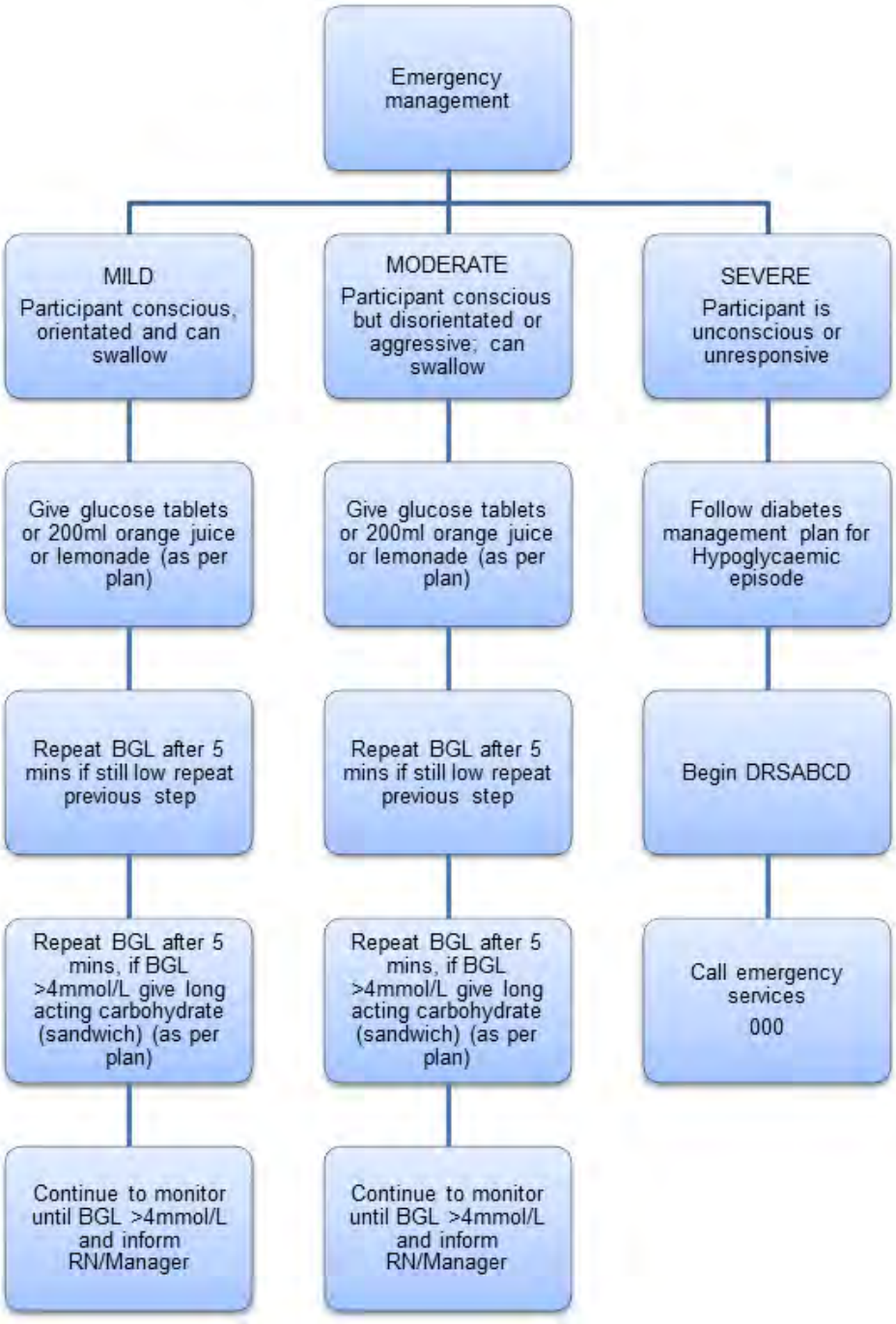
Support workers will follow the emergency hypoglycaemia treatment procedure outlined in Diagram 1.

Diagram 1. Hypoglycaemia emergency treatment procedure

7.2 Emergency diabetes management plan

In an emergency, support workers implement the management plan outlined in Diagram 2.

Diagram 2. The emergency diabetes management plan



7.3 Equipment in the home

Equipment in the home environment required for diabetes management may include, but is not limited to:

- appropriate personal protective equipment

- disposable gloves (powder free)
- lancet or needled device for finger pricking (support workers not to use)
- glucometer
- test strips
- tissues
- medications
- needles and syringes (for insulin administration – not permitted)
- clinical sharps container
- bag or receptacle for medical waste.

8.0 Related documents

Standard documents used for all HIDPA are noted in the introduction.

Document specific to this indicator are noted below

- Diabetes Care Plan
- Subcutaneous Injections Care Plan
- Clinical Practice Guidelines - Diabetes
- Training Plan – Subcutaneous Injections
- Training Plan – Diabetes Management
- Subcutaneous Injection Doctor's Order and Administration Record
- Injection Record Form
- Insulin Administration Form
- Medication Incident Report Form
- Medication Administration Chart
- Client Medication Plan and Consent Form
- Management of Medication Policy and Procedure
- Subcutaneous Injections Policy and Procedure

Seizure Management Policy and Procedure

1.0 Scope

This policy is implemented by all Lifestyle Centred Services Pty Ltd staff who provide care to Clients who may suffer seizures.

2.0 Definitions

Term	Definition
Seizure	A sudden, uncontrolled electrical disturbance in the brain can cause changes in behaviour, movements or feelings, and levels of consciousness.
Convulsion	An abnormal and involuntary contraction of all or some of the body's muscles.
Triggers	Situations that bring on a seizure (e.g., tiredness, lack of sleep, stress, alcohol, missed medication, high temperatures, infection). Triggers differ from person to person.
Epilepsy	A condition where a person has recurrent seizures.
PRN medication	Specific medications in the event of a seizure (individual to each person) supervised by a general practitioner or registered/enrolled nurse.

3.0 Principles of seizure management

Lifestyle Centred Services Pty Ltd's seizure management principles include:

- identifying and minimising exposure to seizure risk factors
- motivating the development of a Seizure Management Care Plan that is overseen by an appropriate health practitioner (e.g., general practitioner, registered/enrolled nurse)
- ensure staff record a description of types, frequency and patterns of seizures, triggers; signs to look for before and after seizures
- risks to look for and action required to respond to risks, incidents, and emergencies for Clients who have a high risk of seizures
- training (Critical Second) our support workers to:
    - understand and follow all care procedures
    - exercise judgement in emergencies, including knowing when to call an ambulance
    - administer PRN medication (if qualified) as outlined in the PRN Care Plan.
    - to position a Client in the event that they have a seizure
    - how to apply first aid including cardio-pulmonary resuscitation

4.0 Roles and responsibilities

A Client's Seizure Management Care Plan is overseen by an appropriate health practitioner (e.g., general practitioner, registered/enrolled nurse). Service Coordinator under the direction and an appropriate health practitioner, conduct any changes to the plan and medication management.

5.0 Care Plan

The Seizure Management Care Plan is developed to ensure the Client's wellbeing and safety. The Care Plan is developed with the involvement of the Client, their family, carer or advocate, Service Coordinator and a health practitioner (e.g., general practitioner or registered/enrolled nurse).

The Seizure Management Care Plan includes details such as:

- types of seizures experienced by the Client.
- signs and symptoms of seizures
- seizure frequency and patterns
- seizure triggers
- signs to check before and after a seizure.
- monitoring and recording requirements
- detailed instructions on medication selection and administration procedures
- information on how to manage risks, incidents and emergencies.
- emergency management options and procedures.
- Common medication used to manage seizures and related contraindications and side effects

Support workers will confirm the Client's consent before administering medications detailed in the Seizure Management Care Plan (as previously agreed with the Client, family, carer or advocate).
Support workers will complete the Seizure Record Form as required, and completed forms inform Seizure Management Care Plan reviews. The Clients' support plan will, if indicated by the Clients conditions, include information on triggers or conditions that can increase risk of seizure for the Clients. This may include constipation, dehydration, high temperature, aspiration, and other issues that may be indicated by the Clients history.
A Client's Seizure Management Care Plan is reviewed monthly/quarterly, or when there is a change in Client's condition, Care strategies developed are based on recent information from the Client, their family or advocate, our staff and health professionals.

Staff follow Lifestyle Centred Services Pty Ltd's documentation procedures for:

- PRN medication
- monitoring and recording of seizures
- recording emergency management procedures
- Common medication used to manage seizures and related contraindications and side effects
- handling, storing, administering and recording administration of post-seizure medication.
- recording changes requested by health practitioners (e.g., general practitioner or registered/enrolled nurse)

- informing Service Coordinator, the Client, their carer or advocate when a change in seizure management has been requested.

A Manual Handling Client Care Plan or a PRN Care Plan is developed with the Client if necessary, and support workers are trained in plan requirements.

• Common types, symptoms, and patterns of seizures

• Common triggers or conditions that can increase risk of seizure such as constipation, dehydration, high temperature, aspiration, and related methods of control

• Common risks associated with seizures

• The impact of associated health conditions on epilepsy

• Observation parameters to identify early indicators of seizure onset, monitor seizures and observe following a seizure

• Expectations for handling, storing, administering and recording use of post-seizure related medication

• When and how to involve or get advice from the health practitioner, or emergency services

• Reporting responsibilities, including handover, recording observations and incident reporting

6.0 Staff training

Lifestyle Centred Services Pty Ltd's training system complies with the high-intensity support skills descriptor for providing seizure management, including that staff follow all care and medication administration procedures and exercise judgement and know when it is appropriate to call an ambulance.

Support workers receive training regarding the Client's specific needs and the type of seizure care support they require. Training includes:

- types of seizures
- types and patterns of common seizure
- how to respond to seizure alerts and alarms including alarms included in wearable health technology appliances
- conditions that can increase risk of seizure such as constipation, dehydration, high temperature, aspiration, and related methods of control for these conditions
- common patterns or clusters of seizures
- seizure triggers and symptoms
- appropriate seizure management and control procedures
- impact of epilepsy
- parameters that guide decisions regarding the dosage of PRN medication and when to administer
- identifying potential side effects of medications
- related health risk complications associated with epilepsy
- factors that increase Client risks and appropriate methods of control
- first aid techniques to check and clear airways, administer CPR and place a person in a recovery position
- interpretation of advice regarding when to request an ambulance

7.0 Safe care

Lifestyle Centred Services Pty Ltd ensures that our support workers are trained to identify and minimise Client exposure to seizure risk factors. Our staff will consult with the Client and their carer or advocate to identify and remove or minimise exposure to potential risks (e.g., burns, falls or other risks related to seizures).

The support worker will observe the Client identify early seizure indicators and take all required and appropriate actions, including monitoring and recording seizure data.

Staff will follow infection control and waste disposal procedures outlined in the Infection Management Policy and Procedure and the Management of Waste Policy and Procedure.

7.1 Equipment in the home may include:

Equipment required for seizure management in the home includes, but is not limited to:

- disposable gloves (powder free)
- disposable apron
- appropriate PPE (e.g., mask, face shield)
- medications and associated equipment
- lubricant (water-based)
- incontinence pad or Kylie
- medical waste receptacle or bag.

7.2 Seizure emergency management pathway

Staff are trained to manage seizures using the emergency management pathway outlined in Diagram 1.

Diagram 1. Seizure emergency management pathway

8.0 Related documents

Standard documents used for all HIDPA are noted in the introduction.

Document specific to this indicator are noted below

- Seizure Management Care Plan
- Manual Handling Client Care Plan
- PRN Care Plan
- Clinical Practice Guidelines – Seizure Management
- PRN Medications Intake Checklist
- PRN Medications Protocols

Stoma Care Policy and Procedure

1.0 Scope

The policy applies to all staff who provide our Clients with stoma care and support.

2.0 Definitions

Term	Definition
Stoma	An artificial opening is made into the abdomen on the body's surface, 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	This 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 allows the passage of air.

3.0 Principles of stoma care

Stoma care procedures will only be performed by Lifestyle Centred Services Pty Ltd staff who have the required knowledge and have been appropriately trained in stoma care.

When providing stoma care to Clients, our staff will:

- follow personal hygiene and infection management procedures.
- monitor the skin condition and keep the stoma area clean.
- replace and dispose of bags as required.
- maintain charts and records as per the Information Management Policy and Procedure
- be trained to recognise, respond to, and report any problems such as blockages, signs of deteriorating health or infection.

4.0 Roles and responsibilities

A Client's Stoma Care Plan is overseen by relevant health practitioners (e.g., registered/enrolled nurse). Any change to a Stoma Care Plan is conducted by Service Coordinator and health practitioners.

5.0 Care plan

The Stoma Care Plan is developed with the Client, their family, carer or advocate, Service Coordinator, our staff and relevant health practitioners (e.g., registered/enrolled nurse).

A Client's Stoma Care Plan is reviewed quarterly or as needed to ensure relevant and current strategies are in place to provide safe care.

If required, a Manual Handling Care Plan will be developed with the Client's involvement and implemented as support workers require.

6.0 Staff training

Support workers will receive training relating specifically to each Client'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
- personal hygiene and infection control procedures
- replacing and disposing of stoma bags
- maintaining charts/records
- monitoring the Client's skin condition and keeping the stoma area clean.
- recognising and reporting problems such as blockages, signs of deteriorating health or infection.

7.0 Safe care

Lifestyle Centred Services Pty Ltd ensures that support workers are trained in infection management procedures per the Infection Management Policy and Procedure and the Management of Waste Policy and Procedure.

Support workers will consult with the Client, their family or advocate to identify, recognise, respond and report any identified issues or problems. If any risk factors are identified, the support worker will immediately involve a qualified health practitioner (e.g., registered/enrolled nurse).

7.1 Equipment in the home

The equipment in the home to provide stoma care may include:

- appropriate PPE (e.g., mask)
- disposable gloves (i.e., powder free)

- disposable apron
- stoma bags and other appliances (e.g., flange extenders, washers, belts, filter covers, stoma measurement guides)
- relevant stoma products (e.g., adhesive remover, barrier wipes, protective pastes, hydrocolloid powder, filler paste, ostomy deodorant, thickening agents)
- toilet paper or disposable soft cloth for cleaning faeces
- medical waste receptacle.

8.0 Related documents

- Stoma Care Plan
- Clinical Practice Guidelines – Stoma Care
- Manual Handling Client Care Plan
- Comprehensive High-intensity Support Assessment Form
- Individual Risk Profile Assessment Form
- Staff Training Plan
- Risk Assessment Form – Module 1
- Risk Assessment Form – WHS
- Infection Management Policy and Procedure
- Management of Waste Policy and Procedure
- Information Management Policy and Procedure

9.0 References

- NDIS (Quality Indicators) Guidelines 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS Practice Standards Skills Descriptor - High-intensity Skill Descriptor
- NDIS Practice Standards and Quality Indicators 2021

Mealtime Management Procedure - Severe Dysphagia

1.0 Scope

All staff must implement this policy when preparing and delivering Client meals.

2.0 Definition

Term	Definition
Dysphagia	Difficulty swallowing • difficulty biting or chewing on food, • coughing or choking on food or fluid, and • food or drink falling from a person's mouth

3.0

3.1 Ensure staff know dysphagia symptoms and risks.

Relevant staff are trained to improve their knowledge and develop skills to support Clients who may have dysphagia. Staff must understand how to identify and respond to early signs and symptoms of dysphagia and a referral to a speech therapist or occupational therapist will be sought as early as possible.

3.2 Support Clients with possible swallowing difficulties to be assessed for dysphagia.

When a Client shows any sign or symptom of swallowing difficulty, staff should support them to promptly consult a GP and a speech pathologist to assess their swallowing and mealtime assistance needs and review their general health.

3.3 Support Clients with dysphagia to have a mealtime management plan.

A Client with dysphagia must have a mealtime management plan written by a health professional. A speech pathologist can prescribe and recommend specific actions to eat and drink safely, develop a mealtime management plan for their needs, and specify a plan review timeframe.

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

Mealtime management plans may include recommendations to:

- assist the Client with menu and meal planning if appropriate.
- improve the seating and positioning supports for a person's safe positioning during meals.
- prepares food and fluids of the required texture and tests the prepared food texture.

- supports the Client to explore ways to enjoy mealtime and feeding, for example, timing, frequency, choice of environment and social company.
- 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 with 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 Clients with oral hygiene consistent with the support plan.

3.4 Support people with dysphagia to eat and drink safely during mealtimes.

Lifestyle Centred Services Pty Ltd must 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 Clients with dysphagia, and medication is taken orally, are prepared as directed, and health professionals recommend mealtime supports and assistance.
- trained staff are available to monitor people with dysphagia during mealtimes.
- staff are trained in how to respond if a Client starts to choke during mealtimes, including when they should call an ambulance.
- staff have knowledge and techniques to deal with suspected choking including how to promptly identify choking and clear airways of food.
- Staff are made aware of the food and fluid preparation requirements set out in the International Dysphagia Diet Standardisation Initiative (IDDSI).
- mealtime safety issues for people with dysphagia are regularly considered in staff meetings and addressed in day-to-day procedures, Clients' documentation, and plans for transition to hospital.

3.5 Ensure mealtime management plans are regularly reviewed.

Mealtime management plans are to be reviewed regularly, and we support the Client with dysphagia in arranging this. The speech pathologist who develops a mealtime management plan will include how often it should be reviewed and specify the circumstances in which you should request a review.

3.6 Ensure medications are regularly reviewed.

Lifestyle Centred Services Pty Ltd supports a Client with dysphagia to have their medications regularly reviewed by a GP, the prescribing medical practitioner, or a pharmacist to assess whether the medications affect their swallowing.

The review can also determine if the medications are suitable for managing swallowing risks. Several medications impact swallowing, particularly medications for epilepsy or mental health conditions. Refer to the NDIS Commission's Practice Alert: Medications associated with swallowing problems.

4.0 Principles of mealtime preparation and delivery

When providing meal delivery and preparation support to Clients, our staff will:

- read, interpret and implement Mealtime Support Plans.
- follow food preparation procedures.
- monitor Client eating to identify and respond to risks.
- determine postural requirements for the Client.
- assist in supporting the Client during mealtimes.

4.0 Roles and responsibilities

Service Coordinator is responsible for managing high-intensity support care. The Client's Mealtime Support Plan is overseen by a relevant health practitioner (e.g., speech pathologist, dietitian). The Mealtime Support Plan is regularly reviewed, and any adjustments to procedures are discussed and agreed upon with the Client, their family, carer or advocate.

Service Coordinator is responsible for:

- ensuring that our team provide healthy food options within services
- confirming each Client undergoes regular mealtime assessments
- ensuring every Client has a current Mealtime Support Plan
- assessing risks associated with Client mealtimes.
- confirming that staff report choking or swallowing-related incidents via our incident reporting system
- investigating incidents according to the Reportable Incident, Accident and Emergency Policy and Procedure
- supervising staff when they complete a Nutrition and Swallowing Risk Checklist on a 12-monthly basis (or as required) for the Client

Our support workers are responsible for:

- adhering to established procedures and protocols relating to nutrition.
- supporting the Client during mealtimes
- consistent implementation of all recommendations from health care professionals relating to safe mealtimes, appropriate support, adequate nutrition and hydration
- offering healthy food options within services
- ensuring Clients are provided with a relaxed, social environment during mealtimes.
- implement behaviour support recommendations for mealtimes.
- providing meals that are visually pleasing to enhance a Client's eating experience.
- monitoring Clients who may be at risk of dysphagia and following the recommended actions to reduce the risk of aspiration and choking.
- meeting the nutritional and hydration needs of the Client.
- reporting choking or other mealtime incidents using the incident reporting system

- contributing to the incident investigation, if required.

Other professionals that may provide services as part of mealtime support include:

- **Speech pathologist:** A speech pathologist may complete a comprehensive assessment of a Client's eating, drinking and swallowing skills and advise on the individual's requirements and safe swallowing management. They may also assess the risk of any cognitive factors that could compromise the safety of the swallowing process. The speech pathologist will consider the Client's preferences, beliefs, best interests, and quality of life issues.
- **Dietitian**: The dietitian will consider any swallowing difficulties when advising on the Client's diet. They will outline nutrition and hydration requirements.
- **Occupational therapist:** The occupational therapist may complete a comprehensive assessment of an individual's mealtimes and provide recommendations to assist with body positioning, mealtime independence, and assistive technology for eating and drinking.
- **Clinical nurse specialist:** The clinical nurse specialist may complete a comprehensive assessment of a Client's mealtimes and provide recommendations to assist when receiving enteral feeding. The clinical nurse specialist may also advise on medication administration and other factors that require consideration concerning the Client's overall health and wellbeing.
- **Training and development:** Critical Second may be involved by organising individual and group staff training sessions throughout Lifestyle Centred Services Pty Ltd.

6.0 Mealtime support plan

The Client's Mealtime Support Plan is developed with the Client, their family, carer or advocate, Service Coordinator and relevant health practitioners (e.g., occupational therapist, speech pathologist, dietitian).

Each Client's plan includes how support workers can best provide mealtime assistance and support. The support worker will communicate with the Client or their advocate regarding the delivery, management and monitoring of food preparation and mealtimes.

This policy is used in conjunction with the Enteral Feeding and Management Policy and Procedure. Service Coordinator the Client, the mealtime preparation and delivery are regularly reviewed by Service Coordinator to ensure ongoing compliance and consistency in care levels. The Mealtime Support Plan identifies risks, incidents, and emergencies and how they are managed by Lifestyle Centred Services Pty Ltd to ensure the Client's safety and wellbeing.

Service Coordinator may adjust the Mealtime Support Plan based on information received from the Client, their family, carer or advocate, our staff, and relevant health professionals. Any changes are documented in an updated Mealtime Support Plan.

7.0 Staff training

Lifestyle Centred Services Pty Ltd trains staff to support mealtime preparation and delivery. Staff are aware of associated health conditions and complications that can impact a Client who requires meal preparation and delivery (including enteral feeding management).

Staff receive training specifically relating to the needs of each Client needing mealtime preparation and delivery support. Further specific training involves:

- signs and symptoms of swallowing and feeding difficulties.
    - 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
- risks associated with eating and swallowing.
    - respiratory problems or choking as well as poor nutrition.
    - swallowing problems can allow food, drinks or saliva to get into the lungs rather than the stomach, which can cause aspiration pneumonia.
    - accidental choking reduction by following expert advice from speech pathologists and other specialists.
    - minimising risk through early identification and management of swallowing problems
- risks associated with not following the mealtime plan.
- food preparation methods/requirements for common conditions (e.g., people with dysphagia)
- awareness of procedures and methods when including medication in food, including an understanding of crushable and non-crushable medication
- understanding of common terminology related to mealtime preparation and modified meals.
- using adapted equipment
- meal-related health topics (e.g., oral health, nutrition and reflux)
- knowing when to respond to problems (e.g., signs of dysphagia or choking)
- implementing strategies to reduce the risk of choking and aspiration.

- incident or identified risks reporting procedures.
- mealtime body positioning.

8.0 Safe care

Lifestyle Centred Services Pty Ltd ensures that support workers are trained in emergency procedures, including:

- how to identify common risks and indicators (e.g., signs of choking or dysphagia)
- strategies to reduce the risk of choking and aspiration.
- mealtime body positioning.

Support workers understand when to involve Service Coordinator or a qualified health practitioner (e.g., speech pathologist, dietitian) to provide safe care to the Client.

The support worker is responsible for monitoring, charting, and recording Client mealtime delivery, as outlined in the Information Management Policy and Procedure.

Any incidents will be reported following procedures in the Reportable Incident, Accident and Emergency Policy and Procedure.

The support worker consults with the Client and their carer or advocates to identify, recognise and report problems (e.g., signs of choking, dysphagia and general discomfort while eating). The support worker will involve Service Coordinator if any of these risk factors are present for a Client.

8.1 Equipment in the home

Equipment required to provide mealtime preparation and delivery in the home may include:

- adapted equipment (e.g., knives, forks, spoons, plates, bowls and cups)
- resources for preparing and cooking food (e.g., kitchen, stove, oven, refrigerator, and freezer).

IDDSI Protocols

8.0 Related documents

- Mealtime Support Plan
- Clinical Practice Guidelines – Choking
- Clinical Practice Guidelines – Food Preparation
- Practice Guidelines - Textured Food Preparation
- Training Plan – Meal Preparation
- Training Plan – Enteral Feeding
- Staff Training Plan

- Nutrition and Swallowing Risk Checklist
- Individual Risk Profile Assessment Form
- Comprehensive High-intensity Support Assessment Form
- Client Medication Plan and Consent Form
- Medication Administration Chart
- Weight Chart
- Enteral Feeding and Management Policy and Procedure
- Information Management Policy and Procedure
- Management of Waste Policy and Procedure
- Reportable Incident, Accident and Emergency Policy and Procedure

9.0 References

- NDIS (Quality Indicators) Guidelines 2018
- NDIS (Provider Registration and Practice Standards) Rules 2018
- NDIS Practice Standards Skills Descriptor - High-intensity Skill Descriptor
- NDIS Practice Standards and Quality Indicators 2021