Student Placement Learning Package
Community and Oral Health

POST ACUTE CARE

Student Name: __________________________________________
On behalf of the Community and Oral Health (COH), I extend to you a warm welcome to our services.

COH offers a variety of sub-acute and community services that support the care provided in the hospitals of Metro North Hospital and Health Service (MNHHS). The Metro North values of respect, teamwork, compassion, high performance and integrity should underpin all activities of our multi-disciplinary teams, including our students.

The nurses employed in COH need to be confident and competent in their area of practice, as they deliver high quality and compassionate care in our diverse health care settings, included bedded services, community health centres and home-based care.

The professional practice of Nurses and Midwives in MNHHS is supported by the Framework for Lifelong Learning, which provides;

- A structured approach to clinical, organisational and professional development opportunities
- Learning and development opportunities along a continuum of lifelong learning
- Direction, planning, implementation and evaluation strategies for workplace learning

Whilst on placement, please take the opportunity to learn as much as you can about our interesting and diverse range of services and consider whether you might consider joining our team following your graduation.

May you enjoy your student clinical placement in COH, as you interact with our teams and patients/residents/clients and strive to exceed your learning objectives.

Karen Lush
Nursing Director Education
Community & Oral Health
Metro North & Hospital Health Service
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For more information, contact:

Community and Oral Health, Metro North Hospital and Health Service, 449 Hornibrook Highway, Brighton QLD 4017, phone 3631 7400 for Community Oral Health Education Team.

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Welcome to MNHHS and Community & Oral Health

Metro North Hospital and Health Service is the public hospital and health service for the north side of Brisbane and is Australia’s largest Healthcare Provider.

This map shows the MNHHS official catchment and the location of key facilities.

The Hospitals are:

- The Royal Brisbane and Women’s Hospital (RBWH)
- The Prince Charles Hospital (TPCH)
- Redcliffe Hospital (RDH)
- Caboolture Hospital (CAB)
- Kilcoy Hospital (KH)

The Hospitals are supported by the services of the Community & Oral Health Directorate (COH).

The services of Community and Oral Health include:

- Rehabilitation
- Transition Care Resi and Community
- Specialised Aged Care
- Acquired Brain Injury
- Interim Care
- Community Care
  - Hospital in the Home
  - Post Acute Care Services
  - Community Palliative Care Specialists
  - Specialist wound clinics
  - Complex Chronic disease team
  - Diabetes team
  - Community Transition Care
- Indigenous Health Units
- Cerebral Palsy Specialist
- Oral Health Services

*Image source: Queensland Health Electronic Publishing Service (QHEPS)*

http://qheps.health.qld.gov.au
Overview of the Package

Community & Oral Health (COH) welcome students for practicum. This package is designed to assist with the onboarding of students on placement within COH. It is expected that by utilising this resource, students will be orientated to policies, standards, protocols, procedures and guidelines to support safe, competent and professional practice whilst practising within the clinical areas. The package also assists nursing students to adhere to their scope of practice as outlined by the MNHHS and education provider relevant to the student’s level of achievement.

Purpose

The purpose of this Orientation Package is to assist nursing students to:

- Participate during the orientation process
- Consolidate pre-existing nursing knowledge
- Transition from theory to practice
- Introduce students to the requirements of the clinical practicum – legal, ethical, professional
- Promote safety for all personnel, as per the National Safety and Quality Health Service (NSQHS) Standards.

Activities

The activities contained in this Orientation Package will be completed as a group and individually, facilitated by the Student Clinical Facilitator (SCF) throughout clinical placement orientation and week 1 and 2 of placement. Please use this Orientation Package as a reference source throughout your placement. Completion of the activities will support your learning and development and contribute towards the ANSAT.
**Metro North Values in Action**

**What are the Metro North Values?**

1) Respect  
2) Teamwork  
3) Compassion  
4) High Performance  
5) Integrity  

**Why?**

Values are the core beliefs that we use to guide our decision making and how we live our lives. They also very strongly govern our behaviour. This is extremely important for us as healthcare providers because our behaviour towards each other as members of a multi-disciplinary team and towards our patients has a significant impact on the overall patient experience.

We also know that in a healthcare setting, workplaces with a positive culture influence the quality of patient care with fewer incidences of surgical error, patient re-admission and infection. These are the primary reasons that Metro North is integrating our values into our systems and processes and using them to bring about a more positive workplace culture for all of us.

**What is Values in Action?**

This unique program aims to integrate our five values into the way we do the following things including:

- Welcome, orient and ‘on-board’ new team members in Metro North  
- Recruit externally and promote internally our vacant positions  
- Provide performance support to our team members  
- Recognise and reward the outstanding efforts of our team members  
- Look after our people’s well-being  
- Celebrate the work we do and improve our sense of belonging in the workplace  
- Build a culture of safety and respect while promoting accountability for our behaviour
Accreditation Standards

See Appendix 1, Appendix 2

All clinical areas of Community and Oral Health are evaluated on an ongoing basis through various accrediting bodies. The accreditation standards that apply to COH are:

1) Aged Care Standards (Cooinda House & Gannet House)

   Four standards:
   - Standard 1: Management systems, staffing and organisational development
   - Standard 2: Health and personal care
   - Standard 3: Care recipient lifestyle
   - Standard 4: Physical environment and safe systems

2) Human Services Standards (Halwyn Centre)

   - Standard 1: Governance and management
   - Standard 2: Service access
   - Standard 3: Responding to individual need
   - Standard 4: Safety, wellbeing and rights
   - Standard 5: Feedback, complaints and appeals
   - Standard 6: Human services

3) National Safety & Quality Health Service (NSQHS) Standards (all other COH services)

The Australian Council on Healthcare Standards (ACHS) is the external accreditation body under which the NSQHS standards are evaluated.
Confidentiality

While on placement within COH, students have access to privileged information (i.e. names, patient diagnoses and conditions). Students are bound by confidentiality not to discuss this information with anyone outside of the work environment. Peoples’ right to privacy and confidentiality of information are supported with legislation, professional codes, Social Media Guidelines, Code of Conduct for the Queensland Public Service and Australian Charter of Healthcare Rights.

**Confidentiality and security of patient information must be maintained at all times:**

- Patient healthcare records, x-rays, etc., being transported must not have patient details visible.
- Diagnostic statements and warning notices must not be displayed on the outside of the patient healthcare record.
- Unauthorized persons should not be permitted to examine patient healthcare records or to read patient information on visual display terminals, computer printouts, etc. Care should be exercised when providing information to persons who appear to have official status such as ambulance and police officers, or unauthorised hospital staff. Concern that an unauthorised person has accessed patient records should be brought to the attention of the line manager.
- Students should not discuss patients where the conversation is likely to be overheard by unauthorised persons, e.g. in lifts, cafe or on public transport. In instances where a discussion must take place and could potentially be heard by others, the information is to be de-identified.
- Do not photocopy or take photos of any patients or patient related data – de-identify and take hand written notes for assignments/case studies.
- Do not take any photographs/videos in the clinical area – no phones/cameras at all in clinical area.
- Do not provide any patient information over the phone – please refer phone call to ward staff.
- Dispose of handover sheets daily in the confidential waste bins provided in the clinical areas.
- Exercise caution when using social media sites.
Social Media

Social media describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips and includes websites and applications used for social networking. Common sources of social media include:

- networking sites (e.g. Facebook, Twitter, LinkedIn, Bebo, Yammer)
- video and photo sharing websites (e.g. Flickr, Instagram, YouTube)
- blogs, including corporate blogs, personal blogs and blogs hosted by media outlets (e.g. comments or your say feature)
- wikis and online collaborations (e.g. Wikipedia);
- forums, discussion boards and groups (e.g. Google groups, Whirlpool)
- Video on Demand (VOD) and podcasting
- instant messaging (including SMS)
- any other websites that allow individual users or companies to use simple publishing tools to share information with a network of individuals.

Whether an online or social media post/activity is able to be viewed by the public or is limited to a specific group of people, students and health professionals need to maintain professional standards and be aware of the implications of social media engagement. Students and health professionals need to be aware that information circulated on social media may end up in the public domain, and remain there, irrespective of the intent at the time of posting.

To support the confidentiality of patients, visitors and staff –

*NO aspects of Clinical Placement should be communicated on Social Media.*

For more information refer to the MNHHS DOC75/15 GUI008: Social Media Guidelines for Staff procedure.
## Essential Information

### Activity 1: Placement essential information

*Please fill in relevant contact information in the table below.*

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<tr>
<th>Student Clinical Facilitator (SCF) details</th>
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<th>Allocated Ward/Unit</th>
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<tr>
<th>Base Site <em>(Please tick box)</em></th>
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<td>☐ North Lakes Health Precinct</td>
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<td>☐ Chermside Community Health</td>
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<td>☐ North West Community Health</td>
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<td>☐ Caboolture Community Health</td>
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<th>Duration of placement (include dates)</th>
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<tr>
<th>Shift Times</th>
<th>AM:</th>
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<th>University/TAFE Unit Coordinator name</th>
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<tr>
<th>Fellow Students Names</th>
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Clinical Placement/Assessment Requirements

Activity 2: Clinical Placement Essential Documents

Please provide information regarding the requirements below.

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Date Due</th>
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<tr>
<td>QLD Health Student Orientation Checklist</td>
<td>Complete on orientation day</td>
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<tr>
<td>Please see on the next page</td>
<td>Valid for 12 months</td>
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<tr>
<td>Education Providers Assessment Tool</td>
<td>Interim (midway) assessment:</td>
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<tr>
<td></td>
<td>Summative (final) assessment:</td>
</tr>
<tr>
<td>Learning Objectives / Goals</td>
<td></td>
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<tr>
<td>Elder abuse staff training record</td>
<td>Complete on orientation day</td>
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<tr>
<td>General/First response evacuation instructions record</td>
<td></td>
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<tr>
<td>Other requirements:</td>
<td></td>
</tr>
<tr>
<td>Basic wound care workbook and Quiz</td>
<td>Commence on Orientation day, completion prior to</td>
</tr>
<tr>
<td></td>
<td>attending wound clinic</td>
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Metro North Hospital and Health Service
Nursing and Midwifery
Student Declaration Reminder

Pre-Placement orientation
I confirm I have watched and / or read all information contained in the Metro North Hospital and Health Service Nursing and Midwifery Orientation Fact Sheet and during orientation and induction.

I declare that I have understood the content of the information contained in orientation and induction. I will use this information to inform my practice as a student nurse. If I have any doubt about these safety concepts and how it applies to my practice, I will ask my facilitator/preceptor/educator for more information.

Name: __________________________________________________________________________________________

Student Number: _________________________________ University / TAFE: ____________________

Date: _________________________ Signature: ________________________________________________________

Annual completion of the Metro North Hospital and Health Service Student Nurse / Midwife and Clinical Facilitator orientation is a mandatory requirement. Students and Clinical Facilitators who have not completed this activity cannot be placed within a MNHHS facility for their placement.
Role Descriptions
Activity 3: SCF and Student roles

Complete the following questions.

1. Explain the role of the SCF

2. Explain the role of the student
Community Teams

Community Transition Care Program (CTCP)

CTCP provides short term care and pharmacy review for older people and those at risk of residential placement after a hospital stay in their own home to complete their recovery process and improve their functioning and level of independence. The program is goal oriented and therapy focused and includes low intensity therapy such as physiotherapy, occupational therapy, speech pathology as well as social work, nursing care and dietetics.

Services Provided: Clients are provided with services based upon their immediate care needs and future planning which could include: Case Management – a designated health professional to coordinate care, establish support and services; Nursing care but is not limited to showering assistance, wound and medication management; Domestic assistance including light housekeeping, laundry, shopping and transport to medical appointments; Additional therapeutic care including physiotherapy, occupational therapy, speech therapy, dietetics and social work; Medical management in collaboration with your general practitioner. Nursing services are available 7 days per week including public holidays; and Allied Health services (Monday to Friday excluding public holidays).

Hospital in The Home (HiTH)

HiTH provides care in a patient’s permanent or temporary residence for conditions requiring clinical care that would otherwise require treatment in the traditional inpatient hospital bed. People requiring nursing care once or twice a day, rather than continuous 24hr care are often transferred to HiTH for their continuing care. Common diagnoses of people cared for within HiTH include osteomyelitis/discitis, cellulitis, infective endocarditis, COPD/Pneumonia/bronchiectasis, meningitis/encephalitis, septic arthritis, sepsis/bacteraemia, MVR/AVR/AF, heart failure/CCF and UTI/pyelonephritis/urosepsis. While in HiTH, you may have the opportunity to perform the following skills: rapid assessment in a community setting, care planning, IV Infusions, IVAB administration, variety of community based IV infusion pumps, IV bolus injections, INR testing, SC/IM Injections, warfarin dosing, wound care – from simple to complex e.g. NPWT wound management, documentation, PICC, CVAD / PVAD management and care, day clinic and communication within the multidisciplinary team. You will be buddied with a CN/RN during your placement.

Post-Acute Care Services (PACS)

PACS services provide a range of hospital avoidance/early discharge options for clients of the RBWH, The Prince Charles, Redcliffe and Caboolture Hospitals. These services are available to people who are or have recently been, inpatients of any of the above-named hospitals. Services are multidisciplinary and are provided by nurses, occupational therapists, physiotherapist, social workers, dietitians, speech pathologists, community health aides, pharmacists and doctors. Staff provide assessment and ongoing care for clients and refer to appropriate services as needed. These services may be provided in a Community Health Centre, or in the home of the client.
Community Palliative Care Service

The Community Palliative Care Service provides care for people who have a life limiting illness with little or no prospect of a cure, and for whom the primary treatment goal is quality of life by providing complex care to people in the community. The aim is to support care for people within home care settings. The service provides specialty care for people with limited life expectancy, complex symptoms associated with disease or its treatment, illness or treatment-related distress that requires specialist Palliative Care evaluation and/or support. People are referred to the service from a range of hospitals within Metro North Hospital and Health Services.

Complex Chronic Disease Team

The CCDT provide clinic-based care in a multidisciplinary team for people living with complex chronic medical conditions, for example, asthma, cancer, heart disease, diabetes, arthritis and stroke who are at risk of admission or readmission to hospital or frequent presentation to Emergency Departments. CCDT provides assessment and intervention to support people in managing their complex care needs and chronic disease to minimise complications. Specialist outpatient clinics are held at North Lakes Health Precinct and Nundah Community Health Centre.

Aged Care Assessment Team (ACAT)

The Aged Care Assessment Team provides free assessments of older people wanting to access Australian Government Aged Care Services. This lets them know what their options are and supports them to choose the help that best meets their needs. Assessments look at the whole person – what they can do for themselves and what they need help with, as well as their health and social needs. ACAT Assessments are needed to access: Home Care Packages, Care in a Residential Aged Care Facility (permanent care or respite care), Transition care after a hospital stay and some restorative programs. Eligibility requirements apply for each type of care.

Diabetes Service

The Diabetes Service aims to empower clients to make healthier decisions about managing their diabetes. The service utilises a multidisciplinary approach to provide clients with diabetes clinical knowledge and skills for self-management and prevention of diabetes related complications. Service is offered at Caboolture, Redcliffe, Chermside and North Lakes in-reaching to The Prince Charles Hospital, Redcliffe Hospital and Caboolture Hospital. The Diabetes Service is clinic-based, and a home visiting service is not offered.
Post-Acute Care Service Overview

The Post-Acute Care service provides a seven day per week post-acute hospital avoidance response to people who present to emergency departments and not requiring admission or are discharged from hospital. Short-term multidisciplinary interventions are provided to address immediate care needs. Services are provided in-home or can be clinic based.

Patients requiring wound care will attend a clinic setting unless there are exceptional circumstances or patient health status requires a home visit.

PACS teams have a range of health professionals including

- Nurses
- Physiotherapists
- Occupational Therapists
- Dietitians
- Social Workers
- Speech Pathologists
- Personal Care Workers
- Allied Health Therapy Assistants
- Pharmacist

Support can be provided for up to 14 days for

- Comprehensive Nursing Assessments
- Personal Care
- Medication Administration
- Wound Management
- Stoma Care
- Catheter Care
- Drain Care
- Nutrition Assessment and Management
- Falls Risk Assessment and Management
- Emotional Support
- Home Safety Assessment
- Equipment Trial
- Swallowing and Speech Assessment
- Chronic Disease Education
- Home Oxygen Education
- Discharge Planning
PACS Team Locations:

Caboolture Community Health Centre
McKean Street
Caboolture
Qld 4510
Ph: 54338303

Chermside Community Health Centre
490 Hamilton Road
Chermside
Qld 4032
Ph: 31394529

North Lakes Health Precinct
9 Endeavour Boulevard
North Lakes
Qld 4509
Ph: 30491213

Keperra Community Health Centre
49 Corrigan Street
Keperra
QLD 4054
Ph: 33358874
POST ACUTE CARE SPECIFIC INFORMATION

Welcome to your placement with the PACS team

This section of the learning package will include the following:

1. Information to assist in preparation for your clinical placement in PACS
2. Developmental activities to guide you in your learning
3. Activities to assist in meeting criteria of your assessments (e.g. ANSAT)

The Nurse Unit Manager or Team Leader is,
Caboolture PACS: Justine Keir
North Lakes PACS: Marilyn Cartwright
Chermside PACS: Lorna Stewart
North West PACS: Donna Ferguson
Clinical Nurse Consultant PACS: Jessica Schluter
Wound Stoma Clinical Nurse Consultant: Patricia Sinasac

Shift Times
0800-1630

Arrive promptly at your shift start time

Clinical Handover Huddle occurs every morning with the multi-disciplinary team meeting around the journey board. New admissions to the service are discussed and clients are reviewed using a case review format.

Please speak with your preceptor regarding the journey board processes and button system.

Your Clinical Nurse Student Facilitator will liaise closely with your preceptor to arrange completion of your formative and summative assessments and confirm days and times to meet for goal setting and observational visits throughout the course of your placement.
Shift Essentials

⚠️ Transport

It is the student’s responsibility to organize their own transportation to and from placement. Discuss with your SCF what the best transport options are to your allocated facility. *Fill in details below*

Bus:
Train station:
Parking:

During your shift

- One 10-minute morning tea break and one 10-minute afternoon tea break & a 30-minute lunch break to be taken in consultation with your buddy RN/preceptor, lunch must be taken prior to 1400.
- Advise staff before leaving and when returning to the clinical area
- Ensure the full shift is completed and you leave on time, attendance record to be signed by SCF (if required)

Absence

- All absences from placement must be reported to the SCF at the commencement of shift
- If absence is required for any reason during the shift, you must inform and notify your buddy RN and your SCF prior to leaving the worksite
- Documentation to support absence is required by your Education provider, e.g. Medical Certificates/Statutory Declaration

Security of personal items

- Do not bring valuables with you on placement
- Make use of lockers or allocated storage areas on wards for personal items, as identified by unit staff

Mobile phones must always be on silent or OFF during work times.
# Work Area Orientation

Complete the following

## Get to Know Your Team

### Nursing
- □ Registered Nurses
- □ Clinical Nurses
- □ Nurse Unit Manager
- □ Clinical Nurse Consultant
- □ Personal Care Workers

### Administration staff
- □ Service Coordinators
- □ Admin Officers

### Allied Health
- □ Social Worker
- □ Dietitian
- □ Physiotherapist
- □ Podiatrist
- □ Occupational Therapist
- □ Speech Pathologist
- □ Allied Health Assistant
- □ Pharmacist

## Search and Find

- □ Staff dining room
- □ Where to leave your bag / store your food
- □ Staff toilets

### Documentation
- □ Client charts

### Information technology and communication

Locate:

- □ Computer/s

Locate:
- □ QHEPS
- □ MIMS
- □ CKN
- □ Clinical policies and procedures

### Equipment and resources

- □ Emergency back pack / equipment
- □ Observation equipment
- □ Fire extinguisher/s
- □ Fire exits
- □ PPE
- □ Cytotoxic Spill Kit

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V1 Effective: January 2022 Review: November 2020
Scope of Practice

Activity 4: Definitions

Complete the following questions

a) Define scope of practice

b) Describe direct/indirect supervision

For more information on scope of practice, refer to the MNHHS PROC/166: Scope of Practice for Registered Nurses/Midwives/Enrolled Nurses procedure.

The Australian Charter of Healthcare Rights (See Appendix 2)

Describes the rights of patients and other people using the Australian health system.

At each point that the consumer (patients, carers, families) engages with the Hospital and Health Service their understanding of The Charter needs to be ascertained by staff, by explaining the brochure to them.
Activity 5: Occupational Violence Prevention

Complete the following questions

a) What is your understanding of occupational violence?

b) What strategies can you employ in verbal de-escalation?

For more information refer to the Occupational Violence Risk Assessment (OVRA) procedure.

Other useful information

Policy on Home Visits and Community Safety POL04683

Procedure on Domestic and Family Violence Training Requirements for all CISS Staff CISSPROC072
Activity 6: Patient Handling & Falls

Complete the following questions

a) Identify three pieces of equipment you may use when transferring a patient (may be different in each area)

b) What strategies should be implemented to maximise patient, staff and student safety throughout the patient handling episode?

c) Falls are quite common in many clinical environments. List 5 strategies to prevent patient falls.

For more information refer to the Manual Tasks PROC003441 and Preventing Consumer Falls and Harm from Falls CISSPROC0064
Activity 7: Cytotoxic Precautions (See Appendix 4)

Complete the following questions.

a) What colour is associated with cytotoxic precautions?

b) Other than cancer, what conditions may be treated with cytotoxic drugs?

c) What role can student nurses perform in the event of a cytotoxic spill?

For more information refer to the Cleaning, Disinfection and Sterilisation, Waste Management and Linen Management 003514 and Medication: High Risk Medicines PROC004513 procedure.
Infection Control

Activity 8: Infection Control

Complete the following questions.

a) Explain why Standard Precautions are used

b) What are the 5 moments for hand hygiene? (See appendix 4)

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⚠️ Bare Below Elbows: If you are not bare below the elbows, you have not performed hand hygiene effectively

c) List items of PPE

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</table>

| d) | Identify 3 conditions the following precautions would apply to |
|---|---|---|---|
| 1. | Contact | | |
| 2. | Droplet | | |
| 3. | Airborne | | |

e) Describe the process employed after a body fluid exposure or needle stick injury

For more information please refer to
Procedures: Hand Hygiene (CISSPROC0005), Standard Precautions, Transmission Based Precautions (CISSPROC0012)

V1 Effective: January 202 Review: November 2020
Medications

Activity 9: Medications

Complete the following questions.

a) List the six rights of safe medication administration (See appendix 5)

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<thead>
<tr>
<th>1.</th>
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<tbody>
<tr>
<td>3.</td>
<td>4.</td>
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<td>5.</td>
<td>6.</td>
</tr>
</tbody>
</table>

b) Complete the following medication calculation formulas

<table>
<thead>
<tr>
<th>Tablets</th>
<th>Solution</th>
<th>IV Infusions</th>
<th>Drops per minute</th>
</tr>
</thead>
<tbody>
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</table>

c) What does PINCHA stand for? (See Appendix 6)

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<thead>
<tr>
<th>P</th>
<th>I</th>
<th>N</th>
<th>C</th>
<th>H</th>
<th>A</th>
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</thead>
</table>

Students must only administer medications under DIRECT SUPERVISION of a Registered Nurse.

For more information refer to the MNHHS PROC/174: Medications Management procedure.

V1 Effective: January 2020
Review: November 2020
Clinical Handover and Patient identification

Activity 10: Clinical Handover

Complete the following question.

When do you perform ‘Clinical Handover’?

The standard process for handing over clinical information should include:

- Clearly identify the patient, yourself and your role.
- State the immediate clinical situation of the patient.
- List the most important and recent observations.
- Provide relevant background/history to the patient’s clinical situation.
- Identify assessments and actions that need to occur.
- Identify timeframes and requirements for transition of care.
- Promote the use of the patient record to cross-check information.
- Ensure documentation of all-important findings or changes of condition.
- Ensure comprehension, acknowledgement and acceptance of responsibility for the patient by the clinician receiving handover

Patient identification is crucial in providing safe care to all patients.

‘Patient Identifiers’ are used in multiple situations such as clinical handover, documentation and procedure matching. List 3 other patient identifiers that may be used in your work area.
Pressure Injury Prevention

Activity 11: Pressure Injury Prevention

Complete the following questions

a) List 3 common risks for developing pressure injuries?

•

•

•

b) What are some strategies you can implement to prevent the development of pressure injuries?

For more information refer to the Pressure Injury Prevention (CISSPROC0003) protocol
Emergency Response

Activity 12: Recognition and Responses to the Deteriorating Patient

Complete the following questions.

a) Complete the following acronym:

<table>
<thead>
<tr>
<th>D</th>
<th>R</th>
<th>S</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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</table>

What is a Code Blue?

⚠️ Once you are in your allocated work area, it is important to familiarise yourself with how staff respond to critical situations

⚠️ The documentation used for monitoring vital signs in Community and Oral Health Services is a modified version of the Queensland Adult Deterioration Detection System (QADDS) (See appendix 7)
Interprofessional Development

Activity 13: Interview

Nurses do not work in isolation when it comes to patient care. Patients in hospital or at home, in the care of one of our community services, have a multi-disciplinary team who work together to provide the best possible outcomes for them. This activity is designed to provide you with the opportunity to learn about and with other health care team members.

**Learning Objectives**

- Describe own role, responsibilities, values and scope of practice effectively to another health professional
- Articulate the roles and scope of practice of other members of the interprofessional collaborative team
- Identify areas of uniqueness and responsibility overlap in roles of health team members

Suggested time for this activity is 30 minutes with a health care team member from a discipline other than nursing. When deciding on which team member to interview, consider what discipline you know the least about. This activity can be done on your own or as a team if working with other nursing students. Please ensure you have verbal permission to interview the team member and consider confidentiality with the information disclosed to you.

**Some suggested questions**

- What is the role of the discipline e.g. physiotherapist?
- How does the person contribute to patient care?
- How does the person in their professional role usually interact with nursing team members?
- How much does the person know about the role of nurses in patient care?

This activity will allow you the opportunity to expand your knowledge of another discipline and to demonstrate engagement under Standard 2 ‘Engages in therapeutic and professional relationships’ on the ANSAT assessment

At the end of the interview complete the following questions.

1. What did you learn about the role of the discipline relating to patient care that you did not know previously?

2. What are the similarities and differences between nursing and the discipline of the interviewee?

3. What else do you want to learn about the team and its members? Have you identified any learning goals or objectives?

4. How will this activity influence your role as a health professional and being a member of a multi-disciplinary team?
Basic Wound Management

Basic skin anatomy

Introduction
This section is designed to provide a description of the skin and the structure/function of each layer.

- The skin is the largest organ in the human body and skin healing is often overlooked by health care professionals (Vowden & Vowden, 2017).

- The skin has several functions the main function being to protect the body’s internal environment from external factors. Openings in the skin (wounds) can leave the body’s internal environment open to pathogen infiltration. As this is the case, it is important that any wound in the skin be left uncovered for as short a time as possible to reduce the chance of bacterial invasion (Carville, 2017).

Epidermis
The epidermis is the outermost layer of the skin and plays the primary role of an external protective layer for the body’s internal environment. Without this layer the body would be unable to retain the water needed to maintain its internal environment and would be open to any pathogens that it met.

The epidermis regeneration process takes around 30 days to complete a full cycle and each of the below layers are made up of cells that are at different phases of this process (Carville, 2017).
**Dermis**
The Dermis connects the epidermis to the rest of the body and contains three different types of tissue; collagen, elastic tissue and reticular fibres. The bases of hair follicles are found in the dermis as well as sebaceous glands, sweat glands and nerves that are responsible for sensing such things as touch, pressure, pain and changes in temperature. The sebaceous glands found in this layer of the skin are responsible for releasing oil that prevents hair from drying out, maintains the elasticity of the skin and inhibits bacterial growth (Carville, 2017).

**Hypodermis/Subcutaneous**
The hypodermis is the largest layer of the skin and contains a large number of fat/adipose cells. Veins, arteries, nerves and lymph channels run through the dermis and hypodermis regulating blood flow and receiving touch sensations. The main function of this layer is to regulate temperature and provide a shock absorbent layer to protect underlying structures (Carville, 2017).
Summary
The skin has a range of functions including protection, internal temperature regulation and sensory perception. Within a health care setting, health care professionals are often presented with patients that have wounds. Depending on its size, the wound will be preventing the skin from achieving several its functions. The most common function that is lost when skin integrity is no longer present is protection. As this is the case it is always important to maintain the integrity of the skin. This can be done by dressing the wound and only exposing the wound to external factors when necessary.
Phases of wound healing

Introduction

This section is designed to provide a description of the phases of wound healing. Through the completion of this section you will gain knowledge and understanding of how the skin heals and how this process occurs.

Normal wound healing occurs in phases. The process begins when disruption of skin integrity occurs below the epidermis. The four phases of wound healing are Haemostasis, Inflammatory, Proliferative, and Maturation phases. These phases often overlap each other but wound healing always follows the same sequence.

Haemostasis

Haemostasis is the skin’s immediate response to tissue injury, it occurs for approximately 30 minutes following the injury. Haemostasis occurs in three key processes: vasoconstriction, platelet activation and coagulation (Singh, Young, & McNaught, 2017). The purpose of this phase is to control bleeding and provide a temporary barrier to bacterial infection.
Inflammation

The inflammatory phase is the beginning of the body’s attempt to heal the wound. It occurs from the time of haemostasis until 3-5 days following injury in acute wounds but can be prolonged in chronic wounds (Singh et al, 2017).

The inflammatory phase is manifested by warmth, redness, swelling and pain. Vasodilation occurs allowing more oxygenation to the wound. This increase in blood flow is the cause of the redness and heat visible at the wound site. The swelling and pain is due to the rise in extracellular fluid (Singh et al, 2017).

Proliferation

The proliferation phase is the ‘repair’ phase which occurs from 2 to 21 days post injury (Carville, 2017). During this period angiogenesis (revascularisation) occurs, granulation tissue is formed, wound contraction occurs, and epithelialisation begins. The new tissue fills the wound cavity and produces new capillaries. The wound edges contract to pull together and reduce the size of the wound defect, thereby reducing the amount of new tissue the body has to produce (Singh et al, 2017). After wound contraction occurs, the surface of the wound is closed by epithelialisation. In a deep wound, epithelial cells move towards each other from the wound margins closing the deficit. This process occurs faster in a moist environment. In a superficial wound, hair follicles may act as islands to help the regeneration (Carville, 2017).
**Remodelling (Maturation)**

In this final phase of wound healing new collagen forms, which is the body’s attempt to provide strong tissue. This phase occurs from three weeks up to two years post injury (Singh et al, 2017). The tissue gradually becomes stronger, leaving a paler, flatter scar. This scar tissue gains tensile strength although it will only ever be approximately 80% as strong as uninjured skin (Singh et al, 2017).

**Summary**
These descriptions may be used to describe normal wound healing or the type of healing that occurs in the acute wound. There is significant overlap in both the cellular and molecular activity, and healing phases can move faster or slower depending on other factors that may be affecting the wound.
Holistic assessment

Introduction
The purpose of completing this section is to emphasise the importance of completing a structured, detailed, holistic assessment of the patient, that provides a clear picture of their current health status as well as identifying other significant contributory factors.

Holistic assessment
1. **Presenting complaint/recent history** – this would be the wound, but it is important to record a brief history as this may give clues as to the aetiology of the wound. This would include a structured pain assessment using an assessment tool e.g. OLDCART (onset, location, duration, characteristics, aggravating/associated symptoms, radiating, treatment).

2. **Age of patient** – all phases of the healing process are affected by the ageing process e.g. fibroblast activity decreases with age subsequently there is poor collagen formation and slowing of healing.

3. **Baseline observations** – these can indicate that there is infection or hypertension present.

4. **Full medical history including the cause of the wound** – this gives the opportunity for the clinician to identify conditions that may have caused the wound to develop or exacerbated the existing wound such as diabetes, vascular disease, immune deficiency disorders, conditions that effect mobility and sensation, malabsorption conditions and anaemia.

5. **Medication/allergies** – some medications can inhibit the body’s natural healing process.

6. **Social history** – this is important to consider when devising the plan of care as it needs to fit in with the patient’s current lifestyle and their current level of family/carer support. It is also important to consider the patient’s family history, as there are several conditions that have strong familial links.

7. **Psychological problems** – stress can raise the level of serum corticosteroids and delay wound healing. Stress can also stimulate the sympathetic nervous system which causes vasoconstriction, reducing perfusion of the wound which delays wound healing.

8. **Cultural influences** – some patients have strong beliefs around the use of traditional medicine and healing. This needs to be considered within the assessment and respected when formulating the plan of care.

9. **Nutritional status** – poor nutrition can be a result of poor diet which may be influenced by a low income, social isolation, an underlying disorder such as Crohn’s Disease or a restricted dietary intake post-surgery.

10. **Lifestyle choices** – cigarette smoking affects healing by reducing the amount of circulating oxygen and causes vasoconstriction and increases blood clotting which decreases tissue perfusion. Alcohol thins the blood and long-term use can cause liver and kidney damage.

Summary
A thorough holistic wound assessment should be conducted which includes both the patient and local wound characteristics. Assessing these factors assists in establishing an appropriate treatment pathway to promote rapid wound healing.

**Documentation / assessment framework**

**Introduction**

Local assessment is an ongoing process and should include assessment of the physical wound characteristic – locations, size, depth, presence of pain, condition of the wound bed.

The length of a wound should always be measured from the direction of the patient’s head to toes and the width should be measured from the direction of the patient’s left to right side.

The direction of areas of undermining should be described using a clock face with the 12’O’clock facing the head of the patient.

In practice, documentation also affects continuity of care. One patient will probably be cared for by several different nurses, therefore a detailed record of assessment and plan of care will ensure that different nurses have the same information about the wound and provide the same care (Wounds Australia, 2016).

To facilitate a standardised approach to wound assessment documentation the T.I.M.E. framework can be used which is based on the work of the International Wound Bed Preparation Advisory Board. This acronym comprises of four components that underpin wound healing (Tissue management, Inflammation and infection control, Moisture balance and Epithelial (edge) advancement) (Harries, Bosanquet, & Harding. 2016).

This framework can be utilised as a treatment strategy for all wounds and provides a systematic approach to the management of wounds by focussing on each stage of wound healing and removing the barriers allowing wounds to heal.

<table>
<thead>
<tr>
<th>T</th>
<th>for Tissue</th>
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<tbody>
<tr>
<td>I</td>
<td>for Infection or inflammation</td>
</tr>
<tr>
<td>M</td>
<td>for Moisture imbalance</td>
</tr>
<tr>
<td>E</td>
<td>for Epithelial edge advancement</td>
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</table>

(Harries et al, 2016)
The first letter of the acronym T.I.M.E.s is ‘T’ for Tissue. This wound bed assessment principle focuses on the Tissue within the wound bed.

- What is the condition of the tissue in the wound?
- Is the tissue at the wound bed viable healthy granulating tissue or non-viable sloughy / necrotic tissue?
- If there is non-viable tissue present in the wound, how much of the tissue is viable and how much is non-viable?

The use of percentages to describe the type of tissue identified can aid wound documentation!

Non-viable tissue impedes wound healing as it:
- Provides an environment for bacteria to flourish increasing the spread of infection
- Hinders the development and movement of the epithelial cells across the wound bed

Non-viable tissue needs to be removed to encourage granulating tissue.

**Autolytic debridement** is available to all nurses using moist interactive dressings i.e. hydrogels, hydrofibres, hydrocolloids and alginates to provide additional moisture onto the wound bed environment. This allows slough and necrotic tissue to become liquefied making it easier to be removed from the wound bed. (Harries et al, 2016).

**Other debridement options:**

- **Sharp debridement** is the conservative removal of non-viable tissue using a scalpel blade by a skilled credentialed clinician (Harries et al, 2016). *It is not an option for all patients and is contraindicated for wounds that have a poor blood supply to support healing.*

- **Surgical debridement** is the excision and resection of necrotic tissue performed when there is extensive infection, undermining/ tunnelling or sepsis (Harries et al, 2016). This procedure is effective in the removal of non-viable tissue but can cause post-operative pain and bleeding.

**Summary**

There are several options when it comes to the removal of non-viable tissue. Each of these options need to be discussed with both the patient and the medical team as not all options are suitable for all patients and all wounds.
The second letter of the acronym is ‘I’ for Infection or Inflammation. This wound bed assessment principle focuses on identifying wound infection (Harries et al, 2016).

Bacteria is present in all wounds! The level of bacteria and the patient’s immunological status influences whether wound infection occurs. When the patient presents with systemic signs of infection as a result of the infected wound, antibiotics may be required. i.e. spreading cellulitis, pyrexia (Mockford, & O’Grady, 2017).

The amount of bacterial load within a wound is classified as either contamination, colonisation, critical colonisation or infection (International Wound Infection Institute (IWII), 2016).

- **Contamination**: non-multiplying bacteria in a wound (IWII, 2016).
- **Colonisation**: bacteria in a wound but is not causing a systemic reaction (IWII, 2016).
- **Critical colonisation**: a multiplication of bacterial organisms which are hindering wound healing (IWII, 2016). There is an immune response locally around the wound.
- **Infection (spreading/systemic)**: the multiplication of bacteria causing an immune response from the patient which overwhelms the healing process (IWII, 2016).

Wound infection is not to be confused with the normal inflammation process in the second stage of wound healing after haemostasis in the first 0-5 days following the wound injury. The inflammatory wound healing stage can continue for approximately 7-10 days (Singh et al, 2017).

![Signs of Wound Infection](image)

(IWII, 2016).

**Summary**

High bacterial loading within a wound or the surrounding tissue can have a large effect of the body’s ability to heal the wound. It is important that infection is identified early and managed effectively.
The third letter of the acronym is **M’ Moisture imbalance.** This wound bed assessment principle looks at the amount and type of wound exudate. During the inflammatory phase, wound exudate is produced as part of normal wound healing to provide wound cleansing and an optimal moist environment for healing. Excess production of abnormal exudate is an indication of infection (Harries et al, 2016).

<table>
<thead>
<tr>
<th>Types of Exudate</th>
<th>Colour</th>
<th>Consistency</th>
<th>Description</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serous</td>
<td>Clear / straw colour</td>
<td>Thin watery</td>
<td>Clear fluid</td>
<td>Normal during inflammatory healing phase</td>
</tr>
<tr>
<td>Sanguinous</td>
<td>Red</td>
<td>Thin watery</td>
<td>Blood</td>
<td>New vessel growth or disruption</td>
</tr>
<tr>
<td>Serosanguinous</td>
<td>Light red/pink</td>
<td>Thin Watery</td>
<td>Blood / clear fluid</td>
<td>Normal inflammatory healing phase</td>
</tr>
<tr>
<td>Seropurulent</td>
<td>Cloudy yellow</td>
<td>Thin watery</td>
<td>Pus/watery fluid</td>
<td>Early signs of wound infection or autolytic debridement</td>
</tr>
<tr>
<td>Purulent/pus</td>
<td>Yellow/green</td>
<td>Thick, Opaque</td>
<td>Pus, cloudy, viscous, malodourous</td>
<td>Wound infection (Carville, 2017).</td>
</tr>
</tbody>
</table>

It is important to choose an appropriate dressing product to manage the excessive exudate in an infected wound and prevent surrounding skin maceration. The amount of exudate can be described as - dry, moist, wet, saturated or leaking.
Evaluation of dressing exudate interaction:
(Assessment of the exudate volume on the wound bed and on the dressings).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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<tbody>
<tr>
<td>Dry</td>
<td>Wound bed is dry; with no visible moisture. The primary dressing is unmarked; dressing may be adherent to wound. <strong>Maintaining a dry environment may be the plan for ischaemic wounds</strong></td>
</tr>
<tr>
<td>Moist</td>
<td>Small amounts of fluid are visible on the removed dressing. The primary dressing may be lightly marked. <strong>In many cases, this is the aim of exudate management</strong></td>
</tr>
<tr>
<td>Wet</td>
<td>Small amounts of fluid are visible on the removed dressing; the primary dressing is extensively marked, without strike-through.</td>
</tr>
<tr>
<td>Saturated</td>
<td>Primary dressing is wet and with strike-through. The dressing change is required more frequently than usual for the dressing type. The surrounding skin may be macerated.</td>
</tr>
<tr>
<td>Leaking</td>
<td>Dressings are saturated and exudate is escaping from primary and secondary dressings onto clothes or beyond; dressing change is required much more frequently than usual for dressing type.</td>
</tr>
</tbody>
</table>

(Carville, 2017).

Summary
The management of moisture is an important aspect of wound care and at times difficult to achieve in the first instance. It is important that your assessment of wound fluid is clearly documented using the correct terminology to enable effective reassessment and justification for product choice.

**E for Epithelial edge advancement**

The fourth letter of the acronym is ‘E’ **Edge of the wound non advancing or undermined** (Harries et al, 2016). This wound bed assessment principle focuses on whether or not epithelisation (growth of epithelial cells over the wound) is occurring at the wound edge. As part of the proliferation phase of wound healing, epithelial cells start to migrate from the edges across the wound bed. As this is the case it is important to keep the wound edges free of debris/build-up and it is also important to consider the wound’s surrounding skin as:
- Excess exudate from a wound can cause maceration of the surrounding skin.
- Dressing products can cause irritation to the surrounding skin.
- Incorrect application/removal of the dressing can cause blistering/trauma of the surrounding skin.
- Excessively dry flaky skin can harbour bacteria.
- Calluses can build up and thickening of the skin, due to neuropathy and imbalance of weight distribution causing pressure.
Summary
The build-up of non-viable tissue/undermining at the epidermal edge of a wound can slow wound healing due to their obstructive nature. As this is the case these obstructions need to be firstly recognised and secondly managed.

The T.I.M.E. tool provides a simple and systematic approach to wound bed assessment. Visual observation and evaluation of each wound bed principle will enable you to provide effective wound care management.

Now complete the following 9 questions.

These will be marked by the wound clinic nurse prior to working in the wound clinic.
Quiz

1. It is ok to leave a wound undressed or covered for an extended period?
   - True
   - False

2. What is the primary function of the epidermis?
   A. Protection
   B. Temperature regulation
   C. Shock absorption
   D. House sweat glands

3. Which is the middle layer of the skin?
   A. Hypodermis/subcutaneous layer
   B. Epidermal layer
   C. Dermal layer

4. Which phase occurs from 2-3 days to 21 days post injury?
   A. Remodelling/maturation
   B. Proliferative
   C. Inflammatory
   D. Haemostasis

5. Scar tissue regains how much of the tissue’s original strength?
   A. 50%
   B. 60%
   C. 70%
   D. 80%

6. The wound is heavily exuding, the surrounding wound edges are macerated, and the primary wound dressing is saturated. Which element of the T.I.M.E. assessment tool is identified as being in imbalance?
   A. Tissue
   B. Infection or Inflammation
   C. Moisture
   D. Edges of the wound
7. On first observation of the wound bed, non-viable tissue is present. What wound bed assessment principle are you using?

   A. M for Moisture  
   B. S for surrounding skin  
   C. E for wound edges  
   D. T for tissue

8. When assessing the exudate from the wound and on the primary dressing you have removed, what factors do you need to consider?

   A. Amount of exudate  
   B. Type of exudate  
   C. Consistency of exudate  
   D. All the above

9. Using the ‘E’ wound bed assessment principle, you are observing

   A. Exudate volume and consistency  
   B. Exercise and activity of the patient to improve circulation to aid the healing process.  
   C. Edges of the wound to determine if the wound size is decreasing or if the wound is not progressing.  
   D. Evidence of local infection

Wound CN name & Signature -------------------------------

Date
Documents and activities to support placement in PACS

Self-directed activity

Week 1

Select a focus client referred to PACS. Discuss with your preceptor / buddy nurse which client may be appropriate for this activity and ask them for help in reading through client charts.

1) Obtain the following information through reading the clients charts

- Diagnosis
- Reason for admission/referral to PACS
- Past Medical History
- What is relevant from the client's past medical history that is important to know for this referral
2) Post home visit for admission to PACS discuss identified domains of care, individual client goals and care plan for the client. Include rationales for referrals and discharge plan.
<table>
<thead>
<tr>
<th><strong>Critical Reasoning Activity Week 1</strong></th>
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<tbody>
<tr>
<td><strong>Patient Diagnosis</strong></td>
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<tr>
<td><strong>Pathophysiology</strong> <em>(e.g. explain normal A&amp;P and the way it has been changed or altered in this disease)</em></td>
</tr>
<tr>
<td><strong>Signs and Symptoms</strong> <em>(Define characteristics of the disease from findings in your nursing assessments)</em></td>
</tr>
<tr>
<td><strong>Clinical Management and/or Treatment</strong> <em>(investigations to help diagnose, medications, therapies, other interventions)</em></td>
</tr>
<tr>
<td><strong>Multidisciplinary Management</strong> <em>(Which AH/nursing/medical teams might you refer to)</em></td>
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# Clinical Handover Week 1

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<th>Section</th>
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<td>Introduce</td>
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<td>Situation</td>
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<tr>
<td>Background</td>
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<td>Assessments</td>
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<tr>
<td>Recommendation</td>
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</tbody>
</table>
Self-directed activity

Week 2

Select a focus client referred to PACS. Discuss with your preceptor / buddy nurse which client may be appropriate for this activity and ask them for help in reading through client charts.

1) Obtain the following information through reading the clients charts

- Diagnosis

- Past Medical History

- Reason for admission/referral to PACS

- What is relevant from the client's past medical history that is important for this referral
2) Post home visit for admission to PACS discuss identified domains of care, individual client goals and care plan for the client. Include rationales for referrals and discharge plan.
**Critical Reasoning Activity Week 2**

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</table>
## Clinical Handover Week 2

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<th>Section</th>
<th>Content</th>
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The NSQHS Standards

Safe and high-quality care requires the vigilance and cooperation of the whole healthcare workforce. It is based on a risk mitigation approach that focuses on implementing the NSQHS Standards as routine practice and identifies healthcare staff responsible for specific actions.

The second edition of the NSQHS Standards comprises eight standards.

Clinical Governance and Partnering with Consumers Standards combine to form the clinical governance framework for all health service organisations. They support and integrate with all the clinical standards, which cover specific areas of patient care. The eight are:

1. **Clinical Governance**, which aims to ensure that there are systems in place within health service organisations to maintain and improve the reliability, safety and quality of health care.

2. **Partnering with Consumers**, which aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care.

3. **Preventing and Controlling Healthcare-Associated Infection**, which aims to reduce the risk of patients getting preventable healthcare-associated infections, manage infections effectively if they occur, and limit the development of antimicrobial resistance through the appropriate prescribing and use of antimicrobials.

4. **Medication Safety**, which aims to ensure that clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks.

5. **Comprehensive Care**, which aims to ensure that patients receive comprehensive health care that meets their individual needs, and that considers the impact of their health issues on their life and wellbeing. It also aims to ensure that risks to patients during health care are prevented and managed through targeted strategies.

6. **Communicating for Safety**, which aims to ensure that there is effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation, to support continuous, coordinated and safe care for patients.

7. **Blood Management**, which aims to ensure that patients’ own blood is safely and appropriately managed, and that any blood and blood products that patients receive are safe and appropriate.

8. **Recognising and Responding to Acute Deterioration**, which aims to ensure that acute deterioration in a patient’s physical, mental or cognitive condition is recognised promptly and appropriate action is taken.

Further information

A full copy of the NSQHS Standards (second edition) is available on the Commission’s website at www.safetyandquality.gov.au.

The Advice Centre provides support on implementing the NSQHS Standards for health service organisations, surveyed and accrediting agencies.

EMAIL accreditation@ safetyandquality.gov.au
PHONE 1800 304 056

Image Source:
https://nationalstandards.safetyandquality.gov.au/resources
Appendix 2 – Aged Care Standards


Standard 1
Management systems, staffing and organisational development

Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of care recipients, their representatives, staff and stakeholders, and the changing environment in which the service operates.

Intention of standard: This standard is intended to enhance the quality of performance under all Accreditation Standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

1.1 Continuous improvement
The organisation actively pursues continuous improvement.

1.2 Regulatory compliance
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about health and personal care.

1.3 Education and staff development
Management and staff have appropriate knowledge and skills to perform their roles effectively.

1.4 Comments and complaints
Each care recipient (or his or her representative) and other interested parties have access to internal and external complaint mechanisms.

1.5 Planning and leadership
The organisation has documented the residential care service’s vision, values, philosophy, objectives and commitment to quality throughout the service.

1.6 Human resource management
There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives.

1.7 Inventory and equipment
Stocks of appropriate goods and equipment for quality service delivery are available.

1.8 Information systems
Effective information management systems are in place.

1.9 External services
All externally sourced services are provided in a way that meets the residential care service’s needs and service quality goals.

Standard 2
Health and personal care

Principle: Care recipients’ physical and mental health will be promoted and achieved at the optimum level in partnership between each care recipient (or his or her representative) and the health care team.

2.1 Continuous improvement
The organisation actively pursues continuous improvement.

2.2 Regulatory compliance
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care.

2.3 Education and staff development
Management and staff have appropriate knowledge and skills to perform their roles effectively.

2.4 Clinical care
Care recipients receive appropriate clinical care.

2.5 Specialised nursing care needs
Care recipients’ specialised nursing care needs are identified and met by appropriately qualified nursing staff.

2.6 Other health and related services
Care recipients are referred to appropriate health specialists in accordance with the care recipient’s needs and preferences.

2.7 Medication management
Care recipients’ medication is managed safely and correctly.

2.8 Pain management
All care recipients are as free from pain as possible.

2.9 Palliative care
The comfort and dignity of terminally ill care recipients is maintained.

2.10 Nutrition and hydration
Care recipients receive adequate nourishment and hydration.

2.11 Skin care
Care recipients’ skin integrity is consistent with their general health.

2.12 Continence management
Care recipients’ continence is managed effectively.

2.13 Behavioural management
The needs of care recipients with challenging behaviours are managed effectively.

2.14 Mobility, dexterity and rehabilitation
Optimum levels of mobility and dexterity are achieved for all care recipients.

2.15 Oral and dental care
Care recipients’ oral and dental health is maintained.

2.16 Sensory loss
Care recipients’ sensory losses are identified and managed effectively.

2.17 Sleep
Care recipients are able to achieve natural sleep patterns.

Standard 3
Care recipient lifestyle

Principle: Care recipients retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

3.1 Continuous improvement
The organisation actively pursues continuous improvement.

3.2 Regulatory compliance
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about care recipient lifestyle.

3.3 Education and staff development
Management and staff have appropriate knowledge and skills to perform their roles effectively.

3.4 Emotional support
Each care recipient receives support in adjusting to life in the new environment and on an ongoing basis.

3.5 Independence
Care recipients are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

3.6 Privacy and dignity
Each care recipient’s right to privacy, dignity and confidentiality is recognised and respected.

3.7 Leisure interests and activities
Care recipients are encouraged and supported to participate in a wide range of interests and activities of interest to them.

3.8 Cultural and spiritual life
Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.

3.9 Choice and decision-making
Each care recipient (or his or her representative) participates in decisions about the services the care recipient receives, and is enabled to exercise choice and control over his or her lifestyle and not being reliant on the rights of other people.

3.10 Care recipient security of tenure and responsibilities
Care recipients have secure tenure within the residential care service, and understand their rights and responsibilities.

Standard 4
Physical environment and safe systems

Principle: Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.

4.1 Continuous improvement
The organisation actively pursues continuous improvement.

4.2 Regulatory compliance
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems.

4.3 Education and staff development
Management and staff have appropriate knowledge and skills to perform their roles effectively.

4.4 Living environment
Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients’ needs.

4.5 Occupational health and safety
Management is actively working to provide a safe working environment that meets regulatory requirements.

4.6 Fire, security and other emergencies
Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.

4.7 Infection control
An effective infection control program.

4.8 Catering, cleaning and laundry services
Hospitality services are provided in a way that enhances care recipients’ quality of life and the staff’s working environment.

www.aacqa.gov.au
Appendix 3: The Australian Charter of Healthcare Rights

My healthcare rights

I have a right to:

Access
- Healthcare services and treatment that meets my needs

Safety
- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect
- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership
- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

Information
- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy
- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback
- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

For more information ask a member of staff or visit safetyandquality.gov.au/your-rights

V1 Effective: January 2022 Review: November 2020
Appendix 4: Cytotoxic Fact Sheet

CYTOTOXIC FACT SHEET

Cytotoxic drugs and related waste are hazardous substances

If control measures are not used, workers may be at risk of adverse health outcomes.

What are Cytotoxic Drugs?
- Substances that kill cells
- Used to treat:
  - Cancer
  - Rheumatoid Arthritis
  - Multiple sclerosis
  - Psoriasis
  - Systemic Lupus Erythematosus (SLE)
  - Ophthalmology Conditions
- Cytotoxic drugs are:
  - Carcinogenic
  - Mutagenic
  - Teratogenic

How might I be exposed?
- Inhalation
- Ingestion
- Dermal absorption
- Mucosal absorption
- Percutaneous injury

How do I recognise Cytotoxics at my facility?
- Containers are:
  - Purple in colour
  - White label with a symbol of a cell in telophase
  - Labelled as 'Cytotoxic'
  - Purple stickers in medical record, on contaminated IV Lines, drainage bags and pathology specimens

What is Cytotoxic Waste?
Cytotoxic contaminated body waste:
- Urine
- Bowel Movements
- Vomit
- Bile
- Fluids drained from body cavities

Requires staff to wear PPE for 7 days after cytotoxic administration when handling body waste

Cytotoxic waste includes:
- Incontinence aids, ostomy bags & disposable nappies/pads

- Linen or clothing that is contaminated with cytotoxic drugs or body waste
- Bedding that is contaminated and is unable to be cleaned
- Materials/equipment used in preparation, transport, administration, & disposal of cytotoxic drugs eg. Disposable medicine cups, IV lines
- Pathology specimens that contain cytotoxic contaminated body waste

PPE to be worn when handling cytotoxic waste and cytotoxic drugs regardless of dose or route
- Impermeable gown with closed front, long sleeves and elastic cuffs
- 1 x pair of purpose manufactured gloves or 2 x pairs of powder-free latex gloves pulled over gown cuffs
- Class P2 (N95) Respiratory Protective Equipment
- Protective Eyewear (Goggles or safety spectacles with side shields as a minimum)

How do I decrease my risk of exposure?
- Eliminate dangerous work practices e.g. all cytotoxic drugs must be prepared in pharmacy
- Substitute hazardous work processes e.g. use needleless access systems
- Use barriers & technology to prevent exposure e.g. use a Cytotoxic Drug Safety Cabinet for drug preparation
- Use hospital policies, Standard Operating Procedures, training, signs and labels
- Use Personal Protective Equipment (PPE)

What do I do if I am personally exposed?
- Clean contaminated skin with soap and copious amounts of water for at least 15 minutes (shower if necessary)
- Irrigate contaminated eye, mouth, and/or nose with normal saline for at least 15 minutes
- Manage contaminated clothing as per hospital policy
- Report to - Manager, Workplace Health & Safety
- Complete a Workplace Incident Report Form
- Follow hospital policy and procedure for management and follow up

What do I do to manage a cytotoxic spill?
- Stay with the spill and get help
- Access a Hazardous Drugs Spill Kit
- If trained, decontaminate the spill by following the hospital policy
- Complete PRIME

Version No: 09 Effective date: 02/2010 Review date: 02/2019

Once you have read this FACT sheet, complete the Staff Training Form


V1 Effective: January 2022 Review: November 2020
Appendix 5: Moments of hand hygiene

5 Moments for HAND HYGIENE

1. **Before Touching a Patient**
   - **When:** Clean your hands before touching a patient and their immediate surroundings.
   - **Why:** To protect the patient against acquiring harmful germs from the hands of the HCW.

2. **Before A Procedure**
   - **When:** Clean your hands immediately before a procedure.
   - **Why:** To protect the patient from harmful germs (including their own) from entering their body during a procedure.

3. **After A Procedure or Body Fluid Exposure Risk**
   - **When:** Clean your hands immediately after a procedure or body fluid exposure risk.
   - **Why:** To protect the HCW and the healthcare surroundings from harmful patient germs.

4. **After Touching a Patient**
   - **When:** Clean your hands after touching a patient and their immediate surroundings.
   - **Why:** To protect the HCW and the healthcare surroundings from harmful patient germs.

5. **After Touching a Patient's Surroundings**
   - **When:** Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched.
   - **Why:** To protect the HCW and the healthcare surroundings from harmful patient germs.

Appendix 6: The 6 Rights of safe medication administration

Appendix 7: PINCHA

Medication safety

As a prescriber, nurse or pharmacist what do I need to know and do about High Risk Medicines?

P – Potassium
I – Insulin
N – Narcotics
C – Cytotoxics
H – Heparin and other anticoagulants
A – Antimicrobials and ADRs

Time to focus on PINCHA


V1 Effective: January 2022 Review: November 2020
Appendix 8: Q-ADDS

## Acute Pain Assessment

**Effective:** January 2022  
**Review:** November 2020

### Q-ADDS

<table>
<thead>
<tr>
<th>Acute Pain Assessment</th>
<th>Pain Score at Rest</th>
<th>Pain Score During Activity</th>
<th>Pain Score at Night</th>
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<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>Mild</td>
<td>Mild</td>
<td>Mild</td>
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<tr>
<td>2</td>
<td>Moderate</td>
<td>Moderate</td>
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<tr>
<td>3</td>
<td>Severe</td>
<td>Severe</td>
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</table>

**Activity Rating:**  
- 0: No activity
- 1: Light activity
- 2: Moderate activity
- 3: Heavy activity

**Activity Limitation:**  
- 0: None
- 1: Limited
- 2: Severe

**Activity Fatigue:**  
- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe

**Activity Precautions:**  
- 0: None
- 1: CAUTION
- 2: HIGH CAUTION

**Additional Observations:**  
- Temperature
- Blood Pressure
- Heart Rate
- Respiratory Rate
- Oxygen Saturation
- Weight
- Glucose

**Other Charts:**  
- Neuropsychological
- Vision
- Memory
- Balance
- Gait

---

### HITH (HOSPITAL IN THE HOME)

**Q-ADDS**

**Conditions for Patients with Chronic Abnormal Physiologic:**

- Respiratory Rate: 0-30 R/min
- Oxygen Saturation: 92-100% of normal
- Heart Rate: 60-100 B/min
- Blood Pressure: 90-140/60-90 mm Hg
- Weight: within 10% of baseline
- Glucose: within normal range

**Regulatory Rate:**

- Respiratory Rate to
- Oxygen Saturation to
- Heart Rate to
- Blood Pressure to
- Weight to
- Glucose to

**Medical Actions:**

- A: As needed
- B: As directed
- C: Every 4 hours
- D: Every 6 hours
- E: Every 12 hours

---

**Authorised by:**  

**Signed:**

**Date:**

**HOSPITAL IN THE HOME (HITH)**
Abuse

Elder Abuse

Elder Abuse in Queensland is defined as any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse can include physical, sexual, financial, psychological, social and/or neglect” (ANPEA, 1999).

Residential Aged Care has very specific requirements in relation to reporting Physical, and Sexual assault. The timeframe requires strict accountability for all staff as it must be reported to the Department of Health and Ageing and the Qld Police within 24 hours of the allegation being made by the Aged Care Facility. (The Aged Care Act.1997 amended in 2007).

Abuse of a disabled person can be recognized as an abuse of “power” as these clients are a captive market. Disability Services Qld are committed to upholding the legal and human rights of each person with a disability and taking action to prevent and/or respond to allegations of abuse and neglect.

Allegations

An Allegation is defined as - to claim that something has happened or suspected of happening on a Resident / Client in a Residential Care Facility.

Types of Abuse

Physical Abuse - Mandatory reporting under the Aged Care Act.2007 / 2011

Physical abuse is a non-accidental act resulting in physical pain or injury, may include physical coercion and physical restraint.

Physical Abuse Signs

- Bruises
- Lacerations / abrasions
- Broken or healing bones
- Burns
- Weight Loss
- Painful or restricted movements
- Agitation
- Cringing or fearful responses.
- Welts / rashes
Sexual Abuse **Mandatory reporting requirement under Aged Care Act 1997 /2011**

Any sexual activity with an adult who is unable to understand, has not given consent, is threatened, coerced or forced to engage in sexual behaviour. Can also include painful administration of enemas, or genital cleansing.

**Sexual Abuse Signs**

- Unexplained presence of infection/ disease
- Bruising to breast / thigh region
- Unexplained bleeding
- Fingertip bruising
- Torn, stained, or bloody under clothing
- Changes in sleep patterns
- Anxiety around named individuals

**Psychological / Emotional Abuse** includes name calling language, shouting, treating a person as a child, withholding affection, or actions designed to intimidate, humiliate, or harass another person. Ignoring residents / clients, disallowing a person access to family and close friends and sleep depreciation.

**Psychological/Emotional Abuse Signs**

- Loss of interest of self or environment
- Helplessness
- Withdrawal
- Apathy
- Insomnia
- Fearfulness
- Indecisiveness about making decisions • Avoidance of particular staff or persons.

**Social Abuse** involves preventing a person from having contact with family and friends and access to social activities. If a person is actively alienated from the group due to their specific spiritual beliefs, practices, or cultural and linguistic diversity, this can be seen as social abuse.

**Signs of Social Abuse**

- Sadness, grief as nobody is visiting them
- Anxiety after visits by certain people
- Withdrawn, lack of interaction with others
- Low self esteem
- Appearing ashamed
- Passivity (not wanting to participate)
- Listlessness

**Financial Abuse** involves the illegal, improper use, or mismanagement of a person’s money, property, resources, Power of Attorney and inappropriate removal of a person’s decision-making powers. Forcing a person to change their personal Will.
Signs of Financial Abuse

- Unpaid accounts
- Bill for things that the resident does not use or did not order
- Loss of jewellery or personal items
- Money missing from resident’s bank accounts
- Resident / client fearful and anxious when discussing finances or certain people are present

Neglect Abuse is the failure of a carer to provide the necessities of life to a person for whom they are caring. It can be intentional or unintentional.

Signs of Neglect Abuse

- Poor Hygiene
- Lack of personal items
- Absence of health aids
- Weight loss
- Pressure sores
- Secretiveness or agitation

Elder Abuse in the Community

- Elder abuse is not limited to occurring in residential facilities
- 88% of people aged 85 and over still reside in their homes or a home setting •
  Elder abuse is more common in the community/home setting

How to report Abuse

- Report to your line manager. The line manager of the unit or Duty Nurse Manager (after hours)
- Treat any report seriously, and act accordingly.
- Never dismiss an allegation made – always refer it for further investigation
- All suspected or actual assaults must be reported to the Line Manager or DNM after hours.
- The Director of Nursing makes the final decision on whether an official report is required.

Very strict timelines exist for reporting abuse or suspected abuse, so it is important to report your concerns ASAP.

Accountability and Responsibility

- There is an expectation that each staff member within Community & Oral Health will report suspected/actual abuse to their line manager.
- Failure to report may result in disciplinary action.
Elder Abuse Awareness Quiz
Community and Oral Health

1. What is the name of the legislated Act for Elder Abuse?
   A. Elder Abuse Act 1997 (amended 2007)
   B. Aged Care Act
   C. Qld health Aged Care policy

2. What is the process for reporting Elder Abuse with Community and Oral Health?
   A. No need to report, someone else will take care of it!
   B. Report to your line manager and/or Duty Nurse Manager!
   C. Report to a colleague and let the receptionist know!

3. Answer True or False to the following statement:
   Is there a requirement for?
   Compulsory reporting of Elder Abuse in Residential Aged Care Facilities if there is suspicion of unlawful sexual contact (sexual abuse) or unreasonable use of force (physical abuse)
   A. True
   B. False

4. Answer True or False to the following statement:
   Very strict timelines exist for reporting abuse or suspected abuse, so it is important to report your concerns ASAP.
   A. True
   B. False

5. What is the time frame for reporting Elder Abuse?
   A. 72 Hours
   B. 12 Hours
   C. 24 Hours

6. Correctly identify the five types of elder abuse
   A. Financial
   B. Communal
   C. Physical
   D. Social
   E. Neglect
   F. Familial
   G. Sexual
   H. Psychological/Emotional

7. Select True or False for the following statement:
   “Elder Abuse Prevention Unit data suggests Elder Abuse occurs predominantly with families.”
   A. True
   B. False

8. Do you understand your obligations as a student doing placement in Community and Oral Health in relation to reporting of suspected/actual abuse?
   A. Yes
   B. No
Elder Abuse Staff Training Record

I understand my responsibilities in relation to Elder Abuse?
As a Queensland Health employee, I am able to apply these principals in the workplace?

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Section 2 – Line manager certification

I confirm the above-named staff member has viewed the video presentation and read the "Elder Abuse FACT sheet" and has adequately answered the above questions in relation to Elder Abuse.

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Please forward this form to your designated data entry person for addition of training records to the Mandatory Training Register. This record must be kept with Department/Service Line of origin, in the building in a locked metal filing cabinet or in electronic form.
Available Resources

The resources and information relevant to Aged Care are available on QHEPS, RACAS.

The resources and information relevant to the Halwyn Centre, Red Hill, and the Acquired Brain Injury Centre at Bracken Ridge and Brighton are available on QHEPS

- Compulsory Reporting of Resident Assault Guidelines 01.02.10
- Compulsory Reporting form for Suspected or Actual Assault of a Resident 01.02.10A
- Compulsory reporting form for missing resident – 01:02:10B
- Response and Investigations into Allegations of Abuse, Neglect and Exploitation of Residents. 01:02:11 Links to Support Services


My Aged Care http://www.myagedcare.gov.au/


Useful Websites

Further reading
Wound Management is an ever-evolving practice with research being conducted into both practice and consumable development daily. Understanding the basics is a good starting point and once you have completed this SDLP you may wish to develop your knowledge further.
To support you the below list of resources has been compiled for you to explore further:


Wound Innovations is a Brisbane-based service that provided clinical consultations and clinician education including several online courses: [https://www.woundinnovations.com.au/](https://www.woundinnovations.com.au/)

Promoting Healthy Skin is a QUT self-directed learning package [http://promoting-healthy-skin.qut.edu.au/](http://promoting-healthy-skin.qut.edu.au/)

Wounds Australia is the peak body for wound care and management in Australia. This link will guide you to a number of resources including information as to becoming a member of the Wounds Australia society: [https://www.woundsaustralia.com.au/](https://www.woundsaustralia.com.au/)

World of Wounds is a peer reviewed online journal providing a wide range of wound related articles: [http://www.worldwidewounds.com/](http://www.worldwidewounds.com/)

European Wound Management Association is a peak body that delivers professional guidance in the field of wound care and through this link you'll find information around educational resources and international guidelines: [http://ewma.org/it/](http://ewma.org/it/)

This link to the Wounds Australia will guide you to a number of publications designed to both guide and improve clinical practice in wound care: [https://www.woundsaustralia.com.au/Web/Resources/Publications/Web/Resources/Publications/Publications.aspx?hkey=1285b5b2-6030-44c3-87c8-5222fc1a88d9](https://www.woundsaustralia.com.au/Web/Resources/Publications/Web/Resources/Publications/Publications.aspx?hkey=1285b5b2-6030-44c3-87c8-5222fc1a88d9)

Dressings is a website that contains a list of wound product data cards designed to guide clinicians and patients in understanding how and why products are used: [www.dressings.org](http://www.dressings.org)

For free access journals, search wound care/management in your itune/google play stores and download free journal apps such as “Wounds”, “Podiatry Today” and “Ostomy Wound Management”.


[https://www.heartfoundation.org.au](https://www.heartfoundation.org.au)

[https://asthma.org.au](https://asthma.org.au)
A Final Note

Thank you for attending clinical placement in Community and Oral Health, we wish you all the best in your journey into the health profession.

Cecelia

Cecelia Boyd Orford
Clinical Placement Coordinator
Community & Oral Health Directorate