Care Documentation Guide Whiddon Residential Aged Care (RAC)

Whiddon

Document Control

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Document Review

Date	Description of review	Initiated by	Version
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4th May 2020	Permanent Admission schedule updated Abbreviation list updated Handover instructions updated	CG Unit	1.1
21st May 2020	Addition of the AutumnCare report matrix Addition Autumn Care reports and rationale	CG unit	1.2
9 June 2020	Introduction of Chemosensory assessment to 30 June 2020	QCC Unit	1.3
24 June 2020	Changes to the aged care service plan from 4 monthly to three monthly Introduction of Chemosensory assessment to 30 June 2020 to be only if require	QCC Unit	1.4
29 June 2020	Changes to Admission Process	QCC Unit	1.5
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4/11/24	NDIS inclusion. SIRS / NDIS Report . Appendix A named .. AC ACC BRUA, Behaviour Resource Utilisation Assessment AFM, Australian Functional Measure DEMMI, De Morton Mobility Index . Role updates New App B Case Conference Guidelines and C Documentation Reqiuirments Guide	GMCR&C	2.1

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Whiddon Care Documentation Guide for Residential Aged Care

Introduction

This manual is important for all team members working with consumers (consumer s) in a Residential Aged Care (RAC) setting. It provides a guide for a structured and standardised approach to care documentation.

Section 1 explains Whiddon's overall care documentation approach. This section also introduces our electronic documentation tool. It provides a quick guide on when to document, which tools to use, and who ideally should be documenting. Finally, a table provides a guide for the admission process.

Section 2 explains everyone's roles and responsibilities. This section also covers the legal aspects of

documentation including why accurate and quality documentation is so important; and who can access a consumer 's care documents, as well as the process.

Section 3 provides guidance on how to write quality care documentation using each tool. Some sections are relevant to all team members, others only apply to Registered Nurses (RNs) – these sections will have (RN) next to the title.

Application

This guide applies to all the team members providing care and services to consumer s in Residential care.

Policy Statement

To maintain clarity and consistency throughout the policy, the terms "consumers," " consumer s," "clients," "elders," and "NDIS participants" will collectively be referred to as "consumers," all such references encompass these groups equally.

Whiddon has an expectation that all professional nursing team members, carers, allied service professionals and medical personal provide professional and optimal health services to all consumer s living in Whiddon Homes.

Whiddon teams understand that health care decisions are a collaborative process and that it is essential that all consumer s and or their representatives are supported and encouraged to be part of the discussions and decisions regarding care and services.

Documentation is a record of care delivered, a record of a consumer 's wellbeing and actions taken to ensure the ongoing safety and care of a consumer . Whiddon has an expectation that robust, timely accurate records are maintained at all times and that internal processes are followed.

All professional team members are bound by their professional standards and codes of conduct, Whiddon expects that all professionals adhere to these and to Whiddon policies and processes.

Definitions

- **Consumer** can be taken to mean, consumer or client. These titles may be used interchangeably in this document. consumer is used predominantly in this manual.
- An **ACAT** assessment (aged care assessment) is an assessment organised by an Aged Care Assessment Team (ACAT, or ACAS in Victoria) and is required for a person who needs to be approved for Government-funded services including a nursing home (aged care home), home care, Residential aged care, transition care or respite.
- **NSAF** is the National Screening and Assessment Form. This is to tool used by the ACAT team to holistically screen and assess people's needs in aged care.
- **ACCR** the Aged Care Client Record (ACCR) is the form completed by the Aged Care Assessment Team following an assessment. It has been replaced by the NSAF but may still be used by people who were assessed before the change.
- **AutumnCare i**s a software program used to support clinical management.
- **eQstats** is a software program that enables the effective management of quality and risk information.

SECTION 1: WHIDDON'S OVERALL APPROACH, CARE

DOCUMENTATION TOOL, AND CHECKLISTS

Whiddon's approach to care documentation

MyLife is Whiddon's award-winning model of care that places relationships at the heart of how we care.

Relationship Based Care (RBC) is how we deliver on this model; enabling team members to truly get to know consumer s by finding out what matters most to them so they can build strong and deep personal relationships. Whiddon team members are required to attend specific RBC training and are then required to apply this model when it comes to documentation and communication.

As we are the consumer s' support team, we have qualifications and experience to support consumer s to live the life they want to live. We must remember that this is their life; and they must be involved in planning and reviewing their care. This involvement should be clearly documented.

Below is a picture of the MyLife Care which supports a person's quality of life. Always think about how your documentation captures how a consumer chooses to live their life. When you write accurate and timely information you are communicating the preferences and needs of the person you are caring for so that everyone else knows how to meet their needs.

Relationship Based Care (RBC) Processes

To ensure that team members are able to deliver the MyLife model of care, the delivery method, RBC, has a set of clear processes. All team members need to work in this way, to deliver person-centred care. Processes can be found in more detail, in the RBC Framework Document.

Whiddon's Electronic Documentation System

Whiddon team members use an electronic system for documentation, it is called AutumnCare.

AutumnCare Basics

Upon admission an electronic file is created for each consumer . This electronic file contains.

- A profile of information about the person; including admission information, representative details.
- Initial Clinical Assessment which forms an Interim Care and Services plan.
- Assessments, including Therapeutic needs, Complex Health Care and Medical Directives, which once completed, create The Agreed Care and Services plan.
- Restrictive Practices and risk assessments. A summary Agreed Care and Services Plan.
- Forms.
- Charts.
- Progress notes.

AutumnCare also has the following functions to support consumer care.

- Alerts.
- Interactive handover tool.
- Appointments.
- Reports

Having all documentation in the same place will improve the quality of information and access to that information. It is important that all services do not create forms or documents that are not in the system.

There are some rules to follow for access to protect people's privacy – see legal section.

To login to AutumnCare.

1 Click on the AutumnCare Connect Logo/Link.

2 The box below will appear.

3 Select your location from the dropdown, unless locked to your work location already.

4 Start typing your name in the 'username' section, the system will locate your name.

5 Click on your name.

6 Enter your 5-digit code in the password area.

7 Talk to your manager if you do not have a login or it is not working.

Basics of Cybersecurity

All Whiddon team members are encouraged to attend the Cybersecurity Awareness e-learning module in My Learning.

In the meantime, here are some high-level points.

- Do not share your login details with anyone.
- When using the system, make sure passers-by cannot see your screen to protect consumer privacy.
- Log off when you have finished.
- Do not take pictures of screens on your phone or try to send information outside the system.
- Report any 'odd' changes to the system such as random messages or entries with your name

that are not yours etc.

A summary of important points about documentation

1. It is critical you understand everyone's roles and responsibilities in documentation,

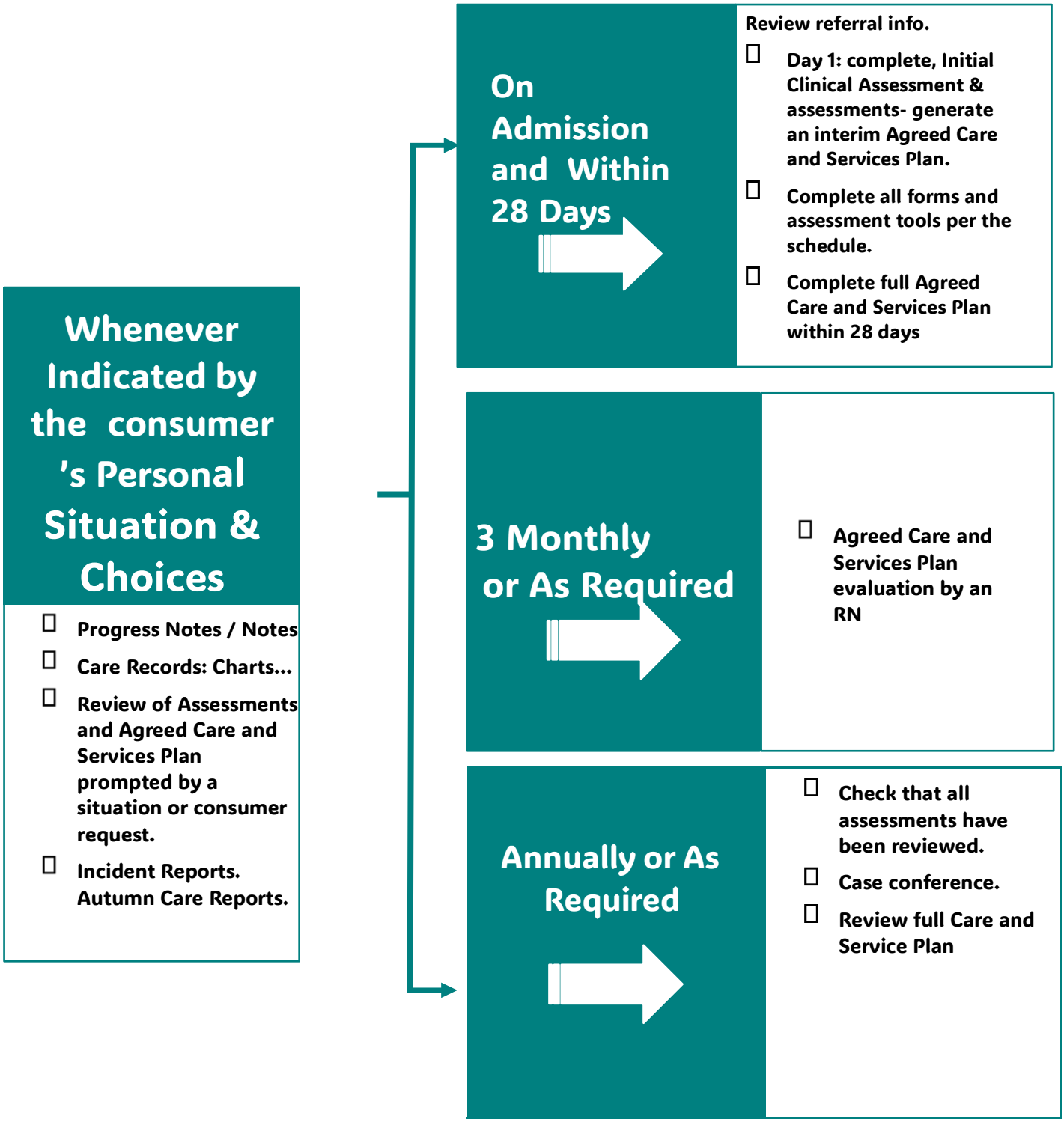
including your own.

2. We must partner with the consumer and/or their representative/s when planning and documenting their care and services.
3. There are a lot of legal ramifications to documentation, so it is important to; ○ Ensure everything important is documented. If things aren't written down, then there is no proof that something happened or was actioned.
    - Document things when they need to be documented. Follow the touchpoints. or

Follow the principles of quality documentation.

- Understand and adhere to legal requirements, when it comes to privacy.

Care Documentation Overall | what, when and where at a glance



Admission Documents and Timelines for Completion

Pre-admission

The ' consumer admission process' and timelines are to be followed.

It is important that a careful decision is made based on the ability to meet the person's needs and expectations. This is ascertained through reviewing documentation NSAF/ACAT, medical information meeting the consumer and/or their representatives and/or completing a pre-admission assessment.

For both permanent and respite admissions

On admission, whether permanent or respite, RNs are responsible for.

- Reviewing documents such as NSAF/ACAT, Discharge/Admission/Transfer forms/Medical Information, and any other information that may be available for the consumer .
- Consultation with the consumer and/or chosen representative/s.
- Attending relevant assessments.

This information will be used to complete an **Initial Clinical Assessment** and create an **Interim Agreed Care and Services Plan**.

Per the ' consumer admission process', the following will be attended as well.

- Medical health summary, medication charts, scripts to the pharmacy.
- Diabetic Medical Directive, and other Complex Health Care assessments as relevant.
- Advance Care Planning Form (forms explained and family advised to take to their local GP).

Permanent admission

The following table lists the assessments that must be completed at the correct time, for all permanent consumer admissions. Correct and timely documentation ensures that consumer s have their care needs met in a timely manner. The initial Agreed Care and Services Plan must be finalised within 28 days of admission.

The consumer or their representative/s are central to the assessment and care planning process and must be involved in compiling this information.

To track the progress of the admission, process an admission checklist form that is available in MyStaffroom is printed and placed into the consumer 's file. Each day the form must be signed by the staff member attending that has completed the form or task.

TIMELINE	ADMISSION PROCESS/ AUTUMNCARE FORMS AND ASSESSMENTS	COMPLETED BY
Day 1 **(within 24 hours)**	Admission details form (All fields to be completed) Consumer Details form (All fields to be completed) NOTE: admission details and consumer details require additional fields to be completed for AN-ACC class, and for admission form the date classified and review date.	Administration team RN to review AC forms and add diagnoses
	Update Evacuation bag and evacuation list	Administration
	The AN-ACC suite of forms to be completed within 1 week of admission.* See pages 17 and 57 for further details	Registered Nurse
	Orientation checklist	AIN/ Registered Nurse
	Contact NOK to advise that the consumer has arrived at the service. Explain the admission process and the type of information that will be collected on day of admission (invite NOK to assist with collecting information if appropriate)	Registered Nurse
	Additional Contact list (Specialist, other services)	Registered Nurse
	Consent forms - Dental exam, dental treatment, Vaccination, clinical photography and collection of medical information	
	Personal Privacy Preferences Form	
	Dietary Needs and Preferences Form (send a copy to the kitchen)	
	MNA (Mini Nutritional Assessment)	
	SSP (Swallowing Screening Pathway)	
	FRAT (Falls Risk Assessment Tool)	
	Behaviour recording Chart and Support Plan (This must be commenced for all consumers who are subject to restrictive practices)	
	Complex Health Assessments (Restrictive Practice form, Risk Assessment, medical directives e.g. Diabetes Directive, Anticoagulant therapy)	
	Complex Care Needs	

TIMELINE	ADMISSION PROCESS/ AUTUMNCARE FORMS AND ASSESSMENTS	COMPLETED BY
	Create charts as per consumer needs (behaviour charts, pain chart, BGL chart, Vital observations chart), pain assessment, self-medication assessment and authority etc.)	
	Advanced Care Planning Form	
	Valuables form	
	Photographic record of belongings	
	Ensure all information is included into the Initial Clinical Assessment form- create the Initial Agreed Care and Services Plan (alert team that initial plan is available to guide care in the handover)	
Day 2 **(within 48 hours of admission)**	Pain Assessment and Management Plan (if not indicated on day 1)	Registered Nurse
	Pain chart (Add a baseline record)	
	PAINAD or M-RVBPI	
	Mobility Assessment	
	Physiotherapy Assessment	
	Skin Assessment (Braden) *NB The Braden is an AN-ACC Requirement, however, sits under Assessments*	
	PAS (Cognitive Skills)	
	Contact consumer / representative to discuss the Initial Agreed Care and Services plan and offer a copy of the plan (explain additional assessments and a full Agreed Care and Services plan will be provided in week 3 of the admission for permanent admission)	
Day 3	Sleep and Nap record	Registered Nurse
	Personal Hygiene and Oral Health Assessment	
	Medication Assessment	
	Assign a My Life Buddy	Activity Officer

TIMELINE	ADMISSION PROCESS/ AUTUMNCARE FORMS AND ASSESSMENTS	COMPLETED BY
Day 4	My Life and Preferences Form	or My Life Buddy
	All about me chart (consumer)	
	Authority for display and publication of photographs and names	
	Authority for hairdressing services	
Day 5	Continence and Toileting Assessment	Registered Nurse
	Communication Assessment	
	Vision Assessment	
	Hearing Assessment	
Day 7	Chemosensory Assessment (new assessment 30 June 2020 is required)	Registered Nurse
Day 8	CSD	Registered Nurse
Day 8 - 14 **(permanent consumer s only)**	Continence record (RN to add to handover)	Team to complete
	Sleep Assessment (RN to add to handover)	
	PAS/cognitive skills checklist.	
	PAINAD or M-RVBPI	
Day 9	All About Me form (team members information)	My Life Buddy
Day 10-15	Daily progress notes	Registered Nurse
Day 15	Cornell Scale of Depression	Registered Nurse

TIMELINE	ADMISSION PROCESS/ AUTUMNCARE FORMS AND ASSESSMENTS	COMPLETED BY
Day 16 (Full Care Plan)	Review all assessments and tick to create a full care plan and archive the Interim Agreed Care and Services plan (alert staff that the full care plan is available to guide care) Discuss the Agreed Care and Services Plan with consumer / representative and offer to provide a copy of the plan	Registered Nurse

The above is a guide. Care needs and diagnoses must inform the actual timing and the suite of other assessments that will be required. For example.

- If the person self-medicates, relevant assessments must be completed.
- Or if a consumer is prone to wandering and getting lost, a wanderer's chart with a full length

photo is created on day 1.

- Medical Directives, including review of Restrictive Practices, and Complex Health Assessments are required on Admission as clinically indicated.
- consumers on high-risk medication regimes must have clear medical directives such as Insulin, Warfarin, Cytotoxic, Psychotropic, Anticoagulant/thrombotic etc.
- Where applicable the following should be noted:
  - Consideration of anticoagulant/thrombotic therapy in incident management should be

reflected in the FRAT, Medication, and Mobility & Skin ACASP's.

  - Need to monitor for Opioid related delirium should be reflected in the Medication &

Behaviour ACASP's.

  - Need to monitor for Digoxin/Sodium Valproate/Lithium toxicity should be reflected in

the Medication & Behaviour ACASP's.

RNs are expected to use their clinical judgment to ensure all correct documents are completed at

the right time. Discuss with the home's clinical leader if unsure.

- The RN is to make relevant referrals to Allied Health, Pharmacy, and Medical Officers as indicated by the results of assessments or as requested by the Consumer.
- The GP needs to review the consumer and complete documentation as soon as possible.
- The RN is to follow up with documenting any outcomes from the review in the consumer 's notes, highlighting interventions as a handover/care alert as a result of the assessments to inform team members of the delivery of care.

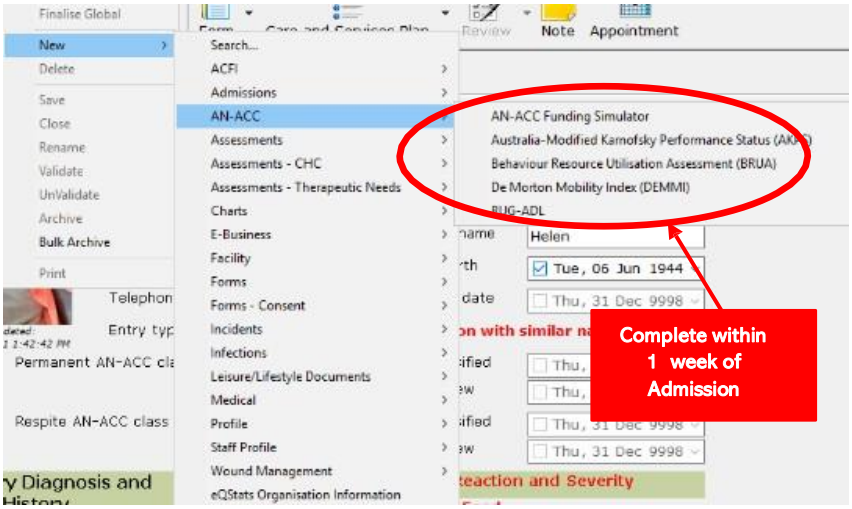
Respite admission

- As a minimum, the list of documentation required for permanent consumer s on day 1 and within 8 days must be completed for all respite admissions as soon as possible.
- Care needs and diagnoses must inform the suite of other assessments that will be required.
- The RN is to make relevant referrals to Allied Health, Pharmacy, and Medical Officers as indicated by the results of assessments. A GP review is required as soon as possible after admission.
- The RN is to follow up with documenting any outcomes from the review in the client's notes, highlighting interventions as a handover/care alert as a result of the assessments to inform team members of the delivery of care.

AN-ACC Assessments

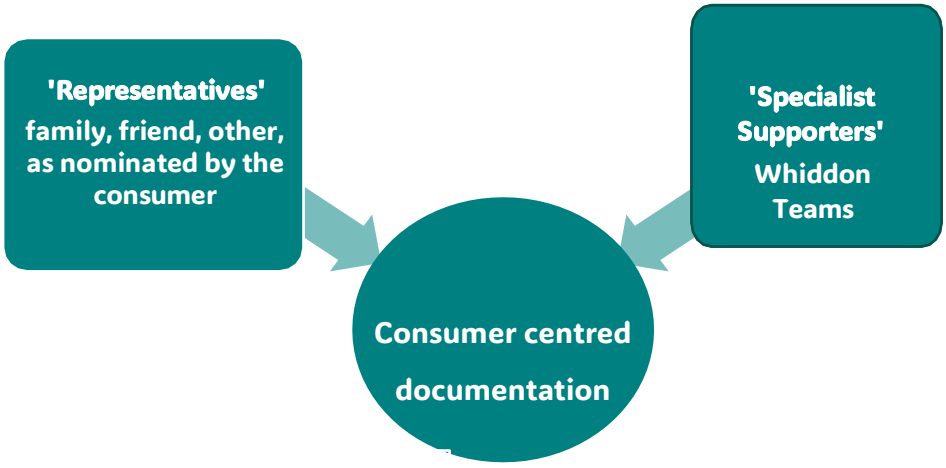
The following AN-ACC assessment tools are required to be completed within 1 week of admission (see appendix on page 49 for further details).

1. AN-ACC Funding simulator
2. Australia-Modified Karnofsky Performance Status (AKPS)
3. Behaviour Resource Utilisation Assessment (BRUA)
4. De Morton Mobility Index (DEMMI)
5. Resource Utilisation Group – Activities of Daily Living (RUG-ADL)



SECTION 2: ROLES, RESPONSIBILITIES, AND LEGAL CONSIDERATIONS

Roles and responsibilities



The consumer

The consumer is the leader. Documentation about the consumer must be developed in partnership with that consumer . Each consumer can choose to be as much, or as little, involved as they like.

To enable this to occur.

➔ Explain what information needs to be collected, why, where it is stored, and how privacy is protected.

➔ Find out what they want; ○ How much do they want to be involved? ○ Who else do they want to involve? ○ Is there anything else that is important to them when it comes to documentation?

- ○ It is important to clarify with consumer s that some documentation needs to be done, for safety or quality of service reasons. If a consumer has a concern, listen and understand why. Then discuss it with them to find a solution that they agree to. For example, they may not want the RBC 'all about me' sheet to be placed in their room however they may be accepting of it being accessible to team members by being filed in an office.
- ○ Document all of this clearly to ensure their choices are respected by completing the Personal Privacy Preferences Form in Autumn Care

➔ Complete relevant documents related to care planning in consultation with the consumer and/or their chosen representative/s.

➔ Organise case conferences via an appropriate medium (face-to-face, telephone, email) with the consumer and/or their chosen representative/s. Follow the case conference guidelines.

➔ Comply with a request for review of care and services, at any time, in a timely manner.

➔ Provide access to consumer s to view their own information, following the correct

process

Their chosen representative/s

consumer s may or may not elect to include other people in the above process. These persons could be family, a friend, or other. Representatives are elected by the consumer to support them in making decisions about their own life.

Some consumer s may have an established 'lack of capacity' due to a diagnosis of cognitive impairment. Whiddon team members cannot determine if someone has capacity; a 'clinical neuropsychologist or other trained health professional, such as a geriatrician or psychiatrist usually make these assessments' (publicguardian.justice.nsw.gov.au).

In the case of established lack of capacity, the representative may be nominated as the consumer 's substitute decision-maker. It is important that they 'stand in the consumer 's shoes' and make decisions as they would have. The clearest way for this to occur is to ensure there is a guardianship order (for accommodation and or care decisions) and/or power of attorney (for financial management). You must obtain the correct legal documents before acting on this. Refer to legal section. Upon admission, establish who these representatives are, whether they have a legal right to access a consumer 's personal information and or to make decisions and when they can make decisions, and how the consumer would like them to be involved. Document all of this clearly to ensure these choices are respected.

Whiddon Team Members

Whiddon team members are expected to work within their scope of practice to support each consumer to achieve their health and wellbeing outcomes.

All Whiddon team members are expected to contribute to and follow the guidelines for documentation. Some documents must either be completed or signed off by a Registered Nurse (RN). See the admissions section.

Registered and Enrolled Nurses have special requirements to maintain their registration as described in the 'Standards for Practice' from the Nursing and Midwifery Board of Australia.

MyLife Buddies have a special role for their consumer /s. They should be involved in care planning and drive the development of the RBC tools, and outcomes, for their consumer buddies. See RBC Framework for more details.

Other Providers of Care

Other providers include General Practitioners (GPs), Specialist Doctors, Nurse Specialists, RN Practitioners and Wound Clinical Nurse Consultants (CNC) and Allied Health Practitioners, Physiotherapists, Osteopaths, Podiatrists, Dieticians, Speech Pathologists or therapists, Clinical Psychologists, Dentists, Optometrists, etc. Same as Whiddon team members, these health professionals are also specialist supporters, critical to positive consumer outcomes. It is important that they document their interventions, and any recommendations agreed with the consumer in their notes. Where ever possible, an AutumnCare login should be organised, and documentation should occur directly in the system.

Legal considerations

Access and privacy of information

It is critical to ensure team member behaviour and interactions do not compromise the privacy of consumer s. Equally, consumer s and sometimes others have a right to access information. It can be hard to know when and how we should provide access to information.

consumer s receive information about how their privacy is protected, you should familiarise yourself with this information.

In terms of access, the legislation provides permission to share information with other health professionals, as long as 'they are an approved provider (GP, approved list of other health professionals, etc.) and they require this information to care for the consumer '

For consumer and their representatives' access, see the table below.

Name of law	Jurisdiction	consumer 's right to access records	Representative's right to access
Privacy Act 1988 and the Australian Privacy Principles (APP)	Commonwealth law:- applies to all health service providers	Australian Privacy Principle: 'Consumers have a right to request access to their personal information.' 'Access can only be denied in certain circumstances - for instance, where access can pose a serious risk to a person's life or health.' (See APP1 and APP12)	Representatives have limited access (See APP 12 and APP 6)
Aged Care Act 1997 and Charter of Aged Care Rights	Commonwealth law: - applies to all aged care facilities which are funded by the Commonwealth	Under the Charter of Aged Care Rights 2019 Resident s have the right to: 5. 'Be informed about their care and services in a way they understand Access all information about themselves, including information about their rights, care and services'.	Representatives do not have automatic right to access, unless a written consent (or direction) of the consumer is submitted to the residential Care Facility. *Sect 62.1* Aged Care Act However, the new Charter of Aged Care Rights allows for consumer s to. 11. have a person of my choice, including an aged care advocate, support me or speak on my behalf

Here are some rules to follow when a consumer requests to see their personal information:

- The request must be made by the consumer , in person. This is to verify the person's identity.
- Ask what they want to see and why, to ensure this is facilitated efficiently.
- A Manager (DCS/DDCS) must be advised prior to disclosure.
- Offer for the information to be provided on the system, with the Manager or RN present, so that any questions can be answered. If necessary, organise an interpreter or translator to ensure the consumer can understand the information provided.
- APP 12.4(b) provides that we 'must give access to personal information in the manner requested by the individual, if it is reasonable and practicable to do so. The manner of access may, for example, be by email, by phone, in person, hard copy, or an electronic record'. Information being provided by email, hard copy or electronic format, must be reviewed by the Manager and Clinical Governance Team at Support Services prior to release.
- Per the table above, the request should not be refused unless 'access poses a serious risk to a person's life or health.' In this instance the consumer s General practitioner should be involved. Refusal and reasoning must be in writing and only after checking with the Clinical Governance Team in Support Services.
- The request must be actioned as soon as possible and within 30 calendar days of the request (APP 12).

Here are some rules to follow when another person requests to see their personal information:

- The request must be in writing to the Executive Administration.
- Evidence of identity and legal right to access must be provided with the request. For example, the consumer has provided verified written approval or there is a guardianship order in place.
- Ask what they want to see and why to ensure this is facilitated efficiently.
- If approved, offer for the information to be provided on the system, with the Manager so that any questions can be answered. If necessary, organise an interpreter or translation, to ensure the person can understand the information provided.
- APP 12.4(b) provides that we 'must give access to personal information in the manner requested by the individual, if it is reasonable and practicable to do so. The manner of access may, for example, be by email, by phone, in person, hard copy, or an electronic record'. Information being provided by email, hard copy or electronic format must be reviewed by the Manager and Clinical Governance Team at Support Services prior to release.
- Refusal to provide access must be in writing and include the reason for refusal by the Executive or their delegate.
- The request must be actioned as soon as possible and within 30 calendar days of the request (APP 12).

Here are some rules to follow when there is a subpoena requesting access to a consumer 's personal information.

A subpoena is an order from a court requiring the Addressee (the person who is the subject of the order) expressed in the subpoena to:

1. Produce to a court a copy of the subpoena and documents or things as directed by the subpoena.
2. Attend a court to give evidence as directed by the subpoena; or
3. Do both.

A subpoena cannot be ignored and must be dealt with promptly. Failure to comply with a subpoena without a lawful excuse is a contempt of court and can result in an arrest.

If you receive a subpoena.

- The Manager or their delegate must manage the subpoena.
- Immediately send a copy of the subpoena to the Clinical Governance Team in Support Services. They will inform the CEO or delegate.
- Once it is established that this is a lawful request, comply with the requirements of the document. You will be given support and direction by the Clinical Governance team.
- Raise an eQstats and upload all requests, letters, subpoena and documents into step 7 categorising it as a SAC 1 -LEGAL.
- Send a copy of all documents requested to the Clinical Governance Team in Support Services.
- The deadline must be met.

Advance Care Directives, Guardianship and Power of Attorney

An **Advance Care Directive**, sometimes referred to as a 'Living Will', 'provides a clear statement that sets out the person's wishes and values that need to be considered before medical treatment decisions are made on their behalf. People do not need to have a terminal illness before considering this.

An **Enduring Guardian** is someone who has been appointed to make some or all decisions regarding lifestyle, health and medical decisions for someone else, when they are no longer capable of doing this for themselves. Enduring Guardians may make decisions such as where the person lives, what services are provided and what medical treatment the person receives. The consumer needs to implement this before they lack capacity, and it only comes into effect when they no longer have capacity

An **Attorney** has the legal authority to look after someone else's financial affairs.

A person can nominate someone they know or an NSW Trustee & Guardian

An application to obtain a guardianship **or financial order** can be made through NCAT, if the person does not have an Enduring Guardian or Attorney and they are no longer able to make their own decisions. A loved one or Whiddon Manager can initiate this process.

If someone states they have Guardianship or Power of Attorney (POA), they must show you the original and/or provide a verified copy of the document to prove this. A verified copy must be kept on file. This then needs to be documented in AutumnCare.

If consumer s do not have these documents/processes in place, it is imperative to discuss their importance as soon as possible. It has been shown that health outcomes for people and their families improve when they are able to talk through their concerns, decisions, preferences and choices with health professionals. It also prevents undue stress if/when these processes need to be enacted.

Anti-discrimination

Whiddon requires that all team members deliver care and services that are inclusive.

Team members must ensure communication and documentation is reflective of the consumer 's social, cultural, language, religious, spiritual, psychological, medical needs and sexual identity. For example, husband, wife or partner or other, can be used and must be representative of the consumer 's choice. Use the consumer 's actual words and don't assume. (See Diversity and Inclusiveness Policy)

Independent advice and advocacy

There are a number of organisations, outside of Whiddon, that can provide independent advice and advocacy. Examples are the Older Person's Advocacy Network (OPAN) and Seniors Right's Service.

There are resources to assist consumer s and/or their representatives to understand health situations and make informed decisions. For example, there are information sheets you can download in several languages. They were created by health. Vic. The website is called: Participating with consumers; and can be found here

SECTION 3: GUIDELINES FOR QUALITY DOCUMENTATION USING AUTUMN CARE TOOLS

Assessments

The assessment process (RN)

Assessment forms, once completed in Autumn Care, feed into and create Agreed Care and .Services Plans, so it is important that the information entered is comprehensive and accurate.

Quality care documentation requires sound clinical reasoning. Clinical reasoning is the process by

which health care professionals 'collect cues, process the information, come to an understanding of a (consumer 's) situation, plan and implement interventions, evaluate outcomes and reflect on and learn from the process' (Hoffman, 2007; Kraischsk & Anthony, 2001; Laurie et al., 2001).

Assessment involves the 'gathering of data relating to a person's physical, psychological, and social status before admission, at the time of admission, and following admission. This gathering of data involves interviewing the person (and his or her nominated representatives), physically assessing the person, and documenting the findings' (Forster, 2003).

The consumer and their chosen representatives are central to the assessment process. They are partners in this process and should be involved in all aspects.

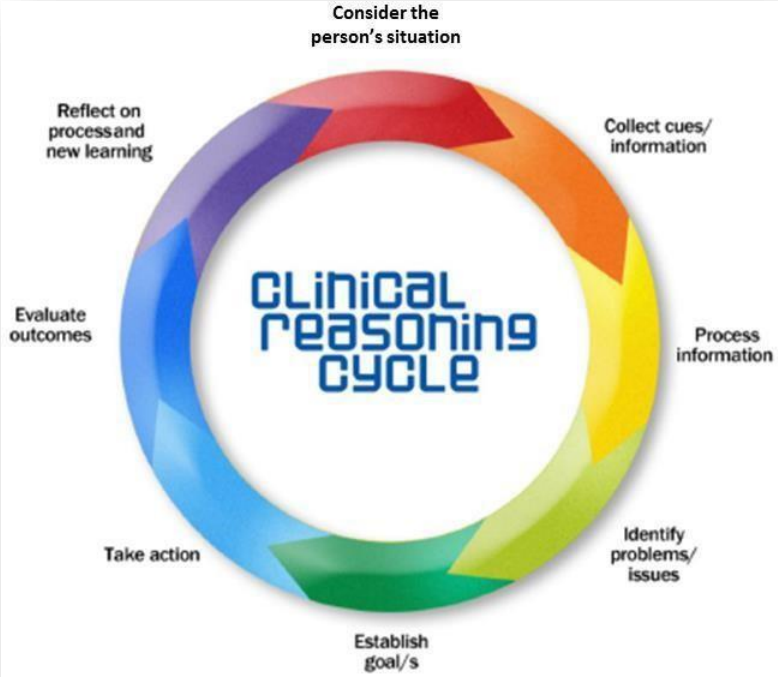


Figure 1: The clinical reasoning cycle

Part 1 of the Assessment Process- requires a pre-assessment workup.

This is the research phase. Begin with all relevant information available, and ask the question; what is this telling me? Begin with an overall clinical profile of the consumer . Include.

- Diagnoses
- ACCR/NSAF
- Hospital Discharge Information
- Letters from Medical Officer / Specialist, etc.
- Current medication
- Physio/OT/Osteopath and Cognitive Assessments

Part 2 of the Assessment Process- requires an objective assessment

This part of the assessment requires meticulous 'observation' - look for both actual and potential issues. The consumer is central to this process and therefore they and/or their representatives need to be supported to be involved.

This requires 3 types of actions as follows.

History	Physical examination	Test
Asking questions Active listening	Examination Observations Measuring vital signs Noting odours	Conducting tests Special investigations

Findings should be documented as you go along. If not performing the objective assessment yourself:

- Liaise carefully with the person who will be.
- Discuss findings with that person.
- Check the assessment tool with the person to ensure they have gathered all the appropriate data.

Part 3 of the Assessment Process -is the analysis

It is now time to pull all the information together in an ASSESSMENT SUMMARY in the free-text box in each AutumnCare Assessment. It paints a succinct picture and should be able to stand alone, even without the assessment tool accompanying it. To document this ensure documentation includes.

- The key findings from all the information gathered in parts 1 and 2.
- Relevant information from other sources i.e. charts.
- The impact on the p consumer 's ability to undertake tasks.
- Causative factors linked to diagnosis, where you can describe the outcome.
- Goals and Nursing Directive.
- The consumer 's point of view.

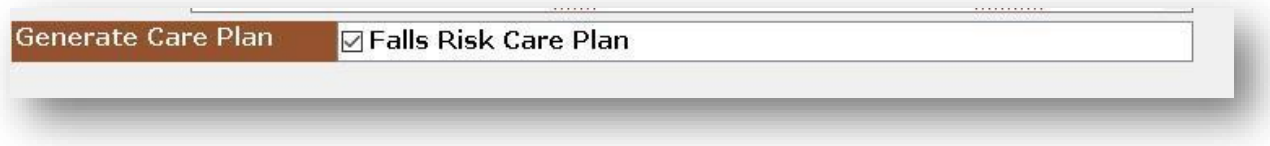
General guidelines for completing assessments

1. The consumer and/or their chosen representatives are partners in assessment and care planning processes and must be involved.
2. Use the same principles for quality documentation as mentioned in the notes section.
3. Use the free text fields to make the information more personal and reflective of the consumer 's choices. Use the person's preferred name in these spaces and add detail not included in the tick boxes. Only using the tick boxes makes the Agreed Care and Services Plan feel impersonal. See above regarding the use of these free text boxes to record findings from the assessment process.
4. Don't leave spaces blank, unless they are optional fields.
5. The top of each assessment will log how complete the assessment is at any point. Make sure it is 100% complete. Below is an example of an incomplete assessment.

Incomplete assessments will show as red in the list of documents showing on the left-hand side of the screen.

Below is a view of the top of the assessment once you open it, it should say < 100% > - here it is only < 88% > complete.

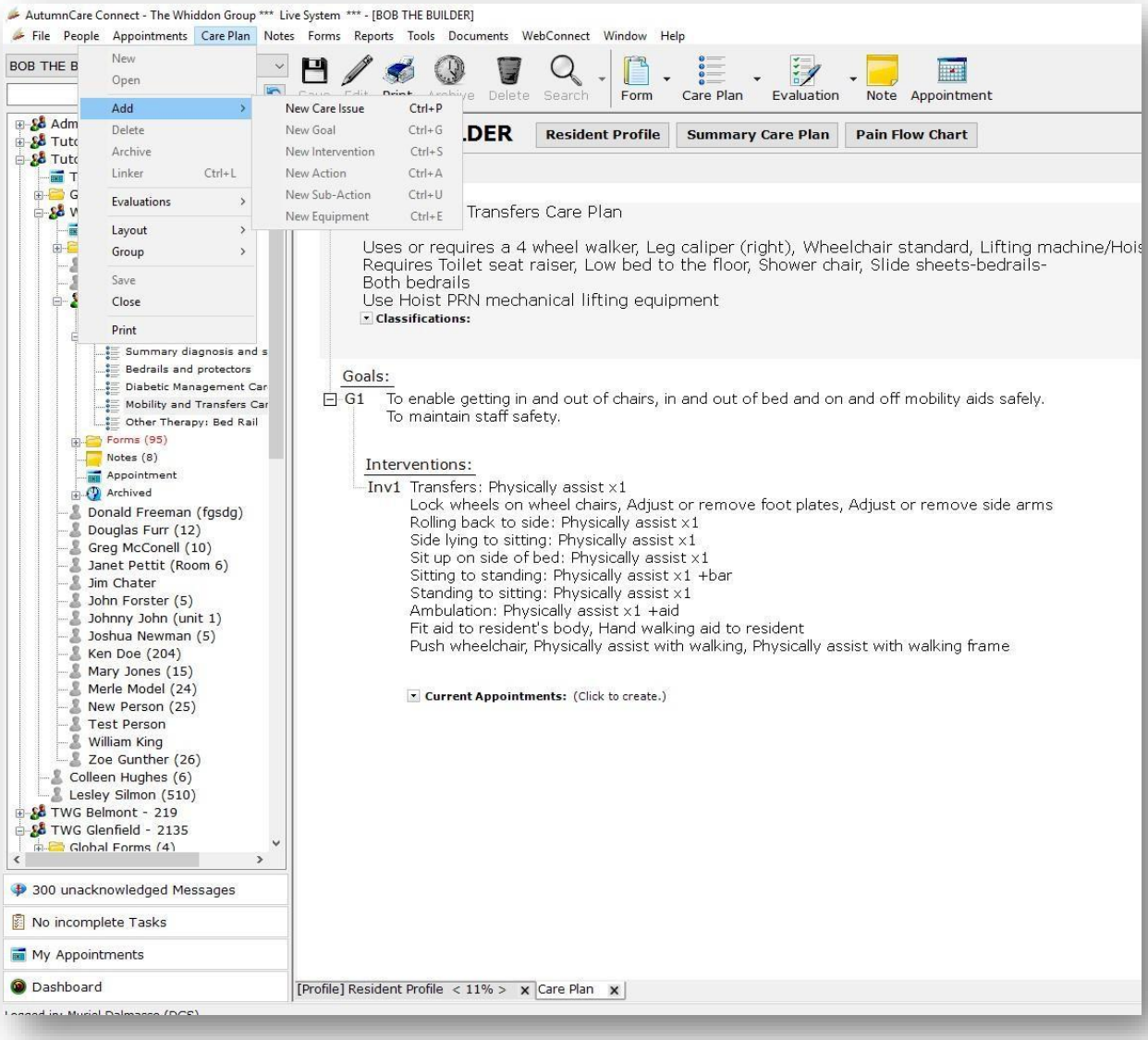
Once the form is complete, tick the box to generate the corresponding care plan.



Agreed Care and Services Plans - Registered Nurse

As explained in previous sections, once completed, the relevant assessments and tools generate the ACASP.

Initial full ACASP's are completed within 28 days of admission.



Agreed Care and Services Plan review (RN)

Agreed Care and Services Plan reviews will occur as changes happen or at least every 3 months.

RN's must oversee and coordinate this task. The goal is to make sure the Agreed Care and Services Plan reflects the consumer 's current needs and choices.

Guidelines for Agreed Care and Services Plan review.

- Read the consumer 's file for the past 3 months including progress notes, correspondence, discharge summaries, doctor's notes and all medication charts.
- Meet/talk with the consumer , their chosen representatives and relevant team members, including the person's MyLife Buddy. Always remember that consumer s and their chosen representatives are partners in their care and central to the process. Organise a formal case conference at least annually.
- Review all assessments 3 monthly & update as needed. All assessments should be archived & redone on an annual basis. Use the 'other' field on the assessments when making changes to customise or to reflect an incident/change in clinical status or preferences.
- Evaluate the consumer 's Agreed Care and Services Plans by going into each individual Agreed Care and Services Plan issue; click on 'add evaluation', make an entry in the box, 'save and close'. Evaluate each care issue documenting any identified changes and results of the review.
- Once the above steps have been completed, proof read the entire Agreed Care and Services Plan to ensure it is congruent, personalised and clear.
- Once this has occurred the overarching Agreed Care and Services Plan Evaluation at the top of the page needs to have a short summary added by clicking on 'add evaluation', make entry in the box and 'save and close'. E.g. 'All care issues evaluated in partnership with the consumer and/ or their representative on XX/XX/XXX (date)'. This allows you to run reports in Autumn Care, to check whether all of the consumer 's Agreed Care and Services Plans under your responsibility have been reviewed in the last 4 months, so it is important to do this as it makes it easier to check.
- Once the consumer 's assessments and Agreed Care and Services Plans are reviewed, an updated

Summary Agreed Care and Services Plan can be generated.

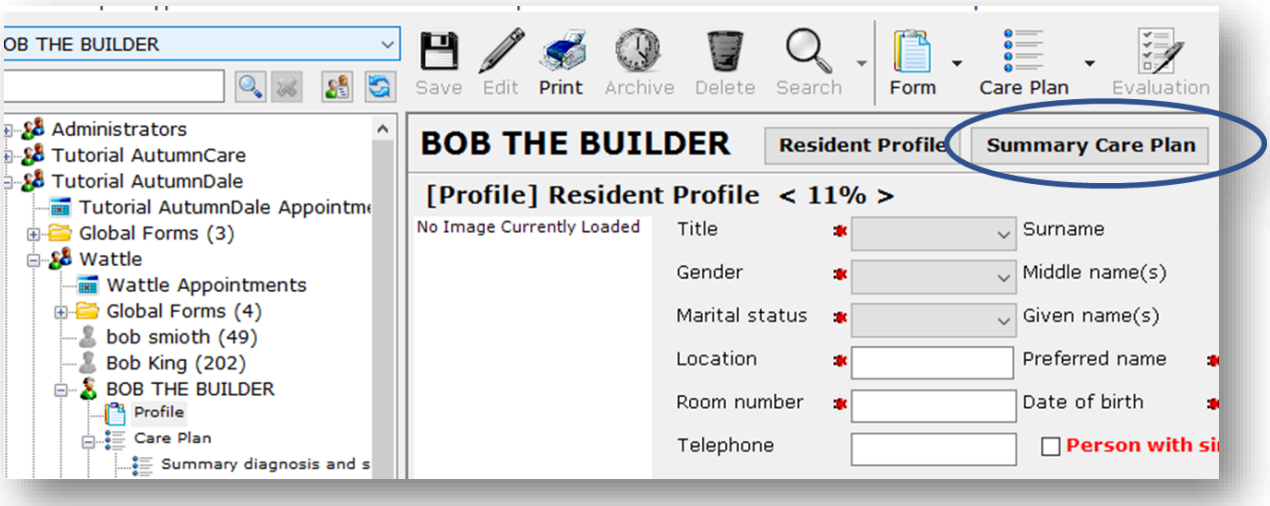
- Other tasks to perform while attending a review include
    - Updating the consumer details page if required, including consumer representative contact names and details.
    - Checking that the consumer s was reviewed by their GP in the last 3 months.
    - Checking that any printed information is correct, i.e. the manual handling card, diet sheets.
    - Checking that the 'Consumer of the Day' form has been completed.
    - The profile photo of the consumer has been renewed within the last 12 months.

Summary Agreed Care and Services Plans

A Summary Agreed Care and Services Plan is a one-page plan of care for an individual consumer . This information allows team members to get a snapshot on how to deliver safe, personalised, appropriate care for the individual person.

It is automatically generated through drawing out information from the assessments and Agreed Care and Services Plan.

It can be accessed through clicking the shortcut in AutumnCare.



Progress Notes or Notes (in AutumnCare)

Why and when to use notes

Accurate documentation supports better quality of life for the consumer s, improved consumer outcomes, and increased safety for everyone. In contrast, failing to document something important could lead to risk for the person and legal repercussions due to something not being done correctly or not being done at all. Also, remember the famous saying 'if it isn't written down, it didn't happen' (unknown).

Whiddon does not expect that 'routine notes' be written on a timed basis. This type of rule can lead to ineffective documentation such as 'no change to client care…'. However, there is an expectation that relevant information or exception reporting be documented in notes at the time of occurrence. With that being said, consumer s lead busy lives, so we would expect to see regular entries.

Documenting as soon as something occurs is critical as that is when you have the best possible memory of that event or information. If you don't, you may forget important details or forget to document at all. If a legal scenario unfolds & your documentation was attended sometime after the event, this may be used to discredit what is written.

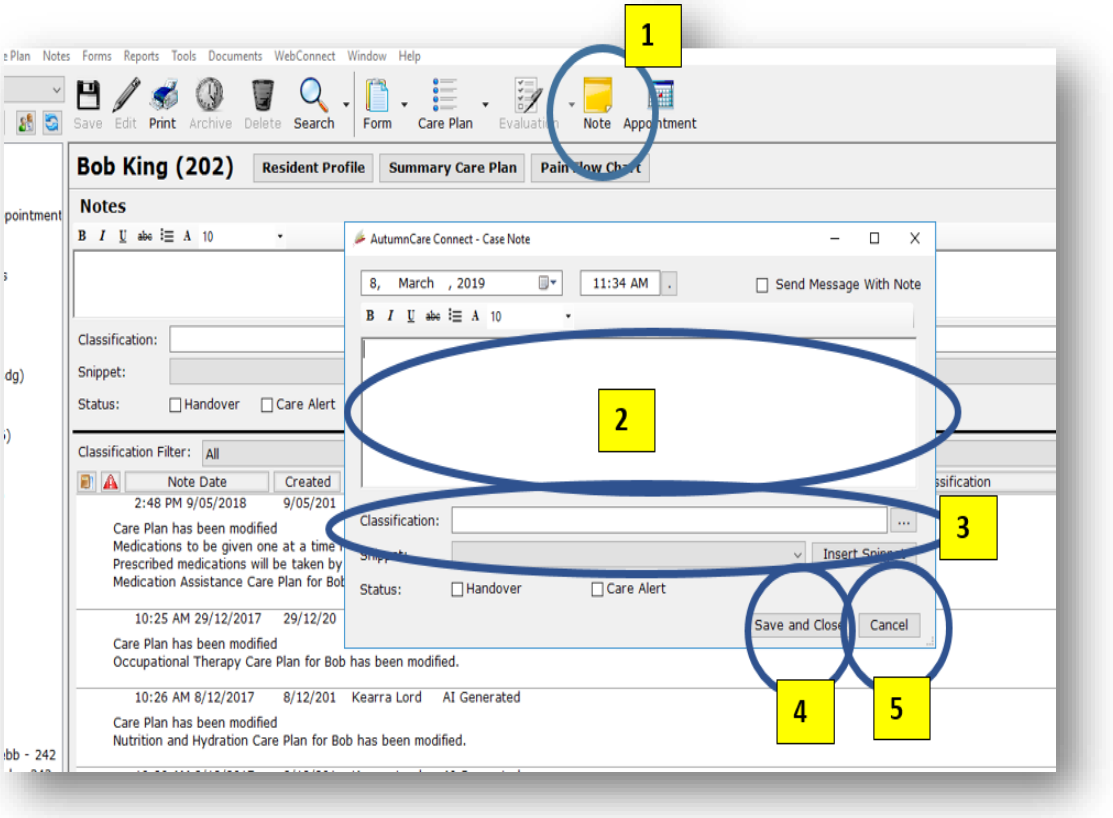
Remember to make it a priority to engage with the consumer and their representative/s around the information you are recording about them. You are discussing their life and thus they need to be directing it. The following table provides some examples of what types of events should be documented.

Things that should be documented in notes	Example
Information that is different to the usual care or Agreed Care and Services Plan.	The consumer 's Agreed Care and Services Plan and Summary Agreed Care and Services Plan state that a consumer can stand up with one person to assist. Today, the consumer was unable to stand with one person. *NOTE: report this verbally as it is a high risk.*
Anything that may indicate a change int he person's health or well-being.	The consumer is usually smiling and cheerful. Today the consumer is crying.
A person's choice to refuse treatment or care.	The consumer doesn't want their medications at lunchtime. *NOTE: it is important to remember that it is a person's right to refuse treatment. You need to record it to explain why the care was not provided. Otherwise, it could be assumed you simply forgot. It is also important as it may point to any possible risks the consumer may be taking, that may need to be discussed further to ensure they are making an informed decision. It will also indicate there may need to be an assessment to see if anything further is going on that needs to be addressed such as illness, depression, cognitive impairment…*
Any care that may have been missed during your shift.	The consumer has a 2nd daily dressing, and it is due today, however, the consumer was out. *NOTE: this will ensure the next team member knows to get it done when the consumer gets back to ensure the wound does not get worse.*
Any complaints.	A consumer tells you they are unhappy about something that happened today. *NOTE: this must also be managed and documented via the Compliments and Complaints process.*
Anything the person may have done that could impact on the status of their health and overall well-being.	A consumer who is diabetic but is choosing to eat lollies. *NOTE: again, a consumer has a right to make their own choices, however, this needs to be documented to provide a possible explanation to any possible issues as a result of the behaviour, but also to ensure important information is given to the consumer , so they make a fully informed decision. This will require the general practitioner's input and possibly the Dietician.*

Where to document notes

Whiddon uses an electronic system called Autumn Care for notes. To document notes in Autumn Care, follow the step-by-step prompts below.

1. Once in a consumer 's 'file'; you need to click on 'Note' to start a new one.
2. Type in the box.
3. Enter your 'Classification'
4. Enter additional classification to highlight information within the notes e.g. Family/ consumer Communication (if applicable).
5. Save and Close to save the note. Proof read first.



The system will automatically record the date and time you saved your note.

The system will automatically record your name. This is why you must never allow someone to document for you or under your login. It is important to always logout of the electronic system to prevent this from occurring without your knowledge. You would be the person called upon if the notes were used for a legal issue.

If you modify notes, the changes will be recorded in the system. If you have made a mistake or need to add to your notes, it is better to write a new note and refer to the other note as 'written in error (date and time)' or 'addition to previous note (date and time)'.

How to write complete and quality notes.

Use the following prompts:

1. **WHEN** did it happen?
2. **WHO** is it about? (Use their preferred name)
3. **WHERE** did it happen?
4. **WHAT** happened?
5. **WHY** did it happen? If you have that information – see objectivity point below.
6. **HOW** did it happen? If you have direct evidence, e.g. you saw it, heard it…
7. **WHAT** did you do about it?
8. **THE OUTCOME** – for the consumer

At 12:00 (**WHEN**), in the dining room (**WHERE**), I observed Mr Bean (**WHO**) to have a skin tear on his right lower arm inner aspect ,6cm , epidermal tear, not raised or red, no discharge (**WHAT/WHERE**). Mr Bean stated he got it as a result of another female consumer scratching him (**HOW** – objective 2nd hand report). Mr Bean further stated she was angry at him because he was in her room (**WHY** – objective 2nd hand report). Dressing attended, wound chart commenced, mandatory report process undertaken and all steps documented in the incident form, added to handover and reported to the Director of Care Services at 12:30. (**WHAT**) GP and family informed at 1200 and 1215 respectively. No further directives given.

(NOTE: this will be a Serious Incident Report or NDIS Report (refer to Incident Reporting Policy including SIRS and NDIS Reporting on MyStaffroom).

Other important points:

➔ Be objective:

- Only document what **you** have seen or heard.
- If documenting something someone else told you, then write it that way as per

the example above 'Mr. Bean *stated/told me* he got it as a result…'

Situation	**Note: Not objective**	**Note: More objective**
In the dining room, you see that Mr. Bean has a skin tear on his left arm. When you ask him how it happened, he says Mrs. Monroe scratched him because she was angry to find him in her room.	Mrs Monroe scratched Mr Bean on the arm because he was in her room.	At 12:00, in the dining room, I observed Mr Bean to have a skin tear (describe it: location, size). Mr Bean stated he got it as a result of another female consumer scratching him. Mr Bean further stated she was angry at him because he was in her room… *NOTE: this will be a mandatory or discretion not to report (See Elder Abuse).*
You observe the below: 	An old Chinese man was left outside and was crying.	I observed a person outdoors. The person was looking upwards and holding a white cloth to the left side of his face just under his eye. The person's mouth was turned downwards. *NOTE: you can only talk about age, race and state of mind with more context (i.e. they are crying and communicates verbally and nonverbally to you that they are sad or upset…)*

➔ Be concise - this means writing just enough to make the message clear without subjective judgement.

➔ Use appropriate language/correct words.

Choose words that are non-judgmental. For example, rather than 'he goes on and on about…' use instead, 'he often…' OR 'on five occasions now, he has mentioned…'

Think about dignity when you are writing. For example, for someone living with Dementia - instead of 'she had been playing with her poo again and put it everywhere in bed and it smelt bad', it would be more appropriate to write, 'Murgatroyd was found with faeces on her hands and in the bed (then document what you did about it…)'. Be clear in your documentation.

Unclear Documentation	Clear Documentation
Disruptive and agitated behaviour	Client is yelling and pacing in hallway
Client appears in pain	Client grimaces when moved from back-to-side
Client is non-compliant	Client said he does not want to take his medication as it makes him feel nauseous
Client is a fall risk	Client stumbles when walking and shuffles feet
Client appears confused	Client is disorientated to time and place
Client is depressed	Client had a flat affect, limited eye contact and cried frequently during conversation
Wound is infected	Skin around the wound is red, warm to touch with purulent discharge, client complains of increased pain over the past two days
Client has poor insight and is a safety risk	Client found outside smoking with portal oxygen tank in use
Client appears to be hemorrhaging	Client has saturated two peri-pads in one hour
Difficulties breathing	Nasal flaring noted and lips blueish tinge

➔ Be thoughtful,

➔ Be respectful,

➔ Make sure your documentation is personal, not generic. Remember that you are documenting about a person.

➔ Make sure your documentation is accurate and timely (as close to the situation as possible).

➔ Use only Whiddon approved abbreviations and recognised medical diagnoses

Accepted Abbreviations

ACCEPTED ABBREVIATIONS			
	CLASSIFICATIONS		**MEDICATION**
RSM	**Residential Services Manager**	**PO**	**Per oral**
CSM	**Care Services manager**	**Mane**	**Morning**
AN-ACC	**Australian National Aged Care Classification**	**OD**	**Once daily**
		Nocte	**Night**
CSM	**Care Service Manager**	**PRN**	**Per Required Need**
CNS	**Clinical Nurse Specialist**	**AC**	**Before meals**
CNC	**Clinical Nurse Coordinator**	**PC**	**After meals**
CN	**Community Nurse**	**BD**	**Twice daily**
RN	**Registered Nurse**	**TDS**	**Three times daily**
EN/EEN	**Enrolled Nurse/Endorsed Enrolled Nurse**	**QID**	**Four times daily**
AIN	**Assistant in Nursing**	**PV**	**Per vagina**
CSE	**Care Service Employee**	**PR**	**Per rectum**
L/O	**Leisure Officer**	**S8**	**Schedule 8**
Dr	**Doctor**	**S4**	**Schedule 4**
LMO	**Local Medical Officer**	**NIM**	**Nurse Initiated Medication**
MO	**Medical Officer**		**MEASUREMENT**
GP	**General Practitioner**	**g**	**Gram**
NP	**Nurse Practitioner**	**mg**	**Milligram**
ACAT	**Aged Care Assessment Team**	**mcg**	**Microgram**
ACFI	**Aged Care Funding Instrument**	**ml**	**Millilitre**
ACCR	**Agreed Care Client record**		**AUTUMNCARE FORMS**
NSAF	**National Screening and Assessment Form**	**ASCOT**	**Adult Social Care Outcomes Tool**
		ACASP	**Agreed Care and Services Plan**

ACCEPTED ABBREVIATIONS			
	OBSERVATION	**CSD**	**Cornell Scale for Depression**
OBS	**Observation**	**CAM**	**Confusion Assessment Method**
TPR	**Temperature, Pulse and Respiration**	**FRAT**	**Falls Risk Assessment Tool**
Bpm	**Beats per minute**	**MNA**	**Mini Nutritional Assessment**
BP	**Blood Pressure**	**PAS**	**Psychogeriatric Assessment Tool**
GCS	**Glasgow Coma Scale**	**OHAT**	**Oral and Dental assessment**
PEARL	**Pupils Equal and Reactive to Light**	**PAINAD**	**Pain in Advanced Dementia**
SaO2	**Oxygen Saturation**	**SSP**	**Swallowing Screening Pathway**
Temp/T	**Temperature**	**RUDAS**	**Rowland Universal Dementia Assessment Scale**
HR	**Heart Rate**	**CMA**	**Comprehensive Medical Assessment**
Neuro obs	**Neurological Observations**	**M-RVBPI**	**Modified consumer s' Verbal Brief Pain Inventory**
	COMPLEX HEALTH CARE		**INFECTION**
IDDM	**Insulin Dependent Diabetes Mellitus**	**UTI**	**Urinary Tract Infection**
NIDDM	**Non-Insulin Dependent Diabetes Mellitus**	**U/A**	**Urinalysis**
T1DM	**Type 1 Diabetes Mellitus**	**MSU**	**Midstream Sample of Urine**
T2DM	**Type 2 Diabetes Mellitus**	**CSU**	**Catheter Sample of Urine**
BGL/BSL	**Blood Glucose Level/Blood Sugar Level**	**A/B**	**Antibiotic**
IDC	**Indwelling Catheter**	**URTI**	**Upper Respiratory Tract Infection**
SPC	**Supra Pubic catheter**	**MRO**	**Multi Resistant Organism**
PEG	**Percutaneous Endoscopic Gastrostomy**	**VRE**	**Vancomycin-Resistant Enterococcus**

ACCEPTED ABBREVIATIONS			
NG	Nasogastric	ESBL	Extended Spectrum Beta Lactamase
TENS	Transcutaneous Electrical Nerve Stimulation	MRSA	Methicillin Resistant Staphylococcus aureus
ROM	Range of Motion	LRTI	Lower Respiratory Tract Infection
CPAP	Continuous Positive Airway Pressure	ILI	Influenza Like Illness
	CARE PLANNING		COMMON MEDICAL ABBREVIATIONS
NCP	Nursing Care Plan	AKA	Above Knee Amputation
ACASP	Agreed Care and Services Plan	BKA	Below Knee Amputation
	DOCUMENTATION	CCF	Congestive Cardiac Failure
(R)	Right	AMI	Acute Myocardial Infarct
(L)	Left	CAL	Chronic Airway Limitation
Mx	Management	NOF	Neck of Femur
Ax	Assessment	CVA	Cerebrovascular Accident
Hx	History	AAA	Abdominal Aortic Aneurism
Dx	Diagnosis	RA	Rheumatoid Arthritis
Rx	Treatment	OA	Osteoarthritis
PHx	Past History	IHD	Ischaemic Heart Disease
c/o	Complaining of	COPD	Chronic Obstructive Pulmonary Disease
r/o	Removal of	COAD	Chronic Obstructive Airway Disease
@	at	CRF	Chronic Renal Failure
#	Fracture	HTN	Hypertension
./c	With	AF	Atrial Fibrillation
v/b	Visited By	ECG	Electrocardiogram
r/v	Review	NOF	Neck of Femur
NBM	Nil By Mouth	ORIF	Open Reduction Internal

ACCEPTED ABBREVIATIONS			
			Fixation
ADL's	Activities of Daily Living	NAD	No Abnormalities Detected
I/O	Insertion of		
PAC	Pressure Area Care	Abdo	Abdominal
HNPU	Has not Passed Urine	O/E	On examination
BO	Bowels Open	T/F	Transfer
BNO	Bowels not Opened	NBM	Nil by Mouth
FBC	Fluid Balance Chart	S/B	Seen by
SOB	Shortness of Breath	TBA	To be Arranged
SOBOE	Shortness of Breath on Exertion	PUF	Pick up Frame
NEB	Nebulizer	FASF	Forearm Support Frame
O_2	Oxygen	NFO	No Further Orders
PPE	Personal Protective Equipment	ATOR	At Time of Report
H_2O	Water	TBC	To be confirmed
BRUA	Behaviour Resource Utilisation Assessment		
AFM	Australian Functional Measure		
DEMMI	De Morton Mobility Index		
RUG ADL	Resource Utilisation Group – Activities of Daily Living		

Recording daily care and other relevant information

There is a list of charts available to use in AutumnCare to record daily care (i.e. bowel chart, leisure and lifestyle activity attendance) or special information (vital signs, continence, wandering, and weight). Charts are selected by the RN to record information relevant to the consumer .

All care team members can complete most of these charts however they must follow RN instructions at all times.

It is important to complete all parts of the chart and to do it as per the agreed schedule. Not doing so could affect the consumer 's care outcomes.

Documentation is evidence that care was delivered.

Documents can be subpoenaed in case of a law suit. They can also be requested by the Aged Care Quality and Safety Commission (ACQSC) in the case of a complaint or assessment contact. You want your documentation to support you in these cases and show that you have been fulfilling your duties to your consumer s as per their agreed plan of care and choices.

Incident Recording

General guidelines

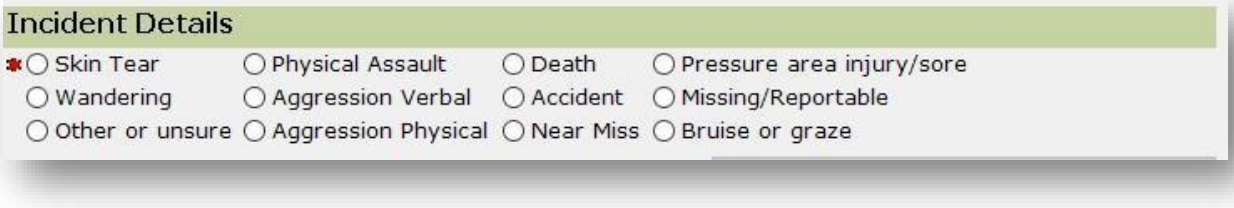
- It is important to document incidents as soon as possible after the actual incident has been managed.
- You need to be accurate, provide relevant detail, demonstrate that you have ensured consumer safety and wellbeing, that you have taken necessary actions including notifying all relevant persons, taken observations & as required implemented first aid. It is important to record the emotional support & reassurance provided.
- Quality documentation of an incident also helps managers (who may not have been there at the time of the incident) to understand what happened, thoroughly investigate and put strategies in place to avoid future incidents.
- All incidents related to consumer s, need to be recorded in AutumnCare first.

In AutumnCare

It is important to use the correct incident form in AutumnCare. There are currently 3 types of incident forms:

1. Medication.
2. Fall; &
3. consumer .

The first two are self-explanatory, the third applies to 'other' types of incidents. Per the options below.



It is important to select the right option, to ensure they are transferred accurately into eQstats, where they will be rated against risk. For example: physical assault is to be used for mandatory reports and will automatically rate this incident as a higher risk to make sure we comply with the requirements.

Make sure you complete all fields of the form as soon as possible after the event. The same as with assessments, you can track your progress for completion of the form. You need to complete to 100%. When you do, the form name will change from red font to black.

You will need to review other parts of the consumer 's file and update any relevant assessments, Agreed Care and Services Plans, forms etc.… to reflect any findings or actions to be taken from the incident. For example, for a fall, you would need to review the Falls Risk Assessment Tool (FRAT).

Incident forms will generate an automatic AutumnCare Message which will be sent to the DCS/DDCS. It will also automatically transfer into eQstats.

In eQstats

Whiddon uses eQstats, a software program which manages quality and risk information.

- Some incidents that are not directly related to consumer s, i.e., damage to a building due to a storm, or an employee injury, are entered directly into eQstats. Follow the steps in 'Reporting workplace and other incidents in eQstats booklet.pdf' which can be found on MyStaffroom.
- Incident reports created in AutumnCare, will transfer to eQstats for a more in-depth review by the Manager.
- It is critical for Managers to complete all steps and fields in eQstats and ensure documentation is complete and of a high quality.
- These incidents must be acknowledged and addressed within the correct timeframes according to their SAC rating. The Severity Assessment Code (SAC) is the method used by Whiddon to determine the appropriate action to be taken for each incident. The score is ascertained by rating the actual & potential consequence of the incident.
- Upload documents that evidence the following: the investigation, the actions taken, the review of these actions, and closure of the risk into the eQstats incident prior to closing it. It is not enough to say in the documentation that the consumer was happy with the result, you could for example upload the minutes of a case conference where they state this.
- Some incidents may lead to Continuous Improvements. These must be entered into eQstats.

- See eQstats processes for more information on the above.

Incident investigations

Some critical or high-risk incidents (SAC 1 and 2 for example) may require a more in-depth investigation and separate report to be undertaken by an independent person from Whiddon. For these, follow the 'Critical Incident Investigation Manual' and use the report format provided.

In some rare situations, external investigators may be engaged.

If unsure, contact the Clinical Governance or Corporate Governance Team at Support Services.

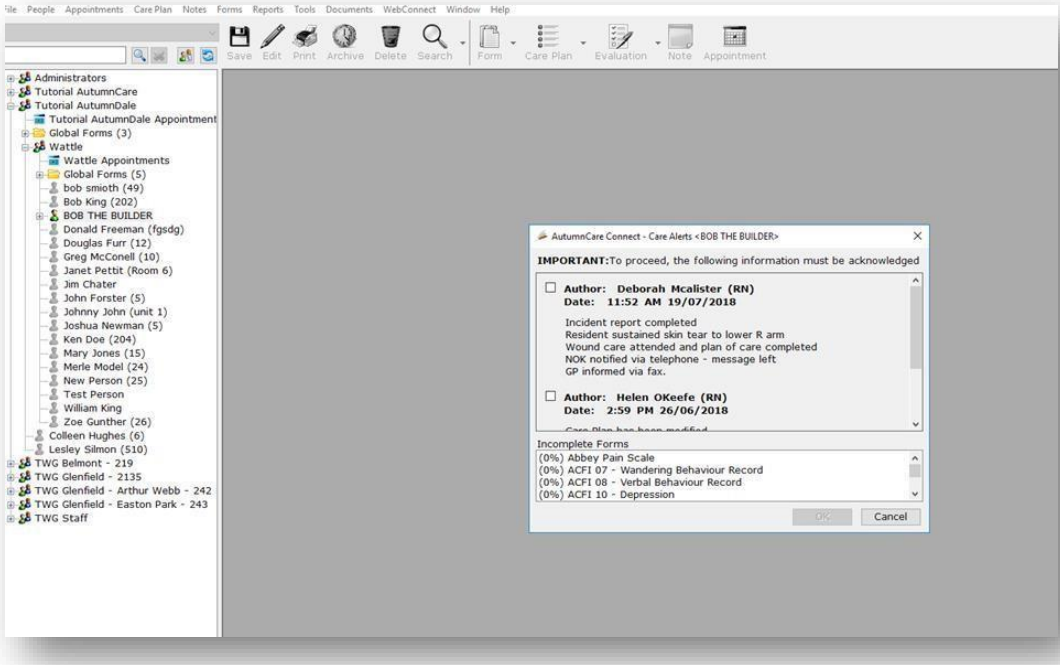
Finalised reports which have been signed off by the Governance Team must be uploaded into the eQstats incident prior to closing it.

Autumn Care Alerts

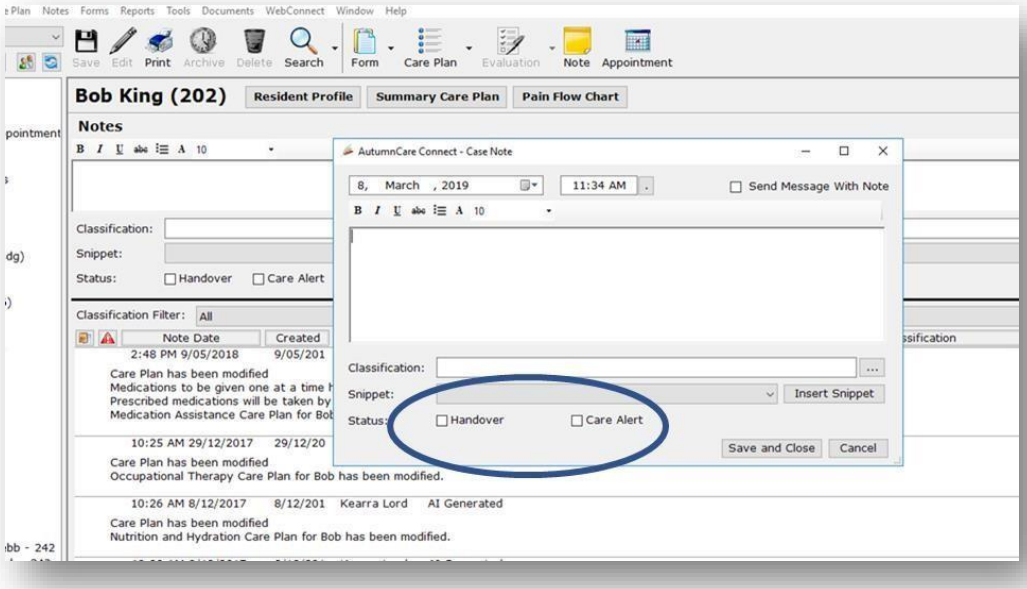
Creating alerts

Important information within the notes, should be ticked as handover and /or care alert in clients notes on A/C.

Care alerts are important clinical or care issues for the consumer : e.g. clients on warfarin, times for cytotoxic or other special medications etc. Care alerts show as an alert when you open a consumer 's file. You cannot access the file until you have read, acknowledged and ticked each alert.



Handover alerts are anything important that must be shared at handover. They will come up in red coloured font. Ticking this will also ensure it comes up in the interactive



handover.

Cleansing alerts

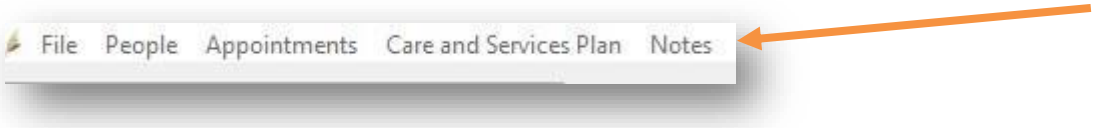
It is important to cleanse notes by removing ticks from Care Alerts and Handover when issues have been resolved, for example once bowels have opened. If this is not done, the information that comes up in alerts is not relevant and will create a risk where team members think it still is an issue or simply click through without reading any of the alerts thus creating "alert fatigue".

Handover

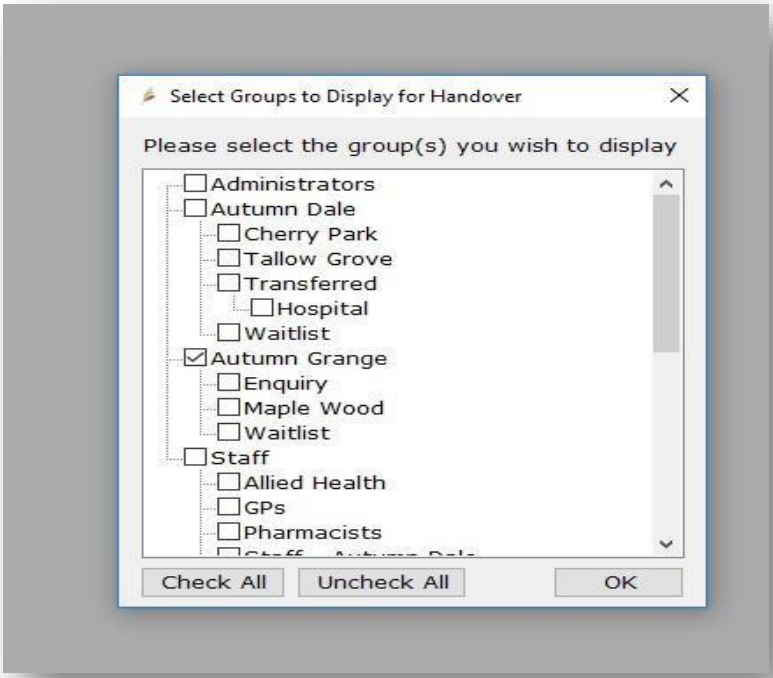
Using the Interactive Handover in AutumnCare

Handover is to be conducted as close to shift start time as reasonable. If the incoming team receive a printed copy of the interactive handover for referencing throughout the shift, these should be protected during the shift and placed in the document destruction bin at the end of each shift.

To run a handover report, all you have to do is go to Notes and select the area you want to create a handover report for:



Tick the area you want to create a handover for:



It will generate a list of handover items for each consumer .

You can then add a note from here or remove it from handover if no longer relevant. It is important to cleanse the report daily, in order to ensure handover is efficient and covers only relevant information.

Printing a Handover Report

How to print handover from a desk top

1. On Tool Bar across top of page, Click on Tools – Click on Add-ins – click on AutumnCare Report IQ.
2. In Report IQ, Click on New tab at the bottom of the page.
3. In Report Wizard, use filter by area - Click on area required for printing.
4. Click on Options tab at top of page – Click on Handover only in Flags section.
5. Click on Text tab at top of page – leave ticks in display option for show dates and show authors
6. Click on grouping- group by members in drop down box.
7. Click on print preview tab found at bottom of page – This will show you what will print
8. Click on print tab at top of screen.
9. Click properties –Click 2-sided print from drop down box, marked 2-sided print with down arrow
10. Then click ok tab at bottom of the page then ok again this should start printing.

How to print handover from a laptop

1. On Tool Bar across top of page, Click on Tools – Click on Add-ins – Click on AutumnCare Report IQ.
2. In Report IQ, Click on New tab at the bottom of the page.
3. In Report Wizard: Use filter by area - Click on area required for printing.
4. Click on Options tab at top of page – Click on Handover only in Flags section.
5. Click on Text tab at top of page – leave ticks in display option for show dates and show authors.
6. Click on grouping - group by members in drop down box.
7. Click on print preview tab found at bottom of page – This will show you what will print.
8. Click on print tab at top of screen.
9. Click Properties – Double sided printing - Click long edge.
10. Click ok tab at bottom of the page then ok again - this will start printing.

Agreed Care and Services Plan Review (ACASP) (RN)

Purpose

An Agreed Care and Service Plan Review (ACASP) is a meeting held between a consumer and/or their representative/s, and the team (Whiddon, MyLife Buddy, GP, Allied Health, etc.)

The aim of an ACASP is to identify clear goals of care for the consumer . It also provides a safe environment where issues and questions can be raised, and appropriate strategies agreed upon. Remember the consumer is the one who ultimately directs care. The ACASP needs to be planned, collaborative, consultative and in partnership.

Having everyone with a stake in a consumer 's care 'on the same page' is vital to achieve the best outcomes for the consumer .

When should an ACASP be organised?

- At least annually or as required or requested.
- If there is a sudden change in well-being that requires a multidisciplinary review.
- Post incident/s.
- Post return from Hospital.
- Concerns have been raised relating to the plan of care, by the consumer or their representative/s; family, friends, etc.… and resolution would benefit from a multi-disciplinary review.

Process - Planning

1. One person must coordinate and be accountable for the entire process.
2. Book date, time and location. Ensure the room is private, large enough for everyone to be seated comfortably.
3. Discuss attendees with the consumer and/or their chosen representatives to ensure they are aware and satisfied as to who is attending.
4. Invite all relevant people: consumer (and/or their family) and the team (Whiddon Team, MyLifeBuddy, GP, Allied Health, etc.…)
5. Collect and review relevant information prior to the meeting.
6. Be prepared.

Process - On the day

1. If possible have a minute taker, who is ideally an attendee, available to type directly into the Agreed Care and Service Plan Review form in AutumnCare.
2. Welcome and introductions.
3. Explain the reason for the meeting.
4. Go through a structured review, as guided by the ACASP and any other information gathered through step 4.
5. Give the consumer first opportunity to speak about what they want to achieve.
6. Agree on actions. If there is no consensus, schedule a follow up meeting so you have time to work on other possible solutions or escalate to Manager for support and guidance.
7. Wrap up: summarise agreements, disagreements, next steps and timeline.

Process – After the meeting

1. Ensure documentation is accurate and complete.
2. Update the ACASP.
3. Take immediate actions where possible (i.e. referrals).
4. Schedule in agreed tasks and follow up. Make sure all agreed actions are completed as agreed and within timeline.
5. Communicate back to the consumer and other attendees. If any items are delayed, communicate this back prior to the initially agreed date, and explain why there is a delay.
6. Complete the ACASP form in AutumnCare to record actual actions and outcomes.

You can watch this video about case conferencing. The example is about end of life. It also covers Advance Care Planning. The video is 14 minutes long & is well worth watching.

Transfers to Hospital

Follow emergency and first aid protocols for emergency transfers.

The consumer 's person for notification needs to be informed of the incident and the consumer 's transfer,

including the location of the hospital if known.

If the consumer 's person for notification is not able to be notified document this in the notes and handover for the next team to attempt to contact the person for notification at regular intervals The RN to complete documents which are to be sent with the client to hospital including:

- AutumnCare Summary Agreed Care and Services Plan printed in landscape
- AutumnCare Hospital Transfer form with comprehensive reason for transfer
- AutumnCare Profile/ Customer details page printed in Landscape
- Copy of all medication charts.
- Other relevant documents – see Hospital Transfer form. Complete the relevant Incident Forms.

The RN to comprehensively and objectively document the Incident in the consumer 's notes including:

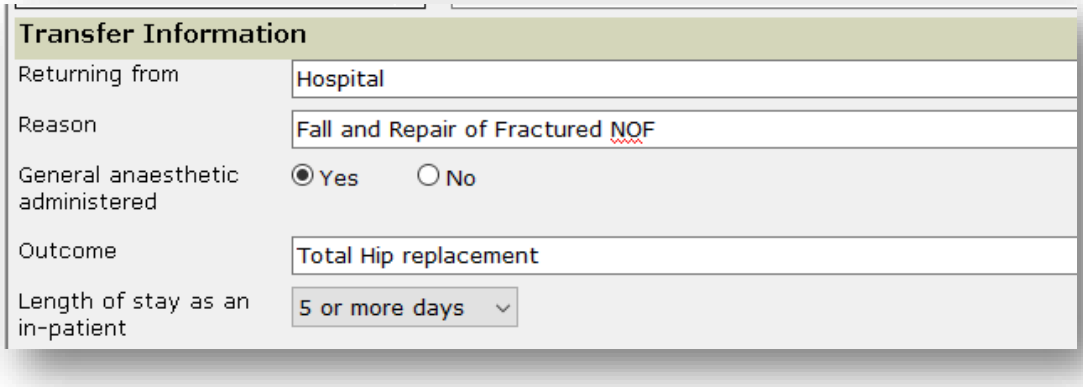
- Overview of the event
- Time of event with calls noted to ambulance service and family
- Any forms and documents attended
- Observations must be taken. E.g. BP/TPR/BGL/O2 Sats / Neuro obs

The RN to advise the Manager in the event of serious injury/ trauma/ fracture if not already aware

Transfer from Hospital

- RN to complete the **Return from Hospital Checklist in Autumn Care**. *Please note

this replaces the 'Consumer Returning from Hospital Checklist' with additional



required fields, namely 'general anaesthetic' and 'length of stay'.

- This checklist will prompt staff to complete all required steps including notifying the kitchen, pharmacy, attending clinical assessments, etc. For example, attend a top to toe assessment and record any new skin issues (i.e. pressure injury). If there is a skin injury complete an incident report
- RN to ensure Next of Kin / person responsible is aware of the Consumer's return.
- RN to update relevant assessments, generate new Agreed Care and Services Plan, if changes.
- GP to be notified of the person's arrival and asked to review for any changes, i.e. change in client's medications.
- Notify any other relevant health professionals, i.e. allied health.
- Ensure the person's return is discussed at handover.
- Organise a case conference, if relevant.

Transfer to another care provider or Whiddon service

The RN to complete documents which are to be sent with the client:

- Autumn Care Summary Agreed Care and Services Plan printed in landscape
- Autumn Care Hospital Transfer form with comprehensive reason for transfer
- Autumn Care Consumer/ Profile page printed in Landscape
- Copy of all medication charts.
- Complete the Discharge/Transfer form in Autumn Care.
- Ensure documentation is complete and accurate.
- Handover to the team.
- Provide emotional support to the person's representative/s and team.
- Change consumer status in Autumn Care.
- Organise for any paper files to be archived.

- ACFI documentation as requested by the new provider

Discharge due to Death

- Provide emotional support to the person's representative/s and team. Particularly the consumer's My Life buddy. Document this in notes.
- Discharge due to death requires Verification of Death Form to be completed (if death occurred at the service).
- RN to complete a consumer incident form in AutumnCare (tick option death) Ensure documentation is complete and accurate.
- Handover to the team.
- Management team to complete the death screening tool in step 8 of the eQstats record.
- Management to complete Critical investigation if required.
- Admin/ management team to change consumer status in Autumn Care after completing the death screening tool.
- Organise for any paper files to be archived.

Discharge due to return Home or permanent transfer to Hospital

- Complete Discharge / Transfer Form and provide a copy to the consumer.
- Copy medication charts and provide to consumer.
- Return all personal belongings, medications, and valuables.
- Provide Summary Agreed Care and Services Plan if transferring to Hospital. Change consumer status in Autumn Care.
- Organise for any paper files to be archived.
- Complete the Discharge/Transfer form in Autumn Care Ensure documentation is complete and accurate.
- Handover to the team.

Autumn Care Messages

Autumn Care messages can be used for communicating between team members and groups.

The system will tell you if you have any unacknowledged messages. All team members must read their messages every time they log in.

It is important to know that Autumn Care messages do not save into a consumer 's specific file, so they should not be used for this.

Autumn Care messages will delete after a certain amount of time. You can choose a timeframe when creating it, or it will be automatic.

Autumn Care Reports

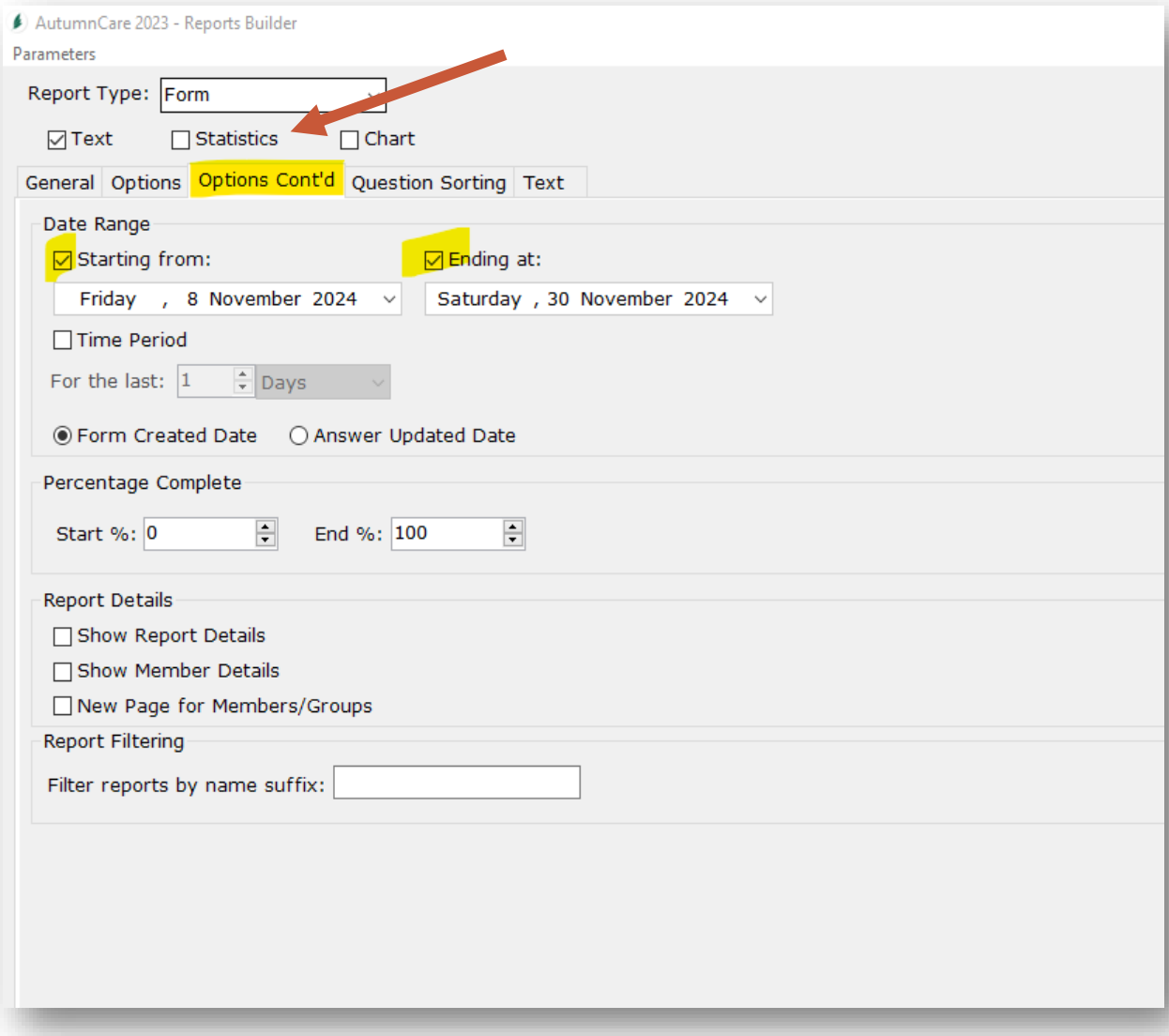
There are a number of reports available in the AutumnCare report drop menu located at

the top of the screen. The reports have been specifically developed to assist with workflows and to improve clinical oversight.

It is important to note that each site must choose or enter the date range required for the specific report

e.g. 1 November 2024 to 30 November 2024 will limit the report to show results specific to the month of November 2024 or choosing to run the report for the past 1-month period if the report is being created on the 1st day of that specific month.

This can be done easily by selecting the date range in the option Cont'd menu.



Reports included in the AutumnCare Report menu include:

Report	Rationale for Report	What is included in report
Compliance Report Air Mattress	To ensure that the consumer 's current weight is compatible with air mattress settings.	Includes consumer s currently assessed as requiring a pressure relieving device and current weight.
Compliance Report Consumer of the Day (Date Last Completed)	To ensure that all consumer s have had a consumer of the day form completed each month.	Report will indicate the date that the last COD was completed
Compliance Report Diet and Fluids	To guide food service (can be printed on A3 and add to servery).	Includes allergies, diet and preferred diet size, fluids, Supplements and special diet types
Compliance Report Restrictive Practice	To identify all restraint types and next review dates.	Includes a description of the restraint being used, the reason for restraint and the next review date.
Compliance Report Wounds	To identify wounds that require review by an RN and a list of next dressing change dates.	Includes wound types, next wound review date, pressure injury stage, and next dressing change date.
Daily Report 5-day Bowel record (Bristol Stool Chart Description)	To identify consumer s at risk of constipation based on date of last bowel motion, size and consistency	Includes bowel chart information yes/ no and column entries with coding as per Bristol stool chart for the past 5 days.
Incomplete Consumer of the Day (<99% Complete)	To identify incomplete consumer of the day forms.	The report will show incomplete COD forms (less than 99% complete)
Incomplete Incident "Falls" Form Report (<99% Complete)	To identify incomplete falls incidents that require further review.	Select a date range: Incident form-falls that are less than 99% complete.
Incomplete Infection Record Report (<99% Complete)	To identify incomplete infection notification forms that require further review.	Select date range. Infection notification forms that are less than 99% complete

Report	Rationale for Report	What is included in report
Medical Directive Anticoagulant	To identify consumer 's prescribed anticoagulant medications and prescribed monitoring/ strategies to manage specific needs.	Indication for anticoagulant therapy, therapeutic range and frequency of INR
Medical Directive Blood Pressure Monitoring	To guide teams to attend BPs as documented on the BP medical directive	BP type (hyper/ hypo) BP ranges, and days of the week
Medical Directive Diabetes Management	To guide teams to attend BGL's as documented on the diabetes medical directive.	Diabetes type, and days of the week BGL's to be attended, and recommended ranges.
CHC Catheter Management	To identify consumer s with a catheter and dates for next catheter changes.	Catheter size, date of insertion and date of next catheter change
CHC CPAP Management	To identify consumer s with a CPAP and guide cleaning instructions	All current: mask size, type and cleaning instructions
CHC Enteral Feeding Management	To identify consumer s receiving enteral feeding and guide next enteral feed change dates	All current- reason for enteral feeding, type of enteral feeding, next date for enteral feeding tube change.
CHC Oxygen Management	To identify consumer s receiving oxygen – cleaning instructions for concentrators	All current, reason for requiring oxygen, date of commencement, continuous, PRN, concentrator
CHC Stoma Care	To identify consumer s with a stoma and guide care	Stoma type and care procedures
Compliance Behaviour Chart Monitoring	To assist with planning and reviewing strategies	Past 7 days: Date, time, behaviour, triggers, interventions and comments
Compliance Weight	To aid weight review and analysis	Weight columns for the past 3- 6 months (date range required)
KPI Infections	To aid data collection and improve review and analysis (date range needed)	Type of infection and date infection reported- date range required
KPI Injury	To aid data collection and improve review and analysis (date range needed)	Injuries reported and types of injuries

Report	Rationale for Report	What is included in report
KPI Medications	To aid data collection and improve review and analysis	Medication incidents (reason for error) – date range required
KPI Transfers to Hospital	To aid data collection and improve review and analysis	Hospital transfers – date range required
KPI Wound Acute or Chronic	To aid data collection and improve review and analysis	List of current chronic and acute wounds
KPI Falls	To aid data collection and improve review and analysis	Falls occurring- date range required
LL Country of Birth and Religion	Aid data collection for Lifestyle team	Country of birth and religion
NQI Skin Assessment last date completed	Aid data collection when performing NQI	Assist with identify skin assessments attended din the past 3-month period

Reviewing AutumnCare Reports

The report matrix provides the recommended frequency as to when these reports should be reviewed.

Report	Daily	Weekly	Monthly
Compliance Report Air Mattress		√	
Compliance Report Consumer of the Day (Date Last Completed)		√	
Compliance Report Diet and Fluids		√	
Compliance Report Restrictive Practice			√
Compliance Report Wounds	√		
Compliance weight			√
Daily Report 5-day Bowel record (Bristol	√		

Report	Daily	Weekly	Monthly
Stool Chart Description)			
Incomplete Consumer of the Day (<99% Complete)		√	
Incomplete Incident "Falls" Form Report (<99% Complete)		√	
Incomplete Infection Record Report (<99% Complete)		√	
Medical Directive Anticoagulant			√
Medical Directive Blood Pressure Monitoring			√
Medical Directive Diabetes Management			√
CHC Catheter Management			√
CHC CPAP Management			√
CHC Enteral Feeding Management			√
CHC Oxygen Management			√
CHC Stoma Care			√
KPI Infections			√
KPI Injury			√

Report	Daily	Weekly	Monthly
KPI Medications			√
KPI Transfers to Hospital			√
KPI Wound Acute or Chronic			√
KPI Falls			√
NQI Skin Assessment last date completed			Quarterly

References

Australian Government, Aged Care Act 1997, <https://www.legislation.gov.au/Series/C2004A05206 > accessed November 2024

Australian Government, Privacy Act 1988, < https://www.legislation.gov.au/Series/C2004A03712 > accessed November 2024

Australian Government, Australian Privacy Principles https://www.oaic.gov.au/agencies-and-organisations/app-guidelines/ > accessed November 2024

Australian Government, User Rights Principles 2014, < https://www.legislation.gov.au/Details/F2014L00808 > accessed November 2024

Care Search palliative care knowledge network Family Meetings - Working with Families - Clinical Care - Nurses - Health Professionals> accessed November 2024

Case Conferences in consumer Residential Aged Care> accessed November 2024

Documentation-Checklist.pdf> accessed November 2024

Monika Blazewicz, 2017: 'Assessment and clinical reasoning' PPT.

NSW Health Capacity and the law - FAQs > accessed November 2024

NSW Trustee and Guardian, < https://www.tag.nsw.gov.au/enduring-guardianship.html > accessed November 2024

Nursing and Midwifery Board of Australia, RN and EN 'Standards for practice'

Palliative Care Aged Care Service Case Conferences in Practice > accessed November 2024

QLD Office of the Public Guardian : What is impaired decision-making capacity? > accessed November 2024

Sinclair, C., Field, S., & Blake, M. (2018). Supported decision-making in aged care: A policy development guideline for aged care providers in Australia. (2nd Edition) Sydney: Cognitive Decline Partnership Centre.

Sinclair, C., Field, S., & Blake, M. (2018). Supported decision-making in aged > accessed November 2024

NSW Nurses and Midwives Association Australian Nursing and Midwifery Federation NSW Branch 'Guidelines on Documentation and Electronic Documentation'. Re endorsed 2021

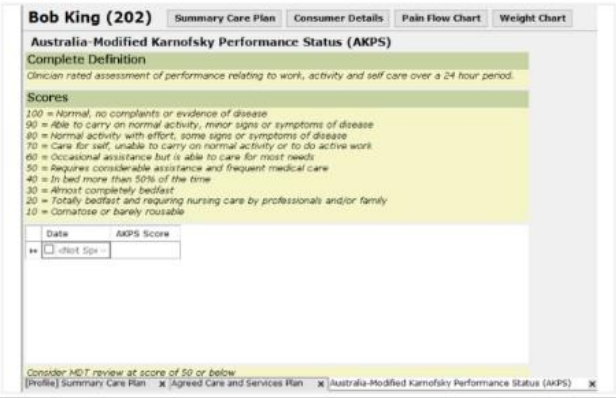
NSW Health Policy Directive: 'Subpoenas'. r PD2019_001 Publication date 08 January 2019 Review 08 January 2024 Status Active

AN-ACC Forms to be completed

The below forms to be completed within 1 week of admission.

1

AN-ACC Funding Simulator



2

Australian Modified Karnofsky Performance Status

This assessment measures a consumer's overall performance ability related to work, activity, and self-care. This is a tool that assigns a status to a consumer based on observations on their ability which ranges from 'normal' to 'comatose or barely rousable'.

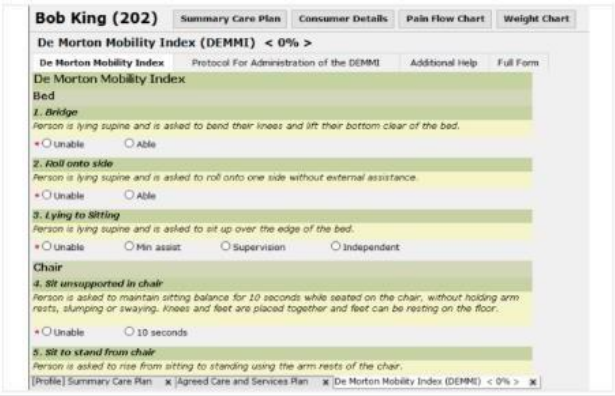
This form is designed in a grid to track changes over time.

3

BRUA Behaviour Resource Utilisation Assessment

This tool is designed to capture the implications of the consumer's behaviour for carers and service providers, in terms of the levels of monitoring and supervision required.

The tool is designed to rate what a consumer does rather than what they are capable of doing, using 5 categories - problem wandering or intrusive behaviour, verbally disruptive or noisy, physically aggressive, or inappropriate, emotional dependence and danger to self or others.

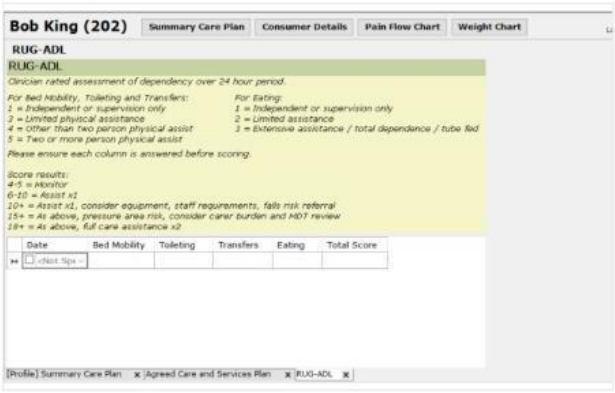


4

De Morton Mobility Index (DEMMI)

The DEMMI is a measure of physical function in older adults. The mobility activities are conducted sequentially from easiest to hardest to assist clinicians to determine whether assistance with mobility is required for that consumer. These activities range from bed, chair, static balance, walking and dynamic balance. This tool scores the consumer from 0 to 100, 0 indicating very poor mobility and 100 indicating independent mobility.

The results from a non-archived form will display in the AN-ACC Funding Simulator.



5

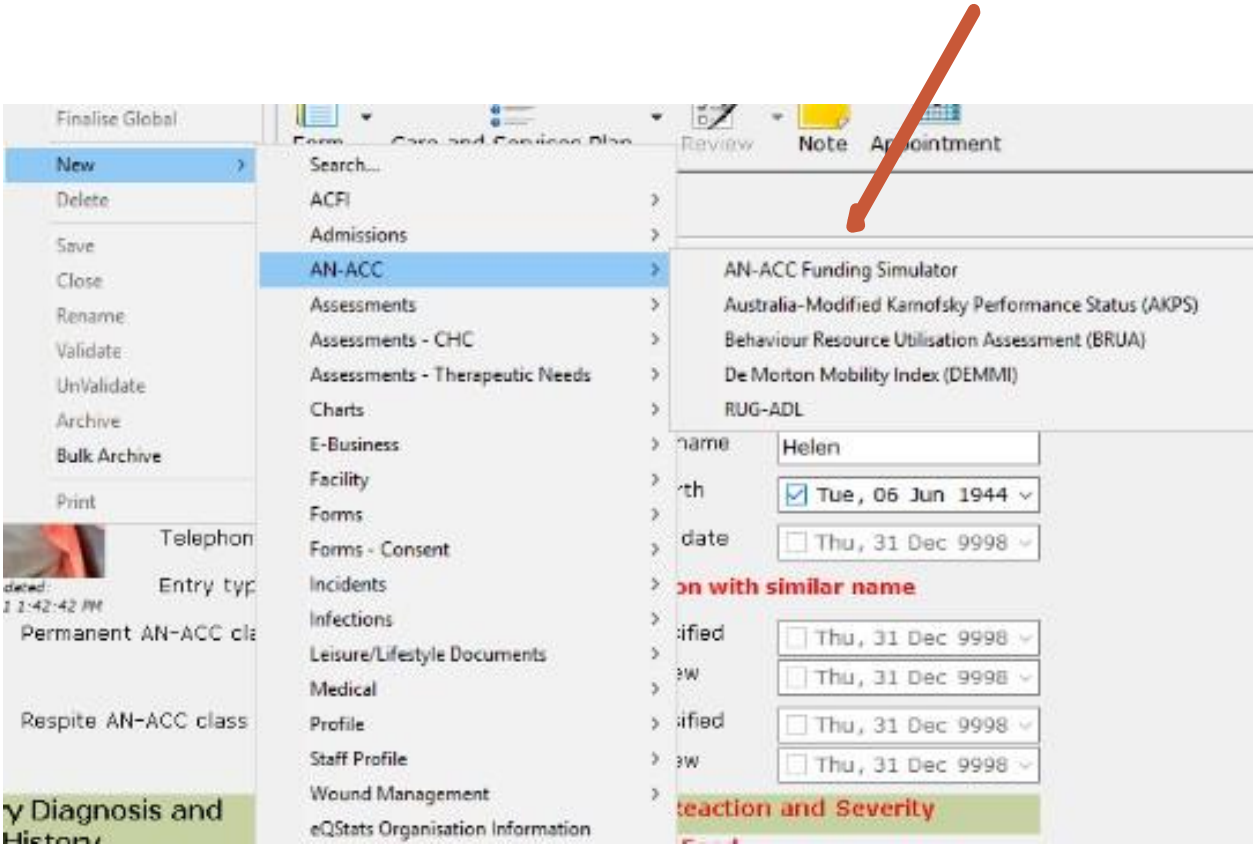
Resource Utilisation Group - Activities of Daily Living (RUG-ADL)

This is a scale that measures a consumer's motor function ability for activities of daily living, incorporating Bed Mobility, Toileting, Transfers and Eating. This is a clinician rated assessment of dependency over a 24-hour period. Each element requires a recorded level of functioning as per the legend in the yellow text. The levels are then combined to produce a score that indicates a consumer's need for assistance with ADLs.

The latest results from a non-archived form will display in the AN-ACC Funding Simulator.

Made with TechSmith Snagit

AN-ACC Forms can be found under Forms/New/AN-ACC



Appendix B Case Conference Guidelines Residential Care

A case conference in is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. This case manager coordinates the health care team and services involved in the care and support of the older person and their family. Complex care requiring a range of providers can also be supported. In the delivery of a palliative approach, a multidisciplinary team is generally needed to provide holistic care

Case Conference Checklist

Specialist Palliative Care

If an older person is involved with a palliative care service, they may already have structures and processes to support palliative care case conferences. Contact the service provider to find out how they organise case conferences for patients.

Conducting the Palliative Care Case Conference in a Residential Aged Care setting

A structured process can make the case conference more useful. Introductions (take the time to orientate the participants)

- Have the RAC staff and GP introduce themselves and you and invite others to introduce themselves stating their role on the team.
- Review the meeting's goals and clarify specific decisions that will need to be made before the case conference ends.
- Establish ground rules for conducting the conversation in a non-patronising or threatening way. For example, you might begin:
  'We would like to hear from all of you. However, if possible, could one person please speak at a time?
  Each person will have a chance to ask questions and express their views.'

Identify the legal decision maker

- Remember that if the older person is competent, they are the legal decision maker.
- If there are nominated substitute decision makers attending and the older person is competent, the substitute decision maker may assist but is not to be the person deferred to for decision-making unless the older person indicates that this is their preference.
- If the older person does not have decision-making capacity, then the designated substitute decision-maker or 'person responsible' should be referred to with regard to decision-making.

Determine what the older person / family already knows

- Have the GP ask: *'What is your understanding of your current medical condition?'*
- The GP should ask about the past one to six months: what has changed (e.g., functional decline, weight loss, recent hospital admissions, changes to medications).

- The GP or Residential aged care nurse should seek to identify the preferences of the older person and family regarding how much detail they wish to be told about the trajectory of dying with the illness.
- Review the current status, prognosis and treatment options for the specific disease(s).
- Allow all healthcare professionals to have their say about what they consider beneficial or non-beneficial treatment under the circumstances.
- Review any issues that arise from the older person, family or healthcare team members.
- Inquire about family circumstances and resources and what will be required from them in the remaining time that is left.
- Ask the older person and their family separately and in turn if they have any questions about the current status, prognosis and treatment options of the disease.

Decision-making (when the older person is competent)

- The GP should ask the older person: *'What decision(s) about your healthcare, lifestyle or medical treatments are you considering?'*
- The GP or Residential aged care nurse should ask each family member: *'Do you have questions or concerns about the plan being discussed?'*
- Ask each family member: *'How can you support the older person?'*

Decision-making (when the older person is deemed not to have decision-making capacity)

- Ask each family member in turn: *'What do you believe this person would choose if they could speak for themselves?'*
- Ask each family member: *'What do you think should be done?'*
- Ask the family if they would like the case management team to leave the room to allow a private family discussion.
- When the care management team returns, confirm with the family the decisions that have been made.

When there is no consensus between parties at the case conference:

- Use time as an ally: schedule a follow-up conference in the near future.
- Try further discussion if time permits and people are agreeable:
    - *'What values are your decisions based upon?'*
    - *'How will the decision affect you and other family members?'*
    - *'What would the consumer say if they could speak?'*
- Identify other resources to facilitate decision-making (e.g. spiritual / religious affiliations) CareSearch resources for nurses and palliAGED resources for family members.

Wrapping up the case conference

- Summarise consensus, disagreements and decisions.
- Outline action plan and the outline of the care plan.
- Caution against unexpected outcomes.
- Identify substitute decision maker or person responsible required for ongoing communication if the older palliative consumer is not competent or does not wish to enter into further decision-making.

Writing it down

It is important to document the key issues and outcomes of the case conference as well as provide this information to participants of the conference:

- Complete a palliAGED has a Case Conference Summary form (122kb pdf)
- Offer a copy of the conference summary to the older person and/or family members, general practitioner and relevant others.
- Amend the person's care plan to reflect the outcomes and action plan from the case conference.
- Provide any written information that you feel would assist the older person and/or family in relation to issues that were raised during the case conference.
- Add an entry to the consumer 's record that a case conference was held.

It should be made clear who is to be responsible for actions / tasks and when these actions/tasks are expected to be resolved or completed. Consider whether someone needs to be made responsible for follow up.

Source palliAGED Nurse – Case Conferences in Residential Care

Appendix C Documentation Requirement Guide

- Reflects the application of the nursing process.
- Assessment, interpretation of findings (analysis) and diagnosis.
    - Includes subjective data (client perspective).
    - Includes objective data (assessment/analysis).
- Plan of care which considers the client's needs, circumstances, preferences, values, abilities and culture, and supports the client in self-management of care.
- Implementation of intervention.
- Evaluation and modification of the care plan.
- Critical inquiry (e.g. identifying cause and effect relationships and distinguishing between relevant and irrelevant data).
- Consultations and referrals including provider's full name, designation and organization.
- Includes the process used to get informed consent and any signed consent forms. Includes the discharge planning and discharge information (e.g. potential barriers to discharge, referrals required to facilitate discharge, client's condition at discharge, teaching or education for self-care and any follow-up appointments).
- Is client-centred
- Includes communication with the client's family or other significant supports.
- Includes telephone health advice provided.
- Includes health education and psychosocial support provided.
- Uses permanent ink and is written legibly. Does not have blank lines. (if handwritten)
- Records events in the order they occurred.
- Records the date and time of each professional interaction or contact (i.e. the date is written in full by month-day-year (e.g. October 9, 2024, at 2010 hrs. instead of 9/10/24 at 8:10) or as outlined in organisational policy).
- Documents as close to real time as possible in order to ensure accuracy of details and timely communication to the team.
- Does not include pre-charted information (i.e. documentation was recorded at the time care was provided so that it is credible and accountable).
- Includes signature and designation in both handwritten and electronic versions (e.g. RN, EN or RN(NP)).
- Education credentials are optional.
- Uses professional language and terminology.
- Avoids abbreviations as they may not be understood and can be misinterpreted.
- Only includes notes of the care provided individually by the writer (an exception to this rule may occur in the role of designated recorder during an emergency event
- Does not include bias (documented conclusions that can be supported by data)

Source Documentation-Checklist. Registered Nurse of Manitoba

End of document