CHCCCS011
Meet personal support needs

Learner Guide

Student Name:
# Table of Contents

How to study this unit................................................................................................................. 4
Element 1: Determine personal support requirements................................................................. 7
Reviewing individualised plan and confirming required equipment, processes and aids............ 7
Methods of assessment .................................................................................................................. 7
Reviewing past assessments .......................................................................................................... 8
Personal care plans ....................................................................................................................... 9
Identifying needs .......................................................................................................................... 9
Confirming required equipment, processes and aids ................................................................. 12
Continence aids .......................................................................................................................... 16
Personal audio-visual aids .......................................................................................................... 17
Identifying requirements outside of scope of own role and seek support from relevant people 20
Seeking assistance due to the limitations of your work role .................................................... 20
Considering the potential impact that provision of personal support may have on the person and confirming with supervisor .......................................................... 22
Considering specific cultural needs of the person ................................................................. 23
Considering specific physical and sensory needs of the person ............................................... 26
Developmental disabilities ........................................................................................................ 27
Autism spectrum disorder ....................................................................................................... 27
Intellectual disability ............................................................................................................... 28
Dual diagnosis ......................................................................................................................... 29
Sensory disability ...................................................................................................................... 29
Neurological impairment ........................................................................................................... 30
Cerebral Palsy .......................................................................................................................... 30
Spina Bifida .............................................................................................................................. 31
Muscular dystrophy .................................................................................................................. 31
Multiple sclerosis (MS) ............................................................................................................. 31
Chronic health disorders ......................................................................................................... 32
ABI Acquired brain injury ......................................................................................................... 32
Communication disabilities ...................................................................................................... 33
Models of disability .................................................................................................................. 34
Identifying risks associated with the provision of support and confirming with supervisor 36
Conducting an environmental risk assessment for functions associated with personal care needs 36
Dignity of risk ............................................................................................................................ 38
Element 2: Maximise participation ............................................................................................ 40
Discussing and confirming person’s own preferences for personal support in a positive way .. 40
Considering and confirming the person’s level of participation in meeting their personal support needs ................................................................. 40
Providing the person with information to assist them in meeting their own personal support needs ... 48
Identifying other services ........................................................................................................... 48
Support services provided by the community services sector .................................................. 51
Home Care (consumer directed care) and Community Care services ..................................... 53
Home care packages ................................................................................................................. 54
Residential Aged Care Facilities ............................................................................................... 56
Element 3: Provide personal support ....................................................................................... 57
Safely preparing for each task and adjust any equipment, aids and appliances ....................... 57
Manual handling techniques for patients and residents .......................................................... 58
Mobility and transfer ................................................................................................................. 61
Taking account of identified risks in the provision of personal support and technical support activities ................................................................................................................. 63
Assisting with catheter care ...................................................................................................... 69
Wound care ............................................................................................................................. 73
Care and prevention of pressure ulcers ...................................................................................... 73
Amputation and stump care ...................................................................................................... 74
Identifying and responding to routine difficulties during support routines, and report more complex problems to supervisor ................................................................. 76
Identifying changes in the person’s health or personal support requirements and report to supervisor ................................................................................................................. 77
Personal support care ............................................................................................................. 79
Bathing and showering ............................................................................................................ 82
Nail care ................................................................................................................................. 86
Pressure area care ................................................................................................................... 87
Amputation and stump care ...................................................................................................... 74

CHCCCS011 Meet personal support needs
Version 1 December 2015
ITS (Aust) Pty Ltd
Page 2 of 146
Circulatory system: Responsibilities of aged care and health support workers and practical aspects of management ................................................................. 91
Falls: Responsibilities of aged care and health support workers and practical aspects of management ................................................................. 92
Caring for a person who is visually impaired ................................................................. 92
Dementia: Implications for aged care and health support workers ................................. 93
Mental health conditions: Implications for aged care and health support workers ............. 95
Integumentary system: Responsibilities of aged care and health support workers and practical aspects of management ................................................................. 96
Integumentary system: Responsibilities of aged care and health support workers and practical aspects of management ................................................................. 97
Gastrointestinal tract: common health problems .............................................................. 98
The immune system: common health problems .............................................................. 99
Endocrine system: common health problems ............................................................... 100
Reproductive system: common health problems ........................................................... 100
Reproductive system: Responsibilities of aged care or health support workers and practical aspects of management ................................................................. 101
Infection control procedures .......................................................................................... 104
How infection spreads – the Chain of Infection .............................................................. 105
Types of infection risks .................................................................................................. 107
Follow hand-washing procedures .................................................................................. 109
Ten ............................................................................................................................... 111
Identifying changes in the person’s health or personal support requirements and report to supervisor ............................................................................................... 111
Working with the person and supervisor to identify required changes to processes and aids ........................................................................................................ 115
Maintaining confidentiality, privacy and dignity of the person .......................................... 118
Performing work to the standard required by the organisation ........................................ 119
Element 4: Complete reporting and documentation ........................................................ 121
Complying with the organisation’s reporting requirements, including reporting observations to supervisor .................................................................................................. 121
Types of documentation ................................................................................................ 124
Completing and maintaining documentation according to organisation policy and protocols ........................................................................................................ 127
Expected standards ........................................................................................................ 130
Adhering to legal requirements in work practice according to workplace policies and procedures and scope of role .................................................................................................. 131
Legislation ................................................................................................................... 131
Medication Legislation and Regulations ......................................................................... 132
Western Australian Legislation ..................................................................................... 134
Regulations and Standards ........................................................................................... 135
The Australian Council on Healthcare Standards (ACHS) ............................................ 135
Duty of care ................................................................................................................... 136
Boundaries, roles and responsibilities ............................................................................ 137
Storing information according to organisation policy and protocols ............................... 140
Computerised records .................................................................................................. 145
Bibliography .................................................................................................................. 146

Copyrigh © This work is copyright. Apart from any use as permitted under the Copyright Act 1968 (Amendment Act 2006), no part may be reproduced by any process without prior written permission of the author Andrea Kelly - Resource Learning: www.resourcelearning.com.au
How to study this unit

You will find review learning activities at the end of each section. The learning activities in this resource are designed to assist you to learn and successfully complete assessment tasks. If you are unsure of any of the information or activities, ask your trainer or workplace supervisor for help.

The participant will be required to demonstrate competence through the following means:

Methods of assessment

- Observation in the work place
- Written assignments/projects
- Case study and scenario analysis
- Questioning
- Role play simulation
- Learning activities
- Class discussion and group role-plays
- Assessment tasks

Asking for help

If you have any difficulties with any part of this unit, contact your facilitator. It is important to ask for help if you need it. Discussing your work with your facilitator is considered an important part of the training process.

Name of facilitator: __________________________ Phone number: __________________
### Welcome to the unit CHCCCS011 Meet personal support needs, which forms part of the 2015 Community services training package.

This unit describes the skills and knowledge required to determine and respond to an individual's physical personal support needs and to support activities of daily living. This unit applies to workers who provide support to people according to an established individualised plan in any community services context. Work performed requires some discretion and judgement and may be carried out under regular direct or indirect supervision.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

### WHAT YOU WILL LEARN

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>PERFORMANCE CRITERIA</th>
</tr>
</thead>
</table>
| **Element 1: Determine personal support requirements** | 1.1 Review individualised plan and confirm required equipment, processes and aids  
1.2 Identify requirements outside of scope of own role and seek support from relevant people  
1.3 Consider the potential impact that provision of personal support may have on the person and confirm with supervisor  
1.4 Consider specific cultural needs of the person  
1.5 Consider specific physical and sensory needs of the person  
1.6 Identify risks associated with the provision of support and confirm with supervisor |
| **Element 2: Maximise participation** | 2.1 Discuss and confirm person’s own preferences for personal support in a positive way  
2.2 Consider and confirm the person’s level of participation in meeting their personal support needs  
2.3 Provide the person with information to assist them in meeting their own personal support needs |
| **Element 3: Provide personal support** | 3.1 Safely prepare for each task and adjust any equipment, aids and appliances  
3.2 Take account of identified risks in the provision of personal support and technical support activities  
3.3 Identify and respond to routine difficulties during support routines, and report more complex problems to supervisor  
3.4 Identify changes in the person’s health or personal support requirements and report to supervisor  
3.5 Work with the person and supervisor to identify required changes to processes and aids  
3.6 Maintain confidentiality, privacy and dignity of the person |
<table>
<thead>
<tr>
<th>Element 4: Complete reporting and documentation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Comply with the organisation’s reporting requirements, including reporting observations to supervisor</td>
<td></td>
</tr>
<tr>
<td>4.2 Complete and maintain documentation according to organisation policy and protocols</td>
<td></td>
</tr>
<tr>
<td>4.3 Store information according to organisation policy and protocols</td>
<td></td>
</tr>
</tbody>
</table>
Element 1: Determine personal support requirements

Reviewing individualised plan and confirming required equipment, processes and aids

As an aged care, or health support worker, it is important that you can identify and meet the needs of your client. It is the care workers role to support elderly people to care for themselves in all matters of personal care. The amount of assistance you need to give will depend on the client’s independence level. Sometimes you may think it takes forever for the client to achieve what it would take you only a few minutes, however our focus is on maintaining the client’s level of independence as much as possible, and being patient and enthusiastic during a personal care routine is very important. Minimal touch and ensuring the client’s dignity is extremely important.

There can be a number of reasons a personal-care-needs assessment may be undertaken but whatever the reason, it involves gathering data which will assist in determining the resident’s capabilities and needs. A care plan is usually developed as part of the person’s individual plan. Once the data are analysed or carefully studied they can be turned into the information needed to clearly state those needs and give a good indication of how the needs can be met. It is important to have an understanding of a care plan needs assessment so you can appropriately explain its purpose to the client. You also need to understand any funding or legal requirements in conducting personal care needs assessments as these form additional reasons for undertaking this process.

There may be different purposes behind such assessments dependent upon the situation such as:
- People living in a residential care environment
- People living in the community.

Methods of assessment

An assessment is the process of gathering information to identify care needs, so therefore an assessment incidentally identifies existing skills. For example, the assessment may identify that a person requires support to shower but can toilet themselves independently.

Interviewing

Interviewing or making formal times to talk with the person is a good place to start when assessing existing skills. The first step in interviewing someone is to establish a relationship with them. The worker has to take the lead in making sure that the relationship is established successfully.

Once you have spent time getting to know your client as their carer and informing them of your role and the goal of assessment, you can begin to ask a range of questions that will help you and your client get the information you both need to help you assess existing skills. Sometimes people believe they have greater skills than they actually possess, or the opposite, where they can do more for themselves than they admit. It is therefore important to work with the person in determining the facts, and not use interviewing as the only form of assessment.
**Observation**

Another way to get information is by observing the person. Obviously you need to tell them that you will be observing them and why—everyone has the right to privacy and if we are going to violate that, we must ask their permission or at the very least tell them that we like to help find out what peoples’ needs are by observing them. Observation can be a good way to back up what you and the person have already talked about. You can assess whether or not you think they are competent in what they are doing or if they need some help to become more competent.

**Talking with significant others**

To add to your picture of what existing skills a person has, you can also talk to significant others in their lives (provided that you have permission from the person you are supporting). Significant others can include family (parents and siblings), friends, carers, advocates and support workers. These people often know the person well and have had lots of opportunities to observe and think about what needs and skills they have.

**Screening tests**

Screening tests are yet another way to identify needs and existing skills. There are a range of screening tests that people can take to help you work out their needs. Professionals such as speech pathologists, occupational therapists and physiotherapists carry out a number of these tests. These professionals are specialists who concentrate on one aspect of a person’s development or impairment. A speech pathologist, for example, will focus on a person’s swallowing where as a physiotherapist will focus on a person’s movement. As a support worker, you might conduct task analyses and baseline assessments to get more information about the person you are working with.

**Reviewing past assessments**

The last main way to help someone to assess their needs is to look at past assessments (however, it’s important to first get permission from the person you are supporting). Some workers in fact will start their assessments by reviewing past ones.

**When past assessments can be a problem**

There can be huge problems with using past assessments as a starting point.

**Some of these problems are:**

- We don’t necessarily know how accurate the past assessments were
- We don’t know how involved the person was in the process
- The past assessor might not have worried too much about what they wrote down about the person; that is, they might not have said what was fact or opinion
- The past assessor might have relied on talking only to the people who care for the person. We may not know if they had ever even seen and spoken to the person
- In the past, some workers felt that they knew best and decided themselves what the person needed—they didn’t believe that they knew what they wanted or needed
- Other workers felt that they could make assessments based on a disability or the person’s age; that is, they treated the disability and didn’t work with the person who just happened to have a disability.

Choosing past assessments as a starting point can colour our assessment of the person we are supporting and prevent us from getting to know them as they are now. As you can see, there can be many problems associated with reviewing past assessments. This doesn’t mean that we should ignore them (though some should be destroyed immediately!). It just means that we should be aware of the problems involved in relying on these past assessments.
When past assessments can be useful

A well-researched and well-written assessment can be a great reference point. We can use past assessments as a basis for measuring change and progress and for showing the person their progress or goals they have not met and seeing if they were realistic. We can also use past assessments to see if we are providing the best services possible and to see how we can improve the way we work.

Personal care plans

A care plan consists of the directions that you follow when you look after a resident. The individualised care plan is a comprehensive informative document that maps out all areas of care for carers to follow. A care plan is developed when a client enters the service and when/if their condition changes. They also are reviewed and updated on a regular basis. It is very important that the client’s preferences are documented in the care plan. For example when they like to wash, what type of activities they like to do, what kind of foods they like to eat, what religion they are and even what funeral arrangements that wish for, and so on.

Identifying needs

When identifying needs it is important to note real needs. For example, dementia in itself may be a problem, but how and in what areas does it impact on the client’s ability to carry out activities of daily living and their ability to function independently? That is the client’s real need. Needs can be actual or potential; that is, a client may have an actual problem, or may be ‘at risk’ of developing a problem if certain strategies or interventions are not carried out. An example may be a client who has urinary incontinence. If certain interventions are not put in place, that client is ‘at risk’ or has the ‘potential’ to develop skin problems.

Therefore they may have an identified need of: ‘potential for skin integrity breakdown related to urinary incontinence’ or ‘at risk of skin integrity breakdown related to urinary incontinence’.

We do need to know why the client is not able to carry out functions without support or assistance in order to be able to plan strategies. It is difficult to rectify a problem if we do not know what causes it. For every need or problem there must be a reason. An example of a need/problem and its cause may be: ‘inability to complete personal hygiene independently related to cognitive impairment’. The problem is ‘inability to complete personal hygiene independently’ and the reason is ‘cognitive impairment’.

From this identified need we would probably require strategies such as:

- Remind the client to wash hands after going to the toilet
- Prompt the client with activities during bathing—if the reason was ‘reduced mobility,’ the strategies or interventions required would be entirely different
- Assist the client to bathroom using a shower chair
- Encourage the client to stand using hand rails in the shower recess.
**Goals/outcomes**

If we have identified an area of need and are planning strategies with the client, there must also be a reason or purpose for doing so. The reason is the goal or outcome the client desires and/or needs. A goal or outcome for the need identified above may be: ‘Client will achieve optimum hygiene and maintain current level of independence’. It is very important that goals be achievable and realistic strategies or interventions are set with that goal in mind. Goals can be changed to suit the client’s changing needs and/or as abilities improve or deteriorate.

**Strategies/interventions**

Strategies or interventions are the actions we put in place to address the identified need or problem and to achieve the goal. These strategies should be those that have been found to be successful throughout the assessment process. Strategies should also be individualised for each client. What is appropriate for one client is not necessarily going to be appropriate for another.

**Review and evaluation**

Care plans must be reviewed and their effectiveness evaluated on a regular and ongoing basis. There is little benefit in putting a plan into place and never reviewing its results and effectiveness. Reviews are carried out at varying intervals and as needs change. The timing of reviews and evaluations will depend on local policy but they are usually done anywhere between two and six weeks. The effectiveness of a plan should be evaluated in relation to the desired goals or outcomes.

**That is:**

- Are goals and outcomes being achieved?
- Are strategies still appropriate for achieving the outcome?
- Are goals or outcomes still appropriate?

Where it is found that needs have changed significantly, it may be necessary to re-assess a particular area of need. Changes to a client’s needs and their care plan must be reflected in their progress notes. This way all staff will be alerted to the change and the required care will be consistent. So at all times staff must document the outcome of their care. For example, if staff adapted the lounge area to allow a client better access to view the television, and hence reduce the client’s agitation—was the action successful? If so, staff need to document that the action resulted in less noted agitation by the client. This then provides the documentation that staff care has impacted and changed the client’s behaviour.

The care plan is a written tool used to document clients’ needs, goals/objectives, care implementation/strategies and evaluation. In an aged care facility it is often called the nursing care plan; however many other facilities adapt the principles to implement and develop their own individual ‘care plan’. Hence it may not always be called the ‘nursing care plan’. It is essential that plans of care be individualised to the clients’ needs. Generic care plans do not address individual needs and are not client specific. Care plans must be formulated by the care team in consultation with the client and/or his or her representative.
<table>
<thead>
<tr>
<th><strong>ASSESSMENT</strong></th>
<th><strong>PLAN</strong></th>
<th><strong>IMPLEMENTATION</strong></th>
<th><strong>EVALUATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This section should contain care issues that you notice. It may involve seeing, hearing, smelling or feeling these issues.</td>
<td>This section should contain your ultimate aim or goal in order to either minimise or remove the care issue. <em>What would you like to happen if this plan works well?</em> <em>To prevent Mr. Jones from falling again.</em> <em>To minimise or eliminate environmental risks.</em></td>
<td>This section must contain exactly how you will manage the care issue. It may involve step-by-step actions required to be taken. <em>How will you achieve your goal or plan?</em> <em>Ensure that there are no loose rugs in his room that he may trip over.</em> <em>Ensure Mr. Jones’ shoes are laced properly.</em> <em>Ensure Mr. Jones reports any episodes of falls.</em> (etc)</td>
<td>This section should contain a statement that says whether your plan has worked or has not worked. <em>Did your interventions or actions work to achieve your plan or aim? How so?</em> It may have information as to when you will review this plan again. You may be required to sign and print your name here. <em>Mr. Jones has not had a fall for over 3 months.</em> <em>Continue current plan.</em></td>
</tr>
</tbody>
</table>

* Mr. Jones has frequent falls at home, due to Parkinson’s Disease
Confirming required equipment, processes and aids

An aid is something that helps a person to do something more easily. The aim of any aid is to maximise the abilities and independence of the person. This type of support can mean the difference between the person managing their daily living skills or having to move into a supported accommodation arrangement. We all have a number of aids in our own homes. It is important that the client is aware of the equipment and aids available to them so they can make informed choices about how best to meet their personal care needs whilst maintaining a level of independence.

Below is a brief outline of the various types of equipment and aids that can be used to make life more comfortable for the client and easier for the carer.

Wheelchairs

A person may experience mobility impairment as a result of accident or injury, chronic medical condition or congenital disability. For example, from paralysis, multiple sclerosis, cerebral palsy, muscular dystrophy, Spina bifida, poliomyelitis, spinal cord injury, back injury, arthritis, broken or sprained limbs, loss of limbs, stroke or brain tumour. Mobility impairments vary—a person may have difficulty with balance, gait and coordination, and experience dizziness, weakness, pain and paralysis. They may use crutches, a walking stick or a wheelchair. People who use wheelchairs have varying degrees of difficulty with mobility. Some may use their arms to propel the chair, others may use an electric wheelchair, which is usually heavier and cannot be easily folded to be placed in a car.

Mobility aids

Mobility aids, commonly walking aids, are tools that are designed to assist walking or enable mobility. Walking aids vary, from those providing some support for those who can walk independently but need aid in stability, to greater support for those who need help to walk, to those providing maximum support and designed to aid those people who are unable to walk even with help.

Walking aids include walking sticks and canes, crutches; various walking frames such as walkers or Zimmer frames, wheeled (rolling) walkers, and wheeled mobility devices such as wheelchairs and power chairs, and scooters. Scooters are a common mobility aid that allows people to access what the community has to offer such as libraries, shops and leisure venues. Many businesses that provide mobility aids can be found on the internet. Mobility Aids is one such business, specialising in providing electric scooters, power and manual wheelchairs, lift and recline chairs, nursing beds and a range of other mobility aids. Their website is: <www.mobilityaids.com.au>

Lifting and transfer aids

Lifting and transfer aids assist people with some weight-bearing capacity to transfer between one surface and another. This may include standing or seated transfer aids, transfer boards or vehicle transfer aids.
Standing transfer aids

Standing transfer aids assist people who can bear weight to actively participate as they transfer from one seated position to another. This eliminates almost all lifting requirements of the carer and reduces risk of injury.

Aids available include:

- Rotating discs allowing an individual to move into a standing position, and then with assistance turn towards the alternative seat and lower without having to move their feet
- Standing aid which has rotating discs on which the person stands using a steel frame which includes handles and knee supports, allowing an individual to transfer independently without carer support
- Walking belts that are worn by the person and allow two carers to hold onto attached handles and support the person as they walk
- Transfer pads, with handles sewn in on either side, which sit under the persons buttocks and can be used by carers to assist the person to move from sitting to standing.

Lying transfer aids:

- Sliding sheets with handles that when placed under a person lying on their back allow carers to move them up and down the bed, onto their side or even into a sitting position
- Air moving elevating lift chairs, or cushions, to transfer a person lying on the floor that has fallen to a seated position using a pump mechanism.
Vehicle transfer aid

Vehicle transfer aids can include:

- Mobile battery operated hoists which can be dismantled and transported
- Swivel car seat adaptation where a swivel mechanism is attached to the base of the existing vehicle seat and allows it to rotate 90° to assist with transferring (can be either manual or power operated)
- Swivel discs that rest on the car seat and allow easy turning as the top moveable disc rotates on the base stationary disc (can also be wedge shaped)
- Transportable steel handles that are used on the ‘V’ shaped door striker plate of most vehicles with grab handle to assist with getting out of a car
- Adjustable straps that can attach to the vehicle grab rail or door to assist with transferring
- Sliding pads/sheets to assist with moving, turning and transferring with models available for aircraft transfers
- Automatic seat lifters which enable a car passenger seat to lift out of a van and swivel 90°
- Curved transfer boards which accommodate for shape of car doors and allow transfer from mobility aid to/from car.

Seated transfer aids and transfer boards

Transfer boards come in a range of materials, designs and lengths and generally have a non-slip surface on the base, with a slippery top surface which may be moveable. The board is placed between two surfaces such as a bed and wheelchair and the individual slides across the board. Transfer boards are also available which have a toilet opening to allow transfer and use of the toilet without removal of the board.
Hospital Beds

Nursing or hospital beds differ from traditional beds as:

- Hospital beds ensure safety as most have side rails to keep the client in the bed. Safety rails or side rails are used for people who may fall out of bed, are prone to confusion or are unsteady on their feet when climbing out of the bed.

- Some hospital beds are electronic or have a foot lever to pump the bed manually up and down. When making a bed, bed bathing, rolling a person, performing a dressing or helping a person to dress, it is important to have the bed at the carer’s height to avoid back injury.

- Some hospital beds have equipment attached such as IV poles to allow for a bag of fluid or blood products to be hung.

- Hospital beds have brakes to ensure safety. The bed is unable to move when the brakes are on and the brakes can be disengaged to move it around the room, to another room or outside.

Breathing devices

Continuous positive airway pressure machines (CPAP machines) give a continuous flow of oxygen or air, usually overnight, for the patient who has sleep apnoea or respiratory disease. There are different devices used for CPAP such as nasal prongs which fit snugly in each nostril and deliver a certain amount of continuous air or oxygen. Another device is a mask which again fits snugly over the nose and mouth. Nasal prong or mask oxygen is used for patients who have respiratory diseases such as emphysema, chronic obstructive airway disease or asbestosis. People who require oxygen usually have a low flow metre to adjust the amount of oxygen necessary. Ventilator—some people require a ventilator if they are unable to breathe on their own. These patients may have had a spinal injury and in this case the position of the injury in the spine determines the type of ventilation required.
Continence aids

Incontinence occurs when there is an inability to control the passage of urine or faeces, causing a social or hygienic problem. For clients who are mobile and continent you may just need to remind them to go to the toilet. These clients should have easy access to a toilet and have facilities to wash their hands afterwards.

Other clients may have continence problems these may include:

- **Stress incontinence**: Loss of urine when the client sneezes, coughs or laughs.
- **Urgency incontinence**: They experience an urge to go to the toilet and must go straight away or they immediately lose the urine.
- **Total incontinence**: Constant loss of control of urine and faeces.

The person’s care plans may include a regular toileting regime to promote continence. For clients who have stress or urgency incontinence there are a range of absorbent pads which are available to insert into underwear to protect skin condition and clothing. You will need to check with clients if they need to be changed on a regular basis. Once again ensure your clients have easy access to the toilet and if they indicate they wish to go to the toilet and you must assist them straight away.

If the client is incontinent, ensure wet clothing is removed straight away and the skin is washed and dried, this is to ensure the skin is cared for and the client’s dignity is maintained. Clients may also be given exercises by a physiotherapist to perform during the day, to help strengthen their pelvic muscle to help improve their continence. You may need to remind and encourage your clients to do these exercises.

Some clients may be incontinent of urine and faeces. Bowel management plans for clients should be in place. These management plans aim at developing regular bowel habits. Clients with no control may have a regular time in the day where they are given a suppository to help empty the bowel and establish a routine. You would need to discuss this situation with your supervisor and follow policies and procedures. To prevent constipation a well-balanced diet, high in fibre with an adequate fluid intake, is important. You can help and encourage your clients to choose a well-balanced diet to help prevent bowel problems. There is a range of products available to protect the client’s skin, clothing and dignity. These include pads, liners, disposable briefs and protective underwear, which need to be changed as required. Ask your supervisor about the range of products your organisation makes available.
Toileting a resident

There are several methods used when toileting a resident:

- **Commodes**: commode is a portable chair or wheelchair with an opening for a pan. When using a commode chair to transport a resident, use a modesty or dignity gown. Some can be placed over the toilet. This is used for residents who have difficulty walking to the toilet.

- **Bedpans and urinals are used when residents cannot get out of bed.** Males use a bedpan for bowel movements and use a urinal for urination. A fracture pan has a thinner rim and is only about a centimetre deep at one end. They are used for residents who have limited range of motion in their back.

Personal audio-visual aids

The Independent Living Centre of Victoria has a huge range of aids for people with a disability. They are a generalist service in that they display a range of aids for people with any type of disability. They have a great website which provides a listing of the various aids, plus costs, suppliers and so on. You can even see what some of the aids look like—all without leaving home. Personal audio-visual aids can help a person read, write, and manage daily living tasks.

Some examples are:

- Magnifying aids
- Audio tapes
- Electronic reading machines
- Computers that use large print and speech
- Braille
- Spectacles
- Hearing aids.

Modified feeding aids

Some care recipients may require feeding due to weakness, paralysis, casts, confusion and behavioural problems. There is a vast range of feeding aids including specialised eating utensils, plate guards, non-slip plates, sip cups, two-handled mugs and rocker knives.
One

Reviewing the individualised plan and confirm required equipment, processes and aids

Read Mr Williams’ profile and personal plan and use the information from them and the scenario to answer the questions.

Scenario

Alison is training Barbara to support Mr Williams. While they are walking up the drive to his house, Alison and Barbara talk about what they will be doing.

Alison reminds Barbara of things to prepare when showering someone:

- Preparing the bathroom.
- Checking the temperature of the bathroom.
- Making sure any equipment to be used is working and clean.
- Taking care as the floor can be slippery.

They discuss Mr William’s personal plan. It includes:

- His preferred name.
- How he likes to do things. In the personal plan it states that he has breakfast independently then, with the assistance of the support worker, he showers, shaves and gets dressed.
- Mr Williams is recovering from a stroke. While it has not affected his speech, continence or memory, it has affected his balance, his right arm is weak and he has lost sensation in his skin in affected areas.
- Mr Williams wants to be able to shower himself in the next month. With this goal in mind, he prefers to try to do things for himself but will request assistance when he needs help. The support worker should be aware of Mr Williams’ goal and desire for independence, and support him in his efforts.

After they arrive at Mr Williams’ house, Alison introduces Barbara and reminds him that they discussed that she would be bringing a new support worker to meet him today. They chat for a while and Barbara tells Mr Williams a bit about herself. Then Mr Williams says he will finish his breakfast before showering and won’t be long. Alison says they will get organised while he eats.

When she comes out to tell Mr Williams they’re ready for him to shower, Barbara notices he has finished eating his breakfast and moves forward to clear a cup and plates from the table. However, Mr Williams asks her to stop. He wants to take care of the task himself as one way of asserting and retaining his independence. Barbara should have remembered that the personal plan covers Mr Williams’ goal and desire for independence. She should support him in his efforts.
To answer, **tick the box(s)**. There may be more than one possible answer for each question.

1. As they are arriving at Mr Williams’ home, what are Alison and Barbara talking about?
   - [ ] Personal plans.
   - [ ] Planning a personal plan.
   - [ ] Following up.
   - [ ] Conducting.

2. How is the personal plan supporting Mr Williams’ needs?
   - [ ] By noticing that he likes to dress after he shaves.
   - [ ] By noting that he needs help with all aspects of personal care.
   - [ ] By noting what he likes for breakfast.
   - [ ] By putting his address on the personal plan.

3. What are two things Alison and Barbara should be aware of because of Mr Williams’ stroke?

4. What does Mr Williams prefer to be called by support workers?
   - [ ] William.
   - [ ] Mr Williams.
   - [ ] Bill.
   - [ ] Johnny.

5. Barbara tells Mr Williams a bit about herself. What is she doing?
   - [ ] Building rapport with Mr Williams.
   - [ ] Empathising with Mr Williams.
   - [ ] Interviewing Mr Williams.
   - [ ] Making sure Mr Williams knows she can only spend an hour with him in the mornings, instead of an hour and a half.
Identifying requirements outside of scope of own role and seek support from relevant people

Care workers must confirm that the personal care they are required to provide to clients is within the scope of their knowledge, skills and/or job role. It is important to know what you can and cannot do. You may be asked to do something that is not in your job description. You should not do anything outside of your job role because if you are not trained to do a task you put the person you are caring for and yourself at risk. If you are unsure ask your supervisor.

Knowledge: The greater your understanding of each client, whether living in their own home or in an aged care facility, and the greater your understanding of aged care practice, the more you will be able to contribute to the overall assessment of their needs.

Skills: Skills refer to the ability to perform certain tasks. They involve putting into practice the knowledge you have gained to assist the client and to perform your job effectively. Skills are also the ability clients have to perform certain tasks.

Some examples are your ability to:

- Assist a person to the toilet
- Cook a meal
- Mow the lawn
- You are required to provide services that enhance the quality of life of a person
- How do we know if the services provided are good for the people?
- It is important to receive reliable feedback from clients and their carers to know whether a service is providing the desired quality of life.

Seeking assistance due to the limitations of your work role

One of the key skills you need to develop is awareness of the limitations of your own abilities and experience. If you feel that a situation calls for experience or skill outside of your range of ability, then refer on. This applies in the long-term sense, eg: clients that you may see over a period of time, and to immediate situations. If, for example, you are unable to deal with a client’s behaviour, call someone immediately. This may be your supervisor, or other more experienced staff, depending on who is readily available. Try not to put yourself in situations where support is not readily available.

Limitations may take one of the following forms:

- Worker limitations, eg: lack of experience or insufficient skill base.
- Work role limitations – the issue may fall outside of your work role.
- Knowledge limitations–the complex care need may require specialist response.
- Agency limitations, eg: the client may be requesting services that are beyond the scope of the agency.

There will be times when the worker/organisation will need to consult a specialist for information about a client, or to refer a client for assessment, eg: health assessments that need to be conducted by medical or health personnel. It is important to remember that while working with older people, you are not working independently, rather you are often working with a team of people from a variety of different fields who all have the best interests of your client at heart. It is therefore important that each of these people continue to communicate and share information to ensure the needs of the client are identified and responded to.
This may include any of the following people:

- Your supervisor – who may be able to direct you to the most appropriate source of professional or specialist assistance
- Other, more experienced staff – intra-agency
- More experienced staff – inter-agency
- Specialist staff or services.

Don’t assume you can handle situations all of the time. There is no credit in ‘going it alone’ if you are not serving the best interests of your clients. Likewise there is no credit gained in working ineffectively. Who you use will depend on the situation and who is available. Liaison with specialists or relevant experts may be intra-agency (within the agency) or inter-agency (skills and resources of specialists from outside of your own agency). Your information base in relation to appropriate liaison will develop over time.

**Effective liaison with others is the product of:**

- Knowing when to consult
- Knowing where to consult
- Knowing who to consult with
- Knowing the procedures/protocols in liaising with relevant experts (eg: interagency
- Referral forms, client ‘consent to refer’ documentation.

**Your source of liaison and consultation may include the following:**

- Aged Care Assessment Team (ACAT)
- Specialist assessment agencies
- General Practitioners
- Specialist Medical advice/medical services
- Drug and Alcohol services
- Psychologist
- Social worker
- Welfare worker
- Community worker
- Support workers or agencies for clients from non-English speaking backgrounds
- Specialist support workers or agencies, eg: Aboriginal and Torres Strait Islander, Youth legal services
- Mental health workers
- Registered nurses
- Counsellors
- Program coordinators (intra-agency and inter-agency)
- Case managers
- Government agencies, eg: Centrelink, child and youth health
- Legal advisers
- Family support workers
- Family or significant others.
Considering the potential impact that provision of personal support may have on the person and confirming with supervisor

When caring for clients you are responsible to act in a legal and ethical way.

Let’s review the term ethics:

- It is an area concerned with making decisions about what is right and what is wrong
- It involves moral values, including what should or should not be done
- You are accountable (responsible) for the care you give.

As an aged care or health support worker appropriate ethical behaviour will include but not just be limited to the following points:

- Respecting the client as an individual
- Carrying out your duties to the best of your abilities
- Asking for help if you are not sure how to perform a certain duty
- Not performing a duty that you are not competent to do
- Keeping client information confidential
- Ensure client’s safety
- Ensuring client privacy and dignity
- Advocate for (acts on behalf of) your clients
- Ensuring the client is informed and involved in decision making regarding all care.

Ways to ensure confidentiality, privacy and dignity include:

- Staff training and awareness in such matters
- Report breaches to your supervisor and ensure the complaint is followed through
- Lead by good example
- Recruit appropriately trained staff
- Follow organisational policies and procedures.

You will come across many issues on a daily basis where you will behave ethically without even thinking about it. If you are unsure of what to do in any situation, always seek guidance from your supervisor.
Considering specific cultural needs of the person

Aged care and health support workers all need to be aware of a client’s cultural needs and respond to these in a sensitive manner. Culture is a combination of our heritage, beliefs and community. These include our traditions and beliefs regarding health and illness, also how we communicate things to do with our bodies. Some cultures have strongly held beliefs regarding religion and personal hygiene, including gender roles and personal space.

Developing cultural sensitivity involves reviewing the influence our own beliefs and culture have on our own behaviour. We need to develop skills that allow us to ask clients about customs and practices that we do not fully understand, without offending. This also includes how we respond to their practices.

Aged care and health support workers also need to be aware of the way culture influences a client’s response to questions regarding personal care. Clients may not answer questions as they may feel it is insulting to be asked about ‘such things’. They may not want ‘intimate’ details shared with family members of the opposite sex. Always consider issues that may arise concerning eye contact, personal space and even the way we communicate including the terminology used for body parts.

Language differences

When your client does not speak the same language as you, you may be required to employ a professional interpreter. This may be done via spoken word or by sign language for people with a hearing impairment, or by a special tactile alphabet for deaf-blind people. In Australia, qualified interpreters have to undergo relevant training and must be accredited with National Accreditation Authority for Translators and Interpreters (NAATI).

There are five levels of NAATI accreditation:

The five levels of NAATI accreditation

Level 1: Language aide level: This is not a recognised level for interpreting or translating. People qualified at this level don’t undertake interpreting as a primary part of their work but may, on occasion; use their language skills to assist in communication.

Level 2: Paraprofessional interpreter level: This level is for interpreting general business conversations and for straightforward, uncomplicated medical, legal or social work interpreting. Often Level 2 is done by casual interpreters and people whose main occupation is not interpreting, but they use their language skills in their work activities when required.

Level 3: Professional interpreter level: This is the first level of a professional, general-purpose interpreter. People at this level have a wide range of subjects in which they can interpret. Agencies such as Translators and Interpreters Service (TIS) and Community Relations Commission for Multicultural NSW—Language Services Division, which are the two main interpreting services in NSW, require Level 3 accreditation as a minimum for employment as a community interpreter.

Level 4: Advanced professional interpreter level: These are professional interpreters who specialise in their field. They are capable of conducting simultaneous (interpreting at the same time as the words are spoken) and consecutive (statement by statement) interpreting at a very high level such as at international conventions, meetings of political leaders, international economic and trade delegations, scientific conferences and conventions.
**Level 5: Senior professional level**: This is the elite level of interpreters. These are small and select groups of specialist interpreters and translators. These interpreters and translators would have met the qualification for Level 4 but in addition they would have proven extensive experience of interpreting at a very high level.

For general-purpose interpreting it is advisable to employ an interpreter with a minimum of Level 2 accreditation but preferably with Level 3 accreditation.

**Valuing differences**

We all bring our own beliefs and values to our chosen area of work. We may or may not need to modify some of these beliefs or values in order to work comfortably and for the benefit of our clients in the work setting. You need to be aware of personal values and how they might impact on your work, as they are so closely related to ethics. In order to leave your personal values out of the client-worker relationship, you need to be aware of the impact they may have when you come across clients who do not behave in ways that you agree with—that is, clients who have different values and beliefs to you. You may find that with such clients you become judgemental or notice that you are encouraging clients to make a decision that reflects what you think they should do (based on your values and beliefs) rather than working with them to come up with their own ideas about how to resolve the issue.

That is why it is so important to have ethical standards, so that we are operating by a professional set of guidelines, not by what we personally think is right or wrong. Ethical codes are guidelines to assist you in making the best possible decision for your client and yourself. They do not always give you the answers. Sometimes ethics can raise more questions than answers. It is always useful to discuss ethical issues with colleagues to get ideas and reinforce that your plan of action meets your ethical responsibilities.
Two

Considering specific cultural needs of the person

Write down what type of needs a client from a culturally diverse background may have while living in an aged care home.
Considering specific physical and sensory needs of the person

Types of disabilities

Physical disabilities

The term physical disability covers a wide range of conditions.

Some examples are:

- Back injury
- Quadriplegia (paralysis from neck down – both arms and legs)
- Paraplegia (paralysis from waist down – both legs)
- Missing limbs
- Arthritis
- Cerebral palsy (see separate reading)
- Medical conditions such as diabetes
- Multiple sclerosis
- Various other congenital (since birth) physical conditions.

Although the cause of the disability may vary, persons with physical disabilities may face the following difficulties:

Access Issues:

- Inability to gain access to inaccessible building or room.
- Decreased eye-hand coordination.
- Impaired verbal communication.
- Decreased physical stamina and endurance.

Support needs

Support needs for people with a physical disability vary greatly, even for two people with the same condition, but could include:

- Physical access, mobility / Exercise
- Dietary help
- Personal care, toileting, eating
- Specialised equipment ranging from computers to tools and appliances to lifting hoists
- Modified furniture such as kitchen bench heights
- Provision of hand rails
- Wide access ways and doors
- Holding, picking up difficulties – provision of appliances etc that are easy to grip
- Hand over hand assistance.
Developmental disabilities

A developmental disability is characterised by delays in learning, speech and communication skills. There may also be delays in gross motor skills (e.g.: walking and running) and fine motor skills (e.g.: holding and using a pencil) depending upon the cause and severity of the disability. People with developmental disabilities may have an intellectual impairment and/or a physical impairment.

This may result in limitations to one or more of the following major activity areas:

- Self-care / Mobility
- Learning
- Receptive and expressive language
- Self-direction
- Capacity for independent living
- Management of money.

Children with Fragile X syndrome are often developmentally delayed. Autism spectrum disorder is another example of developmental delay.

Autism spectrum disorder

Autism spectrum disorders are a group of conditions that vary in their severity and the age at which a child first may show symptoms.

Autism spectrum disorders affect a child's:

- Communication / Social skills
- Behaviour.

The most well known types of autism spectrum disorder are autism and Asperger syndrome.

Autism: Many children with autism have difficulty in understanding and using verbal language and communicating non-verbally. Some never learn to talk and others may be very talkative. They do not develop friends easily and need help to develop social behaviours. They often have unusual and difficult behaviours. They may become easily obsessed with certain objects and are often very sensitive to being touched.

Asperger syndrome: Children with Asperger syndrome develop their learning and thinking skills in unusual ways and at different ages to other children. The syndrome affects their brain functioning. They find other people confusing and find it difficult to form normal friendships and to interact in line with the norms of social behaviour. Their behaviour may range from the unusual, to the very aggressive and disruptive.

Diagnosis

A diagnosis for autism and Asperger syndrome is based on a child’s development and behaviour. The diagnosis is usually made by a multi-disciplinary team who are experienced in recognising autism.

The team will probably consist of two or more of the following professionals:

- Paediatrician
- Psychiatrist
- Speech pathologist
- Psychologist.

The team will observe how the children communicate, how they respond to other people and any repetitive behaviours that the child might display. There is a lot of information regarding autism spectrum disorders. A good place to start is the Autism Spectrum Australia (Aspect) website: http://www.autismspectrum.org.au
**Intellectual disability**

A person is said to have an intellectual disability if they have both the following before they are 18 years of age:

- An IQ below 70 (average IQ is 100)
- Significant difficulty with daily living skills including looking after themselves, communicating and taking part in activities with others.

A person with an intellectual disability may have difficulty learning and managing daily living skills. This is because their cognitive (thought-related) processing is impaired. Children and young people have different abilities and develop at different rates. Some children find learning new skills or information difficult. This may be because they have an intellectual disability.

**Main causes**

- Brain injury due to lack of oxygen at birth or after birth
- Brain infections before or after birth
- Disorder of metabolism, growth or nutrition
- Chromosome abnormalities
- Extreme prematurity (less than 1200g)
- Poor care, diet and inadequate health care
- Drug and alcohol misuse during pregnancy.

**Issues and challenges**

The issues and challenges with individual people with an intellectual disability will vary greatly.

**Some of the challenges that they may face include:**

- Limited attention span
- Limited communication skills possibly requiring non-verbal communication
- Limited language comprehension – allow time for understanding and responses
- Limited or no reading, writing or maths skills or ability -use plenty of visual resources
- Limited reasoning ability
- Limited impulse control.
Dual diagnosis

The term “dual diagnosis” is used within the disability sector to describe someone with a mental illness as well as an intellectual or developmental disability. The term “dual diagnosis” is used within the disability sector to describe someone with a mental illness as well as an intellectual or developmental disability.

Common psychiatric conditions associated with developmental disabilities include:

- ADHD (Attention Deficit Hyperactivity Disorder) – 3-5% of school age children
- Anxiety Disorders (especially in Autism)
- Learning disorders
- Mood Disorders and organic mood disorders (depression, bi-polar)
- OCD (Obsessive Compulsive Disorder)
- Psychoses
- PTSD (Post traumatic stress disorder)
- Personality Disorders.

People with developmental disabilities are at higher risk of developing mental health problems due to a higher predisposition and several vulnerability factors including biological, psychological, social and family factors. Note that people with a mental illness do not always have to disclose a mental illness, for example to an education institution, but if they want funded support they need to disclose the mental illness.

Support

People with a dual diagnosis respond best to a multidisciplinary approach. The approach usually followed will be a combination of effective psychiatric / medical treatment, psychological treatment as well as strong social networks and participation. Major changes to programs should involve a psychologist, psychiatrist or other relevant health professional. Stress plays a major role in the setting off of behaviours of people with mental health disorders.

Sensory disability

What is sensory disability?

People with sensory disability include people who:

- Have significant visual impairment or are blind
- Have a hearing impairment or are deaf
- Are deaf/ blind.

Sensory disability/impairment is when one of the persons senses; sight, hearing, smell, touch, taste and spatial awareness, is no longer normal. Examples - If a person wears glasses they have sight impairment, if they find it hard to hear or have a hearing aid then they have a hearing impairment. A person does not have to have full loss of a sense to be sensory impaired.

What is dual sensory disability/impairment?

It is the combination of both hearing and sight impairment. It is not necessarily a total loss of both senses – indeed the majority of dual sensory impaired people do have some degree of sight and/or hearing. Those with a less severe degree of both sight and hearing impairment may also be referred to as having a dual sensory impairment or loss.
Neurological impairment

When we talk about cognitive, or ability we are referring to the complex processes that enable us to think, know, remember, reason, imagine, predict and to learn, to mention a few. When we refer to cognitive functions we are referring to the higher mental functions of the brain. The brain is involved in many basic functions, such as controlling body temperature, breathing and heart rate, and enabling activities such as walking.

Cognitive deficits/ impairment is a broad term used to describe a variety of impaired brain function relating to the person’s thinking and reasoning ability, concentration, memory and problem-solving abilities. There can be a wide range of severity in cognitive impairment, from mild through to severe. Cognitive impairment can be associated with many disabilities and disorders present at birth or acquired later in life.

If the brain’s ability to process information and communicate with the rest of the body is compromised, a person’s mobility will probably be affected. This leads to muscle wasting and the likelihood of spasticity and/or contractures. It may also lead to bladder and bowel incontinence. This is somewhat dependent upon the area of the brain that is affected and the degree of disability. The more severe the disability, the less independence a person will have.

Cerebral Palsy

Cerebral Palsy describes a range of disabilities associated with movement and posture. Cerebral refers to the brain and palsy means weakness or lack of muscle control. Although cerebral palsy is a permanent condition a child with this condition can achieve greater control over movement as he or she learns motor skills. Cerebral palsy affects about 75,000 Victorians and more than 20,000 people Australia wide.

Cerebral palsy is not a disease, it is a condition and it is not contagious. It is usually the result of changes in or injury to the developing brain before or during birth, or sometimes in early childhood. Cerebral palsy is usually the result of diminished blood supply and lack of oxygen to the areas of the brain, causing damage to brain cells.

Cerebral palsy can affect a person’s:

- Mobility
- Their ability to talk
- Their outward appearance.
- How cerebral palsy affects the body:

Cerebral palsy affects people in different ways, some people experience minor motor skill problems, while other may be totally physically dependent.

Cerebral palsy can be categorised into four main areas, according to the parts of the body it affects:

- **Quadriplegia:** all four limbs are affected and the muscles of the face and mouth may also be affected.
- **Diplegia:** all four limbs are affected, but legs more so than arms.
- **Hemiplegia:** one side of the body is affected.
- **Paraplegia:** both legs, but neither of the arms, are affected.
Types of cerebral Palsy

There are four main types of cerebral palsy:

1. **Spastic cerebral palsy:** this is the most common type of cerebral palsy. Spasticity means stiffness or tightness of muscles, which is most obvious when the person tries to move.

2. **Athetoid cerebral palsy:** athetosis means uncontrolled movements, which often leads to erratic movements.

3. **Ataxic cerebral Palsy:** this is the least common type of cerebral palsy. Ataxia means lack of balance and coordination. If often presents as unsteady, shaky movements called tremors.

4. **Mixed types cerebral palsy:** may involve a combination of types of cerebral palsy.

Spina Bifida

Spina Bifida is a developmental defect which occurs within the first six weeks of pregnancy, caused possibly by a combination of genetic and environmental factors. Some of the spinal bones which normally protect and cover the delicate nerves of the spinal cord do not close. Consequently the spinal nerve tissue protrudes through this gap and forms an open swelling on the back. This could occur anywhere from the back of the head to the lowest part of the spine. Even though surgery at birth closes the gap, the damage to the spinal nerve tissues can never be repaired. The degree of paralysis will depend on the extent of damage to the spinal cord and the position of the lesion. Usually there is some paralysis and loss of sensation in the legs and lower trunk.

This could result in:

- A need to use a mobility aid such as callipers, crutches, a walking frame, walking sticks or a wheelchair
- Various degrees of bowel and bladder incontinence. There are several methods available to manage this problem.
- Hydrocephalus, sometimes known as water on the brain, managed by a surgically inserted "shunt" which directs the fluid to another part of the body for absorption
- Vision impairment and/or learning problems.
- High risk of grazing, cutting, bruising, or burning. Because there is a lack of feeling, protection of the skin is of great importance

All of these associated disabilities will vary from person to person. Many children with Spina Bifida attend regular preschool, primary and secondary schools and universities.

Muscular dystrophy

There are more than 20 types of muscular dystrophy. The best known type is Duchenne muscular dystrophy. This is a muscle wasting disorder linked to a gene on the X chromosome. The defective gene is often carried by women but the disease affects only boys. Duchenne muscular dystrophy results from a single protein in muscle fibres called dystrophin. Every one of the billions of cells which make up muscle fibres is affected, making their repair a huge logistical challenge.

Multiple sclerosis (MS)

This is the most common acquired disorder of the nervous system in young and older adults. To date, there is no known cure or specific treatment for multiple sclerosis (MS) although some very promising drug and surgical therapies are being trialled. MS is a degenerative disorder of the central nervous system (CNS). The damage to the CNS occurs in many widely scattered places and the damaged area is filled with hard material or scars. The course and severity of the disorder vary considerably from person to person, but it is usually slowly progressive. Some people experience alternating periods of remission (symptoms are mild or absent) and relapse (symptoms are present and often severe). Other people with MS do not experience such a pattern.
Spinal cord damage
The amount of damage and the location of spinal cord damage will determine the extent of the
disability that the person will acquire. Severe damage to the spinal cord will cause a total loss of
motor and sensory function below the level of injury.
Cervical cord injury will result in paralysis to all four extremities resulting in quadriplegia/tetraplegia. Depending upon the level of the spinal cord injury there may also be ventilatory paralysis, so the person will not be able to breathe unaided. Thoracic cord injury down to the level of the second lumbar region will cause paralysis of the lower extremities, resulting in paraplegia. There may also be some weakness of the intercostal (chest) muscles which will affect respiration (breathing). There may also be some loss of bladder and bowel function. Lumbar region injury causes a combination of sensory, motor, bowel and bladder function loss.

Chronic health disorders
There are a number of chronic health disorders, eg:
- Respiratory conditions
- Cardiac (heart) and circulatory conditions
- Renal (kidney) conditions
- Diabetes
- Obesity
- Aids and HIV
- Degenerative disorders.
If a person has one of these, it is not uncommon for others to develop, eg: continually reduced lung function can also lead to heart failure, and high blood pressure can lead to kidney failure. People with diabetes are more prone to developing kidney and eye damage. Obese people are more prone to developing high blood pressure and heart disease. People with AIDS have a comprised immune system so are more prone to pneumonia and other infections.

Respiratory disorders
These may include common disorders, such as chronic asthma, chronic obstructive pulmonary disorders (COPD), emphysema and less common disorders, such scleroderma, tuberculosis and others. A person with a respiratory disorder will have difficulty in breathing due to impaired lung function and reduced oxygen levels circulating in their blood. Not everybody with a similar condition will be affected to the same extent.

Heart and circulatory problems
There are many heart and circulatory problems, not all of which will lead to a physical disability, however if the pumping mechanism of the heart is affected, the person will have problems transporting oxygen to the main organs and extremities of the body. This will in turn affect their ability to carry out day-to-day activities.

Chronic pain
Pain can vary from mild to severe. There are many causes of pain but when it in some way hampers or hinders a person in terms of their ability to carry out day-to-day activities, it becomes a disability. Chronic pain can be difficult to treat and control.

ABI Acquired brain injury
What is ABI?
Acquired brain injury refers to any type of brain damage that occurs after birth. It can include damage sustained by infection, disease, lack of oxygen, or a blow to the head. Around 160,000 Australians are coping with some form of acquired brain injury. The term Acquired Brain Injury (ABI) is used to describe all types of brain injury that occur after birth.
The brain can be injured as a result of:

- Alcohol or drugs - these substances can poison the brain
- Diseases - such as AIDS, Alzheimer’s disease, cancer, and Multiple Sclerosis
- Lack of oxygen - called anoxic brain injury
- Physical injury - such as impact to the head, which may occur in car accidents, fights or falls.
- Stroke - When a blood vessel inside the brain breaks or is blocked, destroying the local brain tissue
- Traumatic brain injury (TBI)
- Brain tumour
- Poisoning
- Infection and disease
- Near drowning or other anoxic episodes
- Other disorders such as Parkinson’s disease, multiple sclerosis, and Alzheimer’s disease.

Changes after ABI

Changes as a result of an acquired brain injury can include:

- Medical difficulties: (epilepsy)
- Altered sensory abilities: (impaired vision, touch, smell)
- Impaired physical abilities - (weakness, tremor, spasticity)
- Impaired ability to think and learn: (forgetful, poor attention)
- Altered behaviour and personality: (short tempered, lethargic, flat or depressed)
- Impaired ability to communicate: (slow or slurred speech, difficulty following conversation).

Recovery after brain injury differs from person to person because of the variations in where the brain is injured and extent of the brain injury. Impairments can be either temporary or permanent, and can cause either specific or more widespread disability. Individuals may also find that the nature of their problems may vary over time.

In the longer term most people with ABI report changes in learning, thinking and behaviour while only 25% of people with a severe ABI will experience ongoing physical disabilities. These changes in learning, thinking and behaviour are hard for other people to recognise. People who do not understand the difficulties associated with acquired brain injury may believe the person is lazy or being difficult.

Communication disabilities

For 2.7 million Australians communication is a difficult and often frustrating experience. Getting their message across or understanding others is hard work because they have a communication disability. This can result in feelings of grief, anger, frustration and embarrassment. One in seven Australians has difficulties in communication. People with a communication disorder experience problems when talking to relatives and friends, as well as to strangers. Communication disabilities have an immediate effect on individuals as well as their families, friends, teachers, and work mates.

What is the impact of a communication disability?

People are affected in different ways. There are some who keep quiet, choosing not to contribute to a conversation or work discussion. There are other people who may be unaware of their difficulties; however their communication disability may be apparent to families, friends and colleagues. The impact of a communication disability varies with age, severity, the type of disorder and the situation.
Models of disability

Models of Disability are tools for defining impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs of disabled people. They are often treated with scepticism as it is thought they do not reflect a real world, are often incomplete and encourage narrow thinking, and seldom offer detailed guidance for action. However, they are a useful framework in which to gain an understanding of disability issues, and also of the perspective held by those creating and applying the model.

Medical model of disability

Today disability is studied in two ways. The first is the medical model of disability, which looks at disability as a medical illness that either has to be medically cured at an individual level, or controlled to allow the person with a disability to become a normal functioning member of society. On the other hand, there is the social model of disability that understands disability to be the outcome of social, political and economic processes, which have an impact on the lives of people identified as disabled, as well as on the lives of people who are not identified as disabled.

Whereas the medical model focuses on the individual as a “patient”, in contrast, the social model focuses on the infinite social processes and dynamics of disability. The social model is empathetic to the view that disability discrimination and prejudice is made stronger by a lack of accessible and socially and economically rewarding information, technology, architecture, features and events.

The changes in thinking and the approach to service delivery in disability work over the past 20 years have moved away from the medical model to the social model, which asserts that the impact of a persons’ disability on their life is very much dependent upon the social and physical environment in which they live, the cultural responses to their disability and their own physical and psychological conditions. Disability services work comes out of a perspective of empowerment. The attitude a support worker now brings to the relationship could be seen more as an attempt to identify where the client ‘is’ at present and how worker and organisation practice can best empower the client to work towards where they would like to be in the future.

Social model of disability

The social model of service delivery in disability work has been developed by organisations of people with a disability and powerful lobby groups such as the United Nations in their work on human rights. Current legislation in the form of the Disability Services Act and Disability Discrimination Act and others has been adopted by the Australian and state/territory governments in response to this.

Barriers still exist in education, information and communication systems, working environments, health and social support services, transport, housing, public buildings and amenities. The barriers that prevent any individual playing a part in society are the problem however, not the individual.

These barriers can be:

- Physical: e.g.: exclusion from the built environment, such as buildings with no lift or ramps
- Institutional: e.g.: exclusion from social and educational services
- Attitudinal: e.g.: non-disabled people make negative decisions about the ability of a disabled person to engage in a particular activity.

The social model has been developed with the aim of removing barriers so that disabled people have the same opportunity as everyone else to determine their own lifestyle. It acknowledges that people with disabilities are a part of our society, which includes the economic, environmental and cultural environment in which we live. It incorporates a holistic client-centred approach, which is ‘person-focused’ rather than ‘disability-focused’.
**Tragedy/charity model**

The tragedy/charity model depicts disabled people as victims of circumstance who are deserving of pity. This, along with the medical model, is the models most used by non-disabled people to define and explain disability.

**Market model**

The market model of disability is minority rights and consumerist model of disability that recognising people with disabilities and their stakeholders as representing a large group of consumers, employees and voters. This model looks to personal identity to define disability and empowers people to chart their own destiny in everyday life, with a particular focus on economic empowerment.

**Expert/Professional Model of Disability**

The Expert/Professional Model has provided a traditional response to disability issues and can be seen as an offshoot of the Medical Model. Within its framework, professionals follow a process of identifying the impairment and its limitations (using the Medical Model), and taking the necessary action to improve the position of the disabled person. This has tended to produce a system in which an authoritarian, over-active service provider prescribes and acts for a passive client.

**The social adapted model**

The social adapted model states although a person's disability poses some limitations in an able-bodied society, oftentimes the surrounding society and environment are more limiting than the disability itself.

**Economic Model of disability**

Under this Model, disability is defined by a person's inability to participate in work. It also assesses the degree to which impairment affects an individual's productivity and the economic consequences for the individual, employer and the state. Such consequences include loss of earnings for and payment for assistance by the individual; lower profit.
Identifying risks associated with the provision of support and confirming with supervisor

When assisting clients with personal care either in a facility or in their home, there are always risks to consider. These risks involve both the worker and care recipient. It is important that when we consider there may be a risk to either party that we carefully assess the likelihood of it occurring. We are responsible for our actions and have a duty-of-care to our clients to do no harm. We are responsible for our actions and must follow the safe work polices of our workplace, ensuring we use equipment supplied.

When we attend to a client we must follow the workplace’s procedures and safe work methods eg ensuring that we inspect equipment before use. We are then able to use it with the full knowledge that it is in safe working order. Under WHS legislation it is our responsibility to use equipment provided for manual handling (eg lifting machines, stand aids, slide sheets and Johnny belts). It is always important to maintain good body mechanics when transferring and assisting client movement.

Whilst attending to clients it is also important to consider the risks associated with providing personal care. These include things like wet floors whilst showering or powder being spilt on the floor which becomes a slip hazard. This is often unavoidable but being aware of the risks and putting measures in place will lessen the likelihood of any injuries occurring to clients or staff members.

Caring for clients in their own homes presents unique hazards such as small spaces and sometimes clutter, which may constitute fall or trip hazards.

Clients and their behaviour also may be considered a risk to the safety of staff members. This behaviour may be unintentional or deliberate, outside influences may cause behaviour to change (eg agitation or aggression caused by infection/delirium). It is important that all staff members are aware of client behaviours that pose a risk to their safety. There should be strategies in place to minimise any risk if clients are known to a service.

Our role includes liaising with supervisors to minimise risks to our own and others safety. It is our responsibility to be fully aware of the workplace policies and procedures and what we are expected to do if we find a risk. When placed in a situation that you are unsure of, it is best practice to speak with a supervisor to clarify or report the risk. They will then be able to guide and support you to achieve the best outcome.

Conducting an environmental risk assessment for functions associated with personal care needs

Environmental risk assessment

Environmental risk assessments allows for risks that might arise in daily activities to be identified and plans to be formulated to minimise these risks to allow the client to continue to participate in these activities. For example, maintaining skin integrity is an important consideration when undertaking functions associated with personal care needs particularly of the elderly who have a greater susceptibility to shearing-type injuries such as bruises, skin tears, rashes, excoriations and pressure areas than others. Frequent washing causes dry skin, which can lead to skin irritation and breakdown. Skin tears are painful and could cause major damage if not looked after appropriately. This places an elderly person at risk.
In general, fragile skin, advanced age, use of assistive devices, cognitive/sensory impairment, and history of previous skin tears can put a client at risk of a skin tear. Research has shown that dependent residents who require total care for all activities of daily living are at greatest risk. Their injuries tend to result from such routine activities as dressing, bathing, positioning, and transferring.

Should an issue arise regarding risk for functions associated with personal care needs, you with support from your supervisor should undertake an environmental risk assessment regarding the specific risks associated with a particular activity. This way the person is given support to engage in the experience that they have identified is beneficial and important to them rather than making a determination that they cannot do it. A specific environment risk assessment would then need to be developed and should be included as part of the person’s care plan.

Sample of an individualised environment risk assessment form for John Wright

<table>
<thead>
<tr>
<th>SPECIFIC TASK/ACTIVITY</th>
<th>POTENTIAL HAZARDS /CONSEQUENCES</th>
<th>CONTROL MEASURES</th>
</tr>
</thead>
</table>
| Transferring John from his wheelchair to a vehicle | Manual handling causing injury to John  
Manual handling resulting in strain or back injury to worker | Workers to use appropriate transfer aids provided (transfer belts, swivel seats in cars)  
Training to be provided on safe transfer techniques and methods |
| Helping John in or out of the shower or bath | Manual handling causing injury to John  
Manual handling resulting in strain or back injury to worker | Rails to be attached to the wall for John to hold onto for extra support  
Non-slip mats to be placed on the floor inside and outside the shower or bath  
Bath seat placed across a bath to allow John access, usually used in conjunction with a hand held shower hose  
Use of shower chair [usually plastic with a hole in the middle so that water can escape]; specifically shower chair fitted with wheels which will allow John to be transported to and from the shower  
Use of commode chair [Commode chairs have a seat designed as a toilet seat. The chair is pushed over the toilet for use, these can also be used as shower chairs]  
All workers to gain an understanding of John’s level of independence |
| Shaving                                  | Cuts and bleeding                                                      | Encourage John to use an electric razor  
Physically assist John in shaving  
Use external professionals such as a barber |
Dignity of risk

Dignity of risk involves assisting people with disabilities to make their own decisions, and deal with the outcomes of these decisions. Allowing clients a dignity of risk also empowers them to make decisions and have greater control over their lives. In terms of your role as a disability services worker, you should be aware of your behaviours at all times, to make sure you are not controlling what your client does or doesn’t do.

This means if a male client is fond of a female client and wants to buy her a birthday card that you don’t think is appropriate because of a potentially offensive joke, you can point out that the woman might take offense, but your male client may still choose to purchase the card. The outcome could be that the woman is offended and cancels dinner plans with your client, and this is a risk he has taken, because you allowed him the dignity of risk. While you need to allow your clients a dignity of risk, you should always ensure you are still meeting your duty of care, as duty of care will always override dignity of risk, and both must adhere to workplace health and safety requirements – it is a constant balancing act.

The elderly and younger people with a disability have tended to be protected from taking risks by having much decision making taken away from them. Food, medicines, knives etc have all been shut away.

They have been told:

- Where to live and who to live with
- Who they can or cannot go out with or sleep with
- What activities to do at a day centre
- What excursions to go on
- Whether they can go to a pub for a drink
- How personal care will be provided
- When to cross the road
- What to eat
- When to go to bed
- What to wear
- When and what to watch on TV.

For anyone supporting people with a disability, dignity of risk means letting people have more control over their lives. It also means that people that you support may need to develop their skills at decision making and identifying risks so that they can work out what risks to take.
Three

Identifying risks associated with the provision of support and confirming with supervisor

Your client says she does not feel well. You note that she has not eaten the meals you prepared in advance. She is ‘at risk of falls’ and you notice bruising. Your client asks you not to say anything.

1. What are the risks for your client?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. How would you manage this situation respecting organisational protocols?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Element 2: Maximise participation

Discussing and confirming person’s own preferences for personal support in a positive way

As an aged care or health support worker it is important that you support the older person but at the same time help them to direct their own support services with maximum client participation. This can prove to be a difficult balancing act.

Admission to a nursing home is a major transition in anyone’s life. The transition can have a positive or negative psychological effect on the older person due to a number of factors. It is a psychological stress to move an older, and often frail, person from a familiar environment to an unfamiliar place. The person may experience a sense of isolation due to now being surrounded by unfamiliar faces, objects and names.

The leaving behind of cherished possessions decreases the person’s sense of self-identity and life history. Control may be lost over such choices as when and what to eat, when to shower and when to go to bed. Privacy and time for visitors and phone calls may be limited. Aged care staff need to be aware of the potential loss of self-determination and control and treat all clients as individuals with rights to personal growth, dignity and self-determination.

As a care worker your work will be varied depending on the type of clients you have and the individuals concerned. With each individual you care for, you may have specific tasks you need to complete. It is important that you understand and know how to support and accommodate their personal preferences while completing such tasks.

Specific tasks you may have to carry out may be related to:

- Dietary requirements
- Home cleaning
- Religion and spirituality
- Dressing
- Grooming.

Preferences for personal care may include:

- Time of the day
- Time of the week
- Carer involvement
- Processes
- Procedures
- Products
- Carer preferences, such as male or female.
### Dietary requirements

Every person has personal preferences about the food they like to eat, how it is prepared and the time of the day they like to eat.

**Eating preferences may include:**

- Being vegetarian
- The preparation of the food or consistency of flavour
- Spicy food
- Traditional Australian foods such as meat and three vegetables
- Certain types of meat and/vegetables
- Salt or pepper, or other types of flavorings
- Fast foods
- Dessert after a meal
- A roast dinner on the weekend.

As a care worker it is possible for you to make sure that the food and drink preferences of the individual are being met.

**To do this you should:**

- Make sure that you understand the preferences of the individual and that these are listed in the service/care plan
- Continually discuss with the person their preferences to establish any changes that may occur
- Offer choice and variety in their diet while still respecting and supporting their own personal choice of foods
- Ensure that their preferences allow all of their dietary needs to be fulfilled by consulting with dieticians and other health professionals
- Provide the individual with information about dietary needs if necessary.

If you are assisting a person in their own home it is important that you ensure their personal preferences are being met by assisting with a range of activities related to food preparation.

**You need to make sure that:**

- The individual has food supplies and a variety of food in their home
- The person is capable of shopping on their own
- The person can consume their meals in a way that it enjoyable and comfortable
- You encourage them to share meals with other people wherever possible
- They have enough resources to buy nutritional foods.

It may be important for you to pass on some information that you learn about your client to your supervisor or to another professional such as a dietician or community nurse. It is important that you help them in fulfilling their personal preferences wherever possible, but it is also important that you try to ensure that they consume a balanced and nutritional diet.
Cleaning and maintaining the home

Part of your role as a care worker may include assisting clients to maintain cleanliness in their home. While doing this it is important that you consider the preferences of the individuals by completing the tasks the individuals want done, when they want it to be done. You need to be aware of what the special needs or individual preferences are of the individual. Consult the client, or the service/care plan.

When planning cleaning procedures, some of the client preferences you may need to consider include:

- The frequency and order of the jobs to be done
- Using certain cleaning products
- Using particular equipment for each job
- Returning ornaments and furniture to their original location.

Remember that clients may have specific preferences for a reason.

For example:

Nellie is an active 82-year-old who lives in her own home. Due to a progressive deterioration in her sight, she now receives community care services in order to assist her with meal preparation and maintaining her home. When Rona, a care worker, arrived at Nellie’s house for the first time, Nellie explained very clearly that she needed all furniture and objects to be returned to their original positions and locations. She explained that this was essential because she could not see very well but knows exactly where everything is in her house. If Rona was to move an item of furniture it could mean that Nellie might fall over it or bump into it.

Religion and spirituality

Information about religious preferences should be in the care plan and should be treated respectfully by care workers.

To support and accommodate personal preferences in religion and spirituality you could:

- Talk to clients about events that are approaching that are important to them, such as specific religious days
- Discuss with the client different aspects of their religion to gain a better understanding
- Arrange transportation to religious events
- Adapt routines to meet with religious needs of the client, for example, avoid cleaning the home while a person is praying.
- Remain non-judgemental at all times. Remember many religious beliefs are accompanied by dietary preferences.
Dressing

Many older people or people with a disability may be dependent on assistance in purchasing clothes as well as in the physical process of dressing. It is important that they maintain some control and independence in relation to the clothes they wear. This will assist in the maintenance of self-esteem and personal pride in their appearance. You should therefore encourage the individual to make decisions on the clothing that they like to wear. An individual’s choice of style of clothing will be directly related to their own personal preferences, medical or physical condition, financial position and cultural background. This needs to be taken into account when you assist clients in selecting clothing.

Grooming

Every person has individual preferences about how they like to look. Many people may pay particular attention to making sure that their hair is done in a certain way, that they are clean shaven and are dressed appropriately for all occasions.

Encouraging and supporting personal preferences in grooming is important as it can:

• Increase independence in the individual
• Establish an appropriate grooming pattern
• Increase a client’s self-esteem
• Enable older people to present themselves positively to the general public.

Many older people and some people with a disability have real difficulty in maintaining personal grooming, so it is important that levels of assistance are listed in the care plan and are discussed on a regular basis to ensure that ongoing changes are documented. You may have to provide alternatives that allow older people to increase their level of self-grooming. Since grooming is often considered a personal act it is essential that you are sensitive to the embarrassment your clients may feel when they need assistance with such activities. A client suffering from arthritis may not be able to raise their arms in order to clean their teeth.
To help them with this activity you could take the following approach:

- Establish a familiar routine and emphasise the positive side of this care
- Ask the client when they prefer to have their teeth cleaned so that some level of control remains with them
- Ask the client to explain to you how they like their teeth cleaned so that you can do things their way
- Be patient and understanding. In all these tasks you need to make some decisions with your client and form a strong relationship based on good communication. The more you understand your client’s preferences the easier it will be to fulfil them.

**Time of day and week**

You should always try to negotiate the time of day and week for personal care routines with the client. They have preferences that need to be met but often in an aged-care or home-care setting you may need to work with the client within an existing routine as you will have other clients that require support. This is why it is important to negotiate the best times possible within existing routines. You need to ask yourself whether a particular routine can be moved around to fit the needs of the client. You also need to think about your work load as well. For example, how many high-care clients can you support at any given time? Will your existing work load place you and your clients at risk in terms of WHS? Therefore you need to ask yourself how much time you have and what risks you are exposing your client or yourself to.

**Carer involvement**

It is important that carers be involved in as much of the care as they want to be; however, you may need to consider that they may pose a risk to the client if they lack traditional or good carer skills. You may need to educate in such skills before they become involved. You also need to consider the carers physical strength and whether they should be caring for someone with a physical disability of forty years of age if they are eighty. Such issues need to be negotiated with the client and carer.

**Processes, procedures and products**

You need to consider how the client normally showers, dresses, goes to the toilet etc. You need to look at the environment, what they do and how their personal care needs are being met. You also need to consider what equipment and products are being used. Are they the right products for this person? For example, does the person use powder after showering, and if so does the floor surface become slippery? Is there an alternative product that may be used? People should always have choice regarding such matters but this also needs to be balanced against any risks involved.

**Carer preferences**

The person should always have choice as to whether they want a male or female carer to support them. Some people may not have a preference but others may be quite private and have a strong preference. You will need to try to accommodate this but it may not always be possible.
Activity

**Four**

**Discussing and confirming person’s own preferences for personal support in a positive way**

1. Describe two different strategies you could use to:
   a. Identify a client’s personal preferences.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

   b. Encourage independence.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. How can you ensure that residents /clients have input into their care?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
Considering and confirming the person’s level of participation in meeting their personal support needs

There are many aspects to take into consideration when confirming a client's level of participation in care requirements. On occasion people will underplay the extent of care or assistance they need. This is not done to annoy or create a fuss, usually the opposite is true. People may feel that they are a burden or may be too embarrassed to ask for help.

Taking into consideration that some clients may not understand how much assistance they need due to cognitive problems (eg dementia). They will tell you they have showered independently and don't need help, when in reality they have not. This is not a deliberate lie it their interpretation of their reality and their situation.

It is also important for a care worker to realise that many older people find it difficult to adjust to having a stranger assist them with tasks they have always been capable of doing themselves. A care worker may also find that the client receives assistance from other informal carers such as family members or friends. In these situations the care worker needs to carefully negotiate the role and responsibility of each person involved.

The sharing of these tasks can allow a special bond to develop and friendships to grow providing the care worker with a very rewarding career. The potential impact of provision of personal care support on a client can be both positive and negative. A positive impact may be relief that support is being provided or pleasure at the increased social contact.

Potential negative impact might include embarrassment, fear, disempowerment, discomfort or humiliation. The client may feel a loss of control over their life. There will be a policy and procedure implemented by management and staff, that encourages the client to make as many choices and decisions as possible in relation to their own care and welfare and which help them to feel in control of their own lives. In the residential environment you will find this policy is written under Standard 3.9 Choice and Decision Making and 3.1 Information Provision in the Community Care Common Standards.

Many clients are grateful for the services and assistance they receive. Others regard some assistance as their right and they expect and appreciate quality care. This difference in attitude may affect how clients regard their care service and workers. Clients may find accepting help with personal care is hard to do as they are embarrassed to have someone else there when showering. They might feel frustrated at not being able to dress without help.

Many people in this situation like to have family or their spouse/partner help with their care. They may not like having a stranger helping them with very personal tasks such as using the toilet or bathing and may find this type of help hard to accept. So when providing personal care, workers must be thoughtful about the client’s need for privacy.

Remember it is important that when you are providing support you tell the client what you are going to do and make sure they understand. Ask them what they would like to do first. Allow them to decide where possible, how, when and where they will do an activity. You can encourage the client to help you plan how and when it will be done.

You must respect the dignity of the people you care for by treating them with respect. To have empathy for people means to have a real understanding of how someone else may feel. An older person’s culture will affect the way they feel. Understanding their cultural background will help you to treat them with respect. If you are unsure of how to treat the client, read the care plan or ask your supervisor.
Five

**Considering and confirming the person's level of participation in meeting their personal support needs**

1. Why should client’s preferences for the way in which support is provided be identified and respected?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. Describe how a support worker may confirm an older person’s level of participation in meeting their own personal care needs?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Providing the person with information to assist them in meeting their own personal support needs

Referral should not be used as a way to deal with clients who are difficult, but as a way to meet the needs of clients. When we are making decisions about referring to another service we should consider the option of bringing in a specialist to work with a client. There may also be opportunities to share the case management of a client with another agency. Much depends on why we are referring clients.

When do we choose not to refer?

There are also situations when we may choose not to refer a client, despite the fact that we are not able to provide the perfect service for them.

Such scenarios could include:

- The client may have dementia and or may be confused when requesting referral, consult with next of kin or guardian
- A client has had a negative experience with another service and refuses the referral
- Other issues impact on the success of the referral (eg the service is too far away, or the client has no transport, or there is no childcare or no interpreter service)
- There are no places available at the other service and the client would have to be placed on a waiting list.

In these circumstances you would be better to maintain the client at your service until the situation alters.

The role of the client:

The client should not feel pressured into accepting a referral and should be involved as much as possible in selecting additional or alternative services. To do this, they need to have information about the services that are available. Regardless of the age of your client, they should still be involved in making decisions that affect their lives. For example, older people should be involved in choosing their care options, people with disabilities should have a say in where they live and with whom. You should always check with a client to see if they have had previous experience with the other agency before you refer them. You should talk to them about what their experience was like and what their expectations are. Remember that the client has the right to not accept the referral.

Identifying other services

Your role, as a worker, is to sort through the options with your client to let them know what is available. To do this you need a good understanding of the services in your area and should be able to accurately assess the needs of clients. The assessment process should give you a clear picture of the client’s lifestyle so that you can refer them to an appropriate service.

Keep up to date with what is available and what the criteria is for entry to other services. Try to keep track of changes in staffing as well as policy changes that might affect the type of services that an organisation delivers. Your agency should have a referral source book that lists the agencies and specialists in your area. You should make sure that it is kept up to date as phone numbers and contact details can change frequently.

Keep in mind that you have a duty-of-care to keep your clients safe from foreseeable harm. This means that you have an obligation to find out about the services you are referring clients to. You need to know whether they are reputable and whether or not they have adequately trained staff. The best way to check out another service is to make personal visit. This can be time consuming but is worthwhile as it gives you a much better idea of whether a service is safe and appropriate for your client.
Supporting your client in the referral process

You may feel that it is sufficient to give a client the name and address of the new service, but in some situations you may need to give your client a little more support. You may need to go with them to their first appointment, organise transport or give them a letter of referral.

Writing referrals

Workers are often required to send reports or letters of referral to other agencies.

This information needs to be presented in a way that is:

1. Clear
2. Concise
3. Accurate
4. Reliable
5. Presented appropriately.

Following up: It is important you make arrangements to follow up the progress of a client when you refer them to another service. You may also need to make it clear to your client and the other service that they are able to re-enter your service (providing this is possible). Clients need to know that they are supported and that you are interested in their progress.

You also need to be aware of when you need to terminate your contact with a client. Sometimes when clients move on they can be embarrassed to meet someone who knew them when they were at their lowest point. You need to keep this in mind if you work in a small community. It is always up to the client whether they wish to acknowledge that they know you, especially at the local shopping centre.

Organisational issues and policies: Many agencies have clear policies which determine how they work with other agencies in making and accepting referrals. You should consult your policy and procedure manual to check what it says about referrals.

Supporting the older person's needs, rights and self-determination

All service providers have to meet standards in the way they deliver services and how they treat clients. To be eligible to care for older Australians, service providers must agree to respect their rights, and promote their dignity and independence. They have to be able to provide clients with information that can be easily understood.

Everyone has a right to privacy, confidentiality and access to their personal records, and they must give consent before undergoing any new treatment process. Dignity and independence is a right, as is the right to be treated as an individual, and to have your cultural background and personal beliefs respected. All service providers have a responsibility to make sure that their clients know what their rights are and that they know if there will be any changes to the care they receive.

Residents of a nursing home or hostel or those who receive aged care services in their own home, have rights including the right to:

- Be in charge of their life, money and possessions
- Privacy
- Be treated with dignity and respect
- Good quality care that meets their needs
- Be informed about their rights, care, accommodation and fees
- Complain if not satisfied with their treatment.
Activity

Six

Providing the person with information to assist them in meeting their own personal support needs

You will need to base the answer of this activity on a client/resident you care for.

1. Describe the mental health of the person, the physical health of the person and also your own abilities as a care worker.

2. Briefly explain what types of assistance the person may need and what you can do to assist them to meet their needs in their situation.

3. Give examples or describe a case scenario of a client who needs varied information to maintain independent living.
Support services provided by the community services sector

Community services work takes a range of shapes and forms. Given the range of agencies, occupations and job descriptions, it often seems that diversity looms larger than common ground. Nevertheless, there is a range of service delivery types (or ‘models’) that are common to community services. They represent the community services worker’s tool kit – an opportunity to select ways of working that are a ‘best match’ for the client, the worker and the agency.

Case management: A case manager’s role is to work with a client to assess their needs, plan and set goals, support the client and coordinate others to implement the activities that meet the goals; or monitor and evaluate the options and services required to meet the individual’s needs. A case manager is often the central community worker who coordinates other community workers, allied health workers and professionals to ensure that the individual accessing services is receiving a holistic, integrated service.

A community worker whose role is to provide case management may be called a case manager or a:
- Family worker
- Case worker
- Partnership worker
- Personal support worker.

Education: A community worker may be involved in providing formal or informal education, which may be delivered in community centres or neighbourhood houses.

Information: Many community services agencies provide information as part of their service. Some agencies such as Citizen Advice Bureaus, Community Information Services, Resource Centres and a range of telephone helplines have information provision and referral to other agencies as the core function of their role.

Advocacy: Advocacy may be part of a community worker’s role or the central function of a community service. Advocacy involves providing information to people regarding their rights and assisting them to advocate for themselves, or actually advocating on behalf of an individual or group of individuals. Advocacy may include helping a person write a letter, or attending a meeting or appointment with a person.

Recreation: Recreation workers provide recreation opportunities to members of the community. Recreation services may be provided as part of a community recreation centre, as part of other community agencies, for specific community members or as individual support.

Respite: Respite services are available to give primary carers support in their caring role. A respite worker may support a family or carer by working in the home and supporting the individual who requires care. Alternatively, there are respite services where the individual stays in a respite facility for a period of time.

Community access and inclusion: Community workers are often required to support individuals or groups to access, connect with and be included in valued, meaningful experiences within the general community. For some positions this may be the central function of the worker’s role. The role may be withdrawn as clients are included and involved in the community.

Communication support: A communication aid is a community worker who supports a person with a disability or complex communication needs to communicate. Other community workers may be involved in translating or interpreting spoken or signed languages.

Community health and allied health: Community health and allied health workers may be positioned at community health centres, as part of another community service or may be involved in outreach work. Allied health workers include social workers, dieticians, occupational therapists, speech pathologists, etc.
**Peak bodies:** Peak bodies are organisations formed to represent the views of a number of smaller groups and organisations. Some alliances may actually become a peak body, but this does not necessarily have to be the case. Many small community organisations fight very fiercely to retain their independence and refuse to acknowledge that a peak body represents their views. Peak bodies are generally formed to enable groups and organisations to have their views represented at State/Territory, national and international levels, and to provide policy makers and government with a single body to communicate with.

**Emergency Relief Agencies:** Provide money, food and/or furniture for those in need. Some organisations pay essential bills such as electricity or gas for clients. All are able to provide food either directly through their food bank, or indirectly through the issuing of vouchers that can be exchanged at supermarkets.

**Aged care services**

In Australia, these operate within a system of:
- Health
- Income support
- Housing
- Community care/support.

Services are funded and delivered by various mixtures of Commonwealth, State, and Local governments, and the non-government sector. Workers may be involved in one of the two main areas of service delivery – residential or community care.

**Alcohol and other drugs services**

In Australia, the approach to alcohol and other drugs has been through the National Drug Strategy (NDS). This is a cooperative strategy to ensure a comprehensive, integrated approach to the use of licit (legal) and illicit (illegal) drugs and other substances involving:
- Commonwealth government
- State and Territory governments
- Non-government organisations
- Community.

It drives policy as well as providing funding for a range of programs at National, State and Local levels.

**Disability services:** The Disability services Act 1986 provided a stream of funding for people with disabilities (except psychiatric) so that they could access services. It provided a basis for a set of standards that would ensure a quality service was provided.

**Disability services in Australia operate within a system of:**
- Health
- Income support
- Housing
- Community care
- Employment
- Education
- Community reintegration.

Services are funded and delivered by various mixtures of Commonwealth, State, and Local governments, and the non-government sector. There are numerous service providers within the sector, with skilled case workers who have a thorough knowledge of both general and specific issue.
Youth services: The youth sector is classified as part of the broader community services and health industry, and yet we would be mistaken in assuming that youth work employs the same practices and metaphors as, say, aged care work. There are similarities and parallels of course, but there are also differences. Youth workers are employed in a vast array of positions, in organisations ranging from the local neighbourhood house through to public hospitals, government departments and large non-government organisations.

Home Care (consumer directed care) and Community Care services

Home Care services are designed for people who need support to continue living in the community and who are older and frail or who have a disability. So if you have difficulties with everyday tasks, such as getting dressed or showering, this could well be the extra support you need. HACC services are designed to reach people with the greatest level of need, as decided by HACC service providers.

To be eligible for the HACC Program you must:

- Be living at home, be an older and frail person, or a person with a disability and have difficulty doing everyday tasks such as dressing or preparing meals
- Be a carer of a frail older person or person with a disability, or,
- Be likely to need to go into an aged care home or a hospital for care if you were not being provided with support from HACC.

(HACC) Home and Community Care services

The HACC funded Home Care service maintains a safe, secure, healthy home environment for frail older people and people with disabilities, and their resident carers.

Home based services can provide the following:

- Workers can prepare meals, do shopping, undertake small errands, and pay bills as required
- Workers can also escort consumers to do shopping and pay bills, or to attend medical and related appointments
- The service undertakes essential house cleaning of areas regularly used by the consumer. These include: bathrooms, toilets, kitchens, laundries, living areas, and bedrooms
- Provide housekeeping services appropriate to the individual’s level of physical functioning and their cultural norms
- Provide services which enhance and maintain the abilities and independence of the consumer
- Support carers of frail older people and people with disabilities by undertaking activities necessary to maintain a safe, comfortable and healthy home environment
- Monitor the well being and other circumstances of consumers.

While cleaning tasks form an essential part of Home Care, it is more than a cleaning service. It is focused on enhancing consumer’s independence by providing housekeeping, assistance with personal administration, monitoring and escorting.
Home care packages

The Australian government introduced new Home Care Packages on August 1, 2013, as part of its Living Longer Living Better reform package. A Home Care Package provides services that will help you to remain at home for as long as possible, as well as providing choice and flexibility in the way that the care and support is provided.

Eligibility

Unlike services provided under the Home and Community Care program, to receive a Home Care Package you will need to be assessed by an Aged Care Assessment Team (ACAT). The ACAT helps the elderly, and their carers, determine what kind of care will best meet their needs, when they are no longer able to manage on their own.

A member of the team which may include a doctor, nurse, social worker, and/or other health professional will meet with the person to assess their care needs and how well you are managing at home. They will identify the right services for a client needs and the level of care a person requires. The ACAT will give you a letter stating the types of subsidised services you have been approved for and might also put you in contact with organisations in your area that can deliver these services.

What services are provided?

Home Care Package services are based on a persons individual needs. Your provider coordinates the care and services to support you at home and these are agreed between you and your provider.

Transition Care program: Transition care is a form of flexible care for an older person that is provided at the conclusion of an admission to hospital. It helps to restore a client to their maximum level of health or strength. It provides a package of services that include therapies, eg: physiotherapy and occupational therapy, and either nursing support or personal care. Transition Care can be provided in either a community or residential setting, but to be eligible, a client must be assessed by an Aged Care Assessment Team. They must be assessed as requiring at least low level residential care. The aim of the program is to help older people reach their optimal level of functioning while assisting them and their family or carer to make (if required) long term care arrangements, eg: home care or residential care. It is estimated that the period of transition care would last for approximately eight weeks after discharge from hospital.

Financial support

The government has a range of carer payment options, including the following:

Carer payment (supporting those people who are unable to take a significant part in the paid workforce, because of carer commitments). Payment is subject to income and assets test. Carers who are eligible do not need to be living with the person they care for, but must be providing constant care. Carer allowance, paid to people caring at home for those who require additional care because of disability or severe medical condition. Information about these payments is available at http://www.centrelink.gov.au/ – follow the links to Individuals > Caring.

Choice about involvement in specific aspects of care: The informal carer has the right to decide, in conjunction with the care team, the areas they are able to assist the individual requiring care, as long as this does not put the client/carer at risk, and the tasks are within the informal carer’s capabilities, skills and knowledge.

Example: An elderly woman may wish to be involved in providing assistance with attending to personal care for her husband, however be physically unable to. Were she to carry out these tasks alone, she would be placing both herself and her husband at risk of harm.

Discussions surrounding the informal carer’s involvement in specific tasks are very important to have during the development of a care plan/service delivery plan. Extreme care must be taken to not discourage an individual from maintaining independence or to discourage the informal carer from being involved in the provision of care.
Carer/peer support groups: Carer support groups can be a valuable avenue of support, providing information, referrals and advice to carers. They can provide access to the listening skills of another (or others) who understands the unique challenges and frustrations in caring. Carer support groups can be an answer to the isolation of home-based caring, an opportunity to share experiences, information, strategies and frustrations. Some carer support groups will include a program of activities or guest speakers who will address issues of relevance to that particular group.

Residential care

Residential aged care in Australia is no longer grouped into two major categories - high-level care (previously called ‘nursing homes’) and low-level care (‘hostels’). The funding ratio for facilities is based on a calculation of the number of residents requiring various levels of support. The industry is regulated by National Accreditation Standards linked to a funding formula. Although the standards do not mandate necessary qualifications for personal care workers, it would be difficult for a facility to achieve the standards without a staff training strategy focusing on key areas. The current care models introduced in 2013 in ageing in place aged care.

The following improvements have been implemented in residential care.

- A new means test (income and assets) in residential care to help determine a person’s fair contribution, if any, to their care and accommodation. New income test arrangements also apply to home care
- Greater choice and flexibility for how they pay for accommodation and services, with 28 days to decide how they would like to pay
- Transparent accommodation prices and services, with all residential aged care providers required to publish the maximum amount they charge for accommodation and extra services
- New capping arrangements help make the system more affordable overall for individuals
- Establishment of the Aged Care Pricing Commissioner, an independent, statutory office holder appointed under the Aged Care Act 1997
- Better support to build more residential care facilities, and enhanced quality and amenity of accommodation for residents
- Consolidating and modernising the Schedule of Specified Care and Services.
- Removal of the high care low care distinction, resulting in flexible and more transparent arrangements in permanent residential aged care, reducing red tape for consumers and providers without compromising levels of care provided to residents
- Implementation of the Transitional Business Advisory Service to assist residential aged care providers in relation to the accommodation payment changes.

Conditions of allocation on residential places: The Secretary of the Department of Social Services amended conditions of allocation on existing permanent residential aged care places to remove any low care or high care conditions of allocation with effect from 1 July 2014. You’d not need to do anything for this change to occur. Future allocations of permanent residential aged care places will not have low care or high care conditions of allocation.

Approval of care recipients: From 1 July 2014, new permanent residential aged care approvals are not restricted to a care level. Low care and high care permanent residential aged care approvals valid on 1 July 2014 became permanent residential aged care approvals without any restriction to a particular level of care. Any person with a permanent residential aged care approval may now be admitted to any residential aged care place, subject to availability and the provider’s agreement. All residential aged care approvals valid on or from 1 July 2014 are indefinitely valid, unless approval is for a specific period.
Providing ‘ageing in place’: With removal of the distinction between low care and high care in permanent residential aged care, all permanent residential aged care is provided on an ‘ageing in place’ basis from 1 July 2014. All permanent residents will have the right to indefinite residence, unless the conditions are met for asking a resident to leave residential aged care as set out in the User Rights Principles.

Residential Aged Care Facilities

Residential aged care facilities provide residents with accommodation, personal care, including food and support services, health promotion and lifestyle activities, nursing care and allied health services. Services are mainly provided by staff of the facility with extra input when required from other service providers.

The accommodation offered may vary from a single private room with ensuite bathroom to shared rooms or small wards. Older people can enter residential care if an ACAT assesses them as having physical, medical, social and psychological needs that require the provision of care, and those needs cannot be met more appropriately through non-residential care services. If both partners are living and only one is assessed as needing this kind of care, some residential facilities may offer places to both partners as co-habitees. The same can apply to an older person who has been living with a brother or a sister and only one of them needs residential care. If one partner dies the other can often remain in the facility for as long as they want. It should be stressed that this occurs only by negotiation, and where the facility has the appropriate resources to offer the service.
Element 3: Provide personal support

Safely preparing for each task and adjust any equipment, aids and appliances

We have previously discussed in detail the use of equipment to assist with personal care. Each client will have different care needs and require the use of varying aids to meet these needs. This may also include work processes such as client movement, which involves following the appropriate safe manual handling policy of your organisation.

Whilst using equipment and aids it is important to follow the safe work methods and operating instructions in order to maintain the safety of our clients and minimise exposure to risks. This would also include maintaining the cleanliness of equipment and adequate infection control processes. In each workplace there should be processes in place to clean equipment between client use.

You are in a position to monitor and report the use of transferring and lifting equipment, ensuring that it is kept in good condition and that it is being used correctly. To avoid misuse of equipment and the occurrence of mistakes and risk of injuries, problems can always be reported within the Care Plan and also directly to supervisors. Both may be necessary, as the supervisor will act to resolve the issue and the other workers will need to know that there is a problem.

The physiotherapist may offer a step-by-step instruction sheet to be included in the Care Plan. This is so that all workers know what they are doing, and will follow the same steps, ensuring continuity and minimising risk of injury. The care plan should state clearly whether or not all workers are able to carry out particular procedures.

Examples include:

- Lifting hoists, splints or orthoses, as each worker requires instructions regarding a client’s individual needs. Remember you should be trained in using equipment, before you can carry out any lifting or transferring procedures.
- State when to use equipment. Some individuals using splints have a wearing regime that has to be followed
- Include important safety considerations, particularly in relation to changes in the client’s behaviour, mobility, strength, endurance or their psychological state
- Give clear instructions regarding the maintenance of equipment, with a place to record dates of when this occurs.

Common areas of concern may include:

- Correct use of equipment
- Variations in height and stature of the people lifting
- An unpredictable client
- A cramped environment
- Changes in the client condition.
- Communication problems. An interpreter may be required or the use of sign language or symbols, needed.
Employees have a responsibility to cooperate with their employer’s workplace health and safety policy and follow procedures. This includes attending training regarding the use of equipment and the correct processes to be followed. This responsibility also includes acting in a manner that does not put yourself and others at risk; assessing the risk involved in using equipment and workplace processes; and reporting any potential hazard or unsafe work method. Employers have a responsibility to provide adequate training in the use of equipment and safe work processes. Their responsibility also includes providing, adequate and appropriate equipment that is in safe working order. Safety processes including policy and procedure manuals.

**Manual handling techniques for patients and residents**

An integral part of your work as a health care worker will probably involve moving, or assisting to move your clients from bed to a chair, commode or toilet, or from a wheelchair into a chair. In some cases, the client will be able to assist to some degree. In other cases, the person may be too frail or incapacitated to be able to help you at all.

As the incidence of back injury remains very high in the health care sector, it is vital that you receive the appropriate practical training in manual handling techniques. The following information does not replace the requirement to attend a practical manual handling workshop. The key aspects to moving people are to assess, plan and prepare for the move and to use teamwork, since the moving of a person, more often than not, will involve more than one person. You must be trained to do this safely.

**Procedure for moving/lifting people**

Most community services and health facilities have a ‘no lift’ policy, and each workplace will have its own preferred practice for moving people.

**The principles of the procedure will remain consistent:**

- The worker/s must have a level of fitness greater than that necessary for the task
- Responsibility for ‘warming up’ and maintaining a level of strength and skill rests with the worker
- The working environment should be checked to ensure that it is safe to complete the necessary task
- The needs of the individual must be considered. Explain carefully to the client what is about to be done
- Consult and follow the care plan
- Assess the client. What is the cognitive or cooperative ability of the client?
- Assess the person who is assisting (where applicable). Do they know the procedure? What is their level of fitness?
- Plan the move. Who will give instructions? What are the instructions?

**Perform the move as planned. Follow basic principles:**

- Practise before ‘inflicting’ your ability on a dependent person
- Keep the back straight
- Move the feet
- Use your body weight to assist the move
- Encourage the client to assist where possible, eg: they may be able to turn their head when instructed and so assist the move
- Keep all movements smooth, moving on the count of 1-2-3 often helps
- Evaluate the move – ask both your co-worker and the individual who was moved.
Raising a client from the floor

When the client falls on the floor it is imperative that carers do not panic and try to get the client up off the floor without fully assessing the situation. Reassure the client, place a pillow under the client’s head (unless contraindicated), and cover them with a blanket until adequate assistance and appropriate equipment can be obtained.

Prior to moving the client the following processes need to be considered:

- Check for danger
- Remove the danger from the client or the client from the danger
- Administer first aid as required
- Check the client for fractures or other injuries that may require more controlled handling
- Determine the client’s medical history
- Assess what may have caused the fall
- Ascertian if the client has any disability or restriction in movement that would prevent them from getting up from the floor safely
- Determine the client’s capabilities prior to the fall
- Call for an ambulance or doctor if client is injured.

Methods to get clients off the floor include the following:

- Client can get up by themselves
- Assist client to turnover onto all fours and then use a chair to assist them up
- If there is any doubt about the client’s ability then a mechanical lifter MUST be used
- Using a mechanical lifter with sling
- Using a mechanical lifter with a Jordan Frame or scoop lifter.

Transferring a client to a bath

Procedure:

To get in the bath:

- To avoid having to step over the edge of the bathtub, sit the person down on the bath board first
- Bring their legs into the bath, one at a time
- The person may have to hold onto a rail on the wall or the rail attached to the board
- Do not allow the person to stand up in the bath
- Side wall mounted taps, a hand held shower hose, and soap on a rope all eliminate the need for bending or reaching too far forward when in the bath.
To get out of the bath

- Reverse, the procedure, for getting into the bath
- Ask the person to bring their legs out first by pivoting on their bottom, then move legs out of the bath, one at a time
- Do not allow the person to stand up in the bath
- You may need to assist by helping the person to lift their legs one at a time out of the bath
- Most falls occur when a person is getting out of the bath.

Assisting falling client/residents

Procedure:

If faced with the situation where a client falls, the first thing to do is STOP and THINK!

- If a client begins to fall, health care workers should not try to catch them; sudden moves and the extra weight can lead to serious injuries
- Workers should try to slow the fall by supporting the client/residents weight on their forward leg and concentrating on protecting the client/patient's head
- Difficult patient transfers should be recorded on the patient chart so other workers are aware of the potential hazards
- Don't try to catch the resident/client, or prevent the fall
- Try to slow the fall by lowering the resident/client to the floor (try to maintain a neutral body posture)
- Protect the client/residents head as much as possible as you help them gently to the floor; and get help to lift the resident from the floor.
**Mobility and transfer**

Mobility was identified by the Australian Bureau of Statistics (2005) as the fifth most needed activity requiring assistance. There are many diseases—such as dementia, Parkinson’s disease, Paget’s disease, osteoporosis, cerebral vascular accident (stroke), motor neurone disease, multiple sclerosis and postural hypotension—that affect the aged person’s ability to mobilise. In addition, amputations, fractures, generalised joint stiffness and pain can also affect mobility. When caring for a person, it is always important to remember that you are working under the supervision of a supervisor and as such, changes in the care recipient’s condition should be reported and documented.

**When working with a person who is having problems with their mobility:**

- Be aware of the reason for their immobility—do not assume the care recipient is being difficult
- Encourage the care recipient, be positive and patient
- Ensure gentle handling and rest periods
- Use activity programs, splints if appropriate
- Access mobility aids as much as possible
- Initiate active and passive exercises to maintain muscle and joint flexibility
- Report any changes in the person’s ability to mobilise or transfer safely
- Adhere to WHS, workplace policies and procedures and care plans.

For details of safe lifting techniques refer to your immediate supervisor and ensure you have access to a current accredited manual on safe lifting practices. It is also advisable to arrange for instruction from a Physiotherapist or Occupational Therapist, ensuring that all related requirements of the Workplace health and safety (WHS) legislation are met. One of the main WHS and duty of care issues is that of back and spinal care.

There is a large range of equipment to help lift and/or transfer people with a physical disability. Some can be used by the client independently and some are designed to be used with assistance. For much of this assistive/adaptive equipment, it is essential for the support worker (as well as the client) to have training in the use of it. Ideally such training would be done by the suppliers or the therapists who have recommended it.

**Some of these aids include:**

- Sliding boards
- Turning discs
- Handling slings and belts
- Mobile hoists
- Stair lifts and climbers
- Lifts (elevators).
Seven

Safely preparing for each task and adjust any equipment, aids and appliances

1. List the equipment and aids you have used with older people, eg walking aids, and the safety risk attached to the equipment.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Describe what sort of instruction you have received from your aged care facility to ensure your safety, when using equipment such as lifting machines.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Taking account of identified risks in the provision of personal support and technical support activities

Technical care activities are those personal care provisions that involve the use of machines, aids or equipment to assist the person or the carer we need to have an understanding of such activities and the proper use of the equipment so we can provide appropriate and safe information.

Some of these technical care activities are discussed below.

Hypertension (high blood pressure)

Blood pressure is the amount of force exerted against the walls of an artery by the blood.

Blood pressure (BP) is controlled by:

- The force of heart contractions
- The amount of blood pumped with each heart beat
- How easily the blood flows through the vessels.

Blood pressure constantly changes throughout the day and can be affected by stress, medications, diseases, smoking, drinking, general health and nutritional status. Factors that affect blood pressure include: age, gender, blood volume, stress, pain, exercise, weight, diet, drugs, position, smoking and alcohol.

Presenting problems:

Frequently there are no symptoms at all. Often hypertension is discovered during a medical examination.

There is no concrete measurement for high blood pressure, but the following figures are a useful guide:

- Normal blood pressure: less than 120/80
- High normal: between 120/80 and 140/90.
- High: 140/90 or above.
- Very high: 180/110 or above.

Hypertension (or high blood pressure) is defined as a repeatedly raised blood pressure over 140 and over 90 mmHg – a systolic (the top number) pressure above 140 with a diastolic (the bottom number) pressure above 90. Measurements below 100/60 are called hypotension and should also be reported. It is not unusual for an older adult to have a BP of 160/90, however a sudden change in a care recipients BP must be reported.
Systolic pressure
The maximum pressure exerted when the heart contracts.

Diastolic pressure
- The pressure in the arteries when the heart is at rest
- Blood pressure is at its highest as blood is forced out of the ventricle during the contraction (squeezing) period of the cardiac cycle
- This is called the systolic pressure
- It is at its lowest, when the heart is in the relaxation phase of the cardiac cycle
- This is called the diastolic pressure
- The difference between the systolic and diastolic pressure is called the pulse pressure.

Hypotension (low blood pressure)
The pressure of blood circulating around the body is lower than normal, or lower than expected, given the conditions in the environment. Low blood pressure is only a problem if it has a bad effect on the body. For example, vital organs (particularly the brain) can be starved of oxygen and nutrients if the blood pressure is too low for that particular client.

Symptoms
- Light-headedness, when standing from a sitting or lying position
- Unsteadiness
- Dizziness
- Weakness
- Blurred vision
- Fatigue
- Fainting.

Normal range of blood pressure for different age groups
- Average adult range is systolic 100-135mmHg and diastolic 60-80mmHg
- Blood pressures are rarely taken on infants and children (they are lower than adults):
  - May be taken as an assessment for renal/heart disease
  - <1 year = 85/54
  - 1 year to 6 years = 95/65
  - <10 years = 105/65
  - <13 years = 110/65

Taking blood pressure
- Position client.
- Practice the following competency skill.
Blood pressure is measured using a sphygmomanometer

Blood pressure is usually taken on the upper arm using a sphygmomanometer. There are other styles of equipment for taking blood pressure and the care worker must be trained in the correct use of the equipment used by their organisation.

Aneroid sphygmomanometer

Digital sphygmomanometer

Procedure

1. Wash your hands, consult care plan, gather your equipment, get consent, ensure privacy and establish client’s preferred arm considering risk factors.
2. Adjust valve nut for snug closure, but not too tight.
3. Fit sphygmomanometer cuff loosely above elbow so the manometer is easily visible.
4. Find the pulse and inflate the bulb until you can no longer feel the pulse. Take note of the measurement and deflate immediately.
5. Insert clean ear pieces. The ear pieces should point forward to fit to your ear canals.
6. Insert the diaphragm of the stethoscope under the cuff, over the brachial artery (front of arm).
7. Pump up cuff to around 100 mm Hg first and confirm that you can hear heart sounds. Then pump further so that no heart sounds are heard, approximately 20 mm Hg above the pulse palpation. (Do not go to painfully high pressures of >200 mm Hg unless necessary as this can be damaging to blood vessels.)
8. Slightly loosen valve nut so that pressure drops slowly (the manometer’s needle moves lower).
9. Listen carefully for the first heart sound to appear. Note the pressure at which this occurs. This is the systolic pressure. (The needle will begin to pulse just before the sounds can be heard.)
10. Allow the pressure to continue to slowly drop and note the pressure at which the beats become muffled or indistinct. This is the diastolic pressure.
11. Allow cuff to deflate completely to re establish circulation. Ensure the client is comfortable and record the BP on the appropriate chart.

Vital signs

Vital signs provide information about the client’s general health. Any change in a client’s ‘normal’ results must be documented and reported to the supervisor, as this may be the first sign of illness or infection.
Temperature readings

While an oral temperature of 37°C is generally thought to be a ‘normal’ body temperature, this is an average of normal body temperatures. A temperature may actually be 0.6°C or more above or below 37°C. Temperature measurements can vary throughout the day, depending on how active you are and the time of day. Body temperature is very sensitive to hormone levels and may vary according to the source of the temperature reading.

**Body temperature may be measured from different sites on the body using an appropriate type of thermometer:**

- Tympanic – ear
- Axilla – underarm
- Dermal – skin
- Rectal – anal.

A rectal or ear temperature reading is slightly higher than an oral temperature reading. A temperature taken in the armpit is slightly lower than an oral temperature reading. Cold drinks or food reduce oral temperatures, while hot drinks, hot food, chewing, and smoking raise oral temperatures. Increased physical fitness increases the amount of daily variation in temperature. Exercise raises body temperature. Psychological factors, such as excitement, may also influence body temperature.

**Can a low body temperature be dangerous?**

An abnormally low body temperature (hypothermia) can be serious, even life-threatening. Low body temperature may occur from cold exposure, shock, alcohol or drug use, or certain metabolic disorders, such as diabetes or hypothyroidism. A low body temperature may also be present with an infection, particularly in newborns, older adults, or people who are frail. An overwhelming infection, such as sepsis, may also cause an abnormally low body temperature.

**Can a high body temperature be dangerous?**

Heatstroke occurs when the body fails to regulate its own temperature and body temperature continues to rise. Symptoms of heatstroke include mental changes (such as confusion, delirium, or unconsciousness) and skin that is red, hot, and dry, even under the armpits.

Classic heatstroke can develop without exertion when a person is exposed to a hot environment and the body is unable to cool itself effectively. In this type of heatstroke, the body’s ability to sweat and transfer the heat to the environment is reduced. A person with heatstroke may stop sweating. Classic heatstroke may develop over several days. Babies, older adults, and people who have chronic health problems have the greatest risk of this type of heatstroke.

Exertional heatstroke may develop when a person is working or exercising in a hot environment. A person with heatstroke from exertion may sweat profusely, but the body still produces more heat than it can lose. This causes the body’s temperature to rise to high levels. Both types of heatstroke cause severe dehydration and can cause body organs to stop functioning. Heatstroke is a life-threatening medical emergency requiring emergency medical treatment.
Pulse rate

The pulse is the rate at which your heart beats. As the heart pumps blood through your body, you can feel a pulsing in some of the blood vessels close to the skin’s surface, such as in your wrist, neck, or upper arm. Changes in the pulse rate may indicate heart disease or another problem.

The number of times the heart beats is known as the pulse or heart rate. A normal range for an adult is between sixty and one hundred beats per minute and each individual’s pulse rate can vary. The rate, strength and rhythm must all be observed when measuring a pulse rate.

The usual sites for measuring a pulse are:

- Radial artery – on the wrist
- Carotid artery – on the neck
- Brachial artery – at the elbow
- Femoral artery – at the groin.

Document and report any changes in a client’s pulse rate to your supervisor as this may indicate changes in the condition of the heart and/or cardiovascular function, or the presence of pain or anxiety. Remember to avoid taking a pulse immediately after physical activity. Never use your thumb to take a pulse as it has a pulse of its own which can interfere with your observations. You may have difficulty feeling a client’s pulse, especially if they are elderly. If you encounter this problem, document and report the issue to your supervisor, an alternate site may need to be used or an alternate method devised.

Respiration

Breathing in and out is known as respiration. The resting rate of respiration does not usually change during adulthood. The normal respiration range for an adult is twelve to twenty respirations per minute. When measuring a client’s respiration, observations of rate, rhythm, depth, regularity and sound must be made. Observations are most reliable when your client is resting. Do not measure respirations after physical activity. Remember to document and report any changes to your client’s normal respiration as this may indicate changes in the condition of their lungs and cardiovascular system.
**Assisting with Gastrostomy feeds**

The **Gastrostomy Tube (Percutaneous Endoscopic Gastrostomies) or PEG** is a tube that is surgically inserted into the stomach through an opening in the stomach wall. The person with a gastrostomy tube cannot eat or drink fluids. Commercial or blended fluids are passed through the tube into the stomach. The site of the tube should be kept clean and observed for signs of infection.

**Gastrostomy care**

The person with the feeding tube should:

- When resting in bed, have their legs elevated and kept moving to avoid deep vein blood clots
- Have their sterile gauze pads around the incision site changed regularly
- Be taught to feed themselves properly through the peg feeding tube
- Remain upright for 30–60 minutes after feeding
- Not smoke
- Learn the proper care of their peg tube
- Wash the peg tube and skin around tube regularly to avoid infection
- Learn how to empty the stomach through the tube
- Learn how to recognise and handle such problems as a blocked tube or a tube that falls out of place
- Tape the tube site when not in use to prevent dislodging
- Not take prescription pain medication for more than seven days—after this point, non-prescription pain relievers (such as ibuprofen) can be taken as needed, but avoid taking aspirin or aspirin-containing products
- Resume normal activities as quickly as possible to promote healing.
Assisting with catheter care

A urinary catheter is a rubber tube that is inserted into the bladder to drain urine. A catheter is used before, during and after surgery to drain the bladder or to allow hourly urine drainage in conditions such as acute renal failure. A catheter may be used as a last resort in incontinence.

There are two types of catheters:

1. **Indwelling**: which goes into the urethra. In males this is through the penis. In females through the opening just above the vagina.

2. **Suprapubic**: which goes in just below the bellybutton.

To prevent infection, the area around the catheter is cleaned twice a day for all catheter types and, if the catheter is indwelling, after the client has opened their bowels. Clients may be able to do this themselves or you might have to assist them. Check with your supervisor/policies procedures or client care plan as to what type of cleaning solution you should use.

**Standard precautions**

- Check for kinks, and prevent the care recipient from lying on the tubing
- Keep drainage bag below the bladder
- Pin to bottom sheet and secure on the inner thigh. Place bag in drainage holder and attach to bed (not bed rail as this will be raised above the bladder when the bed rail is raised)
- Check for leaks.

**Perineal care daily and after bowel movements**

- Empty the drainage bag at regular intervals (according to organisational policy)
- Report any complaints of pain, burning, and the need to urinate to the registered nurse
- Observe urine for colour, clarity and odour.
Catheter hygiene

1. Identify the care recipient.
2. Explain the procedure to the care recipient.
3. Wash your hands and apply disposable gloves.
4. Empty the catheter, dispose of the urine and apply clean gloves.
5. Maintain privacy.
6. Protect the bed.
7. Perform perineal care.
8. Wet the washcloths and apply soap.
9. Separate the labia and clean downward from front to back with one stroke.
10. Repeat this until the area is clean, using a clean part of the washcloth for each stroke.
11. Rinse the area with a clean washcloth using the same technique.
12. Check for crusts, abnormal drainage or secretions.
13. Clean the catheter from the meatus down the catheter for about ten centimetres. Use soap and water and a clean washcloth. Avoid tugging or pulling on the catheter.
14. Cover the care recipient.
15. Remove gloves and wash your hands.

Blood glucose

Blood glucose monitoring assesses a person’s ability to use glucose. Assessing blood glucose levels identifies if the body’s glucose level is high (hyperglycaemia) or low (hypoglycaemia). If your client is a known diabetic, regular monitoring of blood glucose levels will determine how successful they have been managing their treatment through diet, exercise and medication. Blood glucose levels are measured in millimoles of glucose per litre of blood (mmol/L).

Normal levels of blood glucose:

- 4-6 mmol/L before meals
- 4-8 mmol/L approximately 2 hours after a meal.

A glucometer is used to assess the level of glucose in the body. A small drop of blood from the tip of the client’s finger is placed on a test strip which is inserted into the glucometer. The glucometer analyses the blood and displays the level of glucose. Ensure that the client has clean hands prior to testing as drink or food residue can give a false reading. The glucometer should be well maintained, calibrated correctly and the correct test strips used.

As there are many different styles of glucometers, the care worker will need to be trained in the correct use and maintenance of the particular style used by the organisation/client. You will need to be familiar with the signs and symptoms of hyperglycaemia and hypoglycaemia to competently observe a client with diabetes. Remember to document and report to your supervisor any changes in a client’s usual blood glucose levels.
Specimen samples

Specimens are small amounts of body fluids or substances that are collected in specific containers for examination and analysis. Specimens are analysed for evidence of disease, to identify health problems, to monitor treatment effects and to identify infection or any other abnormalities. While every body fluid or substance can be analysed, the common specimens taken are urine, blood, faeces, sputum and wound swabs. It is important that you correctly follow the specific procedures for collecting each type of specimen to ensure that contamination does not occur and the correct result is achieved. Remember that all specimens are a potential source of infection and should be handled accordingly.

Therefore:

- Adhere to standard precautions
- Clearly and correctly label specimen collection containers
- Follow organisational policy and procedures, document and report as appropriate.

Urinalysis

Urine samples are collected and tested to determine the presence of abnormal substances. This procedure uses commercially available testing strips. These are thin strips of plastic which are impregnated with chemicals that react with various substances in the urine and change colour. The existence of many disorders or diseases can be identified by the presence of different substances in urine. General observations of urine include colour, concentration, consistency, odour and volume. While there are a variety of urine test strips available, most test for glucose, bilirubin, ketones, specific gravity, blood, pH, protein, urobilinogen, nitrate and leucocytes. Remember to use standard precautions when conducting a urinalysis. The test strip must be fully immersed in the urine and timed correctly to ensure accurate results. Remember to document and report any abnormalities in your client’s urinalysis test to your supervisor.

Application of auto-thrombotic stockings
Deep vein thrombosis (often called DVT) is a common and potentially life-threatening complication that can affect any immobilised person. A thrombosis is a blood clot and a DVT is a blood clot in the deep veins of the leg or groin. While these can be painful and causes swelling in the leg below the clot, the most serious complication of DVT is a pulmonary embolism (embolus means to travel). A pulmonary embolism is a blood clot that travels into the blood vessels of the lung. The clot blocks off the circulation and prevents oxygen from entering the bloodstream. DVT can break apart and cause pulmonary embolism.

To prevent DVT and pulmonary embolism, people in critical care are often placed on a low dose of an anticoagulant (blood thinner). Heparin or other anticoagulants are injected under the skin to prevent clots from developing. You may notice small bruising on the person’s arms, legs or abdomen from the injections. Most people will also have white, elastic stockings on their legs. These stockings are called Thrombo-Embolic-Deterrent stockings. Most people refer to them as ‘TED stockings’. The person should be fitted for these stockings to get the correct size. The stocking compresses the leg in a graduated fashion to increase the return of blood up the leg veins.

Care needs to be taken when assisting a person to put on a stocking so a care plan should exist for workers to consult. The stocking should be rolled up before applying, similar to what you would do with a long sock. There should be no folds or creases and pressure should be even so it is not too tight or loose. The required height and position should be documented in the care plan as should what to observe and what to record.

**Assistance with breathing tubes (under direct supervision of a health professional)**

An endotracheal or breathing tube is a plastic tube used during mechanical ventilation. It is a procedure to assist a patient in breathing. One end of the breathing (endotracheal) tube is placed into the windpipe (trachea) through the mouth or nose. This is called intubation. The other end of the tube is connected to a breathing machine (mechanical ventilator).

**How does it work?**

The breathing tube provides a pathway for oxygen to move from the breathing machine to the lungs. Nurses secure the breathing tube with tape or a plastic device. Because the breathing tube passes through the vocal cords the patient will not be able to speak while the Endotracheal Tube is in position.

**Assisting with simple eye care**

**Eye care needs to be attended in the following situations:**

- In the presence of infection
- Prior to the installation of eye drops
- When the person suffers from dry eyes and needs to have artificial tears installed.

**When undertaking eye care it is necessary to:**

- Wash hands
- Observe the eyes for redness, swelling, changes to the size of the pupils, changes to the conjunctiva (white part of the eye).
- Lay the person on the infected side and, using cotton wool and normal saline, wipe from the inner to the outer canthus of the eye. Use a new cotton wool ball each time you wipe the eye. Attend the non-infected eye first.
- Report any changes in vision.
Wound care

Wound care usually involves cleaning and covering a wound with an appropriate dressing to promote healing and prevent infection. The specific dressing required will depend on the type of wound, the health status of the client and the recommendation of the client’s doctor. Wound care requires good nutrition, hygiene, observation and monitoring to prevent problems or complications.

Care and prevention of pressure ulcers

A bedsore or decubitus ulcer is known as a pressure ulcer. These usually occur when a bony area with only a thin layer of skin is in contact with a firm/hard surface such as a bed or wheelchair. If the pressure on the area of skin is not relieved on a regular basis by repositioning and maintaining good hygiene, then a pressure ulcer develops. Avoiding moisture, minimising prolonged friction and managing incontinence can help reduce the risk of developing a pressure ulcer. The most common sites for pressure ulcers are the buttocks, hips, shoulder blades, heels and the sacral area of the back.

Older clients are more prone to pressure ulcers due to the fragility of their skin but other factors which increase the risk of developing a pressure ulcer are:

- Chronic illness or disease
- Obesity
- Incontinence
- Immobility
- Poor nutrition
- Diminished sense of pain.

While a pressure ulcer can develop within hours, it may take years for the ulcer to heal. There are many different strategies that can be implemented to assist with the prevention and care of pressure ulcers. A care worker must know the care plan for their client and carefully follow the procedures recommended.
Amputation and stump care

When a part or all of an arm or leg is removed, this is called an amputation. The need for an amputation may be caused by diabetes, vascular disease, cancer, injury, trauma or meningococcal disease.

There are various types of amputations:
- Bilateral – both limbs removed (either arms or legs)
- Unilateral – one limb removed (either an arm or leg)
- Trans-tibial – below the knee, midway down the calf
- Through knee – from across the knee joint
- Trans-femoral – above the knee
- Above the elbow – above the elbow
- Below elbow – below the elbow.

Oxygen therapy

Oxygen therapy is the administration of medical oxygen to clients who have low levels of oxygenation. Oxygen therapy may be required for clients who have damaged lungs due to disease, injury, emphysema, asbestosis, lung cancer, chronic bronchitis or a pneumothorax.

The amount of assistance provided will depend on the:
- Knowledge and skills of the care worker
- Oxygen delivery equipment that is available and used for the client
- Organisational policy and procedures.

Oxygen is a highly combustible gas and should be administered in a well ventilated room and kept away from heat and flame. Remember that oxygen is a medication and can be toxic if delivered at high levels over a long period. Report immediately to your supervisor any signs and symptoms that a client is lacking oxygen (hypoxia).
Eight

Taking account of identified risks in the provision of personal support and technical support activities

1. Briefly describe four technical activities you may be required to assist your clients with.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. What would you do if you were asked to perform or provide assistance with an activity for a client, for which you had not received appropriate training?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Identifying and responding to routine difficulties during support routines, and report more complex problems to supervisor

There may be different reasons for not being able to complete allocated work tasks. These may include unreasonable workloads or poor time management skills. The client's needs may have changed and allocated time and resources may not be sufficient to fulfill needs.

It is important as an employee to take responsibility for one's own work and develop skills to monitor and evaluate your own performance. Recognising that in the health care sector that we may work independent but are still part of a broader team. Participating in new learning experiences will assist in improving skills and knowledge.

When unable to perform allocated tasks it is important for your supervisor to be informed. This allows other staff to know where assistance is still required for clients or may result in changes to workload depending on the reasons for not completing workload. When dealing with clients it is also important for them to know if you are unable to a complete task or attend for a scheduled appointment. Always explain the reason behind not being able to assist them, as just telling them you 'will be there soon' only leads to frustration for both parties.
Identifying changes in the person’s health or personal support requirements and report to supervisor

Often one of your key roles as a worker is to identify the client’s immediate concerns and make sure they are followed up and responded to appropriately. For many clients, immediate concerns often revolve around things like:

- Change in environment
- Change in routine
- Change in health
- Financial concerns
- Problems within the family
- Loss of a material object.

Basic skills in observation in order to report changes in a person’s condition

Promoting health rests on taking a holistic approach, one that looks not only at the more obvious health factors, such as diet, weight, exercise and diseases that might impact on health but considers other things, such as the physical and socio-emotional environment. It involves careful observation and the skilful use of questioning skills to verify any changes.

Observing clients is a vital part of the health support or aged care worker’s role. To be able to report changes in a client’s condition or needs, the carer must be a good observer. To observe people in your care, you must use ALL your senses. Observing is much more than just looking at the person.

Anything unusual or out of the ordinary should be noted and reported to the supervisor. For example, you may smell a strange odour, hear a moan or groan or feel an unusual swelling or lump on the skin. Sometimes you will hear a moan only to find that the client is lying injured on the floor with their walking frame on the other side of the room. It is important to remember these observations when the fall is being analysed so that the cause of the fall can be determined accurately. The person finding the fallen client may not be the one undertaking the fall analysis, therefore it is critical that information such as this is clearly documented.

It is important to know your client to be effective in the care you give. ‘Care’ includes being attentive to change and reporting any changes to the relevant person. The health support or aged care worker must first know what is ‘normal’ before they can recognise what is not normal. The age, gender and known medical condition and diagnosis of the client must be kept in mind.

It is good professional practice to establish an organised way of observing. Assisting clients with personal hygiene is a good opportunity to observe skin integrity, communication skills, orientation to time and date for example, and any changes in behaviour. Transferring clients from one position to another can provide an opportunity to observe mobility. If you are not watchful during all interactions with clients then changes will be missed.

Once changes in health status are noticed, it is important to discuss any needs that arise from these, firstly with the client whenever possible, then following organisational protocols – much depends on the situation. In a residential facility there will be staff available to consult, in a group home it may be the service manager/case manager and within the client’s own home, it may be a family member – in each of these examples, the worker is still required to document what was observed and what action was taken.
Activity

Nine

Identifying changes in the person’s health or personal support requirements and report to supervisor

Case study

Mrs. Michael is 85 years of age, and has dementia. This morning she complains of pain in her right shoulder, and says she has severe stomach pain. However in the past she has complained of the same symptoms, but was later found to be her imagination. Mrs. Michael is not your favourite client, but you feel you must do something about what she has told you.

1. Who would you report your observations to?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. What specific information would you need to report?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. Write a brief statement for each example taking care to provide all necessary details and to keep information objective (i.e. free of judgments and assumption).

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Personal support care

The reasons why a person may need assistance with physical personal care activities are as diverse and individual as the degree of assistance each requires.

Regardless of the reason for assistance or the amount of assistance required, there are some general considerations for the personal carer when supporting clients in their daily personal care activities:

- The personal carer's role is one of support and assistance, enabling individuals to live their lives in the way they wish and reside in the place they wish
- There are some important aspects of personal care which need to be acknowledged if this care is to be delivered appropriately and effectively
- The invasiveness of having personal care tasks performed on another person cannot be underestimated
- It is also important for the personal carer to be aware of and practice current health and safety precautions
- When assisting with any personal care activity, the dignity and privacy of the client is a major focus

The following issues carers might need to take into consideration when assisting a person with personal care tasks.

- The client’s own routine and pace
- Health and safety precautions
- Care’s appropriate pace for undertaking tasks preparation
- Independence
- Choice and control
- Privacy and confidentiality
- Use of aids and equipment
- The carer’s reactions and responses
- Focus on the client’s ability not disabilities
- Communication
- Body language.
Toileting and bowel care

To prevent constipation a well balanced diet is important, a diet high in fibre with an adequate fluid intake is important. You can help and encourage your clients to choose a well balanced diet to help prevent bowel problems. There is a range of product available to protect the client’s skin, clothing and dignity. These include pads, liners, disposable briefs and protective underwear, which need to be changed as required. Ask your supervisor about the range of product your organization makes available.

Normally urine is passed easily, without pain or discomfort, it has a slight odour, is clear and straw coloured. If you notice any difference to what has just been described contact your supervisor and document. Normally faeces is passed easily without pain or discomfort, it is brown in colour, formed (not liquid) semi solid (not rock hard), has a distinct smell and excreted in amounts which will vary with each individual. If there are any differences to what has been described contact your supervisor and document.

Before clients bathe offer them the use of the toilet. The assistance you will need to give will depend on the level of independence. You will need to check that there is an individual client plan of care for toileting. If there is not, speak with your supervisor. For clients who are mobile and continent you may just need to remind them to go to the toilet. These clients should have easy access to a toilet and have facilities to wash their hands afterwards. Other clients may have continence problems.

These may include:

- Stress incontinence – loss of urine when the client sneezes coughs or laughs, may also occur during physical exertion.
- Urgency incontinence – they experience an urge to go the toilet and must go straight away or they immediately lose the urine.
- Total incontinence – constant loss of control of bladder and bowel
- Overflow incontinence
- Functional incontinence
- Reflex incontinence
- Mixed incontinence.

As you can imagine any of these situations would be embarrassing. Your role is to ensure the client’s dignity and self-esteem is maintained through patience and understanding, and to implement their individualised care plan. These care plans may include a regular toileting regime to promote continence.

For clients who have stress or urgency incontinence there are a range of absorbent pads, which are available to insert into underwear to protect skin condition and clothing. You will need to check with clients if they need to be changed on a regular basis. Once again ensure your clients have easy access to the toilet and if they indicate they wish to go to the toilet and you must assist them straightaway.

If the client is incontinent ensure wet clothing is removed straightaway and the skin is washed and dried, this is to ensure the skin is cared for and the client’s dignity is maintained. Clients may also be given exercises (by a physiotherapist) to perform during the day to help strengthen their pelvic muscles to help improve their continence. You may need to remind and encourage your clients to do these exercises.

Some clients may be incontinent of urine and faeces. Bowel management plans for clients should be in place. These management plans aim at developing regular bowel habits. For those clients with no control they may have a regular time in the day where they are given a suppository to help empty the bowel and establish a routine. You would need to discuss this situation with your supervisor and follow policies and procedures.
To prevent constipation a well balanced diet is important, a diet high in fibre with an adequate fluid intake is important. You can help and encourage your clients to choose a well balanced diet to help prevent bowel problems. There is a range of product available to protect the client’s skin, clothing and dignity. These include pads, liners, disposable briefs and protective underwear, which need to be changed as required. Ask your supervisor about the range of products, your organisation has available.

**Toileting a resident**

![Image of commode](https://via.placeholder.com/150)

**There are several methods used when toileting a client/resident with limited mobility is an issue:**

- A commode is a portable chair or wheelchair with an opening for a pan for toileting. When using a commode chair to transport a resident, use a modesty or dignity gown. Some can be placed over the toilet. This is used for residents who have difficulty walking to the toilet.

- Bedpans and urinals are used when residents cannot get out of bed. Males use a bedpan for bowel movements and use a urinal for urination. A fracture pan has a thinner rim and is only about 1/2 inch deep at one end. They are used for residents who have limited range of motion in their back.

Encourage independence at all times. Always provide privacy and dignity for the client.

**Implications for aged care and health support workers**

The nursing assistant must be aware of the normal patterns of urination and report any changes to the registered nurse. It is also important to encourage continence in every instance.
Bathing and showering

Our clients will have a preferred routine when it comes to bathing or showering. Some people like to shower early morning others before they go to bed. Some clients do not like to shower every day. Therefore, clients need individual assessment and a plan of care must be worked out with their input. Remember when giving care we should use minimal touch at all times. This ensures maintaining client dignity, self-esteem and independence.

Let's look at the benefits of bathing. It is something that is done on a regular basis with the benefits including:

- Cleansing and refreshing
- Helps to relax the individual
- Helps increase circulation
- It is a time when skin assessment can be carried out.

Support worker responsibilities

As the aged care or health support worker your responsibilities when assisting a client shower include:

- Knowing the client's level of independence
- Not leaving a client alone who requires supervision
- Ensuring correct water temperature
- Ensuring the client can contact you if they require assistance ie having a buzzer or bell at hand
- Organising equipment
- Ensuring privacy
- Ensuring a safe environment.

Various factors affect an individual's choice of the method of attending personal hygiene. These include:

- Bath, shower or sponge.
- Time
- Ability
- Equipment available
- Social and cultural factors
- Compliance.

When giving care we should use minimal touch at all times this ensures maintaining client dignity, self-esteem and independence.

The effects of bathing on ageing skin

As people age their skin becomes more fragile. The sweat glands and the sebaceous glands become less active. It is therefore necessary to review whether the resident needs to be bathed every day (of course if the person is incontinent this needs to be attended to immediately). Care needs to be taken with the use of soaps and the way in which a person is dried.
When attending a bath, shower or sponge, the following points need to be remembered:

- Start with the clean parts of the body – face first to genitalia last
- Ask the resident if they want you to use soap
- Encourage the resident to wash as much of themselves as possible
- Check if dressings are to be removed
- Maintain privacy
- Use aids to promote independence
- Observe for changes to skin
- Encourage as much movement as possible
- Communicate with the resident in a respectful way, remembering they are very vulnerable at this point.

**Oral care**

Another part of everyone’s personal hygiene includes good oral care.

**Clients who do not follow a good routine of oral care can experience the following problems:**

- Coated and inflamed tongue
- Halitosis (bad breath)
- Inflamed and receding gums
- Discoloured teeth
- Dental caries (holes in teeth)
- Ulcers
- Cracked lips.

Note: Some medications can also cause some of these problems.

If oral hygiene is neglected further problems can occur including loss of appetite, the inability to eat, infections and low self-esteem. Part of your role again is to assess your client’s ability to perform oral hygiene and also, if you notice any of the above oral problems reporting them to your supervisor and document. Your role may be as simple as reminding your client to brush their teeth to helping them to perform oral hygiene.

**Oral hygiene should be performed:**

- After meals
- With an appropriate tooth brush dependent on client wishes, often clients will use electric tooth brushes
- With toothpaste and ensure thorough rinsing
- Flossing teeth as per client’s wishes.
**When attending mouth care it is necessary to:**

- See whether the resident has dentures, a plate or their own teeth
- Assess the resident’s ability to perform their own mouth care
- Assess the resident’s preference for cleaning agent
- Assess the presence of infection and observe whether the mucous membrane in the mouth is intact
- Use an appropriate and preferred cleaning agent, remembering to rinse well.

**Hair care**

![Image of hair care]

**We should assess for the following and report changes to supervisors:**

- The general condition of the hair noting any dryness or excessive oiliness
- Hair that is brittle (breaks easily)
- Signs of balding
- Infestation of lice or nits
- Flaking of the scalp
- Redness due to pressure.

Remember: the frequency with which you wash hair is a personal choice. It is not necessary to wash a resident’s hair every day. Just like you would, following bathing, ensure the client’s hair is brushed or combed.

**The benefits of brushing or combing hair include:**

- Stimulating circulation
- Removing dry scalp
- Improved self-esteem.

Ensure if you are brushing/combing hair that the brush or comb is clean, you are gentle and guided by your client’s sensitivity level. Remember there should be minimal touch so if the client can comb or brush their own hair ensure they do it.

**If you are shampooing a client’s hair:**

- Ensure the water temperature is correct
- Hose away from the face
- Use appropriate shampoo and conditioner and always read the instructions
- Always rinse well
- Dry and style in accordance with client’s wishes
- All perming/dying/cutting to be done by a hairdresser.
Shaving

This again is part of most male clients’ routine. Some clients will grow a moustache and/or a beard that need to be groomed by washing and combing. Shaving is a personal preference. It is often difficult to shave the face of an elderly man as the skin does not lie flat and there can be many wrinkles. Shaving is done to remove whiskers that can itch and irritate the skin. Check that your organisation has policies and procedures in place. You will also need to check there is an individual care plan for your client, otherwise confer with your supervisor on how to shave clients. Many will use an electric razor as they are safer.

When using an electric razor:

- Check to see that it functions and is clean
- Use the appropriate setting if adjustable
- Use in a circular motion until the skin is smooth
- Clean razor afterwards.

If using a blade razor:

- Ensure the blade is clean and rust free
- Use warm soapy water or shave cream depending on the client’s wishes
- If you are shaving hold skin firmly
- Shave in the direction the skin is growing
- Rinse the blade frequently
- After shave may be applied depending on client’s wishes.

Some female residents may wish to have their axillas (under arms) and their legs shaved and have their facial hair attended to. (However it is preferable NOT to shave the faces of females if possible. Some sort of depilatory is preferred).
Nail care

Nail care is important for clients. It is important that they are kept clean and well shaped. Dirty nails can spread infections and any area around the nail that is damaged. Torn cuticles are an entry point for infection. If clients are able to care for their nails encourage them to do so. It is recommended that a Podiatrist be consulted for toenail cutting and to assess any foot conditions the client may have. If they need assistance what do you need to do?

We should assess for the following and report changes to supervisors:

- Inflamed areas around the nails, this could indicate an infection
- White or bluish colouring of the nails may indicate circulation problems
- Cracked or brittle nails
- Unusual or irregular shaped nails.
- Hand and fingernail care includes:
  - Nails can be cleaned in the shower with a soft brush
  - Following the shower/bath clean under the nail if there is dirt
  - Moisturise the hands with an appropriate cream
  - Shape the nails as per client’s wishes ensuring there are no sharp areas, using a file.

Foot and toenail care includes:

- Wash and dry feet and between the toes following bathing
- Assess the feet and toe nails as discussed above
- Never cut the toenails of a diabetic or a client with circulatory conditions
- Your organisation or workplace will usually have a visiting podiatrist who will cut clients toenails.

Good foot care is essential especially for client’s who have circulation problems, diabetes, or have para/quadriplegia. For these clients poor foot care could lead to ulcers forming and these in turn could lead to amputation. Report any abnormal findings and document. Check that your organisation has policies and procedures in place. You will also need to check there is an individual care plan for your client, otherwise speak with your supervisor regarding the cutting of client’s nails.

Good skin care

We have looked at assessment of the skin and reporting any changes. On a day-to-day basis we need to assist clients in general skin care. Appropriate soaps or body washes need to be chosen which are suitable for the client’s particular skin type. Harsh soaps can cause dryness itching or rashes.

- Moisturising the skin keeps it supple and prevents dryness.
- If clients are outdoors a good sunscreen is needed to prevent sunburn.

When assisting showering or bathing a client it is important to dry all body areas. Body area’s which are left wet or damp may cause the skin to breakdown forming sores and could lead to infections. The most common areas of concern are under the breasts of female clients and the scrotum area of males. Wearing appropriate clothing and shoes are also important for good skin care. Clothing or footwear that rubs or causes friction can cause damage to the skin.

Good nutrition plays an important role in maintaining healthy skin, and a good fluid intake prevents dry skin. Helping and encouraging clients chose a well-balanced diet is an important aspect of their care. As aged care and health support workers you will ensure good skin assessment and care for your clients if you follow the points we have discussed.
Pressure area care

Clients with impaired mobility are at risk of serious problems that can occur as a result of prolonged pressure on specific body areas.

**The area's most at risk include bony prominences for example**

- Back of the head
- Ears
- Shoulder blades
- Elbows
- Buttocks
- Knees
- Heels.

Clients with mobility limits are restricted in movements. Movement is needed to redistribute weight as required by the body. When pressure is placed on a body part and not relieved blood flow can be interrupted and sores or ulcers can form. If a client has reduced sensitivity (feeling) they will not feel the sensation that you would, indicating it is time to change position, leading to the same situation described above. Incontinence makes the skin more at risk of damage as the skin can breakdown and cause sores.

Shearing forces and friction can damage the skin. This occurs when the skin is dragged across a surface eg being pulled up a bed sheet. Part of the role of the aged care and health support workers as already discussed is to assess client’s skin condition, which could indicate pressure areas, which could or are developing. This is why it so important to notify supervisors and document any changes without delay. Check that your organisation has policies and procedures in place. You will also need to check there is an individual care plan for your client, otherwise confer with your supervisor for the prevention strategies that need to be implemented to prevent pressure sores.

**Some strategies will include:**

- Educating client and carers about pressure sores, their causes and how to prevent them
- Reposition the client on a regular basis, the timing of re-positioning will vary between individuals, re-positioning can be as simple as a client lifting themselves up frequently to relieve pressure on the buttocks
- Use of pressure relieving devices eg heel support, sheep skins
- Moving clients appropriately, to prevent shearing and friction
- Providing good skin care
- Preventing injury to skin by wearing appropriate clothing and footwear
- Promoting, good nutrition.
Hand and foot care

Hand and foot care is necessary for the following reasons:

- Improved self-esteem
- Personal grooming
- Prevention of infection
- Treatment of infection.

When attending hand and foot care it is necessary to:

- Observe for abnormalities: paronychia, hangnail, split cuticles, hammertoe, bunions, corns and calluses – report these in the notes
- Keep nails short and clean (however some residents like to have long, painted nails)
- It is best to attend nail care after a shower
- Cut nails straight across and slightly curved at the sides. Use an emery board to smooth the edges.

It is not the responsibility of the aged care worker to attend to the nail care of a resident or client who has diabetes.

Nail care

Nail care is important for clients it is important that they are kept clean and well shaped. Dirty nails can spread infections and any area around the nail that is damaged ie torn cuticles is an entry spot for infection. If clients are able to care for their nails encourage them to do so.

If they need assistance what do you need to do?

We should assess for the following and report changes to supervisors:

- Inflamed areas around the nails this could indicate an infection
- White or bluish colouring of the nails may indicate circulation problems
- Cracked or brittle nails
- Unusual shaped nails eg spooning or hollowing of nails may indicate anaemia.

Hand and finger nail care includes:

- Nails can be cleaned in the shower with a soft brush
- Following the shower/bath clean under the nail if there is dirt
- Moisturise the hands with an appropriate cream
- Push cuticles back gently
- Shape the nails as per client’s wishes ensuring there are no sharp areas.

Foot and toenail care includes:

- Wash and dry feet and between the toes following bathing
- Assess the feet and toe nails as discussed above.
Foot care for high needs clients

Good foot care is essential especially for client’s who have circulation problems, diabetes, mobility problems, paraplegia or quadriplegia. For these clients, poor foot care could lead to pressure areas or ulcers forming and these in turn could lead to amputation. Report any abnormal findings and document. Check that your organisation has policies and procedures in place. You will also need to check there is an individual care plan for your client, otherwise confer with you supervisor regarding the cutting of client’s finger or toe nails.

Eye care

Eye care needs to be attended in the following situations:

- In the presence of infection
- Prior to the installation of eye drops
- When the resident suffers from dry eyes and needs to have artificial tears installed.
- When undertaking eye care it is necessary to:
  - Wash hands
  - Observe the eyes for redness, swelling, changes to the size of the pupils, changes to the conjunctiva
  - Lay the resident on the infected side and using cotton wool and normal saline, wipe from the inner to the outer canthus of the eye (use a new cotton wool ball each time you wipe the eye) – attend the non-infected eye first
  - Report any changes in vision.
**Hearing aids**

Some of our clients will use hearing aids here are some helpful tips on how to care for them:

- Must be protected from heat, moisture and breakage and direct sunlight
- Mould and tubing should be free from wax and moisture
- The mould is disconnected from battery device before cleaning
- Remove before showering, hair-washing or swimming
- Switched on when in use and adjust volume as desired by client
- Switched off when not in use
- Check battery replacing when necessary
- Do not use hairspray near the aid.
- Do not attempt to clean with a liquid
- Investigate ‘whistling’ - can be as a result of poor fitting ear mould, incorrect positioning of ear mould, cracked or broken tubing, or volume turned up too high
- Insertion- switch on, insert ear mould gently into ear canal, adjusted volume and place the hearing aid tube over the ear.

**Good sleep**

Measures to promote sleep include:

- Consistent bedtime and wakeup time
- Use bedroom for sleep, not eating, TV viewing, reading

Environmental strategies eg:

- Comfortable bedroom temperature
- Diminished noise level
- Darkened room
- Comfortable sleepwear
- Locks/smoke alarms increase security
- Regular exercise
- Leaving bed if unable to fall asleep in 15 mins and returning when feeling drowsy
- Head positioning is helpful with sleep apnoea
- Avoiding large meals just before bedtime and limiting alcohol, nicotine, caffeine and foods that contain MSG
- Foods to help sleep: milk, turkey, lettuce (contains tryptophan)
- Relaxation techniques: meditation, music therapy, guided imagery, progressive muscle relaxation, self-hypnosis.
Circulatory system: Responsibilities of aged care and health support workers and practical aspects of management

As an aged care and health support worker caring for a client with circulatory problems you may be required to: take their vital signs (temperature, pulse, respiration and blood pressure). Lifestyle changes are vital in the ongoing management and prevention of heart disease and as such education plays a key role.

You may also be required to perform the following responsibilities:

- Complete fluid balance chart
- Daily weight of the client
- Assist with oxygen therapy as directed
- Assist with activities of daily living
- Application of antithrombotic stockings.

Instruct and assist the client to sit up slowly. Do not leave the person during an episode. Allow them time to adjust to the position before walking. For example; before waking a client allow them sit them on the side of the bed for a minute or two before walking to the bathroom first thing in the morning.

Lung cancer: Responsibilities of aged care and health support workers and practical aspects of management

As an aged care and health support worker caring for a client with respiratory problems you may be required to: take their vital signs (temperature, pulse, respiration and blood pressure). Lifestyle changes are vital in the ongoing management and prevention of respiratory disease/condition and as such education plays a key role.

You may also be required to perform the following responsibilities:

- Comfortable position of client that facilitates breathing and eases pain (eg orthopneic position)
- Collection of sputum specimens into a sputum container
- Ensure standard precautions practiced when appropriate especially when disposing and collecting sputum
- Assist with activities of daily living.
- Assist with oxygen therapy as directed
- Assist with deep breathing and coughing exercises and postural drainage
- Ensure the client is comfortable and report discomfort to you supervisor.

Osteoporosis: Responsibilities of aged care and health support workers and practical aspects of management

As an aged care and health support worker caring for a client with musculoskeletal problems you may be required to: Take their vital signs (temperature, pulse, respiration and blood pressure). As there are several complications of immobility such as pressure ulcers, constipation, deep venous thrombosis, pulmonary embolus and pneumonia it is important that the aged care workers:

- Access mobility aids as much as possible
- Perform active and passive exercises to maintain muscle and joint flexibility
- Access aids to assist in activities of daily living / involve the client in activity programs.
- Be aware, of how health problems of the musculoskeletal system can affect a person’s appearance and consequently their self-esteem.
- Aged care and health support workers may be required to apply prosthesis. Apply splints as directed by the registered nurse or the allied health professional.
Falls: Responsibilities of aged care and health support workers and practical aspects of management

Falling is one of the most serious and frequent problems associated with the ageing process. Falls are a symptom of a problem that may be related to neurological, sensory, cognitive or musculoskeletal problems. Falls can also occur when residents are on certain medications.

When a resident is admitted to a facility they may undergo a falls risk assessment. This will determine the extent to which the resident is at risk of falling and assist staff in implementing measures to reduce this risk. Various measures can be implemented to firstly reduce the risk of falls eg mobility aids and secondly to reduce injury in the event of a fall eg hip protectors.

Generally, the indications that someone is at risk of falling are:

- Loose shoes
- Loose clothing
- Person is lost or confused and anxious
- Person is swaying or is on a lean
- Person is looking tired
- Person is clutching on to things for support
- Person is short of breath.

Caring for a person who is visually impaired

As an aged care or health support worker it is important that you identify how the person who is visually impaired wants you to assist them as well as ensure that their environment is not cluttered. Depending on the severity of visual impairment visual aids such as glasses should be worn, adequate lighting, telling the person where you are, using large print books, Braille for the blind.

When caring for a person who is hearing impaired:

- Gain the person’s attention
- Make sure the client can see your face
- Do not shout when communicating
- Be patient and speak clearly.

Sight and hearing aids: Responsibilities of aged care and health support workers and practical aspects of management

As an aged care or health support worker caring for a client with visual problems you may be required to:

- Orient the client to their surroundings.
- Encourage independence in activities of daily living
- Observe and report any deterioration in any sight
- Provide visual aids where necessary
- Explain all procedures
- Perform simple eye care.

You may be required to perform the following responsibilities in caring for someone who is hearing impaired:

- Using correct communication techniques such as using non verbals, reducing background noise, gaining the clients attention before communicating
- Provide aids where necessary.
Care of hearing aids: Hearing aids need regular care and maintenance and any defect needs to be reported immediately. Keeping the hearing aid clean is as easy as wiping it with a soft, dry cloth. Any visible wax can be removed using a cleaning tool such as a wire pick. Be careful not to use solvents or alcohol on the hearing aid and keep away from direct heat and water. Also, keep hearing aids away from children and pets.

Care of spectacles: Spectacles (glasses) are also easy to care for. They should be cleaned daily with a lens cleaning cloth and rinsed once a fortnight in warm, soapy water and dried carefully.

Dementia: Implications for aged care and health support workers

It is important to recognise what task the person is having trouble doing and assist them. Prompting them or initiating a task may be of great benefit. Incorporate earlier life skills and interests, and provide a calm, caring, and structured environment. It should be noted that these clients are sensitive to attitudes and seem to know instinctively whom they can trust. Non-verbal language on the part of the carer is very important. It is important to not personalise the behaviour of the client – most of the time their behaviour has nothing to do with the carer; it is part of the manifestation of the disease.

- Observe and record problem behaviours
- Provide a routine
- Provide consistency of care as much as possible
- Ensure client is well groomed to enhance self-esteem
- Diversional therapy

Therapy may include reality orientation, validation, reminiscing but should be individualised.

Parkinson’s disease: Implications for aged care and health support workers

Parkinson’s disease is a chronic progressive disease that is linked to a decrease in a chemical in the brain called dopamine. The client may experience trembling and shaking of the limbs even when the client is resting. They may have stiffness of the limbs and slowness of movement, poor balance, and coordination. They may have a tired mask-like expression, drooling and shuffling when walking. It is important to note that intelligence is not affected until dementia occurs.

The ‘on/off syndrome’: after taking medications for some time, some clients may find that the drugs act for a shorter time. There can be sudden fluctuations in performance, which can be frustrating for carers. A great deal of understanding is needed to recognise the ‘on/off syndrome’ and deal sympathetically with it. ‘Freezing’ occurs when the client cannot move suddenly. In order to overcome this, draw an imaginary line on the floor and ask the client to step over it. This often has the effect of ‘unfreezing’ their movement.

Help may be required in the following areas:

Mobility
- Sit the client in chair that is easy for them to get out of
- Encourage regular exercise
- Always put well-fitting shoes on their feet
- Educate the client on how to turn in a wide circle so they do not fall when turning around
- Educate the client on how to keep their elbows close to sides to reduce the impact of tremor whilst dressing and writing
- Encourage the client to swing their arms when walking to improve balance
- Encourage the client to hold on to something to reduce tremor.
Eating

- Assist client when required but maintain independence
- Ensure food is in small pieces
- Allow plenty of time for eating
- Encourage client to sit upright.

Communication

- As there is limited facial expression and an absence of body language as well as fluctuations in ability, patience is needed when communicating with these clients
- Encourage the client to participate in social activities.

Diet

- Encourage a high fibre diet to prevent constipation
- Ensure the client gets plenty of fluids – depending on the severity of the disease the client may need supervision or assistance with feeding their meal.
Mental health conditions: Implications for aged care and health support workers

Mental health conditions carry a lot of stigma in society. Mental illnesses are a group of diseases that affect the brain and thus behaviours may be affected. The following are some common mental illnesses.

**Schizophrenia:** This is a mental illness in which people have a distorted view of reality, social withdrawal; can be accompanied by delusions and hallucinations. As an aged care and health support worker you may need to provide support with personal hygiene and nutrition. Provide positive reinforcement and help the person to work towards an achievable goal. Do not stigmatise, become understanding of what the person in going through. Develop routines and maintain a stress free environment.

**Personality disorders:** This comprises group of mental disorders in which, a person is unable to adapt to normal social situations. They often find it difficult to relate to people. An example is obsessive compulsive disorder. As an aged care or health support worker you need to reinforce appropriate social behaviour and communication. Diversional therapy, distraction and keeping the client occupied is important. Also establishing rules and being consistent is an important strategy.

**Bi-polar disorder:** A chemical imbalance in the brain, causes the sufferer to experience periods of intense elation, interspersed with periods of intense depression. People with bipolar disorder are at risk of self-harm and suicide. As an aged care or health support worker you are required to report to you supervisor if a client states to you any such expressions.

**Depression:** A feeling of sadness, despair and emptiness that may be caused by feelings of inadequacy, loss, tragedy and/or a chemical imbalance for at least two weeks. The client with depression may have difficulty sleeping, eating and performing their usual activities of daily living. As an aged care or health support workers listen to the client and acknowledge their feelings. Provide support for the person and encourage a positive environment. Always report any changes in the person to your supervisor.

**Anxiety disorder:** Anxiety disorders include phobias and post-traumatic stress disorder. The client may have panic attacks. Often obsessive and compulsive thoughts and actions, irrational fears, persistent or excessive worrying occur. As an aged care or health support worker it is important to be aware that fear is very real to the client. Even though, to you it may be irrational behaviour. Acknowledge the person’s feelings and reassure them that they are safe and if possible, remove the source of the fear. As an aged care or health support worker caring for a client with neurological conditions you may be required to: take their vital signs (temperature, pulse, respiration and blood pressure).

You may also be required to perform the following responsibilities:

- Assist with the client’s rehabilitation
- Work with other members of the health care team
- Assist with activities of daily living
- Encourage client independence.
Integumentary system: common health problems

The following are common health problems associated with the integumentary system. Read through these problems and familiarise yourself with the responsibilities that you have as an aged care or health support worker caring for aged persons with these problems. As always you must remember that you are working under the supervision of an RN/Supervisor and as such all problems need to be reported and documented.

Skin lesions

- Lesions such as keratosis and skin cancers are common. Senile purpura is related to the loss of subcutaneous tissue.
- Most of these lesions cause little discomfort, although skin cancers need to be treated.
- Stasis Dermatitis associated with leg ulcers
- Leg ulcers are common in the older person, and the resulting oedema causes an eczema-like reaction

The leg ulcer needs to be treated by diagnosing the type of ulcer (Does the problem arise because of problems in the veins or the arteries?) Venous ulcers are much more common than arterial and are treated by application of compression (although this should not be used if there are arterial problems)

Psoriasis: Psoriasis is usually hereditary and presents as bright red macules or patches covered with silvery scales. A good healthy lifestyle, stress management and topical medications such as corticosteroids and tar preparations.

Pressure ulcers

There are four stages in the development of pressure areas.

These are:

1. Stage I: area of skin becomes red which does not return to normal colour with relief of pressure.
2. Stage II: epidermis breaks or a blister is present; surrounding area is reddened.
3. Stage III: breakdown in epidermis through the dermis; exudate is present, it may be serious or purulent.
4. Stage IV: breakdown extends into subcutaneous tissue, muscle and bone; exudate is usually present (serous or purulent); sinuses and widely undermined areas may be present.

Some scales include a Stage V: infective necrosis; destruction of muscle occurs rapidly.
Integumentary system: Responsibilities of aged care or health support workers and practical aspects of management

As an aged care or health support worker caring for a client with integumentary system problems you may be required to: Take their vital signs (temperature, pulse, respiration and blood pressure). Personal care will be specific to each client with a skin disorder. Clients will experience changes in self esteem and health aged care and health support worker need to be aware of this and communicate effectively and appropriately and act professionally at all times.

You may also be required to perform the following responsibilities:

- Showering/bathing a person
- Shaving
- Grooming
- Re-positioning
- Pressure area care
- Wound care.
Gastrointestinal tract: common health problems

Read through these problems associated with the gastrointestinal system and familiarise yourself with the responsibilities that you have as an aged care or health support worker caring for aged persons with these problems. As always you must remember that you are working under the supervision of an RN/Supervisor and as such all problems need to be reported and documented.

**Dysphagia:** The client may be on a regime of thickened fluids as chewing and swallowing is difficult. It is important to be aware that not being able to feed oneself and/or having difficulty swallowing amounts to a major loss of independence and can seriously affect a client’s self concept and self esteem. Be patient during assistance with meals and provide support and encouragement. It is important to sit the client in an upright position to facilitate swallowing and to not hurry, remind them to swallow all the contents in their mouth before they take another mouthful.

**Constipation:** Encourage the client to be as active as possible, to drink water and to eat a balanced diet, high in fibre. Check that the client has bowel movements for their frequency (daily), consistency and colour.

**Diarrhoea:** Frequent passing of loose watery bowel motions. Encourage fluids, continued diarrhoea should be monitored to rule out medical conditions.

**Gastroenteritis:** Frequent diarrhoea can result in dehydration. Adequate fluids should be offered and observed. Treatment will depend on the cause but it is important to ensure the client has easy access to the toilet or commode and that standard precautions are practised to maintain infection control.

**Indigestion:** The client will need to be educated about avoiding ‘trigger’ foods, such as spicy foods. Encourage them to eat slowly, chewing well and avoiding drinks with meals. Lying down after a meal should also be avoided.

Gastrointestinal tract: Responsibilities of aged care or health support workers and practical aspects of management

As an aged care or health support worker caring for a client with integumentary system problems you may be required to:

- Take their vital signs (temperate, pulse, respiration and blood pressure).

You may also be required to perform the following responsibilities:

- Maintain clients nutritional and fluid status
- Recording weight
- Assist clients with stoma care
- Complete food charts
- Complete fluid balance charts
- Assist client with feeding
- Assist, with oral hygiene.
The immune system: common health problems

Read through these common health problems associated with the immune system and familiarise yourself with the responsibilities that you have as an Aged care or health support worker caring for aged persons with these problems. As always you must remember that you are working under the supervision of an RN/Supervisor and as such all problems need to be reported and documented.

**Urinary tract infection (UTI):** An infection of the bladder resulting in urgency, frequency and burning on micturition. UTI’s may also cause an elderly client to become confused. The responsibility of the nursing assistant is to encourage fluids and observe for worsening symptoms.

**Conjunctivitis:** It is the responsibility of the nurse assistant to provide eye care as required and prior to assisting with the administration of eye drops or cream.

**Thrush:** It is the responsibility of the AIN to keep the affected area clean — if it is vaginal thrush, perineal care as required and prior to the administration of medications.

**Allergy:** The responsibilities of a nursing assistant in an anaphylactic or allergic episode are to report any allergy to the registered nurse. In the case of anaphylaxis, where a person has difficulty breathing do not leave the client call for medical assistance as this can be a medical emergency.

**Autoimmune disorders:** Autoimmune disorders are condition whereby the body produces antibodies that attack itself. Rheumatoid arthritis is an autoimmune disorder.

**Immune deficiencies:** The responsibility of the nurse assistant is to provide support and palliative care to the client with HIV/AIDS.

**Multi resistant organisms:** Multi-resistant organisms such as MRSA (multi-resistant staph aureus) and VRE (vancomycin resistant enterococci) are of serious concern to hospitals and health facilities. The management of these infections requires high standards of precaution including isolation.

**Urinary tract: Responsibilities of aged care or health support workers and practical aspects of management**

As an aged care or health support worker caring for a client with integumentary system problems you may be required to: Take their vital signs (temperature, pulse, respiration and blood pressure).

**You may also be required to perform the following responsibilities:**

- Urinalysis
- Complete fluid balance chart
- Daily weigh
- Catheter care
- Maintain skin integrity
- Use of incontinence devices
- Assist with continence management programs.

**Immune system: Responsibilities of aged care or health support workers and practical aspects of management**

As an aged care or health support worker caring for a client with immune system problems you may be required to: Take their vital signs (temperature, pulse, respiration and blood pressure). As an aged care or health support worker you will need to be aware of infection control policies and procedures. This includes:

- Hand washing
- Standard and additional based precautions and personal protective equipment.
Endocrine system: common health problems

As always you must remember that you are working under the supervision of an RN/Supervisor and as such all problems need to be reported and documented.

Signs and symptoms of endocrine disorders include:

- Alterations in blood glucose levels
- Weight changes
- Increase or decrease in metabolism.

Diabetes

When caring for a person with diabetes:

- Be aware of the type of diabetes the client has, as different types require different management
- Promote good foot care – ever trim the nails of someone who has diabetes as a ‘nick’ from scissors may cause an infection
- Encourage client and their families/significant others in the selection of well-fitting shoes
- Encourage client to wear stockings or socks
- Encourage client to eat regularly
- Encourage physical activity
- Undertake a blood glucose recording (bgl) and urinalysis according to the requirements specified in the clients nursing care plan
- Be aware of the signs of hypoglycaemia (low blood glucose level – bgl less than 4 mmol) – bought on by exercise, vomiting, too little food, and too much insulin.

Aim to keep blood sugar level (BGL) between 4—8 mmol/L. If variations to this occurs, report this immediately to the registered nurse who will take measures to raise the blood sugar level quickly.

Endocrine system: Responsibilities of aged care or health support workers and practical aspects of management

As an aged care or health support worker caring for a client with endocrine system problems you may be required to:

- Take their vital signs (temperature, pulse, respiration and blood pressure).
- Monitor blood glucose levels.

Reproductive system: common health problems

Read through these problems and familiarise yourself with the responsibilities that you have as a nursing assistant caring for clients with these problems. As always you must remember that you are working under the supervision of an RN/Supervisor and as such all problems need to be reported and documented.

Female reproductive system: When showering observe the client for any changes to breast tissue, specifically dimpling ‘orange peel’ skin, any drawing in or puckering of the skin or nipple and any discharge from the nipple. Report any changes to your supervisor and record your observations in the client’s notes.

Male reproductive system: Any changes, especially bleeding should be reported to the RN or doctor immediately. Report any observation and assessment of the pattern of urination to your supervisor and record your observations in the client’s notes.
Reproductive system: Responsibilities of aged care or health support workers and practical aspects of management

As an aged care or health support worker caring for a client with reproductive system problems you may be required to: take their vital signs (temperature, pulse, respiration and blood pressure). Aged care and health support workers are to be sensitive to the needs of the client who is experiencing disorders of the reproductive system at all times.

Dysphagia or difficulty in swallowing

Some people who are ageing experience difficulty in swallowing, 'dysphagia', throughout their lives. These people may have some physical disability or difficulty in controlling the movements of their mouth to chew and swallow safely. Many people with cerebral palsy have difficulty swallowing, and this difficulty may show signs of increasing as the person gets older. People with Down Syndrome may also show signs of increasing difficulty in swallowing, related both to the physical movement skills of the mouth area, but also the onset of dementia in older age.

Presence of difficulty swallowing or dysphagia can put the person at risk of developing physical illness (eg. respiratory illness) or choking, and reduced levels of nutrition through not getting enough to eat, or not eating a sufficient balance of nutrients. Some people with dysphagia gradually restrict their diets to include only the foods that are ‘easy’ to swallow, and therefore miss out on a range of food types and textures.

There are several reasons that a person may have increasing difficulty in eating and swallowing, and therefore it is important that the person see a medical practitioner for a thorough medical review, and a speech pathologist for assessment of swallowing. The person may also need an assessment by a dietician regarding his or her level of nutrition.

Strategies in the management of dysphagia include:

- A collaborative team approach to the management of dysphagia
- Involvement of the person and his or her family members or significant others in decisions relating to management of the dysphagia
- Assessment of the person’s needs (medical, speech pathology, dietetics)
- Treatment and management as recommended by health professionals
- Adjustment of oral intake according to the texture, taste, temperature and amounts of food given
- Adjustment in the methods of administering food, fluids and medications
- Staff training in managing the dysphagia
- Awareness of signs and symptoms of change in physical status (eg. Respiratory health)
- Use of adaptive equipment (eg. Special cups, spoons, plates)
- Use of supportive seating systems
- Management of coughing and choking so that all staff know how to respond to the person who is coughing or choking on food.
When implementing these strategies, the aged care or health support worker needs to:

- Be aware of the importance of close observation and supervision where required during meal times
- Be aware of the set-up of a quiet calm environment for meal times
- Look for ways to increase the person’s success during meal times, such as through use of visual communication supports to the strategies suggested by health professionals (e.g. slow down, chew and swallow, clear throat, sip of drink)
- Modify the diet as instructed
- Learn to read the person’s non-verbal (facial expression, body language) communication as it relates to meal times (e.g. the pace of the meal, the timing of mouthfuls of food)
- Use the equipment and strategies for increasing success in meal times as instructed
- Document any new difficulties and refer for review or changes of mealtime plans
- Listen to the person’s concerns about any changes relating to meal times and involve him or her in discussion about ways to minimise the impact of changes upon quality of life
- Focus on the person’s enjoyment of the meal
- Respond, to the onset of symptoms of under-nutrition.

Responding to onset of symptoms of under-nutrition

Under-nutrition is a deficiency in intake of energy required for sustaining health. It can be thought of as not getting enough ‘kilojoules’ or ‘protein’ or other nutrients. Under-nutrition is very common in older people, through the person not getting enough kilojoules of energy per day. Many factors combine to impact upon under-nutrition in older people. Under-nutrition can result from not having access to food, having difficulty swallowing, or having metabolic disorders that affect the absorption of nutrients, or having medical conditions that increase the need for increased energy. Some medications contribute to under-nutrition, sometimes because of the side-effect of nausea impacting upon appetite.

Older people tend to eat less, and those who eat alone might be prone to eating less often or preparing meals less often. Physical disability and reduced mobility can make shopping and preparing foods difficult, and this can also result in the older person eating less. Older people may also experience gradual changes and loss of appetite, and some also experience loss of the sense of taste and smell that reduces the enjoyment of eating.

As some people age they may be less able to absorb the nutrients from the food. As people get older, changes in appetite and ability to chew and swallow, the onset of dementia, or any other physical change, can all result in the person eating less. Other factors such as poorly fitting dentures and depression can also impact upon the person’s oral intake and level of nutrition.

It is important that aged care or health support workers are alert to changes in the person’s usual eating patterns as reduction in oral intake that can occur slowly and over a long period of time, and therefore go unnoticed for several weeks or months. It may not be until the person is noticeably thinner that people begin to look at the person’s oral intake and realise that it is substantially less than what it was a month or a year ago.
Signs of reduction in oral intake include:
- Eating less frequently
- Not asking for food
- Not finishing meals, or eating only a portion of each meal
- Picking at food
- Loss of interest in food or food preparation
- Taking longer to eat a meal and ‘running out of time’ to finish
- Getting tired during a meal or ‘running out of energy’ to finish
- Avoiding certain food consistencies with difficulties in chewing
- Narrowing the range of foods accepted – restricting the options, reduced variety.
- Physical symptoms of under-nutrition include:
  - Weight loss
  - Fatigue
  - Feeling cold, difficulty staying warm
  - Diarrhoea
  - Loss of appetite
  - Irritability
  - Apathy
  - Change in responsiveness.

The appearance of people who are under-nourished may not change, depending on the reason for the under-nutrition and the course of progress. Aged care and health support workers need to monitor the person’s weight and seek medical opinion and review by a dietician in responding to symptoms of under-nutrition. Various strategies may be recommended to suit the individual, relating to increasing the energy intake, timing or amount offered at mealtimes, and strategies for increasing the person’s enjoyment of food.

Responding to onset of symptoms of over-nutrition

People who have difficulties in controlling the amounts that they eat are at risk of becoming ‘over-nourished’. Over-nourishment will result in the person building up stores of body-fat, and this can lead to that person becoming overweight. The extent of the extra weight will determine whether or not the person is described as being ‘obese’.

Many public health information campaigns now relate to prevention of overeating and obesity, however little of this has transferred to the lives of people who are ageing. The attitudes of people providing support can often influence the person’s risk of becoming overweight or obese. Sometimes food is used not only for its nutritional value but also as a cultural or emotional tool.

Use of food to comfort the person, or as a reward in the management of behaviour, or as an expression of love for the person can all lead to food becoming very important to the person, over and above its importance in providing nutrients. Use of food as an activity or ‘something to enjoy’ is particularly problematic for people who are ageing, who may have restrictions in the ability to participate in other physical activities that would make use of those nutrients. There is a clear relationship between excess body weight and increased levels of illness and higher rates of death.
**Over-nutrition can have a number of negative health impacts, including:**
- Heart disease
- Diabetes (type 2 diabetes)
- Hypertension (increased blood pressure) and stroke
- Musculoskeletal problems (through increasing pressure on joints)
- Some cancers (eg. Bowel cancer)
- Sleep disorders (eg. Through sleep apnoea)
- Stress incontinence
- Breathing problems.

**Strategies in the management of over-nutrition include:**
- Following recommendations and advice from dieticians and nutritionists
- Involving medical practitioners in the assessment and management of obesity
- Monitoring and maintaining a healthy weight in people who are ageing
- Maintaining the ‘healthy eating’ guidelines
- Balancing the use of food ‘for nutrition’ with less of a focus upon ‘food for reward’ or ‘food for activity’
- Increasing levels of physical activity
- Promoting healthy weight loss principles
- Implementing behaviour management and behaviour change strategies as relating to patterns of eating and eating habits.

**Infection control procedures**

**What is infection?**

Infection can occur when disease-causing organisms known as **pathogens** enter a susceptible body, such as a person whose resistance is low because of illness. If the conditions are right for the pathogen, it is able to multiply and overwhelm the body’s natural defences and infection occurs.

Superficial infection may produce clinical signs such as fever, purulence (pus) and inflammation (warmth, redness and swelling). Deeper infections may produce other clinical signs, for example respiratory infections often produce coughing sputum. However, infection can be present without any visible signs or symptoms of disease. Because of this you should assume that everyone is potentially infectious and treat everyone in the same way by practising infection control procedures. Also remember that a person may be infectious before they become unwell (ie during the incubation period). With some infections, people can become chronic carriers and remain infectious.
How infection spreads – the Chain of Infection

Development of an infection occurs in a process known as a chain of infection (sometimes referred to as cross infection).

For infection to occur, micro-organisms must:

- Enter the body
- Grow and multiply
- Cause a response.

The six links to the Chain of infection are shown in the diagram below:

1. Infecting organism eg: *e-coli* bacteria
2. Means of transmission, eg: unclean water sources
3. Exit point from source, eg: water contaminated with *e-coli* is consumed and exits from body as diarrhoea
4. Means of transmission, eg: eating or drinking utensils
5. Means of transmission, eg: entry point into body via food
6. Susceptible host, eg: a person at risk of infection

The development of an infection is dependent upon an uninterrupted process, referred to as chain of infection.

This process is dependent upon the following elements:

1. Pathogens in sufficient numbers.
2. A reservoir for pathogen growth.
3. A portal of exit from the reservoir.
4. A mode of transmission.
5. A portal of entry to the host, and.
6. A susceptible host.

This chain of infection can be broken by infection control measures implemented by health care workers. The chain of infection as illustrated below provides examples of the ways in which pathogenic microorganisms are transmitted from person to person. For example, an infection may occur when a person is exposed to a reservoir of a potential pathogen. The pathogen may gain entry to the human body to cause an infection.
The six links to the chain of infection are as follows:

1. **(Causative agent):** Causative agents in infection are pathogens. Pathogens are microorganisms that are capable of causing diseases or infections. If micro-organisms from a person's own body cause an infection, it is called an endogenous infection. If a micro-organism derived from sources outside a person's own body causes an infection, it is called an exogenous infection.

2. **A reservoir for pathogen growth:** A reservoir is any person, animal, arthropod, plant, soil, or substance (or combination of these) in which an infectious agent normally lives and multiplies, on which it depends primarily for survival, and where it reproduces itself in such manner that it can be transmitted to a susceptible host.
   
   - **Animate reservoirs** include people, insects, birds, and other animals.
   - **Inanimate reservoirs** include soil, water, food, faeces, intravenous fluid and equipment.

3. **A portal of exit from the reservoir:** A portal of exit is the site from where micro-organisms leave the host to enter another host and cause disease/infection. For example, a micro-organism may leave the reservoir through the nose or mouth when someone sneezes or coughs, or in faeces.

4. **A mode of transmission:** A method of transmission is the movement or the transmission of pathogens from a reservoir to a susceptible host. Once a pathogen has exited the reservoir, it needs a mode of transmission to the host through a portal of entry. Transmission can be by direct or indirect contact or through airborne transmission.

   - **Direct contact** is person-to-person transmission of pathogens through touching, biting, kissing, or sexual intercourse. Microorganisms can also be expelled from the body by coughing, sneezing or talking. The organisms travel in droplets over less than 1 metre in distance and are inhaled by a susceptible host.

   - **Indirect contact** includes both vehicle-borne and vector-borne contact. A vehicle is an inanimate go-between, an intermediary between the portal of exit from the reservoir and the portal of entry to the host. Inanimate objects such as handkerchiefs and tissues, soiled laundry, and surgical instruments and dressings are common vehicles that can transmit infection.

5. **A portal of entry to the host:** A portal of entry is the site through which micro-organisms enter the susceptible host and cause disease/infection. Infectious agents enter the body through various portals, including the mucous membranes, the skin, the respiratory and the gastrointestinal tracts. Pathogens often enter the body of the host through the same route they exited the reservoir; for example, airborne pathogens from one person’s sneeze can enter through the nose of another person.

   The skin normally serves as a barrier to infection. However, any break in the skin invites the entrance of pathogens, such as tubes placed in body cavities (catheters) or punctures produced by invasive procedures (needles, IV).

6. **A susceptible host:** The host (also called the susceptible host) is the human body: someone who is at the risk of infection. Infections do not necessarily occur when pathogens enter the body of the person whose immune system is functioning normally. Whether or not a pathogen will result in infection depends upon several factors related to the host (the person exposed), the pathogen itself, and the environment.
Ways to break the Chain of Infection:
This chain of infection can be broken by infection control measures implemented by health care workers.

- Immunization against infectious diseases
- Early diagnosis of infectious diseases
- Isolation of persons suffering from infectious diseases
- Collection and disposal of waste in communities
- Provision of a pure water supply
- Adequate drainage and sewerage facilities
- Standard precautions
- Additional precautions.

Types of infection risks
Bacteria, viruses and other micro-organisms can enter the body in several ways.

They can enter through the:

- Mucous membrane – the moist lining of the orifices (holes) of the body; for example, the nose, mouth, eyes, anus, genitals
- Nasal passages in the nose and lungs during the act of breathing
- Mouth into the throat, stomach and digestive system
- Skin by needle puncture, cut or graze
- Bacteria, viruses and other micro-organisms leave the body the same way. They can then be passed on to others and infect them.

How people are infected
Support workers, clients and other staff may be exposed to infection during personal care tasks, when handling food or soiled clothing or linen or by just being near people with infections.

Nosocomial infections
Patients in health care facilities may have an increased risk of acquired infections. Nosocomial infections result from exposure to a variety of organisms in these facilities. Hospitals are a particular risk area – high populations of virulent micro-organisms that are resistant to antibiotics may be the most important source of infection. Infections occur through diagnostic or therapeutic procedures – for example, a urinary tract infection may occur after catheterisation – therefore aseptic technique is crucial to preventing infection.

The number of employees having contact with the patient and the length of hospitalisation also influence the risk of infection. Nosocomial infections increase the cost of health care. Prolonged hospitalisation and expensive treatment may leave the patient financially disadvantaged due to lack of reimbursement from Medicare or private health insurances.
Sites and causes of nosocomial infections

Here are some common sites for nosocomial disease and the causes of infection.

- Insertion of urinary catheter
- Disconnected tubing system
- Contaminated urinary drainage bag
- Incorrect collection of specimens
- Incorrect hand washing
- Catheter irrigations.

Traumatic wounds

- Inappropriate hand washing
- Failure to use aseptic technique
- Contaminated aseptic solutions.

Respiratory tract

- Contaminated equipment
- Incorrect aseptic technique during suctioning
- Incorrect hand washing
- Incorrect disposal of mucus secretions.

Blood stream

- Contamination of intravenous fluids
- Insertion of medication additives to intravenous fluids
- Incorrect cannulation technique
- Incorrect management of intravenous lines and fluids
- Incorrect hand washing.

(Crisp and Taylor, 2001)

Personal care tasks

When performing personal care tasks, the risk of infection increases because the support worker is in closer contact with the client and at risk of being exposed to body fluids or other infectious material.

For example, you may need to:

- Assist a client who has the flu and is coughing continuously
- Change the bed linen of a client who has an infectious skin disease
- Assist a client with a salmonella infection with their bowel movements
- Assist a client with a nosebleed and you have broken skin.

Another example of where you may be exposed to infection is if you fail to use, or use in the wrong way, personal protective equipment (PPE) such as gloves or waterproof aprons.
Food handling

There is a risk of infection from food because food may have unsafe levels of bacteria. It may also be because an infected person has handled the food and infected it.

When preparing or serving food, there are some steps that you should follow:

- Wash your hands correctly
- If you have a cut, you need to have it covered by a bandaid
- If you are touching food, you need to wear gloves; for example, if you are preparing sandwiches
- If you have a cold you should not be handling food
- You should always wear an apron
- You should always use clean utensils
- Food must be stored at the correct temperature because bacteria may multiply and cause infection – hot food should be kept hot and cold food should be kept cold.

Follow hand-washing procedures

Routine/social hand washing procedure

A routine/social hand wash is a hand washing technique recommended following social-type contact with clients, after going to the toilet and after covering a cough or sneeze. A plain liquid soap is often used.

1. Using warm water wet your hands thoroughly including palms and back of the hands.
2. Dispense soap into the palm of your hand.
3. Lather the hands with soap.
4. Vigorously rub your hands together cleaning palms, fingers, between fingers, the back of your hands, thumbs and wrists for at least 15 seconds.
5. Thoroughly rinse off the soap.
6. Turn off the taps using the elbow, foot or electronic controls. If the tap has only a normal tap handle and paper towels are available, use paper towel to turn the taps off.
7. Pat dry your hands with a disposable paper towel or a clean cloth towel.
8. In areas where there is a cloth roll towel, make sure you are using a clean section of the towel.
9. Make sure your hands are dried well to prevent chafing.
10. If using disposable paper towel, place the used paper towel in the appropriate waste bin.

(Adapted from: hand washing and hand hygiene 2009). A modified version is demonstrated in the picture below:
1. Wet your hands
2. Apply solution and scrub for at least 15 seconds
3. Scrub back of hands, wrists, between fingers and under fingernails
4. Rinse your hands
5. Turn off water lever using your elbows
6. Dry with paper towel
Activity

Ten

Identifying changes in the person’s health or personal support requirements and report to supervisor

1. Describe how you would deliver personal care in a way which supports an older person’s preferences.

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

2. What do you have to take into consideration when assisting clients with?
   a) Feeding:
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
   
b) Oral care:
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
      ___________________________________________________________________
c) Bathing/showering:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

d) Dressing:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

e) Toileting:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

f) Using continence aids:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
g) Applying pressure stockings?

3. Name 6 continence aids carers can use, when working with a client who is ‘incontinent’?

1.

2.

3.

4.

5.

6.

4. Where would you locate your organisation’s policies and procedures in a Home and Community care agency?

5. How would you ensure that a client’s concerns regarding assistance have been addressed?
6. What are your organisation’s policies and procedures relating to reporting changes in your client’s condition?
Working with the person and supervisor to identify required changes to processes and aids

In your role as an aged care or health support worker, each organisation will have its own policy on the use of certain equipment and performing certain procedures for client assessment are within your job description.

Some pieces of equipment are quite specialised and require in-service training and a competency assessment. For example, a glucometer is used to measure a client’s blood sugar level and requires a certain level of knowledge and skills to use it correctly and understand the significance of the blood sugar reading. Other pieces of equipment are less specialised such as a thermometer although certain skills and knowledge are still required to use it correctly and record the temperature.

When you start employment with any organisation, it is vital to become familiar with the job description that matches the job you have been employed to do. What equipment you may use and the procedures to be followed in the workplace are entirely the decision of the organisation and it will be their responsibility to train you and assess your competence. Even if you have been trained to use a piece of equipment for assessment in another facility and you have had plenty of experience using this equipment, it is still at the discretion of the organisation you are currently working at whether you may use it or not. Those who are working at multiple facilities must be very careful not to confuse roles and responsibilities.

Sometimes the registered nurse on duty is the only person allowed to use a certain piece of equipment for example, the Kangaroo pump which is used to pump liquid food into a client via a tube that directly enters the client’s stomach. Sometimes the registered nurse prepares the feed and starts the machine and the enrolled nurse is required to monitor the machine.

Examples of equipment used for the purpose of assessment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Purpose</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucometer</td>
<td>Measure blood sugar level</td>
<td>Glucose monitor reading (GMR)</td>
</tr>
<tr>
<td>Sphygmomanometer</td>
<td>Measure blood pressure</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>Thermometer</td>
<td>Measure temperature</td>
<td>Temperature</td>
</tr>
<tr>
<td>Kangaroo pump</td>
<td>Nourish client with liquidised food</td>
<td>Parenteral gastric feed (PEG feed)</td>
</tr>
<tr>
<td>Urinalysis strips</td>
<td>Analyse the urine</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>Weighing scales</td>
<td>Measure weight</td>
<td>Weight</td>
</tr>
<tr>
<td>Sterile specimen container</td>
<td>To collect a sample of urine or sputum</td>
<td>Specimen collection</td>
</tr>
<tr>
<td>Faecal specimen container</td>
<td>To collect a sample of faeces</td>
<td>Faecal collection</td>
</tr>
<tr>
<td>Trans medium wound swab</td>
<td>To collect a wound swab</td>
<td>Wound swab</td>
</tr>
</tbody>
</table>

When using equipment, remember the following principles:
- Always follow the manufacturer’s instructions prior to using the equipment – if in doubt, ask
- Only use the equipment if it is your job description
- Immediately report defects or malfunctioning
- Follow organisational policies and procedures
- Use equipment only for the purpose it was designed for
- When using equipment in front of clients, always explain what you are doing.
In your duties, you will be using equipment for different purposes; however some equipment is not necessarily used for client assessment. Even though this equipment is not used for assessment, it is still necessary to observe clients and the way in which the equipment is being used to assess whether the equipment is being used appropriately.

Below are some examples of equipment that is not used for the purposes of assessment however, client observation is still important:

**Examples of equipment not used for the purpose of assessment**

<table>
<thead>
<tr>
<th>EQUIPMENT</th>
<th>PURPOSE</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continence aids:</strong></td>
<td>Assist in continence</td>
<td>Does the uridome stay on? Is there any leakage? Is it used appropriately?</td>
</tr>
<tr>
<td>Uridome</td>
<td></td>
<td>Are pads correct size?</td>
</tr>
<tr>
<td>Incontinence pads</td>
<td></td>
<td>Is client toileted regularly?</td>
</tr>
<tr>
<td>Kylie sheets</td>
<td></td>
<td>How often is Kylie sheet changed?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is client on continence program?</td>
</tr>
<tr>
<td>Manual handling equipment:</td>
<td>To assist in moving, transferring &amp; mobilising</td>
<td>Are slide sheets effective?</td>
</tr>
<tr>
<td>Slide sheets</td>
<td></td>
<td>Is mechanical hoist effective?</td>
</tr>
<tr>
<td>Mechanical hoist</td>
<td></td>
<td>Can client assist in any way?</td>
</tr>
<tr>
<td>Johnny belt</td>
<td></td>
<td>Does client need any other aid?</td>
</tr>
<tr>
<td>Walking stick</td>
<td></td>
<td>Height is important for Rollator and FASF</td>
</tr>
<tr>
<td>Four arm support frame (FASF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rollator</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feeding &amp; drinking equipment:</strong></td>
<td>To assist in feeding and drinking</td>
<td>Can client use equipment appropriately?</td>
</tr>
<tr>
<td>Specialised cutlery</td>
<td></td>
<td>Are there other aids client can benefit from?</td>
</tr>
<tr>
<td>Non slip plate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mug with two handles</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tri flow (breathing device)</strong></td>
<td>To encourage deep breathing</td>
<td>Can client use the Tri flow properly?</td>
</tr>
<tr>
<td><strong>Visual aids</strong></td>
<td>To aid vision</td>
<td>Are these aids satisfactory? Do they improve the client’s vision?</td>
</tr>
<tr>
<td>Magnifying glass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large print books</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing aids</strong></td>
<td>To aid hearing</td>
<td>Can client use the aid appropriately and properly?</td>
</tr>
<tr>
<td>behind the ear</td>
<td></td>
<td>Are these aids satisfactory? Do they improve the client’s hearing?</td>
</tr>
<tr>
<td>in the ear</td>
<td></td>
<td>Can client maintain the aids, eg battery, cleaning?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do they need assistance?</td>
</tr>
</tbody>
</table>

CHCCC011 Meet personal support needs
Version 1 December 2015
ITS (Aust) Pty Ltd
Page 116 of 146
As you can see, there are many different kinds of equipment used in aged care to assist the client in their day-to-day activities. It is also important that the client provides feedback as for the usefulness of these aids. If the equipment is not satisfactory, it is then up to the carer to report to the supervisor and mention it to the staff at the handover report. If the aged care facility requires carers to document changes in the client’s progress notes, then these notes should be documented in the appropriate section in the client’s personal file.

Most importantly, the aged care or health support worker must understand and adhere to their own work role and responsibilities as well as follow organisational policies, protocol and procedures when dealing with equipment and procedures.
Maintaining confidentiality, privacy and dignity of the person

Confidentiality

Maintaining confidentiality, privacy and dignity is all about maintaining self-respect and pride for the older person. It’s about treating older people the way you would wish to be treated – with respect and decency. It’s about doing what is ethical and moral, that is, what is right, maintaining self worth and using discretion. As you will soon learn, confidentiality, privacy and dignity are basically tied together:

We can discuss these issues in a number of different ways. Health records can be kept confidential by keeping files closed and out of view to the public. Privacy and dignity can be maintained by keeping the bathroom door closed whilst the older person is using the shower or toilet. Confidentiality can be maintained by keeping your voice down whilst you are having a conversation with the resident or discussing care needs with your Supervisor or even giving a verbal Handover to the next shift. These are just some examples.

Privacy

Take a minute to think about what privacy means to you? Sometimes, privacy has been described as the right to be left alone, or the right to exercise control over one's personal information, or protection of individual dignity and autonomy. Privacy can be classified as physical privacy such as bag searching or information privacy such as the way in which organisations handle our personal information such as our age, address, sexual preference and so on.

One of the main reasons older people are sometimes reluctant to live in residential care is the fear of losing their independence and autonomy. It is therefore very important to encourage older people to maintain independence by supporting and assisting them. You can assist them to do this by embracing the older person’s right to privacy and dignity. This will help to facilitate trust and confidence and will help to maximise independence, confidence and self-esteem.
Dignity
Privacy and dignity is a basic human right. It is essential as a carer to always ensure that privacy and dignity is maintained. Lack of respect for an individual’s dignity in care can take many forms and the experience may differ from person to person.

Some ways of respecting the older person’s dignity:

- Answer the buzzer or call from the client promptly. A resident who has to wait for assistance can feel unimportant and neglected, or a nuisance.
- Refer to the older person respectfully. Refer to a client using their surname unless they have another preference. Using another name can be disrespectful and undignified.
- When drying the older person after a shower, cover their body as much as possible. Leaving a person’s body exposed is undignified and can create feelings of embarrassment or shame.
- Shut the bathroom door when the client is using the toilet or shower. If you need to be in attendance for safety, try to make the client feel as comfortable as possible and do not stand over them. If the person is overly exposed they could feel vulnerable and treated as an object rather than a person.
- When a client wishes to talk, ensure you sit at the same level and ensure privacy. Draw the curtains and speak softly. Maintain eye contact and use effective communication skills.
- Encourage the client to use a knife and fork by assisting them. Perhaps you need to place the fork into their hand or cut the food up. Eating with fingers can bring feelings of shame and dependence.
- Include the client in decision making and problem solving. This will empower the person.
- Speak on an adult level with clients – they are not children.
- Use a ‘dignity’ gown when transferring an undressed client to the shower.
- Try to provide serviettes not bibs for residents.
- Provide consistent high standard of care within the policies and procedures of the organisation and in a safe manner.
- Never feed a client when they are placed on a commode.

Performing work to the standard required by the organisation

Whilst providing care to clients it is important that we accommodate their personal preferences and respect their rights. This care must still be provided within the guidelines and policies of your organisation. Guidelines are provided to support staff and provide guidance when making decisions regarding care or ethical dilemmas.

When commencing work with any organisation they will request that you read their policy and procedure manual. Most will request that you sign to state that you have read and understood the policies. Once you have signed this, you are actually stating that you have understood what is expected of you in the workplace. If there is anything that you do not understand, speak with your supervisor. There is no reason to think that you must know the policy manual word for word but it would be expected that you would understand key concepts. When unsure of how to respond to a situation and there is no supervisor available to speak with, the policy manual should have enough information to assist you with any problems.
Eleven

Maintaining confidentiality, privacy and dignity of the person

I. Consider yourself in the role of a care assistant in an aged care facility. What are some of the ways you would respect a client’s privacy and dignity? List and describe four ways.
Element 4: Complete reporting and documentation

Complying with the organisation’s reporting requirements, including reporting observations to supervisor

In the community services and aged care industries you will be required to provide ‘hands on care’ to your clients. You will also have to fill in forms, write reports on the support and care given to clients as well as give verbal reports. Imagine having to look after an elderly person with multiple medical, physical and psychological needs without any form of documented information about this person. Providing proper care would be an impossible task. What if your client has fallen? They may have many different care needs as well as require the services of a physiotherapist and an occupational therapist in addition to their usual treating medical officer. A number of people may have input into this client’s needs.

Feedback

The only way to help guarantee an excellent standard of individualised care is if everyone who cares for the client, passes on current verbal and written information to one another. This information includes various assessments, as well as a plan of care that incorporates changes in care needs such as illness, a fall, constipation, or changed behaviour. An understanding of health records and associated documentation is therefore critical to your work role. These records give you and the team, the necessary information to provide relevant care for your clients.

Verbal reports

Verbal reports are used to ensure the person taking over the client’s responsibilities (this could be other workers or the person’s carer) have information concerning the most current care needs of the person. Verbal reports are normally given at the start of each shift—handover or changeover report—when care needs have changed during a shift and when changes occur in a client’s condition or needs such as if they have had a fall with an injury. In the community, verbal reports may also be given over the telephone to the client’s medical officer or other health support or aged care workers.

Health support or aged care workers finishing their shift should also give a verbal report of any tasks or care not completed for clients to the person taking over their responsibilities. You may be required for example, to contact a General Practitioner and advise them of a client who has fallen and sustained an injury.

All verbal reporting should be:

- Clear
- Accurate
- Concise (to the point)
- Factual
- Objective (what you actually see and hear not what you feel or think).

Staff receiving a verbal report should clarify points if they are not clear or they do not understand.
Appropriate verbal reporting mechanisms

There are many different ways of reporting verbally:

- Informing your supervisor of changes in a client’s condition and/or needs
- Relaying messages
- Meal-break handover
- End of shift – handover/changeover report
- Enquiries about the client
- Telephone conversations including informing general practitioners of changes the client is experiencing
- Case/team conference.

As a health support or aged care worker you will have access to confidential and personal information. Generally, it is not part of your role to give callers any information of a confidential nature. (Always check your role statement and the organisation’s policies to ensure you are aware of correct procedures.)

Examples of confidential information are:

- Client details and medical condition
- Worker’s home address and/or telephone numbers (if they are not in the public domain ie in the white pages)
- A client’s financial details
- Injuries sustained as a result of a fall.

Confidentiality during handover reports or telephone conversations must be upheld. You must be mindful of the legal implications surrounding reporting and recording of client’s health care information, so there is not a breach of a client’s privacy rights. It is difficult for example to ensure confidentiality of information if the verbal handover report is given in an area where visitors may pass. Remember, when families are trying to get information about a client who has fallen, they may be quite stressed and very demanding until they know the full details of what has happened and whether or not the client has been injured. You have a responsibility and duty of care to ensure that the information you provide remains accurate but does not breach your client’s confidentiality.

Written reports

There are many types of reports a health support or aged care worker may use to document relevant information when working with a client. The organisation you work for will provide you with training about the documentation available and their expectations regarding written reports. What is written is permanent as soon as it is placed on paper and saved to computer, therefore it is difficult to change or retract. In some cases, written work documents need to be kept for 15 years.
Reports should be brief and complete. In other words, while all important issues need to be documented, ‘padding out’ of the health record should be avoided. If a client has fallen, it is important for example, to include this in the client record as well as any injuries that may have been sustained. It is not necessary however to include a discussion that the client may have had with a visitor immediately prior to fall unless, of course, that is why the client fell.

Health support or aged care workers are responsible for documenting the care they provide and for gathering information about a client to assist in the development of care plans. As outlined by the Commonwealth Department of Health and Aged Care (1999), use of the senses of perception, observation, sight, hearing, touch and smell can assist in gathering appropriate information.

Documentation should occur at the time of, or as soon as practicable following the provision of a service, observation, assessment, diagnosis, management, treatment, professional advice, or any other matter worthy of note (NSW Policy Directive 2005_127 pp. 4). This is particularly important if a client has fallen and sustained an injury. In some instances the client may have to be transferred for medical treatment and if you have been slow to document what has happened, crucial information about the fall may be missed.

Once something is written, it can be very hard to retract – it might also be a legal document that cannot be changed for many years. Health support or aged care workers are often responsible for documenting in the client’s Progress Notes. Some organisations expect their workers to make entries based on ‘exception’ or ‘exceptional reporting’. This means that only significant changes to standard care are documented rather than repeating the same information in each report. Exceptional reporting is dependent on comprehensive individual care plans which outline the standard of care to be provided. An exceptional circumstance is anything that is unusual and is not already in the resident’s care plan. This may include changes to the care or incidents such as a fall which have occurred during your shift. It is only necessary to record things in the progress notes at the end of each shift which are not already included in the standard care plans (Whitney et al 1997).

If, at 1000hrs, you provided exercises according to the care plan you may write ‘Care provided according to care plan’. You may have witnessed a client slip in the shower however, then it is acceptable to write ‘slipped whilst showering’ but if they are injured you would also need to include this. If you observe a bruise on the client and the client tells you they fell, you may write ‘small bruise, approximately the size of a fifty cent piece observed on the client’s forehead, just above the left eye. Client advises they slipped when going to the toilet overnight’. You would also need to talk with the client about ways to avoid this occurring again and ensure this information is also documented.

Good quality writing underpins effective documentation. Good writers plan the writing task. They clearly understand the purpose of the document and draft what they will write, analyse the reader and their needs, write in plain English, use acronyms approved by the organisation and language appropriate to the reader and the context. They also collect the necessary information and carefully edit the finished product.

Writing in plain English means using simple or commonly used words instead of complicated ones. Often writers use complicated words because they think that if the words look impressive, they will look impressive. If you use plain English, your writing has a much better chance of being understood and thus you are more likely to achieve your purpose. Good writing doesn’t just happen. You need to practise and get feedback on your skills. Good documentation will help you defend yourself if there happens to be an investigation into an incident. This investigation may be carried out internally within the organisation or externally involving police, Coroner, or a law court if the incident involves criminal charges or a civil law suit.
Types of documentation

An understanding of health records and associated documentation is therefore critical to your work role. These records give you and the team, the necessary information to provide relevant care for your clients. Every client in the community services and aged care industries has their own health or service record to document information regarding the care provided as well as any incidents which may occur, such as falls. It is also sometimes called a ‘client or resident file’, ‘resident records’, ‘charts’, ‘clinical file’, ‘histories’, and ‘medical files’. These records contain vital information about the client.

Reports and records are used for a wide range of purposes. The primary purpose of documentation however, is to ensure quality outcomes for clients. The Commonwealth Department of Health and Ageing, Documentation and Accountability Manual (1997 4.2) states that effective documentation provides the primary evidence for the provision of quality care to residents. This Manual outlines the key functions of residential aged care clinical records and is available online at available at: http://www.health.gov.au/acc/manuals/dam/chapt4.htm

Generally, the purposes of documentation include:

- Assessing needs and recording information about clients to help plan, implement and evaluate appropriate services
- Recording actions
- Explaining why we did something
- Reminding us of what we need to do next
- Reporting incidents such as falls and documenting any subsequent actions
- Referring clients
- Providing information to external agencies eg a court report
- Planning work or programs
- Advocating for clients and seeking information
- Facilitating communication between workers
- Developing policy and procedures
- Taking minutes of meetings
- Providing information to clients about our service and their rights
- Advertising services
- Lobbying governments or other agencies
- Consulting with the community to identify needs
- Researching issues and education
- Writing funding proposals
- Financial management
- Providing feedback to funding bodies
- Providing evidence of accountability, accreditation and/or quality outcomes
- Conveying ‘bad news’
- Responding to complaints
- Making a complaint.

This list is not all-inclusive. You can see that documentation is instrumental in providing a quality service. Written documentation helps communication between staff and with clients. It also impacts directly on the financial and human resources of the organisation.
In the aged care industry, care records assume a central position in the process of government funding, accreditation and quality monitoring. It is important to understand the standards relevant to your organisation and work role. Standards outline exactly what is required of you and you must comply because your organisation’s ongoing success depends on it. You will be required to document falls and write down how your client has been affected by a fall. Understanding the basics of writing and verbalising reports are therefore very important.

**Telephone reports**

Taking a telephone report may be necessary to relay information to a client, their relatives/significant others, other health support or aged care workers. You may be giving information such as a simple clarification of a client’s condition or the family may have to be contacted following a critical event such as a fall with a head injury.

**Things to do:**

- Always answer the phone politely and pleasantly
- Slowly and clearly state who you are
- Write down a rough outline of the message
- Repeat the message back to the caller to confirm the details
- Be helpful by making suggestions if you cannot do what is being asked, eg. If a relative wants to speak to the supervisor, who has gone to lunch, suggest you could take the caller’s telephone number and have the supervisor ring them back after lunch
- Always end the conversation politely, eg ‘thank you for your call, good afternoon’
- Ensure you pass on messages
- Ensure messages are written in the communication book if they are relevant to all staff and/or documented according to the organisation’s protocols particularly if the information is related to client care.

Telephone reports are an important form of communication so be sure what you say is accurate.
Handover reports

Handover reports are given at the change of each shift from outgoing to oncoming staff. Handover reports emphasise the important issues/events which have occurred for that shift, such as clients going for tests and the appropriate requirements or clients going on outings with their relatives or a client slipping or falling. They should also include abnormal observations (temperature/BP etc) requiring monitoring and actions such as contacting the client’s medical practitioner.

Handover reports can take two forms:

1. Live ‘face-to-face’ reporting to oncoming staff at the change of shift.
2. Tape recorded reporting for oncoming staff at the change of shift.

Things to do when receiving a handover report:

- Listen carefully
- Take notes of the important points relevant to each client
- Use symbols, eg up arrow temp, for increased temperature or down arrow eating for decreased appetite, to assist in gathering as much important information about each person for that shift
- Politely interrupt to ask questions if you need to clarify issues from staff giving the handover report. It is better to interrupt a handover report than miss important information for appropriate care for that shift.

Things not to do when giving a handover report:

- Do not make subjective or judgmental comments about a client or their family members during handover reporting; you must reflect a professional attitude, with only objective and factual information being used to describe the management and care of a patient, client or their families/friends at all times
- Do not make judgmental comments about a client’s cultural and or religious beliefs
- Do not question a staff member about why they did not stop the fall from happening. The fall would need to be investigated in an appropriate manner.


Completing and maintaining documentation according to organisation policy and protocols

Organisations usually have guidelines and procedures regarding:

- How to take messages
- How staff communicate in writing with each other and with clients
- How forms and reports should be written
- Which forms to use for specific purposes
- Who signs written documents
- Who has authority to write on behalf of the organisation
- How incoming and outgoing correspondence is handled
- How quickly documentation needs to be completed
- How to store and protect private information.

To find out about an organisation’s policies:

- Ask your supervisor or work based learning coordinator
- Look at the organisation’s policy and procedures manual
- Ask other staff members
- Inspect current case files, letters, etc if you have permission.

You have a responsibility to find out what the organisation expects and then abide by the rules. If you don’t agree with the organisation’s guidelines and procedures, you need to discuss your concerns with your supervisor.

Each aged care facility or organisation will have their own guidelines and protocol regarding documentation requirements for client health records. They will also have their own guidelines and documentation for reporting and following up on falls. These guidelines help to direct you in the use of the appropriate forms required in your role of care health support or aged care worker as well as provide direction in how to document. Initially, it may seem a little daunting, but with some practice, documenting will become easier until it becomes a routine task requiring little effort.

Important organisational information with regard to health records involves:

- The safe storage of client health records
- Security of health records
- Types of forms to be used
- Specific documentation requirements for example, each ‘group’ of professionals may be required to write their title prior to making an entry, such as ‘physiotherapist’ or ‘nursing report’
- Confidentiality of information.
Policies and procedures provide security safeguards in organisations to protect the information of individuals, including clients as well as staff. Reports are important as a means of providing an indication of a client’s status so that effective evaluation of care options can be planned and implemented. Reports may be written (hardcopy or electronic health care records) or verbal (in person during staff handover or as a telephone report to another health support or aged care worker).

Reports that are inaccurate, do not have enough information, or include irrelevant information, may result in reduced funding and impact on client care. This is particularly so if falls are not documented for example. An expected standard by which aged care facilities are assessed during the auditing process is whether or not falls are documented and followed up to minimise the resident’s future risk of falls. For this reason, aged care facilities in particular are usually vigilant in their documentation and follow up of falls, falls assessments and falls minimisation strategies.

**A good clinical or care record should contain at least the following elements:**

- Thorough documentation when the client is accepted by the service, including medical and social history and physical examination
- Full assessment of care needs
- Care plan or management plan
- Completed medication chart if required
- Other relevant charts.

The structure and content of documentation and information in many organisations is moving from paper based records to a paper free workplace by electronic charting using computers. This form of charting may allow more efficient documentation to take place.

**Written reports and workplace forms should be presented according to the ‘rules’ in the following table:**

**Table: ‘Rules’ of written reports**

<table>
<thead>
<tr>
<th>CLEAR</th>
<th>Write what you mean and mean what you write</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONCISE</td>
<td>To the point, do not ramble on – it’s not a story</td>
</tr>
<tr>
<td>FACTUAL</td>
<td>Write facts, for example ‘Mr Kim staggers when walking’ not ‘Mr Kim is drunk’</td>
</tr>
<tr>
<td>COMPLETE</td>
<td>Do not miss important information. Do not just write ‘c/o pain’, write what you did about it. ‘c/o pain in the left lower leg RN informed immediately’.</td>
</tr>
<tr>
<td>ACCURATE</td>
<td>Accurate. If it is 1024 hrs, do not write 1030 hrs. Write ‘client found in wet bed –approx 250ml urine’ not ‘wet bed – large amount’</td>
</tr>
<tr>
<td>RELEVANT</td>
<td>Only write what is relevant</td>
</tr>
<tr>
<td>LOGICAL</td>
<td>Ensure entries are logical, that is, they make sense</td>
</tr>
<tr>
<td>OBJECTIVE</td>
<td>Do not be subjective or emotional when writing, remain objective.</td>
</tr>
<tr>
<td>USEFUL</td>
<td>Write information that others find useful to provide care. Do not write, for example, ‘Mr Kim sometimes has bad skin’. This entry is not useful without detail.</td>
</tr>
<tr>
<td>SPECIFIC</td>
<td>Be specific when writing. For example, write ‘S/B Dr Wuthers’ not, S/B doctor.</td>
</tr>
</tbody>
</table>

**Progress notes**

Read the example of completed progress notes below. They provide clear information about the type of care given which is according to the nursing care plan. They also provide information about the client’s fall and what has been done in response and who has had made the entry. If you think about the information provided in the above table you will note that the entry is clear, concise, factual, complete, accurate, relevant, logical, objective, useful and specific.
Example of completed progress notes

PROGRESS NOTES

<table>
<thead>
<tr>
<th>MRN: 007311</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname: Cordina Other Name: Maria</td>
</tr>
<tr>
<td>DOB: 26 March 1923</td>
</tr>
<tr>
<td>Doctor: Roper</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.6.09</td>
<td>1010</td>
<td>All care given as per NCP. S Ridley (Ridley) Carer</td>
</tr>
<tr>
<td>17.6.09</td>
<td>1345</td>
<td>Heard resident calling out at 1315 hours and on investigation found Mrs Cordina lying on the floor near the bed. Pressed call bell to request assistance as fresh blood observed on floor and in. Mrs Cordina’s hair. Stayed with resident. Assisted resident to bed after initial review by RN. RN with resident at the time of the report. S Ridley (Ridley) Carer ____________________</td>
</tr>
<tr>
<td>17.6.09</td>
<td>1630</td>
<td>Reviewed resident. 5cm laceration to back of head. Same. dressed with steristrips and dressing applied. Half hourly and then hourly observations attended. Neurological and general observations satisfactory. Conscious. Paracetamol given for headache at 1545 with good effect. Family informed. GP informed. M Lucindier (Lucindier) RN ____________________</td>
</tr>
<tr>
<td>17.6.09</td>
<td>1730</td>
<td>Checked resident. States pain free. Conscious and talking with staff. Ate small amount of sandwiches for evening meal. Observations satisfactory. F. Teangio (Teangio) RN</td>
</tr>
</tbody>
</table>

Social activity documentation

If you are documenting a social activity you should include the time, location and date of the activity; the people involved; any observed interactions between clients and/or other participants; the general mood during the activity and any feedback received relevant to the activity. Example:

Friday 13th November, 2009, the residents of Grevillea Aged Care Facility went on a bus excursion to Green Valley Farm outside Tingha, leaving at 9.00am. They were accompanied by a registered nurse and two assistants in nursing and three family members provided additional support. During the bus trip, entertainment was provided by a guitarist and people sang along with her. Once the group disembarked, they proceeded to participate in all the activities, from feeding the animals to taking pictures. The picnic lunch was much appreciated. Everyone had a happy time and commented that they would like to return soon.

C. Blacksmith R.N
Expected standards

Documentation is an integral component of reporting and has over time, become a more complex task for health support or aged care workers. As explained by Savvy (1997), documentation has a central role in the process of securing government funding and quality monitoring so all records that are part of this process are open to scrutiny.

The challenge health support or aged care workers face is to provide high quality direct care to clients whilst also providing high quality documentation. This documentation should provide adequate information for the planning, implementation and evaluation of a client’s care. There are many factors to be considered when filling out forms and documents. It is essential that they are filled out in accordance with the organisation’s protocols and procedures so it’s very important that you become familiar with your organisation’s requirements. This is the case when a client has fallen. Often the organisation will have guidelines for strategies to be implemented and falls evaluation guidelines. Where these guidelines have been provided it is important to ensure they are used as per the organisation’s protocols.

As aged care or health support workers, we are accountable for the service we provide to our clients and the organisation for which we work. We are also accountable for keeping all forms and documentation up to date. One way of being accountable and ensuring care plans are the most accurate and appropriate is through record keeping.

Think about the type of information you include in reports. There is information about your client’s health and sometimes information about their finances. Not everyone wants this information to be known to other people. Imagine if you were a client and you read that you had a fall because you did not follow the strategies that were recommended. How do you think this would make you feel?

Issues to be aware of when record keeping

There are a number of issues to be aware of in record keeping:

- **Confidentiality:** Information in these records of a person’s life will be very personal in nature. They should therefore be kept in a secure location where only those people who need to view the records can do so. The location where they are kept needs to be secure and access restricted.

- **Language:** Language used in these files should be non-judgmental and positive. Remember that the person who the records are about should be able to read them without feeling insulted. It is a good idea to keep records jargon free as well, so everyone who reads them will be able to understand them. Don’t forget your writing needs to be clear and legible as well. The organisation you work for may have standards that are required of you with regard to this.

- **Identification:** As previously mentioned, you are accountable, so records you are completing should clearly state your name and signature and the date. The order of the documentation should be arranged in an organised way so access to different forms is easy.

- **Accuracy:** Your records should only contain facts. If you include information about what you feel or believe, then you must state this. Don’t use language such as ‘Joey doesn’t like working with Hamish’ because you observed Joey getting irritable with Hamish when working with him. Instead, you could state, ‘Today I observed Hamish telling Joey to ‘shut up’ when Joey was talking with him’: this is fact. You could add, ‘I am concerned that possibly Hamish does not have the patience to work with Joey, I will need to investigate further’: this is a feeling.

- **Including the person’s views and goals, and those of the significant others in their life:** Make it easy for the person to have an opportunity to have their own entries in the records, and allow them to challenge and change entries you may have made. The client can do this if they have the cognitive ability to do so. If the client is not able to do this, then their legal representative may. It is most important that the person consents to information being shared about them. Having the person or a responsible person sign a consent form acknowledges that permission has been granted to do so.
Adhering to legal requirements in work practice according to workplace policies and procedures and scope of role

Legislation

Community service organisations and their employees will need to comply with legislation, regulations and statutory requirements relevant to:

- The prevention of discrimination
- Anti-harassment
- Privacy (National Privacy legislation and principles)
- Equal Employment Opportunity (EEO)
- Freedom of information
- Access and equity
- Social justice
- Mandatory notification
- WHS legislation.

Legislation related specifically to aged care, child care, palliative care, youth services and to the care of people with disabilities etc will be relevant according to the community service sector in which the organisation operates. Workers also need to know their rights and responsibilities under the industrial legislation that applies in their state or territory. Industrial legislation, statutes and regulations impact on work conditions, wages, working hours and the obligations of employers and employees.

Work practices should be constantly monitored to ensure compliance and as an aid to improve efficiency. When coordinating and performing in the work environment, managers, supervisors and community service employees must ensure that the services provided meet identified client needs and uphold client rights. They must also be aware of their legal and ethical responsibilities with regard to workplace relationships and employee rights.

Information

Employees must be provided, by the management of the work organisation, with information about their legal and statutory responsibilities and obligations. They must remain up-to-date with legislation and with any organisational changes that affect the parameters within which they will work. Information might be delivered to employees via in-house training, at staff meetings, via intranet, web pages, and using memos and emails as communication tools. Files containing the information that employees will need, can be held in electronic or hard copy.

Documented information relating to legislation, regulations and statutory requirements should be available from the Human Resource (HR) department in the organisation, from the internet or government printers. This information must be current, relevant and reliable.
By ensuring that employees understand the legal responsibilities and obligations applicable to the workplace it becomes possible to set standards to which employees must adhere. KPIs (Key Performance Indicators) should be set and agreed upon with employees, so that all workers are aware of the standards to which they are expected to perform. In their work performance and in their interactions with clients, management, workmates and other stakeholders, employees must demonstrate understanding of and compliance with their legal responsibilities and with the key statutory and regulatory requirements relevant to their role and to the service sector in which they work.

**Work Health and Safety 2011**

Work health and safety is the responsibility of everyone. Your employer has a duty of care for occupational health and safety to provide a safe working environment for workers and clients. All employers are required to consult with staff on any issues which may affect their health and safety.

Under the Work Health and Safety Bill 2011, each state and territory regulates its own health and safety legislation. There should only be very slight variations to that legislation between the states and territories. All states and territories and the Commonwealth have worked together to develop and implement model Work Health and Safety (WHS) legislation as the most effective way to achieve harmonisation of WHS laws in Australia. By reducing costs and eliminating unnecessary administrative processes, harmonisation is designed to make it easier for workers and for employers who conduct business across multiple states.

**Disability Discrimination Act**

The Disability Discrimination Act 1992 prohibits discrimination against people with a disability in a range of areas including transport, education, employment, accommodation and public premises. While the Building Code of Australia contains specific provisions for access to and around new and existing buildings for people with a disability, the Disability Discrimination Act does not provide any technical details on how to provide that access.

**Mental Health legislation**

The Mental Health Act states that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances. The Act also establishes the procedures for beginning involuntary treatment, by making involuntary treatment orders and through independent review.

**The current legislation in the states and territories is:**

- New South Wales: Mental Health Act 2010
- Victoria: Mental Health Act 1986
- Queensland: Mental Health Act 2000 – subordinate legislation: Mental Health Regulation 2002
- Western Australia: Mental Health Act 1996
- Tasmania: Mental Health Act 1996
- Australian Capital Territory: Mental Health (Treatment and Care) Act 1994
- Northern Territory: Mental Health and Related Services Act 1998

**Sentencing Act 1991**

Part 5 of the Sentencing Act 1991 enables Victorian courts to make restricted involuntary treatment orders and hospital security orders for persons found guilty of offences who require involuntary treatment and care for mental illness.

**Medication Legislation and Regulations**

The State and territory Legislation relevant to the aged care sector could include the following areas of Legislation, Regulations and Standards:

An Act to give to members of the public rights of access to official documents of the Government of the Commonwealth and of its agencies.

Equal Opportunity

Equal Opportunity legislation dictates regulations regarding equal treatment of staff and users of the service without discrimination on the grounds of race, sex, ethnic origin, pregnancy, marital status, age or religion. There are specific provisions that forbid sexual harassment. Harassment may not always be physical. Your organisation will have policies that reflect the requirements of the Act. Equal Employment Officers are trained to ensure that there is no discrimination or harassment in the workplace and that people who want to make a complaint are informed of the procedures to do so. Make yourself familiar with Equal Opportunity procedures that apply in your workplace and who the EEO contact person is.

Racial Discrimination Act 1975 (Commonwealth. No 52, 1975)

An Act relating to the elimination of racial and other discrimination.

Sex Discrimination Act 1984 (Commonwealth. No. 4, 1984)

An Act relating to discrimination on the ground of sex, marital status, pregnancy, potential pregnancy or family responsibilities or involving sexual harassment


Allows The Human Rights and Equal Opportunity Commission HREOC to investigate complaints under acts such as the Disability Discrimination Act 1992, Sex Discrimination Act 1992, and the Racial Discrimination Act 1975, as well as dealing with infringements of human rights. It states that people have a right to respect and dignity, assistance to become as self-reliant as possible, education, training and work, family and social life and protection from discrimination. www.hreoc.gov.au/about the commission.

Freedom of Information Act 1982

The Freedom of Information Act 1982 creates a general right of access to information in documentary form in the possession of Ministers and agencies limited only by exceptions and exemptions necessary for the protection of essential public interests and the private and business affairs of persons in respect of whom information is collected and held by agencies.

Guardianship and Administration Act 1986

The Guardianship and Administration Act 1986 establishes a legislative regime to enable persons with a disability to have a guardian or administrator appointed when they need a guardian or administrator. The Guardianship and Administration Act also governs the performance of medical and dental treatments, special procedures and medical research procedures on people aged 18 years or older who have a disability (intellectual impairment, mental disorder, brain injury, physical disability or dementia), where that person is incapable of deciding whether to consent to the procedure.

Health Records Act 2001

The Health Records Act 2001 creates a scheme to regulate the collection and handling of health information in Victoria. The Health Records Act does not override other legislative regimes for confidentiality (such as section 120A of the Mental Health Act) or access to information (such as freedom of information), but rather complements and supplements those regimes. The Health Services Commissioner administers the Health Records Act.
Aged Care Act (1997)

Based on this Commonwealth Act the industry develops standards and guidelines:

- Standards and Guidelines for Residential Aged Care Services
- Home and Community Care National Service Standards
- Aged Care Accreditation Standards
- Disability Service Standards.

**Western Australian Legislation**

**Criminal Code Act 1913 (WA)**

The present law that governs criminal offences in Western Australia is the Criminal Code Act Compilation Act 1913 which is known as the Criminal Code. The criminal law is predominantly based in statutory law which is the Griffith Code (enacted for Queensland in 1899) and was later enacted in Western Australia in 1902.

The Criminal Code Act 1913 which is the criminal law of Western Australia was enacted in 1913 after amendments were made to the original code. Prior to the enactment of the Code, criminal law in Western Australia is based on common law. Despite codification of the criminal law in Western Australia, the common law has remained an important source of law therein. And all offences are contained in legislation. The most serious offences are contained in the Code, and there are other offences established by other legislations such as Road Traffict Act 1974 (WA) and Misuse of Drugs Act 1981 (WA).

**Equal Opportunity Act 1984 (WA)**

The Equal Opportunity Act 1984 (WA) is a Western Australian law which makes it unlawful to discriminate against a person in certain areas of public life, including employment. This law is regulated by the Equal Opportunity Commission.

**Working with Children (Criminal Record Checking) Act 2004**

The Working with Children (Criminal Record Checking) Act 2004 was passed by State Parliament on 26 November 2004, and was proclaimed on 1 January 2006. Since proclamation a number of amendments have been made to the Act and Regulations. These changes improve the effective administration of the legislation and also improve the protection of children in Western Australia. Legislation can be accessed from the website of the State Law Publisher of Western Australia, which is the official publisher of all Western Australian legislation.

**Child Protection State Legislation & Reporting - WA**

**Local Legislation**

The Department for Child Protection is responsible for overseeing and upholding child protection in Western Australia. Numerous Acts (laws) help to govern and guide the process of child protection.

**These acts include:**

**Principal Acts:**

- Children and Community Services Act 2004 (as amended in 2011)
- Children and Community Services Amendment (Reporting Sexual Abuse of Children) Act 2008 (from 1 January 2009, these mandatory reporting provisions will become a part of the Children and Community Services Act 2004)
Other relevant Acts:
- Working with Children (Criminal Record Checking) Act 2004
- Family Court Act 1997
- Adoption Act 1994
- Family Law Act 1975 (Cth)

Carers Recognition Act 2004 Western Australia
The Carers Recognition Act 2004 formally recognises carers as partners in the provision of care for people who are frail, chronically ill or have a disability. The stated aim of the WA legislation is to improve the culture of service providers by involving and partnering with carers in the delivery of care.

Other relevant WA legislation
- Equal Opportunity Act 1984 (WA) (as amended)
- Public Sector Management Act (1994) (WA) (as amended)
- Disability Discrimination Act (1992) (Commonwealth) (as amended)
- Disability Services Act (1993) (WA) (as amended)
- Racial Discrimination Act (1975) (Commonwealth) (as amended)
- Racial Hatred Act (1995) (Commonwealth) (as amended)
- Sex Discrimination Act (1984) (Commonwealth) (as amended)
- Human Rights and Equal Opportunity Commission Act 1986 (Commonwealth)
- Criminal Code (WA)
- State Records Act 2000 (WA) (as amended)
- Nurses Act 1992
- Nurses Amendment Act 2003
- Poisons Act 1964
- Nurses Board of Western Australia – medication recommendations

Regulations and Standards
Standards are guidelines developed to ensure consistency of practice in human/community service organisations. They may be related to legislation. For example, all states in Australia have developed standards that services receiving government funding must adhere to. These are guidelines or principles for how the service should operate under the legislation.

Standards can be developed without legislation. For example, the NSW Department of Community Services has standards for the Supported Accommodation Assistance programme (non-government services working with homeless people) but no legislation. These standards focus on guidelines about allowing clients the right to complain and be treated with respect, etc.

The Australian Council on Healthcare Standards (ACHS)
The ACHS is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through continual review of performance, assessment and accreditation. Established in 1974, the ACHS has maintained its position as the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care organisations. It is recognised internationally and was the third health care accreditation agency to be established worldwide after the Joint Commission on Accreditation for Healthcare Organizations, USA and the Canadian Council on Health Services Accreditation.
Duty of care

There may be occasions when a client opts to make a choice which may put them at risk. Essentially, they have a perfect right to do this. On the other hand, you have a duty of care towards each and every one of your clients to avoid them coming to harm. Your duty of care to your clients requires you to take reasonable care to avoid injury to others, and damage to property as a result of any action or inaction.

The duty of care can be a contentious issue. If a worker is deemed to have failed to fulfil their duty of care, a charge of negligence, both against the worker and their organisation, may result. To breach duty of care, a worker must be judged to have done something a reasonable person would not have done in a particular situation, or, conversely, to have failed to do something that a reasonable person would do in a particular situation. The background, position and experience of a worker is taken into account, if this judgment is being made.

For you, as a current or future worker in the community services industry, the question of duty of care will not always be a simple one. This is because the ongoing development of your clients towards independence and self-sufficiency, may involve exposure to new and different experiences, some of which require a degree of calculated risk taking. When you do encounter this situation, as you certainly will, the following questions may be useful as a framework when considering whether or not a particular activity should be undertaken.

- How will my actions benefit the person?
- What risks might the person or other people be exposed to?
- What sort of precautions can be taken to minimise the risks whilst still allowing the person’s rights?
- Do the benefits outweigh the risks?
Boundaries, roles and responsibilities

According to the Macquarie Dictionary, boundaries indicate limits, confines or restraints. There are various examples of things which provide boundaries. Examples of boundaries include geographical distance, time, emotional distance (which gives people the space they need to feel safe), verbal boundaries (e.g., saying no), personal space, moral boundaries (what behaviour is appropriate?) and safety boundaries (what limits do I need to stay within to be safe?).

Organisations, workers, clients and stakeholders all have specified roles and responsibilities in the process of service delivery. It is important to be very clear about what these roles and responsibilities are, and to ensure that all other involved parties are clear, in order to minimise confusion and ambiguity, and to maximise the potential for effective delivery of services.

Professional boundaries

It is important to keep your relationships with clients on a professional rather than personal basis. This ensures that the interests of both parties are protected. Most professional codes of ethics warn against forming relationships, outside of the professional relationship, with your current clients. Mixing social and professional relationships often works against the best interests of both parties.

In all relationships, limits have to be set. The relationship established between client and service provider is a special type of relationship, established for a particular purpose. The client enters into this relationship trusting that you, as a worker, will tend to their wellbeing. This is not an equal relationship and whether you, in your work role, wish it or not, you are in a position of power and influence.

You may often be working with people in a highly emotional and, therefore, vulnerable state. The way in which you relate to your client reflects only part of your personality, and may show only the caring part of your behaviour, as most of the time you will be listening to and meeting your client’s needs. This may lead your client to see you not only as a very caring person, but as superior to themselves. Your position and your client’s subjective perceptions may combine to make your client vulnerable to offers of closeness or friendship (explicit or implicit).
Twelve

Complying with the organisation’s reporting requirements, including reporting observations to supervisor

1. Describe the reporting procedures and documentation requirements of your job role?

2. What guidelines would you give to a new carer regarding the best way to give accurate verbal reports to colleagues during handover?

3. Describe your organisation’s policy for the storage and use of health or service records.
4. Describe the procedures for recording client's observations in your workplace.
Storing information according to organisation policy and protocols

When storing and maintaining confidential information, it is essential to keep legal requirements in mind. Ignorance of the law is never an excuse. Because legal requirements change and are often very issue specific, all health support or aged care workers should make it a priority to find out what the requirements are for the area in which they work.

Also, different government departments produce circulars or documents that outline the legal requirements for their staff in relation to storing and maintaining information. Your agency or department should be able to provide you with the relevant documents.

Generally, case notes should be kept for seven years after the last entry. In some medical settings however, they have to be kept for 15 years after the last entry. Notes on people under the age of 18 years also have to be kept for 15 years after that person reaches 18. Care facilities and their employees have a responsibility to ensure that statutory requirements are adhered to in regard to access, privacy, maintenance and storage of comprehensive care records.

Community services documentation and health documentation can be subject to close and careful scrutiny during civil (allegations of negligence) and criminal legal proceedings and therefore must reflect a professional approach. Care reports must meet specific standards and health support or aged care workers must take responsibility for writing professional care reports whilst being mindful of the purpose for which they are used.

It must be:
- Accurate
- Objective
- Legible
- Brief and complete.

Written records are ‘legally accountable’ and therefore the person who gives the care must record their actions or observations factually. This ensures both the client and the health support or aged care worker are protected.

Things NOT to do:
- Do not use yellow sticky notes
- Do not write in pencil
- Do not erase entries
- Do not leave spaces between entries to write things in later
- Do not cross out information so that it cannot be read
- Do not write something on behalf of someone else.

Record all the important issues but do not ‘pad out’ the record with non-essential information. Reports need to be completed within identified timeframes and meet the legal requirements of the state in which you are working.

Aged care and health support workers often need to gather and record information about a person to assist in the development, monitoring and evaluation of service plans. Be observant, this will help in the early identification of potential problems. Document needs and problems but especially document any changes in the client and/or variations in normal service delivery.

Client files are often used to collect and store information which is subject to privacy and confidentiality. Only authorised people caring for the client have access to the files. The information written in these files are regularly monitored and evaluated. Health records are important for all health support and aged care workers. It is essential that they completed according to legal requirements and the standards of the organisation. Doing this provides protection for the client staff completing the documentation and also for the organisation.
Storage of records

The types of information kept within a community services organisation includes: all correspondence, reports, submissions, media releases, forward plans, staff records, manuals, policies and procedures, log books, address and phone lists and client records. Any information that is to be kept must be stored in some way.

Storage systems used within various organisations may include:

- Computers
- Filing cabinets
- Disc, compact disc or DVD boxes
- Archive boxes
- Ring binders and folders
- Bookshelves
- Card file boxes
- Books and journals
- Financial journals and ledgers
- Diaries
- Whiteboards and pin boards.

Let's take a brief look at some of these and the confidentiality implications in using these systems.

Computers

Community services organisations have been progressively moving to the use of computers to store a wide range of records for some time. Two highly confidential areas of information that may be stored on a computer include financial records of the organisation and personal information of both the staff and clients. Since personal computers are readily accessible, and most people have some level of knowledge of computers, it is important that this information is protected in some way.

The simplest way to protect information on a computer is apply a password to all/any information which should not be accessed by everyone. It is important that passwords themselves are protected. It has little value, for example, if the password is written down and taped to the underside of the desk.
Filing cabinets

The confidentiality issue also applies to filing cabinets. Ideally these should be stored in a lockable drawer. Many filing cabinets lock the whole cabinet when the top drawer is locked. Some models are available with individual locks for each drawer, so that information needed on a daily basis may be stored separately in a drawer that is not locked.

Disc, compact disc or DVD boxes

These too could contain highly confidential information, and if they are to be stored on the premises should be lockable. Only authorised personnel should have a key or access to a key. Disc boxes containing confidential information should then be secured in a locked cabinet, office or safe at the end of the day.

Financial journals and ledgers

Where financial information is not stored on a computer, but kept in a handwritten form, these journals and ledgers should also be protected. At the very least they should be stored in a lockable office, ideally though, in a lockable cabinet or safe. This is particularly true where the financial records include personal details of staff and their pay details.
Archive boxes

Archive boxes are used to store paper files that are not used any more, but have to be kept for legal, technical or administrative purposes. Archive boxes are used to accommodate the overflow when filing cabinets are culled regularly, so that only the most current and frequently used files are kept in the cabinet.

Ring binders and arch folders

On occasions there are many documents of a similar type which have to be kept together, but are not required for daily access, eg: some organisations like to store their minutes in a special folder marked just for that purpose. These documents can be stored readily in ring binders or arch folders. They are particularly useful for long documents or thick documents, such as books or manuals that need to be referred to occasionally.

Bookshelves and display shelves

These are extremely useful to community services organisations. They can be used for ready access to items stored in ring binders and arch folders, including minutes, policies and procedures and other relevant documents. Display shelves are useful for displaying information, pamphlets and literature obtained from other organisations that may offer additional services to your clients or residents.
Card file boxes

Card file boxes are generally used for keeping straightforward details about different people or organisations that you may contact on a regular basis. This type of information, normally names, addresses and phone numbers, is entered onto small handheld cards that are stored in a box, usually in alphabetical order. Placed centrally, people can access the information they need at any time. Care must be taken of course to see that the cards are returned to the box after they have been used.

Books

A variety of books may be used in an organisation to keep a record of things that don’t need to be sorted into topics. A typical example would be a telephone message book, where all telephone messages received are written down as they come in. All staff members would know to check the book for messages if they have been off the premises and this is a good way to retain messages in a central location for later reference.

Diaries and log books

Diaries and log books can be a crucial part of a community service organisation’s documentation. Diaries are often placed centrally, recording meetings and other events of interest to staff so that they can see what is planned and arrange their time accordingly. Likewise with log books, these record the movements of the organisation’s vehicles, showing who has taken the vehicle out, where they have gone and how far they have travelled. All of this can be valuable for documenting client care and attendance on clients.

Any information that is not confidential can be stored under any of the other methods. This can then be placed in a situation where anyone who needs to can access the information readily. Most of all when dealing with records and financial aspects of the organisation’s procedures, it is important that all workers make themselves fully aware of their organisation’s security, privacy and confidentiality policies and maintain them at all times.
Computerised records

As with paper-based files, computer files need to be organised in a way that will help you and others find them again. Your workplace computer or network (a group of connected computers) should have an ordered system of folders that represent different sections of the organisation, including work areas, client groups, and special projects. Most likely you will share a group of files and folders with other workers, although there may be confidential or private folders that require special permission to open.

To be able to perform administrative and record keeping tasks using a computer you need to understand:

- Basic computer functions
- Operation of the system, program or database used to create, store and retrieve electronic documents
- The protocols and procedures related to creating, storing and accessing documents.

If you are not sure how the system is organised, or need to use a program you have not used before, ask a more experienced user, or ask for training.
Bibliography

- Berglund Catherine: *Ethics for Health care* (Oxford University Press 1998)
- Bevan Celia: *Successful ageing: perspectives on health and social construction*. Mosby Publishers Australia Pty
- Craven, RF and Hirnle, cj (2000) *fundamentals of nursing: human health and function*, Lippincott, USA.
- Bevan Celia: *Successful ageing: perspectives on health and social construction*. Mosby Publishers Australia Pty Ltd