Student Placement Learning Package
Community and Oral Health Directorate

DIABETES

Student Name: ____________________________________________
On behalf of the Community and Oral Health (COH) Directorate, 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 Directorate
Metro North & Hospital Health Service
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Welcome

Overview of MNHHS and Community & Oral Health Directorate

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 Womens 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 the Community and Oral Health Directorate include:

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

Image source: Queensland Health Electronic Publishing Service (QHEPS)
http://qheps.health.qld.gov.au
COVID-19 Pandemic and Clinical Placement

This new corona virus COVID-19 causes illness of varying severity spanning common cold symptoms through to more serious respiratory symptoms. Some people may not be come unwell at all, others may deteriorate very quickly.

We value clinical placements and the role of student nurses in our services, therefore our desire is to keep you informed and safe whilst on placement. We will review our student placements as the pandemic emerges and new information is known. As a result, you may see changes in the clinical placement or routine care modified to adapt to the requirements for safety.

All staff in Metro North are well-prepared to handle COVID-19 across our facilities. If you are well and remained within the State and in Australia in the past 14 days and have not been in contact with a confirmed or suspected case of COVID-19, you should attend your shift as usual.

**If you have symptoms of illness, or you have been anywhere interstate or overseas in the past 14 days, or in close contact with a confirmed or suspected case of COVID-19, you should not attend your shift.** You should contact your facilitator to advise them. You should also self-quarantine until you receive more advice from a health professional.

COVID-19 is spread through person-to-person contact like other cold and flu illnesses. The best way to protect yourself against COVID-19 is to wash your hands frequently and properly and to use provided alcohol-based hand sanitiser; refrain from touching your face, eyes, nose and mouth and keep 1.5m social distancing.

Generally students are not expected to care for COVID-19 confirmed cases, however, if you are required to care for a patient who has suspected or confirmed COVID-19, you must complete a contact log. The staff and facilitator can ensure this happens. It is very important that you follow correct PPE donning and doffing.

**Who is at risk of COVID-19?**
Everyone should take steps to keep themselves and others safe, to prevent the spread of COVID-19. However, those most at risk of serious infection include:

- people with compromised immune systems (e.g. cancer)
- elderly people
- Aboriginal and Torres Strait Islander people
- people with diagnosed chronic medical conditions
- people in group residential settings
- people in detention facilities.

**What should I do if the public ask me about COVID-19?**
A fact sheet has been prepared for you to share with members of the public, which should address any queries you receive about COVID-19. This fact sheet is paired with a map and directions to the local Screening or Fever Clinic, should these be needed. The public should be encouraged to practice hand washing with the provided product for their use when attending our facilities.

Any concerned members of the public should be directed to the Queensland Health website for further information or 13 HEALTH to discuss any health concerns or symptoms.

**Clinical suspicion and criteria for COVID-19 testing currently includes:**

- Any person who has travelled overseas within the 14 days before the onset of fever (≥38 degrees Celsius) or history of fever (e.g. night sweat or chills) or acute respiratory infection (e.g. shortness of breath, cough, sore throat) with or without fever;
• Any person with close contact in 14 days before illness onset with a confirmed case of COVID-19 and who are now exhibiting fever (≥38 degrees Celsius) or history of fever (e.g. night sweat or chills) or acute respiratory infection (e.g. shortness of breath, cough, sore throat) with or without fever;
• Any person with severe community-acquired pneumonia requiring admission, and no other cause identified, with or without recent international travel; and
• Any healthcare worker with direct patient contact with a fever (≥38 degrees Celsius) or history of fever (e.g. night sweat or chills) AND acute respiratory infection (e.g. shortness of breath, cough, sore throat).

**What should I do if I suspect I have COVID-19?**

Those who suspect they might have COVID-19 should present to a Screening or Fever Clinic for screening, but only if they have symptoms (fever, cough, sore throat, tiredness or shortness of breath) and have:

- Returned from overseas in the past 14 days;
- Have been in close contact with a confirmed case;
- Are a healthcare or aged care worker.

Those who do not meet the above requirements, do not need to be screened at this time. You should call 13 HEALTH for any other health advice.

Over the coming days and weeks of changes in our health system and community, please remember to look after yourself and your family, friends and colleagues. Our people are a precious resource and each and every one is important!

Benestar, our Employee Assistance Provider is available 24/7 by phoning 1300 360 364 to provide support and we will also be putting a range of local initiatives in place to ensure we have, and maintain a focus on healthcare worker wellbeing.

Queenslanders need us at this time to be level headed, focussed and at the top of our game. Keep up the good work.

**Isolation vs. quarantine**

There is still a lack of clarity in the community about the difference between self-isolation and self-quarantine. As healthcare professionals, it is our responsibility to help educate our community, therefore I want to take this opportunity to clarify these terms.

Self-quarantine is used to restrict the moment of a well person who may have been exposed to COVID-19 for the period of time when they could become unwell (14 days in the case of COVID-19). When people return from interstate or overseas or have close contact with a confirmed COVID-19 case, they must go into self-quarantine for 14 days. People in self-quarantine can remain at their own home, even when there are other household members – however, people in self-quarantine should stay away from others in the home, such as stay in a room away from others, sleep in a separate bedroom and use a separate bathroom. People in self-quarantine should not accept visitors. Vulnerable people, like those over the age of 60 or those with chronic disease should stay somewhere else.

Self-isolation is used to separate ill people from those who are healthy. People who test positive to COVID-19 must go into self-isolation immediately and remain in self-isolation until they have been declared recovered from COVID-19. They should strictly avoid contact with other members of their household, preferably by living alone, or only with other positive cases. If people in self-isolation do need to move around, such as attend a hospital upon the direction of their doctor, they should wear a mask, avoid contact with others, and move quickly through common areas.

If is important to note that most confirmed COVID-19 cases won’t feel particularly unwell while they are in self-isolation. They may want to go out and continue living their normal lives, however, I wanted to reiterate that just because they feel okay it doesn’t mean they won’t spread the virus. In fact, if a confirmed case leaves self-isolation it is almost certain they will spread COVID-19 to others. Please remember that this
virus can cause very serious illness, even death, particularly for older and vulnerable people in our community, therefore it is essential we stop the spread.

**Video resource PPE**

- Correct use of PPE (2.5 minutes)
- P2/N95 Mask Fit Checking (2.5 minutes)

**Where should I go for more information?**

Overview of the Package

Community & Oral Health (COH) Directorate 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 facilitated by the Student Clinical Facilitator (SCF) throughout clinical placement orientation. Please use this Orientation Package as a reference source throughout your placement.
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.*

<table>
<thead>
<tr>
<th>Student Clinical Facilitator (SCF) details</th>
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<th>Allocated Ward/Unit</th>
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<th><strong>Base Site</strong> <em>(Please tick box)</em></th>
<th>Brighton Health Campus</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>Northwest Community Health</td>
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<td>Caboolture Community Health</td>
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<td>Nundah Community Health</td>
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<th>Duration of placement (include dates)</th>
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<tr>
<th><strong>Shift Times</strong></th>
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<td>PM:</td>
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<th>University/TAFE Unit Coordinator name</th>
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<tr>
<th><strong>Fellow Students Names</strong></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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<tbody>
<tr>
<td>QLD Health Student Orientation Checklist</td>
<td>Complete on orientation day</td>
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<tr>
<td></td>
<td>Valid for 12 months</td>
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<td>Please see on the next page</td>
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<tr>
<td>Education Providers Assessment Tool</td>
<td>Interim (midway) assessment:</td>
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<td></td>
<td>Summative (final) assessment:</td>
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<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>
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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.
Elder Abuse Staff Training Record

Section 1 – Staff member’s certification

I the undersigned confirm having viewed the video presentation and read the “Elder Abuse FACT sheet” that I understand my obligations in relation to Elder Abuse and can confidently answer the following questions:

- **What is the time frame for reporting Elder Abuse?**
  
  Circle the correct response.

  I. 24 Hours
  II. 48 Hours
  III. 72 Hours

- **What is the name of the legislated Act for Elder Abuse?**
  
  Circle the correct response.

  I. Elder Abuse Act 1997 (Amended 2007)
  II. Aged Care Act 1997 (amended 2007)
  III. Aged Care Act 2010

- **What are the types of elder abuse?**
  
  Circle all that apply.

  I. Financial
  II. Communal
  III. Physical
  IV. Social
  V. Emotional
  VI. Familial
  VII. Sexual

- **Select True or False for the following statement.**
  
  “Elder abuse is more common in the community/home setting”

  True □
  False □
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.
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
Placements in COH

Community Services

*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 over the age of five, 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, 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.
Adults and Children Diabetes Service Overview

About the Service

The Adults and Children Diabetes Service aims to empower clients to make healthier decisions about managing their diabetes. The service provides clients with the skills and knowledge to self-manage and prevent diabetes related complications. Hospital in-patients, highly complex Type 2 diabetes, Type 1 diabetes, adults and children insulin pump therapy are the major services offered.

What services are available?

The service is time-limited to 12 weeks and clients will be discharged back to their GP for ongoing care. Children and adolescents with Type 1 diabetes will continue to receive care three, six and twelve monthly as required.

The service may include:

- Specialist diabetes outpatient clinics
- Paediatric diabetes clinics
- Adolescent diabetes outpatient clinics
- Credentialled diabetes educator and diabetes dietitian clinics
- Group clinical self-management education including CDE, dietitian, podiatrist, exercise physiologist, for all types of diabetes requiring education review, updating and before commencing insulin in Type 2 diabetes
- Group education / seminars – Diabetes in Schools education for staff

Services are available at the following locations:

Caboolture Community Health Centre
McKeans Street
Caboolture Qld 4510

Chermside Community Health Centre
490 Hamilton Road
Chermside Qld 4032

North Lakes Health Precinct
9 Endeavour Boulevard
North Lakes Qld 4509
DIABETES SPECIFIC INFORMATION

Welcome to your placement with the Diabetes Team

This section of the learning package will include the following;

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

The Nurse Unit Manager is Janice Kerrigan

Shift Times

0800-1630

Arrive promptly at your shift start time

On day 1 a team member will meet you in the reception area of North Lakes Health Precinct and welcome you into placement, provide orientation to the workplace and introduce you to your preceptors.

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 in your allocated facility. Fill in details below.

Bus: 
Train station: 
Parking: 

During your shift

- Two 10 minutes tea breaks & lunch/dinner break 30 (breaks to be taken in consultation with your buddy RN/preceptor. Advise staff before leaving and when returning to the clinical area.

After your shift

- Ensure 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

<table>
<thead>
<tr>
<th>Nursing</th>
<th>Administration staff</th>
<th>Allied Health</th>
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<tbody>
<tr>
<td>☐ Registered Nurse</td>
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<td>☐ Social Worker</td>
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<tr>
<td>☐ Enrolled Nurse</td>
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<td>☐ Dietitian</td>
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<td>☐ Diabetes Educators</td>
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<td>☐ Exercise physiologist</td>
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<td>☐ Nurse Unit Manager</td>
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<td>☐ Podiatrist</td>
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<td>☐ Nurse Practitioner</td>
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<td>☐ Psychologist</td>
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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
☐ Fire Extinguisher/s
☐ Fire Exits
☐ PPE
☐ Cytotoxic Spill Kit
☐ Observation equipment
☐ Blood Glucose Monitoring equipment
Scope of Practice

Activity: 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.
Safety and Quality

Activity: Occupational Violence Prevention

Complete the following questions

a) What is your understanding of occupational violence?

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: 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: Cytotoxic Precautions (See Appendix 3)

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.
Activity: 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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<th>Moment 1</th>
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<td>Moment 5</td>
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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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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: November 2019 Review: November 2020
Medications

Activity: Medications

Complete the following questions.

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

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b) Complete the following medication calculation formulas

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<td>Solution</td>
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<td>IV Infusions</td>
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<td>Drops per minute</td>
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c) What does APINCHA stand for? (See Appendix 6)

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

For more information refer to the MNHHS PROC/174: Medications Management procedure.
Clinical Handover and Patient identification

Activity: 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’ (First Name, Surname etc) are used in multiple situations such as clinical handover, documentation and procedure matching. List down 3 other patient identifiers that may be used in your work area

| I | S | B | A | R |

V1 Effective: November 2019 Review: November 2020
Pressure Injury Prevention

Activity: Pressure Injury Prevention

Complete the following questions

<table>
<thead>
<tr>
<th>a) List 3 common risks for developing pressure injuries?</th>
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<tr>
<th>b) What are some strategies you can implement to prevent the development of pressure injuries?</th>
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For more information refer to the Pressure Injury Prevention (CISSPROC0003) protocol
Emergency Response

Recognition and Responses to the Deteriorating Patient

Activity 1: Recognition and Responses to the Deteriorating Patient

Complete the following questions.

a) Complete the following acronym:

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<th>D</th>
<th>What is a Code Blue?</th>
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<td>C</td>
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⚠️ 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)
Documents and activities to support placement in the Diabetes Team

Practice Case Study

Peter has type 1 diabetes, he is a keen sportsman and plays soccer most weekends. On Saturday night he celebrated his 21st birthday with his mates after football. Peter was admitted to hospital at 0300 on Sunday with a Severe hypo. On discharge he was referred to diabetes educator for safety education for diabetes management.

1) Why might Peter have had a hypo at this time?

2) What put Peter at risk of a hypo?

3) What tips might you give Peter to prevent this happening again?
<table>
<thead>
<tr>
<th><strong>Safe Medication Proforma Week 1</strong></th>
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<tbody>
<tr>
<td><strong>Right Drug</strong> – generic name, drug family, trade names you might know it as, poison schedule</td>
</tr>
<tr>
<td><strong>Right Patient</strong> (does this drug match the patient’s condition? Explain how)</td>
</tr>
<tr>
<td><strong>Right Route</strong> – (what is the route of administration, are there other routes, are there some routes that are ‘no nos’)</td>
</tr>
<tr>
<td><strong>Right Dose</strong> – (the dose that is prescribed, is it a usual dose. Can a higher dose be given, if so why? Or lower, explain)</td>
</tr>
<tr>
<td><strong>Right Time</strong> – (what are the best times for giving this medication, does it matter?)</td>
</tr>
<tr>
<td><strong>Interesting information about this medication</strong></td>
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</table>
What I need to know about my client Week 1

Client Diagnosis

- Explain / describe the diagnosis. Why has the client been referred to this service?

Past Medical History

- What is relevant from the client’s past medical history that is important in this episode of care?

Client Medications

- What medications are prescribed? What symptom is being targeted? What is the normal dose? What are the side effects and precautions?

Domains of Care

- What are the Identified domains of care for this client?

Discipline Specific Referrals

- What referrals have been made for this client? What is the rationale for these referrals?
### Critical Reasoning Activity Week 1

#### Patient Diagnosis

#### Pathophysiology *(e.g. explain normal A&P and the way it has been changed or altered in this disease)*

#### Signs and Symptoms *(Define characteristics of the disease from findings in your nursing assessments)*

#### Clinical Management and/or Treatment *(investigations to help diagnose, medications, therapies, other interventions)*

#### Multidisciplinary Management *(Which AH/nursing/medical teams might you refer to)*
Clinical Handover Week 1

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<th>Introduction</th>
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<th>Situation</th>
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<th>Recommendation</th>
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<td>Safe Medication Proforma Week 2</td>
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<tr>
<td><strong>Right Drug</strong> – generic name, drug family, trade names you might know it as, poison schedule</td>
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<tr>
<td><strong>Right Patient</strong> (does this drug match the patient’s condition? Explain how)</td>
</tr>
<tr>
<td><strong>Right Route</strong> – (what is the route of administration, are there other routes, are there some routes that are ‘no nos’)</td>
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<tr>
<td><strong>Right Time</strong> – (what are the best times for giving this medication, does it matter?)</td>
</tr>
<tr>
<td><strong>Interesting information about this medication</strong></td>
</tr>
</tbody>
</table>
What I need to know about my client Week 2

Client Diagnosis

Explain / describe the diagnosis. Why has the client been referred to this service?

Past Medical History

What is relevant from the client’s past medical history that is important in this episode of care?

Client Medications

What medications are prescribed? What symptom is being targeted? What is the normal dose? What are the side effects and precautions?

Domains of Care

What are the Identified domains of care for this client?

Discipline Specific Referrals

What referrals have been made for this client? What is the rationale for these referrals?
## Critical Reasoning Activity Week 2

### Patient Diagnosis

### Pathophysiology *(e.g. explain normal A&P and the way it has been changed or altered in this disease)*

### Signs and Symptoms *(Define characteristics of the disease from findings in your nursing assessments)*

### Clinical Management and/or Treatment *(investigations to help diagnose, medications, therapies, other interventions)*

### Multidisciplinary Management *(Which AH/nursing/medical teams might you refer to)*
# Clinical Handover Week 2

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<th>Recommendation</th>
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V1 Effective: November 2019 Review: November 2020
Reflections for Debriefing Day 10

During your clinical placement we would like you to take some focussed notes for discussion with other students on day 10. People learn from peers discussions, so on day 10, we take advantage of the learning you all have done during your placement and give you the opportunity to share with others, so you can make meaningful clinical experiences that last a lifetime. You may find that in the afternoons when you finish clinic or get back from people homes you have some pare time, this would be a great time to pull out these activities.

Clinical Reasoning: we want you to use the clinical reasoning cycle for one (or two) patients you have observed or provided care for during this placement. There is a table of examples and 2 spare tables for you to make some notes to help you work through this process. Please note, you just need to take some notes for your own memory, there is no need for anything formal. Please remember do not use patient identifying information.

Clinical Reasoning

In the literature the terms clinical reasoning, clinical judgment, problem solving, decision making and critical thinking are often used interchangeably. We use the term clinical reasoning to describe the process by which nurses (and other clinicians) collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process (Hoffman, 2007; Kraischsk & Anthony, 2001; Laurie et al., 2001).

The clinical reasoning process is dependent upon a critical thinking disposition (Scheffer & Rubenfeld, 2000) and is influenced by a person’s attitude, philosophical perspective and preconceptions (McCarthy, 2003). Clinical reasoning is not a linear process but can be conceptualised as a series or spiral of linked and ongoing clinical encounters.

Reflection on practice

1. What have I learnt from this training that will help maintain and develop my professional knowledge and competence?
2. What else do I need to know to extend my professional development in this area?
3. Is there anything that I did not understand and wish to explore further, or read more about in order to clarify my learning/understanding?

References:


Adapted from:
Clinical Reasoning Instructor Resources Copyright © 2009, School of Nursing and Midwifery, Faculty of Health, University of Newcastle.
Figure 2: The clinical reasoning process with descriptors

- **Describe or list facts, context, objects or people.**
  - Consider the patient situation
  - Reflect on process and new learning
  - Collect cues/information

- **Evaluate outcomes**
  - Contemplate what you have learnt from this process and what you could have done differently.

- **Process information**
  - **Identify problems/issues**
  - **Establish goal/s**
  - **Synthesise facts and inferences to make a definitive diagnosis of the patient’s problem.**

- **Take action**
  - **Select a course of action between different alternatives available.**

- **Interpret**
  - Analyse data to come to an understanding of signs or symptoms. Compare normal vs. abnormal.
  - **Discern**
    - Distinguish relevant from irrelevant information; recognise inconsistencies, narrow down the information to what is most important and recognise gaps in cues collected.
  - **Relate**
    - Discover new relationships or patterns; cluster cues together to identify relationships between them.
  - **Interprete**
    - Make deductions or form opinions that follow logically by interpreting subjective and objective cues; consider alternatives and consequences.

- **Match current situation to past situations or current patient to past patients (usually an expert thought process).**

- **Predict an outcome (usually an expert thought process).**

- **Review current information (e.g., handover reports, patient history, patient charts, results of investigations and nursing/medical assessments previously undertaken).**
  - **Gather new information (e.g., undertake patient assessment).**
  - **Recall knowledge (e.g., physiology, pathophysiology, pharmacology, epidemiology, therapeutics, culture, context of care, ethics, law etc.).**
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<tr>
<th>Process</th>
<th>Description</th>
<th>Example</th>
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<td>Consider the patient situation</td>
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<tr>
<td>Collect cues/information</td>
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<tr>
<td>Process information</td>
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<tr>
<td>Identify Problem / Issue</td>
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<tr>
<td>Establish Goals</td>
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<td>Take Action</td>
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<td>Evaluate</td>
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<tr>
<td>Reflect on process and new learning</td>
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<td>Example</td>
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<tr>
<td><strong>Consider the patient situation</strong></td>
<td>Describe or list facts, context, objects or people.</td>
<td>This 60 year old patient is in ICU because he had an abdominal aortic aneurysm (AAA) surgery yesterday.</td>
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<td><strong>Collect cues/information</strong></td>
<td>Review current information (e.g. handover reports, patient history, patient charts, results of investigations and nursing/medical assessments previously undertaken)</td>
<td>He has a history of hypertension and he takes beta blockers. His BP was 140/80 an hour ago.</td>
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<td>Gather new information (e.g. undertake patient assessment)</td>
<td>I’ve checked his BP and it is now 110/60, Temp 38.4. Epidural running @ 10ml/hr.</td>
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<td>Recall knowledge (e.g. physiology, pathophysiology, pharmacology, epidemiology, therapeutics, culture, context of care, ethics, law etc)</td>
<td>BP is related to fluid status. Epidurals can drop the BP because they cause vasodilation. In ICU we have standing orders for epidural management.</td>
</tr>
<tr>
<td><strong>Process information</strong></td>
<td>Interpret: analyse data to come to an understanding of signs or symptoms. Compare normal Vs abnormal.</td>
<td>His BP is low, especially for a person who is normally hypertensive.</td>
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<td>Discriminate: distinguish relevant from irrelevant information; recognise inconsistencies, narrow down the information to what is most important and recognise gaps in cues collected.</td>
<td>His temp is up a bit but I’m not too worried about it – I’m more concerned about his BP and pulse. I’d better check his urine output and his O₂ sats.</td>
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<tr>
<td></td>
<td>Relate: discover new relationships or patterns; cluster cues together to identify relationships between them.</td>
<td>His hypotension, tachycardia and oliguria could be signs of impending shock.</td>
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<tr>
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<td>Infer: make deductions or form opinions that follow logically by interpreting subjective and objective cues; consider alternatives and consequences.</td>
<td>His BP could be low because of blood loss during surgery or because of the epidural.</td>
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<td></td>
<td>Match current situation to past situations or current patient to past patients (usually an expert thought process)</td>
<td>AAAs often have hypotension post op.</td>
</tr>
<tr>
<td></td>
<td>Predict an outcome (usually an expert thought process)</td>
<td>If I don’t give him more fluids he could go into shock.</td>
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<td><strong>Identify Problem / Issue</strong></td>
<td>Synthesise facts and inferences to make a definitive diagnosis of the patient’s problem.</td>
<td>He is hypovolaemic and the epidural has worsened the BP by causing vasodilation.</td>
</tr>
<tr>
<td><strong>Establish Goals</strong></td>
<td>Describe what you want to happen, a desired outcome, a time frame.</td>
<td>I want to improve his haemodynamic status – get his BP up and urine output back to normal over the next hour.</td>
</tr>
<tr>
<td><strong>Take Action</strong></td>
<td>Select a course of action between different alternatives available</td>
<td>I will ring the doctor to get an order to increase his IV rate and to give aramine if needed.</td>
</tr>
<tr>
<td><strong>Evaluate</strong></td>
<td>Evaluate the effectiveness of outcomes and actions. Ask: “has the situation improved now?”</td>
<td>His BP is up for now but we will need to keep an eye on it as he may still need aramine a bit later. His urine output is averaging &gt; 30mL/hr now.</td>
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<td><strong>Reflect on process and new learning</strong></td>
<td>Contemplate what you have learnt from this process and what you could have done differently.</td>
<td>Next time I would … I should have … If I had … I now understand …</td>
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Appendices

Appendix 1: NSQHS Standards 2nd edition

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, surveyors 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

Accreditation 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.

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 complaints 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 the 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 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 as possible from pain.

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 while not infringing 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.

Physical environment and safe systems

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
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 eg. all cytotoxic drugs must be prepared in pharmacy
- Substitute hazardous work processes eg. use needleless access systems
- Use barriers & technology to prevent exposure eg. 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

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


V1 Effective: November 2019 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

Appendix 8: Q-ADDS

### Q-ADDS HITH

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**Total Q-ADDS Score:**

### Instructions

- **If the patient reports any level of chest pain, please follow local chest pain procedures.**
- **If you are concerned about the patient’s gas, do the debride the tissue before consulting with a Medical Officer.**

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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.

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

Abbotts FreeStyle


FreeStyle Libre Application

Diabetes Qld

Look at the different fact sheets

Look at the different Education resources

Diabetes Australia

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