

# GRAMPIANS REGION

## PERSONAL CARE PROTOCOL

OCTOBER 2009

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## INTRODUCTION

The Grampians Region Personal Care Protocol was developed in response to requests from Grampians Region HACC Personal Care Providers for the provision of a document that clarified their role in the timely and effective delivery of personal care services. This protocol does not govern or determine the practices of registered nurses as their practice is determined by their individual registration as a nurse.<sup>1</sup>

This protocol covers the assessment and delivery of personal care services and is inclusive of material relating to both prescription and over the counter medications.

The project to design and develop this protocol was funded through the Victorian Department of Health, Grampians Region. The Grampians Region Personal Care Protocol Steering Committee will meet annually to review the protocol – all other interested parties will be invited to participate in the review. The Policy and Service Advisor for the Grampians Region, Victorian Department of Health will be responsible for initiating the review. Changes to the protocol will be presented at the next available Grampians Region HACC forum.

Any changes to the HACC Personal Care Policy and/or advice relative to assistance with medications that may affect this protocol (between formal annual reviews) will be circulated to all organisations – each organisation is asked to take responsibility to update the relevant sections of their copy of the protocol as appropriate.

The City of Ballarat was the fundholder for this 12 month project. The project commenced in October 2008 and was completed in October 2009.

## AIM OF THE PROTOCOL

The aim of the Grampians Region Personal Care Protocol is to support and guide the delivery of personal care services for Home and Community Care (HACC) providers. The protocol is a tool to be used with the HACC Personal Care Policy – it does not replace the policy.

## STAKEHOLDER CONSULTATION

Grampians Region HACC Personal Care service providers include:

- Home care/personal care services
- Nursing Services
- Linkages Programs
- Planned Activity Groups
- Respite Programs

Stakeholder consultation was extensive:

- A series of focus groups were held in Horsham and Ballarat to promote accessible participation for all organisations and interested parties.
- The engagement of specialist advisors included Pharmacists, Registered Training Organisations, Divisions of General Practice (General Practitioner and Practice Nurses), Primary Care Partnerships, Department of Human Services – Home and Community Care advisor.

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<sup>1</sup> Advice provided by Department of Human Services, HACC and Assessment, 22 July 2009

- Project Coordinator visits and phone contact with regional organisations to engage stakeholders who were finding it difficult to actively participate in the focus groups.
- An email distribution network incorporating members of focus groups, the Steering Committee and other interested parties was implemented to:
  - o Regularly inform them of updated material and changes to the draft protocol
  - o Engage in further discussion on key aspects of the protocol
  - o Provide an ongoing feedback mechanism to gather further input and comment
- Contact was maintained with the full stakeholder group through an email circulation list and individual emails providing the following information:
  - o An initial introduction to the project
  - o Invitations to participate in the Steering Committee
  - o An invitation to participate in the Focus Groups
  - o Final draft of the protocol was sent to all key stakeholders and other interested parties for comment and endorsement
- Community engagement was not specifically sought during this consultation process as the protocol is considered to relate to agreed safe and effective work practices between and within organisations. It is acknowledged that client involvement in tailoring service delivery and the range of services required is important – each organisation is responsible to ensure that their own target population has input into the range and model for service delivery preferred in that catchment area.

To oversee the direction of the protocol a stakeholder leadership Steering Committee was established. This group met regularly throughout the project.

Membership for the Steering Committee was sought by self nomination from the stakeholder group. The Steering Committee comprised sixteen members from the following organisations:

- |   |   |
|---|---|
| • Golden Plains Shire                       | • Ararat Rural City Council                         |
| • Ballarat District Nursing and Health Care | • Ballarat Health Services – Community Programs     |
| • City of Ballarat                          | • Victorian Department of Health, Grampian's Region |
| • Djerrivarrh Health Service                | • East Grampians Health Service                     |
| • Hepburn Health Service                    | • Hepburn Shire Council                             |
| • Hindmarsh Shire Council                   | • Moorabool Shire Council                           |
| • Northern Grampians Shire Council          | • Stawell Regional Health                           |
| • West Wimmera Health Service               | • Yarriambiack Shire Council                        |

A full list of organisations participating in the development of the protocol and endorsing the completed protocol has been included as Appendix G.

# VICTORIAN HOME AND COMMUNITY CARE - PERSONAL CARE POLICY

At all times the development of the Grampians Region Personal Care Protocol was undertaken within the parameters of the:

- HACC Personal Care Policy as documented in the Victorian Home and Community Care (HACC) Program Manual (2003), amendments and advice, and the
- Framework for Assessment in the Home and Community Care Program in Victoria, (2007).

As appropriate, and required, further specific advice has been sought from key advisors within the sector and the Victorian Department of Health.<sup>2</sup>

A review of existing protocols, organisations policies and procedures from within the Grampians Region and the wider sector network was undertaken prior to commencement.

The Victorian HACC Program Manual outlines the policy for Personal Care, (see Appendix H). It is important for all providers of personal care services to develop a familiarity with the Personal Care Policy and Framework for Assessment to ensure they work safely and effectively within its structures.

Please note: The Framework for Assessment in the Home and Community Care Program in Victoria, 2007 now replaces Section 3 in the Victorian HACC Program Manual, February, 2003.

The following excerpts are drawn from the HACC Personal Care Policy<sup>3</sup> and the Framework for Assessment.<sup>4</sup>

## DEFINITION OF PERSONAL CARE

Personal care provides assistance with those tasks which a person would normally do for themselves but because of illness, disability or frailty they are unable to perform without the assistance of another person.

Examples of personal care services include<sup>5</sup>:

- assistance (or supervision) with bathing, showering or sponging
- assistance with dressing and undressing
- assistance with shaving, hair care and grooming
- limited nail care, only following professional assessment
- assistance with mobility (in bed and out of bed) such as to sit up, to turn, to stand and walk, to sit, to transfer to commode, wheelchair, chair or vehicle
- assistance with eating, drinking, cooking, preparation and service of food, preparation of special diets
- assistance with toileting
- assistance with prescribed exercise or therapy programs (see Personal Care Policy in Appendix H for more detail)
- fitting and use of appliance such as splints and callipers, or hoists
- assistance with hearing aids and communication devices
- monitoring self-medication
- escorting to medical and other related appointments.

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<sup>2</sup> Victorian Department of Health, formerly the Victorian Government Department of Human Services

<sup>3</sup> Victorian Home and Community Care (HACC) Program Manual, February, 2003, Pp 93-104

<sup>4</sup> Framework for Assessment in the Home and Community Care Program in Victoria, 2007

<sup>5</sup> Royal District Nursing Service Victoria, Municipal Association of Victoria, Draft 2008

## ASSESSMENT

The need for personal care is determined following an assessment of each individual consumer's needs. It is essential that individual consumers are assessed and have a care plan developed which reflects the person's individual needs. The assessment process and development of care plans should include (where appropriate) health professionals with qualifications and training which are relevant to the needs of the consumer. The identification of appropriate personnel to provide personal care should be undertaken following an assessment of the consumer and should be based on the needs and characteristics of the consumer, not on the tasks to be performed.<sup>6</sup>

Where consumers have an unstable health status and/or complex needs they require assessment by a relevant health professional. This health professional will determine if it is appropriate for a Community Care Worker to undertake care tasks for the consumer.

In 2008 a number of regional and metropolitan Victoria HACC provider organisations were successful in being designated as Living at Home Assessment Services (LAHA). All HACC eligible clients are able to access a LAHA, but not all clients require a LAHA.

Clients who would benefit from a LAHA include: clients requiring more than one service; those clients who have identified a range of concerns that cannot be met by just one organisation; and those clients who have unstable health and/or complex care needs.

All LAH Assessments will be completed using an Active Service Model approach whereby the assessor is striving to: maximise client independence through person centred and capacity building approaches to service delivery.<sup>7</sup>

Some clients will only require a Service Specific assessment which is considered to be: a face-to-face interaction with a consumer who has a straightforward and distinct need for a specific service (such as home care, podiatry, nursing, etc). This assessment is conducted by the service provider responsible for delivering the service.<sup>8</sup> It is anticipated that in many instances a LAHA and Service Specific assessment will be done in conjunction if a designated LAHA service is also able to provide the care being requested.

A LAHA can be completed by a designated assessment service in your local area - a full list of designated providers in the Grampians Region is to be found in Appendix J.

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<sup>6</sup> Victorian Home and Community Care (HACC), Program Manual, February, 2003, P94

<sup>7</sup> Framework for Assessment in the Home and Community Care Program in Victoria, 2007, P14

<sup>8</sup> Victorian Service Coordination Practice Manual 2009, P20

## EXAMPLES OF COMPLEX CARE/UNSTABLE HEALTH

The Royal District Nursing Service Victoria and the Municipal Association of Victoria<sup>9</sup> have developed, and are currently reviewing some indicators to assist personal care provider organisations and referring organisations to determine what is meant by unstable health:

- Poor mobility
- Loss of bladder or bowel control
- Special dietary requirements/limitations eg percutaneous endoscopic gastrostomy (PEG) feeding regimens
- Pain
- Difficulty with breathing/advanced respiratory disease
- Disorientated/confusion/memory loss
- Terminal or life threatening illness in palliative care stage
- Nausea/vomiting
- Recent changes in sensory status, eg visual or hearing
- Diarrhoea/constipation
- Apparent fever/persistent excessive coldness
- Wound (surgical/non-surgical)
- Persistent bruising and/or skin integrity break down
- Significant recent changes in medication
- Multiple (more than 5) and frequent use of medications
- Several recent hospital or respite admissions
- Progressive deteriorating chronic illness
- Any procedure requiring insertion into the body (eg injections)

## SERVICE COORDINATION TOOL TEMPLATES AND PRACTICE GUIDELINES

The Service Coordination Template Tool (SCTT) and practice manuals provide guidance with the processes undertaken by personal care providers in relation to initial contact, initial needs identification, assessment and care planning. The Victorian Service Coordination Tool Templates and Good Practice Guide for Practitioners was revised and released in 2009 – a copy of the revised edition is available on [www.health.vic.gov.au/pcps/coordination](http://www.health.vic.gov.au/pcps/coordination). Careful consideration has been given in the development of tools for this protocol to ensure that they do not duplicate tools available through the SCTT.

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<sup>9</sup> Royal District Nursing Service Victoria, Municipal Association of Victoria, Draft 2008

## DUTY OF CARE

It is a general legal standard that HACC consumers have a right to expect that the people providing nursing or personal care possess the necessary skills and knowledge to provide that care. All staff owe a duty of care to consumers and are responsible and independently accountable for their actions at all times. Therefore, health professionals are obliged to use their professional judgement in regard to the delegation of aspects of a consumer's care to a Community Care Worker. Health professionals should have the ability to decide whether or not to delegate aspects of a consumer's care to Community Care Workers, taking into account relevant legislation, professional codes of conduct, ethics and the policies of professional and registration bodies.<sup>10</sup>

Providers of personal care also have significant responsibilities in this relationship:<sup>11</sup>

- To ensure that Community Care Workers operate within agreed agency and interagency protocols when sharing care to maintain an integrated service system.
- To ensure that Community Care Workers have the appropriate registered training and documented competency in the delivery of specific personal care services.
- To ensure that an accountable system of assessment, referral, training, supervision and monitoring is established and documented within the organisation.
- To ensure that clients have access to the most appropriate service for their needs, delivered by suitably qualified staff in a timely and individualised manner.
- To ensure that any referrals accepted for personal care can be safely and effectively delivered by a Community Care Worker within their organisation. If in doubt the client needs to be referred to a suitably qualified health professional for assessment and advice.
- The Victorian HACC Program Manual provides a section on Principles for Personal Care Service Provision which further supports the role of the personal care provider organisation in working with clients.<sup>12</sup>

Community Care Workers hold their own responsibility for participation in service delivery.<sup>13</sup>

- To work within the parameters of their job as determined by their employment skills, training, and the policies and procedures of the employing organisation.
- To keep up to date with personal care techniques and education requirements.
- To follow client care plans.
- To actively observe consumer well being and reporting to their supervisor or back-up person any changes in consumer health status or conditions.

Community Care Workers delivering HACC funded services are not permitted to make clinical judgements as this is the responsibility of clinical professionals such as Division 1 nurses, doctors, etc. Community Care Workers need to have a clear understanding that their role is to provide assistance or monitoring only.<sup>14</sup>

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<sup>10</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P97

<sup>11</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P98

<sup>12</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P95-96

<sup>13</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P99

<sup>14</sup> Assistance with medication by HACC Community Care Workers, HACC Service Development, Victorian Department of Health September 2009

## COMMUNITY CARE WORKER TRAINING

Community Care Worker training is required before the delivery of personal care services. It is the responsibility of the personal care provider organisation to ensure that each Community Care Worker is appropriately trained and competent to undertake the task being requested of them.

The HACC Personal Care Policy<sup>15</sup> outlines the training relevant to the provision of personal care:

- Registered Vocational Training/Competency based training: (transferable skills)

As stated in the Victorian HACC Program Manual, all Community Care Workers who undertake personal care tasks funded by the HACC Program must adhere to the HACC Personal Care Policy and must have an appropriate minimum Certificate 3 level qualification with the relevant personal care and first aid competency units.

Additional training is required before Community Care Workers can assist with medications. This training, along with first aid and personal care competencies are outlined in Appendix I, Assistance with medication by HACC Community Care Workers, HACC Service Development, Victorian Department of Health September 2009.

The competency CHCICS306A Provide basic foot, skin and nail care has also been included in the CHC08 Community Services Training Package. When this competency has been completed the Community Care Workers will be equipped to undertake HACC funded foot, skin and nail care as long as they have completed first aid and personal care competency units. If the basic foot, skin and nail care - community service focus Skill Set is completed the Community Care Worker is also required to complete the relevant first aid competency unit.

- Non-transferable skills training (specific to individual clients)

Further consumer specific training and supervision is necessary where a Community Care Worker has been delegated a role in the care of consumers with an unstable health status or complex needs. This can be provided by a Registered Nurse Division 1 and/or other relevant health professionals. It is important that training and the supervision of personal care (delivery) are ongoing and not considered as one-off events.<sup>16</sup> These skills required for the provision of personal care service for clients with unstable health and/or complex care needs are considered to be non-transferable, thus not able to be transferred to other clients. See also the section on Assessment on Page 6.

This non-transferable training is clinical in nature and as such does not require educational and training qualifications – it is performed by the relevant health professional within the boundaries of their clinical qualification/registration.<sup>17</sup> In instances where the health professional is unable to deliver appropriate training and supervision, consideration should be given to the complexity of the situation and a determination made as to whether the handover of the service to a Community Care Worker is appropriate.

- In-service training: (skills review/annual refresher training, OH&S)

Organisations providing personal care services should employ staff who have undergone registered vocational training and should provide regular and appropriate in-service or refresher training for staff. In-service training is useful in reviewing and appraising the ability of Community Care Workers, in assessing their competency and in determining future training needs.<sup>18</sup>

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<sup>15</sup> See Appendix H, Home & Community Care - Personal Care Policy

<sup>16</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P95

<sup>17</sup> HACC and Assessment, Aged Care Branch, Department of Human Services Advice, April 2009

<sup>18</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P104

## INCIDENT REPORTING

All organisations providing client care are required to have a formally documented process for recording and reviewing incidents experienced during service delivery.

The mode of recording can be developed by the organisation or through utilisation of a specific risk management software program. The model should include who, what, when, where and the outcome of the incident.

The data recording model should be easily accessible for the purposes of regular review of incidents and the development of patterns relating to who, what, when, where and the outcome. A model of this type will assist organisations to determine areas of strength or weakness and provide data which supports effective change to practice.

Each organisation is responsible for reporting incidents utilising the Department of Human Services Incident Reporting Instruction of March 2008.<sup>19</sup> This document clearly outlines the roles and responsibilities of direct service provider organisations.

## OCCUPATIONAL HEALTH AND SAFETY

Managing workplace health and safety is a legal requirement under the Occupational Health and Safety Act 2004. The Victorian Home Care Industry, Occupational Health and Safety Guide<sup>20</sup> was designed to advise and support the community care sector. Community services employers have a responsibility to promote and protect client's rights and provide services that improve their quality of life while ensuring compliance with Victoria's health and safety laws.<sup>21</sup> By making workplace health and safety a priority, an organisation demonstrates:

- Commitment to the welfare of employees, clients, volunteers and the public
- Social responsibility in regard to its legal, ethical and moral obligations
- Good management practice in that health and safety issues are addressed proactively, resulting in improved organisational performance; and
- Sound financial management by addressing risks and preventing loss through illness and injury.<sup>22</sup>

While a Community Care Worker is working in a client's home that home becomes their workplace and relevant OHS legislative requirements must be met.<sup>23</sup>

The Victorian Home Care Industry, Occupational Health and Safety Guide also promotes the collection of information and the development of plans to ensure that occupational health and safety issues have been considered prior to entering a client's home. For the Grampians Region this process should include the use of a tool for data collection and distribution across referring agencies (subject to client consent and privacy legislation). It is recommended that any tool used by a personal care provider organisation incorporates a pre-home visit assessment, an in-home assessment and a documented risk analysis.

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<sup>19</sup> <https://fac.dhs.vic.gov.au/publicfolder/publications/DHS/policies/IncidentReporting/2008/Incident-Report-Instruction-March>

<sup>20</sup> Victorian Home Care Industry, Occupational Health and Safety Guide, October 2005

<sup>21</sup> Working safely in community services, 1st Edition, October 2005, State Government, Victoria, P4

<sup>22</sup> Working safely in community services, 1st Edition, October 2005, State Government, Victoria, P5

<sup>23</sup> Victorian Home Care Industry, Occupational Health and Safety Guide, October 2005, P6

## CARE PLANNING

The overall goal of care planning is to maximise and enhance the client's independence and quality of life. Care planning recognises and supports the client's strengths and abilities, as well as addressing their needs. Care planning occurs in consultation with the client, and with their carers (who can also be clients), family or friends who may have been asked to be an advocate for them or in some cases a guardian if one has been appointed to make decisions on the client's behalf.<sup>24</sup>

The Care Plan can be:

- **Service Specific** This plan details the type and level of each specific service to be delivered by organisations such as domestic assistance, respite or nursing care.
- **Intra-Agency care plan** Sometimes intra-agency care planning is required when clients are receiving services from multiple parts of the one organisation.
- **Inter-Agency care plan** Where there is multi-agency involvement in delivering services to a client, inter-agency care planning will need to occur in order to coordinate the client's care.

The Victorian Service Coordination Practice Manual 2009 identifies a care plan as the documentation of items agreed to in the Care Planning process. All care plans should include the following items:

- date the care plan was developed
- participants in the development of the care plan
- consumer-stated and agreed issues or problems
- consumer-stated and agreed goals
- agreed actions and the name of the person or service responsible for each action
- timeframe for attaining goals and actions
- planned review date
- consumer acknowledgement of the care plan (signed or verbal)
- actual review date

A copy of the Service Coordination Tool – Care Coordination Plan can be found on the Victorian Department of Health website at: <http://www.health.vic.gov.au/pcps/coordination>

## CARE PLAN REVIEW

All clients who receive personal care services should have their care plan reviewed on a regular basis.

The time between the assessment and the next visit to review the services will vary from client to client based on their needs, capacity for improvement or deterioration and possible risks to staff.

For clients with stable and/or non complex care needs this review must be at least on an annual basis or as required/requested. This review will be completed by the HACC personal care provider organisations assessment team.

Where a client has unstable health and/or complex care needs a relevant health professional should remain engaged to support the client and supervise the ongoing personal care. The review should take place at least six monthly and more often if the client situation changes.

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<sup>24</sup> Framework for Assessment in the Home and Community Care Program in Victoria, 2007 P17

## CLIENT CONSENT

Client consent is an expectation at all levels of service delivery within the HACC service system. It involves client consent to participate in assessment, referral, sharing of information between service providers and service delivery.

Formal written consent is the preferred model but in some instances the client may not be able to sign their name, or the required/requested changes to client care are being managed via telephone, in this case verbal consent by the client must be recorded on the client file. When the consumer is not in a position to give consent the agency seeks the consent of the consumer's advocate or legal guardian.<sup>25</sup> This protocol recommends that at each client review, reassessment or upon request from the client, their documented consent to service delivery or the sharing of information is revisited and formally renewed.

Client's, their advocate or legal guardian must be provided with information in the appropriate community languages, outlining the purpose of the service, access, assessment, review procedures, allocation of priorities, user charges and appeal or complaint mechanisms.<sup>26</sup>

As a support to further understand the concept of consent and the appropriate sharing of information the Department of Human Services Privacy Policy (Endorsed June 2002, Amended August 2005) lists a summary of the key privacy principles and an easy to understand description of what this means:

- Collect only information which we need for a specified primary purpose
- Ensure that the person knows why we collect it and how we will handle it
- Use and disclose it only for the primary or a directly related purpose, or for another purpose with the person's consent (unless otherwise authorised by law)
- Store it securely, protecting it from unauthorised access
- Retain it for the period authorised by the Public Records Act 1973
- Provide the person with access to their own information, and the right to seek its correction. For information in our possession, this right is available through the Freedom of Information Act 1982

For further information about the Health Records Act go to: [www.health.vic.gov.au/hsc](http://www.health.vic.gov.au/hsc)

For further information about the Information Privacy Act go to: [www.privacy.vic.gov.au](http://www.privacy.vic.gov.au)

### Privacy:

The Victorian HACC Program Manual February, 2003 clearly outlines the role of organisations in the collection, storage, sharing and disposal of client information. All organisations must ensure that their policies and procedures are managed in accordance with the National and State Privacy legislation and principles, the Health Records Act and other legislation that applies to local government.

<sup>25</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P36

<sup>26</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P100

## **ASSISTANCE WITH PERSONAL CARE TASKS – OTHER THAN MEDICATION**

The need for personal care is determined following an assessment of each individual consumer's needs. It is essential that individual consumers are assessed and have a care plan developed which reflects the person's individual needs. The assessment process and development of care plans would include health professionals with appropriate qualifications and training, relevant to the needs of the consumer. The identification of appropriate personnel to provide personal care should be undertaken following an assessment of the consumer and should be based on the needs and characteristics of the consumer, not on the tasks to be performed.<sup>27</sup>

Clients who self refer or are referred by family/carer to a HACC personal care provider organisation, (eg local government provider), will be assessed by the personal care provider organisation assessment team. This assessment will utilise the criteria for Assessment for Personal Care provided by the Victorian HACC Program Manual, February 2003, P100 and the Framework for Assessment in the Home and Community Program in Victoria, 2007.

All clients who are deemed to have unstable health and/or complex care needs must be assessed by an appropriate health professional. The health professional will then provide written task instructions and client/Community Care Worker specific training (if appropriate).

Clients referred for a personal care service by a case management service, if deemed by the referring organization to have stable health and non complex care needs, can be referred direct to the personal care provider organisation. Referrals must be accompanied by appropriate written task instructions for service delivery.

When personal care assistance is requested all required equipment and aids must be available to the Community Care Worker prior to commencing the service. These aids can include such things as a hand held shower, shower chair, grab rails, non slip mat, walking aid, wheelchair, etc. If required equipment is not available then consideration should be given to develop alternative forms of assistance such as sponging instead of showering.

Should a client only have a bath in their home, or prefer to bathe rather than shower – no assistance can be offered in bodily lifting the client in or out of the bath. Alternative strategies must be implemented such as the use of a bath board, mechanical aids and/or other equipment for aiding access to the bath. Alternatives can also be explored such as assistance with sponging, bathroom modifications or alternative venues for showering.

It is recommended that all clients requiring assistance with shaving have an electric razor to minimise any safety risks to client and worker.

Clients with significant mobility problems (eg requiring a hoist, support from more than 1 person) should have an assessment by a suitably qualified health professional to ensure that all appropriate aids, mobility training and client/Community Care Worker training is undertaken.

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<sup>27</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P94

If the client is being assessed by a personal care provider organisation, (eg local government provider), for assistance to fit aids and equipment such as splints, catheter bags, pads, pressure stockings, etc, consideration should be given to such things as:

- who ordered the equipment to be fitted
- has the client had a recent review (within 12 months) of their need for the equipment,
- is the aid to be fitted in good condition
- is the task simple or does the Community Care Worker require client specific training in fitting the aid

If in doubt it is recommended that the client be referred to a qualified health professional for further assessment. In the case of clients deemed to have unstable health and/or complex care needs the client should be assessed by an appropriate health professional. The health professional will then provide written instructions and client/Community Care Worker specific training (if appropriate).

All requests to escort clients to/from appointments and other activities should be assessed in relation to the client's level of function and capacity to manage unfamiliar environments. If deemed to require high level support (eg more than one worker required, behavioural problems) assessment by an appropriate health professional is required to ensure client and Community Care Worker safety.

When a Community Care Worker is asked to support clients during a medical appointment it is not the workers responsibility to accept and pass on specific instructions for changes to the client's care. The medical practitioner is requested to complete written instructions detailing changes to the care required – each personal care provider organisation is then responsible, through their own procedures, to implement those changes if appropriate, or refer to another service provider for service delivery.

No assistance with foot, skin and nail care can be given unless the Community Care Worker has completed the relevant training (CHCICS306A <sup>28</sup>). All clients requiring this assistance should have been assessed by an appropriate health professional (eg podiatrist) who will provide written instructions and a determination if any client/Community Care Worker specific training is required. See section on Community Care Worker training, Page 9.

All clients referred for or requesting assistance with prescribed exercise or therapy programs must have an appropriate health professional assessment. The health professional can then provide appropriate instructions as to the tasks required and method of delivery, along with a determination of any requirement for client/Community Care Worker specific training.

Percutaneous Endoscopic Gastrostomy (PEG) feeding is not considered a 'medication' but a 'feed'. However it is important to note that personal care provider organisations cannot assist with any medication within the feed. Any referral for support with this service must be completed following assessment by an appropriate health professional and accompanied by appropriate written instructions and client/Community Care Worker specific training.

Whilst Community Care Workers do have a role in monitoring client's health and wellbeing this is not a clinical responsibility. Community Care Workers are requested to be observant when they work with clients and report changes in such things as behaviour, functional ability, health, (observable or reported by clients) to their immediate supervisor. Each personal care provider organisation must have procedures and processes for reporting concerns raised by Community Care Workers – this is most commonly to the organisations assessment team for further assessment or review.

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<sup>28</sup> CHC08 Community Services Training Package – Provide basic foot skin and nail care

## ASSISTANCE WITH CLIENT MEDICATIONS

This section of the protocol has taken into account the recent Assistance with medication by HACC Community Care Workers advice provided by HACC Service Development, Victorian Department of Health, September 2009.

Various parameters relating to medication service delivery have been set by practitioners in the Grampians Region in relation to what is appropriate for Community Care Workers to do.

Client assessment by an appropriately qualified health professional must be completed prior to a personal care provider organisation undertaking any service in relation to medication.

A medical practitioner is the appropriate assessor for clients being referred for assistance with non Dose Administration Aid medication (eg prescription and over the counter eye drops, application of cream and lotions, etc). The medical practitioner is also requested to complete a written authorisation for a Community Care Worker to assist and to provide task instructions.

It is the role of the qualified health assessor, based on client needs, complexity and stability of condition to determine if it is appropriate for a Community Care Worker to assist with the care, and if so, what (if any) specific client/Community Care Worker training is required prior to handover of support to a personal care provider organisation.

It is the responsibility of the personal care provider organisation to ensure that if there are doubts relating to the client's suitability to be supported by a Community Care Worker they liaise with the qualified health assessor to consider further assessment, client/Community Care Worker specific training or refusal of service. This includes prescribed and over-the-counter creams, lotions, eye drops, ear drops, patches, Epi-Pen use, inhalers with spacers/nebulisers.

The following medication support and assistance is not within the scope of practice for Community Care Workers:

- oxygen therapy
- some skin patches
- injections, however some such as Epi-Pens may be appropriate dependent on clinical assessment
- liquid medication unless assessed by an appropriate health professional (usually a medical practitioner) making a clinical judgement that this is a safe practice for a Community Care Worker
- suppositories
- decision making, preparation or checking of medication eg insulin pens, blood sugar levels

It is recommended that, where possible, all assessments for personal care support with medication be completed in the client's place of residence.

All clients must have an acceptable Dose Administration Aid (DAA)<sup>29</sup>, filled by a pharmacist, prior to personal care support being provided with tablet and/or capsule medication. When a client has been prescribed a change in medication the change must be included in their DAA – no support will be given with tablets/capsules that are not dispensed within the DAA.

No personal care provider organisation should accept a client for assistance with medication from a Dose Administration Aid without appropriate written instructions from a suitably qualified health professional. It is the responsibility of the qualified health assessor to complete the instructions and forward with the SCTT referral to the personal care provider organisation.

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<sup>29</sup> See Glossary for more detail

A Community Care Worker can only be asked to provide assistance with medication if they have completed the required medication training and any relevant pre-requisite units, see Appendix I. It is recommended within the Grampians Region that Community Care Workers also complete the medication training before monitoring/observing self medication.

All clients receiving support with medication are recommended to have a regular comprehensive medication management review (annually or as the situation warrants it) via the General Practitioner or Pharmacist.<sup>30</sup> The decision to initiate and undertake this review is the responsibility of the Medical Practitioner, Pharmacist or client, however a HACC service provider organisation may request a review as considered appropriate.

No assistance with medication or monitoring self medication should be provided to a person on an ad hoc basis. This includes all forms of prescribed and over the counter medications. Assistance should always be given in accordance with the assessment of the person's needs and the instructions in the written care plan.<sup>31</sup>

No assistance with P.R.N.<sup>32</sup> (as needed medication, for example pain medication) medication should be provided unless it is included in the client's DAA and care plan.

No assistance should be provided with liquid forms of oral medication (administration) unless the client has been assessed by an appropriate health professional and it is included within the client care plan.

Providing assistance with medication for children is to be treated in the same way as for adults, using the process of assessment by an appropriately qualified health professional, documented instructions, and client/Community Care Worker specific training where appropriate.

Clients who receive case management programs such as Community Aged Care Packages, Extended Aged Care at Home (EACH) and EACH Dementia can be supported with medication assistance using the same process as with HACC clients. Clients receiving a Linkages Program are HACC funded and therefore the HACC Personal Care Policy and this protocol applies.

#### **Case Manager Program:**

- If it is identified that the client requires assistance with medication it is the Case Managers responsibility to ensure that: any referral for support with this service must be completed by an appropriate health professional and accompanied by appropriate written instructions and any client/Community Care Worker specific training (if appropriate).

#### **Hospital Based Program (eg Post Acute Care, Hospital to Home, etc):**

- If it is identified pre discharge from hospital that the client requires assistance with medication it is the responsibility of the hospital program to ensure that: any referral for assistance with medication must be completed by an appropriate health professional and accompanied by written instructions and client/Community Care Worker specific training (if appropriate).
- If it is identified post discharge that a client requires assistance with medication it is the responsibility of the current service provider to liaise with the hospital program manager: to discuss client funding needs and negotiate an appropriate referral process for further assessment by a qualified health professional.

All personal care provider organisations must have appropriate procedures for reporting issues with medication such as: medication not taken from DAA, tablets/capsules missing from the DAA, client refusal to take medication, etc. This procedure should include reporting responsibilities on the part of the Community Care Worker, action to be taken by supervisors and who is to be advised.

<sup>30</sup> Guiding principles for medication management in the community, Australian Pharmaceutical Advisory Council June 2006, P31

<sup>31</sup> Assistance with medication by HACC Community Care Workers, HACC Service Development, Victorian Department of Health, September 2009

<sup>32</sup> PRN – pro re nata – where necessary, <http://www.medilexicon.com/medicaldictionary.php>

## CONCLUSION

The requirements for service delivery as listed above are not an exclusive list. They are a reflection of discussion at the time they were written. Requests for the delivery of other tasks in relation to personal care must be considered carefully in relation to the task, the client, the situation and the training/competency of the Community Care Worker.

All HACC funded personal care providers are expected to deliver the full range of personal care services as listed on page five. If a client has an unstable health status and/or complex care needs the delivery of these services may be more appropriate for a nursing service. If the client has been assessed by a relevant health professional and it is considered appropriate for service delivery to be referred to a personal care provider organisation, acceptance of the referral will be dependent on the availability of appropriately trained Community Care Workers.

Service provider communities should develop their own clear guidelines for the handover of service and agreed tools for documentation and the provision of instructions. A suite of tools is provided within the Grampians Region Personal Care protocol to support this process – these tools are examples only, and may be used where considered appropriate by the service provider community.

It is the responsibility of each personal care provider organisation to maintain an up to date procedure manual and process for updating as HACC Policy changes and new advice from the Victorian Department of Health is received.

It is the responsibility of each personal care provider organisation to form and maintain effective working relationships with other service providers in their own community. These effective working relationships will promote shared expectations, smooth referral processes and the use of common tools such as a service handover plan and inter-agency agreements for shared care.

## **SUITE OF GRAMPIANS REGION PERSONAL CARE SUPPORT TOOLS**

All of the following tools have been developed through consultation within the Grampians Region, research of similar types of tools used by other organisations and commercial companies where available.

### **1. Service Handover Plan**

This form was designed to provide handover instructions for personal care services. It can be used:

- As a handover tool from one service provider to another – but the form can also be used:
  - o Within personal care provider organisations when completing assessments
  - o By Community Care Workers as instructions for service delivery

The tool can be used for the initial handover of service or as a review tool for clients receiving a service from a personal care provider organisation but requiring regular care need reviews by an appropriate health professional.

This tool can be used electronically and/or as a paper copy. Instructions on how to use the form electronically can be found on the accompanying CD.

### **2. Medical Practitioner – Medication Service Handover Plan**

As nursing services and pharmacists are unable to 'transcribe' medication orders this form was designed for completion by a medical practitioner.

The form allows the medical practitioner to advise the personal care provider organisation of the task requested, the instructions for service delivery and the requirements for review of service need.

It is acknowledged that not all medical practitioners will be prepared to use this form – but for those that are (particularly General Practitioners) it is possible to have the form integrated into their desktop system to increase the useability of the form.

This tool can be used electronically and/or as a paper copy. Instructions on how to use the form electronically can be found on the accompanying CD.

### **3. Client Consent to Service Delivery and Information Sharing**

This form has been designed to capture client consent to the following:

- Consent to service delivery as listed on the form
- Consent to sharing of information with relevant others with the exception of those listed
- Consent to making referrals to another service provider on the clients behalf

The form acknowledges the expectations of the Victorian HACC Program Manual through addressing the key elements of: outlining the purpose of the service, access, allocation of priorities, user charges and appeal or complaint mechanisms.<sup>33</sup>

This form is designed to be used as a hard (paper) copy – it is recommended that each personal care provider organisation has the form printed as a duplication (eg two copies) so that the service provider and the client each have a copy.

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<sup>33</sup> Victorian Home and Community Care (HACC), Program Manual, February 2003, P100

#### **4. Community Care Worker - Assistance with Medication Record - Task Instructions**

Grampians Region personal care provider organisations have chosen to recommend a form that Community Care Workers can sign after each service delivery task relating to medication. This form is designed to be left at the client's house and returned to the provider organisation for replacement or changes to service delivery instructions as required.

It is important for organisations to consider the type of incident reporting processes they currently use and ensure that service delivery incidents are captured, recorded and monitored.

This tool can be used electronically and/or as a paper copy. Instructions on how to use the form electronically can be found on the accompanying CD. It is recommended that providers use the first page of this form electronically and the sign off sheet for the Community Care Workers remains as hard (paper) copy only.

#### **5. Notification of Commencement of Personal Care Support**

This notification is for use by personal care provider organisations as a strategy to ensure that other service providers are advised when a personal care service is commencing and the type of care being provided.

It is recommended that service providers adapt this form for their own use and print it on their organisations letterhead.

This form is not intended to replace the Service Coordination Template Tool for inter-agency care plan documentation.

#### **6. Community Care Worker - Client Specific Training Record**

A client specific (non-transferable skills) training record should be maintained at the personal care provider organisation. This form is a support mechanism for providers to ensure that clients requiring non-transferable skills from the Community Care Worker are not inadvertently sent a carer that is unable to deliver a safe and effective service.

This tool can be used electronically and/or as a paper copy. Instructions on how to use the form electronically can be found on the accompanying CD.

The personal care provider organisation must also maintain a Community Care Worker data base of transferable skills and qualifications acquired and show evidence of maintenance of these skills.

# APPENDIX A:

## SERVICE HANDOVER PLAN

CLICK HERE TO  
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### Service Handover Plan – Personal Care Tasks

New Referral:

Review of Client Plan:

I have assessed this client and endorse that he/she is suitable for assistance by a Community Care Worker.

Assessor Name:		Client Name:	
Organisation:		DOB:	Record No:
Qualification:		Telephone No:	
Date of Assessment:		Address:	

Tasks requested to be undertaken	
Frequency and preferred days/times	
Do any of the above tasks require Client/Worker specific training? Yes <input type="checkbox"/>	(time to be arranged for training)
No <input type="checkbox"/>	

#### Assistance with medication tasks as follows: Dose Administration Aid

**Describe type of assistance and any specific requirements:**

Eg: take tablets from blister pack, put in clients hand, observe while she takes them. Location of locked box if one is used.

**Medication to be taken at the following intervals and times:**

Breakfast (    am)  Lunch (    pm)  Dinner (    pm)  Bedtime (    pm)

#### Existing Household Aids/Equipment:

Shower over bath	<input type="checkbox"/> Bath board	<input type="checkbox"/> Transfer bench	<input type="checkbox"/> Swivel Seat	<input type="checkbox"/> Rails	<input type="checkbox"/> Non-Slip Mat	<input type="checkbox"/> HH Shower
Shower recess	<input type="checkbox"/> Stool	<input type="checkbox"/> Chair	<input type="checkbox"/> Safe to Stand	<input type="checkbox"/> Rails	<input type="checkbox"/> Non-slip Mat	<input type="checkbox"/> HH Shower
Toilet	<input type="checkbox"/> No aid	<input type="checkbox"/> Over toilet aid	<input type="checkbox"/> Toilet Inside/Out	<input type="checkbox"/> Rails	<input type="checkbox"/> Commode	<input type="checkbox"/> Donut

Other Aids/Equipment:

Referral Sent for Further Aids:  Yes  No

#### Assistance with other personal care tasks as follows:

<b>Mobility</b>	<b>Specific Instructions:</b>
<input type="checkbox"/> No aid	
<input type="checkbox"/> Walking Stick	
<input type="checkbox"/> Crutches	
<input type="checkbox"/> Pickup frame	
<input type="checkbox"/> Wheelie walker	
<input type="checkbox"/> Wheelchair	<b>Specific Instructions:</b>
<b>Transfers</b>	
<input type="checkbox"/> Lie to sit	
<input type="checkbox"/> Sit to stand	
<input type="checkbox"/> On/off toilet	
<input type="checkbox"/> In/out shower/bath	
<input type="checkbox"/> Lifting Machine	

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<b>Washing / Drying</b>	<b>Specific Instructions:</b>
<input type="checkbox"/> Upper body	
<input type="checkbox"/> Lower body	
<input type="checkbox"/> Skin Integrity	
<input type="checkbox"/> Feet and Nails	
<input type="checkbox"/> Hair	
<b>Dressing</b>	
<input type="checkbox"/> Upper body	
<input type="checkbox"/> Lower body	
<b>Grooming</b>	
<input type="checkbox"/> Shaving	
<input type="checkbox"/> Teeth	
<input type="checkbox"/> Make up	
<input type="checkbox"/> Dentures	
<b>Toileting</b>	
<input type="checkbox"/> Prompt	
<b>Incontinent</b>	
<input type="checkbox"/> Urine	
<input type="checkbox"/> Faeces	
<b>Aids Used</b>	
<input type="checkbox"/> Pads	
<input type="checkbox"/> Pull up Pants	
<input type="checkbox"/> Catheter	
<input type="checkbox"/> Night time Kylie	
<b>Appliances / Aids</b>	
<input type="checkbox"/> Pressure Stocking	
<input type="checkbox"/> Brace	
<input type="checkbox"/> Hearing Aid(s)	
<input type="checkbox"/> Prosthesis	
<b>Other Tasks/Further Instructions</b>	
<p>Eg: apply non-medicated skin cream (name of product, where and how to apply and frequency of application)</p>	

The personal care provider will endeavour to schedule all client visits at the required time but be aware that this may be affected by conditions outside of their control.

**Client Consent for Handover of Service:** YES  NO

**Estimated time to deliver service: Medications:**  **Other Personal Care Tasks:**

**Medications: Date of next service review:**  **By:**

**Other Tasks: Date of next service review:**  **By:**

Please complete this form and send with the SCTT referral tool to the personal care provider organisation

This form is designed to be used by health professionals (eg Division One Nurse, Medical Practitioner, Pharmacist) when requesting that a personal care provider take on the tasks nominated. The Grampians Region Personal Care Protocol provides further information relating to the role and function of Community Care Workers and the requirements for service delivery.

**GRAMPIANS REGION PERSONAL CARE PROTOCOL**

# APPENDIX B:

## MEDICAL PRACTITIONER - MEDICATION SERVICE HANDOVER PLAN

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### Medical Practitioner – Medication Service Handover Plan

New Referral:

Review of Client Plan:

This form is designed to be used by a Medical Practitioner when requesting that a personal care provider take on the task nominated.

Client Name:		DOB:	
Address:		Client Record No:	
Doctor Name:		Date of Assessment:	
Qualification:		Organisation:	

#### Assist with Medication task as follows:

	Application Instructions/Specific Comments
Name of product	
Where is it to be applied	
Quantity to apply	
Frequency of application and/or preferred time	
Special Instructions	

Please tick appropriate service provider for this medication:

Suitable for nursing service       Suitable for Community Care Worker

#### Assistance with medication task as follows: Dose Administration Aid

**Describe type of assistance and any specific requirements:**

Eg: take tablets from blister pack, put in clients hand, observe while she takes them.

**Medication to be taken at the following intervals and times:**

Breakfast ( am)    Lunch ( pm)    Dinner ( pm)    Bedtime ( pm)

The personal care provider will endeavour to schedule the client visit at the required time but be aware that this may be affected by conditions outside of their control.

Pharmacy Name (if known): \_\_\_\_\_ Phone No: \_\_\_\_\_

#### Length of time medication is required:

Commencement:

Cease Date: \_\_\_\_\_ OR

Continue Indefinitely:  Yes    No

**Review of Medication Task:** (medical practitioner to determine frequency of review)

By: .....

Date of review:

**Signature of Doctor completing this form:** .....

Please complete this form and send at the same time as the SCTT (other) referral tool to the personal care provider organisation

**GRAMPIANS REGION PERSONAL CARE PROTOCOL**

# APPENDIX C:

## CLIENT CONSENT TO SERVICE DELIVERY AND INFORMATION SHARING

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### Client Consent to Service Delivery and Information Sharing

<b>Client Name:</b>		<b>DOB:</b>	
<b>Address:</b>		<b>Client Record No:</b>	

Service to be Provided by (Name of Agency):

Type of Service Eg: personal care	Specific Service Details Eg: assistance with medications am and pm, seven days	Cost Eg: \$3 per hour

The assessment staff member has discussed with me the above level of service provision and I understand these services can be reviewed at any time, at my request or at the request of the agencies assessment worker.

The assessment staff member has explained to me that sharing information with other services providers is recommended to avoid duplication in information collected and care provided. I understand the types of information which will be shared: (please include) demographics, health and wellbeing, home and social situation, services provided.

I consent to this organisation sharing my information with relevant others involved in caring for my health and well being, these include: my doctor, other health professionals, spouse/partner, family, chemist and carer – **with the exclusion of:**

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Consent to Make Referrals to Other Providers:

Name of Provider Eg: Dr Jane Doe	Service Details Eg: Medical Services	Consent to Share all Relevant Information

Record of Consumer Consent:

<p><b>Written Consent</b></p> <p>I understand the nature and cost of recommended services and the type of information which may be shared between my care providers, and as part of a referral - I give my consent for the information to be shared as detailed above.</p> <p>Signed: _____ Date: _____</p> <p>Name: _____</p> <p>Witnessed: _____</p> <p>Assessment Worker Name: _____</p>	<p><b>Verbal Consent</b></p> <p>Should only be used where it is not practicable to obtain written consent:</p> <p>I have discussed the care plan with the consumer or authorised representative and am satisfied that the consumer and/or authorised representative understands the proposed uses and disclosures, and has provided their informed consent to these.</p> <p>Assessment Worker Name: _____</p> <p>Signature: _____</p> <p>Date: _____</p>
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Please ensure that the client receives a copy of this consent document and a brochure explaining privacy protection within your organisation

**GRAMPIANS REGION PERSONAL CARE PROTOCOL**

# APPENDIX D:

## COMMUNITY CARE WORKER - MEDICATION ASSISTANCE RECORD - TASK INSTRUCTIONS

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### Community Care Worker - Assistance with Medication Record - Task Instructions

Please ensure that you follow the instructions as written; sign off the form each time you undertake the task; complete the comments reporting section if an issue arises

Client Name:	DOB:
Address:	Client Record No:
Instructions Written By:	Date:

Assist With Medication Tasks as Follows – (ensure that you always wear gloves when assisting clients with medication)

<b>TASK ONE</b>          <b>Date Medication Commenced:</b> <b>Date Medication to Cease:</b>	<b>TASK TWO</b>          <b>Date Medication Commenced:</b> <b>Date Medication to Cease:</b>	<b>TASK THREE</b>          <b>Date Medication Commenced:</b> <b>Date Medication to Cease:</b>
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Instructions Written By:  
Client Name:

Date:  
Address:



**APPENDIX E:  
NOTIFICATION OF COMMENCEMENT  
OF PERSONAL CARE SUPPORT**

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**Notification of Commencement of Personal Care Support**

**Date:**

**Advisement To:**

**Name:**  
**Organisation:**  
**Address:**

The following client has recently commenced Home and Community Care – Personal Care Service(s) with our agency.

**Client Name:**

**Address:**

**Date of Birth:**

The service(s) received by \_\_\_\_\_ are as follows:

Type of Service	Frequency of Service	Date of Commencement

**Any other comments:**

If you would like further details regarding the above service(s) or would like us to be aware of any other issues which may affect our service delivery please contact me on (telephone number).

Yours sincerely,

**Signature**

**Name:**

**Position:**



**APPENDIX G:**  
**LIST OF PARTICIPATING/  
 ENDORSING ORGANISATIONS**

ORGANISATION	ORGANISATION
Ararat Rural City Council	Ballan District Health and Care
Ballarat District Nursing and Healthcare	Ballarat Health Services – Community Programs
Beaufort and Skipton Health Service - Beaufort	Beaufort and Skipton Health Service - Skipton
City of Ballarat	Djerriwarrh Health Service
Dunmunkle Health Services	East Grampians Health Service
East Wimmera Health Service	Edenhope and District Memorial Hospital
Elmhurst Bush Nursing Service	Golden Plains Shire
Harrow Bush Nursing Centre	Hepburn Health Service
Hepburn Shire Council	Hesse Rural Health Service
Hindmarsh Shire Council	Horsham Rural City Council
Lake Bolac Bush Nursing Service Inc.	Maryborough District Health Service
Moorabool Shire Council	Northern Grampians Shire Council
Pyrenees Shire	Stawell Regional Health
Rural Northwest Health	West Wimmera Health Service
West Wimmera Shire Council	Wimmera Health Care Group
Woomelang and District Bush Nursing Service	Yarriambiack Shire Council

## **APPENDIX H:**

### **HOME AND COMMUNITY CARE – PERSONAL CARE POLICY**

This copy of the Home and Community Care Personal Care Policy was downloaded from the Victorian Department of Health website on the 23rd of September 2009. It contains information about qualifications and competency units for personal care as at 2003.

Assistance with medication by HACC Community Care Workers September 2009 (Appendix I) contains an update incorporating qualifications and competency units in CHC08 Community Services Training Package (endorsed December 2008).

## 7.6 Personal Care

### 7.6.1 Introduction

This section documents the HACC Program Personal Care Policy. It applies to Personal Care as a funded HACC activity and to situations where personal care is provided as part of another HACC activity, such as Respite – Home and Community, Respite – Overnight or by a HACC Response Service

### 7.6.2 Provision of Personal Care

Personal Care describes assistance with activities that people would normally do for themselves but they are unable to perform without assistance because of illness, disability or frailty. Examples of personal care are bathing, dressing, grooming, toileting, and assistance with getting in and out of bed and assistance with mobility and eating.

Personal care services are provided by paid staff as part of the following HACC activities:

- Personal Care
- Respite (Home and Community)
- Respite (Overnight)
- Planned Activity Group-Core
- Planned Activity Group-High
- HACC Response Service component of Service System Resourcing
- as part of a Linkages package.

Volunteers may provide respite services but it is not expected that they will provide personal care as part of the volunteer respite service. Volunteer respite is funded through the activity Volunteer Coordination.

All paid staff delivering personal care, as part of the HACC activities listed above, must have completed appropriate registered vocational training before delivering personal care.

The range of appropriate training is explained in Sub-Section 3.8 Staff Training and Support and repeated below.

HACC funded agencies may be involved in the assessment of personal care needs, the training of personal care workers delivering the tasks, the supervision of the personal care workers undertaking the tasks, or the monitoring and review of the consumer's needs. All staff should have undertaken appropriate registered vocational training.

Personal care is provided in a range of locations, including the consumer's home, at service and community venues, and in a range of community settings.

### 7.6.3 Definition of Personal Care

Personal care provides assistance with those tasks which a person would normally do for themselves but because of illness, disability or frailty they are unable to perform without the assistance of another person.

Examples of personal care service include:

- assistance (or supervision) with bathing, showering or sponging
- assistance with dressing and undressing
- assistance with shaving, hair care and grooming
- limited nail care, only following appropriate professional assessment
- assistance with mobility (in bed and out of bed) such as to sit up, to turn, to stand and walk, to sit, to transfer to commode, wheelchair, chair or vehicle
- assistance with eating, drinking, cooking, preparation and service of food preparation of special diets
- assistance with toileting
- assistance with prescribed exercise or therapy programs\*
- fitting and use of appliances such as splints and callipers, or hoists
- assistance with hearing aids and communication devices
- monitoring self-medication
- escorting to medical and other related appointments.

\*This assistance can be provided on a consumer-specific, non-transferable skills basis. Personal care workers must not be taught a standard set of exercises or a therapy program to use across the HACC target group as this is outside the scope of a personal care worker's role.

### 7.6.4 Determining Need for Personal Care

The need for personal care is determined following an assessment of each individual consumer's needs. It is essential that individual consumers are assessed and have a care plan developed which reflects the person's individual needs. The assessment process and development of care plans should include health professionals with appropriate qualifications and training, relevant to the needs of the consumer. The identification of appropriate personnel to provide personal care should be undertaken following an assessment of the consumer and should be

based on the needs and characteristics of the consumer, not on the tasks to be performed.

### 7.6.5 Consumers with Unstable Health Status

Personal care procedures are regarded as transferable, that is, skills that can be obtained in a registered vocational training program and then applied with a number of consumers. Further consumer-specific education and training is necessary where personal care workers have been delegated a role in the care of consumers with an unstable health status or complex needs.

Some individuals may be assessed as having an unstable health status and/or complex needs. Personal care workers may be requested to provide aspects of care for these consumers, depending on individual circumstances. This type of care can be compared to that which a family member or friend could reasonably be expected to give without endangering the well being of the consumer. However, if a personal care worker is delegated a role in the provision of care to a consumer with an unstable health status and/or complex needs, the ongoing involvement of a Registered Nurse Division 1, and where necessary, other relevant health professionals, in the care of the consumer is essential.

The provision of personal care to consumers with an unstable health status and/or complex needs, requires the skills of a Registered Nurse Division 1 and, where necessary, other relevant health professionals, to train and supervise personal care workers. It is important that training and the supervision of personal care are ongoing and not considered as one-off events. The skills required of personal care workers providing care to consumers with an unstable health status and/or complex needs are regarded as non-transferable, i.e. skills learnt in the context of caring for a particular consumer cannot then be used in caring for another consumer. Consumer specific training is required for every individual consumer with unstable health and/or complex needs.

For the provision of personal care, where a consumer may have unstable health and/or where they have complex needs, it is essential that a Registered Nurse Division 1 and, if necessary, other relevant health professionals undertake the assessment, care planning and evaluate the consumer's care on a regular basis.

A personal care worker who is prepared to be trained in and to perform a particular non-transferable skill would need to be selected to undertake a non-transferable skill. Personal care workers may refuse to be trained in and undertake a non-transferable skill where they feel uncomfortable doing so.

### 7.6.6 Principles for Personal Care Service Provision

The following principles should underpin personal care service provision:

- the services should be adequate to meet the consumer's assessed needs and provided in a flexible manner
- the services should be planned, appropriate, responsive and reliable in order to meet the particular needs of the consumer/carer
- information on all available and relevant services should be provided to enable consumers to make informed choices
- services to the individual consumer/carer should be coordinated and integrated to minimise the number of different service providers involved in the care planning and service provision
- the service system should provide personal care workers who receive appropriate accredited training, ongoing supervision and in-service training
- the continuity of health professionals and/or personal care workers should be a priority for service providers
- the service system should be consumer/carer focused, not agency focused:
- assessment and the provision of care should be based on the individual's need, not the tasks to be performed, or the services currently provided by the agency
- services provided should take into account cultural issues, the consumer/carer's values and religion
- service planning should involve the consumer's carer, if they have a carer, as this is person most aware of the consumer's particular needs apart from the consumer themselves
- individual consumers with an unstable health status and/or complex support needs should be able to move through and within the service system due to changes in need, age or geographic location without experiencing interruption to the provision of services.

### 7.6.7 Integrated Service System

From a consumer's perspective, personal care is delivered most efficiently and effectively when they are receiving services appropriate for their needs, when the services are uncomplicated, and when they are provided in a flexible manner. This requires an integrated service system at the local level, referring to a system of coordinated care.

From a service provider's perspective, clarification of the role of each service provider in assessment, referral, service provision, monitoring and supervision are important elements in the provision of personal care.

From this perspective, personal care services provided within the framework of an integrated service system have several key features:

- a joint commitment to service delivery which ensures continuity of care for consumers supported by clear agency and inter agency protocols
- processes for sharing of information and resources between organisations
- a shared responsibility, or team approach involving all relevant professionals, including a registered nurse division 1, in the assessment of the consumer and care planning
- a protocol for determining the lead agency for case coordination and review
- appropriately trained and qualified staff for all aspects of care.

In all cases, effective hands over of care and referral procedures are important elements. It is important that care arrangements, and any changes to them, are negotiated with consumers and carers. It is also important that agency and inter agency protocols and procedures facilitate timely and appropriate referrals and notification of changes to the consumer's condition to relevant health care disciplines.

Organisations operating within an integrated service system should ensure that cooperative work practices, underpinned by clear agency and inter agency protocols, are adopted and maintained within the local network. The approach to service delivery should be driven by individual consumer needs, the wishes of the consumer and carers, and not the needs of the service provider.

### 7.6.8 Duty of Care

It is a general legal standard that HACC consumers have a right to expect that the people providing nursing or personal care possess the necessary skills and knowledge to provide that care. Consumers also have the right to expect that all those who provide care will take reasonable care to avoid harming them, to protect them from injury, and to take appropriate actions to prevent injury.

All workers and staff owe a duty of care to consumers and are responsible and independently accountable for their actions at all times. Therefore, health professionals are obliged to use their professional judgement in regard to the delegation of aspects of a consumer's care to a personal care worker.

Health professionals should have the ability to decide whether or not to delegate aspects of a consumer's care to personal care workers, taking into account relevant legislation, professional codes of conduct, ethics and the policies of professional and registration bodies.

Service provider organisations should provide support to health professionals in this duty such as training and education and the establishment of written protocols.

### 7.6.9 Responsibilities of Funded Agencies

Funded Agencies involved in providing personal care services have responsibility to ensure that:

- personal care workers operate within agreed agency and inter agency protocols for the hand over of care, case management, training and supervision, and referral of consumers. there should be good liaison between organisations
- appropriate assessment and care planning occurs
- consumers have access to personal care services which will meet their assessed needs
- staff availability is sufficient to respond to referrals, make regular reviews and appropriately liaise with other people involved in the care
- personal care workers have the appropriate registered training, knowledge and skills to meet the personal care requirements of the consumers and that opportunities exist for ongoing staff development and supervision
- remuneration and classification of personal care workers recognise the level of skills and knowledge required to provide personal care services
- an accountable system of assessment, referral, training, supervision, monitoring and review of personal care workers is in place.

#### **Consumers with Unstable Health Status**

Where personal care workers are delegated a role in the provision of care to a consumer with unstable health status and/or complex needs this means that:

- the assessment process includes a registered nurse division 1, who provides or delegates care and maintains responsibility for ongoing monitoring and supervision of those aspects of the consumer's care
- the personal care worker has been trained in consumer-specific care by a Registered Nurse Division 1 and if necessary other relevant health professionals
- there is monitoring and supervision of the personal care worker and the consumer which are appropriate to the type and level of care being provided, and the characteristics of the consumer
- there is an appropriately qualified supervisor, or back-up person for the personal care worker to refer to if necessary. Registered Nurses Division 1, and if appropriate, other relevant health professionals, will be called upon to perform this role
- a process for reporting changes observed in the consumer's condition or status has been specified

- in instances where personal care workers are delegated a role in the provision of care to consumers with an unstable health status and/or complex needs, they receive training in the care required by the specific consumer and the skill levels of personal care workers are assessed as adequate, and are monitored and reviewed. the skills learnt in this context are not transferable.

#### 7.6.10 Responsibilities of Health Professionals

It is essential that individual consumers are assessed and have a care plan developed which reflects the person's individual needs. For the provision of personal care, the assessment process and development of care plans should include health professionals with appropriate qualifications and training, relevant to the needs of the consumer. Appropriate qualifications are: Medical Practitioner, Registered Division 1 Nurse, Occupational Therapist, Physiotherapist, Speech Pathologist, Podiatrist and Dietician. Consumer/carer participation in the development of the care plan is also critical.

In general, the responsibilities of health professionals include:

- working within the expectations and boundaries of their profession. this document should not conflict with accepted professional roles or responsibilities, or the roles and responsibilities of relevant registration bodies
- keeping up-to-date with particular skills, or techniques of assessment, or care provision within their area of professional expertise and addressing their ongoing training needs
- enhancing continuity of care and consumer focused service provision
- regularly monitoring individual consumers, reviewing and updating individual care plans within their area of professional expertise
- implementing agency and inter agency protocols and accepting responsibility for case management, training, and supervision of personal care workers, within their area of professional expertise.

#### 7.6.11 Responsibilities of Personal Care Workers

Responsibilities of personal care workers involved in the delivery of personal care services include:

- working within the parameters of their job as determined by their employment skills, training, local area work agreement (LAWA), contract or award
- keeping up-to-date with personal care techniques and addressing their training needs
- following care plans

- actively observing consumer well being and reporting to their supervisor or back-up person any changes in consumer health status or conditions.

#### 7.6.12 Assessment for Personal Care

Responsibilities of organisations and individuals involved in the assessment process for personal care services include ensuring that:

- the consumer/carer/legal guardian is informed of their right to be involved in decisions regarding their care
- assessment is undertaken by staff with adequate skills and training. for the provision of personal care, assessment will be undertaken by a Registered Nurse Division 1, and if necessary other relevant health professionals, where the consumer's health may be unstable and/or where the consumer has complex needs
- assessment is undertaken according to agreed agency and inter-agency protocols, providing a framework for information to be sought, recorded and appropriate responses to the same
- the consumer and potential consumers of personal care services are provided with information in the appropriate community languages, outlining the purpose of the service, access, assessment, review procedures, allocation of priorities, user charges and appeal or complaint mechanisms
- the assessment function of the service is subject to monitoring and regular review.

#### 7.6.13 Care Planning

Care planning is an outcome of the assessment process. Care plans which include personal care where appropriate, should cover additional details as follows:

- the specific care procedures to be undertaken
- the health professionals and personal care workers involved in each aspect of the care
- any training required of the personal care workers including details of how competency will be assessed, who will undertake the training and in what time frame
- the process for reporting changes observed in the consumer's condition to relevant health professionals
- emergency procedures and phone numbers
- on call back-up people and processes
- the nursing, medical or allied health supervision or monitoring required in the situation (such as, visits from the district nurse at specific intervals)

- support and lines of accountability
- reassessment process and timelines.

Where a person has unstable health and/or complex care needs, the care plan must incorporate all of the above details.

*Refer Sub-Section 7.3 for further information about Assessment and Care Management.*

#### 7.6.14 Allocating Appropriate Workers

The decision of who provides and supervises personal care services should occur during the care planning process and can only be judged on an individual basis, taking into account the characteristics of the consumer, and where appropriate, their carer/s, not the tasks to be performed.

Where it has been decided that aspects of personal care can be delegated to a personal care worker the following should be considered in identifying an appropriate worker:

- the nature and level of the dependence/disability and the level of technological intervention, surveillance and decision making required
- the level of risk of deterioration in health status (including loss of function) and/or of institutionalisation, if appropriate, services are not provided and maintained
- the ability of the person and/or family to regain/maintain independence
- the complexity of the family/social dynamics
- the psychological status of the recipient of care and/or other informal carers
- the suitability and safety of the environment
- the consumer's and carer's wishes (taking into consideration their level of competency to make informed decisions)
- cultural and gender issues expressed by the consumer and/or carer
- the stability of the consumer's condition
- the availability of suitable personal care worker/s. (A worker who is prepared to be trained in and to perform a particular non-transferable skill would need to be selected. Workers may refuse to be trained in and undertake a non-transferable skill where they feel uncomfortable doing so.
- availability of suitable training in tasks and ongoing back-up
- the support and monitoring requirements
- health and safety issues for consumer and paid workers/staff
- the lines of accountability, support and legal liability.

Where a person has unstable health and/or complex needs, all of the above must be considered.

This information must be clearly documented and retained by the service provider.

#### 7.6.15 Hand Over of Care and Referral

Where an assessment and care planning process identifies that personal care should be transferred to another agency or personal care worker it is essential that:

- all parties, especially the consumer/carer, agree to the transfer of service provider responsibilities
- the incoming service provider receives an appropriate 'hand-over' in the care requirements of the particular consumer. if the care is being transferred to a personal care worker and involves a role in the provision of care for a consumer with an unstable health status and/or complex needs, this should include 'one-on-one' training by a relevant health professional. in most instances this would be the role of a Registered Nurse, Division 1.

#### 7.6.16 Stability of Health and/or Complexity of Needs

For the provision of personal care, in situations where a consumer's health may be unstable and/or they have complex needs, it is essential that a Registered Nurse Division 1, and if necessary other relevant health professionals undertakes the assessment, care planning and evaluates the consumer's care on a regular basis.

#### 7.6.17 Personal Care Training

There are several different categories of training provided:

##### **A. Registered Vocational Training**

Personal care workers must undertake appropriate registered vocational training before providing any HACC Program funded personal care services. This includes personal care provided through brokerage and sub-contracting arrangements.

Registered vocational, that is non-professional, qualifications obtained prior to 1994 are not recognised by the HACC Program in Victoria.

Between 1994 and 31 December 2000 workers providing HACC Program funded personal care were required to undertake Certificate III or IV in Community Services (Home and Community Care) including the personal care module. Since 1 January 2001 these courses are no longer provided. Those workers who have obtained Certificate III or IV in Community Services (Home and Community Care) including the personal care module, between 1994 and 2000, may provide HACC Program funded personal care services.

From the 1 January 2001 until 2003 workers providing HACC funded personal care services are required to have the Certificate III in Community Services (Aged Care), including the appropriate personal care competencies, as a minimum qualification. Where a worker has a higher level qualification, eg Certificate IV in Community Services (Aged Care), they must have also completed the appropriate personal care competencies.

In 2003 a new Community Services Training Package will be introduced. The qualification from the new package that will be required for HACC workers undertaking personal care is CHC30202 Certificate III in Home and Community Care and workers must have undertaken the competency units CHCHC302A Providing Personal Care and HLTA2A Apply Advanced First Aid as part of that qualification. Workers who have already obtained the qualifications listed above will continue to have their qualifications recognised by the HACC Program and may provide personal care.

Personal care services are to be provided by a Division 1 Registered Nurse, where required, as noted above.

Where HACC agencies are purchasing or sub-contracting the provision of Personal Care, they may only purchase or sub-contract Personal Care from services whose workers comply with the training requirements documented in this Manual.

### **B. Consumer-Specific or One-on-One Training**

In a situation where a health professional is delegating activities to personal care workers which involve aspects of care for consumers with an unstable health status and/or complex needs, it is important that the personal care worker is given consumer specific training in the care to be provided. The training given to personal care workers in this situation will be relevant for that consumer only. Skills learnt in consumer specific training are considered to be non-transferable. In other words, the personal care worker is not considered competent to undertake the procedure on other consumers without undergoing additional consumer-specific training.

The training required in these circumstances should be detailed in the assessment, and the checks and balances considered appropriate to ensure that the care arrangements are safe should be detailed in the care plan. These checks and balances would involve a defined monitoring and supervision regime of the consumer and personal care worker by a Registered Nurse Division 1, and if necessary other relevant health professionals.

In summary, in situations where consumer-specific or one-on-one training is required, the following must be adhered to:

- the training must be provided by a registered nurse division 1, and if necessary other qualified health professionals with expertise relevant to the area, and who are employed in that capacity

- the training must be provided in the context of passing on information about caring for that specific consumer
- the personal care worker must have had registered vocational personal care training
- the personal care worker must be employed at a skill level commensurate with the tasks.

### **C. In-Service Training**

Organisations providing personal care services should employ staff who have undergone registered vocational training and should provide regular and appropriate in-service or refresher training for staff. In-service training is useful in reviewing and appraising the ability of personal care workers, in assessing their competency and in determining future training needs.

## APPENDIX I:

# ASSISTANCE WITH MEDICATION BY HACC COMMUNITY CARE WORKERS

## Assistance with medication by HACC Community Care Workers HACC Service Development Victorian Department of Health September 2009

This advice supplements the HACC Personal Care Policy in the Victorian HACC Program Manual by advising about assistance with medication by HACC Community Care Workers. This September 2009 advice updates the advice of May 2008 by including reference to competency units in CHC08 Community Services Training Package which was endorsed in December 2008. It has been distributed to departmental regional offices as a pdf document and has been published on the HACC website at [www.health.vic.gov.au/hacc](http://www.health.vic.gov.au/hacc)

Assistance with medication by HACC Community Care Workers is part of personal care and is provided in accordance with the HACC Personal Care Policy. This advice and all HACC policies are consistent with the Australian Pharmaceutical Advisory Council's *Guiding principles for medication management in the community June 2006*. Staff of HACC funded organisations are advised to read this guide which is available from the APAC by calling (02) 6289 7753. This guide is applicable to all HACC activities including HACC funded respite and Planned Activity Groups.

As stated in the Victorian HACC Program Manual, all Community Care Workers who undertake personal care tasks funded by the HACC Program must adhere to the HACC Personal Care Policy and must have an appropriate minimum Certificate III level qualification with the relevant personal care and first aid competency units. See the training section of the Victorian HACC Program Manual for further information. Where a Community Care Worker holds a qualification not listed in the Manual or they have completed a qualification with out personal care and first aid competency units, whether the qualification is listed in the Manual or not, then they must complete these units before undertaking personal care tasks.

In addition Community Care Workers must have completed competency based medication training before assisting with medication. Staff, undertaking personal care tasks that have not completed this training can only monitor self medication as stated in the HACC Personal Care Policy in the Victorian HACC Program Manual.

Monitoring self medication consists of observing and reporting to your supervisor e.g. you have noticed medication has not been taken by the client. Assisting with medication includes the provision of physical assistance with medication or supporting clients with self medication in response to assessed need.

The relevant first aid and personal care competency units are:

*HLTFA 301B Apply first aid* – with updates in accordance with the Australian Resuscitation Council Guidelines and either

CHC02 Community Services Training Package:  
*CHCHC302B Provide personal care in a home and community care environment*

or

CHC08 Community Services Training Package:  
*CHCICS301A Provide support to meet personal care needs*

or

*CHCICS401A Facilitate support for personal care needs*

The relevant medication competency units are: either

CHC02 Community Services Training Package  
*CHCCS304A Assist with self medication*

or

CHC08 Community Services Training Package  
*HLTAP301A Recognise healthy body systems in a health care setting*  
and  
*CHCCS305A Assist Clients with medication (Note pre-requisite HLTAP301A)*

The training package CHC08 Community Services Training Package was endorsed in December 2008 and will be progressively implemented during 2009 and 2010. It replaces CHC02 Community Services Training Package which will be progressively phased out.

If a HACC Community Care Worker has not done any medication training they would need to do the two units from CHC08 Community Services Training Package.

If a HACC Community Care Worker has already attained *CHCHC302B Assist with self medication* from CHC02 Community Services Training Package it is recommended that they complete *HLTAP301A Recognise healthy body systems in a health care context* from CHC08 Community Services Training Package. They may also wish to complete *CHCCS305A Assist clients with medication*.

A new Level IV unit called *CHCCS424A Administer and monitor medications* has been included in CHC08 Community Services Training Package. Please note this unit is not required for the HACC Community Care Worker role.

Since the range of needs and circumstances of people using services funded through the HACC Program is very wide, the HACC Personal Care Policy focuses on organisations delivering HACC funded services ensuring that assessment, care planning and provision of personal care are done by appropriately qualified people.

A person who needs assistance with medication is likely to have either complex care needs and/or unstable health. In such cases an appropriate process would include: assessment by a Division 1 nurse or other health professional, determination if it is appropriate for a Community Care Worker to assist with medication, training for the Community Care Worker specific to the needs of that particular person by a Division 1 nurse or other health professional, ongoing support for the worker from a Division 1 nurse or other health professional and development and implementation of a written care plan for that person (Please note all HACC clients should have a written care plan). Some people who require monitoring of self medication may also have complex care needs and/or unstable health and above process would also apply to them.

Where appropriate the written care plan could include some physical assistance such as with the use of an inhaler depending on the outcome of the assessment of the person's care needs.

Where a clinical judgement has been made that it is not appropriate for a Community Care Worker to assist with medication, assistance can be provided by a HACC funded nursing service.

No assistance with medication or monitoring self medication should be provided to a person on an ad hoc basis. This includes all forms of prescribed and over the counter medications. Assistance should always be given in accordance with the assessment of the person's needs and the instructions in the written care plan.

HACC funded organisations are required to adhere to the HACC National Service Standards. These standards emphasise the need for good quality agency and service management, which includes the development of policies and procedures regarding service provision.

In accordance with these standards and to provide clear guidance to Community Care Workers in undertaking their role, HACC funded organisations should develop written policies outlining the processes that will take place when a Community Care Worker is assisting with medication or monitoring self medication as part of a person's written care plan.

Community Care Workers delivering HACC funded services are not permitted to make clinical judgements as this is the responsibility of clinical professionals such as Division 1 nurses, doctors etc. Community Care Workers need to have a clear understanding that their role is to provide assistance or monitoring only.

Therefore a HACC funded organisation's policy could include:

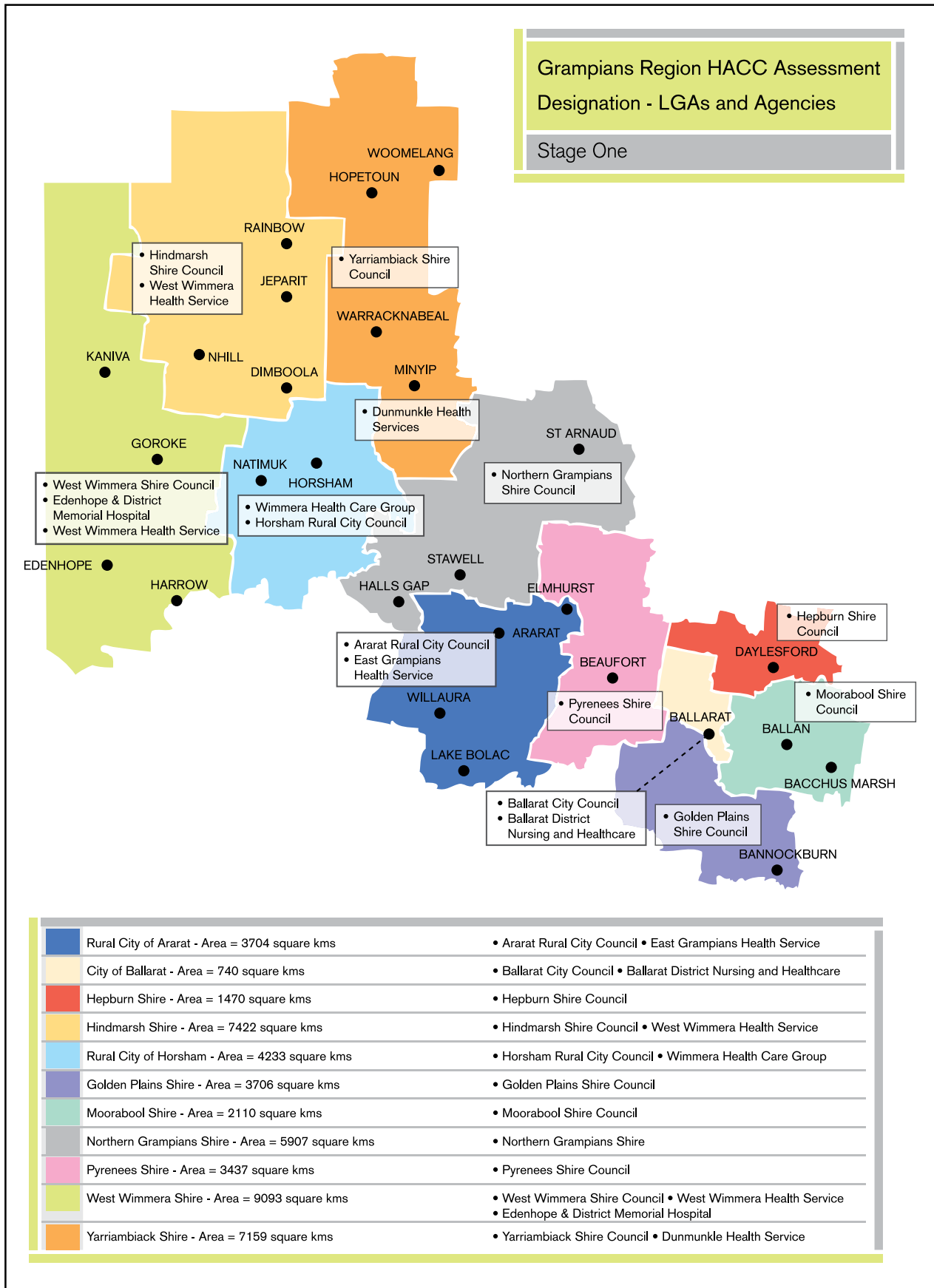
- Material from the HACC Personal Care Policy.
- A statement that the person receiving services or his or her carer is responsible for the person's medication regime.
- A statement that the person receiving services or his or her carer should have received professional advice from their general practitioner or a Division 1 nurse regarding the person's medication regime.
- A statement that the Community Care Worker provides assistance or monitoring with the already prepared medication dosage in accordance with the person's written care plan.
- A statement that the Community Care Worker does not determine the medication dosage or when medication will be given.
- Communication procedures including who the Community Care Worker is to contact if a request is made that is not part of the person's written care plan.
- Emergency procedures.
- Procedures for documenting self medication monitoring and assistance with medication.
- A statement that Community Care Workers are not to deviate from the instructions given to them by their supervisor and that they are not to take instructions from anyone else unless this has been prearranged as part of the care plan or is an instruction from emergency services personnel

As HACC services are provided in the person's own home on a time limited episodic basis, procedures and policies developed regarding monitoring self medication and assistance with medication are necessarily different to those developed for a residential care setting.

Victorian HACC Program documents including the Victorian Home and Community Care (HACC) Program Manual are available at [www.health.vic.gov.au/hacc](http://www.health.vic.gov.au/hacc)

**HACC Service Development  
Victorian Department of Health September 2009**

# APPENDIX J: DESIGNATED LIVING AT HOME ASSESSMENT SERVICES



## GLOSSARY

### **Medicine:**

A substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical or mental welfare of people. Includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route.<sup>34</sup>

### **Community Care Worker:**

Also known within the sector as a personal carer, personal care assistant, paid carer, home carer, home help, care worker.

### **Dose Administration Aid (DAA):**

A device or packaging system where doses of one or more solid oral dosage forms of medicines can be organised according to the time of administration.<sup>35</sup>

The DAA is also commonly called a Webster pack, Blister pack and other trade names.

### **Personal care provider organisation:**

Relates to an organisation providing personal care which is funded by the Home and Community Care Program, Victoria.

### **Ad Hoc Medication and/or Treatment:**

No assistance with medication or monitoring self medication should be provided to a person on an ad hoc basis. This includes all forms of prescribed and over the counter medications. Assistance should always be given in accordance with the assessment of the person's needs and the instructions in the written care plan.<sup>36</sup>

## KEY REFERENCE MATERIAL

- Victorian Home and Community Care Program Manual, February 2003 including:
  - Framework for Assessment in the Home and Community Care Program in Victoria, 2007,
  - Assistance with medication by HACC Community Care Workers  
HACC Service Development  
Victorian Department of Health  
September 2009
- Guiding Principles for medication management in the Community, June 2006, Australian Pharmaceutical Advisory Council
- Barwon South Western Region, Home and Community Care, Personal Care Protocol, Revised April 2007
- Drugs, Poisons and Controlled Substances, Act 1981, Version 083
- CHC08 Community Services Training Package, Australian Government, Department of Education, Employment and Workplace Relations

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<sup>34</sup> Guiding principles for medication management in the community, Australian Pharmaceutical Advisory Council, June 2006, P48

<sup>35</sup> Guiding principles for medication management in the community, Australian Pharmaceutical Advisory Council, June 2006, P46

<sup>36</sup> Assistance with medication by HACC Community Care Workers, HACC Service Development, Victorian Department of Health, September 2009