

*MODEL ETHICAL  
PROTOCOLS  
for  
NURSES*

**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.**

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### **Introductory Note for Nurses**

These *Ethical Protocols for Nurses* are meant to assist nurses employed in a residential aged care setting and who have the overall responsibility for the day-by-day care of residents. Nurses have a unique contribution to make to the care of residents of aged care homes, both within their individual practice and as part of a multidisciplinary team.

The nursing profession's own Code of Conduct and Code of Ethics are in no way diminished by the *Ethical Protocols for Nurses*. The *Ethical Protocols for Nurses* have been developed to identify specific circumstances in aged care homes where ethical issues may arise for nurses, and to provide appropriate guidance for their resolution.

Nurses include registered nurses at all levels and enrolled nurses (or however named). Nurses at different levels have different responsibilities.

**These protocols in no way replace, or seek to amend, clinical procedures as they relate to good clinical practices or best practice. They are intended to be a guide to good ethical practice.**

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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**

In meeting the needs of residents, nurses need to be aware of the expectations and specific personal, cultural and religious needs that the resident has in relation to the care being offered, and which was documented before or on admission. Nurses also need to undertake an assessment of the specific physical, emotional, safety, cultural, language, and social needs of the resident as soon as is practicable following admission and document these needs in an individually designed care plan, and complete any other related documentation that is required by the provider. Nurses should also be aware of the specific needs of the resident and the expectations that the resident has in relation to the care being offered, any limitations in the provision of care, and the standards of conduct and ethical practice upheld by the home. Importantly, nurses' skills are required to assist the resident to settle as easily as possible into a new environment, utilising other staff and/or volunteers as appropriate.

### **1.1.2 Procedure**

Nurses are important to the admission process, making sure that:

- a) the resident is provided with an orientation of the environment and is made as comfortable as possible;
- b) an appropriate and full assessment of the needs of the resident is undertaken;
- c) the resident has any immediate physical, emotional and safety needs attended to;
- d) the resident is provided with appropriate explanation of all processes of admission;
- e) the resident is introduced to other residents as appropriate;
- f) the resident is able to access those facilities within the home that the resident might require; and
- g) he or she knows what action is required in the circumstances of a medical emergency affecting a particular resident.

### **1.1.3 Documentation**

Nurses should ensure appropriate documentation to provide for continuity of care.

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## 1.2 Unjust Discrimination

**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 individuals to have their religious and cultural identity respected**

### 1.2.1 Policy

Unjust discrimination can result in harassment which is unwelcome, offensive, frightening or discomforting conduct. Harassment may consist of sexual advances, jokes that are sexist, racist, agist, or otherwise discriminatory, posters that are agist, sexist, racist or otherwise discriminatory. Compliance with the Commonwealth legal provisions\* concerning equal opportunity in relation to residents is essential. Unjust discrimination also raises ethical problems requiring nurses to be aware of their own behaviour in this regard and also the behaviour of other staff and volunteers, and to respond to instances of unjust discrimination.

### 1.2.2 Procedure

Nurses, because of their role and education are well positioned to contribute to:

- a. raising awareness in other staff of practices of unjust discrimination;
- b. preventing instances of unjust discrimination,
- c. referring complaints about unjust discrimination or harassment to the person designated to receive complaints. (see Protocol 1.16 on *Complaints*).
- d. treating residents and other staff justly;
- e. protecting people who make complaints, or witnesses, so that they are not victimised;
- f. treating seriously reports of unjust discrimination or harassment;
- g. recognising sexual harassment as illegal and subject to disciplinary action;
- h. referring complaints about unjust discrimination or harassment to the person designated to receive complaints. (see Protocol 1.16 on *Complaints*).

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\* including the *Human Rights and Equal Opportunity Commission Act*, the *Disability Discrimination Act*, *Sex Discrimination Act*, *Race Discrimination Act 1983*, the *Sex Discrimination Act 1984*, the *Disability Discrimination Act 1992*, the *Equal Opportunity for Women in the Workplace Act 1999* and the *Equal Opportunity (Commonwealth Authorities) Act 1987*

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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 recognised representative(s)\*] is primarily responsible for making decisions concerning his or her own care. To be able to make these decisions residents need to be adequately informed of their right to consent to care interventions other than emergency treatment in which there is insufficient time for consultation. A “care intervention” is any additional intervention, or withdrawal or withholding of an intervention, in the care of a resident other than that understood to be the normal process of care accepted and agreed upon previously. The legal right of a resident to refuse a care intervention is primary and needs to be respected. If a resident is either temporarily or permanently, legally 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

Nurses are positioned to meet the needs of residents, and to observe and promote their rights in relation to consent by:

- a. ensuring that healthcare practitioners take care to explain clearly and accurately 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. supporting the resident to seek the assistance of a relative or friend and to seek a second opinion when necessary, where the decision to be made is a serious one;
- c. seeking the assistance of an appropriate family member or legally recognised representative(s)\*, when it is assessed by a healthcare practitioner with appropriate expertise, that a resident's capacity to make his or her own healthcare decisions is

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\* for accommodation or for medical treatment decisions

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- reduced, either partially or entirely, temporarily or permanently (eg., by mental illness, dementia, feelings of fear and vulnerability, sickness, pain, ignorance or confusion);
- d. not administering to any *competent* resident any care intervention, until all relevant information has been disclosed and considered, and that the resident's free and adequately informed consent has been given, except in the case of an emergency;
  - e. not administering care interventions to an *incompetent* resident until all relevant information has been disclosed and considered by the resident's legally recognised representative, and that the consent of that representative has been given, except in the case of an emergency;
  - f. referring to the provider and discussing with the resident's medical practitioner, concerns that may arise when the nurse 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, and if necessary, seeking legal review of the representation of the resident;
  - g. acting in the resident's best interests in the case of emergency, if consent cannot be obtained, following the resident's [or the resident's legally recognised representative(s)\*] previously expressed and reasonable wishes and taking into account the views of the resident's family and medical practitioner;
  - h. respecting the residents' right to refuse any intervention which they judge to be futile, overly-burdensome or morally unacceptable;
  - i. not overriding any refusal of treatment by a competent resident who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not the nurse or medical practitioner agrees with the resident's refusal; and
  - j. following established processes to report any intervention contrary to the legally recognised wishes of the resident, of which the nurse is aware.

### **1.3.3 Documentation**

It is essential that nurses ensure there is documentation of:

- a. care decisions by a resident's legally recognised representative(s) for accommodation and medical treatment; and
- b. emergency measures and any other care interventions that are taken without the consent of a resident or his or her legally recognised representative.
- c. Any refusal of care by a resident or their legally recognised representative must be documented together with any other specific advice.

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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

Residents are to be provided with a variety of nutritious foods and fluids sufficient to establish and maintain optimal health and taking into account individual resident's preferences. Also see Protocol 1.5 on *Artificial Nutrition and Hydration*.

### 1.4.2 Procedure

Residents are in need of, and have a right to nutritious food and fluids, which nurses can influence by:

- a. ensuring that residents are offered a variety of fresh foods from the five food groups where the resident is able to eat and in accordance with the expressed preference of the resident;
- b. consulting a dietician on matters relating to nutrition and diet therapy when assessed as necessary;
- c. meeting residents' reasonable food preferences and cultural requirements where known;
- d. monitoring that individual food and fluid *actual intake* is nutritionally adequate and seeking advice if there is doubt; and
- e. monitoring that residents receive food in a timely way and at an appetising and safe temperature.
- f. For residents with swallowing difficulties see Protocol 1.5 on *Artificial Nutrition and Hydration*..

### 1.4.3 Documentation

The actual intake of residents needs to be documented and a care plan devised for those for whom there is doubt about the adequacy of their intake.

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## 1. 1.5 Artificial nutrition and hydration

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### 1.5.1 Policy

Residents with swallowing difficulties (normally assessed by a speech pathologist) or other pathology, may require artificial delivery of nutrition and hydration (by percutaneous endoscopic gastrostomy (PEG), naso-gastric tube or parenterally). Artificial nutrition and hydration is to be initiated on the advice of the resident's doctor or dietician.

A resident requires nutrition and hydration unless his or her body cannot assimilate them, if the resident is in an immediately terminal state, or if the only mode of delivery would impose grave burdens on the resident.

An assessment needs to be made of 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, 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

Nurses are able to support the nutritional status of residents by:

- a. referring residents with swallowing difficulties to a speech pathologist or other appropriate health professional where available;
- b. undertaking a swallowing assessment in the absence of a speech pathologist if he or she is the most qualified person to do so;
- c. referring residents with an undiagnosed eating problem, or an altered eating pattern that continues to pose a threat to the resident's nutritional status, to the most appropriate health care practitioner for review;
- d. requiring review of artificial nutrition and hydration by an appropriate health professional;
- e. monitoring residents who require artificial nutrition and hydration for safety, side effects, and response;
- f. providing adequate training to other employed carers so they can care for those requiring artificial nutrition and hydration; and
- g. devising suitable means to meet the social and psychological needs of those deprived of an ordinary meal event.

### 1.5.3 Documentation

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The resident's documentation should clearly indicate any identified eating problem, the assessments made and by whom, the treatment and its outcomes, and monitoring and evaluation of the problem. 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.

## 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 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 on the *Care of the Dying*).

### 1.6.2 Procedure

Nurses are part of a multidisciplinary team or in some areas are the sole health care practitioners who provide palliative care, and by virtue of their role are in a position to:

- a. ensure all residents have access to palliative care as required;
- b. refer the resident to another relevant health professional (by distance communication if necessary), when the resident requires specific palliative care expertise outside the scope of the home's staff expertise; and
- c. ensure the development of palliative care knowledge and skill, among staff, where palliative care knowledge is lacking.

### 1.6.3 Documentation

The palliative care needs of residents are to be documented and a care plan developed.

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## 1.7 Care of the dying

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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

Nurses aim to provide for the needs of dying residents (and their families) for respect, compassion and care. Nurses are able to, and should, provide hope and comfort at a time when many people find it very hard to face the dependency, helplessness and discomfort that may accompany the process of dying.

### 1.7.2 Procedures

**a. Residents and their families have many specific needs during the dying process, which the nurse can meet by:**

- i. assessing those needs, and providing and coordinating care to meet them;
- ii. providing a high standard of care to meet all the physical, emotional and spiritual needs of the resident and the resident's family; and
- iii. utilising the combined expertise of a multidisciplinary team of health professionals since no one health professional can meet all the needs of a dying person.

**b. 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 family, carers and healthcare practitioners. When caring for a dying resident, nurses seek to establish a relationship of trust, compassion and confidence with all those in their care, and, thereby placing their humanity, knowledge, experience and skill at the service of the dying resident and the resident's family and significant others.

**c. 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 health care 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. Decisions regarding this care are determined by the resident or legally recognised representative and communicated within the multidisciplinary team caring for the resident. (See Protocol 1.3 on *Consent*).

**d. 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

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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 effects - anxiety, fear and distress, but also with its spiritual effects. Depression may become an unrecognised and untreated symptom of illness and nurses should ensure that there is adequate professional assistance to relieve it.

## 1.8 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 nurse'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. Despite any personal beliefs to the contrary, it is never permissible for nurses to end or to cooperate in 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, or to hurry death). *Euthanasia* means a deliberate act to bring about death by action or by neglect of reasonable care in order to end suffering by ending life. (See Protocol 1.7, *Care of the Dying*). Examples of euthanasia include administering deliberate overdoses of otherwise appropriate medications, and the withholding or withdrawing of reasonable life-sustaining forms of care where the person has not made those wishes clear.

### 1.8.2 Procedure

Nurses are sometimes put in a difficult position when a resident is dying, although by recognising their legal and ethical responsibilities, they can best support the resident and protect themselves by:

- a. complying with the law by not being a participant in the practice of euthanasia;
- b. reporting any such incidents;
- c. providing adequate care to relieve discomfort and to give emotional and social support; (see Protocol 1.6 on *Palliative Care*); and
- d. making decisions about treatment and interventions for a resident who is dying, in conjunction with the resident, family or legal representative(s), and other members of the health care team.

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## 1.9 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 or other medical emergency and does not signify withholding ordinary care. In the circumstances of a resident arresting, nurses initiate those resuscitative measures which are within their training and competence, unless there is an adequately documented decision, following consultation with the resident or the resident's representative(s), issued within the past six months and authorised by the resident's own doctor, instructing that the resident is not for resuscitation.

### 1.9.2 Procedure

In order to comply with an NFR order nurses need to be aware of the resuscitation status of individual residents in their care, and the significance of an NFR order and the requirements for an NFR order which include:

#### a. Indications

An NFR order may be issued when:

- i. a resident of sound mind and free of any suicidal ideation (fixation) 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.

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**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)
- iii. those consulted (including the resident, if competent, or the resident's legal representative for medical treatment if there is one).
- iv. indications 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)
- viii. doctor's signature and contact details.

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## 1.10 Risk-taking

**Based on values from the Code of Ethics,  
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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. If appropriate to the resident's situation, discussion should take place on admission and when indicated, concerning the level of risk-taking that the resident (or representative) considers appropriate. Discussion should also include the steps a nurse will take to ensure the safety of the resident whilst respecting his or her wishes and right to choose to participate in activities which involve a degree of risk.

### 1.10.2 Procedure

Frail older people need to be well supported and protected within their decision making and their rights concerning risk-taking. Nurses are able to achieve this and have a responsibility to do so by:

- a. counselling residents, relatives and legally recognised representatives\* on the need for balance between the duty of care owed by staff to residents and the right of individual residents to participate in risk-taking activities;
- b. explaining to the residents, relatives and legally recognised representatives, the nurse's responsibility and commitment and legal duty to provide for the overall safety of residents; and
- c. monitoring, and preventing agreed risk taking behaviour of a resident from threatening the safety of other residents or staff.

### 1.10.3 Documentation

Residents potentially risk-taking behaviour is to be well documented.

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\* for accommodation and medical treatment decisions

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## 1.11 Care of persons living 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. Nurses have a responsibility to ensure that residents who are living with mental illness or with dementia are offered appropriate assistance. Psychiatry and counselling have as their goal, care and support of the individual, rather than social control. Care should always be provided 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 Protocol 1.12 on *Restraints*).

### 1.11.2 Procedure

Residents with mental illness or dementia should not be ignored or taken for granted, and they should be supported, have their needs met and be safe. Nurses are able to provide appropriate care, and should do so by:

- a. ensuring appropriate assessment by a health professional, of residents with symptoms of mental or cognitive impairment to determine whether the condition is reversible or may improve with treatment;
- b. developing a care plan that is founded upon medical, nursing, occupational therapy and other professional advice;
- c. adjusting the resident's living environment to maximise the capacity of the resident to function normally; and
- d. ensuring the safety of the resident and others, which may include modifications to the environment, better assessment and management of the resident's symptoms, or application of restraint.

### 1.11.3 Documentation

The care plan should specify:

- a. any nursing and other health care practitioner assessments and decisions regarding treatment, and any evaluations undertaken;
- b. decisions concerning the physical and social environment;
- c. decisions concerning cultural and linguistic needs; and
- d. safety measures and any documentation relating to restraint.

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## 1.12 Restraint

**Based on values from the Code of Ethics,  
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The right of individuals to be treated with respect  
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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 as developed by the home to protect the resident and to assist the staff in all matters related to restraint, are to be followed.

### 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 home, the resident normally gives much personal information to the home. The trust that is established between the resident and his or her carers is in part, dependant on the carers using that information only in the resident's interests and according to the resident's wishes or presumed wishes. Personal privacy and modesty should be respected and protected.

#### 1.13.2 Procedures

In respecting the privacy and confidentiality of the resident, nurses will understand that:

- a. respect for confidentiality will not normally exclude the resident's family and/or friends from participating in the care of the resident. While nurses should support the resident's family and friends in their efforts to care for the resident, they should respect the resident's right to decide who shall be privy to healthcare and other personal information. Conversations with family, carers and significant 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 being incompetent, 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 unless he or she or the legally recognised representative has consented to further access. In some situations it may be appropriate for nurses to encourage residents to share information for the sake of the health of others. In rare cases it may be ethically or legally necessary for nurses to divulge confidential information in order to prevent serious harm to the patient or to others; and
- d. certain precautions need to be employed, such as:
  - i. being mindful of not discussing the resident's affairs when in the hearing of other residents or relatives or any other unauthorised persons;
  - ii. refraining from discussing a resident with another resident unless specific permission is provided by the resident in question;

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- iii. only discussing specific information about the resident with other staff who have a need to know that information for the benefit of the resident.
- e. the resident's personal modesty and privacy is to be respected at all times and that appropriate action is to be taken to ensure this is recognised and protected by all staff.

### **1.13.3 Documentation**

Healthcare and other personal information about residents should be protected from unauthorised persons. A record is made of the names of those persons whom the resident has specifically requested be provided with his or her health information.

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## **1.14 Conscientious objection**

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The right of individuals to be treated with respect  
The right of individuals to have their religious and cultural identity respected**

The issue of conscientious objection arises when a person has a deeply held personal moral objection to a particular procedure.

### **1.14.1 Policy**

Nurses have a right to withdraw their involvement in activities to which they have a moral objection provided that the timing and nature of their withdrawal is not such that they endanger the safety and well-being of residents in their care, their colleagues or others.

### **1.14.2 Procedure**

Where possible nurses should be encouraged to give advanced notice of the types of activity to which they would have conscientious objection, as soon as it becomes known that they may be asked to be involved, so that other arrangements can be made.

### **1.14.3 Documentation**

Conscientious objection should be recorded to facilitate management and to ensure that responsibility is taken for alternative care of the residents.

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## **1.15 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**

### **1.15.1 Policy**

Residents have a right to use complementary therapies, especially as the effect of many of them has been validated by research. Complementary therapies are therapies other than those usually applied in traditional Western medicine. Staff may cooperate with residents in the use of complementary therapies provided they are known to be safe and that the therapies are administered according to any safety information provided.

Sometimes residents may request a complementary therapy, which a nurse judges to be unreasonable. Nurses should endeavour to gain clarification from the pharmacist or the resident's doctor and explain to the resident why the desired therapy could be harmful and why they are not obliged to comply with the resident's request for assistance.

### **1.15.2 Procedure**

Nurses often use/administer complementary therapies, either at the request of the resident or as part of an holistic approach to care and when doing so should take precautions such as:

- a. seek informed advice from the resident's doctor and/or pharmacist as to the safety of the therapy, especially when used in conjunction with conventional medication;
- b. obtain consent from the resident if the therapy has not been initiated by her or him;
- c. monitor the resident for any side effects;
- d. determine if there are any adverse effects to other residents, such as odour, or risk of injury; and
- e. refuse to administer any complementary therapy if considered to be unsafe, or if there is doubt about its safety.

### **1.15.3 Documentation**

The use of complementary therapies, safety issues addressed, and monitoring process should be documented.

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## 1.16 Complaints

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

### 1.16.1 Policy

Residents and staff have a right to be secure in the environment of the home and in going about their activities. Nurses seek to support residents in a home in which they can function freely and as well as their health permits. In the event that residents' rights and freedoms, or their enjoyment of the home may be in any way compromised, nurses should support residents to make a complaint without fear of reprisal. Nurses also support other staff to report or raise concerns of a professional nature.

### 1.16.2 Procedure

- a. Nurses are able to, and should, support the resident or family to make a legitimate complaint by:
  - i. making available information about internal and external complaint processes;
  - ii. respecting the confidences of the complainant including his or her identity if that is requested or warranted;
  - iii. treating the complainant with respect; and
  - iv. bringing to the notice of the provider activities by a staff member, directed against a resident, family or staff who is making a complaint.
- b. If a nurse believes that he or she has a legitimate concern about personal or professional issues, then these should be raised with the person designated to receive complaints.
- c. Nurses should support other staff to make a legitimate complaint through the appropriate mechanisms within the home.

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### **1.17 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**

#### **1.17.1 Policy**

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

#### **1.17.2 Procedure**

Nurses are in a position to support a resident in their choice of a medical practitioner or other attending health practitioner, by:

- a. assisting residents to secure the services of their own choice of medical and other health practitioners if they are unable to make their own arrangements;
- b. arranging for the attendance of another appropriate health care practitioner in the event that a medical practitioner or other health professional's assistance is required and the resident's choices are unwilling or unable to attend;
- c. respecting the relationship between the medical or other attending health care practitioner and resident (or his or her legally recognised representative); (See Protocol 1.13 on *Privacy and Confidentiality*) and
- d. providing adequate opportunity for attending medical and other health care professionals to communicate relevant information about a resident's care, or review with the nurse, the resident's care plan or assessment of the level of care provided to the resident;

Where nurses are concerned about the standard of treatment being offered a resident they should discuss it with a registered nurse (if available), then with the attending health care professional concerned, and, if necessary, with the resident and the resident's family or legally appointed representative(s).

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## **1.18 Religion**

**Based on values from the Code of Ethics,  
Especially  
The right of individuals to have their religious and cultural identity respected**

### **1.18.1 Policy**

Residents have the right to freedom of thought, conscience and religion. They share with every other member of the community the freedom to change religion or belief, and the freedom, either alone or in community with others and in public or private, to manifest religion or belief in teaching, practice, worship and observance. Residents will also have access to the priest, minister, community elder or spiritual adviser of their choice.

### **1.18.2 Procedure**

Nurses will support, within the limits of the rights of others and in accordance with the philosophy of the home, residents in the exercise of these freedoms and respect their right to hold those beliefs.

### **1.18.3 Documentation**

Information regarding the religious preferences and needs of the resident should be clearly documented and easily accessible.

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## 1.19 Culture, choice, lifestyle and independence

**Based on values from the Code of Ethics,  
Especially  
The right of individuals to have their religious and cultural identity respected**

### 1.19.1 Policy

Residents have the right to freedom of movement and association consistent with the need for safety and security (See Protocols 1.10 on *Risk-taking*, 1.11 *Care of persons living with mental illness and dementia*, and 1.12 on *Restraint*). Wherever possible, nurses will encourage and facilitate residents' safe enjoyment of their independence in living conditions, lifestyle, cultural and social activities.

### 1.19.2 Procedure

On admission, a social history is prepared of resident lifestyle choices and nurses are able to support residents in these choices by:

- a. encouraging and facilitating contact with family and friends, and participating in community and cultural activities of the resident's own choosing;
- b. recognising the rights of married people to live a married life;
- c. enabling residents to invite visitors and welcoming them;
- d. supporting the resident's privacy within the limitations of the home;
- e. making available appropriate seating to meet different needs;
- f. encouraging and facilitating joint activities with residents including those with disabilities, and activities with the wider community;
- g. accepting the resident's choice of activities in which they participate;
- h. arranging organised outings into the wider community in which residents, including those with disabilities, may choose to participate;
- i. altering the environment as required so as to facilitate interaction among residents;
- j. enabling activities in the home to be culturally appropriate;
- k. providing the opportunity for residents to change their circumstances and environment during the day, and encouraging them to do so;
- l. facilitating communication with non-English speaking residents;
- m. making accessible to residents information about current affairs and events; and
- n. if requested, residents will be assisted to organise transport.

### 1.19.3 Documentation

Documentation should reflect the choices of residents, how these will be implemented and any changes made over time.

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## **1.20 Ethical responsibilities in respect of residents' financial and legal matters**

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

### **1.20.1 Policy**

In all financial and legal matters, care is to be taken to avoid conflicts or potential conflicts of interest between the provider, staff and residents. Where such conflicts or potential conflicts arise they are to be declared to the resident or to the legally recognised representative(s) of an incompetent resident. Nurses are to be aware of and to avoid any conflict, or potential conflict, of interest in respect of residents' day to day finances or other financial and legal matters.

### **1.20.2 Procedure**

- a. In response to requests from residents or their legally recognised representative(s) to become involved with financial or legal matters, nurses are to inform the resident or their representative of the processes established in the home to deal with those matters, and to assist with access when necessary.
- b. Accountability processes should be in place for staff where they are involved in assisting residents with their day to day finances;
- c. Requests to witness wills or any other documents pertaining to the financial affairs of residents, made to nurses or other staff are to be referred to the person designated to assist in this regard. Information should also be provided to the resident or their representative(s) about seeking independent assistance.

### **1.20.3 Documentation**

Documentation should reflect any:

- a. day-to-day financial affairs of residents.
- b. requests for assistance in the making of bequests and donations.
- c. action taken to meet requests for assistance in the making of bequests and donations or other financial and legal matters.

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## 1.21 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.

### 1.21.1 Policy

Nurses should be vigilant in recognising incidents of abuse to residents. Where they have reasonable suspicion of abuse, nurses should protect the resident by reporting their suspicions or the incident of abuse to the appropriate authority, in consultation with the provider. The needs of the victim, the rights of those suspected, and the need for a just resolution for all concerned are also to be considered.

### 1.21.2 Procedures

- a. Where a nurse is concerned about abuse to a resident he or she should protect the resident by reporting to the provider knowledge of or suspicion that a resident is the subject of abuse. If the nurse is unable to make a report to the provider, or the provider does not act on the report, the nurse needs to consider reporting any suspicions or knowledge of abuse to the police.
- b. If a nurse witnesses an incident of physical violence he or she should immediately intervene to stop the incident in a way that will not likely cause harm to the nurse, other residents or further endanger the resident being harmed. Whether able to personally intervene or not, the nurse should call the police immediately.

### 1.21.3 Documentation

Nurses should document suspicions or incidents of violence or abuse and any action that they have taken. Such documentation should remain confidential and be made available only to those who need it for appropriate investigation and management, including the police, legal or other authorities.

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