Health Care
Policy and Procedures

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Accommodation Policy and Development Directorate
Ageing, Disability and Home Care,
Department of Family and Community Services NSW
March 2007, amended September 2010, April 2012
Document approval

The document *Health Care Policy and Procedures* has been endorsed and approved by:

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Director-General, ADHC                Deputy Director-General, ADHC
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# Health care policy and procedures (March 2007) amended September 2010, April 2012

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1 Policy position and principles Policy statement

The *Health Care Policy and Procedures* has been developed for staff of Ageing Disability and Home Care, Department of Family and Community Services (ADHC) operated services and funded non-government organisations (NGO) providing accommodation support and centre based respite care. The policy provides the means to plan, document, implement and review the health support needs of people with disabilities, in consultation with clients, families, the person responsible or guardian and health professionals.

### 1.1 Purpose of policy

ADHC’s role is to specify the requirements for all agencies that have the care and support for people with disabilities living in accommodation services (permanently) or respite (temporarily), to ensure a high level quality support is provided.

It is mandatory for both ADHC and NGO providers to comply with the policy. The procedures are discretionary for NGOs but essential for ADHC staff to observe.

The purpose of this policy is to ensure that each person with a disability, residing in an accommodation service or using a centre based respite service, is supported to be as healthy as possible by having a *Health Care Plan* that is developed and implemented to meet her or his individual needs, and reviewed annually.

### 1.2 Target group for policy

The target group for the policy is:

- adults with a disability living in accommodation services, and
- adults and children with a disability who use a centre based respite service

The health care needs of children and young people living in out-of-home care are detailed in the *Maximising Health and Well-Being for Children and Young People Living in Out-of-Home Placements Policy, 2005*.

Users of the policy will be Case Managers, Key Workers and Disability Support Workers involved in individual planning processes for these clients.

### 1.3 Service type for policy

The policy applies to all accommodation support services (including group homes and large, medium and small residential centres) and centre-based respite services.

### 1.4 Legislative framework

*Disability Services Act 1993* and Disability Service Standards

### 1.5 Principles

**Access to health services and practitioners**

Adults with a disability have the right to the same standards of health and medical care as other members of the community.
All clients with a disability have the right to services which optimise their health without compromising their quality of life.

Staff respect a client and their family’s right to choose from the same range of health services as other members of the community, and do not seek to influence a client or family’s choices as a result of their own health care beliefs.

Staff are to ensure that all personal client information is treated in a way that respects the client’s right to confidentiality and dignity. This includes ensuring clients’ health issues are not discussed:

- With staff members other than those who need to know;
- In front of the person if they are not included in the discussion;
- Without their consent; or
- In public.

Health promotion

It is recognised that clients have a right to education and information relating to health and lifestyle options. Clients are supported and encouraged to make informed decisions and exercise choices in relation to health and lifestyle to the extent of their ability.

The creation of a healthy environment will assist clients to make healthy lifestyle choices.

Staff members assist clients to plan a healthy lifestyle and routine that include a high standard of personal hygiene and healthy eating, with regular sleep and exercise patterns.

Early identification of risk

Early identification of health care risks optimises a person’s chances of maintaining good health.

All clients have an annual health care assessment completed by a general practitioner. The Health Care Plan and intervention plans are reviewed quarterly. Simple checklists have been developed to assist staff to identify changes in the health of clients.

When a client appears to be ill or in pain, or when there is an observable change in the client’s health or wellbeing, staff assist the client to access appropriate health care services as soon as possible.

Good practice in response to identified risks

Health care needs are met in the least restrictive manner to ensure the client’s ongoing wellbeing and dignity, whilst maintaining community access where possible.

Staff members ensure that clients have information about and access to appropriate health and medical services.

Adult clients are encouraged to utilise services that promote and support general health, as well as those for specific conditions associated with their disability. Health care interventions are planned and implemented in a manner that recognises the client’s right to dignity, confidentiality, privacy and safety.

Duty of care

Service providers have a duty of care to convey accurate information and daily observations of the client’s health to the treating medical practitioner. With this in mind, the information is best conveyed by the Key Worker or regular staff members who know the client well. Where it is not possible for a staff member to attend an appointment, phone contact prior to or at the time of the appointment is best practice.
Participation and communication

People with a disability are to be supported to make decisions and choices about things that affect them, to a level that is appropriate to their capacity to understand and their decision-making skills. This includes decisions about their health and well-being.

Every person with a disability living in an accommodation support service should be supported to meaningfully participate in the development of his or her individual plan, including the development of a Health Care Plan.

All people with a disability can communicate in some way. Communication may occur through speech, or through augmentative or alternative means such as facial expressions, gestures, signs, touch or behaviour, or with aids such as objects, symbols, pictures, photos, line drawings, computerised devices, printed words, or individualised word, phrase or gesture dictionaries.

Some people with a disability may have marked differences between their receptive and expressive language skills. For example, they may be able to understand verbal conversations directed to them, but have poor expressive communication skills (i.e. find it difficult to make their wants known to others).

To assist clients to communicate their needs and wants and meaningfully participate in decision-making processes, staff and other significant people need to facilitate opportunities for communication. Staff members also need to be aware of and support a client to use any augmentative or alternative communication system that may be in place. If there is little or no accessible communication system in place for the client, then this may become a goal in their individual plan.

Some clients will have a special Communication Plan (a component of the Individual Plan) which may require assessments and advice from speech pathologists, psychologist or occupational therapist.

Support reflects the person’s identity, cultural links, language and religion

Actions and decisions relating to the provision of health care support must take account of the clients’ culture, language and religion.

Recognition of the cultural and linguistic background of a client is influential on the positive development of identity and social relationships. A client’s name, identity, language, cultural and religious ties should be preserved as far as possible.

The service provider should gather information from the client, their family and other significant people or service providers about the cultural and linguistic background of the client on an ongoing basis. This information should be reflected in the planning and provision of care for the client.

Support enhances self-determination for Aboriginal people

ADHC’s Aboriginal Policy Framework (2005) sets out the principles to which it has committed when working with Aboriginal communities.

Developing an understanding of, and being sensitive to cultural and family context, are critical principles to observe when supporting Aboriginal people. Service providers should gather information about their clients’ cultural background, including any specific traditions or customs. This information should be sought from the client, their family and other significant people in the client’s community.

There are a range of Aboriginal health services. These include:
- Aboriginal Hospital Liaison Officers - their role is to provide culturally appropriate support services for Aboriginal patients and their families whilst in hospital including assistance with accommodation and meals.
- Aboriginal Health Education Officers – their role is to run a range of programs both within the Area Health Services and out in the community.
- Aboriginal Mental Health Workers, Aboriginal Vascular/Chronic Care Officers and Aboriginal Drug and Alcohol Workers. Area Health Services can be contacted through the NSW Department of Health on (02) 9391 9000 or for further information www.health.nsw.gov.au.
- Aboriginal Medical Services were set up to provide Aboriginal people with access to health services in a culturally responsive setting. They provide a range of health services including clinics run by a GP, dental health, eye and ear health, and mobile children’s services. Aboriginal Health and Medical Research Council of NSW can be contacted on (02) 9212 4777 or www.ahmrc.org.au for further information.

1.6 Consent requirements

Consent requirements will vary depending on the capacity of the client to make decisions for medical and dental treatment, the type of medical or dental treatment being sought and the mental capacity of the client (i.e. ability to give informed consent).

Consent requirements for ordinary treatment

Consent arrangements for regular health care reviews and visits to the doctor or dentist when a person becomes ill should be documented as part of the individual planning process.

Medical or dental treatment

Written consent is required from the person responsible prior to a client receiving medical or dental treatment that requires surgery.

Consent requirements for emergency treatment

A medical practitioner or registered dentist is permitted to carry out ‘emergency medical treatment’ on any person in New South Wales without obtaining any form of consent. In these instances the ADHC staff member should obtain a certified statement from the medical practitioner or dentist, in writing, that the treatment needs to be carried out as a matter of urgency in the best interests of the person. The staff member should advise the manager and the person responsible about emergency medical treatment as soon as practicable.

Consent requirements for special treatment

The Guardianship Tribunal is responsible for providing consent for most categories of special treatment as outlined in Attachment 3: Information for applicants. Applications for consent to medical or dental treatment form.

For the provision of specific medications that are addictive, psychotropic medication to manage a person’s behaviour or experimental treatment, the matter would be referred to the Guardianship Tribunal.

It is the responsibility of the treating medical practitioner or dentist to obtain consent from the person responsible. If the person responsible is unable to attend the medical appointment staff will provide the practitioner with the contact details of the person responsible.
Policy requirements for consent

Roles and responsibilities relating to the provision of health care support should be clearly documented as part of the development of the client’s Individual Plans and Health Care Plans.

Decisions about the client’s health, medical and dental treatments are made as part of their Individual Plan. The Individual Plan should document the views of the client or the person responsible regarding the provision of health care support.

Accommodation support service staff must respect clients’ rights to choose from the same range of health services as other members of the community, and not seek to influence the client or the person responsible, in their choices. A staff member cannot be the person responsible.

Consent for medical treatment can be provided by the client, guardian, person responsible or the Guardianship Tribunal depending on the treatment.

1.7 Information and applications for consent

Definitions of major and minor medical and dental treatment

Guardianship Tribunal publication: Substitute Consent including definitions of major and minor medical and dental treatment


Information for clients who have a person responsible or are making an application to the Guardianship Tribunal

- Guardianship Tribunal publications: Person Responsible

- Attachment 3: Information for applicants. Applications for consent to medical or dental treatment form – to be completed by the Medical Practitioner (for clients who have a person responsible or for a client who does not have a Guardian – to go before the Guardianship Tribunal)

If you are unsure what to do you can seek guidance from the Guardianship Tribunal on (02) 9556 7600 or 1800 463 928 or TTY 9566 7634.

Information and application form for clients who have a private guardian appointed from the Office of the Public Guardian (OPG)

- Attachment 4: NSW Office of the Public Guardian - Determining whether to consent to proposed medical and dental treatment

- Attachment 5: OPG Application to carry out medical or dental treatment for a person under Guardianship of the Public Guardian

If you are unsure of what to do the OPG can be contacted for advice on (02) 8688 2650 or 1800 451 510. For further information about consent refer to the ADHC Decision Making and Consent Policy and Procedures.
2 Minimum requirements for services funded and operated by ADHC

All clients living in accommodation services will have an identified Health Care Plan that is a component part of the Individual Plan, and incorporates mandatory and optional documentation depending on client needs and requirements.

All clients using respite services will have a Respite Plan incorporating their health care requirements.

All ADHC operated and funded non-government accommodation and respite services are required to have at least one member of staff with a current first aid qualification employed on each shift.

This requirement is made in accordance with the Health Care Policy Principles (section 1.5) relating to access to health services, and with the conditions of the funding agreements between non-government providers and ADHC to comply with relevant policies.

2.1 Accommodation support services

The Health Care Plan is developed collaboratively with clients and their families or carers, general practitioners and service providers. Each client is supported by a Key Worker or Case Manager who is responsible for the coordination of the health care planning. If the client’s planning needs are complex, a Registered Nurse (RN) will assist the Key Worker.

All clients with a disability residing in accommodation services will have an annual health care assessment conducted by their General Practitioner. More regular assessments will be conducted if their health care needs change. The outcome of the assessment is documented in a Health Care Plan which summarises the clients’ health care needs and management interventions.

The Health Care Plan is developed by the nominated Key Worker using information obtained from a variety of sources including the annual health care assessment by the client’s medical practitioner and dental and other specialist medical and allied health assessments.

A number of health problems are known to be more prevalent in people with disabilities. These include epilepsy, diabetes, respiratory illness, nutrition and swallowing difficulty, constipation, mental illness, mobility problems and falls, early onset dementia and life threatening allergies. Health Care Plans for clients living in accommodation services will specifically consider these issues along with any other relevant health issues.

Staff of accommodation and centre based respite services have a duty of care to ensure that any health conditions and identified risks are managed in accordance with the client’s Health Care Plan.

2.2 Centre based respite services

All children, young people and adults with a disability accessing centre-based respite services will have an up to date Respite Plan that outlines their health needs and how these are to be managed during their stay in respite. The Respite Plan will include plans on the management of a client’s medication, and any other health conditions as appropriate for example, epilepsy, diabetes or asthma.

The health care component of the Respite Plan will be updated on a regular basis or when the client’s health care needs change.
The provision of information on a client’s health care needs and health management plans is the responsibility of the client and their family, carer or guardian. Where a client or the family, carer or guardian is unable to provide this information, a care worker or General Practitioner will provide assistance to ensure appropriate health care documentation is included in the respite plan.

Staff of centre-based respite services have a duty of care to ensure that any health conditions and risks identified in the client’s respite plan are managed in accordance with the documented support plans.

2.3 Comprehensive Health Assessment Program (CHAP)
Ageing Disability and Home Care (ADHC) supports the use of the CHAP for the purposes of assessing and documenting a client’s health care needs. ADHC has a license with the University of Queensland which allows the CHAP to be used for clients of ADHC funded and operated accommodation and centre-based respite services. A copy of the CHAP is currently available to ADHC operated services on the ADHC Intranet. Non-government services will access the CHAP on the ADHC website through a specific provider link.

The CHAP is a template of health symptoms and changes completed by a Key Worker who knows the client well, and the family or person responsible, in preparation for the assessment and plan developed by the general practitioner.

ADHC acknowledges that some accommodation services (ADHC operated or funded) may have a different health care planning process or use an alternate standardised comprehensive health care assessment process. Any other health care assessment process must address all the health areas as set out in the CHAP.

2.4 Administering medication
All ADHC funded non-government services follow the NSW Department of Health Circular Guidelines for the Handling of Medication in Community-Based Health Services and Residential Facilities in NSW (2005) for the storage and administration of client medications


ADHC operated group homes, large residences and centre based respite services are required to use the ADHC Medication Policy and Procedures.

3 Definitions and resource documents

3.1 Explanation of terms
Accommodation and respite services
The service types included under the accommodation and respite services are large, medium and small residential centres, group homes and centre-based respite services.

Acute illness
An acute illness has an abrupt onset and is stabilised within a few days.

Disability Support Worker
The staff member on roster who cares for clients on a day to day basis.
Case Manager
The ADHC Case Manager is a member of the Community Support Team (CST) assigned to a respite client. When a client lodges a service request for respite the Case Manager is responsible for the development, management and documentation of the client’s Respite Plan, including the Health Care Plan. The equivalent Case Manager in an ADHC funded non-government service is responsible for developing a Health Care Plan for the client requesting respite.

CHAP
The Comprehensive Health Assessment Program (CHAP) has been developed by staff at the University of Queensland for use by support staff and GPs. ADHC has purchased the right under a licensing agreement to implement the CHAP in NGO and ADHC operated services.

Client Risk Profile
The Client Risk Profile (CRP) is a simple, overarching and uniform risk and safety alert system designed for use throughout ADHC operated and NGO services. The system is designed to provide an easily identified risk classification system with quick reference material on individualised risk management strategies.

The CRP integrates accommodation support service policies with Occupational Health and Safety responsibilities. When implemented correctly within the broader framework of client risk management, the CRP provides an effective and uniform risk alert system that remains sensitive to the individual and changing needs of a client. The CRP sits within the existing Individual Planning process. The CRP is appended to the Client Risk Policy and Procedures.

Contagious
Disease or infection capable of being transmitted from one person to another.

Complex planning needs
Some clients may have complex planning needs. Complex health planning needs are those for which Key Workers need assistance to develop a clients’ Health Care Plan. Examples of a client with complex planning needs can include complex health conditions, difficulties with family situations, multiple health care professionals and unfamiliar treatments.

Exercise
Planned physical activity for recreation, leisure or fitness, with a specific objective such as improving fitness, performance, health or social interaction.

Goals
Goals are client-centred statements of broad aims relating to activities, skills or achievements in life arising from the client’s assessed needs. These are documented and prioritised in the client’s Individual Plan. There are broadly four types of goals – Lifestyle and environment, health, skills development and social and recreational goals. Goals for clients in Accommodation Support services may be long term or short term.

Guardian
A guardian is a person who is legally appointed to make lifestyle decisions on behalf of another person and provide substitute consent to medical and dental treatment when appointed for this function.

Health
The state of body, mind and spirit. Good health refers to the absence of disease or conditions causing pain.
Health care assessment
The process of gathering information on various aspects of the client’s health to evaluate ongoing health or illness needs.

Health Care Plan
The section of the client’s Individual Plan or Respite Plan which describes the client’s health, goals and risks, and the interventions of providers required to address those goals and risks. The *Health Care Plan* includes both ongoing and newly identified health related issues.

Infectious illness
Caused by or capable of being transmitted by a living agent such as bacterium, virus or parasite.

Individual Plan
A document that describes the client’s goals and the services or strategies that will be implemented to assist the client to meet those goals during a twelve-month period. The Individual Plan is reviewed every six months and modified according to the client’s changing needs.

Intervention
An intervention is a planned process, agreed to by the client, the family, guardian, advocate or financial manager, to assist clients to achieve goals identified in their Individual Plans. Interventions are time limited.

Intervention Plan
The Intervention Plan is the document of the intervention relating to one or more goals on a client’s Individual Plan. The Intervention Plan states the objectives and the strategies to achieve the objectives, as well as the timeframe.

Key Worker
The Key Worker is responsible for managing the individual and health care planning needs for clients who are unable to manage without assistance. The Key Worker coordinates the services that are provided to ensure they respond to the client’s assessed needs and priorities. The Key Worker provides the client, family, guardian and advocate with support and collaborates with other service providers to prevent service duplication.

A registered nurse is required when the client, the Key Worker, the family, guardian or advocate need assistance because of:

- The complexity of the client’s health care planning needs;
- The number of services and external providers involved; or
- The Key Worker, family, guardian or advocate lack skills or resources to adequately respond to the health care needs of the client.

A Key Worker is a clearly identified worker within the client’s service who is responsible for the development, coordination, implementation and documentation of the client’s Individual or Respite Plan and the *Health Care Plan*.

Manager
In ADHC this term refers to the Team Leader, Coordinator Accommodation and Respite, Residential Nurse Manager, and Manager Community Support Team (CST).

The Manager has the overall responsibility for supervising the identified Key Worker. The Manager supervises the development, coordination, implementation and documentation of the client’s Individual or Respite Plan and subsequently the *Health Care Plan*. 
Care Plan. The Manager may seek the assistance of a Registered Nurse for clients with complex planning needs.

My Health Care Record (also known as Red Book)
Is produced by the NSW Department of Health to assist carers and health service providers to have ready access to relevant accurate and timely information. The ‘Red Book’ is also to help the client by reducing the need to repeat the same information or medical history every time the client sees a health service provider.

It contains details about the client’s medical condition and the treatment recommended by doctors or other health service providers. It allows the client and the health service provider to keep track of important health records in a single place. That way everyone involved in the care of the individual is aware of what care has been prescribed and given. My Health Care Record or ‘Red Book’ is available at no cost from the NSW Health, Better Health Centre (02) 9816 0492.

The ‘Red Book’ is useful as a minimum requirement of the Health Care Policy and Procedures if the client’s health care needs are simple, or the client is able to be responsible for his or her own Health Care Plan.

Palliative care
Palliative care is the active total care of people whose disease is not responsive to curative treatment. It is generally provided to people of all ages whose condition has progressed beyond the stage where curative treatment is effective, a cure is attainable, or to those who choose not to pursue curative treatment.

Person responsible
The person responsible has authority to consent to minor and major medical and dental treatment only on behalf of a person who is not capable of providing consent. The person responsible is the first of the following that applies:

- A guardian, if any, but only if the Order appointing the guardian provides for the guardian to give consent to medical and dental treatment;

If a guardian with the function of consenting to medical and dental treatment has not been appointed, the person responsible is:

- A spouse or de facto spouse with a close and continuing relationship to the person;
- The carer or person who arranges care on a regular basis and is not paid (the carer’s pension does not count as payment);
- The previous carer of the person before they went into residential care (frequently parents of clients are persons responsible);
- If there is no one in this category that wants to be the person responsible, or a doctor certifies that they are not capable of exercising that function, any close friend or relative can be the person responsible.

The person responsible cannot override a client’s objection to treatment unless the person is also the legal Guardian with that authority in an Order.

Physical activity
Any movement involving large skeletal muscles e.g. walking, climbing stairs, gardening, playing sport or work related activity.
Respite Client Liaison Officer
Manages respite intake for centre based respite services. Liaises with Team Leaders, Respite Officers, Case Managers CST, and health professionals in the review and monitoring of respite plans including health care management plans.

Respite plan
The respite plan provides detailed information on the individual care needs of the client attending the respite centre to ensure the client’s stay in respite is a safe and positive experience, and includes the documented Health Care Plan.

Respite care update form
The respite care update form is sent to family and carers at each respite booking period (every four months) requesting information from the family about the client’s current state of health and individual care needs to update the Respite Care Plan. This ensures the client’s health care needs and individual care needs are addressed during a stay in respite.

Senior Manager
In ADHC this refers to the Manager Accommodation and Respite, Regional Manager Accommodation and Respite, Nurse Manager Accommodation and Nursing Service and Chief Executive Officer (Residences).

Unit
A group home, residential service or centre based respite centre.

Unwell
Being in poor health; sick.

3.2 Legislation
Disability Services Act (1993)
Guardianship Act (1987)
Anti-Discrimination Act 1977
Commonwealth Disability Discrimination Act (1992 (DDA)

3.3 Links
Decision Making and Consent Policy and Procedures
Nutrition and Swallowing Policy and Procedures
Food Services Manual
Individual Planning Policy and Procedures
Individual Planning for Children Living in Out of Home Care Placements Policy and Procedures
Incident Management Policy and Procedures
Client Risk Policy and Procedures
Maximising Health and Well-Being for Children and Young People Living in Out-of Home Placement Policy
My health care record, NSW Department of Health
Orientation to ADHC Disability Services Respite Services Policy
Palliative Care Policy and Procedures
Prioritisation and Allocation Policy and Procedures

The Australian immunisation handbook

Epilepsy Policy and Procedures

Record Management Policy and Procedures

3.4 References

3.5 Attachments
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Attachment 2: Dental review form
Attachment 3: Guardianship Tribunal publications: ‘person responsible’
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Attachment 6: Menstruation chart
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Attachment 12: CHAP Tool
Attachment 13: CHAP summary brochure
Attachment 14: Letter to Doctor re CHAP
4 Operational procedures responding to a medical emergency

How to use these procedures
The procedures are intended to provide Key Workers and Disability Support Workers with protocols and guides for responding to the immediate health care needs of clients, and to plan for their ongoing health care and support in tandem with the Individual Planning process.

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<th>Content</th>
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<td>4.2</td>
<td>Provides guidance for staff in responding to a medical emergency.</td>
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<td>5.1</td>
<td>Describes the procedures for staff to follow when supporting a client with a specific health condition including the clinical backup that may be required.</td>
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<td>5.2 and 5.3</td>
<td>Introduce documents relating to client health records, maintained for the information of health professionals and as part of the health planning and review process e.g. the NSW Health Department publication My Health Record and the CHAP.</td>
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<tr>
<td>5.4 – 5.7</td>
<td>Introduce the Health Care Plan and the link between it and the Individual Planning process. The development of the Health Care Plan, its implementation and review are covered in these sections.</td>
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<tr>
<td>5.8</td>
<td>Details the roles and responsibilities of all the parties involved in developing, implementing and monitoring the Health Care Plan.</td>
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<td>6.1</td>
<td>Describes the procedures for gathering health information to develop a Respite Plan for a client entering respite.</td>
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<td>6.2</td>
<td>Detail the implementation and review of a client’s Respite Plan.</td>
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<td>6.3 and 6.4</td>
<td>Advises staff of the appropriate actions to be taken when a respite client has an acute illness.</td>
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<td>6.5</td>
<td>Details the roles and responsibilities of all the parties involved in developing, implementing and monitoring a Respite Plan.</td>
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<tr>
<td>7.1 – 7.10</td>
<td>Provide information in relation to clients attending specialist appointments or receiving specific health services e.g. dentist, psychiatrist or planned hospital visits.</td>
</tr>
<tr>
<td>Appendix A</td>
<td>A flow chart summarising preparations for the Individual Planning meeting.</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Best practice in health care planning to assist in evaluating the effectiveness of the Health Care Policy on client outcomes.</td>
</tr>
</tbody>
</table>
4.1 Responding to health, medical and dental needs of the client

All staff are responsible for observing and responding to changes in client health and communicating information to the client and relevant supervisory staff and staff working in the unit. When a client appears ill or in pain or when there is an observable change in the client’s health, staff are to assist the person to access appropriate health or medical services as soon as possible. The steps to follow are:

1. When a client appears unwell staff are to assist the client to access medical assistance.

   Indications that a client is unwell include:
   - The client complains of not feeling well;
   - The client describes symptoms that may indicate an illness (see below);
   - The client indicates by actions or gestures that she or he does not feel well; and
   - Staff observe signs that indicate the client may be unwell.

   Some of the signs that indicate illness are:
   - Change in behaviour
   - Fever
   - Difficulty breathing
   - Bleeding
   - Sweating (not related to recent exercise)
   - Vomiting
   - Coughing
   - Shivering
   - Lethargy/sleepiness
   - Appearance of skin conditions (rashes, blisters, sores)
   - Swelling
   - Change of skin colour
   - Change of sleep pattern
   - Change of toilet pattern
   - Change of eating or drinking patterns
   - Facial expressions or body actions which could indicate pain
   - Self injurious behaviour
   - Other behaviours unusual for the client

2. Staff must immediately arrange for the client to be taken by ambulance to hospital if the client appears to be seriously ill (e.g. difficulty breathing) and report this to the Team Leader or Residential Unit Nurse Manager (RUNM) immediately.

3. If a client is transported to hospital, staff will follow the procedures described in Planned Hospitalisation Part 4.5.

4. Staff must contact the client’s GP as soon as possible if the client shows a sign of illness or the client’s temperature exceeds the normal level of 37° Centigrade.

5. Staff must record all observations about changes to a client’s health in the client notes and on the “Urgent Matter Alert” section of the shift changeover checklist.
4.2 Responding to a medical emergency including unplanned admission to hospital or serious illness or injury requiring immediate medical attention

Procedures for staff in ADHC Accommodation and Respite Units, *What to do in a serious event or crisis*, provide staff with direction when a crisis occurs. If a client requires urgent medical assistance the following procedures should be followed:

1. Ensure the immediate safety of the client by applying first aid procedures.
2. Call 000 and ask for an ambulance. Provide contact details and the reason for calling.
3. Some units have Vital Call or Safety Net and these may be used to summon help. When these systems are not available staff should call for help using the emergency 000 number.
4. Contact the Manager or the On-Call Manager as soon as possible. The Manager will co-ordinate communication with the parents or guardian of the person, and determine if there is a need for additional staff assistance to provide support at the unit or at the hospital.
5. Ambulance officers will decide if the client needs to be taken to hospital.
6. When required or where possible staff at the unit will accompany the client to the hospital. The staff member will take the client’s emergency medical file including the medication chart, ‘blister’ pack, a copy of the *Health Care Plan* and the client’s health care card.
7. In cases where there is only one staff member on duty, the staff person is to remain at the unit with the other clients. As soon as possible, additional staff should provide support at the hospital or unit. Support staff must bring a copy of the *Client Risk Profile* and the client’s eating and drinking plan to the hospital and explain them fully to the staff.
8. As soon as practicable the staff member will provide a written report to the Manager of the circumstances leading to the client’s admission to hospital.
9. The Manager will inform the Senior Manager of the client’s illness and admission to hospital.
10. As soon as practicable the staff member is to document the incident in the relevant formats (i.e. client’s file and incident reports).
5 Operational procedures to support health care planning in accommodation services

5.1 Supporting specific health needs
1. Staff provide support and information to clients in accordance with general support, point 7 in order to ensure that clients’ health care needs and goals are met.

2. When a client living in a Large Residential Centre (LRC) has additional clinical health care needs, the Key Worker may request additional planning support from the Clinical Nurse Consultant, Clinical Nurse Educator or allied health professional such as an occupational therapist, physiotherapist, speech pathologist or dietician at the residence.

3. When a client living in a group home has additional clinical planning requirements, the Manager requests support for health care planning from health professionals on the Community Support Team. This service will be allocated in accordance with the Prioritisation and Allocation Policy and Procedures. Alternatively, the Key Worker will need to organise more frequent visits to the GP for advice.

4. Where a Registered Nurse (RN) is allocated to provide health care planning for a client living in a group home, the RN will assist the Key Worker and other unit staff to support the client as necessary throughout the annual health review and with the development of Health Care Plans, and will attend appointments if possible.

5. In assisting clients to develop Health Care Plans, staff ensure that each of the health issues included in health information sheets (Appendix C) and any other health problem that the client may have are addressed in the client’s health care plan summary (Attachment 1).

6. Managers ensure that every client with epilepsy has an Epilepsy Management Plan (Epilepsy Policy and Procedures: Attachment 1) and is supported in accordance with the Epilepsy Policy and Procedures.

7. Managers ensure that staff provide support to clients in accordance with the requirements in general support, point 7.

5.2 My health record
1. Some clients in support will have simple health care information and will have their My Health Record booklet (also known as the ‘Red Book’ - NSW Health Department publication).

2. The Key Worker supports the client to take My Health Record to all appointments with health professionals, along with all relevant medical records, allied health reports and blister pack.

3. The My Health Record is kept on the client’s file.

4. As the My Health Record is a personal medical record, it is the property of the client, not ADHC. If the client transfers to another accommodation service provider, the My Health Record is to accompany the client.
5.3 Annual health review

1. The Key Worker ensures that each client’s health is managed through the Individual Planning (IP) process (refer to the Individual Planning Policy and Procedures, the Individual Planning for Children and Young People in Out of Home Care Policy, and Appendix A of this policy).

2. Prior to the annual Individual Planning (IP) meeting, the client, family and Key Worker complete Section 1 of the Comprehensive Health Assessment Program (CHAP) or an equivalent comprehensive health assessment process incorporating all the health areas identified in the CHAP (see Health Care Policy, Part 2.3).

3. The Key Worker makes the appointment with the GP and requests a longer consultation or several appointments to complete the annual review.

4. The Key Worker informs the client and the person responsible or guardian about the planned medical examination. Consent is not required for any non-intrusive examination and this includes a visual examination of a person’s mouth, throat, nose, eyes, ears, chest and abdomen. This does not include an internal gynaecological examination. (Refer to HCF 4, 5, 6 and 7 for further information about consent for medical and dental treatments.)

5. If the client does not have the capacity to give or withhold consent and objects to the examination, consent must be obtained from the person responsible or guardian.

6. If the annual medical review is to include any invasive procedures such as a Pap smear, blood tests, or prostate examination, the GP must obtain consent from the client, person responsible or guardian.

7. The Key Worker and the client’s family (if available) accompany the client to the appointment with the GP and take My Health Record and the CHAP, with Section 1 completed. The client’s relevant health and medical records e.g. seizure charts and ‘blister’ pack, should accompany the client to the appointment. If the Key Worker is identified as the person to accompany the client and is unable to attend, the Manager will ensure that another staff member, who is familiar with the client’s health status, accompanies the client.

8. The GP considers the information in Section 1 and may discuss any or all of the information. The GP then completes Section 2 of the CHAP. If the GP recommends any medical treatment or health interventions for the client, these are to be recorded in the “Action Plan” at the end of Section 2 of the CHAP.

9. If the GP does not wish to use the CHAP, the Key Worker requests that the GP documents the findings of the comprehensive medical examination and provides a copy to the client for the purpose of health care planning.

10. The GP records comments in the My Health Care Record booklet.

11. The Key Worker ensures that the client has a dental review prior to the annual IP meeting or if specified by the dentist.

12. If the dental review is to include any invasive procedures, including the administration of a sedative or anaesthetic, the dentist must obtain consent from the client or the client’s person responsible or guardian prior to conducting any procedures.
13. The Key Worker or the client’s family accompany the client to the dentist and request that the dentist complete the Dental Review Form (HC F2) after examining the client. The Key Worker takes along the client’s Health Care Plan documents including the blister pack.

14. Prior to the IP meeting the Key Worker obtains reports about any health care interventions which are currently in place to address the client’s health-related goals.

15. The Key Worker, with the assistance of the Manager updates the Client Risk Profile (CRP) to include any relevant health risks for the annual IP meeting (see Client Risk Policy).

16. Prior to the annual IP meeting, the Key Worker ensures that all relevant health care assessments or reviews have occurred and are documented. These include but are not limited to:
   - CHAP (Sections 1 and 2) including a medication review
   - Dental Review (HC F2)
   - Any specialist medical or health services review e.g. Psychiatrist, Neurologist, Nutritionist, Occupational Therapist, Rehabilitation Physician
   - Nutrition and Swallowing Checklist
   - Client Risk Profile
   - Physical Activity Checklist (HC F11)
   - Reviews of any other interventions that are in place to address goals arising from the client’s previous Health Care Plan e.g. hygiene, relaxation.

17. In preparation for the IP meeting the Key Worker ensures that he/she is familiar with each of the health-related assessments and reviews and can explain the information contained in the reports to the client or their family or others attending the meeting. If the Key Worker is uncertain about the meaning of terms in any of the reports, he or she should seek advice from the Manager or a Registered Nurse, or from the practitioner who wrote the report.

5.4 Health care planning at the individual planning meeting

1. The Key Worker presents each of the reports of the health-related assessments and reviews at the client’s annual IP meeting.

2. The client and the person responsible or guardian and the staff attending consider the information contained in the CHAP and the other relevant reports.

3. Based on the health-related assessments and reviews, a Health Care Plan (see Attachment 1) is developed. The Health Care Plan outlines the nature and level of support the client requires to maintain a healthy lifestyle and minimise risks associated with illness.

4. The Health Care Plan includes general issues relating to health maintenance:
   - Medication summary
   - Health professionals
   - Health records
   - Health promotion
   - Support plans
   - Identified risks

Health care goals (in client centred terms) are tabled and detail:
   - Actions to be taken including continuing an existing intervention, arranging an appointment, or requesting a service from the Community Support Team.
Data to be collected e.g. using bowel, seizure and sleep patterns charts.
Existing Intervention and Management Plans e.g. eating and drinking plan, seizure management plan.

5. The Health Care Plan includes monitoring of general health related issues and newly identified health risks and management strategies. These could include, but are not limited to:
- Dental health
- Medication management
- Epilepsy management
- Eating and Drinking
- Mental Health

6. The GP completing the CHAP, the client, the person responsible or guardian and the staff prioritise health issues according to their impact on the client. This is documented under ‘Care Plan’ in the CHAP.

7. The client or the person responsible sign the Health Care Plan to indicate agreement with the plan.

8. The completion of the Health Care Plan is documented as part of the IP and placed on the client’s file.

9. The Manager ensures that completion of the Health Care Plan is recorded on the Client Information System (CIS).

5.5 Health care planning, developing and implementing interventions

1. When a client requires the development of a specific intervention to achieve an identified health-related goal, the Key Worker arranges an appointment or requests a service from the appropriate health professional. The Key Worker documents the date of the appointment or the date the service will be delivered on the client’s Health Care Plan and in the unit diary.

2. If the intervention is requested from staff of a ADHC Community Support Team, the request for service is made and the service allocated in accordance with the Prioritisation and Allocation Policy, 2002.

3. The health professional summarises actions in relation to specific health issues, for example epilepsy, asthma or diabetes.

4. If the intervention involves medical or dental treatment, or is likely to have a significant impact on the person’s lifestyle, the Key Worker obtains consent from the client, person responsible or guardian (refer to Decision Making and Consent Policy). The consent is recorded in the intervention plan. Note: Consent for operations or procedures are documented on specified forms in hospital or day procedure unit records in accordance with their policies.

5. The Key Worker records the intervention plans on the Health Care Plan and informs other staff in the unit through the communication book.

6. The Manager ensures that the CRP is updated following the development of intervention plans that address health-related risks identified on the client’s CRP. The Manager updates the CIS.

7. All staff in the unit are responsible for ensuring that the client’s Health Care Plan, including all the intervention plans, is followed.
5.6 Reviewing the Health Care Plan
1. The Health Care Plan, including each intervention, is reviewed at least three (3) monthly, including the six monthly IP review, or whenever there is a change in the client’s health status or in accordance with the time-frame for a specific health care intervention.

2. The Key Worker or other staff will consult with the GP, physician or relevant health professionals when any other health-related issues arise, or when there is a change in the client’s health status, prior to the planned review.

3. Before a client is referred for a Behaviour Intervention assessment, the Key Worker will arrange for the client to have a medical review, with appropriate consents, particularly if the client is currently taking medication.

5.7 Management of client health information
1. The Key Worker ensures that each client has a client file (according to the Record Management Procedures for ADHC Group Homes).

2. This includes the client’s Health Care Plan and health intervention plans, health history including CHAP, My Health Record, records of all visits to the dentist, GP, medical specialists and other health professionals, medication record and charts, nutrition and swallowing checklist, and health data e.g. weight, menstruation and bowel charts.

5.8 Roles and responsibilities for health care planning in accommodation services
There are a number of people and positions who have a role in the development, implementation, monitoring and review of the Client’s Health Care Plan (HCP) as shown below.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>▪ Is involved in planning and documenting his or her Health Care Plan (HCP).</td>
</tr>
<tr>
<td></td>
<td>▪ Attends medical and dental appointments.</td>
</tr>
<tr>
<td>Family</td>
<td>May be involved in:</td>
</tr>
<tr>
<td></td>
<td>▪ development, review and monitoring of the HCP;</td>
</tr>
<tr>
<td></td>
<td>▪ prioritisation of health care issues;</td>
</tr>
<tr>
<td></td>
<td>▪ accompany the client to attend appointments or reviews;</td>
</tr>
<tr>
<td></td>
<td>▪ decision making around examination and treatment;</td>
</tr>
<tr>
<td></td>
<td>▪ completion of Section 1 of the CHAP; and</td>
</tr>
<tr>
<td></td>
<td>▪ signing the HCP to indicate agreement.</td>
</tr>
<tr>
<td>Guardian, Person Responsible</td>
<td>▪ Makes decisions regarding treatment and examinations.</td>
</tr>
<tr>
<td></td>
<td>▪ Prioritisation of health care issues.</td>
</tr>
<tr>
<td></td>
<td>▪ If possible, attends appointments.</td>
</tr>
<tr>
<td>Key Worker</td>
<td><strong>Supporting Specific Health Needs</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Coordinates the development, implementation, monitoring and management of</td>
</tr>
<tr>
<td></td>
<td>▪ the client’s HCP.</td>
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<tr>
<td></td>
<td><strong>Health Record/ HCP</strong></td>
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<tr>
<td></td>
<td>Ensure the client’s Health Care Plan:</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibility</td>
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</tr>
<tr>
<td></td>
<td>▪ is current;</td>
</tr>
<tr>
<td></td>
<td>▪ is kept on the client’s file; and</td>
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<tr>
<td></td>
<td>▪ accompanies the client to each appointment.</td>
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</table>

**Annual Health Review**

▪ May complete Section 1 of the CHAP in consultation with the client and their person responsible or guardian.

▪ Assists in the completion of the *Client Risk Profile* (CRP).

▪ Makes appointments with medical and allied health practitioners.

▪ Informs the client, their family about planned appointments and examinations.

▪ If required, obtains consent from the person responsible or guardian and documents or files consent on the client’s file.

▪ Accompanies to medical and other appointments.

▪ Obtains reports about any current health care intervention.

▪ Ensures all relevant assessments or reviews have occurred.

**HC Planning at the IP Meeting**

▪ Presents each health report at the IP.

▪ Signs the HCP.

**Implementing the HCP and Developing Interventions**

▪ Arranges appointments for the development of plans to meet goals identified in the HCP.

▪ If required, obtains consent from the person responsible or guardian and documents or files consent on the client’s file.

▪ Records the intervention plan on the HCP

▪ Informs other staff of the intervention plan during staff handover and at the unit staff meetings.

**Reviewing the HCP**

▪ Consults with relevant health professionals when any other health related issues arise or when there is a change in the client’s health status prior to a planned review.

▪ Prior to a referral to a Behaviour Intervention assessment arranges for the client to have a medical review.

**Client Files**

▪ Ensures the client has a client file.

▪ Files health records in the ‘Health’ section of the client’s file.

**Supporting Specific Health Needs**

▪ Appoints Key Worker to coordinate the development, implementation, monitoring and review of the client’s HCP.

▪ Monitors the HCP.
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| **Annual Health Review** | ▪ Ensure that every client has appropriate HCP.  
▪ Ensure staff provide support to clients in accordance with the requirements in *General Support: Part 4* of this policy.  
▪ Appoints another staff member when Key Worker is absent, who is familiar with the client’s health status to attend the appointment with the client.  
▪ Provide advice as required.  
▪ Attends IP.  
▪ Participate in the prioritisation of health needs.  
▪ Update health care information on the CIS.  
▪ Ensures the CRP is updated following the development of interventions.  
▪ Endorse HCP.  
▪ Monitor the currency of *Individual Plan* (IP) HCP’s through the CIS.  
**Change to Health Status** | When there is a change in the client’s health status ensures that HCP, including each intervention is reviewed by the treating medical practitioner |
| **Staff**           | ▪ All staff in the unit are responsible for ensuring that the client’s HCP, including all the intervention plans, is adhered to.  
▪ When aware that a client’s health status has changed documents in client’s file and contacts the TL or RUNM. |
6 Operational procedures for managing the health of clients accessing ADHC operated centre-based respite services

6.1 Supporting health care needs

1. For new centre-based respite clients, the Case Manager, Community Support Team ensures that the client’s health care needs and appropriate management plans (e.g. epilepsy, medication, asthma) are identified and documented in their Respite Plan (refer to the ADHC Orientation to ADHC Disability Services Respite Policy, 2002).

2. In documenting the client’s health care needs and support plans, the Case Manager obtains from the family copies of relevant documentation prepared by the client’s GP and allied health practitioner(s). If appropriate, the Case Manager provides the family, carer or guardian with a copy of the CHAP to enable the necessary supporting documentation to be obtained from the client’s GP.

3. The Case Manager provides case management support to the client, family, carer or guardian to facilitate the development of health care planning for respite as required including assisting in completion of the My Health Record.

4. The agreed Respite Plan is signed by the client, family or guardian and the Case Manager forwards copies of the Respite Plan and associated support plans and all assessments to the client and the family, carer or guardian and the relevant Respite Client Liaison Officer.

5. The Case Manager updates information on the Client Information System (CIS) database, including the Client Risk Profile.

6. The Respite Client Liaison Officer forwards the Respite Plan and associated support plans and all assessments to the responsible Team Leader. The Respite Client Liaison Officer updates information on the CIS database.

7. The Team Leader Respite appoints a Key Worker from the appropriate respite unit and forwards the Respite Plan, associated support plans and all assessments to the Key Worker. The Key Worker creates a file for the client and files the information in the client file.

8. Respite services will not be allocated unless a Respite Plan (RO F3) and relevant support plans are completed and signed by the client’s family, carer or guardian.

6.2 Implementing the Respite Plan and associated support plans

1. The Key Worker in the respite unit informs all staff about the client’s Respite Plan and associated support plans.

2. All staff in the allocated respite unit ensure that they adhere to the Respite Plan and associated support plans.

6.3 Reviewing the Respite Plan and associated support plans

1. A client’s respite and support plans relating to identified health care needs, are reviewed routinely every three months, or whenever there is a change in the client’s health status. The Respite Client Liaison Officer is responsible for sending
the Respite Plan Update Form (APR F3) every three months to the client’s family, carer or guardian for completion.

2. Where a Disability Support Worker or Team Leader becomes aware that a client’s health status has changed, she or he is responsible for documenting this in the client’s file and advising the Respite Client Liaison Officer. The Respite Client Liaison Officer is then responsible for sending the Respite Plan Update Form (APR F3) to the client’s family, carer or guardian for completion.

3. The client’s family, carer or guardian returns the completed Respite Plan Update Form (APR F3) to the Respite Client Liaison Officer who checks the form to ensure that it has been completed.

4. If the Respite Plan Update Form (APR F3) indicates that there has been a change in the client’s health needs, the Respite Client Liaison Officer consults with the client and the family, carer or guardian to review the client’s health care needs and develop an updated Respite Plan and appropriate support plans. The Respite Client Liaison Officer also consults with the client’s Case Manager if one is appointed. In preparing an updated Respite Plan with the client and their family, carer or guardian, the Respite Client Liaison Officer obtains copies of relevant documentation prepared by the client’s General Practitioner and other health practitioners.

5. The agreed updated Respite Plan is signed by the client, family or guardian and the Respite Client Liaison Officer forwards copies of the Respite Plan and associated support plans and all assessments to the family, carer or guardian and the relevant Team Leader. The Respite Client Liaison Officer updates information on the CIS database.

6. The Team Leader Respite forwards the updated Respite Plan and associated support plans and all assessments to the Key Worker. The Key Worker files the information on the client’s file.

7. A respite stay will not be allocated unless the Respite Plan Update Form (APR F3) is returned and changes in procedures for managing health care needs are documented in an updated Respite Plan.

8. The Key Worker informs staff of any changes to the client’s Respite Plan.

6.4 Acute illness when accessing planned respite

1. It is the family, carer or guardian’s responsibility to inform the Respite Client Liaison Officer or Respite Manager that a client is unwell or has an acute or infectious illness at the time of planned respite so that the period of planned respite can be postponed until the client is well.

2. If the person arrives for a planned period of respite from a daytime activity or presents to the unit with the family or carer with an illness or becomes unwell during their respite stay then the procedures outlined in General Support: Part 4 are to be followed. The client’s family, carer or guardian is to be notified immediately.

3. When the client’s family, carer or guardian arrives at a respite centre for planned respite in attendance with a client who is ill, they are advised that the client will not be able to access the planned respite. Staff of the respite unit must advise the Team Leader of the client’s illness immediately so that they can liaise with the family, carer or guardian, if necessary.
4. The family should be made aware that the client is at risk, especially if there is any deterioration and the staff are not trained to manage the situation. Other clients are also at risk if the client’s condition is contagious.

### 6.5 Roles and responsibilities for health care planning in centre-based respite services

There are a number of people and positions that have a role in the development, implementation, monitoring and review of the Client’s *Respite Plan* and associated support plans as shown below.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Client                           | - Is involved in the planning and documenting of their health care identified and documented in their *Respite Plan* (RP).  
  - Attends medical and dental appointments. |
| Family/Carer | **Supporting Specific Health Care Needs**  
  - Participates in an orientation to respite process and the development of the RP.  
  - Provides relevant documentation to the Case Manager for the development of the RP.  
  - Accompanies client to attend appointments or reviews.  
  - Signs the agreed *RP* and associated support plans  
**Reviewing the Respite Plan and associated support plans**  
  - Completes *Respite Plan Update Form* and returns to Respite Client Liaison Officer (RCLO).  
  - Informs the RCLO when the clients health status has changed |
| Guardian, Person Responsible     | - Makes decisions regarding medical and dental treatment or examinations.  
  - If possible, attends appointments. |
| Case Manager (CM) Community Support Team | **Supporting Specific Health Needs**  
  - Ensures the client’s health care needs and appropriate management plans are identified and documented in their RP.  
  - If appropriate, provides the client with a copy of the CHAP for completion.  
  - Obtains relevant documentation.  
  - Ensures the client has a *My Health Record* and updates it when relevant.  
  - Where the family, carer or guardian has been identified as requiring additional support, provides case management.  
  - Updates the CIS database.  
**Reviewing the Respite Plan and associated support plans**  
  - Completes *Respite Plan Update Form* and returns to Respite Client Liaison Officer (RCLO).  
  - Informs the RCLO when the clients health status has changed |
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>plans</td>
</tr>
<tr>
<td></td>
<td>▪ Forwards the completed plans and supporting documentation to the RCLO.</td>
</tr>
<tr>
<td>Respite Client Liaison Officer (RCLO)</td>
<td>Implementing the Respite Plan and associated support plans</td>
</tr>
<tr>
<td></td>
<td>▪ When received by the CM, forwards a copy of the RP including the associated support plans and all assessments to the Team Leader (TL).</td>
</tr>
<tr>
<td></td>
<td>▪ Updates the CIS database.</td>
</tr>
<tr>
<td></td>
<td>Reviewing the Respite Plan including Support Plans</td>
</tr>
<tr>
<td></td>
<td>▪ Sends the Respite Plan Update Form to the family, carer or guardian routinely every four months or whenever there is a change in the client’s health status.</td>
</tr>
<tr>
<td></td>
<td>▪ Checks the Respite Plan Update Form.</td>
</tr>
<tr>
<td></td>
<td>▪ If there are changes to the client’s health consults with the client, family, carer or guardian to develop an updated RP and appropriate support plans.</td>
</tr>
<tr>
<td></td>
<td>▪ Forwards the updated RP and support plans to the TL.</td>
</tr>
<tr>
<td></td>
<td>▪ Updates the CIS database.</td>
</tr>
<tr>
<td>Team Leader Respite (TL)</td>
<td>Supporting Specific Health Needs</td>
</tr>
<tr>
<td></td>
<td>▪ Appoints a Key Worker (KW) for the client.</td>
</tr>
<tr>
<td></td>
<td>▪ Forwards a copy of the RP and support plans and assessments to the KW.</td>
</tr>
<tr>
<td></td>
<td>Reviewing the Respite Plan and associated support plans</td>
</tr>
<tr>
<td></td>
<td>▪ When aware a client’s health status has changed documents in client’s file and contacts the RCLO.</td>
</tr>
<tr>
<td></td>
<td>▪ On receipt of the Respite Plan Update Form or review of support plans, forwards a copy to the KW for action and filing.</td>
</tr>
<tr>
<td>Key Worker (KW)</td>
<td>Implementing the Respite Plan and associated support plans</td>
</tr>
<tr>
<td></td>
<td>▪ Creates a client file.</td>
</tr>
<tr>
<td></td>
<td>▪ Files the client’s RP including support plans.</td>
</tr>
<tr>
<td></td>
<td>▪ Informs staff of the client’s RP and associated support plans.</td>
</tr>
<tr>
<td></td>
<td>Reviewing the Respite Plan and associated support plans</td>
</tr>
<tr>
<td></td>
<td>▪ When aware that a client’s health status has changed documents in client’s file and contacts the TL.</td>
</tr>
<tr>
<td></td>
<td>▪ Informs staff of any changes to the client RP and support plans.</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibility</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Disability Support Worker</td>
<td>Implementing the <em>Respite Plan</em> and associated support plans</td>
</tr>
<tr>
<td></td>
<td>- Implements the RP and support plans.</td>
</tr>
<tr>
<td></td>
<td>- When aware that a client’s health status has changed documents in client’s file and contacts the TL.</td>
</tr>
<tr>
<td></td>
<td>plans.</td>
</tr>
<tr>
<td></td>
<td>- Files the <em>Respite Plan Update Form</em> and support plans in the client’s file.</td>
</tr>
</tbody>
</table>
7 General support

7.1 Choosing and changing health care providers
1. The Key Worker will provide information to the client, person responsible or guardian to support decision making about health care services used by the client.

2. In assisting a client to choose a health care provider, consideration should be given to:
   - The physical accessibility of the health care provider for the client, particularly if the client has a physical disability.
   - The proximity of the health care provider to the client’s place of residence.
   - Whether the health care provider offers home visits.
   - Whether the health care provider is willing to work with other therapists.
   - Whether the client indicates, verbally or non-verbally, that they are comfortable with the health care provider.
   - Demonstrated expertise in the health of people with a disability.

3. If a client chooses to change health care providers, the Key Worker will ask the existing health care provider to arrange for the transfer of necessary files to the new health care provider.

7.2 Medical examinations and medical procedures
1. If a medical practitioner recommends that a client undergo a medical examination or procedure for which the client is unable to give informed consent, the medical practitioner must obtain valid consent from the client’s person responsible or guardian.

2. If the procedure involves a “Special Treatment” the Guardianship Tribunal is responsible for providing consent for most categories of special treatment as outlined in Attachment 3 Application for Consent to Medical and Dental Treatment.

3. Although consent is not required for medical or dental appointments for non-intrusive examinations, the Key Worker should keep the client’s person responsible or guardian informed about appointments or examinations and any health issues facing the client.

4. The Key Worker, or other appropriate staff, provide the client with information relating to the proposed medical examination. This includes:
   - What will happen at the medical examination, including who will perform the examination and when and where it will occur. This information is presented in a way that enhances the client’s understanding, and may need to be repeated a number of times.
   - Active support to ensure the client understands that they may object to the examination or any part of the examination at any time, and support to do this if needed, and if it is appropriate.
   - Adequate information and support to ensure the risk of inappropriate or unnecessary medical procedures is minimised.

---

1 NSW Guardianship Act 1987
2 A client’s objection can be disregarded by a Guardian or “Person Responsible” only if the treatment is a not a special treatment and the client has minimal or no understanding of what the treatment involves and the treatment will cause the client no distress or it will cause some distress but the distress is likely to be reasonably tolerable and only transitory.
Following the appointment, staff provide the client with adequate information regarding her or his medical condition and the outcome of the appointment.

5. If a client is to be seen by a medical practitioner in the surgery, the Key Worker is to ensure that the clinician is aware of the need for a prolonged appointment and that several people may be accompanying the client.

6. When the client attends a general or specialist medical appointment, the person accompanying the client (preferably the Key Worker) takes copies of relevant health-related documents. These could include My Health Record, the client’s Health Care Plan, intervention and management plans, the CHAP, dental, specialist and other health records, and a list of current medications.

7. The Key Worker, or staff member accompanying the client, requests that the practitioner complete the My Health Record or other health care plan files and provides written information about the diagnosis and any recommended treatment.

7.3 Attending appointments without the Key Worker

1. It is best practice for the Key Worker to attend an appointment along with the family member or person responsible to convey accurate information and daily observations about the client’s health. In the case where a Key Worker or staff member is unable to attend (for example if the client is absent from the unit) a family member or person responsible accompanies the client to any medical or allied health professional appointments, and takes the client’s My Health Record or similar document. The Key Worker should make phone contact with the medical or allied health professional prior to or at the time of the appointment. Information obtained at the appointment must be recorded in the health record and returned to the unit. This information must also be communicated to the unit manager or Key Worker on the same day. If information is withheld the client may be placed at risk and staff may not have information to enact their duty of care.

7.4 Dental examinations and treatments

1. All clients will have an annual dental review as specified by the dental practitioner.

2. If a dental practitioner recommends that a client undergoes a dental examination or treatment, and the client is unable to give informed consent for the procedure, the dental practitioner must obtain valid consent from the client’s person responsible or guardian (refer to Health Care Policy, Part 1.7 or the Decision Making and Consent Policy).

3. The Key Worker, or case manager, provides the client with information relating to proposed dental examination. This includes:
   - What will happen at the dental examination, including who will perform the examination and when and where it will occur. This information is presented in a way that enhances the client’s understanding, and may need to be repeated any number of times.
   - Active support to ensure the person understands that they may object to the examination or any part of the examination at any time, and support to do this if needed and if it is appropriate.
   - Following the appointment the staff are to provide the person with adequate information regarding their dental condition.
   - The Key Worker, or staff member accompanying the client, requests that the practitioner complete the My Health Record and Dental Review Form (Attachment 2) to provide written information about the diagnosis and any recommended treatment.
7.5 Planned hospitalisation
1. If a client lives in a group home, the Key Worker may request the involvement of a Registered Nurse (RN) from the Community Support Team or organisation in the planning of the hospitalisation. This service request is made in accordance with the Prioritisation and Allocation Policy 2002.

2. The Key Worker or RN will support the client and person responsible or guardian to participate in the pre-admission planning and discharge planning processes.

3. If the client is unable to give informed consent for the procedure or interventions involved, the medical practitioner must obtain valid consent from the client’s guardian or person responsible.

4. If the procedure involves a “Special Treatment” the Guardianship Tribunal is responsible for providing consent for most categories of special treatment as outlined in Attachment 3 Application for Consent to Medical and Dental Treatment.

5. Staff of ADHC services will liaise with staff of the hospital to ensure that appropriate supports are available to the client throughout the hospital stay. Where possible, this should be negotiated within the context of a local protocol or agreement between the hospital or Area Health Service and ADHC.

6. The Key Worker or RN provide the hospital with the relevant medical history and may include My Health Record, the client’s Health Care Plan, intervention and management plans, the CHAP, dental, specialist and other health records, and a list of current medications.

7. Information is provided to the hospital regarding nutrition and swallowing needs, eating and drinking needs, medication, personal care needs, communication needs, and other support needs such as those required to support the client’s activities of daily living. The client’s Lifestyle and Environment Plan will contain this information and be provided to hospital staff.

8. The Key Worker or RN will provide a copy of the Client Risk Profile to the hospital staff and explain the strategies for managing risks associated with the client while in the hospital. If the client has an Eating and Drinking Plan this will accompany the client and be fully explained to hospital staff.

9. The Key Worker or RN will also provide the hospital staff with the contact details of the client’s person responsible or guardian.

7.6 Psychiatric appointments and other specialists
1. Before a client attends an appointment with a specialist medical practitioner, the Key Worker or another staff member provides support and information to the client. This information includes why she or he is attending the consultation and what is likely to occur.

2. The Key Worker provides the specialist medical practitioner with the client’s My Health Record and reports based on recorded information analysed by a clinical professional. These reports include a comprehensive assessment of the person’s emotional and behavioural disturbance, the client’s personal characteristics, lifestyle and environment and an analysis of the function of the client’s presenting behaviour and associated factors.

3. A client who is receiving a Behaviour Intervention Service is accompanied to the consultation by a ADHC Behaviour Intervention Support Worker with the client and Key Worker whenever possible. If the Behaviour Intervention Support Worker
cannot attend, she or he provides a report about the current Behaviour Intervention to the Key Worker to take to the consultation.

4. The specialist medical practitioner has a legal obligation to obtain consent before prescribing any treatment or therapy. If the client is unable to provide valid consent, the psychiatrist must obtain consent from the person responsible or guardian.

5. The person responsible or guardian and Key Worker should attend consultations, if possible.

6. When psychotropic medication (i.e. medication that affects thinking, feeling, perception or behaviour) is recommended or prescribed, the Key Worker requests that the psychiatrist provide documentation explaining the reasons why the psychotropic medication has been prescribed, and the anticipated benefits and the side effects for which the staff should be checking.

7. When psychotropic medication is prescribed for behaviour management, it is to be only one part of the intervention. The Key Worker requests a Behaviour Intervention service to develop a Behaviour Intervention Plan.

8. For the entire time that the client is taking psychotropic medication, staff must maintain a record documenting any changes in the symptoms being treated and other outcomes.

7.7 Palliative care

1. Palliative Care is the active total care of people whose disease is not responsive to curative treatment. Care is delivered by coordinated medical, nursing and allied health services and is provided, where possible, in the environment of the person’s choice. Control of pain, management of other symptoms and support for psychological, social, emotional issues and spirituality is paramount. It includes the access to grief and bereavement support for the families, partners and carers during the life of the client and following his or her death.

2. Palliative Care is generally provided to people of all ages whose condition has progressed beyond the stage where curative treatment is effective or a cure is attainable, or to those who choose not to pursue curative treatment.

3. Every person with a disability in an accommodation service who has a diagnosed terminal illness, or a progressive advanced disease, must have a Palliative Care Plan. The Plan should be developed and reviewed with the NSW Department of Health’s Area or Regional Palliative Care Services. Refer to ADHC Palliative Care Policy.

7.8 Care of equipment

1. The Manager ensures that clear instructions are available to all staff about the use, care and maintenance of a client’s support equipment. For example when a client has a wheelchair, information about how the client uses the chair i.e. a seating plan, written in consultation with the therapist is to be available and to include care and maintenance of the chair.

2. An equipment plan should include but is not limited to:
   - How the client can gain maximum assistance from the equipment – pictures or photos can be used to assist this description.
   - What the equipment is for and when it is to be used.
   - What maintenance is required.
   - Where to gain assistance should any questions arise about the use of the equipment or when maintenance is required.
The Manager ensures that manual handling equipment is available where required and that staff are trained in its use.

The Manager ensures that equipment is properly maintained and repaired promptly when damaged.

7.9 Health care procedures
1. A client may wish to and be capable of undertaking a health care procedure, other than one that can only be performed by a qualified health professional, e.g. self-injection of insulin or loading and operating a nebuliser. In this case the client is assisted to participate in a training program for the procedure and has a training plan developed in consultation with a suitably trained health professional.

2. When a client is unable to perform a health care procedure independently, the Key Worker documents the process for supporting the client with the required procedure in the client’s Health Care Plan. This information will include what the procedure is, when it is required, any recording or reporting associated with the procedure, and who is to perform the procedure.

3. The Manager ensures that only staff who are appropriately trained and competent support a client with a health care procedure.

7.10 Medications
1. Clients will be supported in accordance with the ADHC Medication Policy.
Appendix A: Steps in preparation for the Individual Planning meeting

Week 1

Key Worker

Contact client’s representatives by phone to set a date and time for the Individual Planning meeting.

Confirm by letter the arrangements made with the client’s representatives enclosing Individual Plan preferences form. If client’s representatives are unable to attend meeting reschedule meeting or arrange for teleconferencing.

Inform all service providers by letter of Individual Planning Meeting enclosing assessment summary form.

Week 2-4

KEY WORKER ORGANISES AND COMPLETES CLIENT ASSESSMENTS

- Lifestyle & environmental review
- Client health record
- Nutrition & swallowing assessment
- Review eating & drinking plan
- Review epilepsy management plan
- Review client risk profile
- Client’s financial/budget plan
- CHAP, client, person responsible and key worker complete Section 1 of the annual medical review
- CHAP, treating medical doctor to complete section 2 of the annual medical review
- Dentist to complete dental health review
- Complete health care action plan in consultation with general practitioner
- All health intervention plans

Week 5

Key Worker completes review of previous Individual Plan in consultation with goal coordinators.

Week 6-7

Gather all individual plan documents, reports and forms required and ensure that all necessary equipment is available for the Individual Planning Meeting.

Week 8

Individual Planning Meeting.
Appendix B: Indicators of best practice in health care

Indicators of best practice in health care planning have been developed to evaluate the effectiveness of the Health Care Policy. Best practice in health care planning will result in full implementation and compliance with the Health Care Policy and Procedures.

Key indicators of good practice are:

- A living and working environment that focuses on and facilitates a healthy lifestyle for all.
- Early identification of health risks.
- Accessing appropriate and responsive practitioners.
- Continual review and vigilance in health care to improve its quality.
- Good and responsive communication between staff, practitioners, families, carers and guardians.

Health care outcomes should be demonstrated by:

- A healthier environment.
- A healthy client whose needs are met.
- Appropriate staff management and treatment of client health care needs.
- Cooperative relationships between family, practitioners, staff and clients.

Below are some of the specific indicators of best practice.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures</td>
<td>Development and implementation of procedures for health care planning. Development and implementation of procedures for responding to a medical emergency (unplanned admission to hospital or serious illness or injury requiring immediate medical attention) for clients. Development and implementation of procedures for planned hospitalisation.</td>
</tr>
<tr>
<td>Key Worker/case worker</td>
<td>Appointment of a clearly identified person from the accommodation service to develop coordinate, implement and document the health care planning process for each client. Nomination of a manager/position to supervise and support the Key Worker. Monitoring and reviewing of Health Care Plans to ensure plans are current, the quality of plans is adequate and that client’s identified health care needs are addressed or are being addressed.</td>
</tr>
<tr>
<td>Health Care Plan</td>
<td>There is a set of documents identified as the Health Care Plan. The Health Care Plan is developed annually and reviewed quarterly.</td>
</tr>
</tbody>
</table>

35
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Health Care Assessment (CHAP)</strong></td>
<td>A GP conducts an annual comprehensive health care review. The CHAP or equivalent tool is completed. A copy of the most relevant CHAP or equivalent tool is contained in the <em>Health Care Plan</em>. If relevant, the client has a <em>My Health Care Record Booklet</em>. The record includes a list of any significant health risks. Medications are listed and dated. The annual Dental Review is in the file. The Mental Health Review is in the file. A Healthy Lifestyle Plan in relation to diet, sun protection, health promotion and disease prevention, weight, nail and foot care, menstrual record, physical activity is in the file. The client has a current <em>Client Risk Profile</em> completed. All risks identified in the <em>Client Risk Profile</em> have an intervention plan. If required, a Communication Plan is included. The <em>Nutrition and Swallowing Checklist</em> is in the file. All risks identified in the <em>Nutrition and Swallowing Checklist</em> are actioned and the relevant professionals develop the plans. The <em>Health Care Plan</em> includes specific intervention plans as identified through the annual comprehensive health care assessment for conditions such as asthma, epilepsy, diabetes, bowel difficulties, allergies, spasticity and osteoporosis. Medications are supplied or dispensed according to prescriptions.</td>
</tr>
<tr>
<td><strong>Intervention Plans</strong></td>
<td>A separate behavioural management plan is developed when needed. The person’s weight is recorded monthly. If the person has epilepsy a separately identified <em>Epilepsy Management Plan</em> is developed, implemented and reviewed. If required the client has a Palliative Care Plan as per the ADHC <em>Palliative Care Policy</em>.</td>
</tr>
<tr>
<td><strong>Requirements for all ‘intervention’ plans</strong></td>
<td>The Person Responsible has signed the plan(s). The Plan includes a summary of the client’s history to date with respect to the identified risk. The Plan comments about significant past medications and why they were stopped. The Plan outlines the everyday risk and client management and may includes a separate emergency plan. The plans have been developed in consultation with the relevant professionals. All staff working with the client are briefed on the intervention plans and understand any risks. The plan is reviewed quarterly or more frequently as specified by the treating medical specialist or professional. The appropriate consent has been obtained and documented for all medical and dental treatments.</td>
</tr>
<tr>
<td><strong>Requirements for clients status documentation</strong></td>
<td>There is a height and weight chart in the file. There are records of immunisation status. There is reference to smoking, alcohol and illicit drug use. There is a record of activity and exercise (Physical Activity Plan).</td>
</tr>
</tbody>
</table>
Appendix C: Health information sheets

Information for the use of staff about Health Promotion and Disease Prevention

A: Cancer prevention and screening

1: Breast cancer
2: Cervical cancer
3: Prostate cancer
4: Skin cancer
5: Bowel cancer
6: Testicular cancer

B: Health targets

7: Oral hygiene
8: Hearing loss
9: Vision impairment
10: Food and nutrition
11: Constipation
12: Epilepsy
13: Thyroid functioning
14: Mental health
15: Osteoporosis
16: Gastro-Oesophageal Reflux and Helicobacter pylori
17: Immunisation
National Immunisation Program Routine Schedule of Vaccines

18: Physical activity
19: Menopause
20: Menstruation

C: Other Targeted Areas

21: Asthma
22: Dementia
23: Diabetes
24: Heart disease
25: Hypertension
26: Pressure sores
27: Respiratory conditions
28: Drug and alcohol
29: Sexually transmitted infections
30: Allergies

D: Health Promotion

31: Preventing the spread of infection
32: Foot care
33: Self esteem
34: Complementary therapies

E. Additional references and resources

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Health promotion and disease prevention

Health promotion strategies are targeted at the whole population. Health promotion interventions aim to increase wellbeing and prevent certain conditions from emerging. Prevention in relation to people at risk of health conditions seek to detect and intervene early to improve outcomes. Health promotion is a key component of public health and is underpinned by a body of knowledge, evidence and interventions.

Health promotion and disease prevention

A: Cancer prevention and screening

1: Breast cancer

Facts:
- Breast cancer is the most common cancer in women.
- In NSW, about 1 in 11 women will be affected by breast cancer.
- The earlier breast cancer is detected, the easier to treat and the more successful the treatment is likely to be.

Increased risk factor:
- Family history e.g. having a close relative who has been diagnosed with breast cancer.
- Never having children and never having breastfed.
- Increasing age. Over 50% of women diagnosed with breast cancer are over 65 years of age. However, breast cancer can affect women and men of any age.
- History of radiation therapy

Other risk factors:
- Being female. Only about 1% of breast cancer occurs in males.
- Early onset of menstruation and late onset of menopause.
- Being overweight, especially after menopause.
- Drinking excessive amounts of alcohol

Symptoms/signs
- A lump or feeling of lumpiness, or thickness, somewhere in the breast or armpit.
- Abnormal discharge from the nipple.
- A nipple that becomes inverted.
- Dimples in the breast.
- A change in the shape, feel or skin colour of the breast.
- A change in the feel or colour of the skin of the breast.
- Pain in the breast is an uncommon symptom of breast cancer.

Screening:
- Breast check as part of annual medical review.
- GP examines to detect early changes.
- For clients who fall under the ‘High Risk’ category a program devised by a breast physician/surgeon should be implemented.
- Breast Screen NSW offers free mammograms every two years for women over 50 and particularly those between 50 and 69 years of age. For those at risk a mammogram or ultrasound from age 40 is recommended.
The GP in some cases may recommend more regular mammograms where the risk of breast cancer is assessed as being higher than usual.

Maintaining a healthy weight, not drinking excessively.

**Role of staff:**
- Screening is done by the GP during the annual medical review.
- All females aged 50-69 years of age will be supported to undergo a mammogram every two years.
- When a client or the person responsible consents to the client undergoing a mammogram, the Key Worker provides support to the client in the manner described for Medical Examinations and Medical Procedures Part 4.2, Health Care Policy.
- Discuss with GP where best to have a mammogram. The Key Worker will arrange an appointment.
- If the GP is concerned by abnormal exam he/she will arrange further examinations. The Key Worker or Registered Nurse (RN) will provide the client and the person responsible with information about this process.
- The client's GP will then determine what further course of action is required. The Key Worker or RN will support the client and person responsible to obtain information to support informed decision-making regarding any necessary procedures.

**Contact details:**
- Local GP
- BreastScreen NSW  Tel: 13 20 50
- NSW Cancer Council, Breast Screen  Tel: 13 20 50
- Cancer Council Helpline  Tel: 13 11 20
- NSW Breast Cancer Institute  Tel: (02) 9845 6728

**Reference:**
- BreastScreen New South Wales; www.bsnsw.org.au Tel: 13 20 50
- NSW Breast Cancer Institute
- The Cancer Council NSW: www.cancercouncil.com.au
2: Cervical cancer

Facts:
- Cervical cancer is the abnormal growth of cells in the cervix (neck of the womb).
- If diagnosed early is one of the most treatable of cancers.
- Pap tests can identify abnormal findings even before cancer has developed fully.
- Early detection increases the likelihood of successful treatment.

Risk factors:
- Ever been sexually active;
- Increasing age;
- Smoking;
- Exposure to the Human Papilloma Virus (HPV or wart virus).

Symptoms/signs:
- Symptoms and signs are uncommon;
- Unexpected bleeding;
- Vaginal discharge;
- Pain.

Prevention/screening:
- Early detection of abnormalities through a Pap test for women between the ages of 18 and 70 years who have NOT had a hysterectomy and who have ever been sexually active.

Role of staff:
- The Key Worker assists female clients aged 18-70 years who have ever been sexually active and their person responsible to obtain information about risk factors, symptoms and screening for cervical cancer in order to support informed decision making about cervical cancer and screening.
- When a client and or their person responsible consents to the client undergoing a Pap Test to screen for cervical cancer the Key Worker provides support to the client in the manner described for Medical Examinations and Medical Procedures Part 4.2, Health Care Procedures.
- The GP or Area Health Service, Registered Nurse (RN) performing the Pap smear will be requesting permission from the person responsible. This may be obtained ahead of time or on the day.
- The Key Worker documents the planned Pap test and asks for the results for the client’s Health Care Plan after the client and person responsible have been informed.

Contact details:
- Local GP
- Women’s Health Nurse, Family Planning Association, Sexual Health Clinic, Community Health Centre, Women’s Health Centre, or Aboriginal Medical Service (Look under Health Services in the front of your local phone book).
- NSW Cervical Screening Program, Tel: 13 15 56

Reference:
- NSW Cervical Screening Program www.csp.nsw.gov.au Tel: 13 15 16
- The Cancer Council NSW: www.cancercouncil.com.au
3: Prostate cancer

Facts:
- The prostate is a small gland situated just below the bladder in men. It wraps around the urethra, the tube that carries urine from bladder to the tip of the penis.
- A normal prostate is about the size of a golf ball.
- Prostate cancer is the second most common cancer in Australian men, behind skin cancer.
- Most prostate cancers are slow growing.
- There is insufficient evidence to support the screening of all men for prostate cancer, i.e. men without any symptoms.

Risk factors:
- Increasing age. Prostate cancer is rare in men under 50 years of age, most common in men over 65 years.
- Family history of prostate cancer.

Symptoms/signs:
- There may be no symptoms in early prostate cancer.
- Changes in urination e.g. increased frequency, difficulty starting the flow, trouble emptying the bladder, etc.
- Enlargement of the prostate gland.
- Change in shape or texture of the prostate gland.

Prevention/Screening:
- A diet with plenty of fresh fruit and vegetables and wholegrain cereals may help protect against a number of cancers and health problems.
- Digital Rectal Examination (DRE) may be performed by a GP if s/he suspects the presence of prostate cancer. She/he may also order a blood test to assist in diagnosing the disorder.

Role of Staff:
- If the client displays any of the symptoms associated with prostate cancer the Key Worker refers the matter to the client’s GP and supports the client as described in the Health Care Procedures, Section 4.2 ‘Medical Examinations and Medical Procedures’.

Contact details:
- Local GP
- Cancer Council Helpline, Tel: 13 11 20

Reference:
- The Cancer Council NSW: www.cancercouncil.com.au
4: Skin cancer

Facts:
- Skin cancer is caused by rays from the sun called ultraviolet radiation (UVR). UVR cannot be seen and is present even on cloudy days.
- UVR is strongest in the middle of the day.
- UVR can be reflected so being in the shade will not offer complete protection.
- Most skin cancers can be cured if they’re found early enough.
- A balance in exposure is required as total protection from any sunlight can result in low Vitamin D levels and a person may develop fragile bones.

Risk factors:
- Regular exposure to the sun;
- Increased age;
- People who get sunburnt easily;
- People who have a lot of moles or freckles;
- People with sun spots (solar keratoses);
- Family history of skin cancer.

Symptoms/Early warning signs:
- A spot, mole or freckle that changes shape, colour or size;
- A new spot that is different from other spots in that area of the skin;
- A sore that doesn’t heal.

Prevention/Screening:
- Following the SunSmart Guidelines issued by the Cancer Council NSW;
- Regular checks of skin, all over, even the soles of the feet;
- Annual check up by Local GP;
- Encourage people to dress in sun smart clothing and sunglasses. Cover as much of a person’s skin as possible with loose-fitting clothes made from closely woven fabrics;
- Choose a hat that protects the face, neck and ears;
- Long trips in the car still require protection from UVR if the windows are down.

Role of staff:
- The Key Worker or other staff provide the person responsible with information and support to maximise their understanding of risks associated with harmful exposure to the sun.
- All staff have a duty of care to protect clients from the risk of sunburn by assisting them to take the following precautions:
  - Minimise time spent in the sun between 11 AM and 3 PM (daylight saving time), 10 AM and 2 PM (Eastern Standard Time).
  - When outdoors, stay in the shade whenever possible.
  - When outdoors, apply a sunscreen that is SPF 30+ and broad spectrum. Use water-resistant sunscreen for swimming, outdoor activities that make the client sweat, and in humid climates.
  - Apply the sunscreen generously and evenly on clean, dry skin at least 20 minutes before going outside. Leave a light film of sunscreen on the skin – don’t rub it in. Re-apply every 2 hours for the best protection.
  - Wear clothes that cover the skin. Loose clothes with a close weave are best.
  - Wear a broad brimmed hat or legionnaires cap and sunglasses.
- The GP checks the person’s skin for warning signs of skin cancer during the annual medical review. The GP may recommend more regular checks for some clients.
- The Key Worker documents the planned skin cancer checks and results in the client’s Health Care Plan.
Contact details:
- Local GP
- Cancer Council Helpline, Tel: 13 11 20

Reference:
- The Cancer Council NSW: www.cancercouncil.com.au
5: Bowel cancer

Facts:
- Bowel cancer is the second most common cancer in NSW.
- It is more common in older people.
- Bowel cancer most commonly occurs in the colon or rectum.

Risk factors:
- Being over 40 years of age.
- Having bowel polyps or previous bowel cancer.
- Having had ulcerative colitis or Crohn’s Disease (together these conditions are known as Inflammatory Bowel Disease) for more than 8 years.
- Having a family history of bowel cancer.
- Having a family history of other cancers.

Symptoms/ Early warning signs:
- Blood in the bowel motion or in the toilet bowel.
- Changes in toilet habits that last more than 2 weeks.

Prevention/ Screening:
- There is no national Screening Program for bowel cancer but GPs have guidelines.
- If the client displays the above symptoms, the GP needs to be contacted urgently and will make appropriate investigations.
- A faecal occult blood test (FOBT) tests for blood in the faeces may be carried out every 2 years for clients over 50 years of age, by the GP.
- If there is a family history of bowel cancer, the GP may recommend a colonoscopy every 5 years.

Role of Staff:
- The Key Worker supports all clients aged 50 years and over or their person responsible to obtain information about risk factors, symptoms and screening for bowel cancer in order to support informed decision making about bowel cancer screening.
- A FOBT should be carried out every 2 years for clients over 50 years of age. For further information the Key Worker should speak with the GP.
- The CHAP Tool reminds the GP of the need to consider a FOBT for clients over 50 years.
- If a FOBT is indicated and the client and their person responsible agree to the test the Key Worker documents that the planned FOBT has been taken and the results are requested for client’s Health Care Plan after the client or person responsible have been informed.

Contact details:
- Local GP
- Cancer Council Hotline Tel: 13 11 20

Reference:
- The Cancer Council NSW: www.cancercouncil.com.au
6: Testicular cancer

Facts:
- Testicular cancer is not common.
- There are two types: Nonseminoma which is more likely in men aged 15-30 years, and Seminoma which is more likely in men aged 25-55 years.
- In most cases testicular cancer is curable.

Risk factors:
- Undescended testes (which is common in people with intellectual disability);
- Family history of testicular cancer.

Symptoms:
- A swelling or lump in the testicle, usually painless;
- A feeling of heaviness in the scrotum;
- Persistent ache in the lower abdomen or the affected testicle.

Prevention/Screening:
- Monthly testicular self-examination if able;
- Testicular examination during annual medical review.
- GP may arrange scrotal ultrasound.

Role of staff:
- The Key Worker supports the client and the person responsible to obtain information about risk factors, symptoms, and screening for testicular cancer in order to support informed decision making about testicular cancer screening.
- Should a person be able to, and choose to, participate in training to conduct regular self-examinations for testicular cancer, a training plan is developed in consultation with a suitably trained health professional.
- If a client is unable to conduct regular testicular self-examinations, the GP conducts the testicular examination at the annual medical review or more often if indicated by the risk factors.
- The Key Worker documents the planned testicular examinations and results in the client’s Health Care Plan.
- The Key Worker informs the person responsible about the testicular examination component of the annual medical examination conducted by the GP and supports the client in accordance with directions described in the Health Care Procedures, Section 4.2 ‘Medical Examinations and Medical Procedures’.

Contact details:
- Local GP
- Cancer Council Helpline, Tel: 13 11 20

Reference:
- The Cancer Council NSW: www.cancercouncil.com.au
B: Health targets

7: Oral hygiene

Facts:
- People’s teeth should be brushed twice each day, once after breakfast and before going to bed at night.
- It is best for people to spit out toothpaste rather than swallow it.
- Dental decay and gum disease (gingivitis) are the most common diseases that affect teeth.
- Decay is caused by plaque which is a sticky film found on teeth. Bacteria found in plaque changes sugars into acids which produce holes (cavities) in the teeth.
- Plaque can cause gum disease, which may lead to the gums becoming inflamed.
- Fluoride can limit the amounts of acid produced in the mouth and help repair any damage before it becomes serious.
- Cleaning teeth with a circular motion to remove food particles from under the gums will help reduce gum disease.
- Clients on anticonvulsant drugs have a significantly higher incident of gum problems.

Prevention:
- In order to prevent decay, teeth should be brushed twice a day with fluoride toothpaste. Regular dental check-ups (at least every year) help maintain healthy teeth and gums.
- Eat a healthy diet.
- Snacking on sugary foods and drinks between meals should be reduced.

Role of staff:
- Each client has a documented daily oral hygiene plan that all staff follow. This plan includes information about the level of support the client requires for good oral hygiene.
- If a client is able to learn teeth brushing skills, a skill development program will be developed, and implemented by all staff.
- Staff implement the following minimum oral hygiene practices to support clients’ in the maintenance of oral hygiene:
  - Teeth are brushed for at least two minutes at least twice a day using a soft toothbrush and fluoride toothpaste.
  - Teach clients’ to massage gums with brush while cleaning teeth.
  - Teeth are also brushed after sugary foods or drinks.
  - A mouth rinse and floss are used whenever possible.
  - If the client cannot rinse, an antibacterial mouth spray or mouth swab is used.
- While clients’ will be supported to have an annual dental review, the Key Worker or other staff will assist the client to attend the dentist before the annual checkup is due if any indicators of oral disease become apparent.
- Any bleeding from gums or suggestion of pain in the mouth requires prompt investigation.

Contact details:
- Dentist.
8: Hearing loss

Facts:
- Hearing loss is classified as mild, moderate, moderate to severe, severe or profound.
- Deafness is another name for profound hearing loss.

Causes:
- Repeated middle ear infection;
- Holes in the ear drum;
- Disorders that damage nerves involved in hearing (degenerative disorders);
- Inherited condition or genetic cause, such as Usher’s syndrome;
- Infections that occur during pregnancy such as rubella (German measles);
- Infections after birth, such as meningitis, mumps;
- Exposure to very loud noise over long periods;
- Abnormalities of the head and face that affect the structure of the ear;
- Premature birth;
- Head injury including loss of consciousness or skull fracture;
- Some drugs.

Treatment:
- The treatment for hearing loss depends on the reason and the severity of the impairment.
- A hearing aid is a device that makes sounds louder. Although they will increase hearing they will not make hearing normal.
- A cochlear implant is sometimes called a bionic ear because it uses technology to allow the person to hear. It is designed to stimulate the surviving nerve cells in the inner ear.

Communication:
- Many hearing impaired people use speech as their main method of communication.
- Other people use a type of signed or written language.
- Some people use a combination of signing and talking known as Total Communication.
- In Australia people with hearing impairment may learn Auslan, the language of Australia’s Deaf Community.

Role of staff:
- If a client is not responding to sounds, or complains of pain in their ears, an appointment with a GP should be arranged.
- All clients will be tested for sensory functioning annually as part of the Annual Medical Review.
- All staff support clients to obtain and use auditory aids such as hearing aids in accordance with the prescribing practitioner’s instructions.
- Staff support clients to maintain hearing aids in a clean, working order.
- If the client requires additional support to adjust to the use of hearing aids or cochlear implants, the Key Worker will forward a service request to the Community Support Team.

Contact details:
- Local GP

References:
- Australian Communication Exchange (Web: www.aceinfo.net.au, Tel: 1800 555 660)
- Australian Hearing (Web: www.hearing.com.au, Tel: 13 17 97)
9: Vision impairment

Facts:
- Vision impairment can affect a person's movement, senses, communication or social interactions.
- People can have many different problems with their eyes or vision (sight). Some are temporary and treatable, whereas other problems are permanent.
- A permanent vision problem is called “vision impairment”.
- There are different degrees of vision impairment from mild loss to total blindness.
- Vision impairment may arise because of problems in the eye, in the ophthalmic nerve or in the back part of the brain called the occipital. The occipital is the part of the brain where we “sense” what we “see”.

Causes Associations:
- People with Down Syndrome and other genetic disorders have a higher incidents of visual problems.
- Maternal infections experienced during pregnancy (e.g. rubella, cytomegalovirus, venereal diseases, toxoplasmosis);
- Consequences of disease (e.g. diabetes, glaucoma, trachoma);
- Complications associated with extreme prematurity;
- Birth complications;
- Trauma, poisoning and tumours;
- Some medications.

Symptoms/signs:
- Headaches;
- Increase in falls/ tripping.
- Tunnel vision;
- Cloudiness or opacity of the lens of the eye.

Treatment:
- Vision impairment may be corrected by wearing glasses or contact lenses.
- Some low vision (when sight cannot be corrected by eye glasses) problems can be treated. For example, when a person has cataracts, surgeons can remove the cataract or perform lens implants.
- Blindness and degenerative conditions are not curable.

Role of staff:
- Staff need to take a client to a GP if they are experiencing the following: any change in vision; sore eyes; or are avoiding light.
- All clients will be tested for visual functioning annually as part of the Annual Medical Review.
- All staff support people to obtain, use and maintain optical aids such as glasses in accordance with the prescribing practitioner’s instructions.
- The Manager and staff will ensure that risks to the client associated with vision impairments are identified in the environment and eliminated or controlled e.g. adequate light in the Unit, handrails on stairs and care taken to place furniture so that it does not obstruct regular walkways.
- Staff should be aware that sometimes a client who has vision impairment might be frightened by new experiences involving different textures or sounds. Clients with vision impairment may need help from staff to learn the social skills that are expected during conversations. They may need encouragement to initiate conversations, and they may also miss out on body language and gestures. They may not be aware when others are looking, smiling or waving at them.
- Staff should be aware that a client with vision impairment may not interact with their peers much, and might not initiate social contact due to reduced eye contact and movement.
The Key Worker should note that clients with vision impairment might be able to access services from Vision Australia. Contact 1300 847 466 for further information.

If the client requires additional support to adjust to the use of sensory aids, the Key Worker will forward a service request to the Community Support Team.

Contact details:
- Local GP
- Ophthalmologist
- VisionCare NSW (Tel: 9344 4122 or 1800 806 851).

References:
- Vision Australia (www.visionaustralia.org.au Tel: 1300 847 466)
10: Food and nutrition

Facts:
- People need a balance of sufficient nutritious foods to nourish their bodies as defined by the Dietary Guidelines in Australia[^3] which are:
  - Eat plenty of vegetables, legumes and fruits;
  - Eat cereals (including breads, rice, pasta and noodles) preferably wholegrain;
  - Include lean meat, fish, poultry or alternatives;
  - Include milks, yoghurts, cheeses or alternatives;
  - Limit saturated fat, have moderate total fat intake to ensure that vitamins are absorbed;
  - Choose foods low in salt;
  - Consume only moderate amounts of sugars and foods containing added sugars.
- Refer to the Nutrition in Practice Manual and Ensuring Good Nutrition Policy 2003 for detailed information about meeting clients’ nutritional needs.
- Physical activity is important for all people to ensure good digestion of food and elimination of waste.

Risk factors:
- Eating and drinking difficulties may mean that a person’s calorie and nutritional intake is poor and the person may end up suffering malnutrition.
- Feeding difficulties in people can lead to choking, which may be life threatening.
- Listeriosis is a rare illness caused by eating food contaminated with bacteria called *Listeria monocytogenes*. The listeria bacterium is common in soil and some raw foods. Eating foods that contain listeria bacteria does not cause illness in most people. Those at risk are pregnant women, newborns, the elderly and people with weakened immune systems.

Reducing risks:
- Correct upright positioning with enough support for eating and drinking is one of the most important things that influence safe swallowing.
- Suitable food and drink should be chosen for a client who has eating difficulties. Food and liquids should be of correct texture and thickness that the person can enjoy and that will safely meet their needs for food, hydration and their ability to digest fluid and food.
- Encourage water rather than milk or fruit juice as the main source of fluids.
- Include red meat 3-4 times per week.
- Include foods that are rich in vitamin C.
- Do not give people iron or other supplements, unless prescribed by a GP.
- To prevent contamination of food by infective agents such as listeria:
  - Thoroughly cook raw food from animal sources, such as beef, lamb, pork or poultry;
  - Wash raw vegetables and fruit thoroughly before eating;
  - Keep raw meat separate from vegetables, cooked foods and ready to eat foods (that is, do not allow the blood from raw meat to come into contact with other food);
  - Use separate cutting boards for raw meat and foods that are ready to eat;
  - Avoid unpasteurised milk or food made from unpasteurised milk (for example soft cheeses);
  - Wash your hands before and after preparing food;
  - Wash knives and cutting boards after handling uncooked foods;
  - Wash hands after handling animals;
  - Perishable foods should be stored in a cold (less than 5 degrees) refrigerator and be washed and eaten as soon as possible.

[^3]: Australian Government, Department of Health and Ageing, National Health and Medical Research Council

Role of staff:

- The Key Worker is responsible for an annual review of nutritional and swallowing risks of the client using the Nutrition and Swallowing Checklist (see the Nutrition in Practice Manual) prior to the Individual Planning meeting.
- The Key Worker completes the Nutrition and Swallowing Risk Checklist, documenting details about the health, and weight of the client and ability to eat and drink.
- If more information about particular topics is needed the Key Worker or staff should consult the Nutrition in Practice manual.
- The Key Worker develops an Eating and Drinking Plan. An Eating and Drinking Plan is an easy to understand record of how to best assist a client to eat and drink, that summarises all information prescribed by health specialists and recommendations for meals.
- The plan may provide details on positioning, seating, equipment, assistance required, food and drink preferences, and food and liquid consistency or suggested food items and quantities.
- The Nutrition in Practice manual should be referred to for all guidelines concerning matters relating to nutrition.
- If there has been a significant change in the client’s health or their weight has changed by more than five percent (5%), the Key Worker ensures that the person receives a Nutrition and Swallowing risk assessment immediately.
- Should any risks be identified from the Nutrition and Swallowing Checklist, an Action Plan is to be developed. The action plan is to be discussed and implemented through the client’s Individual Plan. (For guidelines refer to the Nutrition in Practice Manual).
- The Key Worker ensures that all people who may care for the client (including family members and day program, employers etc) have knowledge of and implement the client’s Eating and Drinking Plan.
- The Key Worker ensures that the Eating and Drinking Plan is kept in the dining area or where staff assisting a client at mealtimes can easily access the plans.
- The Key Worker or other staff ensure that mealtime assistance is provided to the client so they are able to consume an adequate amount of food and fluids in a safe manner. This particularly relates to clients with eating and swallowing problems that require mealtime management prepared by appropriate professionals (refer to the Nutrition in Practice Manual and client Eating and Drinking Plans).
- The Key Worker ensures that recommendations made by the dietitian or speech pathologist are highlighted in the Eating and Drinking Plan and that the Plan is implemented on a daily basis.
- While clients have a choice about the food they eat, staff have a duty to provide healthy a menu at home.
- Food shopping lists and menu plans should be used to avoid impulse buying and to enable balanced, healthy meals to be prepared.
- The staff ensure that food provided is nutritious.

Enteral Nutrition

- Staff who perform the duty of giving enteral nutrition (food via a tube) are to be assessed and reviewed by a qualified professional at least annually.

Contact details:

- Local GP
- Dietitian
- Speech Pathologist
- Occupational Therapist
Physiotherapist

Reference:
- Nutrition Australia: [www.nutritionaustralia.org/Nutrition_for_all_ages](http://www.nutritionaustralia.org/Nutrition_for_all_ages)
11: Constipation

Facts:
- Constipation may be associated with difficulty or straining in defecation and infrequent bowel movements over a period of time.
- The stools are often thick, dry or pasty and cause discomfort or pain as they are passed.
- “Normal” frequency of bowel movements can range from 3 times a day to once every 3 days.
- Constipation is often associated with not enough water in the stool.
- People may develop constipation if there is not enough fibre or bulk in their diet. This can happen when a person is drinking too much milk and not getting enough fibre.
- Constipation can also result from disease or taking certain medications.
- Some people ignore the feeling of needing to go to the toilet, which makes it more difficult for the person to go later.
- People with low muscle tone, neurological conditions, impaired mobility and some genetic syndromes may have difficulty with normal bowel actions.

Risk factors:
- Inadequate dietary fibre intake;
- Insufficient clear fluid intake;
- Reduced mobility;
- Low muscle tone in the gastrointestinal tract;
- Environmental factors such as lack of privacy, or inaccessible toilets resulting in delaying defecation;
- Long term use of laxatives;
- Some medications;

Signs of constipation:
- People may sometimes say that it hurts when doing a poo, but often they don’t say anything.
- They may show signs of holding on.
- Some people may start to soil their pants with brown fluid which is escaping around hard dry faecal material in the rectum.

Prevention/ modification:
- Increasing dietary fibre, such as fresh fruit and vegetables, as well as cereals, rice etc.
- Increasing fluid intake, particularly water (6-8 glasses per day). Clear fluids or water should supplement milk, tea and coffee intake.
- Regular activity/exercise within the person’s abilities.
- Developing regular toileting schedule (e.g. after meals).
- Access to toilets and privacy.

Treatment:
- Use of high fibre additives, laxatives, enemas, or suppositories, should only be given after the client has been seen by a GP, Gastroenterologist for the development of diet and a bowel plan.

Role of staff:
- If a client is experiencing any of the symptoms such as blood in stool, signs of abdominal pain or constipation, the Key Worker/staff documents the symptoms in the client’s file and schedules an to attend an appointment with their GP as soon as possible.
- The GP assesses all risks associated with bowel functioning at the annual medical review and may document instructions or recommendations in relation to
reducing risks or monitoring the client’s bowel function. The Key Worker incorporates the recommendation into a Bowel Management Plan.

- If the client is unable to self-administer medication, including enemas or suppositories, they are administered by staff who are appropriately trained and competent in accordance with the medical practitioner’s instructions, and have obtained consent from the person responsible as documented on the client’s medication chart.
- If the GP recommends dietary changes, the Key Worker reviews the client’s Eating and Drinking Plan and refers the client to a dietician if necessary.

Contacts:
- Local GP
- Gastroenterologist
- Dietician

Reference:
12: Epilepsy

Facts:
- Epilepsy is a disruption of the electrical functioning in the brain which results in seizures or “fits”. There are many different types of epilepsy.
- The part of the brain in which the activity occurs determines the type of seizure the person has.
- Seizures are sudden, uncontrolled episodes of electrical activity in the brain.
- A seizure may result in alterations in behaviour, consciousness, movement, perception or sensation.
- Anybody can have a seizure, but that does not mean that everyone who has a seizure has epilepsy.
- Seizures may be generalised (involving the whole brain) or partial (where the seizure originates in one part of the brain).
- Not all seizures involve convulsions (jerking movements).
- About 3% of the populations have epilepsy, and in 50% of cases the cause is unknown.
- In people with intellectual disability, the incidence of epilepsy is much higher.
- It is most common for epilepsy to begin in children under 5 years, although it can begin at any time.

Risk factors:
- Brain damage or head trauma;
- Abnormal brain anatomy;
- Infection;
- Tumours;
- Genetic predisposition;
- Alcohol/ drug withdrawal.

Managing epilepsy:
- Taking prescribed medication and having regular medication reviews, although medication is not prescribed for every person.
- Medication may cause side effects and needs regular review.
- Having an individual Epilepsy Management Plan with details of all aspects of management of the condition that has been developed and endorsed by a treating medical officer.
- Noting that medication may cause drowsiness or hyperactivity.
- Maintaining a healthy lifestyle.
- Supervising some physical activities closely, such as swimming, bathing (showering is recommended), cycling and climbing by clients with epilepsy.

Role of staff:
- Staff should remain with the client having a seizure to protect and reassure them.
- Do not restrain the client.
- Do not put anything in or near the client's mouth, and remove any dangerous objects around the client.
- Note the time and length of the seizure.
- If the client has not had a seizure before or it is prolonged, call an ambulance. The client's Epilepsy Management Plan will have details about actions to take if the client does not recover from the seizure within a given time frame.
- After the seizure has ceased:
  - Reassure the client.
  - Assist the client to a comfortable position and continue to observe her/him.
  - Record the seizure on the client's seizure chart.
Every client with epilepsy, regardless of the length of time since the last seizure will have an *Epilepsy Management Plan*, which is developed in consultation with a neurologist or other practitioner.

Managers ensure that all staff are familiar with and implement each client's *Epilepsy Management Plan* and support the client with epilepsy in accordance with the *Epilepsy Policy and Procedures*.

**Contact details:**
- Local GP

**Reference:**
- Epilepsy Action Australia (web: [www.epilepsy.org.au](http://www.epilepsy.org.au) Tel: 1300 374 537)
13: Thyroid functioning

Facts:
- The thyroid is a gland located in the front of the neck, just below the Adam’s apple.
- It produces hormones which affect every cell in the body and is particularly important for normal growth and development.
- **Hypothyroidism** occurs when the thyroid is under active.
- **Hyperthyroidism** occurs when the thyroid is over active.
- Hypothyroidism can easily be treated with oral medication.

Risk factors:
- A family history of thyroid disease;
- Previous diagnosis of goitre (swelling in the front of the neck) or nodules;
- Presence of a goitre;
- History of thyroiditis;
- Other autoimmune disorders;
- Partial or total removal of the thyroid;
- Down Syndrome;
- Turner Syndrome;
- Some medications e.g. Lithium.

**Down Syndrome and Thyroid function:**
- The most common hormonal (endocrine) problem in people with Down Syndrome involves the thyroid gland.
- Some people with Down Syndrome also experience Hypothyroidism. This can be treated with medication or, in some cases, surgery.

**Turner Syndrome and Thyroid function:**
- Turner Syndrome affects about 1 in every 2000 female births. It affects many body systems and often involves thyroid dysfunction.
- Treatment with thyroid hormone is important for growth and health in people with Turner Syndrome who have abnormal thyroid function.

**Symptoms of Hypothyroidism:**
- Weight gain;
- Constipation;
- Fatigue or exhaustion;
- Hair, nails and skin re coarse/dry/brittle;
- Puffiness and swelling around the face;
- Aches and pains in joints and feet;
- Depression/restlessness/sluggishness;
- Menstrual irregular;
- A swelling in the front of the neck.

**Symptoms of Hyperthyroidism:**
- Weight loss (despite adequate intake);
- Always feel hot, flushed and sweaty;
- Soft nails;
- Frequent bowel motions;
- Early menopause;
- Fast pulse;
- Muscle weakness;
- Dry eyes, possible protrusion of the eyes;
- Sensitivity to noise;
A swelling in the front of the neck.

**Screening:**
- Thyroid function testing of any person displaying the above symptoms.
- Annual thyroid function tests for people with Down Syndrome, Turner Syndrome or other high-risk groups.

**Role of staff:**
- Clients with Down Syndrome and Turner Syndrome will have thyroid function tests every year as part of their annual medical review.
- All other clients will have a thyroid function test every 3 to 5 years as part of their annual medical review.
- The results will be filed in the client’s health file.
- If a client displays any symptoms of thyroid dysfunction, the Key Worker and other staff document the symptoms in the client’s file. The Key Worker arranges for the client to attend an appointment with their GP.
- The Key Worker documents the GP’s recommendations in the client’s *Health Care Plan*, and all staff implement the recommendations in the *Health Care Plan*.

**Contacts:**
- Local GP
14: Mental health

Facts:
- One in five people experience mental health conditions and studies have shown that 14% of children and young people in Australia have a mental illness. People with intellectual disability have a higher incidence of mental illness.
- Some common mental health illnesses are:
  - Attention deficit disorder;
  - Anxiety;
  - Depression;
  - Psychosis, (including schizophrenia);
  - Obsessive compulsive disorders;
  - Eating disorders.
- Most mental illnesses have a genetic component.
- An imbalance of chemicals (neurotransmitters) in the brain is now felt to be a cause of some mental illnesses. Most drugs used to manage mental illness try to correct this imbalance.
- Using drugs may also affect mental health. There has been a link between onset of psychosis and the heavy use of marijuana and amphetamines.
- Many mental illnesses have their peak onset during adolescence, with depression and anxiety being the most common mental health issues for young people.

Warning Signs:
- Change in behaviour.
- It is seldom possible to identify a single principal cause of any one mental illness. Some of the risk factors associated with a higher likelihood of developing mental health illness are:
  - Family history;
  - Association with some genetic conditions

Triggers:

Depression

Common causes of depression include:
- Low thyroid function;
- Brain injuries and diseases (e.g. stroke, head injury, epilepsy, Parkinson's disease);
- Some steroid and hormonal treatments;
- Chronic pain;
- Serious medical illness;
- Grief and loss of family member;
- Ageing and loss.

Eating disorders

- The causes of eating disorders still remain unclear;
- Biological, psychological and social factors are all involved.

Symptoms:

Depression:
- Expressed feelings of hopelessness or helplessness;
- Loss of interest in what they usually enjoy;
- A lack of energy;
- Changes in sleeping and eating patterns;
- Crying a lot for no reason;
- Feeling anxious.

**Psychosis**
- Have hallucinations;
- Hear voices that may not be heard by anyone else;
- Have false beliefs known as delusions;
- Experience paranoia;
- Have strange and disorganised thinking or behaviour;
- Have difficulty speaking.

**Schizophrenia**
- Confused speech patterns;
- Ongoing delusions - believing things about themselves that no one else believes, such as thinking they are being watched, or have particular powers or abilities they don’t have.

**Anxiety**
- Unexplained panic attacks;
- Phobias like agoraphobia (fear of being in an open space);
- Obsessive behaviour causing them to check and recheck things.

**Attention deficit disorder**
- Problems concentrating and attending to tasks;
- Easily distracted;
- Excessively active;
- Tendency to go off into daydreams more than others.

**Treatment:**
Treatment will be determined and advised by psychiatrists or other medical practitioners with expertise. Psychologists may become involved with specialised counselling if prescribed.

**Role of staff:**
- Staff can support clients by encouraging them to talk about their feelings.
- Ensure that the client is exercising, eating healthy foods and doing activities that they enjoy.
- The Key Worker and other staff should talk to the client, and let them know that staff are there to support them. Staff should create an environment in which the client feels safe.
- Ensure that the contact numbers of the psychologist, doctor or psychiatrist are readily available.
- The Key Worker and other staff learn about mental illness, in particular depression and anxiety, which may help the staff member understand that changes in the client’s mood or behaviour are not directed at them personally.
- The Key Worker or other staff are aware of changes to sleeping or eating patterns, and take note of any mood changes in client.
- If a client displays any symptoms of a mental illness, the Key Worker and other staff document the symptoms in the client’s file. The Key Worker arranges for the client to attend an appointment with their GP.

**Contact details:**
- Local GP
- ADHC Psychologist
- Local Mental Health Team
Reference:
- Lifeline (web www.lifeline.org.au Tel: 13 11 14)
- Beyond Blue (web www.beyondblue.org.au)
- SANE Australia (web: www.sane.org Tel: 1800 187 263)
- Black Dog Institute Tel: (02) 9382 4530
15: Osteoporosis

Facts:
- Osteoporosis occurs when bones are thin and become fragile and are inclined to fracture more easily.
- It is significantly higher in people with cerebral palsy.
- It affects half of all women and a third of all men over 60 years of age in Australia.
- There are often no symptoms of osteoporosis until a bone is broken.
- The most common fractures to result from osteoporosis occur in the spine, the hip and the wrist.
- Some fractures in the spine may not be easily detected so all back pain in middle aged or older clients should be checked for osteoporosis.

Risk factors:
- Too little calcium in the diet;
- Immobility or too little weight bearing exercise;
- Low body weight;
- A high intake of alcohol or smoking;
- Long term use of steroid medications or anticonvulsant therapy;
- Anorexia nervosa;
- Family history of osteoporosis;
- Advanced age;
- Low testosterone in males;
- Low oestrogen in females;
- Thyroid disease;
- Too little sunlight (too much cover through the day).

Symptoms/signs:
- Unexplained pain;
- Curvature of the spine;
- Tenderness over bone;
- Loss of height;
- A fracture, usually of the wrist, hip or spine.

Reducing risks:
- Weight bearing exercise;
- Adequate sunlight;
- A healthy diet with adequate levels of calcium (approx. 1000 mg/day) or calcium supplements prescribed by the client’s GP;
- Adequate intake of Vitamin D;
- Reducing or eliminating tobacco and alcohol use.

Screening:
- Annual medical review;
- Dual Energy X-ray Absorptiometry (DXA) (a safe, painless X-ray to scan for bone density, covered by Medicare for people at risk) may be ordered by the GP.

Role of Staff:
- If a client is experiencing any of the symptoms of osteoporosis described above the Key Worker and other staff document the symptoms in the client’s file and the Key Worker supports the client to attend an appointment with their GP.
- The GP assesses the risk of osteoporosis at the annual medical review and may document instructions or recommendations for assessment and management.

Contact Details:
- Local GP
- Osteoporosis Australia Helpline Tel: 1800 242 141
- Dietitian
Reference:

- Osteoporosis Australia Helpline [www.osteoporosis.org.au](http://www.osteoporosis.org.au) Tel: 1800 242 141
16: Gastro-Oesophageal Reflux and Helicobacter pylori

Facts:

**Gastro-Oesophageal Reflux**
- Is often referred to as reflux or heartburn, which is the burning pain that can be felt in the chest and moves upward during an episode of reflux.
- Reflux is a condition in which the acidic contents of the stomach regurgitate or reflux (wash back) into the oesophagus (the gullet).

**Helicobacter pylori**
- Is a common bacterial colonisation in the stomach.
- It may be symptomless.
- Some people with disabilities develop overgrowth of the bacteria and it becomes an infection of the stomach which is painful and which causes reflux.

Risk factors:

**Gastro-Oesophageal Reflux**
- The stomach acid can cause inflammation and damage to the oesophagus.
- The oesophagus may become ulcerated and scarred. Build up of scar tissue can lead to the oesophagus being narrowed. This narrowing is called a stricture and can lead to difficulty in swallowing.
- Can irritate breathing passages, causing hoarseness of the voice, chronic dry cough, or provoke an asthma attack in someone who has asthma.

**Helicobacter pylori**
- It can be associated with gastritis or peptic ulcer disease.

Symptoms/ signs:

**Gastro-Oesophageal Reflux**
- It may have no symptoms.
- Vomiting, regurgitation;
- Bleeding from the gut;
- Weight loss;
- Loss of tooth enamel
- Dysphagia;
- Repeated coughing or recurrent chest infection.

**Helicobacter pylori**
- Include nausea, vomiting, frequent complaints, and pain in abdomen.
- Gnawing or burning pain in abdomen.
- Can have ulcers that bleed.

Assessment:
- All suspected signs and symptoms need GP, speech pathologist or dietitian consultation, and may need a review by a gastroenterologist and endoscopy.

Treatment:

**Gastro-Oesophageal Reflux**
- If symptoms are mild, lifestyle changes may be recommended before medication, such as avoiding chocolate, fatty foods and spices.
- Avoid aspirin or aspirin containing medicines, ibuprofen or anti-inflammatory drugs as these may irritate the stomach.
- Antacids are used to relieve symptoms.
For more severe cases a medical practitioner may prescribe medication.

**Helicobacter pylori**

- There is a special triple agent formula for treatment of Helicobacter pylori infection, prescribed by the GP following a formal diagnosis.

**Reducing risks:**

**Gastro-Oesophageal Reflux**

- Small frequent meals;
- Position after meals and in bed.
- Cutting out chocolate, fatty foods and spices;
- Reducing weight if overweight.

**Role of staff:**

- The GP assesses the risk of Gastro-Oesophageal Reflux and Helicobacter pylori at the annual medical review and may document instructions or recommendations in relation to further tests, treatment or managing the person’s symptoms.
- When developing the *Health Care Plan*, the Key Worker supports the person responsible to obtain information about any recommendations from the GP about Gastro-Oesophageal Reflux or Helicobacter pylori relating to the person.
- If the GP recommends that a client requires further tests for Gastro-Oesophageal Reflux or Helicobacter pylori, the Key Worker provides support to the person.
- If the GP recommends modifications to the client’s diet, the Key Worker modifies the person’s *Eating and Drinking Plan* accordingly. If necessary, the Key Worker refers the person to a dietician for review.
- The Key Worker documents the Gastro-Oesophageal Reflux or Helicobacter pylori management plan as part of the *Health Care Plan*, and all staff implement the plan.

**Contact details:**

- Local GP
- Speech Pathologist
- Dietitian
- Gastroenterologist
- Dysphagia Clinics

**Reference:**

17: Immunisation

National Immunisation Program Routine Schedule of Vaccines

The Australian Immunisation Schedule specifies the age at which particular vaccinations should be given to adults and children to prevent the spread of certain infectious diseases.

Immunisation schedules for adults with a disability should follow national guidelines. Hepatitis A and B immunisations are indicated for people who live in institutions and immunisation is indicated for contact with persons who are Hepatitis B carriers. Immunisation against influenza and pneumococcus is recommended for the medically vulnerable.

<table>
<thead>
<tr>
<th>AGE</th>
<th>DISEASE</th>
<th>VACCINE</th>
</tr>
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<tbody>
<tr>
<td>Birth</td>
<td>Hepatitis B</td>
<td>HepB</td>
</tr>
</tbody>
</table>
| 2 months | Hepatitis B*  
Diphtheria, tetanus, pertussis  
*Haemophilus Influenzae* type b  
Poliomyelitis  
Pneumococcal+ | Hep B*  
DTPa  
Hib  
IPV/OPV  
7vPCV |
| 4 Months | Hepatitis B*  
Diphtheria, tetanus, pertussis  
*Haemophilus Influenzae* type b  
Poliomyelitis  
Pneumococcal+ | Hep B*  
DTPa  
Hib  
IPV/OPV  
7vPCV |
| 6 months | Hepatitis B*  
Diphtheria, tetanus, pertussis  
Poliomyelitis  
Pneumococcal+  
Hib | Hep B*  
DTPa  
IPV/OPV  
7vPCV |
| 12 months| Hepatitis B*  
*Haemophilus Influenzae* type b  
Measles, mumps and rubella  
Meningococcal C  
Pneumococcal + | Hep B*  
Hib  
MMR  
Men CCV  
7vPCV |
| 18-24 months | Pneumococcal+                        | 23vPPV                  |
| 4 years  | Diphtheria, tetanus and pertussis  
Poliomyelitis  
Measles, mumps and rubella  
Pneumococcal+ | DTPa  
IPV/OPV  
MMR  
23vPPV |
| 10-13 years | Hepatitis B#                        | Hep B#                  |
| 15 –17 years | Adult/adolescent formulation  
diphtheria-tetanus-pertussis | dTpa                    |
| 65 years and over | Influenza  
Pneumococcal disease | Influenza (annual)  
23vPPV (every 5 yrs) |

Notes:
* Total 3 doses required following birth.
Hepatitis B vaccine (Hep B) should be given to all infants at birth and should not be delayed beyond 7 days after birth. Following the birth dose, a total of 3 doses is required to achieve optimum protection in infants and young children. Infants whose mothers are hepatitis B surface antigen positive (HbsAg+ve) should also be given hepatitis B immunoglobulin (HBIG) within 12 hours of birth.

Vaccination of all adolescents 10-13 years of age, is recommended for all those in this age group who have not already received a primary course of 3 doses of hepatitis B vaccine.

Free vaccine administered to eligible children. See below.

**Vaccination for those at increased risk of infection**

Medical conditions that increase the risk from infectious diseases, even in the absence of specific immune defects, demand special attention to the use of current vaccines. This includes the use of influenza vaccine in severe asthma, chronic lung disease, congenital heart disease and Down Syndrome; pneumococcal conjugate vaccine in children with renal failure, persistent nephrotic syndrome and certain anatomical abnormalities; and pneumococcal polysaccharide vaccine in adults with certain chronic medical conditions.

**Influenza**

Influenza vaccine is recommended annually for individuals who are at increased risk of influenza-related complications. This includes:

- All individuals aged 65 years and older,
- All Aboriginal and Torres Strait Islander people aged 50 years and older,
- Adults with chronic cardiac conditions, including congenital heart disease and Down Syndrome, coronary artery disease and congestive heart disease,
- Adults with asthma, chronic lung disease, including bronchiectasis, cystic fibrosis and chronic emphysema,
- Adults with chronic illnesses requiring regular medical follow-up or hospitalisation in the preceding year, including diabetes mellitus, chronic metabolic disease, chronic renal failure,
- Persons with immune deficiency, including HIV,
- Residents of nursing homes and other long-term congregate care facilities.
- Adults with recurrent chest infections.

**Invasive pneumococcal disease**

**Pneumococcal conjugate vaccine (7vPCV)** is recommended for children under 5 years with compromised immune response to pneumococcal infection, including:

- Congenital immune deficiency;
- Immunosuppressive therapy;
- A person who has had splenectomy;
- HIV infection;
- Renal failure or nephrotic syndrome;
- Cardiac disease;
- All premature infants with chronic lung disease;
- All infants born at less then 28 weeks gestation;
- Cystic fibrosis;
- Insulin dependent diabetes-mellitus;
- Cerebrospinal fluid leak;
- Intracranial shunts and cochlear implants.

**Pneumococcal polysaccharide vaccine (23vPPV)** is recommended for:

- All individual 65 years and over,
- Aboriginal and Torres Strait Islander people aged 50 years and over,
- Children aged 5 years and older who have underlying chronic illnesses (as per 7vPCV) above,
- As a booster dose following a primary course of 7vPCV in children at high risk of pneumococcal disease.

**Role of Staff:**
- The Key Worker or other staff provide information about the need for discussion about immunisation with the client’s GP.
- The Key Worker ensures that each client has been given a vaccination record by his/her GP which documents:
  - Details of the vaccine given, including the batch number and brand;
  - The name of the person providing the vaccination;
  - The date of the vaccination; and
  - The date the next vaccination is due.
- This record, together with the evidence that valid consent was given for each vaccination received while the client has been in receipt of ADHC Accommodation Support Services, is filed in the client’s health file.
- The GP reviews each client’s immunisation status annually as part of the annual medical review and completes the ‘Immunisation’ component of Section 2 of the CHAP Tool or record of examination.
- If a client has missed vaccinations as recommended in the Standard Immunisation Schedule, the Key Worker requests that the GP provides information about “catch up” immunisation to the person responsible.

**Contact details:**
- Local GP

**Reference:**
18: Physical activity

Facts:
- The National Heart Foundation of Australia recommended everyone having at least 30 minutes of physical activity every day to help improve health and reduce the risk of developing certain conditions or diseases. Physical activity is any movement involving the large skeletal muscles e.g. walking, walking up stairs, gardening, playing sport, work-related activity.
- If 30 minutes of continuous physical activity is not possible, short sessions of 10-15 minutes can be combined to add up to a total of 30 minutes.
- Taking 10,000 steps per day is an acceptable level of activity that requires a pedometer.

Risk factors:
- Check with the client’s GP before any exercise program is implemented, as some types of physical activities may not be appropriate, or may be detrimental to the client’s health.

Benefits:
- Reduced risk of obesity;
- Increased cardiovascular fitness;
- Healthy growth of bones, muscles, ligaments and tendons;
- Improved sleep.

Prevention:
- Clients are encouraged to maintain a healthy weight by maintaining balance of food intake and exercise. The Key Worker monitors the client's weight by weighing the client at least every month and recording the information on the client's weight chart.
- Clients are encouraged to participate in exercise and physical activity to the extent that they are able, and as recommended by their GP.

Role of staff:
- The Key Worker completes the Physical Activity Checklist and Plan as part of the client’s annual health review (see attachments Attachments 8 and 9).
- The Key Worker or staff assist the person responsible to obtain information about exercise and physical activity options to enable the client to make choices about preferred activities. This may be done in consultation with other health professionals such as a GP, exercise physiologist, physiotherapist, recreation team or other relevant professionals.
- When formal exercise or specific physical activities are planned as part of the client’s Individual Planning process, the Key Worker will document exercise or activity goals and interventions in the client’s Health Care Plan and ensure that all staff are aware of the client’s Physical Activity plan.
- The Key Worker and staff actively facilitate and provide the necessary supports to enable clients’ to utilise services as per their activity goals.

Contact details:
- Local GP

Reference:
- National Heart Foundation's Heartline www.heartfoundation.com.au Tel: 1300 36 27 87
19: Menopause

Facts:
- Menopause refers to the permanent ceasing of menstruation and usually occurs between the ages of 45 and 55.
- It occurs because the female hormones, oestrogen and progesterone, are no longer produced by the ovaries in the same amounts.
- Some women experience menopause much earlier than the usual age.
- Women who have experienced menopause are at greater risk of osteoporosis and heart disease.
- Hormone Replacement Therapy (HRT) replaces oestrogen and can help reduce the risk of osteoporosis. It should be considered after consultation with a women’s health specialist.
- Some women with an intellectual disability may have disturbed menstrual function.

Symptoms/signs:
- Hot flushes (sudden experience of heat rising from the chest to the neck or face);
- Vaginal dryness and urinary problems;
- Mood changes;
- Aching joints;
- Increased incident of constipation;
- Disturbed sleep patterns;
- Heart palpitations;
- Changes in sexual desire;
- Higher risk of osteoporosis;
- Changes in hair pattern may include new facial hair.

Managing Menopause:
- Accept that this is a normal part of life;
- Exercise regularly;
- Eat a well balanced diet;
- Seek medical advice if the symptoms become uncomfortable;
- Continue annual medical reviews for breast examinations and consideration for Pap tests.

Role of staff:
- If the client has been experiencing any of the symptoms described above the Key Worker and other staff document the symptoms in the client’s file and the Key Worker supports the client to attend an appointment with their GP.
- Additional consent is required for screening Pap tests.
- The Key Worker supports the client and the person responsible to obtain information about any recommendations from the GP about managing menopause.

Contact details:
- Local GP
- Women’s Health Centre (refer to your local telephone book)
- Australasian Menopause Society Tel: (07) 4613 4788

Reference:
- Australasian Menopause Society www.menopause.org.au Tel: 07 4613 4788
20: Menstruation

Facts:
- The start of menstruation (or periods) can be anywhere between the ages of 9 - 16.
- Most girls will get their first period about a year after the first signs of puberty appear (when their breasts start to grow and they begin to get body hair).
- May take up to a year until the period cycle is regular.
- Average length of menstruation can vary from three to seven days.
- The average menstrual cycle is 28 days, but can vary from 23 days to 35 days.
- Most girls with a disability will reach menarche (the age at which a woman starts menstruating) at the same age as the general population.
- Problems associated with low body weight may delay puberty. Some congenital conditions are associated with early puberty.
- Pre-menstrual symptoms occur because of the major hormone changes. These symptoms can include:
  - Feeling bloated and heavy;
  - Cramping around lower abdomen, in the legs or lower back;
  - Getting more pimples than usual;
  - Feeling tense, irritable, sensitive, emotional, tired;
  - Breast tenderness;
  - Hair becoming greasier and;
  - Some women with epilepsy find that their seizures are increased just before a menstrual period.

Role of Staff:
- If possible, the Key Worker provides for information to be given to the client before her menstrual cycle commences to reduce the likelihood of distress that may be related to menstruation. Health professionals such as Women’s Health Nurses can assist with information and training material.
- Staff provide information and support to the client to enable her to manage her menstrual hygiene as independently as possible.
- If a young woman has not commenced menstruating by the time she is 16, the Key Worker should refer her to a doctor.
- When a person is unable to manage her own menstrual hygiene, staff assists her to do so in a manner that respects her privacy and dignity.
- Women with intellectual disability may experience Premenstrual Syndrome (PMS) like any other women in the community. The use of a menstrual chart to record the client’s menstrual cycle can be useful in reviewing physical or behavioural changes that may be linked to their cycle. This should be done in consultation with a Registered Nurse or a behaviour intervention support worker. A Menstrual Chart is attached at Attachment 5.
- Painful periods can be helped by hot water battle on stomach, and exercise. If the pain is very bad, a local GP should be contacted.
- When a client’s menstrual cycle changes, staff refers her to a GP for review and support.

Contact details:
- Local GP

Reference:
- Women’s Centre for Health Matters: www.womenshealthmatters.org.au
- Sexual Health and Family Planning www.shfpact.org.au
C: Other Targeted Areas

21: Asthma

Facts:
- Asthma is a disease that affects a person’s breathing.
- In an asthma attack, the airways become narrowed and breathing out becomes difficult.
- This can cause coughing, wheezing and a tightness in the chest.

Risk factors/associations:
- Exposure to smoking before birth or during early childhood;
- Family history;
- Eczema;
- Hay fever;
- Allergic response, especially to dust mites.

Triggers:
- Colds and flu;
- Exercise;
- Inhaled allergens (e.g. pollens, dust mite, moulds);
- Cigarette smoke;
- Changes in weather and temperature;
- Some medications e.g. aspirin;
- Chemicals and strong smells;
- Some food preservatives, flavourings or colourings;
- Proximity to pets.

Symptoms:
- Coughing;
- Shortness of breath;
- Tightness in the chest;
- Wheezing (a high pitched raspy sound when breathing).

Reducing the risk an attack:
- Avoid exposure to allergens;
- Avoid exposure to cigarette smoke;
- Avoid foods, pets, strenuous exercise and other factors known to cause an attack;
- Flu vaccination yearly;
- Consider pneumococcal vaccine.

Management

All clients should have and Asthma Management Plan devised and developed by the GP.

Treatment:
- The GP will draw up an Asthma Plan that will note the triggers and symptoms to look for.
- She/he may prescribe “puffers” or medications of two types: “preventer” eg; “Intol”, or “reliever” eg; “Ventolin”, or combination drugs such as “Seretide”.

Role of staff
- The GP assesses the client’s respiration and asthma risk at the annual medical review and, if asthma is diagnosed, documents instructions or recommendations
in relation to asthma management including storage and cleaning of medication and equipment, for example sprays, nebuliser and spacers.

- The Key Worker assists client's person responsible to obtain information from the GP in order to support informed decision making about asthma management for the client.
- The Key Worker documents the asthma plan as part of the Health Care Plan based on the GP’s instructions and all staff implements the asthma plan.
- The Key Worker or other staff monitor and record the client’s reading on the peak flow meter if recommended by the GP.

Contact details:

- Local GP

Reference:

- National Asthma Campaign web: www.nationalasthma.org.au, Tel: 1800 032 495
- National Australia Council Australia Asthma Management Plan
22: Dementia

Facts:
- Dementia refers to a progressive decline in a person's cognitive functioning.
- It includes loss of memory, intellect, social skills, emotional reactions and difficulty with hand coordination or gait.
- There are many types of dementia.
- Probably the best known is one type called “Alzheimer's Disease” which accounts for 50-70% of all dementias.
- The other main form is vascular dementia caused by small blood vessel changes affecting blood flow to the brain.
- Studies have shown that almost all adults over the age of 40 years with Down Syndrome display cerebral neuropathology (changes to the brain), although the average age for behaviour change is reported to be 54 years.

Risk factors:
- Being over 65 years of age, but it can occur earlier in people with intellectual disability.
- Family history.
- Poor circulation or vascular disease.
- Excessive alcohol consumption.
- Having Down Syndrome or some neurological condition.

Symptoms:
- Change in behaviour;
- Loss of everyday skills;
- Depression;
- Progressive and frequent memory loss for familiar people or familiar activities;
- Confusion;
- Apathy;
- Withdrawal.

Assessment:
Needs psychological or neuro-physiological assessment, GP and ACAT assessments, and management plans.

Treatment:
- At present, there is no cure for dementia.
- Some medications and complementary therapies have been found to delay symptom progression.

Role of staff:
- If a client demonstrates any of the symptoms of dementia as listed the Key Worker and staff documents the symptoms and makes an appointment for the client and their person responsible to discuss with their GP.
- The client may be referred for a psychological review or may be referred to a specialist clinic.
- The staff will document the changes in the client's care needs.

Contact details:
- Local GP
- National Dementia Hotline at Alzheimers Australia (www.alzheimers.org.au) Tel: 1800 100 500 and for Interpreter Services Tel: 13 14 50
- Local Health Centre
Aged Care Assessment Team – contact your local Area Health Service for support, at request of the GP.

Reference:

- Alzheimer’s Association and Down Syndrome Association of Victoria Inc
- National Dementia Helpline Tel: 1800 100 500
23: Diabetes

Facts:
- Diabetes is a condition in which there is too much sugar (glucose) in the blood at different times of the day.
- A hormone called insulin that is secreted by the pancreas normally controls the amount of sugar in the blood.
- If the body doesn’t produce enough insulin, or if the insulin doesn’t work properly, the amount of glucose in the blood becomes too high.
- If left untreated or poorly managed, diabetes can lead to blindness, heart attack, stroke, kidney failure, nerve damage, poor circulation, slow healing of wounds and recurrent infections and death.
- There are two types of Diabetes: **Type 1** (also known as Insulin Dependent Diabetes Mellitus [IDDM] or Juvenile Onset Diabetes) and **Type 2** (also known as Non Insulin Dependent Diabetes [NIDDM] or Mature Age Onset Diabetes).

Risk factors:
- A family history of Diabetes;
- Being overweight;
- Being over 40 years of age;

Symptoms:
- Excessive thirst;
- Excessive urination;
- Unexplained weight loss;
- Weakness and fatigue;
- Blurred vision;
- Tiredness and irritability;
- Tingling and numbness in the feet;
- Excessive weight;
- Slow healing infections;
- **Hypoglyceamic (hypo) event;** A diminished concentration of glucose (sugar) in the blood. This occurs when a person with diabetes has injected too much insulin, eaten too little food, or has exercised without extra food or has a current illness. Taking small amounts of sugar, sweet juice or food with sugar will usually help the person feel better within 10-15 minutes.
- **Hyperglyceamic event;** Too high level of glucose, sugar, in the blood, a sign that diabetes is out of control. It occurs when the blood does not have enough insulin or cannot use the insulin it does have to turn glucose into energy, or when the person has eaten too much food or has a current illness or infection.

Treatment:
- Diet
- Some oral agents

Insulin:
- Adults on insulin need to eat at regular times.
- Skipping meals (feeling too tired, being out, sleeping in) can lead to ‘hypos’ if insulin doses remain unchanged.
- It will take time to work out a routine and to adjust insulin doses to meet the body’s needs.
- Unopened bottles of insulin should be stored in the fridge, not the freezer.
- Opened bottles should be kept in a cool place out of direct sunlight.
- Check expiry dates of insulin.
- In order to avoid the health problems of diabetes mellitus type 1, blood glucose levels should be measured. It is important to check blood glucose levels at regular times and also at different times. In this way insulin doses can be
adjusted to changes in blood glucose levels and if necessary a review of the
current regime can be conducted by the GP.

Healthy Diet:
- It is important for people with diabetes to maintain a healthy diet.
- Carbohydrates are ‘energy’ foods and are important in controlling diabetes. A
  person with diabetes will need to have a diet that contains the right carbohydrates
  (i.e. a combination of quick-acting or slow acting carbohydrates).
- The ‘glycaemic index’ is a way of rating how long carbohydrates are active in the
  blood and maintaining the right level for the right length of time.

Exercise:
- Regular exercise is very important for people with diabetes, as it is very good for
  using up glucose quickly and in some ways it has similar effects to insulin, if the
  level is suddenly too high.
- There is also a long-term benefit as muscles that have been exercised can take
  up glucose more quickly for a number of hours and even up to several days after
  the exercise.
- Exercise and insulin work on the glucose in different ways, and if both are used
  together the person will benefit.

Other factors:
- Annual medical reviews should be carried out.
- Each client that has diabetes should have a Diabetes Management Plan.
- Clients who have diabetes should be linked to a local diabetes team,
  endocrinologist and Podiatrist.
- Regular monitoring of blood sugar levels is necessary, and it is important that
  normal blood pressure is maintained.
- It is important to tell the dentist and other practitioners that the client has
  diabetes.
- Long trips need to be planned in advance so that there are regular meal breaks,
  and extra food must be available.

Role of staff:
- If a client is experiencing any of the symptoms of diabetes described, the Key
  Worker/staff document the symptoms in the client’s file. The Key Worker
  arranges for the client to attend an appointment with their GP.
- The GP assesses a client’s risk of diabetes at the annual medical review and
  documents instructions or recommendations in relation to reducing risks or
  monitoring the client’s blood sugar levels.
- If the GP recommends that a client requires insulin injections or tablets to control
  the diabetes, the Key Worker obtains valid consent from the person responsible.
- If a client requires insulin injections and is able to participate in training to
  administer their own injections, a training plan is developed in consultation with a
  suitably trained health professional.
- If the client is unable to self-administer insulin, insulin will be administered by staff
  who are appropriately trained and competent.
- When the GP requests that Blood Sugar Levels (BSLs) be monitored at home,
  the client will be supported in this procedure by staff who are appropriately
  trained and competent.
- The Key Worker will request that the client’s GP define the acceptable upper and
  lower BSL readings.
- Staff will record the BSL reading on a BSL chart and notify the client’s GP
  immediately if the reading is outside the acceptable range.
- The Key Worker documents the Diabetes Management Plan as part of the Health
  Care Plan in accordance with the GP’s instructions.
- All staff implement the Diabetes Management Plan.
Contact details:
- Local GP
- Endocrinologist
- Diabetes team
- Podiatrist

Reference:
- Diabetes Australia  (Web: www.diabetesnsw.com.au Tel: (02) 9552 9900 or 1300 136 588)
24: Heart disease

Facts:
- Also known as cardiovascular disease (CVD).
- Heart disease is the leading cause of death among Australians (almost 40% of all deaths).
- Heart disease refers to a number of conditions affecting the heart including:
  - Angina (heart pain) and heart attack;
  - Blood clotting and other disease of the heart or blood vessels.
- The most common cause of heart disease is the gradual clogging of blood vessels by fatty or fibrous materials.
- When arteries become clogged less blood is able to flow through them and less oxygen is able to reach the cells of the heart and the person experiences chest pain. Pain may also occur in other parts of the body e.g. the back or shoulders.

Risk factors:
- Family history of heart disease;
- Congenital heart disease (especially for people with intellectual disability);
- Increasing age;
- Diabetes;
- Smoking;
- High blood pressure;
- Being overweight;
- Eating a lot of fatty and salty foods;

Prevention/Screening:
- Stop smoking;
- Reduce fat and salt intake;
- Maintain a healthy weight;
- Exercise regularly;
- Eat plenty of fresh fruit and vegetables, fish and cereals;
- Have a cardiovascular examination as part of the annual medical review.

Role of Staff
- The GP assesses the client’s blood pressure and cardiac functioning at the annual medical review and may document instructions or recommendations in relation to heart disease and hypertension.
- The Key Worker assists the client and person responsible to obtain information in order to support informed decision making about strategies to address heart disease and hypertension for the client.
- The health professional(s) documents interventions to manage the disease.
- All staff implement the intervention plans.

Contact details:
- Local GP

Reference:
- National Heart Foundation's Heartline Web: www.heartfoundation.com.au Tel: 1300 362 787
25: Hypertension

Facts:
- Hypertension is the medical term for high blood pressure.
- Blood pressure (BP) is the pressure in the arteries as blood is pumped around the body by the heart.
- Blood pressure is recorded as two numbers (e.g. 120/80). The first, larger number represents the highest pressure in the arteries as blood is pumped through. The second, lower number is the baseline pressure in the arteries as the heart relaxes between beats.
- Normal blood pressure in adults is around 120/80. A blood pressure reading between 120/80 is considered normal, and 140/90 is at the high end of the normal blood pressure range.
- Repeat readings are usually required before a diagnosis is made. Trends are identified and monitored.
- BP is normally lower in pregnant women except in the case of Pre-Eclampsia a condition in pregnancy marked by the development of sudden elevated blood pressure and protein in the urine during pregnancy. Pre-Eclampsia and other hypertensive disorders of pregnancy are a leading global cause of maternal and infant illness and death.
- High blood pressure can lead to problems like heart disease, heart attack, stroke and kidney disease.
- Hypertension is becoming more common in children, and is usually found in those children that are overweight and obese.

Risk factors:
- Kidney disease;
- Family history;
- Being overweight;
- Eating a lot of salt and fat;
- Having high blood cholesterol;
- Not exercising regularly.

Prevention/ Reducing Risks:
- Reduce fat and salt intake;
- Maintain a healthy weight;
- Good nutrition;
- Exercise regularly;
- Have blood pressure checked at least annually as part of the medical review.

Role of staff:
- The GP assesses the client’s blood pressure and cardiac functioning at the annual medical review and may document instructions or recommendations in relation to heart disease and hypertension.
- The Key Worker assists the person responsible to obtain information in order to support informed decision making about strategies to address heart disease and hypertension for the client.
- The Key Worker or other staff monitor and record the client’s blood pressure if recommended by the GP.

Contact details:
- Local GP

Reference:
- National Heart Foundation’s Heartline web: www.heartfoundation.com.au Tel: 1300 362 787
26: Pressure sores

Facts:
- Pressure sores are also known as bedsores, pressure ulcer, skin ulcers and decubitus ulcers.
- They are areas of localised damage to the skin and underlying tissue caused by constant pressure, friction (rubbing) or shearing (pulling or stretching the skin) or constant exposure to moisture.
- Pressure sores are most likely to develop over areas where the bones lie just below the surface of the skin e.g. ankles, heels, knees, hips, sacrum, shoulder blades, and elbows.
- Pressure sores are preventable but can be very difficult to treat once they develop, are prone to infection, and can be extremely painful.

Risk factors:
- Immobility or reduced mobility (permanent or temporary);
- Constant pressure over a bony area that reduces or stops circulation;
- Friction from rubbing of the skin against a surface, clothing or equipment;
- Poor positioning or transferring techniques that can result in the skin being stretched or pulled;
- Poor skin hygiene;
- Immune problems;
- Post surgery e.g. hip surgery;
- Constant exposure of the skin to moisture (including saliva on the hands or face, or urine);
- Poor nutrition and being under/over weight;
- Diabetes;
- Sensory loss.

What does a pressure sore look like?
- A red area that doesn’t fade after 20 minutes of pressure relief;
- A discoloured, black or dead looking area of skin;
- A scrape or abrasion;
- An open sore.

Prevention:
- Assess the client’s skin condition regularly.
- Ensure that skin is dry, clean and free from bodily fluids or soiling.
- Use moisturisers on very dry skin.
- Reposition an immobile person or assist them to reposition regularly (at least every 2 hours).
- Use pillows or foam cushions to remove contact between bony prominences and other surfaces, including other parts of the client’s own body (e.g. between heels or knees).
- Use lifting devices to move immobile people to reduce friction.
- Ensure that the client’s diet is adequate, including fluid intake.
- Refer a client to appropriate health professionals for advice about positioning, diet and skin care as required.
- Do not massage the area, use doughnut cushions, or use creams on broken skin.

Role of staff:
- The Key Worker refers the client to a physiotherapist or occupational therapist to develop a plan to ensure that the client is correctly positioned to reduce the risk of pressure sores.
- If a client displays any symptoms of a pressure area or develops a pressure sore, the Key Worker and other staff document the symptoms in the client’s file. The
- Clients with reduced mobility, whether it is permanent or temporary, will have a plan to manage pressure area care documented as part of their *Health Care Plan*.
- The Key Worker ensures that all staff are informed about the client’s pressure area care requirements, and implement the care plan.

**Contact details:**
- Local GP
- Local community nurse
- Occupational therapist
- Physiotherapist
27: Respiratory conditions

Facts:
- Respiratory conditions are any condition of the respiratory tract. The areas that are affected by respiratory conditions are the nose, throat, larynx, trachea, air passages and lungs.
- Respiratory conditions are associated with a number of medical conditions.
- Respiratory diseases are further classified according to whether they are acute (lasting a short time, such as acute respiratory infections), or chronic (lasting a long time, usually longer than 3 months, like asthma or chronic obstructive airways disease).

Respiratory conditions include:
- Asthma (see Information Sheet No.21);
- Sleep apnoea: snoring, upper airway obstruction, abnormalities of breathing control, apnoea, and neuromuscular weakness;
- Acute respiratory infections including; Viral bronchiolitis, Croup, pneumonias, tuberculosis;
- Lung disease e.g. sarcoidosis;
- Congenital abnormalities of the lung e.g. cystic fibrosis, pulmonary hypertension;
- Lung malignancy;
- Chronic conditions: COPD; emphysema; bronchiectasis.

Risk Factors
Risk factors for Respiratory conditions are factors that do not seem to be a direct cause of the disease, but seem to be associated in some way. Having a risk factor for Respiratory conditions makes the chances of getting a condition higher but does not always lead to Respiratory conditions. Also the absence of any risk factors is not necessarily a protection against Respiratory conditions.
- Cigarette smoking;
- Dust laden environments;
- Obesity;
- Dysphagia;
- Recurrent infections;
- Pollution;
- Dental disease;
- Reflux;
- Aspiration;
- People with impaired immune systems.

Symptoms/ signs
- Shortness of breath;
- Coughing or persistent cough;
- Coughing blood;
- Wheezing;
- Trouble breathing in cold weather;
- Fatigue;
- Loss of appetite;
- Fever;
- Chest pain;
- Cyanosis (blueness) around lips and finger nail beds;
- Increase or decrease in the amount of sputum produced;
- Change in colour of sputum colour to yellow or green or with the presence of blood.
Role of staff:

- If the client has a diagnosis of a respiratory disease the GP documents instructions and recommendations in relation to the management of the disease.
- The Key Worker and other staff support the client and their person responsible to obtain information from the GP in order to support informed decision making about respiratory management.
- The Key Worker documents the Respiratory Management Plan as part of the *Health Care Plan* based on the GP's instructions.
- All staff implement the respiration management plan. Where the client requires referral to other allied health professionals for the management of their respiration the Key Worker makes the appointment and accompanies the client to the appointment.
- The Key Worker and other staff monitor and record any data relating to the respiration management plan if recommended by the GP. It is important that staff record all chest infections on the clients Health File.

Contact:

- Department of Respiratory Medicine (NSW Department of Health) at your local hospital.
- Local GP

Reference:

28: Drug and alcohol

Facts:
A drug is any substance which when taken into the body changes the way it functions. Therefore medicines, vitamin supplements, caffeine, tobacco, inhalants, alcohol, cannabis, heroin and steroids are all drugs. This information sheet only refers to drug and alcohol that affect the central nervous system.

Main drug groups and their effects
Drugs are often grouped according to their effect on the central nervous system. There are three main groups:

- **Depressants**: slow down the central nervous system and the messages being sent to and from the brain. The heart rate and breathing also slow down. Depressants include: alcohol, minor tranquillisers, inhalants (glue, petrol and spray paint), codeine such as Panadeine, opiates such as methadone, cannabis (marijuana, hashish, hashish oil) and narcotics such as heroin.

- **Stimulants**: speed up the central nervous system and the messages going to and from the brain. They increase the heart rate, body temperature and blood pressure. Stimulants include: nicotine (cigarettes), caffeine (coffee, cola, chocolate, slimming tablets, some energy drinks) pseudoephedrine (found in some cough and cold medicines, cocaine, non-prescription amphetamines, speed, LSD and ecstasy.

- **Hallucinogens**: affect perception. People who have taken them may see or hear things in a distorted way. The senses become confused, especially time, sound and colour. The effects of hallucinogens vary greatly and are not easy to predict. Hallucinogens include: LSD, magic mushrooms, mescaline, ecstasy and marijuana (in strong doses).

The legal status of drugs depends on certain factors. For example alcohol is a legal drug but it is illegal to sell it to people under the age of 18 years.

How do drugs affect people?
The effects of a drug will vary from person to person and depend on:

- The individual: their mood, size, weight, gender, personality, health etc.
- The drug: the amount used, the strength, how it is used (smoked, eaten, and injected) and whether the person has taken other drugs at the same time.
- The environment: whether the person is with trusted friends, alone, in a social setting or at home.

Possible harms include:

- Harms to the body, especially liver and kidneys;
- Harms to relations with others: friends, family, community;
- Harms to lifestyle: employment, education, accommodation;
- Harms associated with breaking the law;
- Mental illness;
- Domestic instability;
- Intoxication can cause impaired judgment and people may take risks they normally would not take.

Signs
It is sometimes difficult to tell if someone is using drugs. The effects of drugs vary greatly from person to person. There are no physical or emotional changes that are specific to drug use only, however if someone is behaving in an unusual way over a long period of time there may be an issue.

Some warning signs include:
- Lethargy
- Changes in eating patterns
- Extreme mood swings and explosive outbursts
- Staying out all night
- Trouble at day placement, employment, school
- Sudden and frequent change of friends
- An unexplained need for money
- Having lots of money
- Valuable items missing
- Trouble with police

**Role of staff**

- The staff member who becomes aware of the situation discusses it with the client’s Key Worker and the manager. The staff members document the client’s behaviour.
- If the manager and or delegate are not sure how to manage the situation they can consult with the Australian Drug Information Network counseling and referral service on Directline on 1800 888 236 (statewide) this service is confidential and available 24 hours a day.
- Get the facts: talk with the client and find out which drug is being taken and how often. The client may have been experimenting with the drug and has since stopped using it. Choose the right moment to discuss their drug use, not when they are intoxicated or under the influence of the drug.
- Inform the client’s person responsible and or guardian about the situation and strategy to manage the situation.
- Refer the client to have counseling. The Key Worker or person responsible escort the client to counseling. The counseling may be done on a one to one basis so it is important to discuss the recommendation and management of the problem with the counselor and record information in a management plan.

**Contact**

- Local GP
- Directline on Tel: 1800 888 236 (statewide) provides confidential 24 hour drug and alcohol telephone counseling and referral.

**Reference:**

- Drug and Alcohol telephone and counseling hotline: Directline on 1800 888 236 (statewide)
29: Sexually transmitted infections

Facts:
Sexually Transmitted Infections (STIs) are infections passed from person to person during sexual activity. There are a number of common infections, all of which need to be treated by a doctor as they may lead to other complications or be transmitted to another person. The best way to prevent the spread of STIs is the use of a condom.

Not all STIs have symptoms. A person might have an STI and pass it on without knowing it. Some STIs can cause long term problems like infertility, birth defects, illness – even death. STIs don’t go away without treatment. There are some common symptoms to watch for, however many STIs show no signs or symptoms and therefore sexually active people should have regular check ups.

Signs of infection:
In the genital area:
- Itching
- Painful sores and blisters
- Discharge
- Smell
- Warts
- Burning or discomfort when passing urine
- Fever and tiredness
- Sore throat

Reduce risk:
- Drinking alcohol or using drugs may affect the ability to make safe decisions.
- Clients need education and support to have access to safe and effective methods of preventing STIs and unintended pregnancy.

Prevention:
- Condoms should be used every time a person has vaginal or anal intercourse and a water based lubricant should be used.
- Dental dams or condoms should be used during oral sex.
- Condoms should be used to cover sex aids.

Role of staff:
- This is a sensitive and confidential area of support which should be undertaken with training, planning and consent.

Contact:
- Local GP

Reference:
- Sexual Health and Family Planning www.shfpact.org.au
- Women’s Centre for Health Matters: www.womenshealthmatters.org.au
30: Allergies

Facts:
An allergy is an unpleasant physical reaction that a person experiences when the body is exposed to a substance to which that person is hypersensitive. Such substances, which are harmless to many people, are called allergens. Allergies can affect a wide variety of organs in the body and manifest a range of symptoms.

Allergic reaction can be provoked by skin contact with poisonous plants, chemical and animal scratches, and insect stings. Ingesting or inhaling pollen, animal fur, moulds, mildew, dust, nuts and shellfish, may also cause allergic reactions. Medications such as penicillin and other antibiotics are also to be taken with care, to avoid an allergic response.

Once an allergy has developed, exposure to the particular allergen can result in symptoms that vary from mild to serious. Anaphylaxis is a severe, rapidly progressive allergic reaction that can be life threatening.

Although any environmental material can cause allergies, certain ones are encountered more frequently than others. These include:

- Inhalants such as pollens, mould spores, animal products, house dust and mites.
- Foods such as cow’s milk, eggs, chicken, shellfish, whitefish, peanuts, soybeans, wheat products, chocolate, celery and all products containing one or more of these ingredients. Some individuals are allergic to food additives.
- Drugs such as penicillin.
- Substances which touch the skin. These include plant oils, cosmetics and perfumes, nickel in jewellery or on buckles and under garment fasteners, hair dyes, topical medications including their additives and occupational chemicals.
- Allergic reactions can be caused by direct contact with latex found in gloves, catheters, condoms, dental dams and other medical devices. These disorders are reportedly caused by allergy to a protein in the latex.

<table>
<thead>
<tr>
<th>Target area</th>
<th>Common Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td>Nasal itching, congestion, sneezing, postnasal drip, watery discharge commonly associated with hay fever.</td>
</tr>
<tr>
<td>Eyes</td>
<td>Itching, redness, swelling, tearing, conjunctivitis and other symptoms.</td>
</tr>
<tr>
<td>Ears</td>
<td>Fluid in middle ear, recurrent infections</td>
</tr>
<tr>
<td>Lungs</td>
<td>Asthmatic symptoms such as shortness of breath, wheezing, tightness in chest, coughing.</td>
</tr>
<tr>
<td>Skin (including lips, inside mouth and ears)</td>
<td>Itchy welts or hives of varying sizes.</td>
</tr>
<tr>
<td>Skin (contact dermis)</td>
<td>Blistery rash, intense itching</td>
</tr>
<tr>
<td>Digestive Tract</td>
<td>Stomach cramps, vomiting, diarrhoea (associated with food allergy)</td>
</tr>
<tr>
<td>Other possible allergy symptoms include headaches, fatigue, hyperactivity and depression.</td>
<td></td>
</tr>
</tbody>
</table>

Prevention
You can’t prevent allergies. All you can do is avoid symptoms by avoiding known allergens. First the substances or environmental factors responsible for the allergy must be identified. These causative factors must be eliminated from the immediate environment, wherever possible.
The diagnosis of allergy begins with the assessment of the client’s clinical history and symptoms. Allergy testing may then be used to identify the specific causes of the allergic reaction.

Early diagnosis and treatment of the allergic person has been shown to modify the course of the disease and prevent subsequent development of other conditions such as asthma.

**Role of staff:**

- If a client is experiencing any of the symptoms of allergic reaction the Key Worker and other staff document the symptoms in the client’s file and the Key Worker supports the client to attend an appointment with their GP.
- If further assessment is required the Key Worker obtains consent from the person responsible or their guardian and makes the appointment with the specialist.
- The outcome of the medical assessment is recorded into an allergy management plan.
- If you notice tongue swelling, difficulty swallowing, difficulty speaking, shortness of breath in yourself or others, this may be a severe allergic reaction requiring emergency care. Ring 000 and get medical help immediately.

**Contact**

- Local GP

**Reference:**

D: Health Promotion

31: Preventing the spread of infection

Facts:
Standard Precautions are designed to reduce the risk of transmission of germs from both recognised and unrecognised sources of infection in an accommodation facility.

Hand washing is the single most important procedure for preventing healthcare associated infections. The frequency and duration of hand washing is dependent upon the nature, intensity, duration and sequence of the work activity.

Risk Factors:
Standard Precautions apply to all clients receiving care in an accommodation facility, regardless of their health status.

Standard Precautions apply to:
- Blood;
- All body substances, secretions and excretions (except sweat), regardless of whether or not they contain visible blood;
- Broken skin; and
- Mucous membranes; secreted bodily fluids e.g. from the nose, mouth and rectum.

Prevention:
Standard Precautions involve the use of safe work practices and protective barriers including;
- Hand washing;
- Wash hands after touching blood, body substances and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed. It may be necessary to wash hands between tasks on the same client to prevent cross-contamination. Wash hands before attending to another client.
- Gloving;
- Wear gloves (clean non-sterile gloves are adequate) when touching blood, body substances, and contaminated items; put on clean gloves just before touching mucous membranes and non-intact skin. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another client. Do not reuse gloves and discard them after use.
- Masking;
- Wear a mask and eye protection or a face shield to protect of the eyes, nose and mouth during procedures that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.
- Appropriate device handling;
- Handle client care equipment that is soiled with blood and body substances in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of germs to other clients and environments. Ensure that reusable equipment is not used for the care of another client until it has been appropriately cleaned and reprocessed; and that single use items are properly discarded after use.
- Appropriate laundry handling; handle, transport and process linen soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of germs to other clients and environments.

**Role of staff:**
- All staff are responsible for controlling the risk of infection between clients, themselves and other people.
- Standard precautions which are taken by staff to eliminate or control the risk of infection include:
  - Cleaning hands with soap and water or an alcohol-based cleanser (except in circumstances where hands are contaminated with blood or other body substances in which case washing with soap and water is recommended) before and after assisting clients with any activity that may involve contact with a client’s body secretions (including handling laundry and eating utensils, assisting with eating, drinking, bathing and toileting).
  - Cleaning hands with soap and water before and after any activity that may involve contact with the staff member’s own body secretions (including eating and drinking utensils, bathing and toileting, coughing, sneezing or blowing the nose).
  - Supporting or assisting clients to clean their hands with soap and water before and after any activity that may involve contact with their own body secretions (including eating and drinking utensils, bathing and toileting, coughing, sneezing or blowing the nose).
  - Wearing gloves when it is expected that staff will come into contact with body fluids e.g. when assisting a client toileting. It is recommended that staff clean their hands with soap and water before and after the removal of gloves.
  - Avoiding coughing/sneezing on others or being coughed/sneezed on.
  - Avoiding handling or preparing food for other people when you are ill.
  - Cleaning surfaces that are contaminated with blood and other body fluids with water and a neutral detergent solution after removing the blood or body fluids with a paper towel. Disinfectant products may be used on surfaces after cleaning, if desired.
  - Ensuring that cups, plates and other eating/drinking utensils are not shared between clients or staff.
  - Ensuring that each client has his or her own toiletry items and that these are not shared with others.
  - Ensuring that face towels, towels, sheets etc are not shared between clients.
  - Washing each client’s laundry separately, where possible. The normal household laundry practice can be followed for washing any soiled clothing or linen.
  - Discarding in a waterproof garbage bag any disposable equipment used in supporting a client’s health care, immediately after use.
  - Placing any Sharp objects or needles that are used in a Sharps container or, if one is not available, a labelled puncture-proof disposable container, storing it in a safe place and disposing of the container appropriately. All facilities should have a Sharps container, which complies with Australian/New Zealand Standard 4261 for reusable Sharps containers; or Australian/New Zealand Standard 4031 for non-reusable Sharps containers.
  - Disposing of soiled continence pads in specially designated bins.

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5 Gloves should be non-latex medical examination gloves.
- Where Residences have an Infection Control protocol in place, all staff of the Residence will comply with the protocol.

Contacts:
- Local GP

Reference:
- NSW Department of Health: Infection Control Policy 2005
32: Foot care

Facts:
- Feet, including toenails need to be looked after in order to avoid a range of problems.
- Corns and callous are the body’s protective mechanism gone wrong. The skin protects itself from pressure by growing more quickly, sometimes becoming so thick that it forms a callous. A focus of pressure within the callous is called the corn.
- For those who have diabetes, foot care is especially important as diabetes damages the nerves and affects the circulation. The body’s processes that normally fight infection respond more slowly when someone has diabetes, and are inhibited by poor circulation.

Risk factors:
- If someone has diabetes the foot may be damaged, and reduced nerve activity prevents the person from being aware of the injury. Some other neurological conditions also associated with a decreased perception of pain.
- Someone with diabetes is also prone to foot ulcers, and the spread of infection.
- Toenail problems could be caused by trauma (i.e. stubbing toe), ill-fitting shoes, poor circulation and infection.
- Toenails can become infected by fungus. Tinea (athlete’s foot) is the most common form of fungal infection.

Symptoms/ Signs:
- Fungal infections: discolouration and thickening of the nail, and separation of the nail from the nail bed.
- Inflammation of the skin: including pain, redness and swelling around the cuticle, and sometimes a discharge of yellow or green pus.

Prevention:
- Ingrown toenails can be prevented by trimming nails straight across, rather than rounding edges, and wearing comfortable shoes that don’t press on the toes.
- Fungal infections spread quite easily. Keep feet clean and dry, wear cotton socks and avoiding sharing towels and footwear.
- A podiatrist will remove corns and calluses and discuss appropriate footwear.

Treatment:
- Acute cases of inflammation of the skin can be treated with antibiotics.
- Treatment of ingrown toenails depends on severity, but may include removing the ingrown nail section using a local anaesthetic.
- Using anti-fungal preparations, as well as professional trimming, shaping and care of the nails can alleviate fungal infections.

Role of staff:
- If a client displays any symptoms of problems with their feet, the Key Worker and other staff document the symptoms in the client’s file and arranges for the person to attend an appointment with their GP. If the client has diabetes they should have an appointment arranged with a podiatrist immediately.
- Corns and callous should ONLY be treated by a podiatrist, if the client has diabetes.
- Staff should ensure that feet are washed daily and dried very carefully. Feet should be inspected daily for sores, cuts, and bruises. Ensure that they have proper fitting footwear. This is particularly important for people with diabetes.
- The *PODIATRISTS REGULATION 1995 - SECT 21 Basic foot care* requires staff to be trained in basic foot care to cut a client's toenails, otherwise a podiatrist is required.
- Clients with diabetes must see a podiatrist regularly for all foot care.

**Contact details:**
- Local GP
- Podiatrist.

**Reference:**
33: Self esteem

Facts:
- Self-esteem is liking yourself, it is not conceit or boastfulness;
- Someone with high self-esteem values herself or himself;
- Part of self-esteem is feeling that you have a place in the world where you belong;
- Lack of self-esteem can be a problem for people who have been part of a family break-up.

Why is self-esteem important?
- Allows people to feel proud and happy with themselves;
- Gives them courage to try new things;
- Helps them to become independent;
- Gives people the willingness to try something again even if they failed the first time;
- Self-esteem helps people to feel that they can develop their own skills and contribute to their community;
- Low self-esteem can be linked to poor health and stress, heart disease and anti-social behaviour.

Developing self-esteem:
- Many people’s self esteem falls when they begin school as they have to cope in a strange new situation with lots of other new children and rules to learn.
- Teenagers experience many changes in their self-esteem because of the changes they are going through in their lives, particularly how they think and look.
- People’s self esteem is greatly affected by the way that their friends, colleagues and parents see them.
- People who have a goal in life often have better self esteem.
- People with intellectual disability may have low self esteem.

Role of staff:
- Staff should support clients and take an interest in their work, day activities, and hobbies.
- Staff should encourage friendships between clients and make friends welcome.
- Exercise helps relieve stress and makes clients feel strong.
- Learning new skills and teaching others new skills builds self-esteem.
- Staff should celebrate achievements and successes with clients, and give them specific praise.
- It is important that staff take an interest in the hobbies and opinions of clients.
- Try and keep clients in touch with their roots as much as possible. Keep a diary of where they have been.

Contact details:
- Local GP.
34: Complementary therapies

Facts:
- Complementary therapies include herbal medicine, traditional Chinese medicine, acupuncture, homeopathy, naturopathy, iridology, aromatherapy, Reiki, meditation and relaxation techniques, as well as dietary therapies, herbs, and vitamins and minerals and many others.

Are they safe?
- The Commonwealth Department of Health and Ageing has established an Office of Complementary Medicine within the Therapeutic Goods Administration that is responsible for assessing data about listed complementary medicines.
- Complementary medicines listed on the Australian Register of Therapeutic Goods (ARTG) are those that have been evaluated as safe for use.
- There is no legal requirement for a person to have formal qualifications or training to identify as a complementary therapist. If therapists belong to professional associations (such as the Australian Association of Acupuncturists) they will usually have a minimum level of training as specified by the association.

Possible problems:
- Prescriptions are not necessary for many herbal remedies and can be purchased in supermarkets or health food stores, which means that people can self-medicate without consulting an expert.
- Complementary medicines can interact with prescribed medications and a GP should be consulted before taking any additional medicines that are not prescribed by the GP.

Recommendations:
- Consult a GP before a client commences complementary therapy.
- Complementary therapies should not be suggested or promoted to clients by care staff.
- A complementary therapist who is a member of a professional association should be consulted.
- Ensure that complementary therapists can provide as much information about the treatment they prescribe as would be expected from a GP.
- Complementary therapies should only be used as directed and stopped if there are any unexpected results or side effects.

Role of staff:
- If a person responsible indicates that they wish the client to access a complementary therapist, the Key Worker arranges for the client to do so.
- The Key Worker also needs to inform the complementary therapist of the client’s medical conditions and current prescribed medications or over the counter medications by taking the following documents to the appointment; the CHAP and health file, including the medication summary.
- The Key Worker requests written information from the complementary therapist about any recommendations involving the administration of therapeutic substances or changes to the client’s diet or lifestyle. This information includes:
- Details about the contents of the substance and its administration or the nature of the diet or lifestyle change;
- The goal of the intervention and desired outcome;
- Any possible side effects, potential interactions with complementary substance and any prescribed or over the counter medicines that the client is taking;
- The date for review of the intervention;
- The proposed duration of the therapy.

- The Key Worker provides this information to the client’s GP who will advise if there are any known interactions with the client’s existing medication, or if there are known risks associated with the intervention.
- If the GP indicates that he/she has concerns about the recommended intervention, this must be documented and provided to the client, and their person responsible or guardian to inform decision making about proceeding with the recommendation of the complementary therapist. The GP’s report must be supported by evidence of the contraindications or risks, and not the GP’s opinion alone.
- The Key Worker documents the recommendation(s) in the client’s Health Care Plan.
- All staff implement the intervention, and document observations in the client’s shift report and health file.

References:
- [Therapeutic Goods Administration](http://www.tga.gov.au) Tel: 1800 020 653
- [Australian Traditional Medicine Society](http://www.atms.com.au) Tel: (02) 9809 5765
- [Australian Natural Therapists Association](http://www.anta.com.au) Tel: 1800 817 577
E. Additional references and resources

- Cancer Helpline Queensland Tel: 131 120
- Medicare Australia: www.medicareaustralia.gov.au
- myDr: www.mydr.com.au
- NSW Department of Community Services: www.community.nsw.gov.au
- NSW Department of Education and Training: www.schools.nsw.edu.au
- Professor John Murtagh, Monash University, Melbourne, Victoria. Menopause www.nevdgp.org.au
- Reachout: www.reachout.com.au