GOLDEN ROSE HOME CARE PTY LTD

TRADING AS : HEART 4 CARE

COMMUNITY NURSING SERVICES FOR VETERANS AND THEIR DEPENDENTS

POLICY AND PROCEDURE MANUAL

March 2026

Version 1.2

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Section 1 Introduction

1. About This Manual

This manual provides a comprehensive framework for delivering safe, high-quality, and person-centred community nursing services to veterans and their dependents. It is intended for all staff members, contractors, subcontractors, and affiliated personnel involved in service delivery, and outlines the policies, procedures, and protocols that ensure consistency, safety, and excellence in care.

The content is aligned with the DVA *Notes for Community Nursing Providers*, the *National Safety and Quality Health Service (NSQHS) Standards*, and *Australian Health Practitioner Regulation Agency (AHPRA)* requirements. It also supports compliance with privacy and data protection laws, the *NMBA Code of Conduct for Nurses (2018)* and *NMBA Code of Ethics for Nurses (2018)*, as well as Workplace Health and Safety (WHS) guidelines.

2. Purpose and Scope

The purpose of this manual is to ensure that all community nursing services delivered to veterans and their families are consistent, compliant, and of the highest standard. Specifically, it aims to:

- Standardise practices to uphold the safety, dignity, and well-being of veterans.
- Provide clear, practical guidance for nursing staff, administrators, and subcontractors.
- Promote best practice and continuous improvement in care delivery.
- Ensure full compliance with DVA requirements, national healthcare standards, and AHPRA codes of conduct.

The scope of the manual covers the entire service delivery process — from initial assessment and care planning to ongoing service provision and follow-up. It also details the operational, ethical, and legal responsibilities of all individuals and organisations involved.

3. Key Definitions

The following key terms and definitions are used throughout this manual:

- **Community Nursing Services**: Health care services provided in the home environment by registered nurses, enrolled nurses, or personal care workers, including clinical and personal care interventions.
- **DVA Client / Client**: A veteran, widow(er), or dependent family member who holds a Veteran Gold Card, Veteran White Card, or other valid identification issued by the Department of Veterans' Affairs (DVA) and is eligible for healthcare services through DVA.
- **Registered Nurse (RN)**: A nurse who holds current registration with the Australian Health Practitioner Regulation Agency (AHPRA) and is qualified to provide clinical assessments, develop care plans, administer medications, and supervise care delivery.
- **Enrolled Nurse (EN)**: A nurse who holds current registration with AHPRA, who works under the delegation and supervision of a Registered Nurse and provides care within their scope of practice.
- **Personal Care Worker (PCW)**: A non-clinical staff member who assists clients with activities of daily living (ADLs) and provides non-clinical care services under the guidance of nursing staff.
- **Care Plan**: A personalised document developed by healthcare professionals in consultation with the client, outlining the goals, required services, and interventions necessary to manage the client's health needs.
- **Clinical Governance**: A framework through which healthcare organisations ensure the safety and quality of care, with a focus on leadership, accountability, risk management, and continuous improvement.
- **Clinical Need:** A condition or situation in which a DVA client requires nursing or personal care services to manage a health issue, injury, or disability, as determined by a comprehensive clinical assessment. Services must be necessary, evidence-based, and align with the client's current condition to qualify as claimable under the DVA Community Nursing Program.
- **Exceptional Case (EC):** A classification used when a client's assessed care needs significantly exceed the scope of services outlined in the standard DVA Community Nursing Schedule of Fees. Exceptional Case status must be approved by DVA in writing and supported by a detailed application, including comprehensive assessment findings and a signed care plan by Registered Nurse.

- **Delegation:** The process by which a Registered Nurse transfers the responsibility (but not accountability) for performing a specific nursing or personal care task to another appropriately trained and competent staff member (such as an Enrolled Nurse or Personal Care Worker), in accordance with NMBA's delegation principles and the organisation's policies
- **Care Classification: The** categorisation of a client's community nursing service into DVA's defined schedules (e.g., Clinical Care, Personal Care, Exceptional Case), based on assessed needs. Classifications determine the type, frequency, and funding level of services claimable under the DVA Community Nursing Program.

4. Document Management and Review Process

This Manual is a living document that will be reviewed and updated regularly to reflect changes in legislation, DVA guidelines, AHPRA requirements, and clinical best practices. The document management and review process is outlined below:

- **Version Control:** This manual will be assigned a version number to track changes. Each updated version will be reviewed by senior management, clinical governance officers, and legal advisors to ensure compliance with the latest regulations.
- **Regular Review:** The manual will undergo a formal review at least once every three years or earlier if significant legislative changes or updates to DVA guidelines, AHPRA standards, or national healthcare standards occur.
- **Update Process:** All revisions to the manual will be tracked and documented. Updates will be communicated to all staff members and relevant stakeholders to ensure that they are informed of the changes. Staff will be required to confirm their understanding and implementation of any new policies or procedures.
- **Staff Access and Training:** The manual will be made available to all staff in electronic format. It will be accessible through the company intranet for ease of reference. Staff will be trained on the contents of the manual during onboarding and will receive annual refresher training to ensure ongoing compliance with the policies and procedures outlined in the manual.

Section 2 Governance and Organisational Compliance

1. Clinical Governance Framework

1.1. Policy Statement

Our organisation is committed to a robust clinical governance framework that ensures the safety, quality, and accountability of all our services. Clinical governance is embedded in every aspect of our operations, providing systematic oversight, continuous improvement, and consumer engagement.

1.2. Purpose and Scope

This policy applies to all employees, contractors, and subcontractors engaged in the delivery of DVA community nursing services.

Its purpose is to:

- Ensure safe, effective, person-centred care.
- Embed accountability for clinical quality and safety at all levels.
- Align organisational practices with DVA guidelines, NSQHS Standards, and relevant legislation.
- Promote a culture of openness, learning, and continuous improvement.

Our Clinical Governance Framework

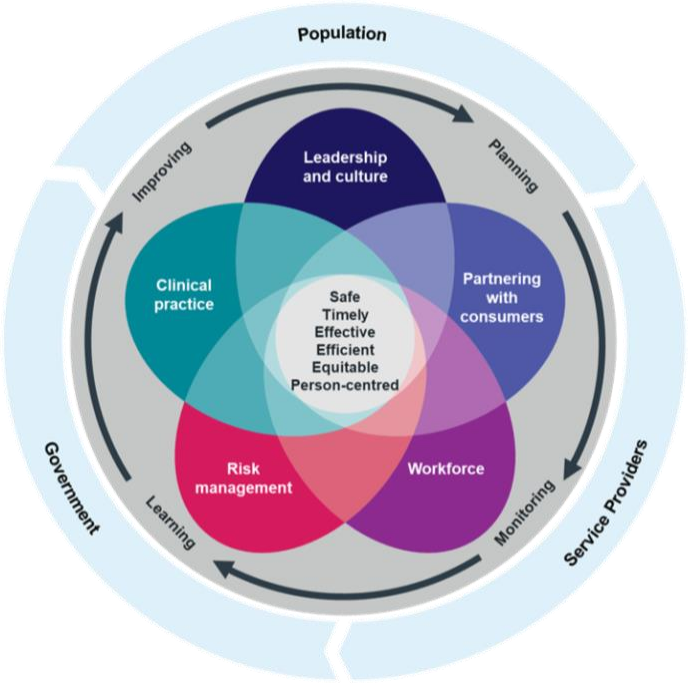


Figure 1: *Clinical Governance Framework*

1.3. Framework Components

The components of our Clinical Governance Framework are as follows:

1.3.1. Governance, Leadership, and Culture

- **Comprehensive Governance Systems**

  Corporate and clinical governance systems are integrated to continuously improve DVA Client safety, care quality, and outcomes. These systems uphold clear standards and regulations, ensuring compliance and consistency in all aspects of clinical and operational practice.

- **Strong Leadership**

  Leaders cultivate a safe, supportive, and positive environment where staff are empowered to engage in decision-making, contribute their expertise, and take ownership of DVA Client care quality. This supportive environment promotes transparency, ethical practices, and accountability across all levels.

- **Organisational Culture**

A culture dedicated to high-quality care is encouraged, with policies and structures focused on DVA Clients-centred services informed by consumer and workforce insights. This commitment to quality care is reflected in the encouragement of innovation and continuous feedback mechanisms.

1.3.2. DVA Client Safety and Quality Improvement Systems

- **Proactive Safety Systems**

  Safety and quality processes are systematically embedded within governance structures to manage and improve DVA Client care effectively, prioritising DVA Client safety at all times.

- **Performance Data and Benchmarking**

  Staff receive relevant data on performance metrics to support individual learning, growth, and team-driven improvement. This data includes DVA Client feedback, clinical outcomes, and incident reporting, which are used to foster a culture of continuous improvement.

- **Data-Driven Decision Making**

  A variety of data is collected and shared with management, guiding strategic decisions that reduce unnecessary variation and enhance quality. By monitoring data across all areas, we identify trends and risks, thus enabling proactive adjustments to policies and practices.

- **Clinical Outcomes Analysis**

  Regular review of clinical outcomes helps identify best practices and areas needing improvement, with insights informing targeted quality improvement strategies.

- **Risk Management**
  - Identify, document, and proactively mitigate or minimise risks.
  - Continuously monitor and evaluate the effectiveness of our risk mitigation strategies to ensure optimal protection.
  - Empower our workforce, partners, and the communities we serve to recognise, report, and address incidents or concerns promptly and effectively.

1.3.3. Clinical Performance and Effectiveness

- **Qualified and Competent Workforce**

  Our workforce is equipped with the necessary qualifications, experience, and oversight to deliver high-quality, safe care. Ongoing professional development and training ensure that all employees maintain and enhance their competencies in line with current standards and advancements in healthcare.

- **Educational Resources and Training**

  Employees have consistent access to training and educational resources to support the continued development of the skills needed to meet DVA Client care standards and adapt to evolving healthcare practices.

1.3.4. Clear Accountability and Ownership

- **Individual and Organisational Accountability**

  All employees are responsible for upholding the standards of clinical governance, taking ownership of their professional roles, and contributing to the company's objectives. This includes adhering to policies, participating in training, and actively engaging in continuous quality improvement initiatives.

1.3.5. Partnering with Consumers

- **Collaborative Care Models**

  Systems are in place to promote meaningful partnerships with DVA Clients, carers, families, and consumers in all aspects of healthcare planning, design, measurement, and evaluation. This ensures that healthcare services are tailored to the needs and preferences of the individuals we serve.

- **Engagement in Personalised Care**

  DVA Clients are engaged as active participants in their own care, ensuring that decisions align with their values and preferences. This DVA Clients-centred approach builds trust and encourages adherence to treatment plans.

- **Health Literacy**

  Efforts are made to improve health literacy among consumers, providing clear, accessible information to empower informed decision-making and encourage proactive health management.

- **Consumer Involvement in Organisational Design**

  DVA Clients and families contribute to organisational design and governance, helping shape policies, programs, and service delivery models that reflect the broader community's needs and priorities.

1.4. Procedures

- Maintain a **Clinical Governance Policy Register** with documented policies.
- Review clinical outcomes and incidents quarterly.
- Record feedback from clients and families, and use this to adjust practice.
- Undertake ongoing professional development and maintain evidence for AHPRA.

1.5. Client Journey

This section outlines our approach to service delivery. The journey depicted in Figure 2 applies universally to all programs and services we provide.

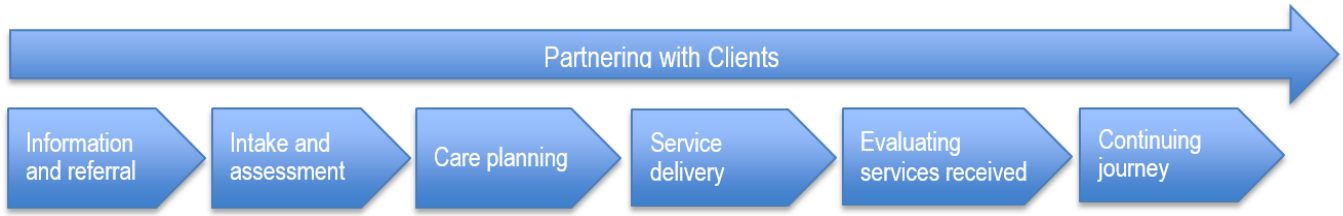


Figure 2: *Client Journey*

Information and Referral: The journey begins by providing clients with relevant information, helping them navigate available services and connect with the right resources.

Intake and Assessment: Clients undergo an intake and assessment process to identify their specific needs and determine the appropriate level of support.

Care Planning: Following the assessment, a personalised care plan is developed in collaboration with the client, outlining tailored goals and interventions.

Service Delivery: Services are then delivered according to the established care plan, ensuring clients receive the support they need.

Evaluating Services Received: After service delivery, feedback is gathered to assess the quality and effectiveness of the services, identifying any areas for improvement.

Continuing Journey: The client's journey doesn't end with service delivery. There is a focus on ongoing support, reassessment, or transition to new services as needed, ensuring continuous engagement and adapting to evolving needs.

Application of the Clinical Governance Framework

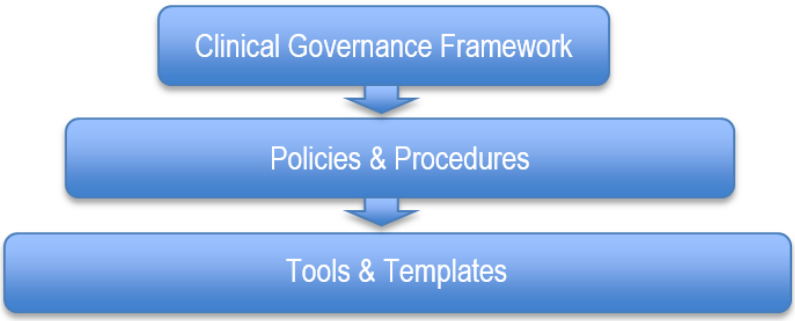


Figure 3: *Application of the Clinical Governance Framework*

The effective implementation of the Clinical Governance Framework will be ensured through well-developed, standardised policies and procedures. Where possible, policies, procedures, tools, and templates are harmonised across the company to promote consistency, facilitate effective oversight, and support comprehensive monitoring and assurance. This standardisation ensures that all team members operate under a unified set of guidelines, enhancing accountability, quality of care, and adherence to best practices across all programs and services.

References

- National Safety and Quality Health Service Standards
- National Model Clinical Governance Framework
- Victorian Clinical Governance Framework
- DVA, Notes for Community Nursing Providers

2. Roles and Responsibilities

2.1. Policy Statement

The organisation maintains a governance structure that ensures accountability, clarity of roles, and compliance with all regulatory requirements.

2.2. Roles and Responsibilities

Every stakeholder associated with a health service has specific responsibilities to contribute to achieving and maintaining high quality and safe care.

ROLE	RESPONSIBILITIES
DVA Clients	DVA Clients are integral to clinical governance, playing a central role by: • Engaging in their healthcare and treatment, as well as that of their families and carers, to the extent they choose. • Collaborating with health services in designing, delivering, and enhancing service quality. • Contributing to system-wide improvements in quality and safety. • Partnering with healthcare companies in governance, planning, and policy-making to co-design and enhance performance monitoring, measurement, and evaluation. • Advocating for DVA Client safety to support optimal treatment and outcomes for themselves and others. • Sharing feedback, insights, and personal experiences to inspire and drive meaningful change.
Personnel	• Maintain personal professional skills, competence and performance. • Comply with professional regulatory requirements and codes of conduct. • Monitor personal clinical performance. • Contribute proactively to fostering an organisational culture that prioritises DVA Client safety and quality. • Clearly communicate their profession's dedication to delivering

	safe, high-quality healthcare. ● Demonstrate professional conduct that consistently reflects a commitment to safety and quality. ● Seize opportunities to deepen understanding of safety and quality theories and systems. ● Actively participate in the management of clinical services. ● Support, mentor, and guide colleagues in providing safe, high-quality care. ● Engage in every phase of developing, implementing, evaluating, and monitoring governance processes.
Management	● Maintain personal professional skills, competence and performance. ● Set up an operational policy and procedure framework. ● Clearly communicate the company's commitment to delivering safe, high-quality care. ● Provide opportunities for workforce education in safety and quality principles and systems. ● Exemplify the company's safety and quality values throughout all management practices. ● Drive the creation of business plans, strategic initiatives, and organisational policies that prioritise safety and quality. ● Embed safety and quality principles into organisational plans, policies, and procedures. ● Establish strong partnerships with relevant health services to promote positive clinical outcomes. ● Periodically, systematically review the design of systems for safety and quality. ● Set up an operational policy and procedure framework, with the active engagement of all staff. ● Implement and resource effective systems for management of - clinical education and training - performance monitoring and management

	- quality improvement and measurement - risk management - incident management - open disclosure - feedback and complaints • Systematically monitor performance across all safety and quality systems.

3. Code of Conduct & Professional Ethics

3.1. Policy Statement

Our company is committed to fostering a workplace environment that supports a collaborative, respectful, and high-functioning team. We recognise that the quality of our internal culture directly impacts DVA Client safety, care outcomes, staff wellbeing, and overall service delivery.

Team members are expected to conduct themselves in a manner that reflects the core values and behavioural standards of our company. We promote and maintain the following foundational attributes as essential to an effective team:

- **Respectful and supportive culture**, underpinned by transparency, psychological safety, and mutual trust. A cohesive and collaborative working environment is strongly associated with enhanced DVA Client safety and clinical outcomes.
- **Shared goals and purpose**, clearly defined through our company's mission statement and operational objectives, which are communicated to and embraced by all staff members.
- **A systems-based approach**, encompassing the development and continuous improvement of both clinical and administrative systems, to ensure consistent and efficient operations.
- **Clear division of labour**, whereby tasks are delegated and distributed appropriately in accordance with role descriptions, competencies, and principles of safe, effective team-based care.
- **Ongoing training and cross-training**, ensuring team members are equipped to perform their duties and provide coverage across roles where required due to planned or unplanned absences, or changes in workload.
- **Robust communication processes**, enabling supportive interpersonal communication and structured information sharing through clearly defined channels, ensuring clarity, continuity, and accountability.

We view these elements as essential not only for effective operations but also for fostering a culture of continuous improvement, mutual respect, and DVA Clients-centred care.

3.2. Purpose and Scope

This policy establishes the expectations for ethical behaviour and professional conduct within the company. It ensures all staff maintain a high level of integrity and professionalism while providing care, ensuring dignity and respect for veterans and their dependants.

3.3. Procedure

All staff and contractors are expected to uphold professional standards of conduct that reflect positively on the company and support the delivery of high-quality, safe, and respectful care to our DVA Clients.

3.3.1. Professional Conduct

- All individuals interacting with DVA Clients, carers, visitors, or other team members are required to maintain courteous, respectful, and professional behaviour at all times. This includes both verbal and non-verbal communication.
- Discrimination, harassment, or any form of unfair treatment based on race, gender, age, disability, sexual orientation, or other personal characteristics is prohibited. All staff must provide services in an equitable manner, ensuring all clients have access to care regardless of their background or circumstances.
- Staff must establish and maintain appropriate professional boundaries with clients, ensuring that all interactions remain focused on the provision of care. Personal relationships or any form of exploitation of clients are strictly prohibited.
- All team members are expected to perform their duties within the scope of their professional qualifications, legal authorisation, and the boundaries set out in their employment contract, position description, and professional codes of practice.
- Under no circumstances may any team member discuss DVA Client information outside the company. Team members are to be constantly aware of their obligation to protect the confidentiality and privacy of DVA Client health information in accordance with the *Privacy Act 1988* and the practice's privacy policies.
- Team members must not make disparaging, critical, or judgmental remarks regarding a DVA Client's care, including treatment provided by other health professionals, whether inside or outside the workplace.
- Adherence to all company policies and procedures is mandatory. Each team member must be familiar with, and act in accordance with, the responsibilities outlined in their role description and contractual obligations.

- All team members are expected to actively contribute to quality improvement processes, including participating in discussions and initiatives aimed at improving clinical safety, operational efficiency, and DVA Client care outcomes.

- Each team member has a duty of care to identify and report any potential infection control risks. They are also responsible for implementing relevant infection prevention and control procedures as outlined in the company's infection control protocols.

- Punctuality is essential. Team members are expected to be ready to commence and complete work at their rostered times. Repeated lateness may be addressed through the disciplinary procedures.

- Any breach of the expected code of conduct will be addressed in accordance with the practice's disciplinary policy (refer to Section - Disciplinary Action and Termination Process). This may include informal counselling, formal warnings, or termination of employment, depending on the nature and severity of the breach.

3.3.2. Ethical Responsibilities

- **Autonomy and Informed Consent**

  Staff must respect the autonomy of veterans and their dependents, ensuring that they make informed decisions about their care. All care provided must be voluntary and based on informed consent. Staff must ensure clients understand the nature and purpose of any care or treatment, answering any questions they may have to enable them to make informed decisions.

- **Beneficence and non-maleficence**

  All actions taken by staff should aim to benefit clients, while avoiding harm. This principle of beneficence requires staff to provide the best possible care based on clinical evidence, and non-maleficence requires staff to avoid causing any harm, whether physical, emotional, or psychological, to clients.

- **Justice and Fairness**

  Staff must ensure that all clients are treated fairly and equitably. Services should be provided in a way that promotes fairness and does not favour one individual

over another. This includes ensuring equal access to care, especially for those in need or experiencing hardship.

- **Professional Competence**

  Staff must continually work towards maintaining and improving their professional competence through ongoing education, training, and reflection. The organisation will ensure that staff have access to regular training and development opportunities to stay up-to-date with best practices and regulatory changes.

3.3.3. Reporting Unethical Behaviour and Breaches of Conduct

- **Whistleblowing**

  Staff are encouraged and supported to report any concerns regarding unethical behaviour or breaches of this policy. The organisation provides a safe and confidential channel for whistleblowers to raise concerns, without fear of retaliation. This can include reports of client abuse, unethical behaviour by staff, or safety violations.

- **Investigation of Reports**

  All reported breaches of conduct or unethical behaviour will be investigated promptly and thoroughly by the relevant managers or clinical governance leads. Depending on the outcome, disciplinary action, including termination, may be taken against the individual involved.

- **External Reporting**

  Serious breaches or unethical conduct may be escalated to external bodies such as AHPRA, WHS authorities, or regulatory bodies if required.

3.3.4. Professional Development and Accountability

- **Performance Reviews**

  Staff members will undergo regular performance reviews to assess adherence to this Code of Conduct. These reviews will ensure that staff are meeting the professional and ethical standards expected by the organisation, and will identify areas for further development or support.

- **Accountability**

  Compliance with this Code of Conduct & Professional Ethics is a responsibility of all staff, contractors, and subcontractors. Non-compliance may result in disciplinary action, including suspension or termination of employment, and may include referral to external regulatory bodies for further investigation or action.

4. Conflict of Interest Management

4.1. Policy Statement

We are committed to maintaining the highest standards of integrity, accountability, and transparency in the delivery of community nursing services. All actual, potential, or perceived conflicts of interest (COI) must be identified, declared, documented, and appropriately managed to ensure that clinical and organisational decisions are impartial and in the best interests of our clients.

4.2. Purpose and Scope

The purpose of this policy is to:

- Ensure that decisions about client care and organisational operations are free from bias or undue influence.
- Provide a clear process for identifying, declaring, and managing conflicts of interest.
- Support compliance with DVA, NSQHS, and AHPRA standards, as well as the Corporations Act 2001 (Cth), Fair Work Act 2009 (Cth), and the Privacy Act 1988 (Cth).

This policy applies to all staff, contractors, subcontractors, and volunteers engaged by our organisation.

4.3. Procedure

4.3.1. Identification of Conflicts

All staff, contractors, and subcontractors must actively consider whether their personal, financial, or professional interests could conflict with their duties.

Conflicts of interest may be:

- **Actual**: A current conflict exists (e.g., a staff member refers clients only to their family-owned business).
- **Potential**: A conflict may arise in future (e.g., considering accepting work from a supplier with whom the staff member has personal ties).
- **Perceived**: A third party could reasonably believe that a conflict exists (e.g., staff accepting gifts from a pharmacy).

Examples of COI include:

- Referring clients to a business owned by staff, their family, or associates.
- Receiving personal gifts, hospitality, or incentives from suppliers or clients.
- Favouring one subcontractor or supplier over another due to personal relationships.
- Providing direct care to immediate family members or close friends.
- Any financial, contractual, or personal interest that could influence professional judgement.

4.3.2. Declaration of Conflicts

Conflicts must be declared:

- On recruitment or engagement (pre-employment screening).
- As soon as a new conflict arises.
- At least annually, through compliance reviews.

Staff must complete a **Conflict-of-Interest Declaration Form** and submit it to their direct line manager.

4.3.3. Documentation

All conflicts will be recorded in the **Conflict-of-Interest Register**, which includes:

- Name of the person declaring the conflict.
- Nature and details of the conflict.
- Date identified.

- Management action taken.

Records will be securely retained for **seven years** in accordance with legislative requirements.

4.3.4. Management of Conflicts

Once a conflict is declared, the organisation will take one or more of the following actions:

- **Disclosure only:** The conflict is declared, recorded, and monitored if low risk.
- **Restriction:** The person is excluded from decision-making relating to the conflict.
- **Independent oversight:** An independent staff member or manager reviews decisions for impartiality.
- **Client referral:** Clients are referred to another provider if impartial care cannot be guaranteed.
- **Contractual action:** Subcontracting or supplier relationships may be altered or terminated if compliance risks arise.

4.3.5. Client Communication

- If a declared conflict affects client care or service access, the client must be informed in writing.
- The client will be offered alternatives, such as referral to another provider, to ensure impartiality.
- Discussions with the client must be documented in the client's record.

4.3.6. Reporting to Regulators

Conflicts must be escalated outside the organisation in the following cases:

- To DVA:
  - Where the conflict directly affects client service delivery or continuity of care.
  - When subcontracting arrangements are entered into, changed, or terminated (mandatory DVA notification within 30 days).
  - Where DVA funding may be improperly influenced by the conflict.
- To AHPRA/NMBA:
  - Where a nurse's professional practice, judgement, or client safety may be compromised by the conflict.

- To Other Authorities:
    - Where a conflict results in fraud, corruption, or other unlawful activity (to regulators such as ASIC, Fair Work Ombudsman, Aged Care Quality and Safety Commission, or police).

All external notifications will be coordinated by the Chief Executive or Clinical Governance Lead.

4.3.7. Monitoring and Review

- The **Conflict-of-Interest Register** will be reviewed quarterly by management (or the Clinical Governance Committee, if established).
- Annual compliance reviews will confirm that all staff have declared conflicts where applicable.
- Any breaches of this policy will be investigated, corrective actions implemented, and serious breaches reported to regulators as required.

5. Subcontracting and Third-Party Arrangements

5.1. Policy Statement

We are committed to ensuring that all subcontracting and third-party arrangements uphold the safety, quality, and continuity of services for clients. Where subcontractors or third parties are engaged, we will remain fully accountable to the Department of Veterans' Affairs (DVA) for compliance with all program requirements, relevant legislation, and industry standards.

All subcontracting arrangements must:

- Comply with DVA's requirements.
- Ensure continuity, safety, and quality of care.
- Maintain full accountability for services delivered.

Subcontracted organisations must be bound by obligations equivalent to those imposed on this organisation under the DVA Agreement. DVA must be granted equivalent rights of access and oversight.

We will only engage subcontractors and third parties who meet the same standards of professionalism, competence, and compliance required of our organisation.

5.2. Purpose and Scope

The purpose of this policy is to:

- Ensure subcontracting arrangements are consistent with DVA Notes for Community Nursing Providers.
- Establish clear procedures for the selection, approval, oversight, and termination of subcontractors and third parties.
- Protect clients' rights, safety, and continuity of care where external service providers are involved.

This policy applies to all subcontracted companies and personnel engaged in delivering community nursing services.

5.3. Procedure

5.3.1. Approval and Notification to DVA

- The management must notify DVA in writing within 30 days of entering into any subcontracting arrangement.
- Notification must include:
    - The subcontracted company's legal name, ABN, ACN.
    - Registered or principal place of business.
    - Completed DVA subcontracting template available on DVA website.
- DVA may request to view and authorise the terms of any subcontract.
- A signed copy of the subcontract must be supplied to DVA on request.

5.3.2. Selection of Subcontracted Companies

The company must ensure that subcontractors are selected based on clear, rigorous criteria to maintain service standards and comply with all regulatory requirements.

Selection Criteria:

- **Eligibility**: Only registered companies with valid ABN/ACN are eligible for subcontracting arrangements. Sole traders and individuals are not permitted.
- **Experience and Expertise**: The subcontractor must have a proven track record in delivering community nursing services or related healthcare services.
- **Compliance with Regulatory Requirements**: Subcontracted companies must:

- Employ suitably qualified and competent personnel in accordance with the requirements outlined in Section 4 – Human Resources of the DVA Notes for Community Nursing Providers.
- Comply with all relevant laws, including anti-discrimination laws.
- Have an employee code of conduct that personnel adhere to.
- Have access to, and demonstrate understanding of, the current DVA Notes and any relevant DVA material.
- Be made aware of the obligations, conditions, and accountability requirements contained in the company's agreement with DVA.
- Comply with the DVA Service Charter.
- Allow DVA to request and review documentation related to services provided under the subcontract, including during audits.

- **Due Diligence**: Before engaging a subcontractor, the company will conduct thorough background checks to ensure the subcontractor and its personnel meet required standards for quality and compliance.
  - **Police Checks:** All personnel working with clients under the subcontract must undergo a Police Check to ensure they do not have a history of criminal offenses that would disqualify them from providing care, especially when working with vulnerable clients.
  - **Work with Vulnerable People (WWVP) Clearance**: If applicable, subcontractors and their staff must hold a WWVP clearance or equivalent, depending on the region and the specific requirements of the role.
  - **Licensing and Qualifications Verification:** Ensuring that all staff have the appropriate professional qualifications, licenses, and certifications.
  - **Insurance:** Verifying that subcontractors hold professional indemnity insurance and public liability insurance.
  - **Work Health and Safety (WHS) Compliance:** Ensuring the subcontractor complies with all relevant WHS laws, policies, and procedures.

5.3.3. Ongoing Management and Oversight

- The company must ensure the continuing suitability of subcontracted companies.
- The company remains fully responsible for the quality and safety of all services delivered by subcontractors.

- The company must provide orientation, training, and access to all relevant policies and procedures to subcontracted personnel.
- Performance of subcontracted companies must be regularly monitored to ensure compliance with this policy, the DVA Notes, and all legal obligations.

5.3.4. Ongoing Performance Monitoring and Reviews

The company will regularly monitor and review subcontractor performance to ensure compliance with all service delivery standards and regulatory requirements.

Performance monitoring includes:

- **Scheduled Audits**: At least annually, or more frequently, if necessary, the company will conduct audits to evaluate the subcontractor's compliance with:
  - DVA requirements
  - Service quality
  - Regulatory compliance
- **Key Performance Indicators (KPIs)**: The company will track KPIs to assess:
  - **Client satisfaction** (via surveys and feedback),
  - **Service delivery** timeliness and reliability,
  - **Incident rates** (e.g., complaints, safety incidents),
  - **Quality of care** (e.g., missed appointments, client outcomes).
- **Corrective Action Plans (CAPs)**: If subcontractors underperform, the company will implement a CAP to address deficiencies. This may involve:
  - Additional training
  - Process improvements
  - Increased oversight
- **Termination of Contract**: If performance remains unsatisfactory after corrective actions, the company may terminate the subcontract. A formal termination process will be followed, with proper notification to DVA and a transition plan for clients.

5.3.5. Contractual Requirements

All subcontracts must contain clauses that:

- Impose obligations on the subcontracted company equivalent to those imposed on the company under the DVA Agreement and Notes.

- Grant rights to DVA (either directly or through the company) equivalent to those in the DVA Agreement.
- Ensure appropriate payment and remuneration of subcontracted companies, including all tax-related obligations.

5.3.6. Accountability

- The company is fully accountable to DVA for all services delivered under subcontracting arrangements.
- Engaging subcontractors does not diminish our regulatory obligations - we remain fully accountable for service quality and compliance.
- Any breaches by subcontracted organisations will be treated as breaches by the company itself.

5.3.7. Breach Handling

In the event of a breach by a subcontracted organisation, the company will adhere to the following process to ensure compliance with regulatory obligations. The company shall also ensure that all actions taken are documented and aligned with applicable laws and best practices.

Steps for Breach Handling:

- **Immediate Notification to DVA:**
  Notify the DVA within 24 hours of becoming aware of the breach or incident. The notification must be in writing and include the following details:
  - The nature of the breach, including any relevant facts and circumstances.
  - The subcontractor(s) involved, and the specific services affected.
  - Any immediate corrective actions that have already been taken or planned.

- **Investigation and Risk Assessment:**
  - Before performing a formal risk assessment, conduct a preliminary investigation to understand the cause and reason behind the breach. This is a critical step to ensure the company fully understands the incident before evaluating the risk and planning further actions.

- Once the cause and reason for the breach are understood, conduct a comprehensive risk assessment. Evaluate the potential impact on clients' safety, service quality, and compliance with regulatory obligations. Consider the likelihood of recurrence of the breach and any long-term consequences for the company, subcontractor, or clients.

- **Corrective Action Plan (CAP)**

  A corrective action plan must be developed to address the breach. The CAP shall:

  - Identify root causes of the breach, which were uncovered during the preliminary investigation.
  - Specify immediate corrective actions to address the breach.
  - Outline preventative measures to ensure the breach does not recur.
  - Define a timeline for completion of corrective actions.

- **Suspension of Services**

  Based on the findings of the risk assessment, the company may need to suspend services provided by the subcontractor to mitigate any further harm or non-compliance.

  Criteria for suspension include:

  - The severity of the breach and its potential harm to clients.
  - Regulatory or compliance risks (e.g., privacy, safety standards).

- **Transition and Continuity of Services**

  If the breach results in the termination of the subcontractor, the company will implement a transition plan to ensure that services are not interrupted, and clients continue to receive the necessary care. This plan includes:

  - **Client notification**, informing them of the change in service provider.
  - **Alternative care arrangements**, ensuring continued care for clients.

- **Transfer of care** to another subcontractor or internal staff, with no interruption in service quality.

6. Whistleblower and Protected Disclosure Policy

6.1. Policy Statement

We are committed to fostering a culture of integrity, accountability, and transparency. Individuals must feel safe and supported to raise concerns about suspected misconduct, unlawful activity, breaches of professional standards, or risks to client safety.

We will ensure that anyone making a protected disclosure ("whistleblower") is treated fairly, their identity is protected as far as practicable, and they do not suffer detriment as a result of speaking up. All reports will be taken seriously, investigated in a timely and impartial manner, and corrective actions will be implemented where necessary.

6.2. Purpose and Scope

The purpose of this policy is to:

- Provide a clear process for raising concerns about serious misconduct, breaches of law, unsafe practices, or unethical behaviour.
- Ensure whistleblowers are protected against victimisation, dismissal, or discrimination.
- Outline the organisation's responsibilities to investigate disclosures and take corrective action.
- Support a culture of openness and accountability in line with clinical governance requirements.

This policy applies to all employees, contractors, subcontractors, volunteers, and officers of the organisation.

6.3. Procedure

6.3.1. What Can Be Reported

Protected disclosures may include:

- Breaches of DVA requirements, NSQHS standards, or AHPRA codes.
- Misconduct such as fraud, theft, or misuse of funds.
- Negligence or unsafe clinical practices that place clients at risk.
- Bullying, harassment, or discrimination.
- Breaches of privacy or confidentiality.
- Any conduct that is illegal, unethical, or likely to cause harm.

Matters such as personal work-related grievances (e.g., pay disputes) are generally not covered, unless they involve victimisation for making a disclosure.

6.3.2. How to Make a Disclosure

Staff may report concerns in one of the following ways:

a. Direct Reporting (Identified Disclosures)

- Email or letter to the CEO or Clinical Governance Lead. Mark correspondence as **"Confidential – Protected Disclosure"**
- In person or by phone to one of the authorised officers listed above. A written record will be made and confirmed with the whistleblower.

b. Anonymous Reporting

Staff who wish to remain anonymous can use one of the following options:

- Anonymous email account (not linked to their name).
- Physical letter posted to the organisation's head office, addressed to "Protected Disclosure Officer – Confidential."

c. External Reporting

Whistleblowers may report directly to external regulators where appropriate:

- DVA – if the matter involves breaches of DVA program requirements.
- AHPRA – for professional misconduct or breaches of clinical standards.
- ASIC – for corporate, financial, or governance-related misconduct.
- Police – if unlawful activity is suspected.

6.3.3. Protection of Whistleblowers

Whistleblowers will not be subjected to dismissal, demotion, discrimination, harassment, or any other detriment as a result of making a disclosure.

Whistleblower identity will be kept confidential unless:

- Consent is given to disclose;
- Disclosure to a regulator is required by law; or
- It is necessary to prevent a serious threat to health and safety.

Retaliation against a whistleblower is strictly prohibited and will result in disciplinary action.

6.3.4. Investigation of Disclosures

- All reports will be acknowledged within 5 business days.
- An impartial investigator will be appointed (internally or externally as required).
- The investigation will be conducted confidentially, with findings documented.
- Outcomes may include corrective actions, disciplinary measures, or reporting to external authorities.
- The whistleblower will be informed of the investigation outcome, subject to legal and confidentiality requirements.

6.3.5. Actions and Outcomes

Where allegations are substantiated, the organisation will:

- Implement corrective and preventive measures.
- Report to DVA or other regulators where required.
- Take disciplinary or contractual action against individuals involved in misconduct.
- Provide feedback to the whistleblower (if not anonymous).

6.3.6. Monitoring and Review

- All disclosures and investigations will be recorded in a Protected Disclosure Register.
- Records will be stored securely, with access limited to authorised officers.
- The register will be reviewed quarterly by management or the Clinical Governance Committee to ensure accountability.
- This policy will be reviewed every two years, or earlier if there are changes to legislation or regulatory requirements.

Section 3 Workforce and Human Resources

1. Recruitment, Credentialing, and Onboarding

- **Policy Statement**

We are committed to fair, transparent, and compliant recruitment, ensuring only qualified, competent, and ethical staff are engaged. All personnel must be credentialed and onboarded before commencing client care to maintain service quality and compliance with regulatory requirements.

- **Purpose and Scope**

This policy establishes a consistent approach to workforce recruitment, credentialing, onboarding, and clearance. It ensures:

- Only suitable staff are appointed.
- All legal, regulatory, and contractual requirements are met.
- The integrity and safety of services provided to DVA clients.

This policy applies to all employees, contractors, subcontractors, and volunteers engaged in community nursing services.

- **Procedure**

1.1. Workforce Planning:

- Review workforce needs regularly to maintain an appropriate skill mix.
- Maintain up-to-date job descriptions specifying duties, qualifications, and reporting lines.

1.2. Recruitment Process:

- **Advertising**
  - Advertise roles using transparent, non-discriminatory methods.
  - Job advertisements must clearly state required qualifications, registrations, and clearance checks.
- **Selection**
  - Select candidates on merit, qualifications, and alignment with organisational values.
  - Conduct structured interviews using competency-based questions.
  - Obtain at least two referee checks for all clinical staff.
- **Employment Offer**
  - Provide a written employment contract or engagement agreement.
  - Contracts must include:
    - Role and reporting lines.
    - Duties and responsibilities.
    - Remuneration and entitlements (as per the Fair Work Act 2009).
    - Compliance obligations (e.g., Code of Conduct, confidentiality, WHS).

1.3. Credentialing (Qualifications, Registration, and Competencies)

All personnel, including those from subcontracted organisations, must complete mandatory credentialing and screening before commencing work.

- **Registered Nurses (RNs):**
  - must hold current AHPRA registration with no restrictions
  - a minimum of one year supervised post-registration practice (however a minimum of two years' post graduate experience including wound management is recommended)

- completed infection prevention and control training
- medication management competency
- current manual handling competency
- current Basic Life Support (BLS) certification

- **Enrolled Nurses (ENs):**
  - must hold current AHPRA registration with no restrictions
  - a minimum of one year supervised post-registration practice (however a minimum of two years' post graduate experience including wound management is recommended)
  - completed infection prevention and control training
  - current manual handling competency
  - current Basic Life Support (BLS) certification
  - medication management competencies (where applicable)
- **Personal Care Workers (PCWs):**
  - must hold one of the following qualifications:
    - a Certificate III in Home and Community Care, Aged Care or Disability (pre-December 2015)
    - a Certificate III in Individual Support (post December 2015)
    - a Certificate III in Health Services Assistance
    - a student in the second or third year of Bachelor of Nursing degree at an Australian university or accredited higher education provider.
  - completed infection prevention and control training
  - medication assistance competency (where applicable)
  - current manual handling competency
  - current Basic Life Support (BLS) certification
  - current Provide First Aid certificate

1.4. Screening and Clearance Requirements

Prior to commencing employment, all staff must provide evidence of:

- National Police Check (within the last 3 years); OR, if the organisation is registered for NDIS services, a NDIS Worker Screening Check (within the last 3 years).

- Working With Vulnerable People (WWVP) registration/clearance or state/territory equivalent, if required by jurisdictional law.
- Proof of identity and right to work in Australia (e.g., passport, birth certificate, visa).
- Immunisation status consistent with the Workforce Immunisation Policy.

1.5. Renewals and Monitoring

- Police Checks and NDIS Worker Screening: renewed every 3 years.
- WWVP or equivalent: maintained in line with state/territory requirements.
- AHPRA registration: verified annually and tracked for renewal.
- Expiry dates recorded in a Workforce Register; reminders issued 3 months before expiry.
- Staff will be suspended from client duties if any clearance lapses.

1.6. Onboarding and Induction

All new personnel must complete a structured induction prior to delivering services, covering:

- Organisation mission, values, and governance.
- DVA Community Nursing Program requirements, including referrals, eligibility, and reporting.
- Policies and procedures: Code of Conduct, Privacy and Confidentiality, WHS, Risk and Incident Management, Infection Prevention and Control.
- Clinical governance framework, escalation of care, and documentation standards.
- Training in manual handling, BLS, First Aid, and infection prevention.

Completion of induction must be properly documented, and records must be securely stored.

- Employee Induction Program (Alignment with DVA Requirements)

The organisation maintains a structured Employee Induction Program aligned with the DVA Notes for Community Nursing Providers – November 2025 to ensure all staff are prepared before commencing client care.

Induction Components

• Overview of the DVA Community Nursing Program (eligibility, referral, documentation and reporting requirements);

• Orientation to organisational policies and procedures (Code of Conduct, Privacy & Confidentiality, Infection Control, WHS, Risk & Incident Management, Clinical Governance);

• Mandatory training modules: infection prevention and control, manual handling, Basic Life Support (BLS), and Provide First Aid;
• Cultural safety and diversity, including Aboriginal and Torres Strait Islander health perspectives; and
• Emergency management procedures and incident reporting.

Evidence of Induction
Each new staff member completes an Induction Checklist signed by the supervisor before client contact. The checklist and evidence of module completion are retained in the Personnel File and Training Register.

1.7. Probation

- All staff are subject to a probationary period of 3–6 months.
- Supervisors will monitor performance, competencies, and compliance during probation.
- A formal probation review will determine confirmation or termination of employment.

1.8. Record Keeping

- All recruitment, credentialing, clearance, and onboarding documentation will be securely stored in accordance with the Privacy Act 1988 (Cth).
- Personnel files must include contracts, verified qualifications, clearances, training records, and induction checklists.
- A Workforce Register will be maintained for audit purposes, recording:
  - Staff names, roles, and qualifications
  - AHPRA registration numbers and expiry dates
  - Clearance check numbers and expiry dates
  - Immunisation status

1.9. Monitoring and Review

- No staff member may commence duties without completing recruitment, credentialing, clearance, and induction requirements.
- Lapses in registration or clearances will result in immediate suspension from client duties until resolved.
- Falsification of credentials or documentation will result in disciplinary action and referral to AHPRA, DVA, or other authorities.

- Recruitment and credentialing processes will be audited annually as part of the Quality Improvement Program.
- This policy will be reviewed every two years, or earlier if legislation, DVA Notes, or regulatory requirements change.

2. Roles and Scopes of Practice (RN, EN, PCW)

2.1. Policy Statement

We are committed to ensuring that all staff work strictly within their professional scope of practice, as defined by their qualifications, regulatory authority, and competency.
No staff member will undertake duties outside their approved scope, and appropriate supervision will always be provided to maintain safety and quality of care.

2.2. Purpose and Scope

The purpose of this policy is to:

- Define the roles and scopes of practice for Registered Nurses (RNs), Enrolled Nurses (ENs), and Personal Care Workers (PCWs).
- Ensure client safety by preventing staff from performing tasks beyond their competence or regulatory authority.
- Clarify supervision and accountability requirements across the workforce.

This policy applies to all clinical and care staff employed, contracted, or subcontracted by the organisation to deliver community nursing services.

2.3. Procedure

2.3.1. Registered Nurses (RNs)

Registered Nurses hold primary responsibility for the delivery and coordination of community nursing services. They must:

- Conduct **comprehensive face-to-face assessments** of clients in their homes, including a holistic review of health, functional capacity, and care needs.
- **Report assessment outcomes** to the client's General Practitioner (GP) or relevant medical practitioner.
- **Develop a tailored nursing care plan** informed by assessment findings and client goals.
- **Delegate aspects of care** to ENs and PCWs, taking into account their scope of practice, competencies, and capabilities.
- **Monitor, supervise, and provide guidance** to ENs and PCWs in the delivery of delegated care.
- Ensure all **clinical progress notes and assessment documentation** are legible, accurate, up to date, and consistent with industry best practice.
- **Document all delegation decisions** clearly in the client's clinical record.
- Provide services in line with their position description, DVA program requirements, and the NMBA Registered Nurse Standards for Practice.

2.3.2. Enrolled Nurses (ENs)

Enrolled Nurses provide nursing care under the direction and supervision of an RN. They must:

- Deliver delegated clinical tasks such as wound care, vital signs monitoring, medication administration (if authorised and competent), and personal care.
- Work within their scope of practice as defined by the NMBA Enrolled Nurse Standards for Practice.
- Escalate changes in a client's condition or care needs immediately to the supervising RN.
- Ensure all care provided is documented in progress notes and the client's record.
- Not perform comprehensive assessments or independently develop nursing care plans.
- Accept responsibility for their delegated tasks and seek clarification if a task is outside their competence

- Enrolled Nurses may only administer medications where they have completed appropriate competencies, the task is documented in the care plan, and they are working under the direction and supervision of a Registered Nurse

2.3.3. Personal Care Workers (PCWs)

Personal Care Workers support clients with daily living activities and provide delegated care under RN supervision. They must:

- Provide personal care services such as hygiene, nutrition, mobility assistance, and support with activities of daily living.
- Carry out tasks explicitly delegated in the care plan by the RN.
- Assist with medication only if they have completed a recognised competency, the task is included in the care plan, and the RN has delegated and supervises the activity. All medication assistance must comply with relevant State or Territory legislation (e.g., Poisons and Therapeutic Goods Acts) and PCWs must not administer medications beyond what is legally permitted in their jurisdiction.
- Report any client concerns, incidents, or health changes to the RN or EN immediately.
- Not conduct clinical assessments, make independent care decisions, or provide unsupervised clinical interventions.

2.3.4. Accountability and Supervision

- RNs hold ultimate accountability for all client care and outcomes.
- ENs and PCWs are accountable for performing only those tasks delegated to them and for working within their assessed competence.
- The level of supervision provided by RNs will depend on:
    - The complexity of the client's needs.
    - The risk associated with the task.
    - The competence and experience of the staff member.
- All delegated tasks must be planned, supervised, and documented in the client's care plan and clinical record.

2.3.5. Monitoring and Review

- Compliance with this policy will be reviewed through documentation audits, care reviews, and staff performance assessments.
- Breaches of scope will result in corrective action, retraining, and, where required, referral to AHPRA, DVA, or other regulators.
- This policy will be reviewed every two years or earlier if DVA requirements, NMBA standards, or NSQHS Standards change.

3. Delegation and Supervision of Care

3.1. Policy Statement

We will ensure that delegation of care is carried out safely, ethically, and in compliance with professional standards and DVA requirements.
Registered Nurses (RNs) retain accountability for all delegated care and must ensure that any task assigned to Enrolled Nurses (ENs) or Personal Care Workers (PCWs) is appropriate, within their competence, and supported with the right level of supervision.
All delegated care must be planned, supervised, and documented in the client's clinical record.

3.2. Purpose and Scope

This policy establishes a consistent process for delegation and supervision of care to ensure:

- Client safety and service quality are maintained at all times.
- Delegated tasks are matched to the skills and competence of the staff member.
- RNs retain accountability while enabling effective teamwork.

This policy applies to all RNs, ENs, and PCWs employed by or contracted with the company to provide community nursing services.

3.3. Procedure

3.3.1. Delegation

An RN must delegate aspects of care to others according to their competence and scope of practice. This includes:

- delegation of aspects of care according to role, functions, capabilities and learning needs
- monitoring aspects of care delegated to others and providing clarification/assistance as required
- recognising own accountabilities and responsibilities when delegating aspects of care to others
- delegation to and supervision of others consistent with legislation and organisational policy.

The RN must recognise the differences in accountability and responsibility between RNs, ENs and unlicensed care workers (i.e. PCWs).

- Delegation is the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse or a person who is not a nurse.
- Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service.
- The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances, delegation may be preceded by teaching and competence assessment.
- For further details see the NMBA's National framework for the development of decision-making tools for nursing and midwifery practice (2013).

3.3.2. Principles of Delegation

- Only RNs may delegate tasks to ENs and PCWs.
- Delegation must be consistent with:
    - The client's nursing care plan.
    - The delegated staff member's scope of practice and competence.
    - Relevant legislation, standards, and organisational policies.

- Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation.
- **Accountability cannot be delegated.**
- The RN who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.

3.3.3. Planning Delegation

Before delegating, the RN must:

- Assess the client's needs and risks.
- Confirm the task is suitable for delegation.
- Confirm the EN or PCW has the necessary competence and understanding.
- Provide clear instructions and expected outcomes.
- Ensure the task is documented in the client's care plan and clinical record.
- Maintain clear and open communication channels.
- Regularly reviewing and updating delegation practices.

3.3.4. Supervision Requirements

The level of supervision must be determined by the RN and depend on:

- Task complexity – higher risk tasks require closer supervision.
- Client condition – unstable or deteriorating clients require direct RN involvement.
- Staff competence and experience – new or less experienced staff require closer oversight.

Supervision may include:

- Direct supervision – RN is physically present and observing.
- Indirect supervision – RN is readily available for support, consultation, and review.

The RN must always be accessible when care is being provided by ENs or PCWs.

3.3.5. Documentation

- All delegated tasks must be documented in the client's clinical records.

- Documentation must include:
  - Task delegated.
  - Person responsible for the task.
  - Date and time of the task.
  - Observations, outcomes, and follow-up actions.

3.3.6. Monitoring and Review

- Delegation practices will be reviewed through clinical audits, incident reviews, and performance appraisals.
- Any inappropriate delegation or breach of scope will be addressed through retraining, supervision, or disciplinary action.
- Serious breaches will be referred to AHPRA, DVA, or other regulators as required.
- This policy will be reviewed at least every two years, or earlier if DVA requirements or professional standards change.

4. Staff Competency and Training

4.1. Role-Specific Orientation and Training Induction

Induction is tailored to each role in accordance with the DVA Notes for Community Nursing Providers:

• **Registered Nurses (RNs):** Care planning, delegation, clinical documentation, and DVA audit requirements.

• **Enrolled Nurses (ENs):** Practise under RN supervision, safe medication administration, and communication/escalation to RN/GP.

• **Personal Care Workers (PCWs):** Delivery of delegated personal care, infection control, and escalation/communication protocols.
Attendance is mandatory and recorded in the Training Register.

4.2. Policy Statement

We are committed to ensuring that all personnel are qualified, competent, and up to date with their professional obligations. Staff must complete initial and ongoing training, including mandatory competencies, annual refreshers, and continuing professional development (CPD). We maintain accurate records of all qualifications, training, and registrations to meet DVA compliance requirements and support safe, effective service delivery.

4.3. Purpose and Scope

The purpose of this policy is to:

- Ensure staff maintain competence through structured training and assessment.
- Establish minimum competency requirements, annual review processes, and refresher training schedules.
- Support staff to meet their professional CPD obligations and to engage in ongoing development.

This policy applies to all staff involved in the delivery of community nursing services.

4.4. Procedure

4.4.1. Competency Assessment

- Competency assessments will be conducted upon commencement of employment, annually, and as required when introducing new procedures, equipment, or regulatory updates.

- Assessments will include:
    - Practical skills assessments
    - Written knowledge assessments covering core competencies, clinical procedures, medication management, infection control, and DVA-specific requirements.
    - Peer reviews and feedback from supervisors, colleagues, and DVA Clients.
    - Self-assessment to encourage reflection on practice and identification of training needs.
- Non-compliance or failure to meet competency standards will result in immediate additional training, a tailored development plan, supervised practice, and a re-assessment within a specified timeframe to ensure competency is achieved.
- Responsibilities:
    - Management: Ensure all training programs meet regulatory requirements, maintain accurate records, develop, implement and schedule regular training programs.
    - Personnel: Complete all required training, maintain certifications, and adhere to policies.

4.4.2. Mandatory Competencies

- **First Aid and Basic Life Support (BLS):**
    - Personnel must hold current First Aid and BLS certificates.
    - Certification must be renewed annually.
    - Training must be completed through a registered training company (RTO)

- **Infection Prevention and Control:**
    - Mandatory training at induction.
    - Annual refresher, plus additional training when guidelines are updated.
    - Further information and recommended courses on COVID-19 and infection prevention and control can be found at:
        - Department of Health and Aged Care – COVID-19 resources and training
        - Australian Commission on Safety and Quality in Health Care:

- Infection prevention and control for aged care eLearning modules
- Infection prevention and control – advanced education eLearning modules

- **Medication Management Competency**
  - Where applicable, personnel administering and/or assisting with medications must maintain medication management competency.
  - Nurses: Competency in safe administration of medicines, including Schedule 8, renewed annually.
  - PCWs: Medication assistance competency (if delegated this responsibility), with annual reassessment.

- **Anaphylaxis Management**

  All clinical staff must complete annual refresher training in recognition and emergency response to anaphylaxis.

4.4.3. Continuing Professional Development (CPD)

All personnel are required to engage in ongoing continuing education and professional development, with a particular focus on enhancing skills and knowledge related to community nursing services. This commitment to regular, ongoing training ensures that staff remain up-to-date with best practices and maintain a high standard of care.

- Registered Nurses and Enrolled Nurses must complete at least 20 hours of CPD annually in line with NMBA registration standards.
- CPD must be relevant to community nursing and documented in the staff member's professional development record.
- Personal Care Workers are encouraged to engage in CPD activities relevant to their role, including short courses, in-service education, and workshops.
- Staff are supported through access to training programs, professional development leave (where applicable), and internal learning opportunities.
- Staff are encouraged to utilises DVA's online training resources for community nursing providers to stay current with program requirements

4.4.4. Training Records and Documentation

- **Mandatory Competencies and Certification**

  All clinical and care staff must maintain current certifications:

  - **Manual Handling** – practical assessment renewed annually;
  - **Basic Life Support (BLS)** – renewed annually via an accredited provider
  - **Provide First Aid (e.g., HLTAID011)** – renewed every 3 years with annual CPR update; and
  - **Infection Prevention and Control** – completed at induction and at least annually thereafter

- Comprehensive records of all completed training and competency assessments must be maintained for each staff member.
- Training records will be kept up-to-date and securely stored.
- Records must be readily accessible for audit purposes and meet the requirements of the Australian Health Practitioner Regulation Agency (AHPRA) Standards for Nursing.

Certificates are recorded in the Personnel File and tracked in the Training Register. Staff may not deliver services if certifications have lapsed.

4.4.5. Monitoring and Review

- Competency and training compliance will be monitored through quarterly audits of the Training Register.
- Annual workforce reports will be used to review training effectiveness and identify improvement opportunities.
- This policy will be reviewed every two years, or earlier if DVA Notes, legislation, or clinical standards change.

5. Performance Review and Disciplinary Procedures

5.1. Policy Statement

Staff performance will be regularly reviewed to ensure competence, adherence to professional and organisational standards, and alignment with our values.

Where underperformance or misconduct occurs, issues will be managed in a fair, transparent, and timely manner consistent with the Fair Work Act 2009 (Cth), relevant industrial instruments, and professional codes of conduct.

5.2. Purpose and Scope

This policy establishes a structured process for:

- Conducting performance reviews,
- Supporting staff development through feedback and improvement plans, and
- Managing performance issues, misconduct, or breaches of standards through appropriate disciplinary procedures.

5.3. Procedure

5.3.1. Performance Review Process

- Formal reviews are conducted at the end of probation and annually thereafter.
- Informal reviews may be held throughout the year as part of supervision and quality assurance.
- Performance is assessed against:
    - Role description and key responsibilities.
    - Adherence to organisational policies and procedures.
    - Compliance with professional standards and DVA requirements.
    - Contribution to teamwork, client outcomes, and continuous improvement.
- Reviews are documented using a standardised appraisal form.
- Staff are encouraged to provide self-assessment and feedback.
- Constructive feedback will be provided, highlighting strengths and areas for improvement.
- A performance development plan will be agreed if gaps are identified, setting clear goals, actions, and review timelines.

5.3.2. Addressing Underperformance

- **Early Intervention**

- Concerns are discussed with the staff member promptly through supervision or informal counselling.
- Additional support, training, or supervision may be provided.

- **Performance Improvement Plan (PIP)**
  - Where issues persist, a formal PIP may be initiated.
  - The plan will:
    - Outline specific areas requiring improvement.
    - Set measurable performance goals.
    - Provide a timeline for review (usually 4–12 weeks).
    - Identify supports (mentoring, training, supervision).
  - Progress will be monitored, and outcomes documented.

5.3.3. Disciplinary Procedures

Where misconduct, serious breaches, or continued underperformance occur, the following graduated process will apply, unless the matter warrants immediate escalation:

1. **Verbal Warning** – For minor breaches; documented in supervision records.
2. **Written Warning** – For repeated or more serious issues; placed on personnel file.
3. **Final Written Warning** – Where behaviour or performance remains unsatisfactory.
4. **Termination of Employment/Engagement** – For persistent underperformance, gross misconduct, or breaches of law, DVA requirements, or professional codes.

Serious Misconduct

- May result in immediate suspension or termination without progression through the above stages.
- Examples include:
  - Client abuse or neglect.
  - Fraud, theft, or dishonesty.
  - Breach of confidentiality or privacy.

- Contractual and regulatory breaches
- Working outside scope of practice or without valid registration/clearances.

- Such matters will be referred to regulators (e.g., AHPRA, DVA, Police, Fair Work Ombudsman) as required.

5.3.4. Procedural Fairness

- Staff will be informed of concerns and given the opportunity to respond.
- Investigations will be impartial and documented.
- Staff may be supported by a representative during formal meetings.
- Outcomes will be communicated in writing.

5.3.5. Documentation and Records

- All performance reviews, PIPs, warnings, and disciplinary actions will be documented and stored securely in personnel files.
- Records will be retained in line with legal and organisational requirements.

5.3.6. Monitoring and Review

- Trends in performance issues will be reviewed annually to identify systemic improvements in recruitment, training, or supervision.
- This policy will be reviewed every two years, or earlier if legislation, DVA requirements, or employment standards change.

6. Workforce Immunisation Policy

6.1. Policy Statement

We are committed to protecting the health of our clients, staff, and the community by ensuring our workforce is appropriately immunised against vaccine-preventable diseases.

6.2. Purpose and Scope

The purpose of this policy is to:

- Minimise the risk of transmission of infectious diseases within the workplace and client homes.
- Ensure staff are aware of their responsibilities regarding immunisation.
- Provide clear procedures for immunisation evidence, record-keeping, and compliance monitoring.

This policy aligns with the Australian Immunisation Handbook, jurisdictional requirements, and all relevant Australian legislative and regulatory standards.

This Workforce Immunisation Policy applies to all employees, contractors, volunteers, and other personnel working within the company who provide direct or indirect services to clients in their homes. It includes administrative, clinical, and support staff who may be exposed to infectious agents or pose a risk of transmission to clients.

6.3. Procedure

6.3.1. Immunisation Requirements

The company requires the following vaccinations in accordance with the Australian Immunisation Handbook and jurisdictional requirements:

- **Influenza (annual vaccination):** Annual influenza vaccination is strongly recommended for all healthcare workers, especially those caring for individuals at higher risk of influenza-related complications.
- **Measles, Mumps, Rubella (MMR):** Healthcare workers born during or since 1966 are recommended to have received 2 doses of measles- and rubella-containing vaccines, unless they have documented evidence of immunity.
- **Varicella (Chickenpox):** Employees must provide evidence of immunity or receive the varicella vaccine, especially those who have not previously had chickenpox.
- **Pertussis (Whooping Cough):** A booster dose of dTpa (diphtheria, tetanus, pertussis) is required for employees, particularly those providing care to vulnerable clients.
- **Hepatitis B:** Staff must be vaccinated against Hepatitis B if there is a reasonable expectation of exposure to blood or body fluids.
- **Other Vaccinations:** Additional vaccinations may be required for certain employees based on the nature of their role, exposure risk, or jurisdictional health directives.

6.3.2. Evidence of Immunisation

- Staff must provide documented evidence of their immunisation status or proof of immunity (e.g., serology results) prior to commencing client-facing duties.
- Immunisation records will be sighted and securely stored in personnel files.
- Staff are responsible for keeping their immunisation status current and providing updated records when vaccinations are received.

6.3.3. Exemptions:

- Employees may apply for a medical exemption where a vaccine is contraindicated. Exemptions must be supported by a medical certificate or documentation from a medical practitioner.
- Temporary deferrals may be granted for employees who are pregnant or have a temporary medical condition that contraindicates vaccination.
- Non-medical exemptions (e.g., conscientious objections) are not accepted under this program.

6.3.4. Non-Compliance

- Staff who fail to meet immunisation requirements without a valid exemption may be excluded from client-facing duties.
- Persistent non-compliance may lead to disciplinary action in line with the organisation's performance and conduct procedures.

6.3.5. Documentation and Record-Keeping

- The company shall maintain a secure immunisation register for all employees.
- The register records the employee's vaccination status, dates of vaccination, and evidence of immunity.
- Records are retained for the duration of employment and comply with confidentiality and privacy laws, including the Privacy Act 1988 (Cth).
- Employees must provide updated vaccination records if they receive additional vaccines or booster doses.

6.3.6. Compliance and Monitoring

- Audit and Review: Regular audits are conducted to ensure compliance with the vaccination program. Expiry and renewal dates will be monitored, with reminders issued as required.
- Data Reporting: Immunisation data is included in infection control compliance reports provided to senior management and may be submitted to regulatory authorities if required.

6.3.7. Information, Education, and Support

- The company provides information to employees on vaccine-preventable diseases, vaccination schedules, and the importance of immunisation.
- Resources from the Australian Immunisation Handbook are made available to employees.

6.3.8. Review and Continuous Improvement

- This Workforce Immunisation Program will be reviewed annually or in response to changes in the Australian Immunisation Handbook, jurisdictional requirements, or public health advisories.
- Feedback from employees and health authorities will be incorporated to ensure continuous improvement.

6.3.9. Relevant Legislation, Standards, and Guidelines

- Australian Immunisation Handbook
- Fair Work Act 2009 (Cth)
- Work Health and Safety (WHS) laws and state-based health directives
- RACGP - Infection prevention and control guidelines

7. Staff Health, Safety and Wellbeing

7.1. Policy Statement

We are committed to creating and maintaining a safe, healthy, and supportive work environment where staff are able to perform their duties effectively while maintaining their own wellbeing.

7.2. Purpose and Scope

The purpose of this policy is to promote staff wellbeing and resilience in the workplace, establish systems for supporting physical and mental health, and ensure compliance with organisational obligations under the Work Health and Safety Act 2011 (Cth).

7.3. Procedure

- **Wellbeing Support**
  - Provide access to confidential support services (e.g., counselling or Employee Assistance Program). Encourage staff to raise concerns about workload, fatigue, or stress with managers. Promote initiatives such as health promotion activities, debriefing sessions, or wellness workshops.
- **Workforce Culture**
  - Foster a respectful, inclusive, and supportive workplace environment.
  - Zero tolerance for bullying, harassment, or discrimination.
  - Encourage teamwork, open communication, and peer support.
- **Workload and Fatigue Management**
  - Monitor staff workloads and rostering to minimise fatigue.
  - Provide reasonable opportunities for breaks and recovery time.
  - Adjust duties or offer flexible work arrangements where feasible to support work–life balance.
- **Occupational Health Support**
  - Facilitate access to health assessments or workplace adjustments if staff experience illness or injury that affects their ability to work.
  - Support safe return-to-work arrangements where needed.

- **Monitoring and Review**
  - Conduct regular staff wellbeing surveys to identify stressors and areas for improvement. Review sick leave, turnover, and exit interview data to identify workforce wellbeing trends.
  - This policy will be reviewed every three years, or earlier if workforce needs or legislative requirements change.

Section 4 Clients Access and Rights

1. Eligibility Criteria Policy and Procedure

1.1. Policy Statement

Our community nursing services may be provided to clients on a private or alternative funding basis; however, only eligible veterans can be claimed through the DVA Community Nursing Program.

1.2. Purpose and Scope

To define eligibility for DVA community nursing services.

Applies to all staff responsible for client intake, referrals, and admission.

1.3. Procedures

1.3.1. Eligibility for DVA Funding

- **Gold Card Holders**: Eligible for all clinically assessed nursing and personal care needs.

- **White Card Holders**: community nursing services can only be provided for DVA-accepted conditions or under special eligibility programs (e.g. **Non-Liability Health Care** for mental health, cancer, tuberculosis, or **Provisional Access to Medical Treatment** for certain conditions). If a client is receiving services under a provisional access program and their claim is later **declined**, DVA-funded community nursing eligibility will cease.
- **Orange Card Holders**: Not eligible for community nursing services. Orange Cards are limited to pharmaceuticals and dressings under RPBS.

1.3.2. Other Clients

- Services may be provided to clients without DVA eligibility, but costs must be covered through private funding or other programs.

1.3.3. Verification

- Staff must check the card and confirm eligibility via the DVA Provider Enquiry Line (1800 550 457).
- Eligibility must be recorded in the client record, including accepted conditions for White Card holders.

1.3.4. Clinical Need Requirement

- Services are only claimable if there is a clinical need established through assessment.
- If no ongoing need is identified, only the assessment may be claimed.

1.3.5. Documentation

- Record card type, verification details, and funding arrangements in the client file.
- Note any alternative funding arrangements for ineligible clients.

2. Referral and Admission Process

2.1. Policy Statement

All DVA community nursing services must commence following a valid referral from an authorised health professional. Admission will only occur once eligibility, referral validity, and clinical need are confirmed.

2.2. Purpose and Scope

To provide a standardised intake process that ensures only eligible and appropriately referred clients are admitted to services.

Applies to all staff managing referrals, intake, and admissions.

2.3. Procedures

2.3.1. Referrals Authorised Referral Sources

Valid written referrals may only be accepted from the following professionals:

- General Practitioners (GPs).
- Nurse Practitioners (NPs)
- Treating medical practitioners in a hospital.
- Hospital discharge planners.

2.3.2. Referral Format

- Referrals must be provided on the referral source's official letterhead or using the DVA Community Nursing referral form.
- Informal Enquiries: If a client, family member or other party informally requests community nursing (e.g. a phone enquiry without a referral), staff must advise that a written referral from an authorised referrer is required. No service can commence until an appropriate GP, hospital doctor, nurse practitioner, or discharge planner provides a valid referral.

2.3.3. Referral Content Requirements

Each referral must include sufficient clinical and client information to support admission. This includes:

- authorised referral source details, including provider number (for a referral from a discharge planner or treating medical practitioner in a hospital, the hospital's provider number must be used)
- the medical condition/s the client requires community nursing services for, and clinical details of the condition/s including recent illnesses and injuries
- if medication administration or assistance is required, a medication authority or signed current medication chart/list that includes medication information
- a measure of the person's level of independence. If the level of independence has not been included in the referral, the Registered Nurse should assess this as part of

the initial comprehensive assessment. If assistance with eating to meet a clinical need is determined, a nutritional assessment must also be conducted to determine the nutritional risk

- other health / support services the client is receiving
- whether an aged care assessment has been conducted by an Aged Care Assessment Team (ACAT) assessor, and the outcome of any assessment.

2.3.4. Referral Periods

- **GP:** Valid for **12 months**.

- **NP referrals: Valid for 6 weeks**
  - If services are required beyond 6 weeks, an updated referral from the client's GP is mandatory.
- **Hospital referrals**: Valid for **6 weeks post-discharge**.
  - If services are required beyond 6 weeks, an updated referral from the client's GP is mandatory.

- A new referral is required if:
  - The client is transferred to another provider.
  - The client is discharged and later readmitted.
  - Ongoing services extend beyond 12 months.

2.3.5. Eligibility Verification

Once a valid referral is received:

- **Confirm Veteran Card Holder Status**

  Client is eligible to receive community nursing services if they have an assessed clinical need for nursing and/or personal care at home and are a:

  - Veteran Gold Card holder; or

- Veteran White Card holder and need this service for an accepted service-related condition.

  If a client has a Veteran White Card, contact DVA to determine if the client can receive DVA funded community nursing services before providing care to the client: 1800 550 457

- **Check the Validity of the Referral**
  1. All clients need a written referral if they are either:
     - new to receiving community nursing services
     - have been out of care from a CN provider for over 28 days
     - at the end of each continuous 12 month period of care
  2. A written referral must come from an authorised referral source:
     - General Practitioner (GP)
     - Treating medical practitioner in a hospital
     - Hospital discharge planner
     - Nurse practitioner specialising in a community nursing field
  3. The referral period shall be valid:
     - Referrals from a GP are valid for 12 months.
     - Referrals from hospitals and Nurse Practitioners are valid for six weeks.
     - A new referral is required if the DVA Client has been out of care from the community nursing provider for over 28 days or wishes to change providers.
  4. The referral shall outline the necessary services required to meet the assessed nursing needs for relevant medical conditions.

2.3.6. Admission Confirmation

- **Intake Record** - Enter the referral into the organisation's intake system and open a client record.
- **Admission Confirmation** - Confirm acceptance of referral and formally admit the client.

- **Handover to Clinical Team** - Forward referral and client details to the nursing team for comprehensive assessment (refer to Assessment Policy).

2.3.7. Referral Conduct

- We will never offer payments, gifts, or other inducements to any referrer (GP, hospital, etc.) to generate referrals, nor represent itself as a 'DVA-preferred provider'. Such practices are expressly forbidden by DVA and violation may result in termination of our DVA agreement.

2.3.8. Non-Acceptance of Referrals

- If we are unable to accept a referral (e.g. due to capacity or scope limitations), we will immediately inform the referrer by phone and in writing, stating the reasons the referral cannot be accepted. This prompt notification allows the referrer to make alternative arrangements for the veteran's care.

Note: A DVA Veterans' Home Care (VHC) Assessment Agency may identify a veteran's need for community nursing and refer the client to their GP to arrange a DVA community nursing referral. Staff should be aware of this pathway and be prepared to liaise with the GP if a VHC assessor has recommended community nursing services.

3. Informed Consent Procedures

3.1. Policy Statement

We respect client autonomy and will obtain informed consent before delivering any services.

3.2. Purpose and Scope

To ensure that clients (or their representatives) understand and agree to services before care commences.

Applies to all staff involved in care planning and service delivery.

3.3. Procedures

Before commencing our community nursing services, written informed consent must be obtained from the client. If the client is unable to provide consent, a designated representative (such as a guardian, Power of Attorney, legal representative, or person with a guardianship or administration order) may give consent on their behalf. Clients must be informed that DVA has the right to access their clinical records without requiring the client's consent for audits and investigations.

- **Consent Requirements**
  - Consent must be informed, voluntary, and specific.
  - Clients must receive information in a form they understand (verbal and/or written).

- **Information to Provide**
  - Explanation of proposed services.
  - Client rights and responsibilities.
  - Role of the community nursing personnel and an explanation that different staff (RNs, ENs, or PCWs) may provide services over time based on clinical requirements and staff availability.
  - How the client's personal information may be shared with other health providers as needed for their care – and that in some instances, information might be shared without obtaining additional consent at the time if it is clinically necessary.
  - How to provide feedback or complaints.
  - DVA (or its authorised representatives) has the right to access all records held about the client's care, for monitoring and audit purposes.

- **Who May Give Consent**
  - The client.
  - A nominated representative (i.e. person authorised to represent the client including a guardianship or administrative order, Power of Attorney, legal representative etc.) if the client cannot consent.

- **Documentation**

- Consent form signed and filed in client record.
- Any withdrawal or change in consent is documented immediately.

This process ensures that clients or their representatives have all necessary information to make informed choices about their care and understand their rights, responsibilities, and avenues for support.

4. Client Rights and Responsibilities

4.1. Policy Statement

We uphold the rights of all clients to safe, respectful, and person-centred care, while expecting clients to also respect staff and the care process.

4.2. Purpose and Scope

To define the rights and responsibilities of clients and staff in community nursing services.

4.3. Procedures

4.3.1. Client Rights

- Be treated with dignity, respect, and cultural sensitivity.
- Participate in decisions about their care.
- Receive safe, evidence-based, person-centred care.
- Privacy and confidentiality of personal information.
- Access to feedback and complaints processes.

4.3.2. Client Responsibilities

Clients are expected to uphold the following responsibilities. Staff should familiarise themselves with these guidelines to help communicate them clearly and professionally to clients when needed:

- **Maintain a Safe Environment for Nursing Staff**
  - Clients should ensure their home environment is safe and free from hazards that may impact the nursing staff's ability to provide care effectively.
- **Treat Nursing Staff with Respect**

- Clients are expected to treat all nursing staff with courtesy and respect, fostering a positive and professional care environment.

- **Inform Nursing Staff of Any Changes in Health**
  - Clients should communicate any changes in their health to the nursing team promptly, allowing staff to adjust care plans as necessary to meet evolving needs.

- **Take Responsibility for Actions and Choices**
  - Clients are encouraged to be mindful of how their actions and choices affect their health and to actively participate in decisions related to their care.

- **Provide Accurate and Complete Information**
  - Clients are responsible for providing relevant health and personal information to ensure nursing staff can deliver appropriate and personalised care.

- **Notify Staff in Advance of Visit Cancellations**
  - Clients should give ample notice if they need to cancel a scheduled visit. This allows the team to reallocate resources effectively and maintain efficient scheduling.

- **Report Any Concerns Promptly**
  - Clients should be encouraged to voice any concerns or issues with their care as soon as possible so the provider can address these promptly and improve their care experience.

- **Inform the Provider of Changes in Service Needs**
  - If a client plans to change providers, they are responsible for informing the current provider in advance and specifying the date when services will no longer be required.

Staff should review these responsibilities with clients at the beginning of service and as needed throughout the care relationship. Reinforcing these expectations helps establish a mutual understanding, contributing to a positive and safe care experience for both clients and nursing staff.

4.3.3. **Carer Involvement and Rights** – *We* acknowledge and supports the rights of carers as partners in veteran care, in line with the **Carer Recognition Act 2010** We commit to:

- Recognising Carers as Partners: With the client's consent, carers (family or other primary support persons) will be treated as partners in the client's care and involved in care planning and service coordination as appropriate. This means we value carers' knowledge of the client and will include them in discussions about care goals and routines (as long as the client agrees).

- Respect and Communication: Carers will be treated with respect and kept informed about the client's care (within privacy consent bounds). We will provide information, training, or instruction to carers so they can support the client's care plan at home, and we will listen to carer inputs or concerns.

- Support for Carers: We recognise that caring for veterans can be challenging. We will, where possible, provide information on support services for carers, encourage carers to give feedback or make complaints if needed, and work collaboratively to ensure the wellbeing of both the client and their carer.

- Carer Recognition Act Compliance: We uphold the principles of the Statement for Australia's Carers as outlined in the Carer Recognition Act 2010. All staff are made aware of these principles, which include acknowledging the invaluable contribution of carers and respecting their needs and views.

4.3.4. **Staff Responsibilities**

- Communicate clearly and respectfully.
- Document client rights and responsibilities at admission.
- Review rights and responsibilities with clients regularly.

- Treat clients with dignity and respect: Show respect for each client's rights, preferences, and individuality. Avoid any behaviour or language that could be perceived as dismissive or disrespectful.
- Prioritise client choice and autonomy: Actively involve clients in decision-making regarding their care. Encourage them to express their preferences and ensure they feel their input is valued.
- Ensure care is safe, appropriate, and tailored to client needs: Deliver services that are clinically safe and personalised to each client’s unique health requirements and circumstances. Assess and adjust care as needed to meet these individual needs effectively.
- Promote a safe and comfortable environment during visits: Ensure clients feel secure and at ease when you visit. Establish a warm, professional atmosphere and be mindful of their comfort and privacy.
- Listen to client concerns and support feedback or complaints: Pay close attention to any concerns clients may raise about their care. If they express dissatisfaction, guide them through the feedback or complaint process in a supportive and professional manner.
- Demonstrate competence and compassion in all interactions: Exhibit both technical skills and empathy when providing care. Show clients that they are in capable, caring hands by consistently performing your duties to a high standard.
- Instil confidence through professionalism and expertise: Build trust by being reliable, knowledgeable, and by following best practices. Demonstrate your commitment to high-quality care in every interaction, ensuring clients feel confident in our services.

5. Refusal of Services

5.1. Policy Statement

We respect the rights of clients to refuse community nursing services at any time, in full or in part. Our responsibility is to ensure that clients (or their representatives) are fully informed of the implications of refusal and that their decision is clearly documented and communicated to all relevant parties.

Refusal of services will never affect a client's eligibility to access DVA community nursing services in the future. Our approach is guided by the principles of respect for client autonomy, informed choice, and duty of care.

5.2. Purpose and Scope

This policy provides clear guidance on how to respond when a client or their authorised representative refuses community nursing services.

5.3. Procedures

5.3.1. Identify and Confirm Refusal

If a client or their nominated representative (such as an authorised guardian, Power of Attorney, or legal representative) indicates a refusal of community nursing services, clarify the scope of the refusal (whether it pertains to some or all services) to ensure accurate understanding and documentation.

5.3.2. Inform the Client of Consequences

- Clearly and respectfully inform the client (and/or their representative) of the potential consequences of refusing the proposed community nursing services. Explain how this decision may impact their health and any risks associated with their refusal.
- Offer alternative support options if appropriate, and address any concerns or misunderstandings the client or their representative may have regarding the services.

5.3.3. Notify Relevant Parties

- General Practitioner (GP): Notify the client's GP in writing of the refusal, including details of the refused services and any expected impact on the client's health and well-being.

- Nominated Representative: If a representative is involved, they should also receive written communication regarding the refusal and its potential consequences.

5.3.4. Document the Refusal and Actions Taken

- Record the refusal and all subsequent actions taken in the client's care documentation. This should include:
    - Date and time of refusal
    - Details of services refused
    - Summary of the discussion with the client or representative about the expected consequences
    - Notification details sent to the GP and representative
- Ensure this documentation is thorough and factual, preserving all relevant information for future reference.

5.3.5. Re-engagement and Future Services

- Refusal of services does not remove future eligibility.
- Staff must inform the client (and representative, if applicable) that they may request services again at any time by contacting the provider or their GP.
- The refusal must not negatively affect future service access or client relationships.

5.3.6. Monitoring and Review

- Patterns of repeated refusal must be reviewed by the Care Coordinator to identify if additional client education, alternative approaches, or reassessment is required.
- This policy will be reviewed every three years, or earlier if DVA program requirements change.

6. Cultural Safety and Diversity

6.1. Policy Statement

We are committed to delivering community nursing services in a manner that is culturally safe, inclusive, and responsive to the diverse backgrounds of the clients we serve. We acknowledge the unique rights, histories, and needs of Aboriginal and Torres Strait Islander peoples and recognise the importance of culturally respectful practice to support health and Principles of Cultural Safety wellbeing.

All clients will be treated with dignity, respect, and fairness, regardless of culture, language, ethnicity, religion, age, gender identity, sexual orientation, disability, or socio-economic background. Cultural safety will be embedded into care planning, service delivery, and organisational practices.

6.2. Purpose and Scope

This policy establishes the organisation's framework for ensuring culturally safe, inclusive, and responsive care. It ensures compliance with the DVA Notes for Community Nursing Providers, NSQHS Standards, and other relevant Australian legislation and codes.

This policy applies to all employees, contractors, and subcontractors involved in delivering community nursing services.

6.3. Procedures

6.3.1. Principles of Cultural Safety

- Respect the cultural identity, values, beliefs, and preferences of every client.
- Recognise the impact of culture on health, illness, communication, and care expectations.
- Avoid assumptions, stereotypes, or discriminatory behaviour.
- Promote environments where clients feel safe to express cultural needs without fear of judgement.
- Provide information in formats and languages that are understandable and accessible to the client.

6.3.2. Diversity and Inclusion in Care Delivery

- Provide equitable access to services regardless of cultural, linguistic, religious, or social background.
- Recognise and respect clients from culturally and linguistically diverse (CALD) backgrounds, adapting communication and care approaches to meet their needs.
- Offer interpreter services when language barriers exist.
- Incorporate cultural dietary needs, religious observances, and family structures into care planning when relevant.
- Recognise the intersection of culture with other diversity factors such as age, gender identity, disability, and sexuality, ensuring inclusive service delivery.

6.3.3. Staff Training and Competency

All staff will complete mandatory cultural safety and diversity training as part of induction.

Training will include:

- Principles of cultural safety in healthcare.
- Understanding unconscious bias and its impact on care.
- Aboriginal and Torres Strait Islander health perspectives.
- Working with interpreters and CALD communities.

Annual refresher training and ongoing professional development will be provided to strengthen staff knowledge and practice.

6.3.4. Communication and Engagement

- Ensure communication is respectful, clear, and adapted to client needs (e.g., plain language, translated materials, or visual resources).
- Encourage clients and families to participate in decision-making about their care.
- Provide culturally appropriate options for feedback and complaints (including through representatives or community elders if requested).

6.3.5. Monitoring and Review

Cultural safety practices will be reviewed through:

- Care plan audits.
- Feedback and complaints from clients and families.
- Staff training completion records.

This policy will be reviewed every three years, or sooner if required by changes to DVA program requirements or national standards.

7. Complaint Handling and Feedback

7.1. Policy Statement

The company values and encourages feedback, both positive and negative, as it is essential for improving the quality of care and service delivery. All complaints will be handled respectfully, fairly, and confidentially, with a focus on resolving issues effectively and implementing improvements to enhance client satisfaction.

7.2. Purpose and Scope

The purpose of this policy and procedure is to establish a clear, accessible, and professional approach to managing feedback and complaints related to the delivery of nursing care to Veteran Card Holders.

This policy applies to all staff involved in providing or supporting nursing care services, including administrative staff, nursing staff, and management. It is designed to address feedback and complaints from clients, their families, carers, and other stakeholders.

7.3. Definitions

- **Feedback**: Any comment, suggestion, or compliment provided by a client or stakeholder that is not a complaint but provides insights into service delivery.
- **Complaint**: Any expression of dissatisfaction by a client or stakeholder about the quality of care or services provided, or any other aspect of the company's operations.
- **Complainant**: The individual or representative providing the complaint.
- **Resolution**: The process of addressing a complaint to the satisfaction of the complainant and the company.

7.4. Procedures

7.4.1. Feedback Collection and Documentation

7.4.1.1. Receiving Feedback

- Encourage clients, families, and carers to provide feedback through multiple channels, such as verbally during visits, via email, or through feedback forms provided in client welcome packs or on the company website.

- Accept feedback graciously and thank the individual for their input.

7.4.1.2. Documenting Feedback

- All feedback, including compliments, suggestions, and observations, must be documented in the client's file and the feedback log by the receiving staff member.
- The feedback log should be reviewed periodically to identify potential service improvements.

7.4.2. Complaints Management Process

7.4.2.1. Receiving a Complaint

- Listen to the complaint respectfully, acknowledging the client or representative's concerns.
- Record the details of the complaint, including:
    - Complainant's name, relationship to the client, and contact details.
    - Date and time the complaint was received.
    - Description of the issue or concern.
    - Desired resolution, if stated by the complainant.

7.4.2.2. Complaint Acknowledgment

- Acknowledge the complaint in writing within 48 hours, expressing appreciation for bringing the concern to our attention and providing information on the next steps in the resolution process.
- Provide contact information for further communication and the expected timeframe for resolution.

7.4.2.3. Assessment and Investigation

- The designated staff member will assess the complaint to determine its nature and urgency.
- Investigate the issue by:
    - Reviewing relevant documentation, including the client's care records.
    - Interviewing any involved staff members.
    - Collecting any additional information needed for a thorough understanding of the issue.

7.4.2.4. Resolution and Response

- Based on the investigation, determine an appropriate course of action to resolve the complaint.
- Communicate the resolution to the complainant within 14 days of receiving the complaint. If additional time is needed, inform the complainant of the expected resolution date.
- Resolution may include actions such as:
    - An apology or acknowledgment of error.
    - Corrective actions (e.g., adjustments to care plans or staff reassignment).
    - Process improvements to prevent recurrence of the issue.
- Document the resolution in the complaints log, noting the resolution date and outcome.

7.4.3. Escalation and External Review

7.4.3.1. Internal Escalation

- If the complainant is not satisfied with the initial response, offer to escalate the complaint to a senior manager.
- The senior manager will review the complaint and provide a final decision on the matter.

7.4.3.2. External Review Options

- If the complainant remains dissatisfied, inform them of their right to escalate the complaint externally, such as to the DVA or an appropriate ombudsman.
- Provide contact details and guidance on accessing these resources.

7.4.4. Documentation and Record-Keeping

7.4.4.1. Complaints Log

- Maintain a secure, centralised complaints log documenting:
    - Date and time the complaint was received
    - Complainant's details and relationship to the client
    - Description of the complaint
    - Actions taken and resolution details
    - Date the complaint was resolved
- Review the complaints log periodically to identify patterns or recurring issues and implement service improvements as needed.

7.4.4.2. Client Record Documentation

Ensure that all complaints and feedback related to a client's care are recorded in their file and referenced in care reviews if applicable.

7.4.5. Continuous Improvement

- Management will review feedback and complaints data regularly to identify trends, areas for improvement, and opportunities for staff training.
- Summarise trends in periodic reports to inform staff about service improvements and encourage ongoing quality enhancement.

7.4.6. Staff Training and Compliance

- All staff must receive training on this Feedback and Complaints Management Policy and Procedure during onboarding and through annual refresher training.
- Training will include skills in handling complaints, respecting client perspectives, and following the documentation and resolution process.

Section 5 Service Delivery

1. Scope of Services

1.1. Policy Statement

We are committed to providing safe, high quality, person-centred community nursing services that support the health, independence, and wellbeing of veterans and their eligible dependants.

Our scope of services is defined to ensure that:

- All care is clinically necessary, evidence-based, and aligned with the client's assessed needs.
- Services comply with the Department of Veterans' Affairs (DVA) Community Nursing Program, the National Safety and Quality Health Service (NSQHS) Standards, and relevant Australian healthcare legislation.
- Clear boundaries are maintained between what is provided under community nursing and what falls outside of scope, ensuring appropriate referral pathways are used where required.
- Provide nursing services approved under the DVA Community Program (CNS16 contract)

1.2. Purpose and Scope

The purpose of this policy is to:

- Define the range of services that may be provided under community nursing.
- Clarify exclusions to avoid inappropriate use of the program.
- Support staff in understanding the limits of practice and guiding clients on available services.

1.3. Procedures

1.3.1. Services Included in Scope

We provide a primary care service that aims to support the general health of a DVA Client with low risk, simple clinical interventions. We will ensure our services do not overlap with other programs the client receives (e.g. CVC or Veterans' Home Care). If a client is in the CVC Program with a GP practice nurse as care coordinator, we will not duplicate clinical support. Our services will complement, not replace, other providers

Community nursing services may include:

- **Clinical nursing interventions** such as:
    - Wound assessment, treatment, and management.
    - Medication administration, monitoring, and assistance with self-administration.
    - Monitoring of health status, including vital signs, skin integrity, and symptom management.
    - Support during recovery following hospital discharge or surgery.
    - Palliative and end-of-life care.
    - Chronic disease support
    - Mental Health Monitoring
- **Personal care interventions** where these are linked to an assessed clinical need, such as:
    - Assistance with showering, toileting, and continence care.
    - Support with mobility and transfers.
    - Assistance with nutrition and eating where there is a clinical requirement.
- **Education and support** for clients and carers in managing health conditions and treatments.
- **Coordination of care**, including communication with GPs and other healthcare professionals.

1.3.2. Services Out of Scope

Within the scope of our community nursing services for veteran card holders, we do not deliver advanced or acute nursing interventions typically requiring specialised clinical equipment, hospital-level care, or constant monitoring. This includes interventions that exceed the capabilities of a home-based environment or fall outside the scope defined in the DVA Community Nursing Schedule of Fees

We do not deliver community nursing services to a client in any of the following locations:

- an acute care facility (including hospital in the home programs)
- a residential aged care facility
- a multi-purpose centre
- a community centre
- a clinic in any location

Under our community nursing services, we do not provide in-home respite care or supervision, or provide services to meet needs associated with Instrumental Activities of Daily Living (IADLs), including:

- companionship and emotional support, transportation, meal preparation, shopping, communicating with others, managing finances, cleaning/dishwashing, routine laundry
- childcare in some short-term and crisis care circumstances
- lawn mowing, gardening, cleaning gutters
- arranging for medications and filling prescriptions

2. Comprehensive Assessment and Reassessment

2.1. Policy Statement

All clients will undergo a comprehensive, Registered Nurse (RN)-led assessment at admission and regular reassessments. Assessments are holistic, evidence-based, and documented, ensuring services reflect current needs.

2.2. Purpose and Scope

To ensure safe and individualised care by identifying health, functional, social, and environmental needs. Applies to all RNs conducting assessments.

2.3. Procedures

An assessment by a Registered Nurse is essential to determine a client's nursing care needs accurately and ensure services align with their current health status and personal care requirements. This comprehensive assessment ensures that care is appropriate, evidence-based, and responsive to each client's unique situation.

Initial comprehensive RN assessment must occur **within 5 days** of referral receipt, as per DVA guidelines.

Assessment Process

1. **Face-to-Face Comprehensive Assessment**

An RN must conduct a face-to-face assessment in the client's home to accurately gauge nursing care needs and ensure comfort in the home environment. Assessments are required:

- Conduct a holistic initial assessment within 5 days of referral, including physical, psychological, cultural and social needs
- **Upon receiving a referral** from an authorised source, confirming the need for community nursing services.
- **Following a transfer from another Community Nursing (CN) provider**, to ensure continuity and appropriate transition of care.
- **Annually**, on the 12-month anniversary from the start of care, if there have been 13 consecutive 28-day claim periods, indicating a continuous need for service.

2. Environmental Risk Assessment

As part of the initial comprehensive assessment conducted at the client's first face-to-face visit, the RN must perform an environmental risk assessment of the client's home or place of residence.

The purpose of this assessment is to identify any risks to the safety of both the client and staff delivering services.

Procedure:

- The RN must inspect the client's environment to identify hazards such as:
    - Poor lighting or visibility
    - Clutter or trip hazards
    - Unsafe flooring or steps
    - Pets that may pose risks
    - Access and egress challenges for staff or emergency services
    - Any other factors that may affect the safe delivery of care
- Discuss any identified risks with the client and/or their carer, seeking their input on mitigation strategies.
- Document identified risks and agreed mitigation measures in the client's care plan and records.
- Where risks cannot be adequately mitigated, escalate the matter to the Care Coordinator or Manager for further review and planning.

- Review environmental risks regularly (e.g. during scheduled reviews or if circumstances change) and update documentation accordingly.

This environmental risk assessment ensures that the services are delivered in a safe, effective, and responsive manner, in line with best practice and DVA requirements.

3. **Use of Validated Assessment Tools**

   The RN must employ validated assessment tools that align with current community nursing industry best practices to ensure accuracy and consistency. These tools should cover all aspects of health, including physical, mental, and functional capacity.

4. **Independence and Functional Assessment**

   Where a client's level of independence is not documented in the referral, the RN should conduct an initial assessment of Activities of Daily Living (ADL) using an industry-recognised measure. This assessment identifies areas where the client requires support to maintain independence safely.

5. **Clinical Need Verification**

   For community nursing services to be provided, the client must demonstrate an assessed clinical need. If the assessment concludes that there is no ongoing need for nursing services, only the initial assessment is claimable (using the item code NA99), and no ongoing services should be billed.

6. **Coordination of Allied Health Services**

   The RN should identify any additional support services that may benefit the client, such as occupational therapy, delivered meals, or other community services. Where appropriate, the RN should request the GP to arrange these referrals.

7. **Assessment of Personal Care Needs**

   If a client is assessed as requiring low-level personal care services without a clinical need for additional community nursing services, they should be referred to the Veterans' Home Care (VHC) Program.

   The client shall be referred to a VHC Assessment Agency on 1300 550 450.

If a client is assessed as requiring above 1.5 hours of personal care services per week this may not be considered low level personal care, and services may need to be provided through the community nursing program.

When a client is assessed as requiring personal care services as well as having a clinical need for community nursing services, all of the personal care services required should be provided through the community nursing program.

Reporting and Communication of Assessment Outcomes

- **Documentation**. The RN should document all findings in the client record
- **Reporting to GP**: The RN must report the outcomes of the comprehensive assessment to the client's GP. If the original referral did not come from the GP but ongoing services are needed, an updated referral from the GP must be obtained.
- **Communication with Client and Carer**: The RN must clearly communicate assessment outcomes to the client, and if applicable, their carer. This ensures they understand the care plan, expected services, and any additional support available.

3. Nursing Care Plan Development

A nursing care plan must be developed, completed, and signed by an RN following the comprehensive assessment. The nursing care plan serves as a comprehensive guide for delivering personalised, consistent, and safe care to the client. Developed collaboratively with the client, and when appropriate, the carer and family, the care plan ensures that all care needs are documented and regularly updated to reflect the client's evolving condition and preferences. The care plan must be developed in alignment with industry-recognised, evidence-based best practices within the community nursing industry and should be developed within 7 business days of initial assessment. Care plans must be signed by the RN and client (or representative), and reviewed/updated at least every 3 months**.** All services must be delivered in accordance with the nursing care plan.

Development and Documentation:

1. **Collaborative Development**
    - The RN must involve the client in developing their care plan to ensure it aligns with their needs, preferences, and goals. If applicable, the client's carer and family should also participate in this process to support a holistic approach.
    - The client, and if applicable the carer / family, must sign the nursing care plan.

2. **Timely Access to Care Documentation**
    - The client must be provided with, or be able to access in a timely manner, an up-to-date copy of their care plan. This ensures they are informed and empowered regarding their own care.

3. **Regular Updates and Revisions**

    The care plan must be updated consistently:
    - At each assessment and review: Following comprehensive reassessments, the care plan should reflect any new findings.
    - As changes occur: Revisions should be made when the client's needs, goals, or preferences evolve, when there is a shift in their physical or mental health, or when any new risks are identified.
    - When additional information becomes available: If any new factors that could impact the client's care arise, these should be integrated promptly into the care plan.
    - At a minimum, the nursing care plan will be formally reviewed and updated by an RN at least every 3 months, in line with DVA requirements. After each review, any changes to the care plan will be documented, and the reviewing RN will sign and date the care plan to confirm it reflects the current assessed needs.

4. **Ongoing Accessibility and Reference**

    The care plan must be accessible to the client and relevant staff. Personnel are required to reference the most current care plan during each service visit to ensure all care aligns with the documented plan.

Components of the Nursing Care Plan:

A nursing care plan must include the following essential elements:

1. **Clinical and Personal Care Needs**
    - Document all clinical and personal care needs identified from the comprehensive assessment, specifying activities required to meet these needs.
2. **Level of Independence**
    - Assess and record the client's level of and capacity for independence, noting any support needed for Activities of Daily Living (ADLs).
3. **Client Goals and Agreed Actions**
    - Establish the client's short- and long-term care goals, incorporating their personal values, preferences, and cultural needs, with clear actions to achieve these goals.
4. **Clinical Interventions**
    - Include specific clinical and nursing interventions aligned with best practice standards to ensure safe and effective care.
    - Any aids, appliances, or nursing equipment required to successfully complete interventions.
    - A summary of other health services and/or supports the client is receiving that support their health and wellbeing, to provide a holistic overview of the client's care needs.
    - All medication interventions including if medication is being administered by an RN/EN or assisted by a PCW.
5. **Desired Outcomes**
    - Define outcomes for each care goal to assess care effectiveness.
6. **Delegation of Care**
    - Delegate care activities appropriately within the RN's Scope of Practice.
7. **Review Dates and Schedule of Services**
    - Specify scheduled review dates and the agreed days and approximate timeframes for service delivery.
8. **Wellbeing and Quality of Life Supports**
    - Identify supports to promote the client's wellbeing, independence, and quality of life, with a focus on reablement strategies.
9. **Risk Management**
    - Identify care risks and outline mitigation strategies
10. **Emergency Contacts:**

- Include up-to-date contact details for the client's GP and next of kin/emergency contact in the care plan, to be used if urgent issues arise.

Aged Care Assessment Team (ACAT) Assessment

Where an ACAT assessment has not been conducted, the RN should facilitate one within the first 28-day claim period for eligible clients.

4. Clinical Progress Notes

Purpose and Scope

This policy outlines requirements for maintaining clinical progress notes as part of client care documentation. This ensures safe, high-quality, and consistent care, and supports team communication.

This policy applies to all staff providing clinical and personal care services to clients.

Policy Statement

All visits and contacts where care is delivered must be documented through detailed clinical progress notes. Notes must be objective, factual, and completed in a timely manner to ensure they reflect the care provided and support continuity of services.

Requirements

- Clinical progress notes must be written for every visit or contact where care is delivered.
- Notes must be contemporaneous- that is, completed as soon as practicable after the visit or contact.
- All entries must be objective, factual, clear and legible.
- Abbreviations should be standardised and approved within the company.
- Corrections must maintain the integrity of the original record (no erasing or deleting).
- Clinical progress notes must be securely stored in the client's record in accordance with privacy, confidentiality, and information management requirements.

- Document each visit including assessment findings, interventions, outcomes, client consent, and any incidents
- Store all records securely in compliance with Privacy Act 1988 (Cth) and state health record laws.
- Notes must include:
    - Date and time of the visit or contact
    - Name and role of the staff member providing care
    - Services or interventions provided (including clinical and personal care)
    - Client's response to care or interventions
    - Any changes in the client's condition or circumstances
    - Communication with the client, carers, family members or other health professionals, as relevant
    - Any issues identified and actions taken (including referrals or escalation)

Review and Use

- Clinical progress notes must be regularly reviewed by the care team to inform ongoing assessment, care planning, and review processes.
- Accurate and complete clinical progress notes help deliver safe, high-quality, and person-centred care. Staff are encouraged to seek clarification or support if unsure about documentation requirements.
- Records must be readily accessible to authorised personnel involved in the client's care.

5. Review of Care

Purpose and Scope

This policy establishes mandatory processes for reviewing client care at structured intervals, ensuring services remain safe, effective, appropriate, and responsive to changing needs.

This policy applies to all personnel involved in the assessment, planning, delivery, and coordination of community nursing services.

Policy Statement

Clients receiving community nursing services must have their care needs reviewed at the following minimum intervals:

- **Seven (7) days** after admission

- **Every twenty-eight (28) days** during ongoing care
- **Every three (3) months** for clients with continuing services

Procedure

1. **Seven-Day Review**
    - Conducted by a Registered Nurse (RN).
    - A client classified under the Personal Care schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid must be reviewed every seven days.
    - All clients with Exceptional Case status must be reviewed at least once per week.

    Includes review of:
    - Initial assessment findings.
    - Current nursing care plan.
    - Client's early response to care.
    - Must be documented in the client's care record.

2. **Twenty-Eight-Day Review**
    - Conducted at the end of each 28-day claim period.
    - Required for all clients receiving ongoing care.
    - Conducted by a RN for Clinical Care, or by an EN when only Personal Care is provided without any clinical add-ons.

    Includes review of the nursing care plan and clinical documentation to verify that the classifications and care delivered reflect the item number/s claimed, including the:
    - core schedule visit type classification
    - opposing schedule visit type add-on (if required)
    - other care and service/s provided from the schedule (if required)
    - changes in the client's health status and care needs
    - must be documented in the client's care record

3. **Three-Monthly Review**
    - The three-monthly reviews must be conducted prior to the end of every third 28 day claim period regardless of the type of community nursing services being delivered.
    - Conducted by an RN.

- Includes comprehensive reassessment of:
    - Client's clinical condition.
    - Functional status and independence.
    - Medication management needs.
    - Environmental risks.
    - Goals of care and service appropriateness.
- All delegated care details must be appropriately documented in clinical records and kept in the client's file.
- Must result in an updated nursing care plan reflecting any required changes.
- The changes must be implemented in consultation with the client or their nominated representative.

If the review identifies a change to services is required, the RN must:

- Notify the client's GP as relevant.
- Reclassify the client within the Schedule of Fees if there is a change to the majority of care (e.g. from clinical to personal care).

- Identify if the client may require assessment through the Exceptional Case process.
- If a client's needs significantly exceed the standard Schedule of Fees (e.g., high-frequency or 24-hour care), the RN must initiate an Exceptional Case application.

- We will submit the DVA Exceptional Case form and obtain DVA's written approval before providing any care beyond normal schedule limits.

- Each EC application must include comprehensive assessment findings and be signed by the assessing RN.

- Consider discharging the client from community nursing services if there is no ongoing clinical need.

- For clients classified as Palliative Stable in the community, determine whether claiming this item continues to be appropriate.

- Where there is no clinical need for community nursing services and only non-clinically necessary personal care is required, discharge the client and refer them to Veterans' Home Care (VHC) for an assessment for personal care services.

4. **Ad-Hoc Reviews**
    - Conducted whenever there is a change in the client's assessed care needs.
    - Includes review and update of assessment documentation and the nursing care plan.
    - Conducted by an RN.
    - Must be documented in the client's care record.

6. Medication Management

Governance and Legislative Framework

Medication management practices are implemented in accordance with the DVA Notes for Community Nursing Providers (effective November 2025) and applicable State or Territory medicines and poisons legislation, supported by organisational clinical governance arrangements.

Medication Management – Nurse-Initiated Medicines and Prescribing Authority

In accordance with Australian State and Territory legislation, relevant clinical guidelines, and this organisation's Medication Management Policy, certain medicines are defined as **potential nurse-initiated medicines**.

Nurse-Initiated Medicines (Schedule 2 and Schedule 3)

Some unscheduled medicines and Schedule 2 (Pharmacy Medicines) and Schedule 3 (Pharmacist Only Medicines) may be administered by a **Registered Nurse (RN)** without authorisation by an authorised prescriber, where:

- the RN is suitably trained and competent;
- administration is within the RN's scope of practice;
- administration complies with applicable State or Territory medicines and poisons legislation; and

- the decision and administration are documented in the client's clinical record.

Nurse-initiated medicines are limited to low-risk medicines approved under organisational policy and do **not** include Schedule 4 or Schedule 8 medicines.

Endorsement for Scheduled Medicines – Registered Nurse Prescribers

Under the Registration standard: *Endorsement for scheduled medicines*, a **designated Registered Nurse Prescriber**, who is suitably educated, qualified, and holds the appropriate NMBA endorsement, may prescribe **Schedule 2, 3, 4 and 8 medicines** in partnership with an authorised health practitioner. Prescribing must occur:

- under a documented clinical governance framework; and
- with an active prescribing agreement.

The designated Registered Nurse Prescriber is **personally responsible and accountable** for prescribing within their authorised scope of practice and endorsement.

Personal Care Workers and Medication Decisions

Personal Care Workers (PCWs) are **not authorised** to make any decisions about whether a medicine should be administered. If a PCW has any concern regarding a client's medication management, they must immediately seek assistance and direction from a Registered Nurse.

Alignment with national guiding principles

Our organisation recognises the Department of Health and Aged Care's *Medication Management in the Community – Guiding Principles* and commits to implementing these principles throughout our medication-management practices. This includes a person-centred approach to medicines care, promoting shared decision-making, and ensuring safe, effective and quality use of medicines. We will reference the latest edition of the Guiding Principles (and any successor documents) in staff training and policy reviews.

Key elements from the Guiding Principles incorporated into our procedures include:

- **Safe prescribing and dispensing:** ensuring medicines are prescribed and supplied according to current clinical guidelines, with clear documentation of purpose, dose, route and timing.
- **Medication reconciliation and review:** obtaining and validating a complete list of all medicines (including over-the-counter, complementary and herbal products) at admission and regularly thereafter to minimise risk of omissions, duplications or interactions.
- **Client engagement and education:** involving clients (and carers) in decisions about their medicines, explaining the purpose and potential side effects and encouraging them to report concerns or adverse effects.
- **Clear roles and responsibilities:** Registered Nurses (RNs) are accountable for medication management decisions, Enrolled Nurses (ENs) and Personal Care Workers (PCWs) may assist only within their scope and under RN supervision, and PCWs must never make decisions to administer, alter, withhold or substitute medicines.

- **Risk management:** identifying and documenting potential medication-related risks, implementing strategies to prevent medication errors, and ensuring proper storage, handling and disposal of medicines.

Medication management is a critical aspect of providing safe and quality care to clients.

The following are some of the key requirements and procedures involved:

1. Medication Assessment

Upon admission or receipt of a referral, an RN must conduct a comprehensive medication assessment. The assessment must include:

- Review of the Client's Medication Regimen: Obtain and review a complete list of the client's current medications, including prescription, over-the-counter (OTC) medications, complementary medicines, and supplements. Verify the accuracy of the medication list against available medical records, referral documents, or medication charts.
- Verification of each medication's purpose, dosage, frequency, route, and timing.
- Identification of allergies, contraindications, or drug interactions.
- Discussion with the client (and carer if applicable) to confirm understanding of each medication's purpose and potential side effects.

2. Documentation

- Document all medications in the client's care plan in the medication management section, including details from the initial assessment and any updates.
- A medication authority or signed medication chart must be provided by the prescribing/referring medical practitioner. All prescribed medications must be documented on a medication chart approved and signed by the client's GP. Any changes to medication orders must also be confirmed in writing and signed by the GP.
- Maintain accurate and up-to-date records of all medication administration events, including time, dosage, route, and any observations or adverse reactions.
- Each medication administration record must clearly identify the worker who administered or assisted with the medication, including the worker's full name, role designation (RN, EN or PCW), and initials or signature. All medication documentation must be legible.

3. Medication Administration

3.1. The client must be classified under the Clinical Care Schedule.

3.2. Medications should be administered by trained and authorised staff according to the prescriber's instructions. The care must be provided by an RN or EN with an approved qualification in administration of medications if the client requires the administration of:

- prescribed medications (Schedule 4 and above)
- Schedule 8 drugs if dispensed from a bottle/packet, including Schedule 8 transdermal patches
- prescribed medicated eye drops (Schedule 4 and above)
- prescribed creams
- Schedule 4 and Schedule 8 medications may only be administered under the authority of a current, signed medication order from an authorised prescriber. Under no circumstances may RNs, ENs, or PCWs initiate or alter these medications without written prescriber authorisation

Nurse-Initiated Medications (Schedule 2 & 3):

Only suitably trained Registered Nurses (RNs) may initiate and administer certain non-prescription medications – specifically unscheduled medicines, Schedule 2 “Pharmacy Medicines” and Schedule 3 “Pharmacist Only Medicines” – without a direct prescriber order. This practice is allowed only in accordance with state/territory law and organisational policy. (Each Australian state and territory has its own drugs and poisons legislation; this policy sets a minimum standard nationally, and RNs must always comply with any stricter local requirements.)

Scope & Approved List: Nurse-initiated medicines are limited to a small, approved list of low-risk over-the-counter items that the organisation has authorised for RN initiation. Examples may include simple analgesics (e.g. oral paracetamol for mild pain), basic antacids for indigestion, mild laxatives, or other safe OTC remedies

- The approved list is defined by our clinical governance team (e.g. Medication Advisory Committee) and aligns with best practice. RNs must be familiar with

this list and must not initiate any medication that is not on the approved list or that is prohibited by local law.

Conditions of Use: Nurse-initiated medicines are intended for one-off or occasional use to promptly manage minor symptoms

- The RN must use clinical judgment to assess the client's need, considering the client's current medications, allergies, and medical history. If a nurse-initiated medicine needs to be given more than once or becomes a regular need, the RN must contact the client's GP or treating prescriber as soon as possible to obtain a formal order or include it on the medication chart
- Nurse-initiated therapy is not a substitute for proper medical review – any ongoing medication requirement should be formally prescribed by an authorised practitioner.

Governance & RN Accountability: The organisation's medication governance framework oversees nurse-initiated medication use to ensure safety and compliance. Only RNs who have been deemed competent in medication management (through training and assessment) may utilize nurse-initiated medicines. RNs are accountable for their decision to initiate a medicine and must stay within the bounds of their training and the approved list. Enrolled Nurses (ENs) or other staff cannot independently initiate medications; however, an EN may administer a nurse-initiated medicine if the RN has made the decision, the medicine is on the approved list, and doing so is within the EN's scope under direct RN supervision. All use of nurse-initiated medicines is subject to review. Managers or clinical leads will monitor adherence to this policy (e.g. through audits or incident reviews), and any improper use will be addressed through supervision, further training, or other appropriate actions.

Documentation: Clear documentation is mandatory whenever an RN initiates a medication. The RN must record the medicine name, dose, time, route, and reason

for giving it, as well as the client's response. This entry should be made in the client's progress notes and, where applicable, on the medication chart (e.g. in the "nurse-initiated" or once-only section). Documentation ensures that other healthcare providers are aware of the administration. The RN should also inform the client's GP or treating doctor (for example, via phone call or secure message) about any nurse-initiated medicine given, especially if there is any possibility of repeated doses or follow-up needed. This communication and documentation are crucial for continuity of care and medication safety.

Supervision & Safety Checks: Before administering a nurse-initiated medicine, the RN must perform standard safety checks (correct client, medicine, dose, etc.) as per the "eight rights" of medication administration. If there is any uncertainty about the appropriateness of giving the medicine, or if the client's condition is complex, the RN should seek advice from a senior clinician or a doctor. RNs should only proceed if they are confident the medicine is safe and necessary. In all cases, the client must consent to the medication after being informed of its purpose. After administration, the RN should monitor the client's response and manage any adverse effects, just as with any medication administration.

Exclusions: This nurse-initiated medication policy does not extend to any prescription-only or controlled drugs. Schedule 4 (prescription) and Schedule 8 (controlled) medications cannot be initiated or given by an RN without a valid order from an authorised prescriber. RNs who hold a prescribing endorsement (e.g. as a designated RN prescriber or nurse practitioner) have separate prescribing authority beyond this policy; unless an RN is formally endorsed to prescribe, they must not independently prescribe, supply or initiate Schedule 4–8 medications

Registered Nurses (RNs) who are not endorsed as prescribers (i.e., not Nurse Practitioners or formally authorised under State legislation) must not prescribe, initiate, adjust, or cease Schedule 4 or 8 medications. These medicines must only be prescribed by a medical practitioner, and administration must follow a valid, signed medication chart

- All Schedule 4–8 medications in the community setting require a doctor's (or other authorised prescriber's) written order, and RNs must continue to follow those orders for such medicines. This nurse-initiated medicines provision is strictly limited to unscheduled, S2 and S3 substances and must never be used to bypass the need for proper medical authorisation for higher-schedule drugs.

Endorsed Registered Nurse Prescribers (Scheduled Medicines)

- Where the organisation engages an **Endorsed Registered Nurse Prescriber**, prescribing of scheduled medicines may occur **only** in accordance with the Nurse and Midwife Board of Australia (NMBA) endorsement requirements, relevant State or Territory drugs and poisons legislation, and the DVA Notes for Community Nursing Providers.

- Where the organisation **does not** engage an **Endorsed Registered Nurse Prescriber**, all Schedule 4 and Schedule 8 medicines are prescribed solely by an authorised medical practitioner and administered strictly in accordance with a current, signed medication chart

An Endorsed Registered Nurse Prescriber must:

- Hold current **NMBA prescribing endorsement** appropriate to the medicines being prescribed;
- Prescribe **Schedule 2, Schedule 3, Schedule 4 and Schedule 8 medicines** only **within their authorised scope of practice**;
- Operate under a documented **clinical governance framework**;
- Maintain an **active prescribing agreement** with an authorised medical practitioner, as required by legislation; and
- Ensure all prescribing decisions are supported by appropriate clinical assessment, documentation, and communication with the client's treating medical practitioner.

Prescribing by an Endorsed Registered Nurse Prescriber is separate and distinct from nurse-initiated medicines and does not apply to Registered Nurses or Enrolled Nurses who do not hold prescribing endorsement.

The Endorsed Registered Nurse Prescriber is personally responsible and professionally accountable for all prescribing decisions made within their authorised scope of practice. This accountability includes ensuring compliance with NMBA standards, State or Territory legislation, the organisation's clinical governance framework, and the requirements of the DVA Community Nursing Program. All prescribing activity is subject to internal clinical review, audit, and external regulatory oversight.

A client can be assisted with self-administered medication by PCWs when the following criteria are met:

- Personal Care Workers (PCWs) and Medication Assistance : PCWs may assist clients with self-administration of medicines only under the delegation and supervision of a Registered Nurse (RN) and in accordance with the nursing care plan.
- PCWs are not authorised to make any clinical decisions about whether a medicine should be taken, altered, or withheld, nor to change doses or substitute products.
- If a PCW has any concern (e.g., a missed or refused dose, side-effects, uncertainty), they must immediately contact the supervising RN for direction before proceeding.
- The RN remains accountable for all clinical judgement and delegation decisions.
- the client's medical condition/s is/are stable
- there is a medication authority or medication chart signed by the prescribing medical practitioner
- there is a nursing care plan in place which includes medication contraindications (interactions and side-effects) and emergency contacts; and
    - there is a blister pack filled by a registered Pharmacist which meets the DVA Dose Administration Aid service requirements; or
    - it is over-the-counter medication, or prescribed/non-prescribed cortisone or topical cream;
    - if assisting with a sub-cutaneous injection this must be pre-filled
- the PCW:
    - has completed the required assistance with medication administration competencies recognised by the Health Industry Skills Council
    - adheres to the relevant Commonwealth and State/Territory Drug Acts
    - adheres to the CN provider's Medication Administration/assistance Policy/ies
    - the PCW is working under the delegation of an RN, and any change in health status is reported immediately to the RN

- the RN (or an EN with an approved qualification in administration of medication) conducts a face-to-face visit and reviews the client on a weekly basis if assistance with the self-administration of Schedule 8 drugs is involved
- the provider conducts annual medication competencies for the relevant PCWs and keeps individual PCW records for auditing and safety requirements.

If the above criteria cannot be met by a PCW, the care must be provided by an RN or EN and classified under the Clinical Care schedule.

3.3. Verification Prior to Administration

- Compliance and Audit : Medication management practices are reviewed through routine internal audits and clinical reviews. Documentation of medication administration/assistance must comply with DVA requirements and be available for audit at any time. Non-compliance triggers corrective actions including retraining or disciplinary review.
- Verify the client's identity and confirm medication details against the medication chart.
- Check that the medication aligns with the prescription or doctor's orders, ensuring no discrepancies in dosage or timing.
- Obtain informed consent before administering each dose, explaining the medication and its purpose.

3.4. Administer medications following the "eight rights" of medication administration:

- Right client
- Right medication
- Right dose
- Right route
- Right time
- Right documentation
- Right reason
- Right response

3.5. Observe the client for immediate reactions and provide support as needed.

4. Documentation of Administration

Where a client requires medication administration or assistance with medication, the care interventions are to be documented in the medication management section of the nursing care plan for each prescribed dose and time of administration. A medication authority or signed medication chart must be provided by the prescribing/referring medical practitioner.

- Record the administration event in the client's medication chart, noting the date, time, and any pertinent observations.
- If a client refuses medication, document the refusal, reason (if provided), and any immediate action taken.
- Report any adverse reactions or side effects to the prescribing physician and document the incident in the client's care record.

5. Monitoring and Review

A client classified in the Personal Care schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid must be reviewed by an RN (or an EN with an approved qualification in administration of medication) **every seven days.**

All clients with **Exceptional Case** status must be reviewed by an RN at **least once per week**.

- Observe the client for changes in health status that may affect medication efficacy or tolerance.
- Monitor for any side effects or adverse reactions, documenting findings and reporting them to the prescribing GP as necessary.
- Conduct regular checks on medication storage to ensure compliance with safety and handling guidelines.
- Collaborate with the client's GP or authorised prescriber to conduct a medication review:
    - Every six months, or sooner if there is a change in the client's condition.
    - Following hospital discharge or any major change in medication.
    - To discontinue or adjust medications if deemed unnecessary or inappropriate.

- Update the client's care plan and medication chart based on the outcomes of the medication review.

6. Storage and Handling of Medications

6.1. Safe Storage

- Store medications securely in the client's home, following manufacturer instructions for temperature and light sensitivity.
- Ensure that medications are inaccessible to unauthorised individuals, especially in households with children or pets.
- Staff members are required to regularly inspect medication storage areas for expired or unused medications. This task must be completed during every medication administration shift change or, at a minimum, on a weekly basis.
- Expired or unused medications identified during these checks are to be separated immediately to prevent their use.

6.2. Controlled Substances

- For prescribed controlled substances, adhere to the regulatory guidelines for documentation, storage, and disposal. All practices must comply with the relevant State or Territory legislation (e.g., Poisons and Therapeutic Goods Act 1966 (NSW), Medicines and Poisons Act 2019 (QLD), or equivalent), including legal authorisation, record-keeping, and handling requirements.
- Maintain a record of controlled substances in the client's file, tracking inventory, administration, and disposal details.

7. Medication Disposal

7.1. Medications must be identified for disposal if they are:

- Expired or beyond their safe use date.
- No longer required by the client due to a change in prescription.
- Damaged, contaminated, or deemed unsafe for use.

7.2. Approved Disposal Methods

- **Return to Pharmacy:** Medications should be returned to an authorised pharmacy.
- **Incineration or Destruction by Licensed Facility:** For certain controlled substances and hazardous drugs, arrange for incineration or destruction

through a licensed waste disposal company that complies with state and federal environmental laws.

- **Home Disposal (Exception):** In cases where medications must be disposed of immediately and cannot be returned to a pharmacy, small quantities of non-hazardous medication may be disposed of following local waste guidelines. However, this should be an exception and documented with clear rationale.

7.3. Controlled Substances and Hazardous Waste Disposal

Controlled substances and hazardous waste require specific handling and disposal methods to ensure compliance with Australian laws and protect public health and safety.

These substances **cannot be disposed of at home** and must be managed through approved, secure processes.

- **Return to Authorised Facility**
  - All controlled substances and hazardous medications must be returned to an authorised pharmacy or licensed disposal facility. Pharmacies participating in the Return Unwanted Medicines (RUM) program are equipped to manage the safe disposal of these medications.
  - Controlled substances and hazardous medications must be separated and placed in specialised containers designated for pharmaceutical waste. These containers are designed to prevent leaks, spills, and accidental exposure, ensuring the safety of handlers and the environment.
  - High-risk medications should be stored in purple-lidded containers or other containers specifically approved for hazardous waste, as outlined in Safe Work Australia guidelines.

7.4. Documentation

Detailed records must be maintained for compliance and accountability, including:

- **Medication Details**: Include the name, strength, and quantity of the medication being disposed of.

- **Reason for Disposal**: Document the reason for disposal, such as expiration, change in prescription, or damage.
- **Date, Time, and Method**: Record the date and time of disposal, as well as the method used (e.g., returned to pharmacy or incineration at licensed facility).
- **Disposal Authorisation**: Record the authorisation for disposal, including the names and signatures of the healthcare professional who authorised and implemented the disposal.

7.5. Secure Transport and Destruction

- Once medications are prepared for disposal, they must be transported securely to the authorised facility.
- All transport and destruction steps must adhere to relevant state and territory regulations, ensuring safe handling of potentially dangerous goods.

7.6. Record Retention and Compliance Audits

- All documentation related to medication disposal, including logs for controlled substances, should be retained for a minimum of seven years or as required by local regulatory authorities.
- Regular compliance audits should be conducted to ensure proper handling, documentation, and disposal procedures are in place, identifying any areas for process improvement.

8. Adverse Event Management and Reporting

If an adverse reaction occurs:

- Follow immediate first-aid and emergency protocols as appropriate.
- Document the event in detail, noting the reaction, time, intervention, and follow-up action.
- Inform the client's GP and coordinate follow-up care as needed.

9. Incident Management and Reporting

In the event of a suspected medication error, immediate and thorough action is required to ensure client safety and compliance with reporting standards. The following steps must be taken:

9.1. Immediate Response

- Stop Administration: Staff must immediately halt the administration process as soon as a potential medication error is identified.
- Notify the Care Manager: Staff must promptly notify the Care Manager about the suspected error for further assessment.
- Inform the Client: The care recipient must be informed of the potential error in a clear and compassionate manner, ensuring they understand the steps being taken to ensure their safety.

9.2. Assessment by the Care Manager

- The Care Manager will assess the situation to determine the nature and severity of the error, reviewing factors such as the medication involved, dosage, and potential impact on the client's health.
- If necessary, the Care Manager will provide immediate care to the affected client to stabilise their condition and address any immediate health concerns.

9.3. Communication with Healthcare Providers

The Care Manager must contact the client's GP or relevant medical practitioner to discuss the error and determine the appropriate course of action. This may include adjusting medication, monitoring for adverse effects, or seeking emergency medical intervention.

9.4. Documentation

The Care Manager is responsible for documenting the medication error in the incident report system, providing a detailed account of the event, including:

- Description of the error
- Date and time of the incident
- Steps taken to address the error and provide care
- Communication with healthcare providers
- Follow-up actions and monitoring requirements

This documentation is essential for tracking and analysing medication errors, helping to prevent recurrence and improve medication management practices.

10. Continuous Professional Development

To ensure safe, effective, and compliant medication management, all staff involved in medication handling and administration must participate in ongoing training and education. Continuous Professional Development (CPD) is essential for maintaining competency, staying current with best practices, and adapting to changes in medication management protocols, regulations, and emerging treatments.

10.1. Mandatory Training Requirements

All nursing and support staff involved in medication management must complete mandatory training, covering topics such as:

- Safe handling, storage, and disposal of medications, including controlled substances and hazardous drugs.
- Recognizing and managing adverse drug reactions and medication errors.

Training must be updated annually or as required.

10.2. Updates on Best Practices and New Medications

- Staff should receive training on the latest best practices in medication management, including new developments in pharmacology and updated clinical guidelines.
- Regular updates on new medications, including potential interactions, side effects, and specific administration guidelines, should be provided to ensure all staff are knowledgeable and prepared.

10.3. Regulatory and Policy Compliance

- Staff must stay informed on changes in legislation, including state and federal regulations related to controlled substances and medication disposal, and any new guidelines from regulatory authorities.
- Training should also cover the company's internal policies and procedures, ensuring that staff understand and adhere to all documentation, reporting, and safety protocols.

10.4. Competency Assessments

- Competency assessments should be conducted regularly to verify that staff are proficient in all aspects of medication management. Assessments may include practical evaluations, knowledge quizzes, and supervised administration to ensure compliance with best practices.
- Staff who do not meet competency standards should receive additional training and mentorship until they demonstrate the required level of skill.

10.5. Documentation of CPD Activities

- All training and development activities should be documented in each staff member's professional development record. This includes the date, type of training, topics covered, and outcomes of any competency assessments.
- Regular audits of CPD records should be conducted to ensure compliance with professional development requirements and regulatory standards.

7. Client Not Responding

The purpose of this policy and procedure is to establish a standardised, compliant approach for managing situations when a client does not respond during a scheduled in-home visit.

The company is committed to ensuring client safety by implementing individual or generic client non-response plans, developed with each client's input where possible. If a client does not respond during a scheduled visit, staff will follow the established non-response procedure to confirm the client's wellbeing while respecting their autonomy and privacy.

Definitions

- Non-Response: The absence of response from the client after reasonable attempts to contact them at the scheduled time of service.
- Individual Client Non-Response Plan: A plan developed with the client that outlines specific steps and contact persons to be engaged if the client does not respond during a scheduled visit.

- Generic Non-Response Plan: A standardised plan implemented when a client has not developed an individual non-response plan, ensuring client safety during non-response events.

1. Development of Non-Response Plans

1.1. Individual Client Non-Response Plans

- Upon initiation of services, the RN should discuss and develop a customised non-response plan with each client, if they agree.
- The plan should include:
  - The name and phone number of a designated contact person for welfare checks.
  - Specific instructions based on the client's preferences and needs.
- Document the individual plan in the client's care file, including any emergency contacts, and ensure it is accessible to all staff.

1.2. Generic Non-Response Plan

- For clients who decline an individual plan, a generic non-response plan must be implemented.
- This plan includes a standardised approach to contact attempts and welfare checks if the client does not respond.

1.3. Client Reminder System

- Implement a reminder system to notify clients of upcoming visits. This may include phone calls, text messages, or reminders agreed upon with the client.
- Document reminder notifications in the client's record to support consistent and effective communication.

2. Initial Contact Attempt During Scheduled Visit

2.1. Scheduled Visit Non-Response

- If the client does not respond when the nurse arrives at their home:
  - Knock on the door and wait a reasonable period.
  - Attempt to contact the client by phone, if available.
  - If no response, attempt another phone call and wait an additional few minutes.

- Contact next of kin or carer

2.2. Observation and Assessment

- Conduct a visual check of the home exterior (if safe) for signs of activity or potential safety concerns.
- Avoid entering the home without consent unless there are clear signs of an emergency.

3. Escalating to the Client's Emergency Contact or Care Coordinator

3.1. Notifying the Emergency Contact

- If the client remains unresponsive:
  - Contact the emergency contact listed in the client's individual or generic plan, inform them of the situation, and ask if they can confirm the client's wellbeing.
  - Request that the emergency contact reach out to the client or check on them if possible.

3.2. Escalation to Care Coordinator

- If the emergency contact cannot confirm the client's wellbeing or is unavailable, contact the Care Coordinator to escalate the situation.
- The Care Coordinator may attempt further contact or initiate a welfare check through local authorities if necessary.

4. Involving Emergency Services

- If the Care Coordinator assesses that a welfare check is needed, they may contact emergency services to request a welfare check at the client's address.
- Provide emergency services with relevant client details, including recent contact attempts, emergency contact information, and any health concerns.

5. Documentation and Reporting

5.1. Documenting Non-Response Incidents

- Nursing staff must document all attempts to contact the client, including:
  - Date and time of each contact attempt.
  - Details of the conversation with the emergency contact, if applicable.
  - Actions taken, including escalation steps or involvement of emergency services.

5.2. Summary of Events

- Document a summary of events in the client's care file as required by the DVA, particularly if the non-response plan was activated.
- Ensure the record includes the outcome of the incident and any follow-up actions needed.

5.3. Incident Report

- Complete an incident report for each non-response event to support quality assurance.
- Review the incident with the Care Coordinator and assess if further action or adjustment to the plan is necessary.

5.4. Claiming Guidelines

- If a client non-response plan was not activated or followed, a claim for the visit should not be submitted as per DVA guidelines.

6. Follow-Up Actions

6.1. Client Communication

- If the client is located and safe, follow up to inform them of the actions taken and review their non-response plan preferences.
- Ensure that the client's emergency contact details and any other information in their plan are updated if necessary.

6.2. Review and Quality Assurance

- Review all non-response incidents periodically to identify trends and improve non-response protocols.
- Adjust training or procedures as necessary based on review findings to ensure efficiency and enhance client safety.

7. Staff Training and Compliance

- All staff must complete training on these Client Non-Response procedures, including the development and implementation of individual and generic non-response plans, contact attempt protocols, and emergency escalation steps.
- Staff must complete refresher training annually, or as required if updates to the policy or procedure occur.

8. Client Care Handover/Transfer Between Personnel

Handover or transfer of client care between personnel shall be managed with a structured process to ensure that critical information is communicated effectively, reducing the risk of errors and maintaining high standards of care.

Procedure for Client Care Handover/Transfer:

Use **ISBAR** (Identify, Situation, Background, Assessment, Recommendation) methodology.

1. **Handover Initiation:**
   Handover is required when there is a change in personnel responsible for the client's care, including shift changes, leave cover, or transfer to another team member.
2. **Information to be Transferred:**
   - Client's personal details and medical history.
   - Current care plan, including medication schedules, treatment plans, and special needs.
   - Any recent changes in the client's condition.
   - Upcoming appointments or scheduled treatments.
   - Key contact information, including client's GP and emergency contacts.
3. **Handover Methods:**
   - Verbal Handover: Conducted face-to-face or via a secure communication platform, ensuring both parties have an opportunity to ask questions and clarify information.
   - Written Handover: Documented in the client's care records, ensuring all relevant details are accurately recorded and accessible.
4. **Responsibilities of Personnel:**
   - Outgoing personnel must provide a complete and accurate handover to the incoming personnel.
   - Incoming personnel must review the handover information and seek clarification if required.
5. **Handover Documentation:**
   - Maintain detailed records of all handovers, including date, time, and personnel involved.
   - Update the client's care plan and records to reflect any changes communicated during the handover.
6. **Client Involvement:**

- Inform the client of any changes in their care team.
- Provide reassurance to the client to ensure they feel supported during the transition.

7. **Monitoring and Review:**
    - Regular audits of handover processes to ensure adherence to this policy.
    - Continuous improvement initiatives based on feedback from personnel and clients.

9. Client Care Transfer to Another Provider

All client transfers shall be managed in full compliance with DVA requirements. Transfers due to capacity or other contractual reasons are not permitted once services have commenced, unless prior approval is obtained from DVA.

Contacting DVA

- **DVA Provider Enquiry Line:** 1800 550 457
- **Email Enquiries:**
    - General CN program information: nursing@dva.gov.au
    - Exceptional Cases: exceptional.cases@dva.gov.au
    - Contractual Matters: NMBCN@dva.gov.au

Procedure for Client Transfer:

1. **Initiating a Transfer:**
    - Transfers initiated due to client choice or relocation do not require prior DVA approval.
    - For transfers due to capacity or contractual reasons, prior approval from DVA is mandatory.
2. **Developing a Transfer Plan:**
    - An agreed transfer plan must be established before any transfer takes place.
    - The plan must include agreed wording and an approach for notifying the client.
3. **Notification and Coordination:**
    - Obtain the client's informed consent prior to sharing any personal or clinical information with the receiving provider. Document the consent in the client's record
    - Inform the client of the transfer details using the agreed approach.
    - Coordinate with the receiving CN provider to ensure continuity of care.
    - Ensure the client's GP is involved in the transfer process.

4. **New Referral Requirement:**
    - A new referral from the GP is required when a client is transferred to another CN provider.
5. **Supporting a Smooth Transfer:**
    - Provide all necessary support to ensure there is no disruption in CN services during the transfer.
    - Ensure all client records and care plans are shared with the receiving CN provider.
6. **Documentation:**
    - Maintain accurate records of the transfer, including communication with the client, GP, receiving CN provider, and DVA where applicable.
7. **Monitoring and Review:**
    - Regularly review transfer processes to ensure compliance with DVA policies and continuous improvement in client care.

10. Referral to Other Health Professionals or Legal Authorities

We are committed to ensuring that clients receive the most appropriate care and support. Where required, staff will refer clients to external health professionals or legal authorities to ensure their safety, well-being, and access to specialised care. The referral process will be managed with confidentiality, respect, and in accordance with regulatory requirements.

1. Triggers for Referral

A referral to a health professional or legal authority is required in the following circumstances:

1.1. Health Professional Referral

- Changes in the client's health status requiring specialised care (e.g., sudden onset of illness, injury, or decline in mobility).
- Mental health issues or psychological distress requiring support from a psychologist or counsellor.
- The need for ongoing care or intervention from an allied health professional (e.g., physiotherapy, podiatry, occupational therapy).
- Clinical signs of malnutrition, dehydration, or other health risks that require additional support.

1.2. Legal Authority Referral

- Client Abuse or Neglect: If there is suspicion, allegation, or evidence of physical, emotional, financial, or sexual abuse of a client.
- Mandatory Reporting: Where a legal obligation exists to report certain matters (e.g., child protection, elder abuse, or domestic violence) to the relevant authorities.
- Aggressive or Violent Behaviour: If a client, family member, or visitor exhibits threatening or violent behaviour towards staff or other clients, referral to the police may be required.
- Breach of Legal Obligations: Where a breach of the law or non-compliance with DVA or other regulatory requirements is identified.

2. Referral Process

2.1. Identification of Need

- The staff member identifies the need for a referral during service delivery, routine assessments, or as a result of a client or family request.
- If the referral is urgent (e.g., in the case of serious injury, aggression, or an imminent threat), the staff member must act immediately and contact emergency services (e.g., 000) before proceeding with the formal referral process.

2.2. Consultation and Consent

- Where appropriate, consult with the client (or their legal guardian) regarding the need for referral.
- Obtain consent from the client before making the referral, unless urgent action is required to prevent immediate harm.

2.3. Referral to Health Professionals

- Contact the appropriate health professional directly to make the referral (e.g., GP, allied health professional).
- Provide the health professional with relevant client information to support the referral, ensuring confidentiality and privacy.

- Document the referral in the client's file, including the reason for the referral, the health professional's name, and any follow-up actions required.

2.4. Referral to Legal Authorities

- For urgent matters (e.g., violence, abuse, or immediate danger), contact police or emergency services immediately.
- Complete the required documentation (incident report) and submit it to the relevant legal authority.

2.5. Follow-Up and Review

- Track the outcome of the referral to ensure the client's needs have been met.
- Maintain a record of all communications related to the referral, including dates, times, names, and actions taken.

Section 6 Care Environment

1. Policy Statement

We are committed to delivering community nursing services in environments that are safe, private, culturally respectful, and conducive to quality care. Services will normally be provided in the client's home, but may also occur in other agreed safe environments, provided they meet DVA program requirements.

All staff will ensure that client environments are assessed for safety risks, support dignity and privacy, and allow effective delivery of care. Where risks cannot be controlled, services may be modified, suspended, or relocated in consultation with the client, their representative, and the referrer.

2. Purpose and Scope

This policy ensures that:

- Care is provided in environments that meet DVA requirements for community nursing services.
- Environmental risks are identified, documented, and managed.
- Services are provided in a manner that respects privacy, cultural needs, and the wellbeing of clients and staff.

This policy applies to all staff delivering community nursing services under the DVA program.

3. Procedures

Care Environment Settings

- **Primary setting**: Client's home is the main environment for service delivery.
- **Alternative settings**: Care may be delivered in temporary or alternative safe locations if:
- Agreed with the client and authorised by the organisation.
- Risks have been assessed and deemed acceptable.

- **Exclusions**: DVA community nursing services cannot be delivered in acute hospitals, residential aged care facilities, or multipurpose centres.

4. Environmental Risk Assessment

- Conducted at the first home visit by an RN as part of the initial comprehensive assessment.
- Assessment must consider:
    - Physical hazards (e.g., trip risks, poor lighting, unsafe furniture, unsafe pets).
    - Infection control risks (cleanliness, sharps, exposure to smoke).
    - Access and egress for staff and emergency services.
    - Cultural or privacy considerations.
- Risks must be documented in the client's clinical record and risk register if significant.

The care environment for community nursing services provided to veteran card holders is the client's own home.

- The community nursing services shall be delivered to a client face-to-face in their place of residence.
- Where face-to-face services cannot be delivered and it is clinically appropriate to do so, these services may be delivered remotely, such as by telephone or online.
- The community nursing services shall be delivered in a safe, effective and responsive manner to facilitate positive outcomes for the client, and in a manner that promotes privacy, dignity and respect for the client, including taking into account the client's culture and diversity.
- The community nursing services shall be delivered in accordance with the nursing care plan.
- All clients shall be provided a contact for emergency purposes 24 hours a day, 7 days a week.

Section 7 Risk Management

1. Risk Management Policy and Procedure

Purpose and Scope

The purpose of this policy and procedure is to establish a structured framework for identifying, assessing, managing, and mitigating risks to ensure the safety, well-being, and quality of care for clients and staff. This policy aims to support compliance with the Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers and the Aged Care Quality Standards.

This policy applies to all staff, clients, contractors, and stakeholders involved in the delivery of community nursing services and extends to all activities and environments where care is provided.

Policy Statement

We are committed to fostering a proactive risk management culture that ensures compliance with legal, regulatory, and contractual obligations. Risk management processes will align with the principles outlined in AS ISO 31000:2018 Risk Management – Guidelines, promoting systematic, transparent, and evidence-based practices.

We are dedicated to:

- Ensuring the health, safety, and well-being of clients, staff, and stakeholders.
- Identifying and mitigating risks that could adversely impact service delivery, quality of care, or company operations.
- Maintaining a robust clinical governance framework to oversee and manage risk effectively.
- Continuously improving risk management practices through regular reviews and staff engagement.

Procedures

1. **Risk Identification**

Risk identification involves proactively detecting and recording risks that may arise in clinical, operational, financial, or environmental contexts.

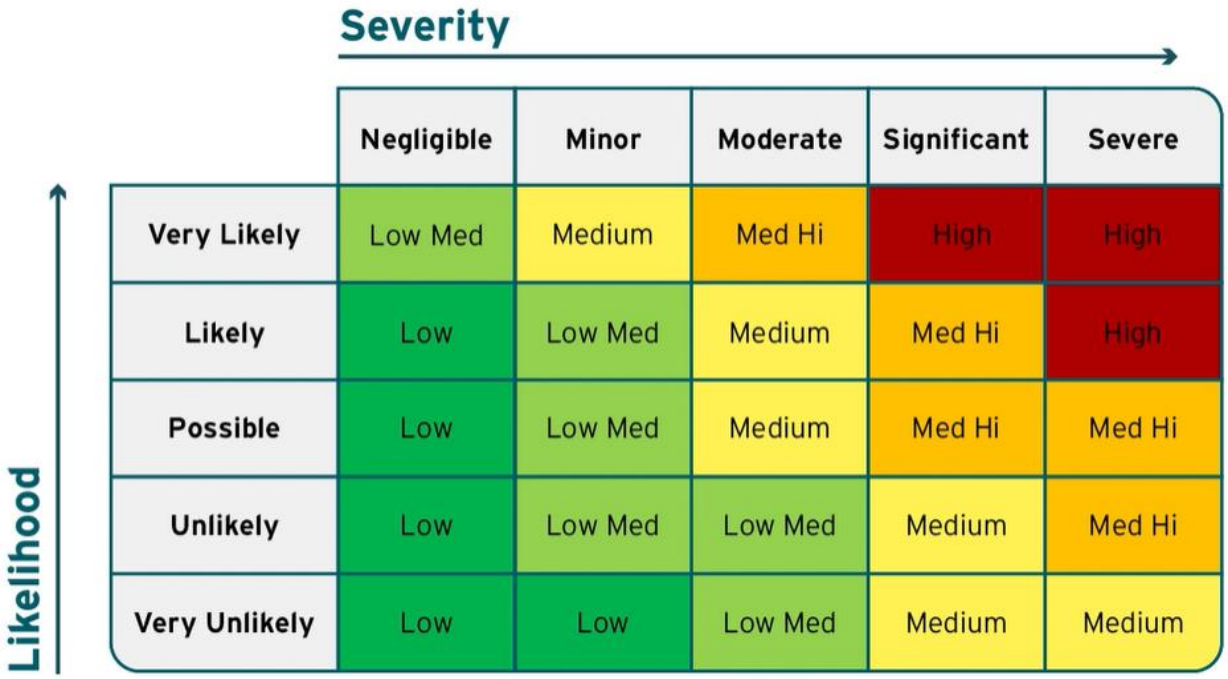
- Regularly identify risks through client assessments, staff feedback, audits, and environmental scans.
- Classify risks into categories, including but not limited to:
    - Clinical risks (e.g., medication errors, infection control breaches)
    - Operational risks (e.g., staff shortages, technology failures)
    - Financial risks (e.g., funding disruptions, cost overruns)
    - Environmental risks (e.g., physical hazards, extreme weather events)

2. Risk Assessment

Assess risks based on their potential likelihood and impact to prioritise management efforts.

- Utilise a risk matrix to rate risks on a scale of low, medium, high, or extreme.
- Document all identified risks in the Risk Register, including:
    - Risk description and category
    - Assessment of likelihood and impact
    - Assigned risk level
    - Responsible person(s) for managing the risk
    - Timeframes for action and review

Risk Assessment Matrix



3. Risk Control and Mitigation

Implement control measures to eliminate or minimise the likelihood and/or impact of identified risks.

- Develop tailored mitigation strategies, such as:
  - **Staff training** to address gaps in skills or knowledge
  - **Policy updates** to strengthen organisational procedures
  - **Process improvements** to streamline service delivery and reduce errors
- Assign clinical governance oversight for high-risk areas to ensure appropriate monitoring and intervention.
- Establish a system for escalating extreme risks to executive management and relevant authorities as needed.

4. Monitoring and Review

Risk management is an ongoing process requiring regular monitoring and review to ensure effectiveness.

- Conduct **monthly risk review meetings** to:
  - Evaluate the status of existing risks
  - Identify new or emerging risks
  - Review and update the Risk Register
- Perform periodic audits and surveys to assess the effectiveness of risk controls and identify areas for improvement.
- Incorporate risk management into routine **continuous improvement activities** to foster a culture of safety and compliance.

5. Reporting and Communication

Maintain open and transparent communication regarding risk management across the company.

- Share relevant risk information with staff during team meetings and training sessions to promote awareness and accountability.
- Report significant risks, including those assessed as high or extreme, to the executive team and, where applicable, external authorities (e.g., the DVA, ACQSC).
- Maintain a record of all communication and actions taken regarding risk management to ensure traceability and accountability.

6. Responsibilities

- **Executive Team**: Ensure organisational alignment with risk management objectives and approve risk management policies and mitigation plans.
- **Clinical Governance Committee**: Provide oversight for clinical risks and high-risk areas, ensuring appropriate management and escalation procedures are in place.
- **Risk Manager**: Maintain the Risk Register, coordinate risk reviews, and lead risk mitigation efforts across the company.
- **Staff Members**: Identify and report risks in their areas of responsibility, participate in training, and comply with risk management procedures.

7. Compliance and References

This policy and procedure align with the following regulatory and industry standards:

- DVA Notes for Community Nursing Providers
- Aged Care Quality Standards
- AS ISO 31000:2018 Risk Management – Guidelines
- Work Health and Safety Act 2011 (Cth)

2. Incident Management Policy and Procedure

Purpose and Scope

This policy ensures a structured, consistent approach to the management of incidents, accidents, and dangerous occurrences that may occur during the delivery of services in clients' homes. The objective is to maintain the safety of clients, staff, and any others present while meeting legal and regulatory obligations.

This policy applies to all incidents, including but not limited to:

- Clinical incidents (e.g., medication errors, treatment-related harm) occurring during service delivery.
- Workplace accidents (e.g., slips, trips, and falls) at the client's home.
- Dangerous occurrences (e.g., environmental hazards, equipment malfunctions) encountered in the client's home.
- Any events involving clients, staff, or visitors at the service location.

Policy Statement

The company is committed to:

- Prompt and effective management of incidents to ensure safety and mitigate risks during in-home service delivery.
- Maintaining transparency and accountability throughout the incident management process.
- Using incident data to drive continuous improvement and minimise the likelihood of recurrence.
- Meeting all obligations under the Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers and the Aged Care Quality Standards.

Procedures

1. Incident Reporting

1.1. Immediate Reporting

- All incidents that occur in a client's home must be reported to a supervisor or manager immediately.
- Complete an *Incident Report Form* within 24 hours of the incident, capturing relevant details such as the time, location (client's home address), and nature of the incident, as well as those involved.

1.2. Notification to Authorities

- Reportable incidents must be promptly communicated to the DVA and any other regulatory bodies as required. Reportable incidents include:
  - Any serious harm, injury, or threat to the health, safety, or well-being of a veteran. This encompasses incidents such as abuse, neglect, assault, or significant medical events.
  - It also includes cases where a death occurs during the provision of care or is linked to the care provided.
  - Release of hazardous chemicals into the environment
  - Dangerous incident that exposes a person to serious risk, even if no injury occurs.

- For serious incidents, notify relevant authorities without delay.
  - **WorkSafe ACT**:
    Phone (Notifiable Incidents): 13 22 81 (24/7 emergency line)

- SafeWork NSW
  Phone (Notifiable Incidents): 13 10 50 (24/7 emergency line)
- NT WorkSafe
  Phone (Notifiable Incidents): 1800 019 115 (24/7 emergency line)
- Workplace Health and Safety Queensland (WHSQ)
  Phone (Notifiable Incidents): 1300 362 128 (24/7 emergency line)
- SafeWork SA
  Phone (Notifiable Incidents): 1800 777 209 (24/7 emergency line)
- WorkSafe Tasmania
  Phone (Notifiable Incidents): 1300 366 322 (24/7 emergency line)
- WorkSafe Victoria
  Phone (Notifiable Incidents): 13 23 60 (24/7 emergency line)
- WorkSafe WA
  Phone (Notifiable Incidents): 1800 678 198 (24/7 emergency line)

Written Notification Requirements

- A written notification of the incident must be submitted to the DVA and other relevant authorities as soon as practicable and within the required timeframe.
- The notification should include a detailed description of the incident, persons involved, immediate actions taken, and any known contributing factors. Copies of incident reports, investigation reports, and any photographic evidence should be attached to the written notification.
- Written notifications must be stored securely as part of the incident records and retained for a minimum of 7 years.

1.3. Stakeholder Communication

Inform family members, guardians, or other stakeholders about the incident where appropriate, ensuring sensitivity and professionalism in all communications.

2. Incident Investigation

2.1. Assign an Investigation Team

An *Incident Investigation Team* will be appointed for all significant incidents. This team may include management, safety officers, and staff involved in delivering the in-home service.

2.2. Root Cause Analysis (RCA)

Conduct a thorough RCA, considering factors unique to the client's home environment:

- Physical hazards (e.g., uneven flooring, poor lighting)
- Accessibility issues (e.g., limited mobility support)
- Equipment and tools used during service delivery

2.3. Corrective Actions

Based on the investigation findings, recommend and implement corrective actions specific to in-home service settings, such as providing additional training, modifying service protocols, or addressing identified environmental risks.

2.4. Report Submission

Submit detailed investigation reports to the DVA and other required bodies within the stipulated timeframe.

3. Follow-Up Action

3.1. Support for Affected Individuals

Provide immediate support, including first aid, medical assistance, or counselling, to affected individuals in the client's home.

3.2. Monitoring and Evaluation

- Track the effectiveness of corrective actions implemented. Conduct follow-up checks to ensure safety measures remain effective.
- Assess the effectiveness of the incident management process and make corrections if necessary.

4. Preservation of Incident Site

- Following an incident, the site where the incident occurred must be preserved to allow for an effective investigation.
- No changes should be made to the incident site unless it is necessary to prevent further harm or danger.
- Where it is safe to do so, restrict access to the site by using barriers, signage, or supervision.

- Document the state of the incident site through photographs, diagrams, and written descriptions before any alterations are made.

5. Documentation and Record Keeping

5.1. Detailed Record Maintenance

- Maintain comprehensive records of all incidents, including those occurring in clients' homes, investigation findings, actions taken, and communications.
- Store records securely for a minimum of 7 years, ensuring confidentiality and compliance with privacy legislation.

5.2. Trend Analysis and Preventive Action

- Regularly review incident data to identify patterns or trends, particularly those specific to in-home service environments.
- Use insights to implement proactive measures to prevent similar incidents.

6. Compliance and Notification

6.1. Regulatory Compliance

Follow all applicable regulatory requirements, including those outlined in the *Aged Care Quality Standards* and workplace health and safety legislation.

6.2. Stakeholder Notification

Notify relevant parties, including clients, families, and authorities, promptly and appropriately.

7. Responsibilities

- **Staff Members**:
  - Report all incidents promptly and accurately.
  - Adhere to specific safety protocols for in-home service delivery.
  - Participate in investigations and corrective actions as required.
- **Supervisors and Managers**:
  - Ensure incidents are managed effectively and in accordance with this policy.
  - Facilitate communication with affected parties and regulatory bodies.
- **Incident Investigation Team**:
  - Conduct thorough investigations and recommend preventive measures.
  - Ensure compliance with all reporting and documentation requirements.
- **Executive Leadership**:

- Oversee the implementation of this policy and ensure organisational adherence.
- Use incident reports to guide continuous improvement efforts.

NSQHS Standards Compliance Framework

Policy Summary

- Implement the NSQHS Standards (2nd edition) across all clinical and organisational functions.
- Conduct annual self-assessment audits against the Standards.
- Document compliance evidence for accreditation and DVA contract reporting.
- Assign a Clinical Governance Officer to oversee compliance monitoring.

Procedure

1. **Implementation of Standards**
   - Embed the 8 NSQHS Standards (2nd ed.) into policies, procedures, and day-to-day clinical practice:
     - Clinical Governance
     - Partnering with Consumers
     - Preventing and Controlling Healthcare-Associated Infection
     - Medication Safety
     - Comprehensive Care
     - Communicating for Safety
     - Blood Management
     - Recognising and Responding to Acute Deterioration
2. **Annual Self-Assessment Audits**
   - Maintain a **Compliance Evidence Folder** (digital and/or physical) with:

2.1. Policies and procedures aligned to each Standard.
2.2. Training records (e.g., hand hygiene, medication safety).
2.3. Audit reports
2.4. Consumer feedback and engagement evidence.
2.5. Evidence must be available for:
2..5.1. **DVA contract reporting**.
2..5.2. **Accreditation audits**.

3. **Clinical Governance Oversight**

Assign a **Clinical Governance Officer** responsible for:

- Coordinating compliance audits.
- Maintaining the evidence register.
- Reporting to the Clinical Governance Committee and Board.

3. Emergency Management Policy and Procedure

Purpose and Scope

To ensure the staff is fully prepared and capable of providing a coordinated, effective, and timely response to emergencies while safeguarding the health, safety, and wellbeing of clients, staff, and visitors in home-based care settings. This policy also ensures continuity of care during emergencies in clients' homes.

This policy applies to all staff delivering services in clients' homes and encompasses all potential emergencies, including but not limited to medical emergencies, natural disasters, fire incidents, pandemics, and other critical situations that may arise during the provision of care.

Policy Statement

We are committed to maintaining a robust emergency management procedure that adheres to all legal and regulatory requirements. The procedure will ensure a proactive approach to emergency preparedness, response, and recovery for home-based care services while prioritising the continuity of care and minimising risks to clients and staff.

An emergency is a situation of grave risk to health, life or environment. A disaster is any phenomenon, natural or man-made, that has the potential to cause extensive destruction of life and property.

Disasters and emergencies include:

- flood
- fire
- heatwave
- snowstorm
- storms or cyclones
- pandemic

Procedures

1. **Emergency Preparedness**
   - **Risk Assessment:**
     - Conduct regular risk assessments to identify potential emergency scenarios relevant to home-based care, including medical emergencies and home-specific hazards (e.g., fire risks, accessibility issues).
     - Evaluate each client's home environment for potential risks during the initial assessment and review this information periodically.
     - Keep a register of clients at risk including client contacts and next of kin.
   - **Emergency Equipment and Resources:**
     - Provide staff with portable emergency kits that include:
       - First aid supplies.
       - Contact lists for emergency services and organisational support.
       - Relevant client information, such as emergency contacts and medical alerts.
   - **Emergency Contact List:**
     - Maintain an updated contact list of:
       - Emergency services (fire, police, ambulance).
       - Register of clients, client emergency contacts and next-of-kin.
   - **Communication Channels:**
     - Ensure staff have access to reliable communication devices (e.g., mobile phones) during home visits.
     - Use multiple communication channels (e.g., SMS alerts, direct calls) to notify staff and clients of emergencies.

2. **Staff Training:**
   - Conduct mandatory training for all staff annually on:
     - Recognising and responding to emergencies in clients' homes.
     - Administering first aid, managing fire risks, and evacuation procedures tailored to home environments.
   - Include scenario-based training for emergencies that may arise during home visits
   - Train staff on safe evacuation techniques for clients in various home environments, including those with mobility challenges.

- Provide staff with guidance on managing shelter-in-place situations in clients' homes, such as during severe weather events or external threats.
- Ensure clients and staff understand how to identify safe areas in the home and access necessary supplies.

3. Responding to Emergencies in Clients' Homes

3.1. How to Safely Evacuate Clients If Necessary

Step 1: Assess the Situation

- Determine the nature and severity of the emergency.
- Evaluate the immediate risks to the client and staff (e.g., fire, structural damage, gas leak).

Step 2: Initiate Evacuation

Follow these steps to ensure a safe and efficient evacuation:

a. **Inform the Client:** Calmly explain the situation and the need to evacuate. Provide clear, simple instructions tailored to their needs (e.g., visual aids or step-by-step guidance for clients with cognitive impairments).

b. **Assist the Client:** If the client has mobility challenges, use appropriate techniques to assist them. For example:
   - Use mobility aids (e.g., walkers, wheelchairs) if available.
   - Employ safe lifting techniques if the client requires physical assistance.

c. **Gather Essentials:** Quickly grab necessary items, such as medications, identification, and a phone, if it is safe to do so.

d. **Follow Pre-Identified Routes:** Use the safest and most direct evacuation route identified during the initial home risk assessment. Avoid elevators if the home has them.

Step 3: Move to Safety

- Take the client to a safe location outside the home, such as a designated assembly point or a safe neighbour's house.
- Ensure both staff and the client are clear of potential hazards (e.g., debris, smoke).

Step 4: Contact Emergency Services (if not already done)

- Provide the address and a description of the emergency.
- Inform emergency personnel of the client's condition, mobility status, and any special requirements.

3.2. When to Call Emergency Services

- **Immediate Situations Requiring Emergency Services:**
  - Fire, gas leak, flood, or other structural hazards.
  - Life-threatening medical emergencies, such as chest pain, difficulty breathing, unconsciousness, severe bleeding, or suspected stroke.
  - External threats, such as intruders or violent behaviour.
- **Steps for Calling Emergency Services:**
  - Dial **000** and request the appropriate service (fire, ambulance, police).
  - Follow the operator's instructions and remain on the line until told to hang up.
- **Non-Emergency Situations:**
  - For less critical issues (e.g., minor injuries, property damage), contact the appropriate local non-emergency number for advice.

3.3. How to Communicate with the Client and Their Family or Emergency Contact

Step 1: During the Emergency

- **With the Client:**
  - Use calm, clear, and reassuring language to explain what is happening.
  - Tailor communication to the client's needs, considering language, sensory impairments, or cognitive abilities.
  - Provide simple, step-by-step instructions.
- **With Emergency Contacts:**
  - If safe to do so, contact the client's family or emergency contact immediately after ensuring the client is safe.
  - Provide the following information:
    - The nature of the emergency.
    - The actions taken (e.g., evacuation, medical assistance).
    - The client's current location and condition.

Step 2: After the Emergency

- **With the Client:**
  - Provide updates about the situation and actions being taken to resolve it.
  - Address any questions or concerns they may have.
  - Offer emotional support or referrals for counselling services if needed.
- **With the Family or Emergency Contact:**
  - Update them on the client's status and the resolution of the emergency.
  - Provide information about next steps, such as arranging alternative care or temporary accommodation if necessary.

Step 3: Document the Incident

- Complete an incident report detailing:
  - The nature of the emergency.
  - Actions taken by staff, including communication efforts.
  - Outcomes and follow-up steps.

Step 4: Follow-Up Communication

- Check in with the client and their family/emergency contact within 24-48 hours to:
  - Address any ongoing concerns.
  - Provide updates on additional steps being taken (e.g., repairs, additional assessments).

4. **Post-Emergency Emergency Contact List:**

- **Debriefing and Review:**
  - Conduct post-emergency debriefings with staff involved in home-based emergencies to identify lessons learned and areas for improvement.
  - Document findings and update the emergency management procedures as needed.
- **Support for Clients and Staff:**
  - Provide access to counselling and support services for clients and staff impacted by the emergency.

- Communicate with clients and families to address concerns and provide updates on service continuity.

- **Continuous Improvement:**
  - Review and update the emergency management procedures annually or after any significant event.
  - Incorporate feedback from staff and clients into future training and plan development.

4. Emergency Contact List

How and when to call the emergency services in Australia:

Triple Zero (000)

Triple Zero (000) is Australia's main emergency service number. You should call 000 if you need urgent help from police, fire or ambulance services.

Telstra answers calls to the emergency service numbers 000 and 112 and transfers the call, and information about your location, to the emergency service you request.

You should only call 000 when:

- someone is seriously injured or in need of urgent medical help
- your life or property is being threatened
- you have just witnessed a serious accident or crime
- If a situation is not urgent, you should look up the number of your local police, fire or ambulance service.

Other emergency service numbers

Australia also has 2 other emergency service numbers, but they only work on some services:

- 112 can only be dialled on a mobile phone
- 106 can only be used with a teletypewriter (TTY) or a device for the deaf. 106 is a text-based emergency service number for people who are deaf, or who have a hearing or speech impairment

State Emergency Service (SES)

You cannot contact the SES by dialling 000. Calls to 000 can only be transferred to police, fire or ambulance services.

The phone number for all SES units is 132 500.

Antimicrobial Stewardship (AMS)

Policy Summary

- Prescribing and administration must comply with Therapeutic Goods Administration (TGA) and jurisdictional Poisons and Therapeutic Goods legislation.
- Adhere to Therapeutic Guidelines: Antibiotic (updated 2021).
- Report suspected antibiotic resistance to the client's GP and, if required, to public health authorities.
- Promote client education on safe and appropriate antibiotic use.

Procedure

1. **Governance and Oversight**
    - The Clinical Governance Committee oversees the Antimicrobial Stewardship (AMS) program.
    - The Clinical Governance Officer ensures compliance with national and jurisdictional standards.
    - AMS outcomes are reviewed quarterly and reported to management.
2. **Prescribing and Administration**
    - All antimicrobial prescribing must comply with:
        - *Therapeutic Goods Act 1989 (Cth)*.
        - State/Territory Poisons and Therapeutic Goods regulations.
    - Antibiotics must only be prescribed by authorised medical practitioners.
    - Nurses must verify:
        - Correct medication, dose, route, and duration.
        - Indication and documented prescriber order.
    - Administration records must be complete, legible, and stored securely
3. **Therapeutic Guidelines Compliance**
    - Adhere to *Therapeutic Guidelines: Antibiotic (2021)* for all prescribing and clinical decision-making.
    - Use narrow-spectrum antibiotics whenever clinically appropriate.
    - Avoid prophylactic or extended antibiotic use unless explicitly directed by a prescriber.
4. **Monitoring and Review**

- Monitor client response to antibiotic therapy at each visit.
- Observe for signs of adverse drug reactions or treatment failure.
- If antibiotic resistance is suspected:
  - Report immediately to the GP.
  - Escalate to the Clinical Governance Officer.
  - Notify public health authorities if required under local regulations.
- Document all observations, reports, and outcomes.

5. **Client and Carer Education**
   - Educate clients and carers on:
     - The importance of completing prescribed antibiotic courses.
     - Risks of self-medicating or sharing antibiotics.
     - Recognising and reporting side effects or allergic reactions.
     - Safe disposal of unused medications.
   - Provide written information where possible (e.g., DVA-approved leaflets).
6. **Data Collection and Reporting**
   - Maintain an AMS Log of all antibiotic use, including:
     - Indication, duration, prescriber, and review date.
   - Review data quarterly for prescribing trends and compliance issues.
   - Feed outcomes into CAPA and risk management reviews.
7. **Training and Continuous Improvement**
   - All clinical staff must complete annual AMS training.
   - Training includes antibiotic resistance awareness, prescribing protocols, and documentation standards.
   - Incorporate AMS compliance into internal audits and management reviews (ISO 9001 Clause 9.2 and NSQHS Standard 3).

5. Anaphylaxis Management Policy and Procedures

Purpose and Scope

Anaphylaxis is a severe, potentially life-threatening allergic reaction that occurs rapidly and requires immediate medical intervention, even if emergency medication has been administered on site.

This policy outlines the management of anaphylaxis, ensuring all staff are equipped to recognise, respond to, and prevent anaphylactic reactions.
All staff members must uphold the highest standards of care and strictly adhere to this policy, as timely and appropriate action is critical to safeguarding the individual's life.

We are committed to ensuring the safety of clients by:

- Promptly recognising and responding to anaphylaxis
- Ensuring all staff are trained in anaphylaxis management
- Maintaining appropriate equipment and medications
- Checking for expiry and completeness of Anaphylaxis kits at least monthly, or more frequently as per organisational policy

Definitions

- **Anaphylaxis**: A severe, potentially life-threatening allergic reaction.
- **Anaphylaxis Response Kit**: A kit equipped with the appropriate materials and procedures to assist in anaphylaxis management.
- **Adrenaline (Epinephrine)**: The first-line treatment for anaphylaxis.

Procedure

1. **Overview of Anaphylaxis**

   Anaphylaxis is a severe, potentially life-threatening allergic reaction that typically involves respiratory and/or cardiovascular symptoms. While mild or moderate allergic reactions may precede anaphylaxis, they may not always occur before a severe reaction.

2. **Prevention and Preparation**
   - Obtain and document allergy history from all clients.
   - Review and maintain action plans for clients with known allergies.
   - Ensure adrenaline auto-injectors are within expiry dates.
   - Review and maintain allergy and anaphylaxis response protocols. Refer to ASCIA's standard Action Plans for Anaphylaxis as a best-practice guide (www.allergy.org.au/anaphylaxis).

3. **Signs and Symptoms**

   Anaphylaxis should be suspected if any one of the following signs is present:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in the throat
- Difficulty talking or hoarse voice
- Wheeze or persistent cough (unlike the cough in asthma, the onset of coughing during anaphylaxis is usually sudden)
- Persistent dizziness or collapse
- Abdominal pain, vomiting

4. Staff Responsibilities in the Event of Anaphylaxis

If an anaphylactic response occurs, follow these steps:

- Administer adrenaline immediately via an auto-injector.
- Call emergency services (000) for an ambulance.
- Place the client in a lying position with legs elevated, unless breathing difficulties require them to sit.
- Administer additional adrenaline if no improvement after 5 minutes.
- Commence CPR at any time if the person is unresponsive and not breathing normally.
- Do not allow the DVA Client to stand or walk until they are haemodynamically stable, which is usually a minimum of 1 hour after 1 dose of adrenaline and 4 hours if more than 1 dose of adrenaline.

5. Post-Emergency Care

- Stay with the DVA Client until emergency services arrive.
- Notify next of kin and primary healthcare provider.
- Document the incident and treatment provided.

6. Equipment Required for Acute Management of Anaphylaxis

- Adrenaline auto-injectors (e.g., EpiPen) with current expiry dates
- Airway management devices (e.g., oropharyngeal airways)
- Bag-valve mask for assisted ventilation
- Blood pressure monitor
- Stethoscope
- Pulse oximeter
- Emergency contact list and action plans

7. **Training and Education**

   All nursing staff must complete annual training in:

   - Recognition of anaphylaxis
   - Administration of adrenaline
   - Emergency response protocols

8. **Documentation and Record-Keeping**
   - Maintain records of clients' allergies and action plans.
   - Document all anaphylaxis incidents and management.

9. **References**
   - Australasian Society of Clinical Immunology and Allergy (ASCIA) Resources: https://www.allergy.org.au/anaphylaxis
   - ASCIA Guidelines - HP Acute Management of Anaphylaxis 2024: https://www.allergy.org.au/hp/papers/acute-management-of-anaphylaxis-guidelines

6. Waste Management

Purpose

This policy ensures the safe, compliant, and environmentally responsible management of all types of waste generated by community nursing services in accordance with Safe Work Australia guidelines, state and territory environmental and health regulations, and industry best practices.

All waste shall be managed efficiently and effectively to minimise environmental impact. Staff shall actively work to reduce waste generation, prioritise the reuse of multi-use items, and recycle suitable materials wherever possible. This approach supports environmental sustainability while maintaining safe and compliant waste management practices.

All staff must adhere to waste segregation, handling, storage, transportation, and disposal procedures to protect staff, clients, and the environment while ensuring compliance with relevant Australian legislation.

Waste Management Principles

1. **Minimisation** – Reduce waste generation where possible.

2. **Segregation** – Correctly separate waste into appropriate categories.
3. **Safe Handling & Storage** – Ensure all waste is contained and stored safely before disposal.
4. **Compliance** – Follow all legislative and regulatory requirements.
5. **Environmental Responsibility** – Encourage recycling and responsible disposal practices.
6. **Documentation & Audit** – Maintain records of waste disposal and conduct regular compliance audits.

Waste Segregation and Collection

All waste must be correctly identified, segregated, and disposed of in designated waste bins or containers.

- **General Waste (Non-Hazardous):**
  - General waste is waste which can be disposed of in the general waste bins. It does not contain hazardous material, will not cause infection and does not contain private or confidential information.
  - General waste can be bagged at point of generation and disposed of in the general waste bins. Items such as incontinence pads may be disposed of in the general waste bin if they are securely bagged in a strong plastic bag to contain any odours or leakage.

  Disposal:

  - Place in black or dark green general waste bins.
  - Ensure secure bagging before disposal.

- **Clinical Waste (Biohazardous):**
  - Clinical waste is any waste that poses a potential risk of harm or infection, including items contaminated with blood or bodily fluids, such as dressings, gauze, and saturated bandages, as well as full sharps containers.
  - All clinical waste must be double-bagged and disposed of in designated clinical waste bins.
  - Pharmaceutical waste, including expired or unused medications, drug containers, IVs, tubes, bottles, syringes, and needles, should also be treated as clinical waste and handled according to regulatory requirements for safe disposal.

  Disposal:

- Double-bag all clinical waste before placing it in yellow-lidded clinical waste bins.
- Sharps must be placed in approved sharps containers (rigid, puncture-resistant, and yellow in colour).
- Arrange collection through a licensed clinical waste disposal service.

- **Pharmaceutical Waste (Including Controlled Substances)**:
  - Expired or unused medications, including controlled substances, that require proper disposal. Pharmaceutical waste shall be disposed of in accordance with the procedures outlined in the Medication Management section.
  - Place pharmaceutical waste in containers labelled “Pharmaceutical Waste” and keep them in a secure area until collection.

  Disposal:
  - Store in purple-lidded pharmaceutical waste bins (or other Safe Work Australia-approved hazardous waste containers).
  - Controlled substances:
    - Must be recorded in a disposal log and destroyed under supervised conditions.
    - Must be disposed of via a licensed pharmaceutical waste disposal service.
    - DO NOT dispose of controlled substances in general or clinical waste.

- **Cytotoxic Waste (Chemotherapy & Hazardous Medications)**

  Includes chemotherapy drugs, cytotoxic-contaminated materials, and waste from clients receiving cytotoxic treatments, such as:
  - Cytotoxic medication containers and administration materials (IV bags, tubing, syringes)
  - PPE and contaminated dressings
  - Urine, faeces, and bodily fluids of DVA Clients receiving cytotoxic therapy (handled within 7 days of treatment)

  Disposal:
  - Use purple-lidded cytotoxic waste bins or purple hazard bags.
  - All cytotoxic waste must be sealed, labelled, and securely stored before collection by a licensed cytotoxic waste disposal provider.

  ⚠ Precaution:

- Staff handling cytotoxic waste must use special PPE.
- Avoid direct contact with contaminated materials.

- **Confidential Waste:**
  - Confidential waste includes any documents or materials that contain private, personal, or commercially sensitive information.
  - To protect privacy, all confidential waste should either be shredded or have personally identifiable information redacted before disposal. This ensures compliance with privacy laws and prevents unauthorised access to sensitive information.

Recycling: Recyclable waste, such as paper, plastic, glass, and metal that can be safely recycled, should be disposed of in recycling bins. Staff should make every effort to correctly separate and dispose of recyclable materials to support environmental sustainability efforts.

- **Bulky Waste (Incontinence Aids, Large Disposable Items):**

Includes bulky disposable items used in community care, such as:

- Incontinence pads, adult nappies, sanitary products
- Disposable bed protectors
- Other bulk medical disposables

Disposal:

- Double-bagged and placed in general waste bins.
- Ensure bags are strong and leak-proof to contain odours.

⚠ Alternative Disposal:

If disposal volumes are high, a clinical waste collection service should be used.

Glossary of Waste Types

Clinical Waste – Items contaminated with blood or bodily fluids (e.g., dressings, gloves, swabs). Dispose in yellow-lidded clinical waste bins.

Pharmaceutical Waste – Expired or unused medications. Includes Schedule 8 drugs. Store in purple-lidded bins for licensed collection.

Cytotoxic Waste – Waste from chemotherapy (e.g., PPE, IVs, contaminated dressings). Use purple-lidded cytotoxic bins.

Sharps Waste – Needles, syringes, and lancets. Use yellow, puncture-proof sharps containers.

Confidential Waste – Client documents or labels with personal information. Shred or securely destroy.

Waste Handling & Disposal Procedures

Refer to Safe Work Australia's 'Cytotoxic Drugs and Related Waste – Risk Management Guide' for PPE and disposal protocols

1. All waste must be placed in appropriate containers and segregated at the point of generation.
2. Label all waste containers clearly with the correct waste category.
3. Securely seal waste bags or containers before disposal or collection.
4. Clinical, pharmaceutical, and hazardous waste must be disposed of via licensed waste disposal services in accordance with Australian state and territory regulations.
5. Maintain compliance with environmental and health regulations for waste transportation and disposal.

Waste Disposal

- Coordinate with approved waste disposal services for regular collection of clinical, pharmaceutical, and hazardous waste.
- Ensure that all waste is transported and disposed of in compliance with environmental regulations and state/territory guidelines.
- General waste can be disposed of through standard waste removal services as per local council guidelines. Ensure bins are securely closed to prevent pests and accidental spillage.
- All sharps must be disposed of in designated, puncture-resistant sharps containers. Once containers are full, they should be sealed and disposed of via a licensed disposal service.

Sharps Management

- **Use approved sharps containers** at the point of care.
- Containers must be:
    - Clearly labelled "SHARPS".
    - Puncture-resistant, leak-proof, and conforming to AS 4031.

    - Replaced when ¾ full and sealed before transport or disposal.
- Staff must never recap, bend, or remove needles.
- Report sharps injuries immediately and complete an **Incident Report Form**

Storage and Transport

- Clinical and sharps waste must be stored in a designated secure area, away from public access.
- Waste awaiting collection must be in sealed, labelled containers.
- Transport only via **licensed clinical waste contractors** in compliance with environmental and transport regulations.

Documentation and Record-Keeping

Maintain a waste disposal log for **clinical, hazardous, and pharmaceutical waste** documenting the following:

- Date and time of waste disposal
- Type and quantity of waste
- Method of disposal (e.g., returned to pharmacy)
- Name of the waste disposal service

Incident Reporting

- Document any waste management incidents in the incident report system.
- Record corrective actions taken and review the incident for any needed changes to waste management practices.

Staff Training and Compliance

- All staff must complete training on waste handling, segregation, disposal procedures, and spill management.
- Training should be conducted annually and whenever regulatory changes or updates to this policy occur.

Regular Audits

- Regular audits shall be conducted of waste management practices to ensure compliance with this policy and identify areas for improvement.

- Audit findings shall be used to adjust procedures and provide targeted training to address any compliance gaps.

7. Infection Control

Purpose

The company is committed to providing safe, high-quality care by implementing effective infection control practices to prevent the spread of infections. All staff must adhere to the infection control procedures outlined in this document to ensure the safety of clients, their families, and staff members.

Evidence-Based Infection Prevention Framework

The organisation maintains an evidence-based infection prevention and control system aligned with national standards and guidance, including:

- National Hand Hygiene Initiative
- Australian Guidelines for the Prevention and Control of Infection in Healthcare
- Australian Immunisation Handbook
- Antimicrobial Stewardship Clinical Care Standard
- Australian Therapeutic Guidelines
- Department of Health and Aged Care – Infection Prevention and Control in Aged Care

These references guide organisational policies, staff training, clinical practice, and quality improvement activities.

Evaluation and Response to Infection Risks

Infection risks are identified through clinical assessment, incident reporting, staff feedback, audits, and monitoring of client health status.

Identified infection risks are evaluated by a Registered Nurse and managed through appropriate escalation, infection control precautions, referral to medical practitioners where required, and review of care practices.

All infection incidents and control measures are documented and reviewed as part of continuous quality improvement.

Equipment and Reusable Device Management

The organisation maintains systems to assess infection risks associated with new equipment, devices, and products prior to clinical use.

All reusable equipment utilised across multiple clients is cleaned, disinfected, or reprocessed in accordance with manufacturer instructions and relevant infection control guidelines.

Equipment is routinely maintained, repaired, and upgraded as required, with records retained to demonstrate safety and compliance.

Definitions

- **Infection Control:** Measures implemented to prevent and control the spread of infectious diseases by minimising or eliminating sources of infection and interrupting the transmission pathways, in alignment with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.
- **Standard Precautions:** The minimum infection prevention and control practices that must be applied to all client care, regardless of the client's infectious status, as per nationally agreed definitions. These precautions include hand hygiene, use of personal protective equipment (PPE), respiratory hygiene, environmental cleaning, safe handling and disposal of sharps, and cleaning and disinfecting of shared client care equipment.
- **Transmission-Based Precautions:** Additional infection prevention and control measures required when caring for clients with known or suspected infections that are transmissible by contact, droplet, or airborne routes. These precautions are used in addition to standard precautions to prevent the spread of infection and are consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.
- **Antimicrobial Stewardship (AMS):** A coordinated approach to promoting the appropriate use of antimicrobials to improve client outcomes, reduce resistance to antibiotics, and decrease the spread of multi-drug-resistant organisms.

1. **Responsibilities for Infection Prevention and Control**
    - Executive Management: Responsible for ensuring adequate resources, support, and training are provided for infection prevention and control.
    - Infection Control Officer (ICO): Responsible for monitoring compliance, leading audits, and overseeing infection control strategies.

- Care Manager: Coordinates infection control efforts, including communication with clients, GPs, and health services, and ensures adherence to infection control policies.
- Staff Members: Responsible for following infection control procedures, attending training sessions, and reporting non-compliance or risks.

2. Equipment Safety & Infection-Risk Management

- **Evaluation of New Equipment, Devices and Products**

  Our organisation maintains processes to ensure all new clinical equipment, reusable devices, and infection-prevention products are assessed before use with clients. This assessment considers infection-control risks, safe use, and compliance with the DVA Notes for Community Nursing Providers (effective November 2025).

  Before introducing new equipment or products, the organisation will:

  Review manufacturer instructions for infection-prevention requirements, cleaning methods, and safe handling.

  Assess whether the item can be safely cleaned, disinfected or sterilised according to best-practice standards.

  Confirm the item is suitable for use in a community environment and does not introduce additional infection risks.

  Document the assessment and approval prior to the equipment being used with clients. Provide staff with training or instruction (as required) to ensure correct use, cleaning and storage.

  The Registered Nurse in charge is responsible for ensuring that any new clinical device meets infection-prevention requirements and that staff understand their responsibilities prior to use.

- **Maintenance, Repair and Upgrading of Existing Equipment**

  To minimise infection risk and ensure equipment remains safe for client care, the organisation implements routine maintenance and repair processes for all reusable clinical equipment and devices. These processes include:

  Ensuring all reusable equipment is kept in safe, clean working order, following manufacturer schedules for servicing, recalibration, and safety checks.

  Removing equipment from service immediately if it is damaged, unsafe, or cannot

be effectively cleaned. Documenting all maintenance, repairs, replacements and upgrades.

Reviewing infection-control requirements whenever repairs or upgrades occur to ensure the equipment continues to meet best-practice standards.

Reinforcing staff responsibilities for ongoing daily cleaning, storage and correct use of reusable equipment.

Equipment may only return to service once it is confirmed safe, functional, and able to be cleaned or disinfected according to infection-control standards.

- **Cleaning of Reusable Devices Used on Multiple Clients**

  Reusable devices that are used across more than one client are cleaned and disinfected according to:

  Manufacturer recommendations Infection-prevention best practice The organisation's Infection Prevention and Control Policy Cleaning processes are documented, monitored through routine audits, and reinforced through ongoing staff competency assessments.

3. Processes for Assessing Compliance

- **Compliance Monitoring:** Regular audits of hand hygiene, PPE usage, sharps management, environmental cleaning, and disinfection activities.
- **Quality Improvement Plan:** Address areas for improvement identified during audits and non-compliance investigations.
- **Reporting:** Audit outcomes and compliance rates are reported to management and included in organisational reporting structures.

4. Standard Precautions

Standard precautions are applied during all client interactions to reduce the risk of infection transmission. In a home care setting, standard precautions include:

4.1. Hand Hygiene

- Perform hand hygiene using soap and water or an alcohol-based hand rub:
  - Before entering and after leaving the client's home.
  - Before and after direct client contact.
  - After contact with blood, bodily fluids, or contaminated items.
  - After removing gloves or other PPE.
- Encourage clients and family members to practice regular hand hygiene.

- **Hand Hygiene Program:**
    - The organisation maintains a formal Hand Hygiene Program aligned with the National Hand Hygiene Initiative (NHHI) and jurisdictional infection control requirements.

Objectives

- Prevent infection transmission among clients, staff, and the community.
- Achieve full compliance with the NHHI “Five Moments for Hand Hygiene”.
- Monitor, audit, and continuously improve hand hygiene practices.

Program Elements

1) Education and Training

Mandatory hand hygiene training at induction and annually thereafter.

Training content based on NHHI and Australian Guidelines for the Prevention and Control of Infection in Healthcare.

Competency records are maintained in the Staff Training Register.

2) Monitoring and Auditing

Quarterly audits conducted by the Infection Control Officer using NHHI tools.

Results discussed at Clinical Governance meetings and included in Quality Improvement Reports.

Corrective action plans implemented for any non-compliance.

3) Facilities and Supplies

Adequate soap, alcohol-based hand rub, and single-use towels are available for all staff; portable kits are provided for home visits.

4) Client and Carer Engagement

Staff provide education and prompts to clients and carers on effective hand hygiene.

5) Reporting and Continuous Improvement

Quarterly compliance summaries are reported to management; persistent non-compliance triggers retraining or disciplinary action.

- References

Australian Commission on Safety and Quality in Health Care (2024), National Hand Hygiene Initiative Implementation Guide.

- NHMRC (2021), Australian Guidelines for the Prevention and Control of Infection in Healthcare.

DVA (2025), Notes for Community Nursing Providers – November 2025.

4.2. Personal Protective Equipment (PPE)

- Use PPE based on the task and level of exposure risk in the home setting:
    - Gloves: Wear gloves when in contact with blood, bodily fluids, or contaminated surfaces.
    - Masks and Eye Protection: Use face masks and eye protection when there is a risk of splashing or aerosol generation.
    - Gowns: Wear gowns to protect skin and clothing when providing care that may involve direct contact with bodily fluids.
- Ensure PPE is disposed of appropriately within the client's home after use.

4.3. Respiratory Hygiene and Cough Etiquette

- Educate clients and family members on covering their mouth and nose with a tissue or elbow when coughing or sneezing.
- Dispose of tissues immediately in a sealed bag and encourage hand hygiene afterward.

4.4. Environmental Cleaning and Disinfection

- Clean and disinfect high-touch surfaces within the client's immediate care area regularly, especially after performing procedures.
- Use disinfectants appropriate for home care settings and compliant with Australian standards.
- Regularly monitor and audit the cleaning practices to ensure adherence to the Australian Guidelines for Prevention and Control of Infection in Healthcare and identify areas for improvement.

4.5. Equipment Sterilisation

- Sterilise reusable equipment (e.g., stethoscopes, thermometers) between each client visit.
- Use single-use equipment when possible to minimise cross-contamination risks.

5. Aseptic Technique

Aseptic technique is a set of practices that protect DVA Clients from healthcare-associated infections and protects healthcare workers (HCW) from contact with blood, body fluid and body tissue. Aseptic technique is required for procedures where contamination could introduce infection.

Aseptic technique, when performed correctly will:

- Minimise contamination of key sites
- Protect DVA Clients from their own pathogenic microorganisms that may cause infection
- Reduce the transmission of microorganisms
- Maintain the sterility of equipment and key parts used for aseptic procedures

For optimal aseptic technique to occur, all the elements of standard precautions must be used by the healthcare worker.

5.1. Principles of Aseptic Technique

Aseptic technique involves:

- Key-Part Protection: Ensuring sterile equipment (e.g., needles, syringes, catheters) remains sterile until use.
- Key-Site Protection: Avoiding contamination of vulnerable DVA Client sites (e.g., open wounds, IV insertion points, urinary catheters).
- Hand Hygiene & PPE: Performing hand hygiene before and after procedures and using appropriate sterile gloves, masks, and gowns.
- Non-Touch Technique: Avoiding direct hand contact with sterile areas and maintaining a sterile field.
- Sterile Equipment and Environment: Using single-use sterile supplies where applicable and ensuring a clean clinical area.

5.2. Procedures Requiring Aseptic Technique

Procedures requiring aseptic technique include, but are not limited to:

- Wound Care and Dressing Changes
- Catheterisation and Urinary Care

- Injection and Medication Administration – Intravenous (IV), intramuscular (IM), subcutaneous (SC), and intradermal (ID) injections
- Enteral and Parenteral Nutrition – Gastrostomy tube management and IV feeding

5.3. Principles of Aseptic Technique

There are essential principles that should be applied when performing a procedure that requires aseptic techniques. These principles are:

5.3.1. Sequencing: a series of actions that ensure each procedure is performed in a safe and appropriate order. Sequencing includes assessing risks to DVA Client safety and the HCW and identifying strategies to mitigate these risks prior to starting the procedure. When considering the steps for sequencing, the HCW should consider the following points:

- Performing a risk assessment:
  - Are there environmental or DVA Client factors that increase the risk for the procedure?
  - Is the procedure technically difficult or an emergency situation?
  - Is there a risk of infection transmission or contamination risk with this procedure?
  - Do you know how to perform this procedure?
  - What PPE do you need for this procedure?
  - What action is required to mitigate these risks?
- Pre-procedure preparation
  - Prepare the environment
  - Select the correct equipment; check the condition, integrity and expiry date of each item required for the procedure
  - Plan each step of the procedure to avoid a breach in asepsis
  - Inform the DVA Client and prepare them for the procedure
- Performing the procedure
  - Set up the equipment immediately prior to performing the procedure
  - Maintain standard precautions
  - Perform the procedure in a safe, logical order

- Post procedure practices, handover and documentation
    - Remove gloves and perform hand hygiene
    - Settle the DVA Client
    - Pack away equipment and dispose of waste
    - Document the outcome from the procedure including any breaches in asepsis, any corrective actions taken at the time of the procedure to minimise any infection risks or if multiple attempts were required to complete the procedure

5.3.2. Environmental control

There are many factors which can increase the risk of infection and DVA Client harm during a procedure. These factors include:

- Other activities that are occurring in the nearby environment that may increase the risk of contamination during the procedure (e.g. for example bed making, dusting, or cleaning)
- Fans and open windows can cause air turbulence and contamination of the aseptic field.

Prior to aseptic procedures, ensure there are no avoidable nearby environmental risk factors.

5.3.3. Hand hygiene: Perform hand hygiene before a procedure and after a procedure or body fluid exposure.

Hand and wrist jewellery must be removed prior to the procedure and performing hand hygiene. If gloves become grossly contaminated or torn during a procedure, the gloves need to be removed, hand hygiene must be performed, and new gloves applied.

5.3.4. Maintenance of aseptic fields

Ensure that the aseptic field, the key parts, and key sites are always protected.

- Cleaning and/or disinfection of equipment and DVA Client prior to procedure(s)
- Establishing an aseptic field
- Use of sterile equipment
- Maintenance of the aseptic field, including protecting the key sites and key parts

- Use of a non-touch technique

5.3.5. PPE: Correct selection and use of sterile and non-sterile PPE

Consider the following points:

- What PPE is required to protect the DVA Client, the aseptic field and yourself during the procedure?
- What is the correct sequence for putting on and removing PPE?

6. Transmission-Based Precautions

For clients with known or suspected infections that are highly transmissible, apply transmission-based precautions in the home as follows:

6.1. Contact Precautions

- Use gloves and gowns for all interactions with the client and their environment.
- Minimise contact with surfaces within the client's home and bring only essential equipment.

6.2. Droplet Precautions

- Wear a surgical mask when within close proximity of the client if respiratory symptoms are present.
- Encourage the client to wear a mask when interacting closely with staff.

6.3. Airborne Precautions

- Use a fit-tested N95 respirator if the client is known or suspected to have an airborne infection.
- Conduct care in a well-ventilated area of the home, if possible, and limit exposure time.

7. Incident Management and Reporting

7.1. Exposure Incidents

- In the event of an exposure incident (e.g., needlestick injury, contact with infectious material), immediately perform appropriate first aid and report to the Care Manager.
- The Care Manager will assess the exposure and initiate any required follow-up, including medical evaluation and incident documentation.

7.2. Infection Outbreaks

If an outbreak occurs within a client's home or affects multiple clients, implement enhanced infection control measures, including increased PPE use, additional environmental cleaning, and notification of relevant health authorities as per regulatory requirements.

7.3. Documentation

- Document any infection control incidents in the incident report system.
- Record corrective actions taken and review the incident for any needed changes to infection control practices.

8. Tools for Assessment, Reporting, and Review of Infection Control Risks

- **Risk Assessment Tools:** Infection control risk assessments will be conducted at the commencement of services and regularly during ongoing care. The risk assessment process will identify potential hazards, determine risk levels, and document risk mitigation strategies. Tools include risk matrix and infection control checklist.
- **Reporting Tools:** Staff must report any infection control incidents, potential exposures, and near misses using the Incident Report Form. These reports are reviewed and logged into the Incident Management System for follow-up actions.
- **Review Tools:** Infection control practices and incident reports will be reviewed during regular audits and post-incident reviews. The review process will identify areas for improvement, update training content, and support the continuous improvement of infection control protocols.
- **Quality Improvement Plan:** Audit outcomes are used to inform a continuous quality improvement plan. Corrective actions and training are implemented as needed.
- **Client Involvement:**
  - Information on infection prevention shall be available in culturally and linguistically appropriate formats.
  - Clients shall be encouraged to engage in decisions about their care and infection control measures.

- **Infection Risk Communication:** Infection risk must be communicated when care is transferred between clinicians or health services.
    - **Pre-Transfer Communication:** Prior to transferring a client's care to another clinician or health service, the responsible staff member must communicate all relevant infection-related information.
        - This includes the client's current infection status, any recent exposure to infectious agents, the use of transmission-based precautions, and ongoing antimicrobial therapy.
        - All infection-related details must be documented in the client's transfer summary or discharge summary.
    - **Communication Tools:** Phone or electronic handovers are used to ensure infection control information is effectively transferred.

9. Processes and Responsibilities Relating to Antimicrobial Stewardship (AMS)

- **Lines of Communication with Client's GP:** Communication with the client's GP is essential for ensuring the appropriate use of antimicrobials. Staff must communicate any signs of infection to the GP promptly.
- **Prescribing and Therapy Duration:** Where applicable, staff must obtain information on the antimicrobial prescribed, dosage, and the expected duration of therapy. This information must be documented in the client's care record.
- **Monitoring and Review:** Staff must monitor the client's response to antimicrobial therapy, noting any adverse effects or signs of resistance. Any concerns must be promptly escalated to the GP.
- **Roles and Responsibilities:**
    - **RN:** Responsible for coordinating communication with the GP and ensuring that information on the prescribed antimicrobial and its duration is accurately recorded.
    - **Staff:** Responsible for monitoring the client's response to antimicrobial therapy and reporting concerns or changes in the client's condition.
    - **GP:** Responsible for prescribing antimicrobials, advising on appropriate duration, and providing guidance on any necessary adjustments to treatment.

10. Mandatory Infection Control Training

10.1. Training Schedule

- **Induction Training**: All new staff must complete infection prevention training as part of their induction program before commencing duties.
- **Annual Training**: All staff must complete annual refresher training to reinforce infection prevention knowledge and ensure continued compliance.
- **Ad-Hoc Training**: Additional training must be provided whenever infection control guidelines are updated, new risks are identified, or new equipment, procedures, or PPE are introduced.

10.2. Training Content

Training content must include but is not limited to the following key topics:

- **COVID-19 Specific Protocols**: Updates on COVID-19 infection prevention measures and relevant jurisdictional requirements.
- **Hand Hygiene**: Techniques for proper handwashing and the correct use of hand sanitiser, in line with the National Hand Hygiene Initiative.
- **Personal Protective Equipment (PPE)**: Correct selection, donning, doffing, and disposal of PPE, including gloves, masks, gowns, and eye protection.
- **Standard and Transmission-Based Precautions**: Guidance on how to apply standard precautions and implement contact, droplet, and airborne precautions where necessary.
- **Cleaning, Disinfection, and Waste Disposal**: Procedures for cleaning high-touch surfaces, disinfecting reusable equipment, and disposing of clinical and general waste.
- **Incident Reporting**: Reporting exposure incidents, handling infection outbreaks, and following escalation protocols.

10.3. Record Keeping

- Training records must be maintained for all staff, detailing participant names, training dates, topics covered, and assessment outcomes.
- Documentation must be retained as part of the company's compliance records and made available for audits and inspections.
- Evidence of training completion must be available upon request by regulatory authorities or during internal audits.

11. Audits and Compliance Monitoring

- Regular audits shall be conducted to assess adherence to infection control practices in clients' homes, identify areas for improvement, and ensure alignment with community nursing standards.

  The scope of the audits shall include, but is not limited to:
  - Hand hygiene practices, including education and competency assessments.
  - Use of personal protective equipment (PPE).
  - Safe handling and disposal of clinical waste.
  - Cleaning and disinfection of reusable equipment.
  - Adherence to standard and transmission-based precautions.
- Audit results shall be thoroughly reviewed by management to identify non-compliance, potential risks, and areas for improvement. Corrective actions, including staff re-education, policy revisions, and additional training, will be implemented promptly.
- All audit findings, including identified non-conformities, corrective actions taken, and follow-up reviews, must be documented and securely maintained as part of the company's compliance records. Documentation will also include a schedule for ongoing audits to ensure continuous compliance and quality improvement.
- Audit reports shall be submitted to relevant regulatory bodies as required and made available during inspections or upon request.

Reference

- National Hand Hygiene Initiative

- Australian Guidelines for the Prevention and Control of Infection in Healthcare
- Australian Immunisation Handbook
- Antimicrobial Stewardship Clinical Care Standard
- Australian Therapeutic Guidelines
- Department of Health and Aged Care - COVID-19 Resources and Training

8. Work Health and Safety (WHS) Policy and Procedure

Purpose and Scope

This policy outlines the company's commitment to fostering a culture of safety and providing clear guidelines for managing risks in community nursing services delivered at clients' homes.
This policy and procedure apply to all employees, contractors, and visitors at all workplaces where services are provided.

This policy is developed in compliance with the following legislation and guidelines:

- Work Health and Safety Act 2011
- Work Health and Safety Regulations 2011
- Department of Veterans' Affairs (DVA) Notes for Community Nursing Providers

Procedures

1. WHS Responsibilities

1.1. Management Responsibilities

- Ensure compliance with WHS laws, regulations, and standards.
- Provide training, information, and supervision to employees to ensure safe work practices are followed.
- Conduct regular risk assessments and safety audits for all client home environments where services are provided.
- Ensure incidents, hazards, and near-misses are reported, investigated, and addressed promptly.
- Promote a culture of continuous improvement in workplace health and safety.

1.2. Employee Responsibilities

- Comply with all WHS policies, procedures, and safe work practices.
- Take reasonable care of their own health and safety and that of others.
- Report any incidents, hazards, or unsafe practices to management.

- Participate in WHS training and follow instructions for safe work practices.
- Use personal protective equipment (PPE) as required.

1.3. Client and Family Responsibilities

- Ensure the home environment is free from foreseeable hazards that may endanger the health and safety of nursing staff.
- Notify the nursing provider of any known hazards or risks in the home environment.

2. Hazard Identification

2.1. Routine Inspections:

- Conduct regular inspections of client homes to identify potential hazards such as:
  - Slippery floors
  - Inadequate lighting
  - Trip hazards
  - Unsafe equipment or environments
- Document findings using a hazard identification checklist.

2.2. Incident Reporting:

- Promptly report hazards and incidents through the designated reporting system.
- Review and investigate incident reports to identify systemic issues.

2.3. Client-Specific Risks:

- Assess unique risks associated with individual client needs and home environments, including:
  - Mobility challenges
  - Exposure to hazardous materials
  - Unsafe handling of medical equipment

3. Risk Assessment and Control

3.1. Risk Assessment:

- Prioritise hazards based on the severity of potential harm and likelihood of occurrence.
- Use a risk assessment matrix to categorise risks into high, medium, or low levels.

3.2. Control Measures:

- Implement controls following the Hierarchy of Controls:
  - **Elimination**: Remove the hazard, such as repairing unsafe furniture or equipment.

- **Substitution**: Use safer alternatives, such as non-slip mats.
- **Engineering Controls**: Provide assistive devices like hoists for manual handling.
- **Administrative Controls**: Develop safe work procedures specific to community nursing tasks.
- **Personal Protective Equipment (PPE)**: Ensure staff have access to and use appropriate PPE (e.g., gloves, masks, gowns).

3.3. Client Collaboration:

- Work with clients and their families to address hazards identified within their homes.

4. Training and Education

4.1. Onboarding and Refresher Training:

- Deliver comprehensive WHS training for new staff during onboarding.
- Provide annual WHS refresher courses covering:
  - Hazard identification
  - Safe handling of medical equipment
  - Infection control and prevention

4.2. Toolbox Talks:

- Conduct monthly toolbox talks addressing common hazards and safety strategies in community nursing, such as:
  - Manual handling techniques
  - Safe disposal of sharps
  - Emergency procedures

4.3. Client Awareness:

- Educate clients and their families on their role in maintaining a safe home environment.

5. Incident Response

5.1. Reporting and Investigation:

- Require immediate reporting of all incidents, injuries, and near misses using the company's WHS Incident Report Form.
- Investigate incidents to:
  - Identify root causes

- Document findings in an Incident Report

5.2. Corrective Actions:

- Develop and implement action plans to address identified risks.
- Monitor the effectiveness of corrective actions.

5.3. Support for Affected Individuals:

- Provide support to employees, clients, or others affected by incidents, including access to counselling services if necessary.

6. Monitoring and Continuous Improvement

6.1. Performance Monitoring:

- Collect and analyse WHS data, including incident trends and hazard reports, to assess the effectiveness of safety measures.
- Use KPIs, such as incident response times and reduction in hazards, to track progress.

6.2. Annual Review:

- Review WHS policies and procedures annually to ensure they reflect:
  - Current legislation
  - Industry best practices
  - Feedback from employees and clients

6.3. Staff and Client Feedback:

- Solicit regular feedback from employees and clients to identify potential improvements in WHS practices.
- Actively involve staff in safety discussions and decision-making.

Emergency and Disaster Management

Policy Summary

- Maintain an Emergency Response Plan in accordance with State/Territory emergency management frameworks.
- Train staff annually in fire safety, evacuation, and disaster response.
- Ensure access to emergency equipment (first aid kits, defibrillators, communication devices).
- Establish procedures for continuity of services during floods, bushfires, pandemics, and other disasters.

Procedure

Governance and Planning

- The organisation maintains an Emergency and Disaster Management Plan (EDMP) that covers preparedness, response, and recovery.
- The plan complies with State/Territory Emergency Management Acts and aligns with:
    - NSQHS Standard 1 – Clinical Governance
    - ISO 9001:2015 – Operational Control and Business Continuity
    - DVA provider obligations for service continuity
- The Clinical Governance Officer oversees plan implementation and review.
- The Emergency and Disaster Management Plan is aligned with the organisation's Business Continuity Plan to ensure coordinated preparedness, response, and service recovery during disruptions. Both documents are reviewed together during annual audits and post-incident reviews

Risk Assessment and Preparedness

- Conduct an annual emergency risk assessment identifying location-specific hazards such as:
    - Fire, flood, bushfire, severe storms.
    - Power outages and equipment failures.
    - Pandemics or infectious disease outbreaks.
    - Cybersecurity or communication disruptions.
- Document risks and controls in the Risk Register
- Ensure emergency contact lists, evacuation maps, and roles/responsibilities are current and accessible.

Training and Drills

- All staff must complete annual emergency and disaster response training, including:
    - Fire safety and evacuation procedures.
    - First aid and CPR/BLS refreshers.
    - Pandemic and infectious disease protocols.
    - Crisis communication and coordination.

- Conduct mock drills or tabletop exercises at least annually; document outcomes and improvement actions.

Emergency Equipment

- Maintain and routinely inspect emergency response equipment:
  - First aid kits (fully stocked and within expiry).
  - Automated External Defibrillator (AED) – tested monthly.
  - Fire extinguishers, alarms, and smoke detectors.
  - Communication devices (mobile phones, radios).
- Equipment checklists and maintenance logs maintained for audit.

Response Procedures

- In the event of an emergency:
  - Activate the Emergency Response Plan.
  - Ensure staff and client safety first.
  - Notify emergency services (000) and management immediately.
  - Follow evacuation or shelter-in-place procedures as appropriate.
- Maintain clear communication lines with staff, clients, and authorities.
- Document all actions, timelines, and communications in an Incident Report Form

Business Continuity and Service Recovery

- Implement contingency plans to maintain essential community nursing services during disruptions.
- Key priorities include:
  - Maintaining contact with vulnerable clients.
  - Ensuring medication supply continuity.
  - Protecting client records and data
- Post-event recovery includes:
  - Damage assessment and restoration of operations.
  - Debriefing staff and psychological support if needed.
  - Integrate lessons learned into revised policies.

Review and Continuous Improvement

- The Emergency and Disaster Management Plan is reviewed:

  - Annually, or
  - After any actual emergency or major drill.
- Audit outcomes, drills, and incident reviews feed into the CAPA system for ongoing improvement.

Business Continuity Planning (BCP)

Policy Summary

- Maintain a documented Business Continuity Plan (BCP) that identifies essential services, critical staff, and contingency arrangements.
- Back up all client records daily in compliance with the *Privacy Act 1988 (Cth)*.
- Test continuity and IT recovery systems at least annually.
- Establish agreements with partner providers to ensure care continuity in case of service disruption.

Procedure

1. **Purpose and Scope**
   - The **Business Continuity Plan (BCP)** ensures uninterrupted delivery of essential community nursing services during and after disruptions (e.g., power outages, system failures, pandemics, or natural disasters).
   - Applies to all staff, systems, and client services under the organisation's operations.
2. **Governance and Responsibilities**
   - The **Clinical Governance Officer** is responsible for developing, implementing, and maintaining the BCP.
   - Department Heads ensure continuity measures are in place for their respective functions (clinical, HR, IT, admin).
   - Staff are trained on continuity procedures as part of annual compliance training.
3. **Identification of Essential Services and Critical Roles**
   - The BCP identifies:
     - **Essential Services** – Clinical care, medication administration, wound care, emergency response, client communication.
     - **Critical Roles** – Clinical Managers, RNs, IT administrators, Client Coordinators.

        - **Critical Dependencies** – IT infrastructure, communication systems, supplier and partner networks.
    - Each essential service has defined **maximum allowable downtime** and recovery priorities.
4. **Data Backup and Information Security**
    - All electronic client records are **backed up daily**, with:
        - Encrypted cloud storage and local redundancy
        - Access restricted to authorised personnel.
        - Retention and deletion policies compliant with the *Privacy Act 1988 (Cth)*.
    - Paper records (if any) stored in secure, fire-resistant filing systems.
5. **Contingency and Continuity Measures**
    - In case of disruption:
        - Activate the **Business Continuity Plan**.
        - Redirect client calls and services to designated backup sites or partner providers.
        - Prioritise critical clients (e.g., palliative, high-dependency, post-surgical).
    - Maintain manual documentation if electronic systems are down.
    - Communicate updates to staff, clients, and DVA as required.
6. **Partnership and Outsourcing Agreements**
    - Establish and maintain **formal agreements (MOUs or SLAs)** with partner nursing providers and suppliers to ensure care continuity.
    - Ensure partner organisations meet ISO and NSQHS requirements for clinical safety, data privacy, and service quality.
7. **Testing, Review, and Maintenance**
    - Conduct **annual testing** of:
        - Emergency communication systems.
        - IT recovery processes and data restoration.
        - Staff response and coordination.
    - Document test results, lessons learned, and improvement actions
    - Review and update the BCP:
        - Annually, or
        - After any major incident or organisational change.
8. **Audit and Continuous Improvement**

- BCP compliance is reviewed as part of annual **internal audits and management reviews**.
- Non-conformities addressed and monitored by the Clinical Governance Committee

Section 8 Information and Data Management

1. Purpose and Scope

This policy outlines the principles and practices for managing information, privacy, documentation, and record-keeping to ensure compliance with the DVA Notes for Community Nursing Providers, Aged Care Quality Standards, and relevant Australian privacy laws. The policy ensures that all client information is managed confidentially, securely, and in accordance with legal and regulatory requirements.

This clinic is committed to protecting the privacy, confidentiality, and integrity of client and organisational information. Information and data management will comply with the Privacy Act 1988 (Cth), the Australian Privacy Principles (APPs), the My Health Records Act 2012 (Cth), and contractual obligations under the Department of Veterans' Affairs (DVA) Community Nursing Program.

All staff must handle information responsibly, ensure accuracy, maintain security, and uphold legal, ethical, and professional standards in managing client data.

This policy applies to all staff, contractors, and third-party service providers involved in community nursing services provided to clients in their homes.

Key Legislative and Regulatory Frameworks

- Privacy Act 1988 (Cth)
- Australian Privacy Principles (APPs)
- Aged Care Quality Standards

- DVA Notes for Community Nursing Providers
- State and Territory Health Records Acts

2. Procedures

1. Privacy and Confidentiality

1.1. Collection of Information

- Collect only information necessary for the delivery of high-quality community nursing services.
- Obtain informed consent from clients before collecting any personal or health information.

1.2. Use and Disclosure

- Use client information solely for its intended purpose or as required by law.
- Share information only with authorised personnel or as agreed upon with the client.

1.3. Access and Correction

- Allow clients access to their information upon request, in compliance with the APPs.
- Correct inaccuracies in client records promptly.

1.4. Breach Management

Report and investigate any data breaches in line with the Notifiable Data Breach Scheme.

2. Documentation Standards

2.1. Timeliness

Document all client interactions and care provided immediately or within 24 hours.

2.2. Accuracy

- Ensure documentation is clear, factual, and free from errors.
- Avoid subjective or personal opinions unless relevant to care.

2.3. Professionalism

Use professional language and approved abbreviations in all documentation.

2.4. Client Involvement

Engage clients in documenting care plans and service agreements whenever possible.

3. Record-Keeping and Management

3.1. Types of Records

3.1.1. Client Records

All records and information related to the client and the care service provision are categorised as client records. Client records include:

- valid referrals
- assessments
- nursing care plans
- clinical nursing notes
- dated reviews of care and the outcomes
- related care documentation
- claiming history

3.1.2. Staff Records

All information related to the workers and employees is categorised as staff records. These include:

- Employment Agreement
- Performance Appraisal
- Background Checks
- Academic Records or Degrees
- Certification or Licensing Records

3.1.3. Governance Records

All company related documentation is categorised as governance records. This includes:

- Policies and procedures, protocols, templates
- Business plan
- Reports
- Compliance records
- Risk register

3.1.4. Financial Records

Financial records include:

- Annual Budget

- ACFR and QFRs
- P&L Reports
- Monthly Expense Reports

3.1.5. Storage

- Store all records securely in locked filing systems or encrypted electronic databases.
- Back up electronic records daily to prevent data loss.

3.1.6. Retention

- Retain records for at least seven years or as required by law.
- Ensure secure destruction of records no longer required.

3.1.7. Access Control

- Restrict access to client records to authorised personnel only.
- Implement role-based access controls for electronic records.

3.1.8. Auditing and Monitoring

- Regularly audit records to ensure compliance with documentation and privacy standards.

3.1.9. DVA Access:

- DVA or its authorised representatives may request access to any client records. We will provide all relevant documentation promptly for audits, reviews, or investigations. Staff must ensure all records are accurate, complete, and legible at all times.

4. Data Security and Access Controls

4.1. Limit access to client records to authorised personnel on a “need-to-know” basis.

4.2. Maintain audit logs to record access and changes to client records.

4.3. Back up electronic records daily and store backups securely.

4.4. Protect physical records (if held) in locked storage with restricted staff access.

Procedure

4.5. Access Control Principles

4.5.1. All access to electronic and physical information must comply with *Privacy Act 1988 (Cth)*.

4.5.2. Access privileges are based strictly on job role, responsibility, and the “least privilege” principle.

4.5.3. Access is approved by the Clinical Governance Officer or authorised IT Administrator and documented in the Access Control Register

4.5.4. User accounts are reviewed quarterly and immediately revoked upon resignation, role change, or termination.

4.6. Authentication and Authorisation

4.6.1. All systems containing client or organisational data must:

4.6.1.1. Use strong passwords (minimum 12 characters, alphanumeric, special symbols).

4.6.1.2. Implement two-factor authentication (2FA) wherever supported.

4.6.1.3. Enforce automatic session time-out after 10 minutes of inactivity.

4.6.1.4. Restrict multiple failed login attempts (lockout after 5 tries).

4.6.2. Administrative access to servers and backup systems requires dual authorisation.

4.7. Data Encryption and Secure Storage

4.7.1. All electronic data (at rest and in transit) must be encrypted to at least AES-256 standard.

4.7.2. Transmission of client information must occur only through secure, encrypted channels (TLS/SSL, encrypted email, or DVA-approved portals).

4.7.3. Portable devices (laptops, tablets, USBs) must be encrypted and password protected.

4.7.4. Cloud storage providers must be located in Australia and comply with *Australian Privacy Principle 8 (Cross-border disclosure of personal information)*.

4.8. Audit Logs and Monitoring

4.8.1. System audit logs must capture:

4.8.1.1. User login/logout activities.

4.8.1.2. Record creation, modification, and deletion events.

4.8.1.3. Failed access attempts or policy violations.

4.8.2. Logs are retained for at least 12 months and reviewed monthly by IT Administration.

4.8.3. Unusual activity triggers investigation under the Information Security Incident Procedure

4.9. Data Backup and Recovery

4.9.1. Electronic records are backed up daily using automated, encrypted processes.

4.9.2. Backups are stored in two secure locations:

4.9.2.1. Primary on-site encrypted server.

4.9.2.2. Secondary off-site or cloud storage within Australian data centers.

4.9.3. Data restoration tests occur quarterly to verify backup integrity.

4.9.4. Backup records and verification logs are maintained for audit **and retained for a minimum of seven (7) years**, or longer if required by regulatory or contractual obligations.

4.10. Physical Record Protection

4.10.1. Hardcopy client files (if held) are:

4.10.1.1. Stored in locked filing cabinets or secure rooms with key-controlled access.

4.10.1.2. Accessible only to authorised staff.

4.10.1.3. Never left unattended in vehicles or public spaces.

4.10.2. Physical record removal from site requires documented authorisation.

4.10.3. Disposal of paper records is performed via secure shredding by licensed contractors with disposal certificates retained for records control.

4.11. Review and Continuous Improvement

4.11.1. The Privacy officer reviews access controls, authentication protocols, and encryption measures annually or after any security incident.

4.11.2. Improvements and identified vulnerabilities are documented and tracked through management review.

5. Record Retention and Disposal

5.1. Purpose and Compliance Framework

This procedure ensures consistent retention, protection, and disposal of client and organisational records in accordance with:

- *Privacy Act 1988 (Cth)* and *Australian Privacy Principles (APP 11 – Security of Personal Information)*
- Relevant *State/Territory Health Records Acts* (e.g., *Health Records and Information Privacy Act 2002 (NSW)*)
- DVA Community Nursing provider obligations

5.2. Retention Standards

Records must be retained for the following minimum periods, unless otherwise required for legal, insurance, clinical, or auditing reasons:

Record Type	Retention Period
Adult client health records	7 years after last date of service
Child client health records	Until the client reaches 25 years of age
Workplace health and safety records	7 years or as per WHS legislation
Incident, complaint, or investigation records	Minimum 7 years
Financial, HR, or governance records	Minimum 7 years (or longer if required)

All community nursing claim records and care records will be retained for a minimum of 7 years and kept accessible for DVA review if required.

Records subject to ongoing litigation or audit must not be destroyed until written clearance is provided by the Clinical Governance Officer.

5.3. Secure Storage Prior to Disposal

- Records approved for destruction must remain securely stored until formal disposal is authorised.
- The Record Retention Register must include:
  - File ID or reference number
  - Record type and date range
  - Responsible department
  - Disposal approval date

5.4. Disposal Authorisation and Methods

- Disposal must be authorised in writing by the Privacy Officer or Clinical Governance Officer.
- Paper Records:
  - Destroy using cross-cut shredding or licensed incineration.
  - Ensure no loose or unshredded pages remain.
- Electronic Records:
  - Securely wiped using DoD- or NIST-approved software.
  - Backups deleted per retention schedules.
  - Obtain destruction certificates from external vendors.

5.4. Destruction Register

Maintain a permanent Record Disposal Register including:

- Record identifier and description
- Date and method of destruction
- Name of authorising officer
- Name of disposal contractor (if used)

6. Notifiable Data Breach (NDB) Procedure

6.1. Follow the *Privacy Amendment (Notifiable Data Breaches) Act 2017 (Cth)*.

6.2. Immediately report suspected or actual data breaches to the Privacy Officer.

6.3. Assess the breach within 30 days, considering:

6.3.1. Type and sensitivity of information involved.

6.3.2. Risk of harm to individuals.

6.3.3. Likelihood of unauthorised access, use, or disclosure.

6.4. If serious harm is likely:

6.4.1. Notify the *Office of the Australian Information Commissioner (OAIC)*.

6.4.2. Notify affected individuals with recommendations to minimise risk.

6.4.3. Notifications should be made in writing (letter or secure email) where possible, or by phone if urgent, with all communication documented

6.5. Document all data breaches and corrective actions taken.

Purpose

- To ensure that all actual or suspected data breaches are managed in compliance with the *Privacy Amendment (Notifiable Data Breaches) Act 2017 (Cth)* and *Privacy Act 1988 (Cth)*.
- To minimise the risk of harm to individuals and maintain trust in the organisation's handling of personal information.

Definition of a Data Breach

A *data breach* occurs when personal information is lost, accessed, disclosed, or used without authorisation.

Examples include:

- Lost or stolen devices containing unencrypted data.
- Accidental email disclosure of client details.
- Unauthorised database access.
- Inadequate disposal of sensitive records.

Reporting Requirements

- All staff must immediately report any suspected or actual breach to the **Privacy Officer**.
- Reports must be made as soon as practicable, ideally within 24 hours of discovery
- The Privacy Officer logs each breach into the **Data Breach Register** and commences an assessment.

Assessment and Investigation (within 30 Days)

- The Privacy Officer must assess the breach to determine:
  - **Nature and type** of information involved.
  - **Number of individuals affected.**
  - **Risk of serious harm**, considering sensitivity, context, and accessibility of data.
  - **Likelihood of unauthorised access or misuse.**

- Assessment findings are documented in the **Data Breach Assessment Report**.
- If assessment cannot be completed within 30 days, the Privacy Officer must provide interim updates to management and OAIC (if applicable).

Determining Notifiability

- If the breach is likely to result in *serious harm* to any individual, it is deemed a **Notifiable Data Breach (NDB)**.
- Serious harm may include physical, psychological, financial, or reputational damage.
- The Privacy Officer must seek input from management and legal counsel before proceeding with external notifications.

Notification Requirements

- If serious harm is likely:

  Notify OAIC using the official NDB online form.

  Notify affected individuals, including:

  - Nature of the breach.
  - Information involved.
  - Recommended actions to mitigate harm (e.g., password change, credit monitoring).

  Keep records of all correspondence and submissions.

Containment and Corrective Actions

- Immediately contain the breach to prevent further exposure (e.g., revoke credentials, isolate affected systems, retrieve sent emails).
- Implement corrective actions and security improvements such as:
  - System reconfiguration or patching.
  - Staff retraining or access revocation.
  - Policy or process updates.
- All actions are recorded and reviewed at the next management meeting.

6.6. Post-Incident Review and Continuous Improvement

- Conduct a debrief after every incident to identify lessons learned.
- Update the **Information and Data Management Policy**, **Access Controls**, or **Training Programs** as required.
- Report outcomes and preventive measures during the next **Management Review Meeting**

6.7. Recordkeeping

- Maintain a **Data Breach Register** including:
  - Date and nature of breach.
  - Assessment summary.
  - Actions taken and notification details.
  - Approval and closure by the Privacy Officer.
- All records must be retained for **at least seven (7) years** for audit and accountability.

7. Staff Training

7.1. Provide all staff with mandatory training on:

- Privacy laws and principles.
- Documentation and record-keeping practices.
- Reporting and managing data breaches.

7.2. Conduct annual refresher courses and updates on changes to regulations or company policies.

8. Continuous Improvement

8.1. Feedback Mechanisms

- Collect feedback from clients and staff regarding information management practices.
- Use feedback to improve processes and policies.

8.2. Policy Review

- Review this policy annually or following significant legislative changes.
- Engage stakeholders, including staff and clients, in the review process.

References

- Privacy Act 1988 (Cth)
- Australian Privacy Principles (APPs)
- Aged Care Quality Standards
- DVA Notes for Community Nursing Providers
- Notifiable Data Breaches Scheme (Office of the Australian Information Commissioner)
- Data Retention and Disposal Guidelines

Section 9 Quality Improvement and Compliance

1. Purpose and Scope

The company is committed to a culture of continuous quality improvement (CQI) that ensures safe, effective, and person-centred care for all Department of Veterans' Affairs (DVA) clients

The company will monitor performance against clinical and organisational standards, including the National Safety and Quality Health Service (NSQHS) Standards, the Aged Care Quality Standards where applicable, DVA contractual obligations, and professional standards of practice.

All staff are required to actively participate in quality improvement activities, support compliance reporting, and engage in reflective practice to improve service outcomes.

The aims are to:

● Demonstrate continual improvement in service delivery and client outcomes.

● Ensure compliance with NSQHS Standards, the Privacy Act 1988 (Cth), and DVA contractual requirements, and Aged Care Quality Standards.

● Embed a culture of safety, accountability, and learning across all organisational levels.

● Use evidence, data, and feedback to guide decision-making and corrective actions.

2. Commitment to Continuous Quality Improvement (Strategic & Operational)

2.1. Strategic Integration

Continuous Quality Improvement (CQI) is integrated into the organisation's strategic and operational planning. Each department develops and monitors objectives that align with DVA requirements, NSQHS Standards, and organisational goals. CQI priorities, including infection control, client satisfaction, and care plan compliance, are approved by the Clinical Governance Officer and reviewed regularly through audit and performance reporting

2.2. Operational Implementation

● Each department develops operational CQI objectives consistent with organisational strategy, such as:

- ○ Reducing infection rates through stronger IPC compliance.
- ○ Improving client satisfaction scores by 10% annually.
- ○ Ensuring 100% care plan completion within required timelines.
- ○ Enhancing staff training participation and clinical documentation accuracy.

● Department heads are accountable for monitoring performance and submitting CQI reports quarterly.

2.3. Framework and Methodology (PDCA)

● All CQI activities follow the Plan–Do–Check–Act (PDCA) cycle to ensure improvements are planned, implemented, measured, and standardised:

○ Plan: Identify opportunities for improvement, set measurable goals, and allocate resources.

○ Do: Implement the improvement initiative on a pilot or full scale

○ Check: Measure outcomes using key performance indicators (KPIs) and data analysis.

○ Act: Integrate successful practices into standard procedures and review outcomes during management meetings.

2.4. Resourcing and Support

● Management commits adequate resources—human, financial, and technological—to support ongoing quality initiatives.

● Training and development are prioritised for staff involved in quality, risk, audit, and data analysis functions.

● The organisation encourages innovation, feedback, and professional development as part of its CQI culture.

2.5. Governance and Communication

● Quality and safety outcomes are standing items on monthly Team Meetings, Clinical Governance Meetings, and Management Review Meetings.

● Each meeting includes updates on:

- Improvement projects and outcomes.
- Audit findings and CAPA status.
- Risk register updates.
- Staff feedback and client satisfaction results.

● Meeting minutes are documented and reviewed by the Clinical Governance Officer for follow-up actions.

2.6. Monitoring and Evaluation

- Progress toward CQI objectives is tracked using performance dashboards and reported quarterly to management.

- Trend analysis (e.g., infection rates, incident frequency, audit outcomes) is used to identify emerging risks or systemic improvement areas.

- Achievements and lessons learned are communicated to all staff to reinforce engagement and shared ownership of quality outcomes.

- Client and carer feedback is actively gathered through **surveys, complaints data, and informal discussions** during care. This feedback is reviewed quarterly and used to identify improvement opportunities. Significant themes are escalated to the Clinical Governance Committee and included in quality improvement planning

References

• Australian Commission on Safety and Quality in Health Care (2021). National Safety and Quality Health Service (NSQHS) Standards (2nd ed.)

• Department of Veterans' Affairs (2023). Community Nursing Provider Guidelines and CNS16 Contract Requirements

• Australian Health Practitioner Regulation Agency (2023). Standards, Codes and Guidelines
• Safe Work Australia (2023). Model Code of Practice: How to Manage Work Health and Safety Risks

• Standards Australia (2018). AS/NZS ISO 9001:2016 Quality Management Systems – Requirements

• Australian Government (1988). Privacy Act 1988 (Cth)

• Australian Digital Health Agency (2022). My Health Records Act 2012 (Cth)

• National Health and Medical Research Council (2021). Australian Guidelines for the Prevention and Control of Infection in Healthcare

• Therapeutic Guidelines Ltd (2021). Therapeutic Guidelines: Antibiotic

• ASCIA (2024). Action Plans for Anaphylaxis and Clinical Resources – https://www.allergy.org.au

• Office of the Australian Information Commissioner (OAIC). Notifiable Data Breaches Scheme Guidelines – https://www.oaic.gov.au

• Department of Veterans' Affairs. Veterans' Home Care (VHC) Program Guidelines

Section 10

Version History

Version	*Revised By*	*Review Date*	*Amendments*
1.0	Ajay Handa	May 2025	Initial Draft
1.1	Ajay Handa	December 2025	Notes for Community Nursing updates
1.2	Ajay Handa	March 2026	Revised based on the Notes for Community Nursing Updates November 2025