22 December 2015

Rebecca Johnston-Ryan
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
Southbank, VIC, 3006
cpuresponses@coronercourt.vic.gov.au

Dear Rebecca,

Investigation into the death of Marjorie Hall – Request for a Response (COR 2013 004527)

We refer to the above matter and your request for a response by 22 December 2015.

Pursuant to this request, please find below responses from Bupa Care Services Pty Ltd (**Bupa**) in relation to each of the recommendations.

Prior to addressing the recommendations, we would also like to take the opportunity to advise that since the incident involving Mrs Hall in 2013, Bupa has undergone significant business wide transformational change that focussed particularly on the development of policies and procedures (known as "Work Instructions" or "WI") relating to the delivery of resident care in a safe and repeatable way, from pre-admission through to departure (The Resident Journey). Business processes supporting this in a centralised system have also been implemented – specifically an electronic resource called the "Bupa Management System" which is available to all central and care home staff alike thorough Bupa's intranet.

Recommendations and Bupa's Responses

1. ***With the aim of minimising risk and preventing like deaths, I recommend that the emergency response training, including cardiopulmonary resuscitation training that Bupa provided as a result of the incident, is undertaken annually by all Bupa Aged Care Facilities.***

   We note that Bupa refined and implemented a WI to support staff in managing medical emergencies in February 2015. This WI details the correct process for responding to an emergency situation, including directing staff to commence Cardio Pulmonary Resuscitation (*please see Appendix – Medical Emergency*). An excerpt of the WI is also set out below for ease of reference:

   a) The first person to arrive must press the emergency buzzer:

   i. Danger – check for danger to self and casualty;

   ii. Response – check response by shake and shout;

   iii. Airway – clear the airway;

   iv. Breathing – check for breathing;

   v. Circulation – check for pulse;

vi. Commence - CPR if required.

In response to the Coronial Recommendations Bupa undertook a review of the existing schedule for education, and Bupa acknowledges that it would be beneficial for all staff to have dysphagia and emergency response training annually as a combined module.

Bupa has recently expanded the scope of an existing role and appointed a Nurse Manager for Clinical Education and Development. The Nurse Manager has developed a proposal for this combined dysphagia and emergency responses education to be rolled out to our 68 care homes nationally in 2016; with the intention of running these sessions annually thereafter (*please see Appendix – CPR and Management of the Choking Resident*). It is anticipated that records for this training will be maintained in our Learning Management System.

2. With the aim of minimising risk and preventing like deaths, I recommend that all changes made by the Bupa Aged Care Edithvale dementia unit, as a result of this incident, be implemented at all other Bupa Aged Care dementia units.

a) Emergency response training for staff;

Please see the above response for recommendation 1.

b) Training in relation to dysphagia and choking in the elderly;

In September 2014, a Safety Alert was issued to all facilities which required the scheduling of education for all staff who supervise and provide food to residents (*please see Appendix – Safety Alert*). This training was completed in and around late 2014. Due to the number of training records (we estimate there would be around 5,000 held across the facilities) we have not attached them to this response. Going forward the topic of dysphagia will be covered in the new *CPR and Management of the Choking Resident* education session.

It is also noted that Bupa took a special interest in dysphagia management throughout 2014. This was achieved through Clinical Leadership Fora, held in four states across the business. This targeted education to our clinical staff focussed on managing residents with dysphagia, modified textured diets and medications management in those with dysphagia. This education was provided by an Aged Care specialist, Dr Huong Van Nguyen.

c) A door has been installed in the dementia unit to restrict residents from accessing the kitchen area, reducing the risk of being able to access food and fluids.

As the design of each Bupa home differs it has not been possible and / or appropriate to implement this specific change across all facilities. However, Bupa has implemented a number of other measures to ensure that residents living with dementia cannot access food unsupervised, as follows:

- Bupa has implemented “satellite serveries” in its dementia units (and has moved away from fully stocked kitchens in those units).
- Meals are prepared in the care home main kitchen and transported to the satellite serveries, where all meals are served by catering staff under the supervision of care staff, who provide assistance to residents with their meals.

- To ensure the safety of residents the servery is staffed at all times when food is available for preparation, serving and cleaning up. This approach minimises the risk of residents being able to access any food unsupervised.

d) Modified meal trolleys have been purchased for use in the dementia unit. The trolleys have special zipped covers, preventing residents from accessing the food trays whilst they are being transported on trolleys;

Bupa confirms that all new trolleys that can be purchased through our centralised procurement system have a zipped cover that prevents residents from accessing food trays whilst they are being transported on trolleys.

A Safety Alert *(please see appendix Safety Alert –Trolleys)* has been created and disseminated to all facilities to direct staff that all food trolleys need to be utilised with the zipped cover. All facilities that do not currently have a cover for their trolleys are required to purchase and have the covers in place by the end January 2016. In the interim, staff have been reminded by Work Health and Safety Team that, in order to ensure the safety of our residents, food trolleys cannot be left unattended at any time.

e) An audit of the nutrition and hydration arrangements for the residents in the dementia unit has been carried out, and a handover tool prepared for staff to highlight residents at risk of choking;

In response to this recommendation, a review of existing care home processes for handover was undertaken. Analysis of this information identified an opportunity to establish a business wide repeatable process for handover communications that contain specific resident information and risk alerts. As a consequence, a working group of clinical leaders has been formed to review best practice literature and contemporary practice, to develop a handover tool with specificity for aged care.

It is anticipated that this new handover tool will be developed for use early in 2016. In the interim, all care homes will be asked to complete a Nutrition and Hydration Audit in January 2016, to identify all residents who are at risk of choking. Staff will use this information to make notations on their current handover documents (please see *Appendix – Hand Over Working Group*).

We are happy to provide a further update to the Coroner if required, following the implementation for the new handover tool and the completion of the Nutrition and Hydration Audit.

f) Staff meetings have been held in relation to upcoming emergency training, updating Plans of Care and the door and trolleys in the dementia unit;

Staff meetings will be held next year in relation to the *CPR and Management of the Choking Resident* training as it is rolled out across the facilities.

Work Instructions are in place at all care homes that direct nursing staff to create person centred care plans for all residents and these care plans include all specialised nursing care needs (like a risk of choking). (Please see *Appendix- Care Planning WI*).

We refer our response at 2(c) above in relation to the installation of the door in the dementia unit – as this change has not been made across all facilities, there have not been meetings on this point.

We refer to our response at 2(d) above in relation to the trolleys - and in particular, the Safety Alert that has been issued to all homes.

g) In April 2014 Bupa's resident admission process was updated to ensure Admission Data Base Assessment records a resident's risk of dysphagia and choking

This change was implemented across all Bupa care homes (i.e. it was not an Edithvale specific measure). Bupa confirms that this measure is already in place.

3. With the aim of minimising risk and preventing like deaths, I recommend that Bupa Aged Care review the process for adding or updating information to the 'Plan of Care' document. Currently it is hand written by the reviewing practitioner, care directions are confusing and not written chronologically with a legible name and date from the practitioner. This is an important care document and I recommend that it should be reprinted each time it is altered by a practitioner, with the new plans of care dated and set out chronologically.

On admission to Bupa, residents have their health and personal care needs assessed utilising an Admission Database Assessment tool. The information gathered from the assessments are formulated into an Interim Care Plan, which drives care delivery during the interim period whilst the ongoing clinical assessments are conducted. Once the admission period is completed a person centred Care Plan is developed through consultation with the resident, their person responsible and staff who are involved in the resident's care. This Care Plan is devised to reflect the clinical care, medical needs and preferences for each resident and is readily available for all staff to follow.

All Care Plans are reviewed and evaluated in response to changes in health status and care needs of each resident and this may mean updating the care plan frequently, as the care needs of some residents may change frequently. (Please see *Appendix- Care Planning WI*). Residents' care needs are formally reviewed and updated every three months (and additionally as required).

Bupa acknowledges the Coroner's recommendation for staff to re-print the resident's care plan after each time it is updated. Residents' care plans are living documents and can be updated frequently, at times more than daily. To ensure clear and legible care needs are documented, Bupa will update our *Care Planning WI* to direct staff to re-print the resident's care plan during the three monthly review (only where changes have been made in the preceding 3 months) and whenever multiple changes are documented (please see *Appendix – Amended WI*).

Assessed care needs and strategies outlined in a resident's care plan are all current at a point in time. As such, we believe it is not appropriate to chronologically set out changes to care plans; however, all changes for an assessed need are chronologically set out for that need within the care plan.

Please contact me on via mobile on 0418 586 253 or by email at Maureen.Berry@bupacare.com.au if you wish to discuss this or require any further information or documentation.

Yours sincerely

Maureen Berry
Director Clinical Service Improvement
Bupa Aged Care, Australia

RESIDENT JOURNEY PROCESS

WI Res-4.4.17 Medical Emergency

4.4.17.1 Medical Emergency Responsibility: All Staff

a) The first person to arrive must press the emergency buzzer:
   i. Danger – check for danger to self and casualty;
   ii. Response – check response by shake and shout;
   iii. Airway – clear the airway;
   iv. Breathing – check for breathing;
   v. Circulation – check for pulse;
   vi. Commence - CPR if required.

b) The second person to arrive, contacts the Person in Charge / General Manager.

c) Follow instructions of Person in Charge / General Manager, which may include calling for an ambulance.

d) The most senior clinical person available should remain with the resident until such times as the emergency is resolved, or medical assistance has arrived, or the resident is transferred to hospital via ambulance.

e) Move swiftly. Do not run, and converse in a normal manner.

f) Refer to WI Res-4.9.1 Incident Management if the medical emergency results in or is a result of:
   i. A resident's death and is not directly attributable to the resident's medical condition such as suicide, assault or fall;
   ii. A resident having a fall and sustaining a fracture or head injury;
   iii. A medication incident where medication is given to wrong resident or is incorrectly given to the resident such as wrong medication, dose or time;
   iv. A staff/contractor/visitor incident that results in serious injury or death.

g) Trauma counselling should be offered to all staff involved following critical incidents.

h) BCSA has engaged the services of a professional company called PPC Worldwide to manage our Employee Assistance Program (EAP) called "Employee Assist" and they can provide specialised counselling services to employees. Refer to WI PM-03.1 Employee Assist.

i) The RN must document the emergency in the resident's FM Res-04.5 Progress Notes, FM Res-04.3 Plan of Care, and if appropriate on a FM Res-4.24 Resident Incident Notification form.

- **Records**
  FM Res-04.5 Progress Notes
  FM Res-04.3 Plan of Care
  FM Res-4.24 Resident Incident Notification

- **References**
  WI Res-4.9.1 Incident Management
  WI PM-03.1 Employee Assist

- **Key Related Words**
  Emergency; Incident; medical emergency;

- **History**
  16.09.14 WI Res-4.18 Medical Emergency renumbered to WI Res-4.4.17 Medical Emergency

Training: Cardiopulmonary Resuscitation (CPR) and Management of the Choking Resident

Communication Strategy

- Discuss training plan with Regional Directors and Operations Director
- Participate in General Manager cluster teleconferences to outline:
    - Necessity of training i.e. mandatory for all clinical staff
    - Chosen provider
    - Timeline for roll out
    - Cost management
- Include snippet in Nuts and Bolts to inform the clinical workforce of upcoming training
- In 2016 Clinical Capability Educator and/or Nurse Manager to participate in Care Manager cluster teleconferences to continue to support this initiative

Implementation Strategy

- Schedule training dates for care homes throughout 2016 with clear accountabilities identified to General Manager for completion
- Delivery of unit of competency HLTAID001- Provide CPR to around 5300 people in our clinical workforce (care workers, enrolled nurses and registered nurses)
- Completion of training across all care homes by December 30, 2016

Fire and Safety Australia (provisionally preferred)	
Unit delivery length	2-hour workshop, maximum 15 per session
Capacity to deliver nationally	Able to deliver nationally on-site in care homes
Course content covering management of choking episode?	Roughly 30-45 minutes is dedicated to management of choking episode but will be tailored to suit our needs
Relevance of unit to aged care/elderly residents?	Workshop to be customised for the aged care resident
Trainer qualifications	All trainers have a Certificate IV in Training and Assessment and hold competencies in advanced CPR and First Aid

CSI Safety Alert

To:	General Managers, Care Managers, Clinical Managers
cc:	Director of Operations, Regional Directors, Regional Support Managers, Clinical Service Improvement Team
From:	Clinical Service Improvement Director
Subject:	**Root Cause Analysis Outcome (RCA) – Diets and Consistencies**
Reference:	002_2014
Date:	1/09/2014

What happened?

- A number of RCAs have been undertaken in 2014 in light of the Bupa Critical Incident policy. It has become apparent that the below issue contributes to a key area of concern and can have a negative impact on our residents.

Issues

1. We must ensure adherence to individual diet plans of each resident at all times, whether they are eating in the dining room, enjoying happy hour or are on a day trip. Additionally, we need to assist our residents with food and drink as outlined in their care plans at all times, never becoming complacent in any situation in which food and drink are present.

What needs to be done?

- In September 2014, schedule education for all staff who supervise and provide food to our residents in regard to diets and food consistencies. Your care home's Speech Pathologist may be able to assist in this process. This includes specific education for student nurses prior to asking them to supervise residents eating.

Why does this need to be done?

- This issue has been identified as a root cause in a critical incident that has resulted in a serious consequence for the resident concerned. Steps have been taken to modify the practices at the particular care home, however, it is incumbent on all Managers to ensure the issue outlined above is addressed, communicated and educated to all relevant staff in their care homes.

2.32 Policy Nutrition and Hydration
3.38 Procedure Nutrition and Hydration
3.24 Procedure Assisting Resident at Mealtimes

In the meantime, please don't hesitate to contact a member of the Clinical Service Improvement Team with any questions or for further clarification.

Maureen Berry
Clinical Service Improvement Director

CSI Safety Alert

Bupa Care Services

SAFETY ALERT – (Action Required)
Covers for Food Trolleys Mandatory

To:	**All General Managers, Catering and Kitchen Staff**	**Cc:**	**Regional Directors, Regional Support Managers CSI Team, Maintenance Officers**
From:	Jasmine Yee Yet (WHS Team)	**Pages:**	1
Date:	9 December 2015	**Email:**	jasmine.yeeyet@bupacare.com.au

SUBJECT: COVERS FOR FOOD TROLLEYS MANDATORY – ACTION REQUIRED

To all General Managers, Catering and Kitchen Staff

We recently had an incident and as a result, the use of trolley covers is now mandatory on all food trolleys.


Trolley cover - durable PVC

What you need to do (General Managers)

1. Check that you have trolley covers available for use during food service.
2. If you don't have covers available, these must be purchased and made available for use by the 29th of January 2016.
3. If the trolleys are at a height that limits visibility, then two people are required to move the trolley. This MUST be considered when selecting trolleys and covers, as visibility will be restricted once the covers are in place. If the person can't see where they are going then two people **MUST** be used to complete the activity.
4. Hold a meeting with your staff to implement the use of trolley covers and reiterate the importance of keeping the covers closed when leaving the trolley unattended.
5. Monitor the implementation by conducting spot checks.

What you need to do (Catering and Kitchen Staff)

1. Use the issued trolley covers.
2. Ensure the covers are zipped at all times when the left unattended.
3. If you can't see where you are going then two people must move the trolley.

If you have any questions please do not hesitate to contact me.

Thank you.

Jasmine Yee Yet
Health and Safety Consultant
Bupa Care Services

Project: Clinical Handover

Working Group Members

Michelle Wicky (Nurse Manager Clinical Education and Development)

Sue Bunworth (General Manager, Bupa Bonbeach – BMOC)

Michelle Parish (General Manager, Bupa Bateau Bay)

Debbie Keys (Regional Support Manager)

Terri Cause (Non-Clinical General Manager, Bupa Tugun – BMOC, Commissioning)

Amanda Caruana (Clinical Manager, Bupa Templestowe – BMOC, Commissioning)

Vanessa Fernandez (Care Manager, Bupa Waratah)

Lisa Burton (Care Manager, Bupa Sutherland – BMOC, Commissioning)

Terms of Reference

Committee Name Clinical Handover Project Committee

Objective Systemise clinical handover procedures across Bupa Aged Care Homes and review elements for inclusion based on evidence base and best practice standards, including dysphagia and food consistency intolerances.

Membership and Appointment

- Key team members as identified from Director of Operations
- Representative from RD, GM, CLM and CM group
- Representative from different states and metropolitan vs regional

Chairing Michelle Wicky

Meeting Frequency Commence weekly meeting initially from January 2016

Minute Recording Committee to decide minute taker

Folder to be set up on F drive for written minutes to be stored centrally

Reporting Committee to decide on stakeholders, whom will decide frequency of reporting to them as a group from the committee

Chair to be responsible for reporting to stakeholders and mode of communication to be negotiated between Chair and stakeholders

RESIDENT JOURNEY PROCESS

WI Res-03.2 Care Planning

3.2.1 Purpose

a) The purpose of this document is to ensure that staff develop a unique person centred FM Res-04.3 Plan of Care which is about supporting the person to live their lives as they want to live it; gathering information and working with the person rather than assuming that we know "what is best" for them, based purely on a clinical perspective.

b) That clinical nursing documentation reflects person centred care & best practice in line with assessment, planning, strategy and review to best evaluate the person's needs and the care strategies implemented in meeting individual goals.

c) FM Res-04.3 Plan of Care are to ensure continuity of care for the person and all care staff are required to follow the plans of care.

3.2.2 Policy

Responsibility: General Manager, Care Manager

a) On admission, the health and personal care needs are assessed using FM Res-3.19 Admission Database Assessment and an FM Res-02.7 Interim Care Plan is developed to drive care delivery during the interim period whilst the ongoing clinical assessments are conducted. Electronic care homes: Care plans are automatically generated from assessments completed on Leecare.

b) Any admission with special care needs must have plans in place as soon as appropriate to manage their care needs (e.g. complex care needs, physical aggression, absconding, safety risk etc.). Electronic care homes: Extra Care Plans not generated from Assessments can be completed within Leecare for specific needs as per the following;

i. Acute Care Needs / Care Support Plan.
ii. Diabetes Management Plan.
iii. Advanced Healthcare Directives / Palliative Care plan.
iv. Wound / Skincare Management Plan.

c) The plans of care must address the following:

i. Person's current abilities and strengths;
ii. Level of independence;
iii. Identified deficits / potential risks / needs including social, psychological, emotional, spiritual and physical needs;
iv. The person's personal preferences, individual habits, routine and idiosyncrasies;
v. Personal care needs;
vi. Health care needs;
vii. Rehabilitation / maintenance of function needs;
viii. The person's expectations (goals);
ix. How to meet these expectations (strategies).

d) In addition to the above, for the people living with dementia or unmet needs, the plans of care must include:

i. Strategies for minimizing episodes of unmet needs - finding out why they are behaving this way and what they are trying to tell us;
ii. A description of how best to managed this over 24 hours;

iii. A description of diversional, motivational, recreational therapy and meaningful moments for 24 hours that reflect their former routines and activities.

e) Registered Nurse (RN) shall develop FM Res-04.3 Plan of Care after 30 day assessment period on overall profile of the resident (ref: FM Res-3.22 Data Collection Planner for New Admission).

f) FM Res-04.3 Plan of Care should be developed through consultation with the person, person responsible and appropriate care staff who are most frequently involved in the person's care (FM Res-4.10 Staff Care Conference Record and FM Res-4.11 Family Conference Record).

g) FM Res-04.3 Plan of Care are developed with input from other allied health professionals and strategies documented within the plans of care.

h) FM Res-04.3 Plan of Care is a communication tool that should be readily available to all staff including allied health involved in the ongoing care including respite care (FM Res-02.7 Interim Care Plan). It must contain current information. It is therefore essential that all components of the plan of care are reviewed and updated on a regular basis and as the need arises in response to changes in the resident's health status.

i) FM Res-04.3 Plan of Care must be clear, concise, accurate and current at all times to provide the intended direction of care and the basis of evaluation.

j) FM Res-04.3 Plan of Care must be signed and dated by the RN.

k) Amendments to FM Res-04.3 Plan of Care must be dated and signed e.g. new entries or deletions.

l) FM Res-02.7 Interim Care Plan are completed and implemented to inform care provision for respite admissions.

m) RN must ensure that FM Res-04.3 Plan of Care is evaluated, reviewed and amended either when clinically indicated by a change in condition (re assessment) or at least three monthly whichever is the earlier.

n) The evaluation must correlate with the plans of care and identify whether a person's condition is stable, improved or deteriorated and the extent to which the desired goals or outcomes of care have been achieved. Input from the person and family should be sought where able.

o) An evaluation must be documented appropriately, signed and dated on FM Res-04.3 Plan of Care and recorded in the FM Res-04.5 Progress Notes.

p) Management team is to ensure that there is an effective system in place to ensure care plans are developed and reviewed within required time frames.

q) RN is responsible for care planning and must sign off on each domain of care to indicate she / he is authorizing the strategies contained in the plan.

r) Initial Assessments and Care Planning must be attended by an RN or Nurse Practitioner; and ongoing management and evaluation can be carried out by an RN, Nurse Practitioner or an

Enrolled Nurse (EN) acting FM Res-04.3 Plan of Care; Where an Enrolled Nurse has managed and evaluated an existing care plan, it must be countersigned by an RN.

s) The RN validating and endorsing the entry made by EN is therefore accountable for the content of FM Res-04.3 Plan of Care that she / he has countersigned and ensures that goals and strategies are appropriate to the needs of the person.

t) Any staff member who comes into contact with the resident can make a meaningful contribution to creating a plan of care that directs the staff to care for the resident in a way that the resident wants to be cared for.

u) All RNs and ENs (ENs practicing within the scope of their delegation, as per point (r)) involved with resident's care and wellbeing are responsible and accountable to:

i. Ensure that plans of care are developed and evaluated in a timely manner and kept up to date;
ii. Implement care delivery either directly or indirectly;
iii. Facilitate coordination of all members of the health care team;
iv. Discuss needs, problems, planning, implementing & outcomes with Resident / Relative / Representative & staff;
v. Attend to reassessment if required.

3.2.3 Care Plan Development — Responsibility: Registered Nurse, Care Manager

a) Plans of care are developed by gathering information about the person from:

i. Needs Assessment / referral documentation;
ii. Talking to the person / family / staff;
iii. FM Res-3.22 Data Collection Planner for New Admission; or for Electronic care homes use: FM Res-3.28 Leecare Assessment Schedule Guidelines ;
iv. FM Res-02.6 Map of Life .

b) Immediately after obtaining initial information and recording on the FM Res-3.19 Admission Database Assessment and the FM Res-02.7 Interim Care Plan the RN should begin to document the person's actual or potential problems and their capabilities; their needs / wants / expectations and how to meet these expectations through appropriate care strategies to be employed.

c) Review the completed assessments with additional interaction with the person / family to help develop and refine the FM Res-04.3 Plan of Care (ref: FM Res-3.22 Data Collection Planner for New Admission

d) The expectations acknowledge the uniqueness of each individual, their history and preferences and are to be determined by the Person / Person Responsible in conjunction with the RN and with input from other staff and the allied health team and appropriate to the person.

e) Care is implemented under the direct or indirect supervision & delegation of the RN who will remain accountable for the delivery of care.

f) Record the care provided on the appropriate documentation (i.e. FM Res-04.5 Progress Notes, medication charts, FM Res-04.8 Bowel Record).

g) Once FM Res-04.3 Plan of Care have been developed and implemented the FM Res-02.7 Interim Care Plan should be archived.

h) FM Res-04.5 Progress Notes are used to record ongoing care of the resident and to document the responses the resident has to care.

i) FM Res-04.5 Progress Notes supplement FM Res-04.3 Plan of Care. It provides records of exception reporting.

j) Document in FM Res-04.5 Progress Notes when new treatments or strategies are commenced.

k) Record in FM Res-04.5 Progress Notes when FM Res-04.3 Plan of Care needs to be or has been altered.

l) All care plans are required to be reviewed and evaluated in respond to changes in health status and care needs, and at least every 3 months.

m) Evaluation is an ongoing process. It reflects the fact that care planning is dynamic and each person is an individual with unique needs and different responses to care strategies.

n) An evaluation must be documented appropriately, signed and dated on FM Res-04.3 Plan of Care, and recorded in the FM Res-04.5 Progress Notes.

o) RN to discuss/contact with Resident / Person Responsible after GP / Allied Health visits & document in FM Res-04.5 Progress Notes especially if care needs have changed and update plan of care.

p) Once the assessment data is collected the RN is responsible for ensuring FM Res-04.3 Plan of Care reflects the resident's current care needs and preferences.

q) FM Res-04.3 Plan of Care includes the type and nature of the problem or potential problem, the cause(s) and / or contributing factors, achievable goals which are derived from the needs, wants and requirements of the resident, and will also address what the resident will do and when and how this will be accomplished. Refer to Background to Person-Centred Care Planning.

r) The RN is responsible for ensuring all areas of FM Res-04.3 Plan of Care are complete and appropriate to the resident's care needs.

s) RN is to countersign all assessments and FM Res-04.3 Plan of Care if attended by other care staff.

t) Residents' choices regarding their care are to be reflected on FM Res-04.3 Plan of Care and residents should also be consulted on a day to day basis regarding their care choices.

3.2.4 Care Plan Completion

Responsibility: Registered Nurse, Care Manager

Once FM Res-04.3 Plan of Care has been completed, the RN is responsible for ensuring that the resident and / or their representative is consulted about the FM Res-04.3 Plan of Care and given the opportunity to

comment using the FM Res-4.10 Staff Care Conference Record and FM Res-4.11 Family Conference Record .

3.2.5 Lifestyle Activity Plan — Responsibility: Care Manager

a) Lifestyle staff shall ensure that each resident has an FM Res-02.8 Individual Activity Plan that is current and evaluated at least 3 monthly.

b) Lifestyle Actvitiy Plans must include activites as per a Psychiatric Mental Health Care Plan, where provided; and indicate modified texture diets and fluids where specified.

- **Records**
  FM Res-02.7 Interim Care Plan
  FM Res-02.8 Individual Activity Plan
  FM Res-02.6 Map of Life
  FM Res-3.19 Admission Database Assessment
  FM Res-3.22 30 Day Data Collection Planner for New Admission
  FM Res-04.3 Plan of Care
  FM Res-04.5 Progress Notes
  FM Res-4.11 Family Conference Record
  FM Res-4.10 Staff Care Conference Record
  FM Res-04.8 Bowel Record

- **References**
  Background to Person-Centred Care Planning

- **Key Related Words**
  Admission; Assessments; Care plans; Consultation; Representatives; Residents;

- **History**
  20.09.14 Full content review and change
  21.11.14 Formatting to sections 3.2.2, 3.2.3 and 3.2.5. Hyperlink added to section 3.2.5 as well as records.
  19.02.15 Hyperlinks amended throughout.

RESIDENT JOURNEY PROCESS

WI Res-03.2 Care Planning

3.2.1 Purpose

a) The purpose of this work instruction (WI) is to ensure that staff develop a unique person centred FM Res-04.3 Plan of Care which is about supporting the person to live their lives as they want to live it; gathering information and working with the person rather than assuming that we know "what is best" for them, based purely on a clinical perspective.

b) That clinical nursing documentation reflects person centred care & best practice in line with assessment, planning, strategy and review to best evaluate the person's needs and the care strategies implemented in meeting individual goals.

c) FM Res-04.3 Plan of Care is to ensure continuity of care for the person and all care staff are required to follow the plans of care.

3.2.2 Policy

Responsibility: General Manager, Care Manager

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b) Any admission with special care needs must have FM Res-04.3 Plan of Care in place as soon as appropriate to manage their care needs (e.g. complex care needs, physical aggression, absconding, safety risk etc.). Electronic care homes: Extra Care Plans not generated from Assessments can be completed within Leecare for specific needs as per the following;

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v. Personal care needs;
vi. Health care needs;
vii. Rehabilitation / maintenance of function needs;
viii. The person's expectations (goals);
ix. How to meet these expectations (strategies).

d) In addition to the above, for the people living with dementia or unmet needs, FM Res-04.3 Plan of Care must include:

i. Strategies for minimizing episodes of unmet needs - finding out why they are behaving this way and what they are trying to tell us;
ii. A description of how best to managed this over 24 hours;

iii. A description of diversional, motivational, recreational therapy and meaningful moments for 24 hours that reflect their former routines and activities.

e) Registered Nurse (RN) shall develop FM Res-04.3 Plan of Care after 30 day assessment period on overall profile of the resident (ref: FM Res-3.22 Data Collection Planner for New Admission).

f) FM Res-04.3 Plan of Care should be developed through consultation with the person, person responsible and appropriate care staff who are most frequently involved in the person's care (FM Res-4.10 Staff Care Conference Record and FM Res-4.11 Family Conference Record).

g) FM Res-04.3 Plan of Care are developed with input from other allied health professionals and strategies documented within the plans of care.

h) FM Res-04.3 Plan of Care is a communication tool that should be readily available to all staff including allied health involved in the ongoing care including respite care (FM Res-02.7 Interim Care Plan). It must contain current information. It is therefore essential that all components of FM Res-04.3 Plan of Care are reviewed and updated on a regular basis and as the need arises in response to changes in the resident's health status.

i) FM Res-04.3 Plan of Care must be clear, concise, accurate and current at all times to provide the intended direction of care and the basis of evaluation.

j) FM Res-04.3 Plan of Care must be signed and dated by the RN.

k) Amendments to FM Res-04.3 Plan of Care must be dated and signed e.g. new entries or deletions.

l) FM Res-02.7 Interim Care Plan are completed and implemented to inform care provision for respite admissions.

m) RN must ensure that FM Res-04.3 Plan of Care is evaluated, reviewed and amended either when clinically indicated by a change in condition (re assessment) or at least three monthly whichever is the earlier.

n) During the evaluation of the care plan, where hand written amendments are identified, the evaluator must confirm the amendments and must then include these in the electronic document. Once this is done, the electronically amended care plan must be printed and placed in the resident’s clinical file.

o) The evaluation must correlate with the plans of care and identify whether a person’s condition is stable, improved or deteriorated and the extent to which the desired goals or outcomes of care have been achieved. Input from the person and family should be sought where able.

p) An evaluation must be documented appropriately, signed and dated on FM Res-04.3 Plan of Care and recorded in the FM Res-04.5 Progress Notes.

q) Management team is to ensure that there is an effective system in place to ensure care plans are developed and reviewed within required time frames.

r) RN is responsible for care planning and must sign off on each domain of care to indicate she / he is authorizing the strategies contained in the plan.

s) Initial Assessments and Care Planning must be attended by an RN or Nurse Practitioner; and ongoing management and evaluation can be carried out by an RN, Nurse Practitioner or an Enrolled Nurse (EN) acting FM Res-04.3 Plan of Care; Where an Enrolled Nurse has managed and evaluated an existing care plan, it must be countersigned by an RN.

t) The RN validating and endorsing the entry made by EN is therefore accountable for the content of FM Res-04.3 Plan of Care that she / he has countersigned and ensures that goals and strategies are appropriate to the needs of the person.

u) Any staff member who comes into contact with the resident can make a meaningful contribution to creating a plan of care that directs the staff to care for the resident in a way that the resident wants to be cared for.

v) All RNs and ENs (ENs practicing within the scope of their delegation, as per point (r)) involved with resident's care and wellbeing are responsible and accountable to:

i. Ensure that plans of care are developed and evaluated in a timely manner and kept up to date;
ii. Implement care delivery either directly or indirectly;
iii. Facilitate coordination of all members of the health care team;
iv. Discuss needs, problems, planning, implementing & outcomes with Resident / Relative / Representative & staff;
v. Attend to reassessment if required.

3.2.3 Care Plan Development — Responsibility: Registered Nurse, Care Manager

a) Plans of care are developed by gathering information about the person from:

i. Needs Assessment / referral documentation;
ii. Talking to the person / family / staff;
iii. FM Res-3.22 Data Collection Planner for New Admission; or for Electronic care homes use: FM Res-3.28 Leecare Assessment Schedule Guidelines ;
iv. FM Res-02.6 Map of Life .

b) Immediately after obtaining initial information and recording on the FM Res-3.19 Admission Database Assessment and the FM Res-02.7 Interim Care Plan the RN should begin to document the person's actual or potential problems and their capabilities; their needs / wants / expectations and how to meet these expectations through appropriate care strategies to be employed.

c) Review the completed assessments with additional interaction with the person / family to help develop and refine the FM Res-04.3 Plan of Care (ref: FM Res-3.22 Data Collection Planner for New Admission

d) The expectations acknowledge the uniqueness of each individual, their history and preferences and are to be determined by the Person / Person Responsible in conjunction with the RN and with input from other staff and the allied health team and appropriate to the person.

e) Care is implemented under the direct or indirect supervision & delegation of the RN who will remain accountable for the delivery of care.

f) Record the care provided on the appropriate documentation (i.e. FM Res-04.5 Progress Notes, medication charts, FM Res-04.8 Bowel Record).

g) Once FM Res-04.3 Plan of Care have been developed and implemented the FM Res-02.7 Interim Care Plan should be archived.

h) FM Res-04.5 Progress Notes are used to record ongoing care of the resident and to document the responses the resident has to care.

i) FM Res-04.5 Progress Notes supplement FM Res-04.3 Plan of Care. It provides records of exception reporting.

j) Document in FM Res-04.5 Progress Notes when new treatments or strategies are commenced.

k) Record in FM Res-04.5 Progress Notes when FM Res-04.3 Plan of Care needs to be or has been altered.

l) All care plans are required to be reviewed and evaluated in respond to changes in health status and care needs, and at least every 3 months.

m) Evaluation is an ongoing process. It reflects the fact that care planning is dynamic and each person is an individual with unique needs and different responses to care strategies.

n) An evaluation must be documented appropriately, signed and dated on FM Res-04.3 Plan of Care, and recorded in the FM Res-04.5 Progress Notes.

o) RN to discuss/contact with Resident / Person Responsible after GP / Allied Health visits & document in FM Res-04.5 Progress Notes especially if care needs have changed and update plan of care.

p) Once the assessment data is collected the RN is responsible for ensuring FM Res-04.3 Plan of Care reflects the resident's current care needs and preferences.

q) FM Res-04.3 Plan of Care includes the type and nature of the problem or potential problem, the cause(s) and / or contributing factors, achievable goals which are derived from the needs, wants and requirements of the resident, and will also address what the resident will do and when and how this will be accomplished. Refer to Background to Person-Centred Care Planning.

r) The RN is responsible for ensuring all areas of FM Res-04.3 Plan of Care are complete and appropriate to the resident's care needs.

s) RN is to countersign all assessments and FM Res-04.3 Plan of Care if attended by other care staff.

t) Residents' choices regarding their care are to be reflected on FM Res-04.3 Plan of Care and residents should also be consulted on a day to day basis regarding their care choices.

3.2.4 Care Plan Completion — Responsibility: Registered Nurse, Care Manager

Once FM Res-04.3 Plan of Care has been completed, the RN is responsible for ensuring that the resident and / or their representative is consulted about the FM Res-04.3 Plan of Care and given the opportunity to comment using the FM Res-4.10 Staff Care Conference Record and FM Res-4.11 Family Conference Record .

3.2.5 Lifestyle Activity Plan — Responsibility: Care Manager

a) Lifestyle staff shall ensure that each resident has an FM Res-02.8 Individual Activity Plan that is current and evaluated at least 3 monthly.

b) Lifestyle Actvitiy Plans must include activites as per a Psychiatric Mental Health Care Plan, where provided; and indicate modified texture diets and fluids where specified.

- **Records**
  FM Res-02.7 Interim Care Plan
  FM Res-02.8 Individual Activity Plan
  FM Res-02.6 Map of Life
  FM Res-3.19 Admission Database Assessment
  FM Res-3.22 30 Day Data Collection Planner for New Admission
  FM Res-04.3 Plan of Care
  FM Res-04.5 Progress Notes
  FM Res-4.11 Family Conference Record
  FM Res-4.10 Staff Care Conference Record
  FM Res-04.8 Bowel Record

- **References**
  Background to Person-Centred Care Planning

- **Key Related Words**
  Admission; Assessments; Care plans; Consultation; Representatives; Residents;

- **History**
  20.09.14 Full content review and change
  21.11.14 Formatting to sections 3.2.2, 3.2.3 and 3.2.5. Hyperlink added to section 3.2.5 as well as records.
  19.02.15 Hyperlinks amended throughout.
  25.05.15 Amendments to 3.2.1 a) and c), 3.2.2 b) c) d) h) n)