

*MODEL ETHICAL
PROTOCOLS
for
ATTENDING HEALTH CARE
PROFESSIONALS*

This protocol in no way affects the operation of the Aged care Act 1997 and Principles under that Act and should never be used as a substitute for the provisions of that Act and those Principles.

Introductory Note for Attending Health Care Professionals

The *Ethical Protocols for Attending Health Care Professionals* have been developed to facilitate discussion between nursing homes and attending health care professionals. “Attending health professionals” includes all those who visit the home to deliver professional health care, such as medical professionals, specialist nurses, dietitians, occupational therapists, and physiotherapists. The care relationship is between the attending health professional and the resident and his or her representatives for medical treatment if the resident is not competent. Often the decisions and advice of attending health professionals are for care that is implemented by the provider, nursing and other staff.

It is vital that there be a clear understanding between the attending health professional and the staff. Documentation of medical decisions and advice is most important. To avoid misunderstanding and inefficiencies, the terms used need to be unambiguous. It is helpful if there are standard ways of recording instructions on matters of ethical sensitivity.

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1.1 Ethical Responsibilities on Admission

**Based on values from the Code of Ethics,
Especially
The rights of the individual to life, liberty and security
The right to an appropriate standard of care to meet individual needs**

1.1.1 Policy

Attending health care practitioners should ensure that the provider is aware of the specific medical and other health needs of the resident.

1.1.2 Procedure

On being informed of an admission or pending admission of his or her patient to a home for the aged, medical practitioners should, with the consent of the patient, ensure that the home is informed about:

- a) what should happen in the circumstances of a medical emergency affecting the resident, including the possibility of a cardiac or respiratory arrest;
- b) medication and other prescribed treatments for which the resident will require assistance from the home;
- c) any assessment that has been made by the practitioner which involves specific measures to be taken by the provider or the staff.

1.1.3 Documentation

The above matters should be provided as written advice for inclusion in the resident's file at the home. The provider may make such advice available to the resident or the legally recognised representative(s) of an incompetent resident.

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1.2 Choice of medical practitioner and other attending health care practitioners

**Based on values from the Code of Ethics,
Especially
The right of competent individuals to self-determination
The right to an appropriate standard of care to meet individual needs**

1.2.1 Policy

Residents have the right to choose their own medical and other attending health care practitioners.

1.2.2 Procedures

The providers ensure that

- a) residents are assisted to secure the services of their own choice of medical and other health care practitioners if they are unable to make their own arrangements.
- b) in the event that a medical practitioner or other health care practitioner's assistance is required and the resident's choices are unwilling or unable to attend, then arrangement is made for the attendance of another;
- c) the relationship between the medical or other attending health care practitioner is respected as being between the resident (or his or her legally recognised representative) and the practitioner;
- d) access for attending health care practitioners chosen by the resident is facilitated, but the provider is entitled to require that the advice of attending practitioners to staff complies with the home's *Code of Ethics, Guide to Ethical Conduct*, and the philosophy and documentation standards of the home. (The latter is essential for maintaining continuity of care).
- e) attending health care practitioners are aware that they have responsibilities for the independent assessment of the health well-being of their patients and that their advice for improvements in the health care of the resident is most welcome;
- f) attending medical practitioners (and other health care practitioners when appropriate) have an important role in assessing and giving advice or instruction in relation to all matters affecting the health care of the resident but particularly matters such as the resident's status in relation to medication, nutrition and hydration, artificial nutrition and hydration, restraint, competence, the existence of mental illness and depression, not for resuscitation orders, complementary therapies and risk-taking;
- g) attending medical and other health care practitioners have the opportunity to give advice indicating the need for consultation with other health care practitioners, or for review of the resident's care plan or assessment of the level of care provided to the resident;
- h) medical practitioners are encouraged to liaise with senior nursing staff and other carers about the health care needs of the resident;
- i) attending health care practitioners are encouraged to attend to residents in a timely manner when called by the home – the resident has the right to prompt medical attention.

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1.2.3 Documentation

The provider seeks to ensure that

- a) attending medical or other health care practitioners are advised and consulted concerning appropriate standards of documentation of their advice or instructions for the care of the residents in the home and the need for a common standard for continuity of care;
- b) attending medical or other health care practitioners are advised of the particular importance of documenting in a consistent way their assessments, advice or prescriptions in relation to medication, nutrition and hydration, artificial nutrition and hydration, restraint, competence, the existence of mental illness and depression, not for resuscitation orders, complementary therapies and risk-taking – nurses will not administer medication to a resident unless the appropriate medication order is documented within legal guidelines;
- c) nursing and other staff document information required by the medical or other health care practitioners attending a resident.

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1.3 Consent

**Based on values from the Code of Ethics,
Especially
The right of competent individuals to self-determination
The right of individuals to be treated with respect
The rights of the individual to life, liberty and security**

1.3.1 Policy

Each resident [or his or her legally recognized representative(s)*] is primarily responsible for making decisions concerning his or her own care. Residents are to be adequately informed and their consent obtained for interventions by attending medical or other health care practitioners, other than emergency treatment in which there is insufficient time for consultation. The right of a resident to refuse a care intervention is to be respected. If a resident is either temporarily or permanently incompetent, or reduced in his or her ability to understand or make decisions, the resident's family and his or her legally recognised representative(s)* will be consulted in relation to consent or refusal.

The terms competent and incompetent have a legal meaning. Any labelling of people risks harm to dignity, but the terms have been used in this Handbook because they have an established meaning. "Incompetence" is complex and means more than being unable to make a decision. "Incompetence" is relative to the type of decision being made and the ability of the individual to respond in a way that is reasonably related to the circumstances.

1.3.2 Procedures

The attending medical practitioner (or other attending health care practitioner where appropriate) will take reasonable steps to ensure that:

- a) he or she explains clearly and accurately to the resident, the resident's condition, the nature of treatment options, the resident's prognosis with and without treatment, and the risks and harms inherent in any proposed treatment and which the resident would be likely to think significant in making a decision;
- b) provision is made for those with English language difficulties;
- c) where the decision to be made is a serious one, residents are encouraged to have the assistance of a relative or friend and, if they desire, to seek a second opinion;
- d) the assistance of an appropriate family member or legally recognized representative's* is to be sought when a resident's capacity to make his or her own healthcare decisions is reduced, either partially or entirely, temporarily or permanently (e.g., by mental illness, dementia, feelings of fear and vulnerability, sickness, pain, ignorance or confusion), and this assessment is supported by a clinical diagnosis by a healthcare professional with appropriate expertise;

* for accommodation or for medical treatment decisions

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- e) except in the case of an emergency, health care interventions are not to be administered to any *competent* resident until all relevant information has been disclosed and considered, and the resident's free and adequately informed consent has been given, and the resident is competent to consent, and is not being coerced or intimidated;
- f) except in the case of an emergency, health care interventions are not to be administered to an *incompetent* resident until all relevant information has been disclosed and considered by the resident's legally recognized representative, and the consent of that representative has been given;
- g) in the event that the practitioner considers that the decision of the resident's representative(s) is not based on a judgement about what is in the resident's best interests, taking into account not only the resident's medical condition and prognosis but also the resident's previously expressed and reasonable wishes, the practitioner will ensure that legal review of the representation of the resident is sought;
- h) in the case of emergency, if consent cannot be obtained, the practitioner will ensure that he or she act in the resident's best interests, following the resident's [or the resident's legally recognized representative(s)*] previously expressed and reasonable wishes and taking into account the views of the resident's family and relevant others;
- i) the moral right of residents to refuse any intervention which they judge to be futile, overly-burdensome or morally unacceptable, is respected, and that the attending healthcare practitioners does not override any refusal of treatment by a competent resident who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not the practitioner agrees with the resident's refusal.

1.3.3 Documentation

The attending practitioner will seek to ensure that there is documentation of:

- a) the process for informing the resident about and obtaining his or her consent for care interventions;
- b) the practitioners decisions concerning treatment he or she prescribes for a resident;
- c) any decisions by a resident's legally recognised representatives in relation to medical treatment; and
- d) emergency measures and any other interventions that have been delivered or withdrawn by the practitioner without the consent of a resident or his or her legally recognised representative.

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1.4 Nutrition and hydration

**Based on values from the Code of Ethics,
Especially
The right to an appropriate standard of care to meet individual needs
The right of individuals to have their religious and cultural identity respected**

1.4.1 Policy

Medical and other attending health care practitioners relevant to the nutritional status of the resident will assess and make recommendations in relation to residents whom they attend and who have difficulties in achieving nourishment sufficient to establish and maintain optimal health, taking into account individual resident's preferences.

1.4.3 Documentation

The attending practitioner is to review the documentation by staff of the actual intake of residents and the care plan devised for those for whom there is doubt about the adequacy of their intake.

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1.5 Artificial Nutrition and Hydration

**Based on values from the Code of Ethics,
Especially
The rights of the individual to life, liberty, and security
The right to an appropriate standard of care to meet individual needs
The right of individuals to have their religious and cultural identity respected**

1.5.1 Policy

Residents with swallowing difficulties (normally assessed by a speech pathologist) may require artificial delivery of nutrition and hydration (by PEG, naso-gastric tube or parenteral). Artificial nutrition and hydration is not to be initiated on the grounds of the convenience of the staff or the providers.

Nutrition and hydration should always be provided to a resident unless his or her body could not assimilate them, the resident is in an immediately terminal state in which nutrition and hydration would not help to sustain life, or the only mode of delivery would impose grave burdens on the resident.

Any resident who initially presents to a home with a previously undiagnosed eating problem, or who is already a resident and whose eating habits have altered without obvious cause, should be fully assessed to determine the cause of the problem and the most appropriate treatment. An eating problem may include lack of appetite, difficulty chewing or swallowing, or other physical disabilities that impede eating. These problems ultimately may or may not require artificial nutrition and hydration.

1.5.2 Procedure

Attending practitioners will review and assess the needs and circumstances of the resident to ensure that:

- a) residents with swallowing difficulties are assessed by a speech pathologist where available or other appropriate health care professional;
- b) residents with an undiagnosed eating problem, or an altered eating pattern that continues and poses a threat to the resident's nutritional status, are assessed by the most appropriate health professional;
- c) there is medical guidance and review of artificial nutrition and hydration for those who require it.

1.5.3 Documentation

- a) The attending practitioner should review the resident's care plan and give advice so as to ensure that the care plan reflects any identified eating problem, that the appropriate assessments have been made, and that the appropriate outcome or treatment has been instigated.
- b) The review and advice is to be recorded.
- c) The rationale for artificial nutrition and hydration is to be recorded by the health care practitioner who orders such treatment, the type and frequency of the nutrition required, together with specific monitoring and evaluation of the artificial feeding.

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1.6 Palliative care

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The right to an appropriate standard of care to meet individual needs
The right of individuals to have their religious and cultural identity respected**

1.6.1 Policy

Specialist palliative care should be available to all residents who are suffering mentally or physically. In the case of a dying resident, palliative care is especially oriented to caring for, and accompanying, the dying person and his or her carers in the final phase of life, upholding that person's dignity and respecting his or her spiritual, physical, emotional, cultural, and social needs. It also encompasses care for the bereaved family and others. Though it is integral to all health care, the relief of symptoms has a special place in the care and support offered to people with advanced, progressive disease. (See Protocol 1.7, *Care of the Dying*).

1.6.2 Procedure

Attending medical practitioners should seek to ensure that their patients have access to palliative care expertise, including specialist referral, if required, or by distant communication if necessary.

1.6.3 Documentation

The palliative care needs of residents who are suffering pain or discomfort are to be documented. Attending medical practitioners should review the care plan in this respect and document any prescriptions or advice issued.

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Care of the dying

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Especially
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The right of competent individuals to self-determination
The right to an appropriate standard of care to meet individual needs
The right of individuals to have their religious and cultural identity respected**

1.7.1 Policy

Attending practitioners should give advice in order to assist carers within the home to be especially aware of the needs of dying residents (and their families) for respect, love and care.

1.7.2 Procedures

a) Establishing Trust

A resident who knows that his or her life is nearing its end, and in particular that an illness is likely to end in death, may need an increased level of support from healthcare practitioners. The practitioner should aim to establish a relationship of trust, compassion and confidence with the resident in his or her care, and, thereby place their humanity, knowledge, experience and skill at the service of the dying resident and the resident's family and significant others.

b) Avoiding Over and Under Treatment

When evaluating the use of life-sustaining technologies, two extremes should be avoided: on the one hand, an insistence on futile and overly-burdensome treatments, and on the other hand, the deliberate withdrawal of reasonable care in order to bring about death. Since good medicine treats a person rather than a condition, respect for persons requires that they neither be under-treated nor over-treated. Rather, when people are dying they should have access to the care that is appropriate to their condition. (See protocol on Consent)

c) Depression and Dying

In receiving physical, psychological, social, cultural, and spiritual support, residents may need help to make the most of what remains of their lives, not only by the alleviation of their suffering but also by the respect accorded their personal dignity. Vulnerable residents may need to be protected from pressures that lower their self-esteem or encourage self-abandonment. They may need help not only with the many symptoms of illness such as pain and discomfort and its psychological sequelae - anxiety, fear and distress, but also with its spiritual effects such as crises of faith, hope and love. Since depression, for example, is often an unrecognised and untreated symptom of illness, attending practitioners should strive to ensure that there is adequate medical and nursing assistance to relieve it. Attending practitioners must ensure that there is adequate professional assessment and assistance available to dying residents.

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1.7 Euthanasia

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The rights of the individual to life, liberty, and security
The right to an appropriate standard of care to meet individual needs**

1.8.1 Policy

In the care of dying residents, the attending practitioner's aim is to maximise the residents' capacities to live their remaining life as fully as possible, to relieve discomfort and distress, and to provide reasonable, supportive care throughout the dying process. It is never permissible for the practitioner to instigate, co-operate with or ignore the deliberate ending a resident's life (whether that decision is made to relieve a resident's suffering by euthanasia, to comply with the wishes of the family, to assist suicide, or to vacate a bed). By *euthanasia* is meant deliberately bringing about death by action or by neglect of reasonable care in order to end suffering by ending life (See *Care of the Dying*, especially 1.7.2(b)). Examples of euthanasia include administering deliberate overdoses of otherwise appropriate medications, and the withholding or withdrawing of reasonable life-sustaining forms of care.

1.8.2 Procedure

Attending medical and other practitioners

- a) are asked to comply with the law and the philosophy of the home in relation to the care of the dying, and are informed that it is the policy of the provider in the event of euthanasia being attempted to report such matters to the police;
- b) should ensure that adequate expert advice and assistance is provided to relieve discomfort and to give emotional and social support. (see protocol on Palliative Care)

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1.8 Not for Resuscitation

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The right to an appropriate standard of care to meet individual needs
The right of competent individuals to self-determination**

1.9.1 Policy

A not for resuscitation (NFR) order is a prior instruction issued by the resident's own doctor to be acted upon in the event of the resident arresting. An NFR order is specific to the urgent circumstances of an arrest and does not signify withholding ordinary care. In the circumstances of a resident arresting and in the absence of an NFR order staff will initiate those resuscitative measures which are within their training and competence. They will call for emergency assistance unless there is an adequately documented decision, issued within the past six months and authorised by the patient's own doctor (after consultation), instructing that the resident is not for resuscitation.

1.9.2 Procedure

Attending medical practitioners will ensure that, if an NFR order is in his or her opinion warranted, the requirements for issuing an NFR order are met. They include:

a) Indications

An NFR order may be issued when:

- i. A resident of sound mind and free of any suicidal ideation or temporary depression, and in possession of the relevant medical information about his or her condition, makes a competent decision, free from any coercion by others, to refuse resuscitative interventions that the resident would consider to be overly burdensome or futile (unlikely to succeed), were he or she to arrest;
- ii. The resident's legally recognised representative for medical treatment decisions, in possession of the relevant medical information about the resident's condition, has reasonable grounds for believing that the resident, if competent, would refuse resuscitative interventions on the grounds that they would be overly burdensome or futile were he or she to arrest; or
- iii. The resident's doctor judges that the resident's condition is such that in the event of an arrest attempts to resuscitate would be futile or would in themselves be overly burdensome for the resident.

b) Consultation

In making an NFR order the resident's doctor should consult the resident (if possible), the resident's legally recognised representative for medical treatment, his or her family, nurses, and other carers.

c) Documentation

To be valid, an NFR order must contain the following information:

- i. date of the order
- ii. date for review of the order (no more than six months)

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- iii. those consulted (including the resident, if competent, or the resident's legal representative for medical treatment if there is one).
- iv. the indication for issuing an NFR Order
- v. treatment to be continued (eg. clearing blocked airways, oxygen, medication for existing conditions such as antibiotics)
- vi. specific resuscitative measures to be withheld (eg. calling an ambulance for full scale para-medical resuscitation or attempting cardiac massage or intubation)
- vii. doctor's signature and contact details.

1.10 Risk-taking

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The rights of the individual to life, liberty, and security
The right of competent individuals to self-determination**

1.10.1 Policy

Risk taking is a normal part of everyday life and residents are not necessarily deprived of this right as long as they do not unreasonably threaten their own or others' safety or rights.

1.10.2 Procedure

On or soon after admission, discussion between the attending health care practitioner and the provider should take place if there are measures the practitioner considers warranted to ensure the safety of the resident and others. The resident's wishes and right to choose to participate in activities which involve a degree of risk are to be respected.

1.10.3 Documentation

The attending health care practitioner will ensure the discussion of special measures for a resident's participation in potentially risky activities is well documented.

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1.11 Care of persons with mental illness or dementia

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The rights of the individual to life, liberty, and security
The right to an appropriate standard of care to meet individual needs**

1.11.1 Policy

Mental illnesses and dementia vary in extent and kind. People with mental illness or dementia, including those who are aged, have the same rights as every other member of the community. The practitioner has a responsibility to assess and give advice in order to ensure that residents who are living with mental illness or dementia are offered appropriate assistance. Residents in need of mental health treatments should have access to services that enable them as far as possible to recover their mental health and to function and live life as fully as their health allows. Psychiatry and counselling have as their goal not social control but care and support of the individual. They should always be conducted in ways that respect the dignity and privacy of residents. Physical and chemical restraints should only be used as a last resort to protect the resident or others from harm (see section headed “Restraints”).

1.11.2 Procedure

The attending practitioner is responsible for ensuring that the development of mental illness or dementia in a resident is not to be ignored or taken for granted in an older person, by:

- a) arranging for appropriate medical investigation to determine whether the condition is reversible or may improve with treatment;
- b) reviewing care plans.

1.11.3 Documentation

The medical practitioner should:

- a) Specify in writing any medical investigation undertaken or to be undertaken and any treatment decisions made by him or her;
- b) Specify any advice concerning the physical and social environment;
- c) Specify and advice concerning cultural and linguistic needs; and
- d) Review any safety measures undertaken and any documentation relating to restraint (see section headed “Restraints”).

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1.12 Restraint

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The rights of the individual to life, liberty, and security
The right to an appropriate standard of care to meet individual needs**

The term restraint as used in this protocol includes any means by which physical, chemical or environmental restriction of the person is achieved.

1.12.1 Policy

Restraint is a very rare intervention because it is the deprivation of freedom of one person by another person or persons. Use of restraint inhibits a person's independence and can reduce their safety and well being. Any decision to use restraint of whatever kind is not to be taken lightly and the best interests of the resident should always be paramount. Every effort is to be used to identify what those best interests are.

1.12.2 Ethical Issues in Practice

- a) Alternatives to restraint are to be considered and implemented prior to a decision being made to use restraint.
- b) The well being of the resident is the primary consideration in the decision making process and during the period of any restraint.
- c) Restraint is to be used only as a last resort and only to the extent necessary to prevent harm and in compliance with the law.
- d) The least restrictive option, in terms of restraint type and duration, is to be adopted if a decision is made to use restraint. Any use of restraints will be monitored and reviewed and will be employed as part of an overall care plan devised in consultation with all those who care for the resident, his or her family and legal representative.
- e) Care planning will first be aimed at reducing the need for restraint and then if restraint is used, minimising the impact of restraint on the resident and compensating for any social and psychological adverse effects.
- f) Best practice procedures and protocols are developed by the home to protect the resident and to assist the staff in all matters related to restraint.

1.12.3 Documentation

Documentation is to include all aspects of the decision making process, outcomes of that process, implementation and outcomes of any strategies.

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1.13 Privacy and confidentiality

**Based on values from the Code of Ethics,
Especially
The right to privacy and confidentiality**

1.13.1 Policy

In entering into a relationship with a healthcare practitioner, a resident provides information of a private nature in order to facilitate his or her care. The trust that is established between the resident and the practitioner is dependant on the latter using that information only in the resident's interests and according to his or her wishes or presumed wishes.

1.13.2 Procedures

- a) Respect for confidentiality will not normally exclude the resident's family and/or friends from participating in the care of the resident. While healthcare practitioners should support the resident's family and friends in their efforts to care for him or her, they should not fail to respect the resident's right to decide who shall be privy to healthcare and other personal information. Conversations with family and carers others should give priority to the resident's wishes and must not exclude the resident from discussions or decisions about his or her own health care.
- b) In the event of the resident's incompetence, then the matter of who may receive confidential information is a matter for the legally recognised representative(s) and those others whom the resident has already admitted or might reasonably be presumed to want admitted into his or her confidence.
- c) Much healthcare information is stored in medical files, electronic records, healthcare databases and genetic registers. To the extent that records identify a resident they should be treated as confidential and should only be accessible to those in a therapeutic relationship with the resident, in accordance with privacy principles, unless he or she or the legally recognised representative has consented to further access. In some situations it may be appropriate for healthcare professionals to encourage residents to share information for the sake of the health of others. In rare cases it may be morally or legally necessary for healthcare professionals to divulge confidential information in order to prevent serious harm to the patient or to others.

1.13.3 Documentation

Appropriate forms of protection of healthcare and other personal information about residents should be implemented to ensure patients have confidence in the system of recording and maintaining information.

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1.13 Complementary therapies

**Based on values from the Code of Ethics,
Especially
The right of the individual to be treated with respect
The right of competent individuals to self-determination
The right of individuals to have their religious and cultural identity respected**

1.14.1 Policy

Residents have a right to use complementary therapies. Complementary therapies are therapies other than those usually applied in traditional Western medicine. There is a broad range of complementary therapies many of which have an empirical basis. Staff may cooperate with residents in the use of such therapies provided they are known to be safe and administered according to any safety information provided.

Sometimes residents may request a test or treatment or place conditions on their treatment, which an attending healthcare professional judges to be unreasonable. Those engaged in the care of the resident should endeavour to explain to the resident why they think the desired test, treatment or conditions are unreasonable. They shall explain why they are not obliged to comply with the resident's request for assistance or, in some cases, to undertake further care of the resident.

1.14.2 Procedure

The resident's medical practitioner and pharmacist should be informed about any complementary therapies being used and they should give advice about their safety, especially in relation to interaction with medication prescribed.

1.14.3 Documentation

Complementary therapies should be documented so as to be available for the information of attending healthcare practitioners and other carers.

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1.15.1 Elder Abuse

**Based on values from the Code of Ethics,
Especially
The right of individuals to be treated with respect
The rights of the individual to life, liberty and security**

People who are aged are sometimes subjected to abuse by those who exploit their increasing frailty. That abuse may take the form of neglect, financial exploitation, theft, violence, threats of violence or other behaviour that causes distress or physical harm.

1.15.1 Policy

Attending health care practitioners are encouraged to be vigilant and, where there is reasonable suspicion, they should report the matter so that appropriate investigation and management to prevent further abuse can occur. That investigation and management should respect the rights and needs of the victim, the rights of those suspected, (especially their right to a good name), and the need for a just resolution for all concerned.

1.15.2 Procedure

Attending practitioners should report knowledge or suspicion that a resident is the subject of abuse to a senior staff member or the chief executive officer, and if necessary to the police or other relevant authorities.

1.15.3 Documentation

Attending practitioners should document such suspicions and any action that they have taken. Such documentation should be such as to be held confidentially and made available only to those who need it for appropriate investigation and management, including the police or other authorities.

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